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Access to out-of-hospital emergency care in Africa: Consensus conference recommendations



Accès aux soins d'urgence hors de l'hôpital en Afrique : recommandations de la Conférence de concertation

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Out-of-hospital emergency care (OHEC) should be accessible to all who require it. However, available data suggests that there are a number of barriers to such access in Africa, mainly centred around challenges in public knowledge, perception and appropriate utilisation of OHEC. Having reached consensus in 2013 on a two-tier system of African OHEC, the African Federation for Emergency Medicine (AFEM) OHEC Group sought to gain further consensus on the narrower subject of access to OHEC in Africa. The objective of this paper is to report the outputs and statements arising from the AFEM OHEC access consensus meeting held in Cape Town, South Africa in April 2015. The discussion was structured around six dimensions of access to care (i.e. awareness, availability, accessibility, accommodation, affordability and acceptability) and tackled both Tier-1 (community first responder) and Tier-2 (formal prehospital services and Emergency Medical Services) OHEC systems. In Tier-1 systems, the role of community involvement and support was emphasised, along with the importance of a first responder system acceptable to the community in which it is embedded in order to optimise access. In Tier-2 systems, the consensus group highlighted the primacy of a single toll-free emergency number, matching of Emergency Medical Services resource demand and availability through appropriate planning and the cost-free nature of Tier-2 emergency care, amongst other factors that impact accessibility. Much work is still needed in prioritising the steps and clarifying the tools and metrics that would enable the ideal of optimal access to OHEC in Africa.

Les soins d'urgence hors de l'hôpital (OHEC) devraient être accessibles à tous ceux qui en ont besoin. Cependant, les données disponibles suggèrent qu'il existe un certain nombre d'obstacles à cet accès en Afrique, qui sont principalement liés aux difficultés en termes de connaissances du public des OHEC, de leur opinion sur ces derniers ainsi que de l'utilisation des OHEC appropriée par le public. Un consensus ayant été atteint en 2013 sur un système des OHEC d'Afrique à deux niveaux, le Groupe des OHEC de la Fédération africaine pour la médecine d'urgence (AFEM) a cherché à obtenir un consensus plus large sur le sujet plus précis de l'accès aux OHEC en Afrique. L'objectif de cet article est de rapporter les résultats et les déclarations issus de la réunion de concertation sur l'accès aux OHEC de l'AFEM tenue à Cape Town en Afrique du Sud en avril 2015. La discussion était organisée selon six dimensions d'accès aux soins (à savoir la sensibilisation, la disponibilité, l'accessibilité, le logement, l'abordabilité et l'acceptabilité) et a abordé les deux systèmes d'OHEC de Niveau 1 (premier intervenant au sein de la communauté) et de Niveau 2 (services préhospitaliers formels et services médicaux d'urgence). Dans les systèmes de Niveau 1, le rôle de la participation et du soutien communautaire a été souligné, ainsi que l'importance d'un système de premier intervenant acceptable pour la communauté dans laquelle il est intégré afin d'optimiser l'accès. Dans les systèmes de Niveau 2, le groupe de concertation a souligné la primauté d'un seul numéro d'urgence gratuit, le fait de faire correspondre la demande en ressources des Services médicaux d'urgence à la disponibilité grâce à une planification appropriée, et la gratuité des soins d'urgence de Niveau 2, entre autres facteurs ayant une incidence sur l'accessibilité. Un travail poussé est encore nécessaire en matière de classement des étapes par priorité et de clarification des outils et critères qui permettraient un accès idéal et optimal aux OHEC en Afrique.

Introduction

The adoption of World Health Assembly Resolution 60.22 established a landmark health care policy tool to improve emergency care access and availability globally with its call that "...a core set of trauma and emergency care services are accessible to all people who need them."¹ In November 2013, the African Federation for Emergency Medicine's

(AFEM) Out-of-Hospital Emergency Care (OHEC) Committee, through a consensus process, described a two-tier system for African OHEC: Tier-1 being first responder and community-based, whilst Tier-2 described formal prehospital services and emergency medical services (EMS).²

Results of a recent Africa-wide EMS survey revealed that less than 9% of Africans are served by EMS, and the real number may be significantly less than 9% given multiple known barriers to accessing care.³ Two studies have specifically assessed barriers amongst African populations that impede their access to prehospital emergency care and

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transportation. Mould-Millman et al. concluded that perceptions of public ambulance services in Accra, Ghana, were generally favourable, although utilisation was low.⁴ The authors urged public health education as one intervention to help improve extremely low awareness of the toll-free medical emergency number and for education on the appropriate use of ambulances, whilst the transport and care capacity of local ambulance services were increased. These were felt to be priority pragmatic solutions to help minimise barriers to access and improve use of the EMS system. In Libreville, Gabon, investigators conducted a short oral interview of a small convenience sample of patients and visitors at a local emergency centre.⁵ Qualitative results from this study indicated that misperceptions, lack of awareness, alternative forms of transport, and cost were all barriers to accessing prehospital resources. Broccoli et al., through focus group discussions in Zambia, identified that barriers to access included the absence of emergency transportation, healthcare provider deficiencies, a lack of community knowledge, and a poor national referral system, amongst other issues.⁶

The issue of appropriate access to OHEC is critical in matching demand and provision of valuable limited Tier-1 and Tier-2 resources: over-utilisation of these resources strains OHEC systems and thwarts their effectiveness, whilst under-utilisation results in wastage and cost-ineffectiveness.

In April 2015, AFEM held a third meeting in Cape Town, South Africa that included an OHEC consensus group. Following from the consensus statement in 2013, on advocacy and development of OHEC in Africa,² the 2015 meeting focused on the narrower subject of access to OHEC in Africa. This paper's objective was to describe the process and consensus statements on access to OHEC in Africa arising from this meeting.

Process

After a set of plenary presentations on the morning of the 2015 AFEM Consensus Conference, three smaller groups broke away to focus on specific consensus discussions. One of these was the OHEC Access group comprising of ten participants with expertise in African OHEC systems. The OHEC Access consensus group discussion began with a short presentation (CS). This presentation provided background to the subject of OHEC access and reviewed relevant terminology, the Penchansky and Thomas' conceptual frameworks of access to care,⁷ and barriers to access from the scientific literature.

Prior to the Consensus Conference meeting, two of the authors (CS and NMM) constructed a table with columns derived from the five dimensions of Penchansky and Thomas'

access model (Table 1). To this, a sixth dimension, *awareness* was added which was thought to be relevant to the discussion of access, and particularly in an African context. Awareness was defined as when and how members of a community access emergency care. Grid rows were a set of discussion foci based partly on the approach used in the 2013 AFEM Consensus Conference consisting of (i) principles of access (what should be in place to ensure adequate access), (ii) development of access (what needs to be done to ensure adequate access) and (iii) any other considerations relevant to access. This access grid was used to guide the consensus discussion that took place for the remainder of the day and its use was introduced and explained as the final part of the presentation.

As was the case with the 2013 AFEM Consensus Conference, discussions in the OHEC group aimed to produce recommendations that were applicable and could improve access to existing African OHEC systems that were cost-effective, implementable, measurable and capable of being scaled-up.

The agenda for the day was divided into access recommendations for Tier-1 (first-responder/community-based) and Tier-2 (EMS/prehospital care) OHEC systems. The access grid served as a framework for the consensus discussions and resultant majority-supported recommendations. All recommendations were briefly reviewed at the end of the day for final approval by all present at the general consensus conference.

Outputs

Consensus outputs are divided into those relating to Tier-1 and Tier-2 systems, and are presented for each tier under sub-headings of the six access factors identified above.

Tier-1 (First-responder/Community-based) Systems

Awareness – A single toll-free emergency telephone number should be known by all members in the community. The working group agreed this was likely the most important principle of access related to awareness in Tier-1. In addition, there should be broader knowledge in the community concerning how and when to activate Tier-1 and Tier-2 resources. The key driver for public awareness of EMS access was seen as community education. It was suggested that conventional methods of public education about access to OHEC could be utilised, but also that communities themselves could be a source for ideas on how best to achieve public education in an effective way.

Availability – Every effort should be made to encourage community engagement and involvement in order to increase the number of available community responders. The working group acknowledged that calculating an adequate number of commu-

Table 1 Five dimensions of access to health care.⁷

Dimension	Description
Availability	The relationship of the volume and type of existing services (and resources) to the clients' volume and needs
Accessibility	The relationship between the location of supply of services (or resources) and the location of clients
Accommodation	The manner in which the services (or resources) are organised to meet the needs of clients and clients' perceptions of the appropriateness of the way services are organised
Affordability	The relationship between the cost and perceived value of services and the clients' ability to pay
Acceptability	The relationship of the clients' perceptions and attitudes towards the service (or resources) to the actual characteristics of the service, as well as to the perceptions and attitudes of providers towards certain clients

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