

The South African Academy of Family Practice's Rural Health Initiative (RHI) is proud to be able to bring you the following section of the journal, that concentrates on issues pertaining to rural health in South Africa. We seek to provoke discussion on these issues and would encourage anyone interested in rural health to offer contributions to future issues.



☀ Country Practice (Part 4) - Memoirs of the late Dr. DH Girdwood ☀ (Bedford, Eastern Cape)

The RHI presents the reflections of a rural GP, the late Dr DH Girdwood, written in his retirement a few years ago. Dr. DH Girdwood was a general practitioner who had his practice in Bedford, Eastern Cape, from 1949 until he retired in 1983. He passed away in July 2001 and permission to publish these memoirs was obtained from his son, Dr. AH Girdwood, who is a gastroenterologist practising in Pinelands. It provides a fascinating account of the experiences of a rural doctor, in the South African context. These reflections have been artificially divided into 4 parts. We welcome similar reflections on past experiences from other readers.

The black practice constituted most of my work throughout my period of practice and, although it was a heavy burden, I did enjoy it. As patients, I enjoyed their cheerfulness and humour and patience. Nutritional problems featured significantly, particularly kwashiorkor amongst babies, which often persisted despite milk being available at the municipal clinic. It occurred usually in early weaned babies left in the care of grandmothers, and responded to hospital treatment. Although treatment was necessarily prolonged, the response was certainly better than with marasmic babies, who probably suffered from total starvation as against the high carbohydrate, low protein malnutrition of the kwashiorkor babies. In older children and adults one saw many cases of pellagra, which appeared to be a manifestation of a general vitamin deficiency rather than a specific nicotinamide deficiency. A more specific deficiency was scurvy. Initially I did not recognise these cases that presented as adult men with painful calves. These seemed to occur mostly in men employed on the roads, away from their wives and responsible for their own feeding arrangements. They responded dramatically to 1 gram of ascorbic daily for 10 days.

With much of the black practice one had to deal with the impoverishment associated with unemployment and inadequate housing. This applied to

those in the village and not to the farm labourers. This was particularly so during the full spate of Verwoed apartheid legislation and Joy, as a town councillor at that stage, saw more of this than I did. The influx control law was in full operation and the hardship it caused has left its bitterness today. In a letter to my parents in February 1962 she wrote:

“At a municipal meeting we received a reply from the Bantu administrator in King William’s Town in answer to our letter asking him to visit Bedford and explain the influx control law and, if he could, suggest solutions to the problems its implementation poses. A negative reply was received from the administrator - pressure of work being the excuse. At this point a councillor, who happens to be a secretary of the Nationalist party in Bedford, said. ‘He is afraid to come; there is no solution as the law stands today.’So the problem of human suffering piles at our door.....We have 7 families who have been told to get out of the town by the Bantu representative and the magistrate.....they have already been told to get out of Cradock, Adelaide and Somerset East. They ask in all humility where must they go. When one goes to the authorities and asks them where the 7 families must go they have no answer but just reread the ordinance. So we have little groups of corrugated cardboard dwellings underneath the

mimosa trees on the exits of the town. By law if they move 100 yards per day they cannot be taken by the police.”

An interesting clinical condition I came across was the occurrence of amoebic liver abscesses in blacks who had never left the district. Amoebiasis is not supposed to occur in this district but it obviously does, as these cases without doubt were genuine amoebic liver abscesses. I probably would not have recognised them had I not worked in Durban at King Edward VIII hospital, where they were incredibly common. The first case I saw looked just like a terminal liver cirrhosis with a grossly swollen, hard liver and marked cachexia. He had come as a last resort from a neighbouring town. There was one point of marked tenderness and he had a raised white cell count. With some trepidation I pushed in a large needle and out came typical anchovy pus. He responded dramatically to repeated tappings and a course of emetine injections. I continued to see cases of this sort until I retired, about one or two a year. Later, when emetine was no longer used, metronidazole was dramatic in its effect.

I suppose we all have some rather dramatic experiences during our professional life. I think my most dramatic was when a little coloured boy of about 2 was brought to the house with stridor which had come on suddenly. I took the child up to hospital and was

about to examine him when I was suddenly called to the maternity delivery room where an arm had presented. While dealing with this I was suddenly called back urgently to the stridulous child - the airway had blocked completely. I just seized a scalpel and incised the neck - blood everywhere. I reached the trachea and made an incision into it. Air did not suck in as I hoped and prayed it would. Then I saw a bean blocking the trachea below my incision. Luckily I could hook it out and air rushed in. The wound healed without problems despite total lack of sterility and I still see this patient, now an able bodied seaman in the navy, when he visits the village and tells everyone at hand the story.

One of the most time-consuming and frustrating exercises as a district surgeon was the annual statistical and written report submitted every February. It took countless hours of preparation and, based on the number of hours spent in the year on the many different facets of one's work, so one's remuneration was determined. It always struck me as a senseless method of deciding this - where a doctor was left to judge his own worth - with the conscientious and painstaking record keeper coming short, compared with the unscrupulous. Since my retirement, this has altered. An irritating feature was that nobody seemed to read these reports or, if they did, to act on them. For example, in 1969 there appeared an excellent article in the SAMJ about the clinical syndrome of endemic syphilis appearing in a Karoo practice. I realized that I had been seeing these cases and thought that they were cases of congenital syphilis, and that this was a new syndrome as far as I was concerned. I pointed this out in my annual report that year. Some years later, this particular article in the SAMJ won the award as the best article

by a single practitioner, so its merit was recognised. However, no recognition was made of the syndrome by the health department, although I reiterated it each year and specifically notified cases occurring. In 1973 there was still no recognition of this and a further article appeared in the SAMJ, this time by Prof Scott of Bloemfontein, in which he stated that this syndrome was still unrecognised in country practice. I wrote to him and he suggested that I write to the health department, enclosing his letter to me. No reaction followed, and endemic syphilis only became notifiable in 1980.

Partnership in medical practice has many advantages and notably the possibility of proper holidays, which as far as I was concerned, were absolutely vital if one was to give of one's best. One only realized the shortcomings in the service one gave, after returning from holiday with a totally different outlook. On the other hand a partnership is not an easy relationship. My father told me that a partnership with a brother was not easy and should be avoided - wives often being the stumbling block. Wives are very conscious and concerned with disparity of workload. My uncle, Dr RL Girdwood, asked a very important question about prospective partners when a partnership was first mooted. "Is he jealous? If so, don't join forces!" I think this is a very vital question and if each partner could be free of jealousy and wives equally so, it would be plain sailing, but I should not think this happens very often. Looking back, our partnership had many good points. I became a reasonably competent anaesthetist. He became a competent surgeon, but did know his limitations, which is so important. He never tackled anything he could not cope with completely. I could never have worked

happily with a courageous GP surgeon who took on things he could not handle completely, complications and all. Charles Louw was an excellent surgeon but this aspect of him worried me. He did things when I felt a GP surgeon should not have tackled them, although I must admit they worked. We got on extremely well and he is one of my greatest friends, but I preferred Willem as a partner. I realized this on rare occasions when asked to give an anaesthetic by Charles but declined because it was not an emergency. He was fed up with me for this decision. Willem under similar circumstances went along with me completely. In any life-threatening situation, when not to operate would have been fatal, I always gave the anaesthetic, phoning up the magistrate and explaining my action beforehand. All in all our partnership was a happy one. Willem was a first rate diagnostician and I had complete confidence in him as a doctor. Instinctively we kept our distance from each other. Living in each others' pockets could have been disastrous and, since our retirement, we see more of each other than we ever did in practice, playing bridge weekly with two rather special patients, a mother and daughter; one was his patient and the other mine.

Looking back would I choose this life again? Unquestionably I would but would have liked to have been better prepared for it. My son and son-in-law with their 5 year hospital training after graduation acquired so much expertise that, with the war, I never could get and missed out a lot on that account. Of all medical practice, a country practice has been most rewarding, living in the country, having tremendous job satisfaction despite all the pressures and worries, the reward of countless friends of all ages, and being part of an enduring community. □



Caring for HIV/AIDS patients



An open letter to the Honourable Minister of Health, Dr Tshabalala-Msimang

We, the undersigned health care workers attending the annual RuDASA conference (Rural Doctors Association of Southern Africa), would like to express our extreme frustration at the circumstances under which we have to provide care to HIV positive people. We

are only too aware in rural areas of the urgency of the situation, being at the coalface of the pandemic and having to care for large numbers of very ill and dying patients. We believe that HIV infection can be transformed into a chronic, treatable illness, with a

commitment by all stakeholders.

We believe the following are essential requirements to provide the citizens of South Africa with an acceptable standard of care:

1. A clear demonstration of **political will and vision** at the highest level

- of government, including the Dept of Health.
2. **Provincial support** for HIV care, in the form of posts, appropriate budget and resource allocations. For example in Mpumalanga province there is no HIV programme director, which affects the roll out of programmes such as PMTCT.
 3. **Prevention Programmes**, namely:
 - Community education programmes regarding risk-reducing behaviour.
 - VCT available at all clinics, including rural clinics.
 - Post exposure prophylaxis for occupational exposure and sexual assault.
 - Commitment to the ongoing roll-out of the PMTCT programme in all the provinces. We would like to express our dismay at the possible de-registration of NVP.
 - Improve condom distribution programmes including female condoms.

4. An appropriate **Care Package/ Treatment Programme**

- Availability of adequate medication to treat Opportunistic Infections at all levels, including rural clinics.
- National Treatment Guidelines for the use of ARVs, similar to the National TB and STI guidelines, to be drawn up by a panel of experts and to be widely circulated.
- Training programmes to be implemented for all categories of staff, to prepare them for the use of ARVs.
- Pilot sites to be identified and capacitated with the necessary infrastructure, including lab facilities for the monitoring of ARV use.
- Provision of generic ARV drugs, starting at the pilot sites (including in rural areas) and with time to be rolled out to other sites as they meet predetermined criteria

to provide ARVs.

5. The provision of ARVs in the public sector will necessitate attention to many of the current **infrastructural problems** compromising the health care system.

As RuDASA we undertake to support pilot sites and the training of health workers and would like to commit ourselves to engage and work with stakeholders at district, provincial and national level.

As health care workers we are all committed to providing an excellent standard of care to the communities we serve. We urge you to show courage and leadership in this crucial struggle affecting our country.

(Signed by health care workers attending the 7th Annual RuDASA Conference in Worcester, August 2003. Accepted at the AGM as an official letter on behalf of RuDASA.) □



Dr Victor Fredlund: Rural Doctor of the Year



During the 7th Annual RuDASA Congress, the Rural Doctor of the Year Award was presented to Dr Victor Fredlund.

Dr Fredlund has been working at Mseleni Hospital in Northern KwaZulu-Natal since 1981 and has been Medical Superintendent there since 1985. A notable achievement has been the establishment and ongoing running of a programme of hip replacement surgery for the local community. Mseleni joint disease is a particular disabling form of destructive osteoarthritis which occurs in the Mseleni area, creating the necessity for hip replacements in many people. In view of the impossibility of getting large numbers of patients into a programme for hip replacement surgery at the tertiary referral centre in Durban (350km away), Dr Fredlund, flying in the face of conventional wisdom, established a programme of hip replacement surgery at Mseleni Hospital, a rural district hospital. A large number of patients have now been able to receive artificial hip replacements as part of that.

Dr Fredlund strives to maintain a high standard of care in the hospital, and has facilitated an ongoing programme of early morning teaching ward rounds.

In addition to his procedural skills and his ongoing involvement in clinical issues, he is actively involved in community projects including the provision of water to the community and an orphanage in the community.

In accepting the award Dr Fredlund had the following to say:

“I was reading a book on management recently in which the author said you must identify the one thing that you can do well to excel. I had problems with that, so I decided the ‘one thing’ would have to be ‘doing many things’. When the need is there and you have a skill that could benefit the people around you, you need to offer your contribution. Don’t say, ‘it’s not my responsibility’. This might involve teaching some mathematics, preparing a VIP latrine programme, facilitating a water programme, delivering babies or doing total hip arthroplasty. Fill the gap.

Training of doctors from the region is key for the development of the future services. I have a vision of Mseleni staffed by a core of local origin doctors with a mixture of shorter stay doctors

from various countries and communities. For many years we have benefited from but been too dependent on overseas trained medical staff. However the other extreme of xenophobia and only local staffing will lead to medical isolation. How much better to see the free exchange and interaction between communities. I remember one G.P. from the U.K. who told me how he had been a missionary in West Africa and had then been able to take back what he had learnt in community interaction to his general practice in the West of England in a small rural village, reinventing the extended family and community responsibility in that practice. Medicine requires the constant cross fertilisation of ideas and perspectives and a healthy mix of medical staff should be maintained in the future”.

Congratulations to a worthy winner of the Pierre Jaques Award.

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7th Annual RuDASA Conference: Skills for Rural Practice

The seventh annual Congress of the Rural Doctors Association of Southern Africa (RuDASA) was held at the Boland College in Worcester in the Western Cape, on 7th and 8th August 2003. About 180 rural doctors, other health workers and medical students gathered to discuss issues relating to rural health.

Overview

A substantial part of the programme concentrated on clinical issues of relevance to rural practitioners, assisting them to update their knowledge and skills in order to improve their practice. In addition there were some broader issues tackled such as the ethics of managing HIV/AIDS, the role of health care workers in managing partner abuse, and how to improve the quality of care in district hospitals. There was also a major workshop held under the auspices of the Rural Health Initiative (RHI) of the South African Academy of Family Practice/Primary Care, on the topic of "Home Based Care and Palliative Care". The intention is to work towards developing a programme in this particular area, as there has been a focus on this in the sites that have been sponsored by the RHI.

Policy issues

Alongside this there was a strand of the congress which focussed on policy issues, which is what will be highlighted in this brief summary. In terms of this focus, the congress was opened by Dr Joey Cupido, Chief Director of Health in the Western Cape. In his comments he noted that for any policy implementation to succeed there needs to be a clear strategy for decentralisation to provinces and districts, and a clear process of monitoring and evaluating outcomes. The focus in the 2010 planning framework that has been developed for the Western Cape is on equity in accessing quality care for all people, urban and rural.

A Rural Health Strategy

The first keynote address was given by Dr Yogan Pillay, the Chief Director for Strategic Planning in the office of the Director General, National Department of Health. He presented a rural health

strategy for South Africa. He outlined the contents of a draft document which was drawn up by a task team including RuDASA representatives, seeking comments from delegates at the congress as part of the process of developing a rural health strategy for the National Department of Health. Some of the key elements in his presentation were the following:

- a. There is an acknowledgement that rural health issues are not being tackled systematically in South Africa.
- b. There is a need for a strategy to make this happen, and to implement the good policies and plans that already exist in the Department, which somehow do not impact sufficiently on rural areas.
- c. There are a number of issues that impact on health services in rural areas such as poor health infrastructure, lack of sufficient health personnel and poor capacity in rural areas.
- d. There are a number of government-led initiatives currently taking place including the integrated rural development programme in which thirteen rural nodes have been identified as a particular focus of inter-departmental development activity. There have also been initiatives to increase the number of health care providers in rural areas, particularly the Cuban doctor programme and the community service doctor programme. Furthermore, the Department has announced an increase in rural allowances for rural doctors. The clinic upgrading and building programme improved the number of clinics available in rural areas. The hospital revitalisation programme is also having some impact, though limited, on rural hospitals.
- e. In terms of what needs to be done, the areas that were mentioned included:
 - i. developing infrastructure and support for health care professionals working in rural areas,
 - ii. facilitating foreign doctors to work in rural areas,
 - iii. increasing the number of community service health professionals who work in rural areas and ensuring that they are adequately supported,
 - iv. making sure that rural health facilities are benefiting from the revitalisation programme, and
 - v. strengthening linkages between rural health care providers and academic institutions.
- f. One of the big issues that Dr Pillay raised was how you address capacity building in a way that enables rural areas to absorb and use the resources that are made available, whether these are financial or infrastructural resources.
- g. Part of the challenge is to identify and support best practices and to make sure these are institutionalised and communicated to other areas. The focus of the strategy will be in trying to implement existing or new policies and plans in the rural development nodes, and to roll out those that work to other areas.
- h. The intention is that each province should develop a rural strategy which is linked to a national strategy.

Responses to the strategy

In the parallel session on rural health policy which followed this plenary, Professor David Sanders, Head of the School of Public Health at the University of the Western Cape, spoke of the need for a strategy as opposed to a policy on rural health. He said, "Policy is the refuge of those who are strategically destitute". In other words,

he argued that there needs to be a strategy to implement policies that already exist, thus concurring with Dr Pillay. He suggested a framework for planning comprehensive care where every disease or illness is looked at in terms of preventive, promotive, curative and rehabilitative care, and a plan is made in terms of each of these components. He suggested that the capacity to perform tasks requires responsibility on the part of those required to perform the tasks, authority being delegated to them, resources to implement them and, fundamentally, the knowledge and skills to perform the tasks. All of these are needed together.

Professor Sanders suggested that a number of key actions are vital for implementing a rural health strategy:

1. We need to implement policies that already exist.
2. We need to find and replicate existing best practices.
3. We need to facilitate local action.
4. We need to strengthen the capacity for primary health care delivery especially in the context of the comprehensive care described above.
5. The composition of the district health management team needs to be reconsidered and the district medical officer concept, where a clinician who understands comprehensive care takes a strong role in district health management, needs to be considered.
6. Community service doctors need to have better pre-service orientation, there needs to be support of these doctors from specialists on a contractual basis, and there needs to be appropriate postgraduate training for doctors in districts.
7. There needs to be strengthening of the community health worker programme and implementation of a mid level worker who can provide comprehensive care as described.
8. Finally, undergraduate training needs to be redesigned with the focus on the location of where medical students are trained.

In the same session, Professor Steve Reid, the Director of the Centre for Rural Health at the Nelson R Mandela Medical School, University of Natal, spoke about access to health care as a

key issue in rural health. He discussed the various barriers to access and the need for a strategy which looks at political, economic, social, educational and other issues in addressing access. He argued the need for evidence based advocacy for access to rural health care.

A strategy workshop

A workshop was then held on the draft rural health strategy, looking at what areas might have been left out or particularly need to be addressed by such a strategy. Approximately 30 participants, with extended experience in rural health at different levels, participated in the discussion, together with Dr Pillay as well as Dr Bennet Asia, Director for District Health Services in the National Department, who will be responsible for implementing any rural health strategy.

Some of the issues that came out of this process included the following:

1. The concept of prioritising particular programmes which can be used to improve the entire system e.g. the nutrition programme or the TB programme.
2. Hospital based specialists in secondary and tertiary hospitals should have district responsibilities as part of their job descriptions so that they are required to support district hospitals and district activities in rural areas.
3. The district hospital should be a part of the district and not separated from it.
4. A section of the strategy needs to be developed around increasing the number of students from rural areas, decentralising bursaries to districts so that they can be awarded to rural origin students, and re-orientating the focus of medical schools towards ensuring the service delivery needs are being met through their educational programmes. As part of the latter, there needs to be closer links between departments of Health and Education to ensure that there is responsiveness in health care professional training.
5. Emphasising what was mentioned by Dr Pillay, there needs to be an easing of the bureaucratic problems in recruiting foreign doctors together with a clear strategy towards

recruiting suitable foreign doctors.

6. At the same time, there need to be clear retention strategies for South African doctors, including increasing the number of community service doctor posts in rural areas, making sure the community service doctors are supported so that they are more inclined to stay, and encouraging local graduates to spend time in rural areas through various mechanisms including rural rotations as part of any specialisation.
7. There must be more undergraduate training in rural areas and rural districts. This requires support and resources.
8. There needs to be a comprehensive human resource plan and not piecemeal solutions to the problem.
9. Equity in resource allocation is an underlying necessity.

Mid-level health workers

As part of the discussion on the health strategy, a workshop was also held on mid-level medical workers, in the light of an announcement by the Minister of Health earlier in the year that such a cadre of workers would be introduced. As part of this there were inputs from Dr Rudi Thetard, who is currently working in Malawi with the Equity Project, and from Professor Jannie Hugo who has been part of a Department of Health/Health Professions Council delegation to the USA and Tanzania to look at the issue of mid-level workers. Arising from lively discussion there was a statement produced which was adopted at the annual general meeting of the Rural Doctors Association, in which delegates expressed the expectation that they would contribute to discussion and planning around such a cadre of worker (See below).

HIV/AIDS

During the conference a letter to the National Minister of Health regarding the HIV/AIDS situation was also drafted and adopted by delegates at the conference. (See below)

Rural Doctor of the Year

Another event during the Congress was

the announcement of winner of the second annual rural doctor of the year award, the Pierre Jaques Award. This is a prize given jointly by RuDASA, the South African Academy of Family Practice/Primary Care and the South African Medical Association. There were a number of excellent nominees. The committee chose Dr Victor Fredlund from Mseleni Hospital as the

winner of the Pierre Jaques Award for 2003. (See below)

The way ahead

A new committee was elected at the AGM. Dr Elma de Vries continues as chairperson and Dr John Tumbo as treasurer, with Dr Ntoden Ndumato from Limpopo province taking on the position of vice-chairperson and Dr

Hoffie Conradie (Western Cape), the conference convenor, taking on the role of secretary.

The 2004 conference will be held in Limpopo province, at a venue still to be arranged.

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RuDaSa statement on midlevel medical workers



(The following statement on midlevel medical workers was adopted at the Annual General Meeting of RuDASA during the conference in Worcester in August 2003.)

The Rural Doctors' Association of Southern Africa (RuDASA) notes the decision of the Minister of Health to establish a new category of health care workers, in the form of midlevel medical workers, to assist with the provision of health care especially in rural areas. Although we do not have enough information to make an informed response, and have not yet had sufficient discussion to achieve consensus in regard to the place of midlevel medical workers, we wish to make the following points which we believe are of critical

importance:

1. We expect to be included in discussions and planning in regard to this issue, in view of its importance for rural health care.
2. Any plan on midlevel health workers should be part of a comprehensive rural health strategy and, especially, a clear human resource plan for rural health care.
3. A team approach to addressing health care needs is fundamental and essential.
4. Second-rate care for rural people is

not an option.

5. Any midlevel worker must be part of the primary health care team and must enhance access to high quality, comprehensive primary health care, in any context, not just the rural one.

We wish to contribute positively to discussions on the place and development of midlevel medical workers, as part of the process of addressing the health care needs of rural people. We look forward to being consulted on this matter. □