RURAL HEALTH ISSUES

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 will concentrate on issues pertaining to rural health in South Africa. We hope to provoke discussion on these issues and would encourage anyone interested in rural health to offer contributions to future issues.

RHI
RURAL HEALTH INITIATIVE

FORMING A COMMUNITY WIDE NETWORK: A STORY OF A HOME-BASED CARE PROJECT.

THE STORY OF A VOLUNTEER

I met Anna Dzimbiri nine years ago when I became involved in the work of the Care Groups (an organisation teaching health prevention strategies to rural women) in the Tzaneen municipal area. She was one of the first to volunteer to work with us when we started a volunteer home-based care programme. At that stage "we" consisted of a co-ordinator from CHoiCe, a community nursing NGO (who previously trained community health workers of the farms) with four of the NGO's trainers, representatives of the Public health service from each of the five areas in the municipality and me.

Anna Dzimbiri stays in a village named Nkambako. She and five other women are volunteers in the village. I visit them from time to time and do home visits with them. I also work at the health centre three kilometres from their village. They frequently bring patients to me, we discuss problems and I arrange to visit them and the patients if necessary.

This is the story of a day in Anna's life.

It is 05h30 on a Friday morning: Anna has to go with the late Maria's children to the social worker in Nkowankowa (the township 30km away) to see if she can arrange a foster care grant for them. Maria, who died six months ago, was a single mother with four children under 18 and no near relatives. This will be the fifth time that Anna has gone with them to the social worker to resolve the matter. Unfortunately two of the children did not have birth certificates and she has had to go twice to Tzaneen, 40km away, to arrange this. The process takes longer this time than the previous occasion because the social worker she was dealing with before has resigned and she has to continue with a new social worker.

On the way to the bus stop, she stops in at Rose to ask her to give Simon his TB tablets (Simon is her DOTS patient) and to help Masasa with his breakfast (Masasa is a terminally ill AIDS patient who stays alone).

She is back by 11h00. Anna has managed to see the social worker and at last all the paper work is ready. On her way home she passes by Masasa's house to check if he had his breakfast. Anna talks to him for a few minutes, and then quickly sweeps his two-roomed house and prepares his food for later in the day, putting it next to his bed.

Anna then decides to visit Aunt Sophie, who has stage four Ca Cervix and spends most of the time in bed and in pain. Her tablets are finished, so Anna had collected some from the clinic the previous day for her.

One of Anna's children walks past and she gives him R10 to buy tinned fish, as it is long past 13h00 and too late to prepare lunch. She quickly pops in to greet granny Lea who has diabetes and high blood pressure. Granny Lea needs more support these days. She is not on speaking terms with her daughter-in-law at present.

Then Anna goes to see if Mable took her TB tablets. Mable has TB and AIDS. She is now much better but there was a time when she could not walk from her bed to the shade in front of her home. Anna used to help her wash her clothes and sweep her room. Luckily she is much better now and she has started to do her own chores.

Anna reaches home at 17h00, just in time to prepare supper. Just as she is preparing to go to bed at 19h30, there is a frantic knock at the door. Susan's mother-in-law (from the street below) is very ill and they need Anna's help. When she arrives, it seems as though the old lady has had a stroke. She is semi-conscious and cannot move her right arm and leg. Anna offers to go and phone the ambulance from the public phone. She stays with the family until the ambulance arrives at 22h30. Anna is exhausted when she gets into her bed at last – what a day, what an evening!

There are almost 200 volunteers like Anna working in 50 of the 80 villages in the Tzaneen municipal area.

The home-based care programme

Tzaneen lies in the eastern part of the Limpopo Province. The municipal area has a population of 340, 000. The prevalence for HIV positivity in the anonymous antenatal survey of 2000 conducted in the Limpopo Province was 11.5%. It is estimated that there could be around 38 000 people who are HIV positive in the municipality.

The Tzaneen AIDS Committee was formed during an AIDS Workshop that was held in 1998 to establish the extent of AIDS-related activities in the district. The committee consisted of Department of Health (DOH) representatives from each of the five local service areas, NGO's in the area, and other government departments such as education and police. A task team was established to take the initiative in implementing a project for the support of AIDS patients. A partnership was established between the Department of Health and CHoiCe (an NGO which formerly trained health workers for the farms in the area).

A DOH representative from each of the five local service areas and one trainer from CHoiCe formed the core of the teams in each of the local areas. These teams identified volunteers for the home-based care project in their local areas through community meetings.

The task team developed a curriculum to train the volunteers. The co-ordinator from CHoiCe also participated later in the development of the national curriculum for home-based care volunteers. Each year since 1999, a number of volunteers have been identified and trained.

The local area co-ordinators (one from the DOH and one from CHoiCe) facilitate monthly meetings with the different groups of volunteers at their local clinic. The clinic nurses are also involved in these meetings. The purpose of these meetings is to liase with the professional nurses at the clinics, to report on the sick people the volunteers have visited, to debrief the volunteers and to support and motivate them in their work. The co-ordinators also visit problem patients with the volunteers.

The volunteers are supplied with a T-shirt which has the caregiver logo printed onto it. This serves as their uniform. They are also provided with an identification card and a treatment box with items to assist with emergencies at patients' homes such as cleaning (gloves, jik, soap), oral rehydration ingredients and material for attending to wounds and sores. Training was provided regarding the utilisation of the contents prior to the distribution.

Food parcels are available to distribute to patients who are exceptionally needy.

A general meeting is held every two months between the co-ordinators from the five local areas, health managers, other NGO's, churches, the private sector and government departments

The home-based care programme runs concurrently with the community-based DOTS programme that trains volunteers to support TB patients to take their treatment daily. The home-based care volunteers support all patients with chronic and terminal illness for the following reasons:

- The stigma attached to AIDS.
- Many patients do not disclose their status to the volunteers.
- Others are unwilling to have their status disclosed to people in their communities.
- It would be unethical for health workers to disclose the names of HIV positive patients to volunteers without permission from the patient and family.

Presently the volunteer training consists of a number of modules. The aim is to take each volunteer through a 59-day training course over a two-year period to complete the full national training course for home-based care volunteers. The training is done by the two co-ordinators in each local area. The course consists of the following modules:

- A five-day introduction to home-based care (which we call the "Hope" course.) The focus of this training is to change attitudes and focus on hope.
- The 4-day DOTS course
- A 3-day basic first aid module
- 10-day home nursing programme
- 10-day lay counselling course.

The remaining days are covered in one-day monthly in-service training sessions.

Since last year a volunteer co-ordinator was selected from the existing volunteers to work with the other two co-ordinators. She has a mobile phone at their disposal. Her main function is to liase between the NGO and DOH co-ordinators and the volunteers.

Costs involved

CHoiCe funds this project through a grant from the National Department of Health and funds from the Rural Health Initiative (of the SA Academy of Family Practice/Primary Care). The main expenses are the travelling costs of the co-ordinators, refreshments at the monthly meetings, cost of food-parcels, treatment boxes, refilling the treatment box supplies and the training costs. Up to this point in time the volunteers have not received a stipend or salary. It is an area that is receiving attention.

It this project reproducible?

The essential ingredients of a successful home-based care partnership are the following:

1. A dedicated project co-ordinator(s) with a clear vision and lots of perseverance. He/she can be either from the DOH or the NGO.
2. An active NGO: the NGO is essential to channel funds and assist with transport.
3. Funds for training, transport, food-parcels and incentives for volunteers.

My opinion is that without these it would not be easy to reproduce this model elsewhere.

Acknowledgements:

I wish to acknowledge the whole CHoiCe team and all the home-based care volunteers in the Tzaneen Home Based Care Project. I would also like to acknowledge especially Colleen Jackson with whom I worked closely in the home-based care project and who critically reviewed this article.

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THOUGHTS AFTER THE 6TH RUDASA CONGRESS: THE LIVELY BEAT OF DRUMS IN THE MISTY MOUNTAINS OF SABIE

Art is long and time is fleeting
and our hearts, though strong and brave
still, like muffled drums, are beating
funeral marches to the grave.
H.W.Longfellow (1807-1882)

The annual RuDASA conference has been the highlight of the year for rural doctors since the first one in 1997. This year was no exception. The programme was varied, the speakers challenging and the discussions lively. As always, the best part was meeting the 'brave hearts' from all over, who despite overwhelming odds, are dreaming up new ways of meeting the challenges of rural health. Louis Jenkins said: "The other conference attendants positively encouraged me away from my growing pessimistic view of South African public medicine, and gave me new hope for the heart and soul of this big machine we find ourselves in."

At the Home Based Care Workshop, Gert Marincowitz and Clare Murphy described how two very different communities were responding to the AIDS disaster. The discussions that followed got heated at times around issues such as the ethics of using 'hungry volunteers', the cost of care and whether we needed more 'crazies' to get things moving. Clare mentioned the importance of a document clearly setting out the 'Commitment and Understanding' of all involved. When all is said and done, it could be asked whether we are playing on the wrong drum. Education and awareness have failed, hospitals are failing and public servants, who should be leading, are with one voice making excuses and hoping the NGOs will do all the work. Countries like Brazil and Thailand have abandoned Home Based Care for active treatment with Anti-Retroviral Drugs. Liz Thompson did a very lively report on the Barcelona AIDS conference, where the main theme was treatment of HIV. ("Muffled drums are beating"?)

Prof Thanyani Mariba, Dean of the Faculty of Health Sciences at Pretoria University, presented some innovative ideas about how to improve the recruitment and retention of doctors in rural areas. Interventions are needed at different levels, starting with the targeting of high school students in rural areas to consider careers in the health sciences, plus recruiting more students of rural origin. More bursaries are needed, linked to a contract of working in a rural area after graduation. He said that medical schools should take responsibility for educating appropriately skilled doctors. It is difficult for students trained in academic hospitals - where they could easily refer to a specialist - to function in a rural setting where they suddenly have to be the ones that have to solve any type of problem. Prof Mariba continued to highlight incentives to attract health professionals to rural hospitals. Apart from monetary incentives, there are other options, e.g. subsidised accommodation, tax rebates, increased leave days and a supportive working environment. He also mentioned the challenge for rural doctors to find employment for their spouses. One can only hope his ideas will reach the ears of the authorities before it's too late. He warned that, unless there is co-ordination, we will end up with many horses trying to pull one cart in different directions. The result will be much effort and a broken cart.

Dave McCoy outlined the complexities and future planning around the much heralded and little seen District Health System. He explained the relationship between municipal and district structures. Devolution is essential but hazardous. Instead of increased efficiency, accountability and collaboration, we may end up with more fragmentation, bureaucracy, inequity and the capture of the system by a self-indulgent elite.

The session on Lot Quality Assurance Sampling by Bernhard Gaede was thoroughly enjoyable. It placed the theme of patient care in the context of budget concerns into perspective. Quality of care is a complex interaction of both objective and subjective components, and a variety of approaches are needed to obtain an integrated assessment. The Lot Quality Assurance Sample method uses a small random sample of in-patient notes in order to assess whether objective targets for the

quality of care have been reached. The targets are based on indicators developed by different sections (medical, nursing, pharmacy and administration).

Several presentations focused on the skills needed by a rural doctor. These will contribute to the development of a diploma in rural medicine by Steve Reid of the Nelson R Mandela Medical School in Durban.

The conference was also attended by health professionals other than doctors and the program included presentations on the integration of traditional healers into primary health care, exploring indigenous health knowledge, culturally congruent care and the challenges of cross-cultural care.

A highlight of the conference was the handing over of the Pierre Jaques Award for Rural Doctor of the Year to Dr. Thys von Mollendorff. This was done in recognition of his years of service as a rural practitioner who had always been available to teach the junior doctors, and his commitment to putting patients first, even in the face of political interference. This will become an annual award, and is a partnership between RuDASA, the SA Academy of Family Practice/Primary Care and SAMA.

Despite an invitation to speak at the conference as well as numerous phone calls, the Provincial Department of Health was conspicuous in its absence. One of the Mpumalanga delegates mentioned that this was an example of how much co-operation health workers in Mpumalanga received from the Provincial Department.

It seems that working in a rural area needs a brave, stout heart not a muffled drum!

We would like to thank Andrew Cumberlege and his team for a well organised and stimulating 6th Conference. The 2003 Conference will take place during August at Worcester in the Western Cape, and will be linked to the Academy of Family Practice National Congress.

Compiled by Louis Jenkins, David Cameron and Elma de Vries

WINNING STORIES FROM RURAL HEALTH WORKERS

A few years back the Medical School sent out one of their senior anaesthetist who was semi-retired, to visit our rural hospital in order to teach us how to do it. His patronising attitude during his introductory lecture to the five of us, made us feel incompetent and irritated, so when we were told that a patient with an ectopic came in mid-morning, we seized the opportunity to learn first-hand practical tips from this fount of academic excellence. When we got to our humble theatre, we could see that he was somewhat disconcerted by the green painted walls, the WWII operating table, and particularly by the absence of a cardiac monitor, which was in the process of being fixed for the previous two years. He insisted that a junior nurse stand next to the patient and say a "beep" every time she felt the pulse. This pleased our eminent visitor, who set about drawing up the induction drugs in an irritatingly pompous way, as if we had never done anything like it before.
Finally, the patient was asleep and the operation was under way. Just as we were all settling down, the associate Professor suddenly realized that the beeping had stopped. "Where is the cardiac monitor?" he demanded. To which came the reply, which subsequently became a quotable quote: "She's gone to the toilet".

Steve Reid

I'm from one of the Rural Hospitals, which was having some specialties like – Internal Medicine, Obstetrics and Gynaecology, Orthopaedics, Paediatrics etc.

One day two men in one village took some anti-psychotic drugs belonging to one psychotic patient at home (their cousin). They took these drugs with the idea that they will become euphoric and drunk. Instead they became, disturbed in autonomic and muscular activity function, with body cramps and pains, especially at the back of the neck (torticollis). These two guys went to hospital and separated themselves into different sections:
Man A – went to the Internal Medicine Department;
Man B – went to the Orthopaedics Department.

The Internal Medicine medical officer, realized that Man A – had taken antipsychotics and gave him an antidote and he got well. The Orthopaedic medical officer, gave man B a neck collar, and he remained in pain.

When the two men met again, one well and the other still the same, – they asked why this had happened? "Doctors must not treat what they are not sure of" they concluded.

MB Vamela

I was doing research at Mbilane, which is in a rural area falling under a tribal leader. I was studying Primary Health Care. I was entering the homesteads to talk to the people there and ask about their problems. I also had to look and study their way of living.

In one of the homesteads, I requested to see their toilet, because my intention was to teach them about the VIP toilets. The toilet was built up with corrugated iron and wood sheets. The toilet seat was closed. Inside the toilet itself was a big three-legged pot, legs pushed down into the ground and the lid was put upside down. Inside the pot there were a number of valuables e.g. ID documents, money, birth certificates for children.

The old lady said they keep these valuables there because thieves have never, and will never, go to the toilet during a housebreak, but will go into the house. She said they use the veld as a toilet. She said they had been successfully practising this method of a "pot in a toilet" for more than 15 years now.

It was an interesting research.

I gave them health education on diseases due to pollution and the importance of having a VIP toilet - in reality!

Themba Dlomo

2003 RUDASA Committee

Lunch

Marietjie de Villiers delivering a National Women's Day address

Dr Pierre Jaques and his wife

Early morning near Graskop

Relaxation

Authors of winning stories

Thys von Mollendorff being handed the Pierre Jaques Rural Doctor of the Year award by Ian Couper