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

RIVER DOC – A CASE PRESENTATION

At 6am a concerned Mother phoned requesting that I see her 22 year old son who had been ill, seen by several doctors and was not getting better. She explained that a malaria test done on Saturday had been negative and he had been sent home on antibiotics (doxycycline) for tick bite fever. I had seen Rupert once before at my rooms, about 2 years ago, when a gum pole timber had fallen on his back, fracturing traverse processes of L3 and L4. I told Mom to come in immediately as I knew this kid was no whinger.

I strolled down to the surgery a little early to collect my thoughts, read his file and get a test kit out. My wife, as usual the faithful unpaid assistant, was there to handle all the odd jobs – allowing me to focus on the medical job at hand. Rupert walked in, sick, head low. Pale as opposed to his usual tan. A tinge of jaundice.

Friday, ten days ago, he had been sick on the river near Tugela Drift – A cholera/typhoid area. He had no diarrhoea – Cholera excluded. He had thought alcohol had been the cause as he had felt well again on Saturday. Sunday he was a lot worse. Monday well, so went home to Sodwana. Tuesday he had a temperature of 41°C, taken by a paramedic and was rushed by Medical Rescue International to a doctor where he was treated for flu, as the Malaria test taken was negative. Wednesday better. Thursday he had fever again like on Tuesday. Friday better. Saturday early morning he was sick again and phoned Mom. Despite treatment he felt no better and now was vomiting "black stuff". Generalised muscle pains and crawling skin. Malaria as a diagnosis screamed out but with the many cases I'd seen before (mainly in Bindura, Zimbabwe) such a clear 48hr cycle was unusual.

On examination the following features noted. The 9-stick urine result, urobilinogen ++++. Pallor, tinge of jaundice, mild dehydration and good vital signs. This surprised me as falciparum of this duration usually had the non-immune patient in severe trouble. Temperature 38°C. No hepatosplenomegaly. Maybe the doxycycline had helped. The spleen I was sure to find on scan. On the scan a mild splenomegaly substantiated the diagnosis.

I called the professional sister, who lives on the surgery premises, as I wanted her to see the signs and know the symptoms of classical malaria. She often covered for me on her own, as locums in rural solo country practice are something of the past. We would now confirm diagnosis on one of the better test kits.

The test was NEGATIVE. I was so sure. Unlikely test faulty. More likely it was vivax or ovale. Typhoid must be considered. He certainly must be admitted to a major hospital. My excellent staff kicked into gear. I spoke directly to the casualty officer.

Rupert had VIVAX! My first case in my practice in the Natal Midlands. He spent about 5 days in hospital. I spoke to the physician that I refer to and he asked me to ensure Rupert take a 14 day course of primaquine phosphate. Speaking to his Mom, he was told by a local pharmacy the drug is unavailable in South Africa, so to date he had not taken prophylaxis against recurrence. My staff organised for the medication to be imported as a matter of urgency.

In conclusion I personally have noted the following points with regard to malaria:

- It is preventable by reducing bites and appropriate chemoprophylaxis. A myth that one should not use prophylactic medication is still common.
- Malaria especially falciparum is a medical emergency. 1:100 non-immune people will die even in the best centers; 1:5 due to cerebral malaria.
- Splenectomy, infants and pregnancy carry a high risk
- Don't forget to look for associations of importance: G6PD deficiency, epilepsy, porphyria, psoriasis, pilots, concurrent cardiac medication.
- Unexplained febrile illness – always take a travel history
- Follow up patients who have had malaria
- I have since learned that over the past three years the incidence of vivax and ovale malaria has increased to 5% of all malaria cases in South Africa.
- Trust your clinical findings and understand the significance of test results.

Lawrence Archer
Natal

ARRWAG CONFERENCE: "COMPETITION FOR GPS"

I was privileged to be one of the keynote speakers at the Third Conference of the Australian Rural and Remote Workforce Agencies Group conference in Adelaide, South Australia, 22nd – 25th April 2002. ARRWAG is a body funded by the Commonwealth (federal) government to co-ordinate the activities of the workforce agencies which exist in each state in Australia, with the specific task of recruiting health professionals for rural and remote areas, and supporting them once they are there. Its other roles include advocacy on behalf of the individual rural workforce agencies, contributing to national policy development, and supporting quality research to ensure appropriate data is available.

The other international keynote speakers at the conference were Dr John Wynn-Jones from the Institute of Rural Health in Wales and Prof. Steve Reid from the Nelson R. Mandela School of Medicine at Natal University. The challenge the 3 of us jointly presented to the conference was to consider an ethical recruitment policy which moves away from a reliance on overseas-trained doctors (OTD's). At present Australia trains 1200 doctors and employs a further 250 OTD's annually. We addressed the need for global responsibility, social justice and equity, to balance the rights and autonomy of individuals and nations, and the national responsibility of any country to train sufficient health workers for its own needs. The message was heard clearly and much debate was stimulated. This was certainly one reason that the issue gained prominence at the subsequent 5th World Rural Health conference in Melbourne.

Another keynote address was delivered by Dr Greg Down, chairman of ARRWAG. He discussed a survey amongst medical students in Australia which indicated that, while many are prepared to go to rural areas, very few are willing to consider going for longer than 5 years i.e. they are ready to go but not to stay. Furthermore, workforce data indicates an increasing trend amongst rural GPs of both sexes to do more part-time work, to work in groups rather than in solo practices, to want employment for spouses, and to avoid on-call duties; these changes all have major implications for workforce planning.

There were many other workforce issues discussed by the Australian speakers at the conference. I will highlight a few.

Dr Helen Tolhurst, describing a major government-funded research project on women in the rural medical workforce, indicated that despite feminisation of the general medical workforce and the medical student population, only 25% of rural and remote GP's in Australia are women.

Dr Lara Wieland, a Queensland GP, presented a model of practice where 2 doctors share one job in a remote aboriginal community, each flying in to spend 2 weeks per month there, overlapping for one day only. This highlighted the importance of flexibility – changing the job to suit the person rather than the person to suit the job.

Ms Pat Anderson, Chairperson of the National Aboriginal Community-controlled Health Organisation in Australia described the difficulties many doctors find working in community-controlled health services, because doctors are used to being in control, and to getting things done their own way.

Dr Roger Sexton described the "Dr. Doc" programme in South Australia, which seeks to provide health care for rural doctors. This arose out of a survey looking at the health of rural doctors, which highlighted many problems.

Dr Jane Greacen, CEO of the Rural Workforce Agency of Victoria, explained the assessment and support of Australian residents who were trained overseas and the challenges this presents. The process is clearly aimed at achieving a level of clinical competence to allow unsupervised rural practice in Victoria.

Ms Lynne Pezzullo, an economist, provided a model for estimating workforce needs based on a regression analysis. The data she presented suggest that Australia will need between 500 and 2000 new GP's per annum over the next 15 years. Where will these come from? This, together with the figure provided by Dr Wynn-Jones that the UK is expected to need 16 000 new doctors over the next 5 years to cope with increased health expenditure, brings us back to the need for regulation of international recruitment drives.

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"RIVONIA STAFF VISIT THE RHI TEAM AT ELLISRAS HOSPITAL-LIMPOPO PROVINCE"

Recently Ms Lucille Pick and Ms Penny Bryce did a whirlwind tour of the RHI sites in Limpopo Province, to evaluate the progress of the projects and to offer assistance where possible. Pictured here (from left to right) are: Johanna Nong, Peter Masango, Annikie Maluleka, Lucille Pick, Herman Sebolo, "Dr Charles" Kyeyune (superintendent), Martha Putuka, Penny Bryce and Maria Ntuli the RHI team at Ellisras Hospital.

"RHI VISIT TO TAUNG HOSPITAL"

A visit was also made by Penny Bryce to Taung Hospital, Northwest Province, where a meeting was held with several of the local support and care groups, who provide immeasurable service and assistance to the community, as volunteer groups. Also present were hospital staff and members of the Department of Health, who work with the groups and the community. The visit was hosted by Dr Philemon Mahuma (pictured second from the left), who is the new RHI facilitator, having taken over from Dr di Mattia.