

# 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.



## WONCA 5TH WORLD CONFERENCE ON RURAL HEALTH, MELBOURNE

The theme of the conference was "Working together – communities, professionals, services", and it was attended by delegates from 28 countries.

### CONFERENCE OVERVIEW

The delegates from South Africa reflected a spirit of co-operation – apart from the doctors, there were also nurses, physio's and a social worker who presented papers. The delegates hope to meet again at the RuDASA Conference at Sabie, 9-11 August 2002.

#### Rural Health and Social Justice

A significant theme was the role of rural health professionals in issues of social justice in their respective communities and countries. Numerous presentations explored this theme which was most lucidly enunciated by two plenary speakers, Prof. Florence Manguyu, a paediatrician from Kenya, and Dr MK Rajakumar from Malaysia. Both of them clearly highlighted the burden of disease falling on the poorest countries and people, particularly in rural areas and particularly on women and children.

Manguyu said that every minute 350 women fall pregnant around the globe, 190 of those are unwanted pregnancies, 110 will have complications during pregnancy, 40 an unsafe abortion, and every minute one woman dies from complications related to the pregnancy. She highlighted three aspects that need attention in order to improve women's health in developing countries: access to contraception, education for girls and increasing the social status of women.

Rajakumar asked whether we as doctors have a special responsibility to act on poverty and inequity. He suggested that "there is a collective consensus

among every one of our associations that we do have a special responsibility, but individually we are trapped in a world whose only currency is money."

He believes that rural physicians have the temperament and character, the knowledge and skills, to help other rural people, and said: "We naturally belong with those people who are struggling to build a better world." He challenged every department of Primary Health Care/Family Medicine to have a strategy for helping poor people.

In a riveting address, Dr Helen Caldicott drew us into the huge threat of nuclear war, which remains real and alive in view of the ageing Soviet nuclear infrastructure, the American defence systems already in place, and the likelihood of rogue attacks from smaller groups using nuclear weapons following the September 11 tragedy. She said that we work so hard to cure our patients, but if nuclear war breaks out, it will all be in vain.

Prof. Roger Rosenblatt from Seattle reminded us that the WONCA symbol is the earth. He started his talk with a case study of the earth as a patient with fever (global warming), asthma (air pollution), alopecia (deforestation), thrush (loss of biodiversity) and scabies (overpopulation, because half the world's women do not have access to contraception). He called on the delegates to adapt an ecological perspective and to play our part in rural areas, thinking and acting locally in terms of environmental sustainability.

It was exciting to see that the rural health movement is seeking to engage in much wider issues than the practice of medicine in rural areas.

#### Aboriginal Health

There was a significant input from Australian Aboriginal people and sessions were often started with acknowledgements to the original owners of the land. An Aboriginal woman, Pat Anderson, quoted Steve Biko when she spoke about family violence in Aboriginal communities:

"The logic behind white domination is to prepare the black man for the subservient role in this country ... reduced to an obliging shell, he looks with awe at the white power structure and accepts what he regards as the 'inevitable position'. Deep inside his anger mounts, but he vents it in the wrong direction - against his fellow man in the township ..."

She explained that when people have been oppressed, feelings of powerlessness lead to frustration and anger. This leads to violence that is not directed at the oppressors, but is turned inward to the family, community and the self. The violence against the self includes alcohol and substance abuse. Some people say "It is my body, I will do with it what I want," as if their area of control ends at their skin.

Her presentation produced many such parallels to the situation in the numerous poor communities in South Africa where frustration often leads to child abuse and family violence. Anderson suggested that improved education and health care, within a system that empowers people to make their own decisions, is part of the solution.

#### Innovative education

An exciting development in rural medical education is rural based medical schools. Case studies from Australia, Canada, New Zealand and the Philippines were presented. It was mooted that medical schools should



reflect local socio-economic and political realities, and should be "socially responsible". At these schools the emphasis is on problem-based learning and community-based education, with a significant part of the training taking place in the community under guidance of GP's.

### Medical students

There was an enthusiastic delegation of medical students at the conference. At medical schools in Australia, rural student clubs provide peer group support for rural origin students, and encourage students to consider a career in rural health. They have a passion for rural and remote Australia. The government provides funding for the rural clubs, and academic staff support them. In South Africa, only UCT and UNITRA's medical schools currently have rural clubs (called the "Rural Support Network"). It is planned to expand them to have clubs at each South African medical school.

### Gender and health

Presentations on gender and health varied from focusing on women's health issues, to research about the needs of rural women doctors. Since more than half of medical students are female, the Australian government recognises the importance of making rural practice attractive to women doctors and research grants are provided to study this topic. Jo Wainer, a sociologist from Monash Medical School, Australia, concluded one paper as follows:

"Women live complex, multi-factorial lives and weave a delicate dance between their professional and intimate selves. They are attracted to rural practice by the challenges and autonomy of rural medical practice, by the beauty and safety of the rural environment. Substantial structural change to rural practice will be required to support and nurture these women, who will be the backbone of rural practice in the near future."

Discussions focused around women doctors' need for flexibility and the opportunity for them to spend less time working after-hours. An important issue that often arose was the view that women doctors did not always feel appreciated and valued by their colleagues for the work they did.

### On call: the effect on the children of Family Physicians

A fascinating study was undertaken in Alberta, Canada, by Dr. Ron Gorsche. Children of rural family physicians were asked to complete questionnaires on whether the need for a parent to do calls had any impact that their lives. The primary effect identified was feelings of abandonment and loss, with 57% of the children indicating that their parent had missed an important event in the past six months due to being on call. Other major effects of calls upon the lives of the children included disruptions and inability to plan things, or an inability to carry out those plans, sleep deprivation, altered moods and a fear of being alone.

The children described a transitional period surrounding the on-call period. This "On-Call Syndrome" restricts activity and social events the day prior to a call, means an absence of the parent, and any recreation, on the day of the call, and is followed by the parent being 'major grumpy', tired and non-communicative on the day following call. The to catch up on sleep and chores extends to the second day post call. Then, for most families, the process starts all over again. Recreation, leisure time, travel and transportation opportunities for the child are influenced by the primacy of the on-call schedule. Cancellations, failure to attend or arriving late at events, all cause embarrassment and contribute to the child's sense of playing 'second fiddle' and interfere with both parent and peer relationships.

### Working together in a team

Dr Michael Boland from the UK spoke about generalists being different from other health professionals, in that we see patients with a variety of conditions. In the UK, GP's deal with 96% of problems, and refer 4% to a specialist. He estimates that a nurse practitioner can deal with 67% of the problems, referring only 33% to the GP.

### Melbourne Manifesto

The Melbourne Manifesto was adopted at the conference as a code of practice for the international recruitment of health professionals. The background to the Manifesto is recruitment of health care professionals (HCP's) from poorer countries by wealthier coun-

tries to their own rural and under-served areas. This is done in lieu of training sufficient numbers of HCP's in their own countries. It leads to a drain of highly trained professionals away from the countries that can least afford to lose them. The effects are impacting negatively on the already seriously under-resourced health systems and, as a result, the health status of developing countries. The Manifesto recognises that the development of an ethical code should balance the rights of individuals to emigrate against the needs of communities. An important principle is the responsibility of each country to ensure that it produces sufficient numbers of HCP's for its own current and future needs; retains them; and plans for both rural and urban areas. Countries should ensure that the working conditions and educational opportunities in their own countries are sufficient to encourage HCP's to work in areas of need. A "memorandum of understanding" between governments is suggested, with clear guidelines on recruitment and exchange programs.

Delegates came away from Melbourne with a deepened appreciation of the role rural health professionals have in the communities that they serve and in the world which we all share. The conference crystallised the implicit values of social justice and a commitment to the underserved and disadvantaged, equally strongly in developed as in developing countries.

*Elma de Vries and Steve Reid*

## RURAL RECRUITMENT

I attended many of the presentations on rural recruitment. All of the **Australian and Canadian models seemed to start with:**

1. Government recognizing that rural recruitment and retention was a problem
2. Government commitment to fund potential solutions to the recruitment problems (with bursaries and scholarships, incentives, funding of rural health clubs etc.)
3. University commitment to increase the number of rural students accepted into their facilities
4. University outreach programs to



encourage scholars in rural areas to consider a career in health, with a particular emphasis on rural and remote health care.

Non of the models presented were starting from the rural service providers (which is where we are starting from with the Mosvold project)-with us promoting health sciences as a career option in the local schools, looking for suitable scholars, places at university, funding, support for students etc.

However, I was struck by the fact that for any recruitment program to be a success, there need to be a number of "joined up" activities which include the following:

1. Promotion at rural schools of career possibilities in the health sciences
2. Reserved allocation / quota of places at training institutions for rural origin students
3. Financial support for rural origin students with a "workback" commitment
4. Support for students at university (Rural health clubs)
5. Appropriate rural exposure in curriculum
6. Suitable placements for internship
7. Decentralized, rurally based, accessible, post-graduate training programs
8. Attention to factors that facilitate the retention of staff (housing, adequate facilities, support, career opportunities for spouses etc)

We need to continue to lobby for political support for rural health issues, for provincial bursaries linked to rural districts, and for rural quotas at universities.

Andrew Ross

## THE WHO-WONCA CONSULTATION

One of the pre-conference meetings was the WHO-WONCA Co-Sponsored Invitational Consultation with the title "Health for all Rural People". A group of 80 invited delegates from around the world met for 3 days at Traralgon, 2 hour's drive from Melbourne, one of the sites of the Monash University School of Rural Health. Charles Boelen, previously of the WHO, teamed up with the

WONCA Working Party on Rural Practice in the preparation for the consultation. The workshop aimed to produce an action plan based on the Durban Declaration, in order to put into practice the policies and ideals that have been so eloquently written. Drawing on the experiences of 18 case studies, the expert facilitators helped the group to develop workable models and recommendations for implementation in different settings around the world. The role of the rural family doctor was highlighted as expected, but the crucial role of community ownership of health initiatives was given even greater prominence: it was clear to participants that projects and programmes succeed when they are community driven. A document was produced aimed at convincing five key players of the need for rural health projects: policy makers, health managers, health professionals, academic institutions and communities. It is expected that, being a WHO document and process, this will assist in getting a number of projects off the ground in different countries.

Steve Reid

## "THINGS IS CROOK\* IN D'BUSH"

(\*crook = Australian slang for unwell/unhealthy)

### Report on the Murray River Pre-conference

Health care in many rural areas in Australia is on the decline. The "superdoc" of yesteryear, who could cope with anything and do everything, who worked long hours and who was prepared to stay for a lifetime, is rapidly disappearing.

"Future doc" has different plans and expectations. She/he would like flexible hours, time for the family, less procedures, less after hours work, a supportive network of family and colleagues to share the load.

When the kids reach secondary school, it is time to pack up and move back to the city again.

The dilemma that faces the Australian health authorities is whether to train more local doctors or open the doors to more overseas trained doctors (OTD's). The first option is costly and

slow with no guarantee that they will be willing to go to the rural areas. The second option is quick and "cheap", but risky. Although they can be forced to work in under-serviced areas, OTD's need careful accreditation, supervision and support. Some would also question the ethics and the wisdom of relying on attracting doctors from foreign countries, especially those from the less developed world.

A third option is to look at the way doctors are trained. Are teaching hospitals "toxic" to medical students, especially those who may have thoughts of working as primary care doctors? Paul Worley and his team from Flinders Medical School in Adelaide, in partnership with the local GPs, community and health authorities of the Riverland, a farming area along the Murray River 150 km north of Adelaide, have developed just such an alternative option.

Selected medical students spend the whole of their penultimate year working in an attachment scheme with GP's of the area. At the end of the year these students take the same exam as their classmates who have stayed in the city doing the usual rotations through specialist departments. Paul and his team have been able to show that this rural do as well, if not better than their city counterparts and many of them make rural general practice their career choice.

Such community based medical education schemes need a network of enthusiastic role players. Like a fragile ecosystem, each is dependent on the goodwill and co-operation of the other. Gradually the medical ecosystem of the Riverland is being restored.

Although this system of community based medical education is unique and heavily dependent on the unique geography of the area, the principles learnt could be used to develop similar alternatives in many other areas in the world. Working closely with a suitable role model, having one's learning stimulated by actual patients seen in the community setting rather than a tertiary hospital, experiencing continuity of care by closely observing the gradual evolution of common illnesses, can be achieved in many settings.

David Cameron