

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.



We are devoting this issue to a report on the Fourth WONCA World Rural Health Congress and a short introduction to what RHI can do for you!

REPORT ON THE FOURTH WORLD RURAL HEALTH CONGRESS CALGARY, CANADA, 16-19 AUGUST 2000

This conference was the fourth in a series of international conferences on Rural Health, the second such conference having been held here in Durban, South Africa in 1997. The World Organization of Family Doctors (WONCA) has supported a Working Party on Rural Practice, chaired by Prof Roger Strasser of Australia, and this group has taken responsibility for not only organizing this annual conference, but also drawing up and disseminating policy documents on rural health.

The Australians have been in the forefront of many developments in rural health, with significant national and state funding for various programmes. Canada has produced a number of progressive initiatives, and the USA has also developed federal programmes for rural health issues, but have not contributed to the WONCA group as much as expected. Amongst the developing countries, Pakistan, South Africa, India and Nepal have been active in this group.

And so it was now the Canadians' turn to host the conference, and this was appropriate to their commitment to the movement. The conference venue, a downtown hotel in Calgary, as always lead to comments on the irony of holding a conference on rural health in such an urban setting. This was

somewhat alleviated by the proximity of the Canadian Rocky Mountains, which many delegates visited after the conference. After 5 days in conference rooms with no windows, this was a welcome breath of fresh air!

The conference was opened by the Federal Minister of Health of Canada, Mr Alan Rock, who showed his familiarity with the issues of rural health: access to care, retention of professionals, accountability, and the place of the new technologies to support and enhance health care of high quality. He also spoke of the need for research into rural health issues, including indicators that would be useful for monitoring. Health Canada has established a Federal Office of Rural Health, and broadened the Medical Research Council to the Canadian Institutes of Health Research, which include rural sites. It was encouraging to hear a national minister speak with such commitment, and report on the steps they have taken about the issues which are of most concern to rural practitioners: if this was the case in South Africa, we might be in a better position!

The authors attended the following presentations, although as always, there were many more that ran concurrently, that would have been fascinating as well.

- **Increasing the supply and retention of rural primary care physicians: outcomes and critical factors of the 25 year old Physician Shortage Area Program (PSAP)**
– Prof Howard Rabinowitz, USA

This keynote presentation had as its central thesis that the selection of the right students is the key to the successful recruitment and retention of doctors for rural areas. He holds that two factors can predict the greatest likelihood of graduates choosing a rural career, namely the selection of those who grew up in rural areas, and those who express an interest in primary care on application to medical school. Prof Rabinowitz's views are well known as he has published his findings extensively, but they have not been replicated in many countries: other authors stress curriculum factors as being of at least equal importance.

- **Women in rural medicine**
– Jo Wainer, Australia

This was a fascinating presentation on how the role of women as healers has changed through the ages. In many countries, more than 50% of medical graduates are women, and yet very little attention is paid to the issues which affect their career choices, which are significantly different to those of men. Better and more flexible working conditions for women will benefit

everyone, rather than expecting women to be like men to succeed. This has as much relevance to South Africa as to any other country, and deserves further attention.

- ***The emerging pandemic of diabetes in aboriginal peoples: what should we do?***

-Stewart Harris, Canada

While the issue of diabetes is not as pressing in our context as that of HIV/AIDS, the principles of community participation that underscored this presentation were salutary. He spoke of the "Coca-Colanization" of the indigenous people, who have a high intake of refined sugars and fats, on top of a genetic predisposition to diabetes. Working in a remote rural community, through the traditional leadership, and appealing to the community's concern for its own youth, the presenter showed how numerous public health measures have been accepted over time by the community as a whole, resulting in a reduction of the impact of the rapidly rising incidence of insulin-dependent diabetes in the indigenous peoples. This was a very relevant case-study of community involvement, initiated by a medical practitioner, in a rural community, and had relevance for us all in South Africa. In our context of HIV/AIDS, it seems to me that every practitioner, indeed every health worker, every employer, if not every citizen of the country, needs to be involved in some activity within their sphere of influence, to combat HIV/AIDS at a community level. This presentation made it clear how such a community-wide issue can be tackled within the rural practitioner's sphere of influence.

- ***Clinical partnerships and teamwork in rural practice***
- Ian Couper, South Africa

Ian gave an excellent discourse on the issues of teamwork, with numerous very practical examples and stories taken from his experience at Manguzi Hospital. It was pleasing that a South African was invited to give this talk. Teams are essential for rural health care to work, as they are much more

effective than individuals as long as we recognize the different roles people play in teams. Doctors need to lose some of their arrogance and professional protectionism, and play their part but not necessarily as leaders. Partnerships are an important model for relationships with patients, communities and colleagues.

- ***Postgraduate education for rural family practice***
- Jim Rourke, Canada

The postgraduate qualification in Family Medicine in Canada follows a 2-year programme, with an optional 3rd year for rural practice, which focuses on the specific skills required for rural practice. Rourke outlined the details of the College of Family Physicians of Canada Rural working group's specific recommendations for improving the proportion of family medicine graduates who choose a rural career after graduation, including undergraduate as well as postgraduate options. These programmes need to be expanded and developed further. Although we are some way from a specific rural focus in postgraduate Family Medicine training in South Africa, these recommendations were extremely useful and will be applicable in South Africa in time.

- ***Developing a rural medicine education, research, and development unit: challenges and successes***
- Jim Rourke, Canada

Jim Rourke outlined the challenges and highlights of establishing a rural medicine unit over the past 4 years, operating from a small rural community where he practices as a Family Physician. His experience with the Southwestern Ontario Rural Medicine Unit (SWORM) was a source of great encouragement to those of us with similar visions for this country. A key insight became apparent during this talk, namely the comparability of South African and Canadian public health systems, despite vast differences in resources.

- ***Nurse-doctor clinical partnerships in rural health***
- Christopher Moorhouse, Australia

This somewhat academic presentation developed the idea of "working at the boundaries" of professional scopes of practice, but the practical application of these ideas was unfortunately not made clear.

- ***Living in small communities: can Sociological training help us to survive ?***

- Martin London, New Zealand

The presenter invited comment on a training course which he had been involved in running for rural practitioners, mostly nurses and some doctors, on sociological issues such as conflict, teamwork, roles and boundaries, communication and ethics. It stimulated me to consider a similar component in the courses we offer in South Africa. The effects of the course were not evaluated however.

- ***Mentoring of female doctors in rural communities***
- Australia

The recruitment and retention of female doctors is even more of a problem than of males, so this was an interesting presentation, as the Australians (with ample resources) designed a specific programme to address this issue. It would appear to be working to a limited extent, although women tend to follow their partners rather than vice-versa (even in Australia !), and it confirmed the value of one-on-one mentoring relationships in supporting rural practitioners.

- ***Establishing a successful rural undergraduate program***
- Canada

The evolution over 10 years of a 4-week Family Medicine clerkship which was entirely community-based, was described, including the strengths and the challenges that the presenters have faced. These include use of computers, and the development of 24 common presentations which were linked to

the principles and goals of family medicine. Acceptance of the clerkship was high, but the presenters were concerned about "service fatigue" and the remuneration of preceptors. These issues are similar to those facing educators at South African medical schools who are responsible for community-based undergraduate experiences.

PAPERS PRESENTED

In addition to the keynote presentation by Ian Couper, the following papers were presented by South Africans:

- *Developing mentors in northern KwaZulu-Natal, South Africa* (together with Dr Ian Couper)
- *Putting Disability on the Agenda*, by Ian and Jacqui Couper.
- *Retention of doctors following compulsory community service: the challenges in South Africa*, by Steve Reid
- *Problems in implementing rural health policy in developing countries*, by Nethia Naidoo and Steve Reid, together with other presenters from Pakistan and Nepal.
- *An evaluation of the first year of compulsory community service in South Africa*, Steve Reid (poster)

Interest in the South African situation was high, partly because of the previous conference in Durban. The recent introduction of community service poses unique challenges and opportunities for rural practice and education, which need to be taken up. The difficulties of implementing policies on rural health in the face of all the other priority issues facing government health departments in developing countries, were discussed. It was felt that the WHO should be contacted through WONCA to bring pressure to bear on these governments to implement rural health policy. The following inputs into the policy document on rural practice were put forward, with specific reference to developing countries:

- Use of the "Social Medicine" approach
- Population-based rather than exclusively individual-based health planning
- Intersectoral and multi-disciplinary initiatives
- Efforts need to be pitched at a national level, rather than local.
- Marketing skills should be used to advocate for rural health issues

RECOMMENDATIONS FROM THE CONFERENCE

A number of recommendations were added to those arising from previous conferences, which have been adopted by WONCA. These recommendations have been incorporated into two documents written by the WONCA Rural Working Party to which the author has contributed. Significant amongst the new recommendations were the following:

- The need for additional skills acquisition by rural doctors, which need to be officially recognized as an optional part of general practice or family practice training.
- Each country should be encouraged to meet their own needs for medical workforce in rural areas, and health services and governments which employ doctors from developing countries should be required to make a contribution to the support of rural doctors in their country of origin. (This issue was much debated, and the stand of the South African government in closing the doors to doctors from other African countries was noted)
- The need to educate medical students, trainees and doctors about cultural issues in rural communities
- A "Calgary Commitment to Women in Rural Practice" was adopted, which pledged to work towards implementing recommendations

concerning issues identified by rural women, lead by a working group (see previous RHI column for this statement in full).

CONCLUSION

The similarities of the Canadian health system with South Africa, became apparent during this conference. Firstly, there is practically no private practice in Canada, contrasting with the USA: the country relies on an increasingly expensive national health service delivered by provinces. Although obviously geographically much larger and better resourced than South Africa, Canada has a similar sized population and a similar output of doctors from its 12 medical schools each year (1500 as compared to 1200 per year in South Africa, from 9 medical schools). As a result of its geographical size, Canada faces extreme rural health issues, in needing to provide health care to small remote groups of indigenous people in the far northern areas, many of which can only be reached by air. These similarities made me appreciate the applicability of Canadian experiences to South Africa, a comparison which had previously considered impossible.

The large number of South African doctors currently working in Canada is of great concern to us in South Africa, as we are continually losing valuable professionals. The Canadians acknowledge the high quality of SA medical graduates, who generally find work in rural areas in Canada, not least in response to continual advertising pressure in the SA medical journals. In terms of foreign policy, the South African government has recently blocked the registration of foreign-qualified doctors in this country, specifically in order not to deplete other African countries of its professionals. This is an issue of international ethics, but reflecting on it through the conference, there is a degree to which Canada should have some moral obligation towards SA, particularly in the area of rural health.

The lessons learnt at a conference such as this, need to be translated into action in terms of the teaching and research that we undertake in South Africa, for those of us in university positions. These will be focused in the following areas:

- Community service doctors' support
- Post-graduate vocational training
- Undergraduate curriculum changes
- A skills-based rural option within a post-graduate Family Medicine programme

- Teamwork and the nurse-doctor relationship
- Policy implementation for rural health in South Africa

Virtually every presentation was relevant to the South African situation, as so many of the issues are similar, despite vast differences in resource levels. The appropriate selection and training of health professionals in a manner which would encourage them to choose rural practice, and the necessary conditions to support them to maintain high standards of practice,

are issues which every country faces, whether 'developing' or 'developed'. With isolated attempts to address the problem in South Africa, ranging from Cubans to Community Service, and now the Certificate of Need, a comprehensive approach is urgently needed to tackle the rural-urban imbalances systematically, at undergraduate, post-graduate and health service level, underpinned by appropriate research of high quality.

*Steve Reid, University of Natal
Ian Couper, MEDUNSA*

⚙️ RURAL HEALTH INITIATIVE ⚙️

During this first part of this year, we hope to bring another two projects into being, so we thought of giving you an outline of the sort of guidelines that we give to people who are interested in developing an RHI site. If you have any questions or comments, please contact:

Penny Bryce
saacadpb@netactive.co.za
or Dr Julia Blitz (Director)
082 452 7849.

Projects

RHI believes that a hospital must not be seen in isolation from either the community it serves, or from the referral hospital that it uses. Therefore, we are interested in projects that allow the doctors to move out of the hospital into the clinics and communities to provide quality primary care as close as possible to the patient's home, even to the point of home-based care. We are also interested in how peripheral hospitals can improve the support

offered to it by its referral hospital. This can be achieved on a number of fronts:

- specialists visiting the peripheral hospital to give lectures and bedside teaching
- doctors going to the referral hospital to upgrade their skills
- fast and efficient communication mechanisms between the doctors at the two hospitals - this is achieved by cell phones, e-mail and in the future we hope to also use telemedicine in the form of digital transfer of patients data.

We see RHI as supporting two roles of the doctor, namely:

- the doctor as clinician, and
- the doctor as teacher.

Doctor as clinician

In this role, RHI sees itself as being able to provide

1. opportunities to upgrade clinical skills by attending courses, congresses, workshops, etc.

2. access to up-to-date clinical information via internet access,
3. provision of a relevant on-site medical library (books and journals),
4. facilitating the connection between doctors at the site and their colleagues at their referral hospital,
5. facilitating the development and production of relevant course material.

Doctor as teacher

This falls into a number of different areas, namely teaching self, medical and nursing colleagues, patients and the community. In this role, RHI sees itself as providing access to

1. learning how to teach - courses, programmes, etc
2. learning how others have taught - visits to sites of excellence
3. means of assessing teaching - video recording and playback equipment
4. educational equipment - overhead and slide projectors, flip charts, computers with internet access, etc

INVITATION TO ALL COMMUNITY SERVICE DOCTORS

You will be receiving several free copies of SA Family Practice during this year. If you find the journal interesting and informative and would like to continue receiving it after this service ends, please contact Penny Bryce at the South African Academy of Family Practice / Primary Care on (011) 807 6605.

Be Proactive, be Professional, get Involved with your Future!