

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.



CRISIS IN RURAL SOUTH AFRICA

RURAL DOCTORS ASSOCIATION OF SOUTHERN AFRICA (RUDASA)
POSITION PAPER: JANUARY 2001: CRISIS IN STAFFING OF RURAL HOSPITALS

INTRODUCTION

This short paper aims to bring to the attention of policy-makers and senior managers in the provincial and national Departments of Health (DoH), and the Health Professionals Council of SA (HPCSA), the crisis that is currently facing many rural hospitals in the country in terms of staffing by Medical Officers, particularly those at a senior level with experience. RUDASA is seeking constructive solutions to the issues of recruitment and retention of professional staff in rural areas, and the recommendations below are given in a sincere attempt to advocate for the health of our patients, from the perspective of the frontline of health care in rural and underserved districts.

1. Community Service

Community service (CS) has improved the situation in some provinces, but two serious shortcomings of the scheme are becoming apparent: the lack of senior doctors to supervise them, and the fact that only a quarter of CS doctors are in fact allocated to rural hospitals. The most needy hospitals appear to be avoided by CS doctors in their choices, and a number of rural hospitals in the Eastern Cape which desperately need more staff, for example, have no CS doctors in 2001. In addition, the annual turnover of CS doctors who need to be trained on the job each year, and the high proportion of them who head overseas after their year, are issues of concern.

Recommendations:

The allocation process for community service be redrawn to ensure that the most needy rural hospitals receive doctors before filling posts in urban tertiary hospitals.

Community service be viewed as a training year, requiring appropriate input and supervision (mentoring) and a clear structure.

Undergraduate and intern training to achieve specific levels of competencies in at least Caesarian sections and anaesthesia, such that CS doctors can perform these tasks independently in rural hospitals.

2. Senior South African Doctors

The recruitment and retention of senior doctors who are prepared to commit themselves to the longer term in rural practice, is an issue that demands a comprehensive approach. The issues that need to be addressed include student selection, the orientation of undergraduate and incentives, non-monetary incentives, and posts for follow-on employment after community service.

Secondly, the public service ruling that any new appointment must occupy a first-leg Medical Officer post until that post is upgraded, is severely hampering efforts by rural superintendents to recruit doctors from other positions.

Thirdly, those community service doctors who show an interest in

pursuing a career in rural medicine need to be encouraged by appropriate incentives or bursaries for further study.

Recommendations:

The DoH to plan with relevant stakeholders, a comprehensive strategy to attract and retain senior doctors in the public health system. These stakeholders should include the medical universities, provincial departments of health, and RUDASA.

The specific recruitment of South African-qualified doctors back from Canada and the United Kingdom, to work in rural hospitals in South Africa, needs to be given attention by provincial health departments. This cannot be accomplished without significant incentives, and the involvement of the national DoH.

Opportunities be provided for and/or created to allow for the promotion-on-transfer of doctors to rural hospitals.

Those who have served an extra year in a rural or underserved area, should be given preference for specialist training posts as registrars, as they have been relatively disadvantaged by giving their service away from the academic centres.

3. Cuban Doctors

Cuban doctors have alleviated the crisis in a number of provinces, but two shortcomings of this scheme have become increasingly obvious. Since

Cuban doctors are trained as specialists, their lack of generalist skills makes it difficult for most Cubans to handle the wide scope of rural practice in South Africa, unless they are family physicians who are prepared to learn anaesthetics and procedural skills. Secondly, the cultural and language differences make communication difficult

Recommendations

If the scheme is to be continued, more family physicians who are prepared to cover all specialities need to be recruited into the scheme.

Proficiency in the English language needs to be a prerequisite for entrance.

4. Foreign Doctors

Foreign doctors from other countries have filled the gap in many rural hospitals for years, and have provided the senior support and experience that is vital in many institutions. However, with the successively tight restrictions on the registration of foreign-qualified doctors by the HPCSA, together with the increasing difficulties foreign doctors experience with the Department of Home Affairs in obtaining and renewing

work permits, this essential source of doctors for rural hospitals has been completely cut off. This does not make sense with respect to the countries which can afford to export doctors, and those whose graduates were recognized in SA until recently (e.g. UK, Belgium, etc). Those foreign doctors already providing valuable, often irreplaceable service in rural hospitals are being made to feel increasingly insecure and unwelcome, and are migrating in significant numbers to other countries where they are welcomed, thus further depleting South African rural hospitals of experienced personnel.

Recommendations

That restrictions on registration of foreign-qualified doctors from those countries which have an adequate number of doctors, be lifted immediately.

That appropriate recognition be given to those foreign-qualified doctors who have served in rural hospitals for more than 10 years, in terms of promotion.

That a consultation be arranged between the Department of Health, the HPCSA and the Department of Home

Affairs to ensure there is a common understanding of the role of foreign doctors and approach to their employment in rural areas.

Conclusion

It is clear that a co-ordinated and comprehensive approach to the staffing of rural hospitals is needed, both to address the present crisis and to plan for the future.

Thus it is recommended that a rural health unit be established in the Department of National Health to ensure adequate staffing of rural hospitals, in terms of all categories of professionals, and to work with bodies such as the HPCSA and Universities as part of a comprehensive strategy.

Drafted by Dr Steve Reid,
RUDASA Chairman: Dr Ian Couper; and
RUDASA Secretary: Dr Elma de Vries
Correspondence to: The Secretary, RUDASA,
PO 1833, Brackenfell 7561
e-mail: elmadv@mweb.co.za
RUDASA is a voluntary organization of rural doctors in the public and private sectors, and is registered as a special interest group of the SA Medical Association.

☼ BUILDING A DISABILITY PARTNERSHIP: ☼ ☼ THE CASE OF THE CENTRAL REGION ☼

“Nothing about us, without us”

I. INTRODUCTION

The need for improved service delivery to people with disabilities is evident in the Eastern Cape Province and is probably true for most of the country. There are ongoing crises with the payment of disability grants; inadequate rehabilitation services that do not reach those in need; education facilities are either inappropriate or hostile and high levels of unemployment are the reality for most people with disabilities. In addition, a recent survey commissioned by the Department of Health nationally (The National Disability Survey, 1999) reveals an

extraordinarily high prevalence of disability in the Eastern Cape. While the national prevalence is calculated at 5.9%, the prevalence in the Eastern Cape is the highest of all the provinces at 8.9%.

What is not so evident is that many of these problems can be addressed at a local level. Rather than waiting for solutions to flow down from national or provincial level, it is possible to build partnerships of providers and clients at a local level, to utilise existing policy and legislation and to begin to address the problems facing people with disabilities.

Disability is clearly an intersectoral issue. Major issues of concern are

education, health (especially around assistive devices), employment, transport, welfare and others. In addition, while government is a major provider, there are other significant groups. These include the disability movement, support groups for people with disabilities, service non governmental organisations (NGOs) and the private sector.

Health practitioners (doctors, therapists and nurses) are often faced with seemingly intractable problems with regard to children and adults with disabilities. To deal with the problems is far beyond the health arena and needs the concerted efforts of a variety of roleplayers. This paper

describes such an initiative, based in the Central Region of the Eastern Cape province. The region is both urban (e.g. East London) and rural (e.g. Butterworth) and serves around two million people.

2. BUILDING A SOLID TEAM

The Regional Department of Health initiated the process. In the initial phase there were three key objectives:

1. to build a partnership between government departments (including health), NGOs, the disability movement, business and labour so as to address issues facing people with disabilities in the Central Region.
2. to inform all roleplayers of the new policy/legislation; to discuss how it affects people with disabilities; and to examine opportunities offered by these new policies/laws.
3. to develop, implement and monitor regional/district intersectoral strategic and operational plans around disability issues.

Around a hundred participants from across the region attended a workshop series. Five workshops were held over a four month period. At each workshop time was taken to share and discuss new policies and legislation, and time was spent in developing implementable plans. These were finetuned back in the districts.

The workshop series brought together a number of different roleplayers : Disabled People South Africa (DPSA), Disabled Children's Action Group (DICAG), other disabled people's organisations (DPOs), government departments (particularly Health, Welfare, Education and Labour but also Transport, Public Works, Local Government and Housing and Sports, Arts and Culture) and NGOs (particularly REHAB - a local service NGO - and DSSA - Down Syndrome South Africa).

One of the problems identified is that people do not have sufficient time to keep abreast of new policies/ legislation

and thus to seize opportunities offered by the legislation. In addition, since 1994 there has been an outpouring of new and, in many cases, radically different policies and legislation. One sector particularly affected is the disability sector. The shift has been from a medical model addressing disability to a developmental model of addressing disability issues. The workshop series tries to address this. The following legislation/policy was covered: the Labour Relations Act (LRA), the Employment Equity Act (EEA) and the agreements at the job summit; the White Paper on an Integrated National Disability Strategy (INDS); the South African Schools Act, the policy on education for learners with special needs; community-based rehabilitation.

District plans were developed concurrently with the workshop series by intersectoral district teams. This process was supported by the regional organisers meeting with each district team and finetuning the plans. Final plans were presented at a buy-in occasion in June 1999 that marked the completion of the first phase (this was held 6 weeks after the workshops were completed). The occasion was attended by a wide variety of people involved in disability issues.

It is important to realise that the workshop series had a profound impact on many, if not all, of the participants. Besides challenging all to review their beliefs, attitudes and actions regarding people with disabilities, we have realised the need to create intersectoral teams (including people with disabilities) that can start to address, in a systematic, planned and incremental fashion, the challenges facing people with disabilities.

3. ACHIEVEMENTS

The following section will document some of the achievements. Some are directly related to the initiative and others indirectly related. One of the initial problems was raising funds to support some of the activities. This problem was resolved in June 2000.

a) Education

A lot of attention has been placed on inclusive education (or mainstreaming children with disabilities in 'normal' schools). The focus of REHAB and the Foden Centre (local NGOs) has shifted from the special school approach to supporting children in 'normal' schools. Foden Centre is now being seen as a stopover and not a daycare centre. Children with disabilities have been mainstreamed in Ginsberg, Komgha, East London, Butterworth, Breidbach and Grahamstown (i.e. in both rural and urban areas). The district groups are offering support to the learners, the teachers and parents. People from DPSA and Office of the Status of Disabled People (OSDP, Provincial office) have run successful awareness days in several of the districts. Art and poster competitions have been organised to further enhance awareness in schools. The local press have covered some of these activities. Funds have been recently raised to run workshops in the districts on inclusive education for teachers, parents and other interested people. Several workshops were run in 1999/2000. Rhodes University, in conjunction with the Department of Education and REHAB, are developing a stand alone module (that will also be part of their Higher Diploma in Education) on inclusive education. DANIDA (the Danish Funders) have granted substantial funds for inclusive education. Because of the partnership developed in the Central Region, Mdantsane has been chosen as the provincial pilot site and the tender has been awarded to a consortium led by our education members. The funding will be used for teacher training, learner support and workshopping governing bodies. The consortium will develop materials to assist parents and NGOs in their struggles to mainstream children. Plans are being developed to access old computers and to develop specific district based support teams.

We have learnt that each struggle to include a child with disability in a mainstream school is a local struggle.

Parents (often with support from NGOs and health practitioners) need to engage with their local school and negotiate acceptance of their child. To do this fears and preconceived attitudes often need to be addressed. Once accepted, we have been repeatedly surprised at the positive response from the school with respect to the children with disabilities. We have mainstreamed children with both physical and intellectual disability. Mainstreaming is seen as one option that the child and their parents should have available. During 1999 and 2000 we have realised the need for materials to assist parents in their negotiations. The DSSA booklet on inclusive education has been invaluable. In 2001 we want to develop a booklet of stories describing the local experience. We want parents, children and educators to realise the benefits of mainstreaming through discovering what has been happening in the schools in the region.

b) Health and Welfare

Progress has been made with developing homecare programmes for many disabilities. Following a visit to Natalspruit Hospital, a rehabilitation unit is being established at Cecilia Makiwane Hospital with an outreach programme. Previously most patients with severe disabilities were referred out of the region and in many cases out of the province. A successful programme in basic rehabilitation and homecare skills has been run for the Village Health Workers (VHWs) in Peddie. REHAB and the Department of Health collaborated on this initiative. More funding has allowed the programme to rollout into other parts of the KingWilliams Town District. A further 60 VHWs are being trained. Although there has been no formal evaluation, anecdotal evidence suggests that the VHWs are making an impact in the communities that they are serving.

Much discussion has evolved around the daycare centres. Most agree that they play a role in support for people/children with disabilities and as respite care, but should not be seen as an end

in themselves. Our goal is inclusion. The role of the grant-in-aid has been discussed. People on a disability grant can apply for this to employ a caregiver. We are hoping in 2001 to utilise this grant. A directory of services for people with disabilities has been compiled, funding has been found and it should be available shortly.

c) Employment

The Employment Equity Group successfully applied for an employment/ placement officer. This person is based at REHAB. Databases of potential employees have been developed. Skills training courses for people with disabilities are being run. A number of people have been successfully placed in the private sector and negotiations are ongoing with a number of employers (recently, in one company, 15 people were placed). Funds have been raised from the Thabo Mbeki Development Trust (TMDDT) to initiate commercialising protective workshops. The TMDDT has opened an office in East London and actively solicit proposals through the regional disability forum that meets quarterly. The Department of Labour is actively involved with the district teams. In Butterworth, RUTEC (a NGO) and Bethel College (a church based organisation) are now working with people with disabilities. Recent developments include a voluntary placement programme for a short time period. This allows employers to try out people with disabilities and for the volunteer to gain experience and develop confidence and esteem. A autistic adult was offered a casual job following a successful volunteer placement.

4. PROBLEMS, LESSONS LEARNT AND THE WAY FORWARD

The following need highlighting:

- We have created a powerful strategic alliance that has benefitted all partners.
- We have built a forum where issues can be discussed, where initiatives and contacts can be shared.
- We have established a forum that

has allowed access for funders.

- The partnership has allowed us to take on new initiatives. For example, the group has agreed to host an African Conference on Intellectual Disability scheduled for October 2001 in East London. This is a joint initiative through OSDP, DPSA, DICAG, REHAB and DSSA.
- We have realised that we only need small amounts of funding to support our work and this fundraising is achievable.
- There is still divergence of opinion on a number of fundamental issues (e.g. the role of day care centres, does inclusion mean inclusion for all?), but we realise that these issues can be debated and further understood. The discussion deepens our understanding.
- People with disabilities and professionals working in the disability sector need to work together and need support. Both have and continue to be marginalised. The partnership allows for mutual support and renewal.
- Finally, we understand the need for sustained and ongoing maintenance of the partnership. It has become the lifeblood for many of us and a highly creative venture for realising our vision and goals.

5. CONCLUSION

Some of the reasons for the relative success of this initiative include the fact that the partnership is driven at a local level. The regional group responds to what is happening on the ground. Local (or district groups) are intersectoral and embrace both professionals and people with disabilities. There is a role for all health professionals to contribute in this fashion. The key to the success is the partnership that has been created.

*Andrew Mckenzie
BSc (UCT), MBChB (UCT), MPH (Leeds),
DPHCE (Wits),
Department of Health,
Eastern Cape Province.
e-mail: amckenzie@freemail.absa.co.za*