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 thejournal, 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.

In this issue we cover the third in the series Rural Hospital Focus, report on the National RuDASA congress, feature a report on the activities of the WONCA Rural Working Party in terms of international developments and the Calgary Commitment to Women in Rural Family Medical Practice from the 4th WONCA World Rural Health Congress that was held in Canada in August. We look forward to hearing your comments and receiving any contributions.

☼ RURAL HOSPITAL FOCUS - DEBATING POINTS ☼

ACCOMMODATION

In this column, I have looked at two of the three main issues that I believe to be critical in most rural hospitals. This month I focus on the third, viz. accommodation. Once again, I am raising issues for debate and discussion, and invite responses.

People outside of rural hospitals usually have little understanding of why accommodation is needed, let alone some of the difficulties relating to the allocation of housing. Doctors working in rural hospitals, however, often experience accommodation issues as one of the most common causes of tension and unhappiness, possibly second only to call rosters!

Why is accommodation needed in the first place? Why is the rural hospital different? There are a number of reasons. Firstly, in order to work in a rural hospital, in nearly all cases doctors are required to relocate themselves. It is not simply a matter of changing jobs - by their very nature, rural hospitals are away from areas which doctors usually live in. Secondly, unless the rural hospital is near an established town there is seldom accommodation - to rent or buy - in the local community. Housing of any sort is usually very difficult to obtain and in tribal areas outsiders cannot buy land. Even where towns are nearby, the overtime call roster may make it difficult for doctors to stay elsewhere. And those rare local graduates returning to serve their own communities often do not wish to live in the community because of the excessive demands placed on them by family and friends. Thirdly, most rural doctors are short-term workers who have no interest in, or incentive to, obtaining their own accommodation. Finally, many rural doctors as we well know are foreign graduates, whose insecurity about ongoing employment makes them very reluctant to consider alternatives.

Note that I am not advocating living in a hospital compound as the best model, only describing what is the practice. Doctors who have made the effort to live in the communities they serve have usually found this to be a very rewarding and fulfilling experience which enhances their ability to meet the needs of the people.

So, we have agreed that doctors need accommodation. This is the easy part. How does one allocate this? Almost every rural hospital I know has too little accommodation. The housing is also often old and in need of repair. The types of units available vary from large old mission houses to flatlets to rooms in "nurses" homes. It is difficult to decide who gets what. If seniority is the basis for allocation, how are families dealt with? A doctor's family is often the critical factor in determining how long he or she will stay. If the family is unhappy - and accommodation is very often the key factor in this - the doctor will leave, no matter how personally fulfilling /her job is, making utilitarian approaches to housing allocation very short-sighted.

One major complication is that it is not only doctors who need accommodation. Most of the professional staff of a rural hospital are not local people and need accommodation. It is easy enough to establish the principle that local residents do not get housing (even though they often demand it and are most aggrieved when they do not get it). But how does one decide whether a house should be allocated to a doctor, a matron, a therapist or a laboratory technologist? In some hospitals, housing units are allocated to specific sections and there can be no movement in this - so that much needed houses even stand empty because posts are vacant in particular sections. This approach does reduce conflict but does not help the shortage of space. In other

hospitals there is flexibility, and the needs and situation of each staff member requesting accommodation is taken into account. This allows for more creative and functional usage of space, but does produce conflict as staff question why a colleague is given a particular house or room.

There is no doubt in my mind that the Department of Health should put budgetary resources into building accommodation units, but the types of units should be locally appropriate (not designed in Pretoria!) and there should be a clear local policy framework in each hospital for allocating these units.

Related to accommodation, one provision of the Public Service regulations which is prejudicial towards rural doctors is the non-payment of housing subsidies for houses that are not being lived in. Because doctors often cannot and usually do not wish to purchase houses in rural areas, there should be support given to them to buy houses in cities. This would be an incentive that would encourage rural doctors by giving them the security of a place to go to when they move on.

The need for accommodation will no doubt increase, as more categories of health professionals are required to do community service, filling long vacant posts. One can only wonder if there is any strategy that exists in the provincial departments of health to ensure that there will be the accommodation needed. Prefabricated units and mobile homes are only short-term solutions, as they deteriorate quickly. One solution would be to provide funds to rural hospitals to enable them to use local builders and materials to develop appropriate housing units. However, arguments of standards, aesthetics and ongoing maintenance are usually raised in terms of this.

I believe, though, that the problem of staffing rural hospitals cannot be adequately addressed if the question of housing is not considered.

Ian Couper
Dept. Family Medicine & Primary Care
MEDUNSA

☼ THE RURAL GENERAL PRACTITIONER ☼
-AN INTEGRATOR IN RURAL HEALTH CARE
REPORT ON THE 4TH RUDASA CONGRESS

The 4th annual congress was held in Queenstown in the Eastern Cape, during September. Delegates were treated to a welcoming dinner by the mayor of Queenstown, the honourable Mr GN Xoseni. In an opening speech, the Director General of the Eastern Cape, Dr Mvuyo Tom, emphasised a holistic approach to rural health and said that rural doctors need to do more than just treat patients.

The keynote address on Saturday morning was delivered by Prof. Kaya Mfenyana from the Department of Family Medicine UNITRA. He explored the congress theme (The rural general practitioner – an integrator in rural health care), and described what a rural practitioner ought to be – a doctor who would care for the whole patient, regardless of age, sex or disease. The rural practitioner ought to see patients in their context, especially if she/he lives in the same area as do the patients.

Many of the attributes Prof Mfenyana mentioned, are shared by family physicians and rural doctors alike. A question asked during the congress, was whether a rural practitioner and a family physician is the same thing, or two different things? The chairman, Ian Couper, responded by saying that he would not like to see the Australian Scenario repeated here: In Australia, the family physicians and rural doctors are two separate groups. Couper said that rural medicine is wider than family medicine, and includes other specialities, e.g. community health specialists, surgeons, paediatricians, etc. We need to work together.

Many fascinating and highly relevant topics were discussed in the parallel sessions. AIDS and TB received a lot of attention, and rural doctors could relate to what was discussed, because of their personal experiences with patients. Several doctors presented their own research, ranging from disability and rehabilitation, to the use of a Road to Health Chart in rural clinics.

Helen Strong from SAMA presented the findings of research that she had done among doctors. The main problems reported were remuneration, and lack of senior support for junior doctors.

In a session on CPD for rural practitioners, it was decided that there seems to be a discrepancy between what doctors feel they need to learn, and the teaching available for CPD points. It was agreed that small groups are more useful for relevant learning than lectures by specialists. Two or more doctors can form a small group and register it for CPD points through the Academy of Family Practice.

Dr Eddie Mhlanga, chief director of Maternal, Child and Women's Health, delivered an inspirational keynote address on Sunday morning. He said that rural doctors may sometimes feel forgotten, and inferior to urban colleagues. Rural doctors should however realise that there are young people looking up to them as role models. When he was a young boy, a rural doctor was the role model that inspired him to study medicine. It is a privilege to be a rural doctor, to see the patient as a whole person. Rural

doctors can act as agents of change, and should research what they see around them.

Other relevant topics that were discussed, included circumcisions and the role of the doctor in clinic visits. Chris Ellis spoke about cross-cultural communication in his entertaining way. In the Poverty and Health workshop, the discussion centred on development and the importance of community partnerships.

RuDASA recognises that an interest in rural medicine needs to be encouraged from an early stage in medical training. Students from each medical school were invited, and their attendance was sponsored. Students from UCT, UNITRA, UP and US attended. They enjoyed meeting rural doctors, and had the opportunity to tell the congress about what their medical schools are doing for rural health, and recruitment of students from previously disadvantaged communities.

The highlight of the congress was the interaction between people, and the cross-pollination of ideas. It was very encouraging to see what rural doctors are doing to improve the health of rural communities, often against the odds. A decision was taken to continue choosing rural venues for future congresses, "to place us in our context".

The 2001 congress will be held September/October in Taung in North West Province. RuDASA however fully supports the WONCA 2001 Congress, and encourages members to attend, especially the day that will be committed to rural health.

Abstracts from the RuDASA congress are available from Elma de Vries (elmadv@mweb.co.za).

Elma de Vries
Secretary: RuDASA
Senior Medical Officer: Mitchell's Plain Community Health Centre
Lecturer: Department of Primary Care, UCT

☼ WONCA ☼

WORKING PARTY ON RURAL PRACTICE MEETING

The World Organisation of Family Doctors (WONCA) Working Party on Rural Practice is an official sub-committee, chaired by Professor Roger Strasser of Australia, which has as its vision the development policies for WONCA on rural practice and to promote rural health.

I was privileged to attend the Working Party meetings held in Canmore and Calgary, Alberta, Canada, in August this year, before and after the Fourth World Rural Health Congress. I attended on behalf of Dr Neethia Naidoo, the Southern African representative, who was not able to go.

It was a good learning experience to be part of this team of about 20 people from all over the world, all enthusiastically committed to developing rural health care around the world, in both developed and developing countries each with their own unique challenges.

A few issues that were discussed are of particular interest. The next World Rural Health conference, the fifth in the series, will be held in Melbourne, Australia from 28th April to 5th May, 2002. The theme is "Working together: Communities, Professionals and Services." (For more information, see their website www.ruralhealth2002.net) The 6th World Rural health conference will be in Spain and Portugal in 2003.

More immediately, there will be a Rural Day at the WONCA 2001 World Conference of Family Doctors/General practitioners to be held in Durban next year (see www.wonca2001.org.za). The conference is from 13th to 17th May, with the rural day, which the Working Party is organising, on Wednesday 16th. It is an exciting chance for rural South African doctors to meet with colleagues from all over the world and hear them speak.

Another exciting forthcoming event is a proposed WHO-WONCA Joint Invitational Conference on Rural Health. It is recognised that in order to have any influence on governments with respect to rural health, WHO must be involved. Following meetings between WONCA and the WHO, it seems very likely that such an Invitational Conference on Rural Health will be called by WHO, in conjunction with the Working Party, gathering together key people in health administration in the major regions of the world to look at problems and strategies in rural health care.

A meeting of the WONCA Rural Information Technology Exchange (WRITE) group, a sub-committee of the Rural Working Party, also took place in Calgary. WRITE looks at issues related to information technology development to assist rural health care. The group is aware of the need to focus on low technology applications and a monograph is being developed on this topic. Future projects include the facilitation of an annotated bibliography-cum-assets register, and setting up a clearinghouse to pass on resources, e.g. from developed to developing countries.

A new sub-committee, a Working Party on Women in Rural Practice, was also formed in Calgary, in response to the Calgary Commitment to Women in Rural Practice adopted at the end of the 4th World Rural Health conference. Their task is to develop a policy on women in rural practice for the Working Party, which has in turn

committed itself to work towards gender equity.

A CD-ROM with the rural health policies developed by the Working party and adopted by the WONCA Council, previous conference recommendations, and statements such as the Durban Declaration was presented to each member present. I can thus provide material from this resource to anyone who is interested. (The material is also available through the working party website, which can be reached through the WONCA website, www.wonca.org.)

Ian Couper

☼ WONCA ☼
CALGARY COMMITMENT TO WOMEN IN RURAL FAMILY MEDICAL PRACTICE

Preamble

We, the rural health professionals of the world, meeting in Calgary at the 4th World Rural Health Conference, recognise and celebrate the special essential contribution which women in rural practice have made and continue to make to the health of their communities.

Based on the secure knowledge that the equal contribution of women to public policy is essential to secure the future of life on this planet and enhancement of the human condition, the Calgary Commitment to Women in Rural Medical Practice will make visible the work of women.

This is particularly important given the increasing presence of women in rural medicine, the challenges facing women in rural practice, and the inequities of commitment to and resources for these issues around the world.

We will recognise the diversity of women's contribution to rural health by supporting the development of practice, policy, funding and research initiatives that reflect the following principles:

Principles

- Rural medical practise must be structured to reflect the way women experience their lives.
- Sustainable rural practice for women must be flexible, safe, locally developed and culturally appropriate.
- The promotion of women's involvement in policy development is essential to ensure the contribution of women is included.
- The work which women do as rural doctors, at the request of their patients, must be appropriately valued and financially rewarded.
- The many contributions of women to rural medical practice must be included in core medical curriculum.
- Women want diversity and flexibility without pressure to conform to existing professional, training and practice structures.
- Local teamwork and partnerships are necessary to ensure that initiatives are developed which are appropriate to the local area.

Commitment

This conference commends the WONCA Working Party on Rural Health for the work done to implement recommendations from the 2nd World Rural Health Congress concerning issues identified by women. In particular, we note the inclusion of many of the recommendations in the Policy on Rural Practice and Rural Health, and women in the scientific program of conferences. To continue the essential work of restructuring rural practice to attract women, this Conference commits to working toward the equal representation of women on the WONCA Working Party, conference organising committees, and other working parties developing policy on issues in rural practice.

In order to advance issues, which have been identified by women, this Conference supports the development of a WONCA Policy on Women in Rural Practice.