WELCOME TO RHI

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 three issues of particular interest to RHI, namely home-based care of AIDS patients, recruitment of doctors to rural practice and support of community service medical officers during their rural time.

THE CHALLENGE OF HOME-BASED CARE

I first met Rosina Sindane in May 1999. Her next door neighbour, Mrs. Masina, came to ask for help at the local clinic in Maboloka, a dusty village in North West Province, where I was working as a visiting doctor. Her husband had died of AIDS 3 months before. She was now alone at home with her three children aged 11, 9 and 6. Mrs. Masina had heard she was ill and had been caring for her as best she could. Rosina was now so ill however, that Mrs. Masina was worried that she was not doing enough for her. I visited her in her small cement brick house with one of the local TB DOTS supporters, Thabo Maseko. She was obviously terminally ill with pulmonary TB not responding to treatment, severe oral thrush and severe oedema of her legs. Together with Mrs. Masina, we worked out a simple care plan. Thabo would visit the neighbour twice a week bringing her TB treatment, oral nystatin drops and paracetamol and ung meth sal for her legs. The family was destitute and so Thabo would also bring a weekly food parcel from donations we receive from various churches in Pretoria. Thabo also spent time reassuring Mrs. Masina that she had been and was doing a wonderful job caring for Rosina and her children (this included cooking the children breakfast and lunch and supervising their homework and bathing in the evenings). I would support Thabo by giving him advice on management of problems as they arose. Three months later I received a phone call on a Sunday morning from Mrs. Masina to say that Rosina was unconscious. She asked me to come immediately. When I arrived, Rosina was obviously dying. Mrs. Masina and I sat next to her on the bed until she died about 10 minutes later, while her children sat anxiously outside the kitchen door. Telling the children their mother had just died was one of the most difficult things I have done. We all cried for sometime. As the family had no burial society, Thabo and I had to raise funds to pay for Rosina's funeral. We also had to trace her distant family in Mafikeng who later took the children to stay with them. Our encounter with Rosina and Mrs. Masina, helped us realize that home care can work in a desperately poor situation like Maboloka. As AIDS begins to kill hundreds of thousands of people across South Africa, it is obvious we need to develop an affordable, appropriate and compassionate system of home-based care.

WHAT ARE THE ESSENTIAL ELEMENTS OF HOME BASED CARE?

1. This might be stating the obvious – but a home is essential. One of the biggest challenges is providing care to homeless people or people who live in shacks, which offer virtually no shelter.
2. A caregiver at the home. This is usually a family member, but could be a caring next-door neighbour or friend. The caregiver is responsible for day to day care of the patient, feeding, washing, medication, emotional support etc.
3. A supporter who can visit the caregiver regularly (usually a DOTS supporter or trained lay health worker). The supporter is responsible for advice and emotional support of the caregiver (and patient), delivering medication, assisting with welfare issues (food parcels, disability pensions, assisting with funerals and care of orphaned children).
4. A supervisor of the supporters (preferably a doctor or nurse), who advises and supports and does home visits when requested.
5. A local clinic / health institution. This should provide basic medicines and supplies, blood and sputum collection facilities (for confirmation of TB and HIV if necessary).
6. A community hospital. This should provide a back-up for patients requiring hospital admission (for example generally well HIV+ patients with acute severe illness or terminally ill patients with no home care giver). An alternative to this would be a community-based hospice such as exists in Winterveldt (Odi District), North West Province. This church supported hospice is run by lay health workers providing basic palliative care under the supervision of a medical professional. It especially fulfils a

back-up role in the care of terminally ill people living alone, or homeless people or to give respite to exhausted families.

WHAT ARE THE COSTS INVOLVED?

1. Salaries / stipends. Although home carers are always unpaid (because they are caring for a family member or close friend), we have found that the commitment required from the supporters of home carers requires that they be given some form of remuneration, if they are to perform their role meaningfully and reliably.
2. Food and clothing for terminally ill patients. This can often be accessed from churches and NGO's.
3. Medicine and surgical supplies. This can be provided by local health facilities.
4. Transport costs. The distances in rural areas require much travelling either on public transport or in vehicles owned by local NGO's or government.
5. Funeral costs for destitute patients.
6. Foster care / placement of orphans.

WHO IS RESPONSIBLE FOR HOME BASEDCARE?

In Odi District, North West Province, we have found that a partnership can work between government clinics, DOTS supporters and local church based NGO's. Although this might not be reproducible in every health district in the country, churches (especially women's groups), are a widespread network with the potential of providing home care. With proper training and linking with existing government health facilities (or even sympathetic GP's), a viable network could be established. Although one would have assumed that the government would have taken responsibility to develop such a programme, this has not happened. It is therefore up to concerned NGO's and health professionals to take the lead always with the intention of drawing in district health facilities.

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☼ RURAL HOSPITAL FOCUS - DEBATING POINTS ☼

This is the first in what is intended to be a regular column addressing issues related to rural hospitals, rural practitioners and rural district health care. The aim is for this to serve as a discussion starter.

Initially I will look at the 3 major problems encountered in almost every rural hospital I have worked in or visited, here in South Africa or elsewhere in the world (including South America, Canada, China, Malaysia and Australia) viz. staffing, accommodation and transport.

Let me focus first on the issue of **staffing**, i.e. the problem of getting sufficient doctors with appropriate qualifications and experience to practice in rural areas. This "definition" already introduces a debatable point – staffing is not just about numbers of doctors, it is also about the type of doctors! I will return to this shortly.

One only has to open the SAMJ and scan the job advertisements to notice that staffing rural health services is a world wide problem: we have all seen the adverts for rural doctors in Canada, Australia and New Zealand, and probably know colleagues working there. Professor Jim Rourke, a Canadian rural practitioner and teacher, suggests there is an international directional flow of doctors from West and Central Africa, to South Africa, to Canada, and to the United States, each preceding country filling the gaps for the next country.

South Africa is definitely no exception to this phenomenon. Any rural hospital medical superintendent will tell you that s/he spends a lot of time and energy on recruitment, with little response. We all know that foreign qualified doctors make up the majority of rural hospital doctors.

One might argue that urban centres also have staffing problems. The reality though is that when an urban hospital advertises a vacant post, they are often able to hold interviews to select the best candidate out of a group of applicants, whereas a rural hospital advertising a post usually considers itself very fortunate if one suitably qualified person even shows interest!

The National Department of Health has made some attempts to address this problem. The first strategy was to bring in Cuban doctors. They have certainly made a significant contribution in many places. However, they are at best a short-term solution. The need is to get more South African doctors to these areas. The second strategy aimed to do that viz. Community service. Although community service is not aimed only at rural hospitals but at all government hospitals, it has certainly made a major impact on staffing levels. This is very positive.

However, community service can only be seen as a small part of the solution (if it is to be any part – my focus here is not to debate community service yet again). To assess the impact of community service one would need to see how many community service doctors stay on in rural hospitals after their compulsory year. Of the first group, very few did, and it seems likely the same will apply to the present group.

A hospital or district health service cannot function effectively with recruits who stay for only a year. A solid core of doctors is needed to provide continuity, ongoing quality improvement, and support and development of short-term doctors and other staff. My experience is that it takes new doctors from 3 to 6 months to settle down into rural hospital work and to make a positive contribution.

Thus senior doctors need to be supported and encouraged by the system. They are the essential backbone of the rural health service. They are the ones who are needed to support, nurture and teach community service doctors. It is on this group that there has been too little focus – in fact, no attention has been given to them at all in my opinion. It is for this reason I defined staffing as a problem of quality as well as quantity.

To recruit and retain such senior doctors we need to explore all the different strategies which have been used internationally, such as:

i. Structured vocational training, with a rural focus;

ii. Incentives, such as rural allowances, locum schemes, study support, relocation bonuses, sabbatical leave, promotion opportunities, etc.;

iii. Recruitment of rural students into medical school and monitoring of students during their training;

iv. Transformation of the undergraduate curriculum to allow for rural attachments;

v. Preferential access to postgraduate training for rural doctors; etc.

The South African Medical Association (SAMA) has established a Rural Health Task Team which incorporates representatives from the S.A. Academy of Family Practice/Primary Care and the Rural Doctors' Association of Southern Africa to address some of these issues.

Constructive contributions to this debate will be useful.

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☼ GROWING YOUR CROP OF "COSMOS" ☼

Doctors serving their year of Community Service provide a vital resource for the delivery of health care services within South Africa's public health system. In the brief time since the programme was implemented (January 1999), many hospitals have come to depend upon their 'cosmos'. From the perspective of the community service doctor, the year can be experienced either as *a test of endurance*, or as *an expedition into personal growth and professional self-confidence.*

Interestingly, these two alternatives do not seem to be related to work load, nor are they entirely related to getting the placement of their choice. A qualitative study in three provinces during 1999[1], as well as our experience in the Northern region of the Eastern Cape suggest several key experiential factors that affect the attitude 'cosmos' take toward their year:

- *Administrative issues* – correct payment of salaries, and suitable accommodation
- *Experience of support* – in patient care (how do I manage this patient *here*), in solving health system problems such as poor lab service or poor transport to the clinic, and response to personal needs (e.g. family problems, discouragement, loneliness)
- *'Am I making a difference?'* – primarily in patient care, but also in solving health system problems, and sharing expertise gained during internship with colleagues
- *Development of new skills* – managing patients with less resources, communication within the health system, and working within a smaller hospital
- *Chaos* – meaningless shambles within the hospital or health system may erode the value the 'cosmo' gives to the experience
- *Friendship with other 'cosmos'* – having a sense of 'we are in this together' often supplies crucial encouragement during the year.

As a more experienced doctor working with community service doctors within a rural region, I wrestle with the question **'How can we address these factors so that 'cosmos' may choose to experience personal growth and professional self confidence during their year?'** Our road has not been entirely smooth, but here are twelve suggestions coming from the Eastern Cape.[2] While many of them have largely been put in place in our region, the last few are ideas for the road ahead, so that it may be said of us too: 'they possess the power of thinking before they acted, and of acting too'.[3]

1. Develop a region-based community service doctors programme which contextualises the national programme goals and appoint provincial and regional co-ordinators who implement allocations, support, and site development. Choose co-ordinators who care.
2. Appoint a community service facilitator in each institution whose job description is to befriend, support and solve problems alongside the 'cosmo' as well as maintain programme standards, and perform quarterly evaluations. Again, pick facilitators who care.

3. Monthly meetings for all 'cosmos' in a district or region – this is the vital mechanism for 'cosmo' training, communication, problem solving, and letting off steam. It allows 'cosmos' to compare experiences, enhances their perspective, and fosters links between institutions.
4. 'Cosmo' job descriptions should be creatively worked out between district managers, medical superintendents and community service facilitators in each facility. Utilise 'cosmos' effectively while maintaining supervision, support, and a fair distribution of work.
5. Base allocations within the region, on consideration of needs as well as real capacity to utilise, support/supervise, and to suitably accommodate 'cosmos'. Use a regional meeting to compare job descriptions, and accurately judge the above capacities.
6. Develop a list of locally needed key skills and competencies. Use the list early on to discover where the 'cosmo's' strengths and training needs lie. Refer back to the list during monthly meetings, evaluations, and in the clinics/on the wards.
7. Start the year with a day of welcome, introductions, group building, and listening as 'cosmos' describe how they feel about the year ahead. Provide them with a welcome packet that provides phone numbers, a map, practical tips, and locally developed care guidelines.
8. Rotate 'cosmos' six monthly between health centres/district hospitals, and the regional hospitals. This gives greater equity regarding placement, a broader experience, and ensures that you can fill posts in difficult hospitals where 'cosmos' are less likely to apply.
9. Community clinic visits by 'cosmos' bring health services beyond hospital walls. These visits cost the hospital 'medical officer time', but provide greater access to care, encourage clinic use, and build experiences where 'cosmos' are highly valued.
10. Fix the salary problems. Nothing destroys a 'cosmo's' motivation faster than not being paid properly.
11. Develop human resource policies comprehensively within the health service, so that 'cosmos' and medical officers alike are utilised by explicit strategies that support work in rural and underserved areas. Where they don't exist, develop provincial health plans with realistic language and specific objectives and strategies. This can reduce chaos and utilise 'cosmos' in ways that have value.
12. Create a 'diploma in rural health' through the College of Medicine, giving academic value to skills, competencies and experience gained in rural settings.

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