

# **REPORT OF THE 5<sup>TH</sup> WONCA WORLD RURAL HEALTH CONFERENCE**

held in

**MELBOURNE, AUSTRALIA**  
30<sup>th</sup> April – 3<sup>rd</sup> May 2002

## **INTRODUCTION**

The **World Organization of National Colleges and Associations of Family Doctors** (WONCA) is one of the largest medical organizations in the world. WONCA has established a Working Party on Rural Practice, which has arranged a series of world conferences on rural health, the second of which was held in Durban in 1997. The fifth in the series of conferences, was held in Melbourne from 30th April to 3rd May 2002, with the theme “Working together: Communities, Professionals, Services”. It attracted close to 1000 delegates from 26 countries, and was the largest gathering of its kind so far, attracting a far more multidisciplinary audience than before. South Africa was well represented by thirty-one members from government, academic institutions, rural hospitals, and allied health workers such as social workers and physiotherapists.

It was a very full conference in terms of the programme: each of the main days had a plenary session with 4 keynote speakers, 4 parallel symposia, and a host of free paper sessions running parallel throughout the afternoon, closing with “village meetings” to discuss the days events in 5 groups. The conference organization was outstanding. The most noticeable feature was the communication, which was regular and most informative at all stages, from planning to the closing ceremony. They had the Australian ABC network present doing live recording to the website of all speakers' presentations.

There were four main themes, namely Recruitment and Retention of the Rural Health Workforce, Gender Issues, Indigenous Issues and Rural/Urban Interface. There were 4 presentations per theme in 3 one-hour sessions each day, so the information overload was enormous. The final hour of each day was dedicated to smaller group discussions reviewing the day's proceedings and working towards a 'declaration'. An interesting feature was a clinical skills workshop which ran constantly over the 3 days for anyone wanting to increase their technical clinical skills. One session which attracted a lot of attention was 'emergency assistance for aircraft passenger crises. And there were the usual posters and poster facilitated presentations.

# PRE-CONFERENCE WORKSHOPS

## 1. WHO-Wonca Invitational Conference (HARP)

One of the pre-conferences was co-sponsored by the World Health Organization (WHO) and by the World Organization of Family Doctors (WONCA). It was held at the **Monash University School of Rural Health** in Traralgon, 2 hour's drive from Melbourne from 27<sup>th</sup> to 29<sup>th</sup> April, and was attended by about 80 invited people, representing WHO and Wonca different health professional groupings, academic institutions, governments, NGO's, etc. The South African Department of Health was represented by Dr Tim Wilson and Mrs Gladys Crisp-Mokoto. Nethia Naidoo attended as a member of the Wonca Working Party on Rural Practice, and Ian Couper and Steve Reid were part of the organizing committee. In addition, Andrew Ross was invited to present the Ingwavuma Scholarship Scheme as a case study.

The initiative for this workshop, entitled "**Health for All Rural People**" (HARP), came from Dr Charles Boelen who recently retired from the WHO and who now works as a consultant. He wrote the WHO document "**Towards Unity for Health**" (TUFH) which stresses the crucial role of the generalist in developing comprehensive health services, and the need to address "the big 5": policy makers, health managers, academics, health professionals and communities. By linking this TUFH initiative to the generalist doctor organization WONCA, and specifically its working party on Rural Health, they were exploring ways of incorporating family doctors into the system.

Part of the initial process was the presentation of a set of scenarios describing particular experiences in selected places around the world, which I had had a hand in organizing before the conference. The two scenarios presented from South Africa were the Ingwavuma Scholarship Scheme and the national Integrated Sustainable Rural Development Strategy presented by Dr Tim Wilson. Other scenarios came from Australia, New Zealand, India, Pakistan, Nepal, Vietnam, Scotland, Spain, Vanuatu, Honduras, Argentina and the USA, and they all highlighted different problems and solutions. The guiding principles were:

- Justice
- Addressing poverty
- Community development
- Health care
- Range of interventions
- Equitability
- Appropriate technology
- Sustainability
- Ongoing monitoring

This was an intense few days of working hard as a group to develop a strategic plan for rural health. The task was to "Think locally and act globally". It was extremely well facilitated by two professional facilitators and 3 actors who called themselves "animators". A draft document was formulated, in 3 parts: one part which will be edited as the formal outcomes document, and will be submitted to the WHO and Wonca for ratification and then distributed; a second part with recommendations for Wonca to act upon; and a third part consisting of ideas which came out of the working groups for use by individuals. We hope to be able to use the first document in South Africa to promote the development of generalist nurses and doctors in the district health system in rural areas.

## **2. Rural nurse practitioners: Working together to improve Rural Health Care delivery: 29<sup>th</sup> – 30<sup>th</sup> April 2002**

This workshop was attended by Mrs Mapule Maelane of the Witbank campus of the University of Pretoria, Dept of Nursing Sciences.

The concerns raised mostly alluded to the following critical issues:

1. Lack of effective multidisciplinary approach and role recognition as a problem.
2. Universities commitment to increase affordable opportunities to rural students (disadvantaged provinces without nursing academic departments), with recruitment as a major problem.
3. Nursing departments and academia, not advancing in outreach programs to the true rural areas, to encourage vigorous rural recruits for nursing professional careers.
4. University training programmes not inclusive of adequate rural clinical practical opportunities, to facilitate rural exposure and valuable experience.
5. Governments to play their role in the academia and rural health professional development.

Many models were presented for use in addressing health challenges in rural or disadvantaged areas. Projects that were initiated, promising improvement and good outputs, revealed the determination and commitment of practitioners already in rural areas. These models emphasized the need for:

- Quality of care and improved performance management,
- Approaches of care based on shared vision, values and empowerment principles
- Effective partnership of consumer and provider
- Critical local thinking and local acting, then regional and ultimately global, for competitiveness, and working together to improve the health of all our customers.

## GENERAL IMPRESSIONS OF THE MAIN CONFERENCE

The major impression left by the two conferences is that governments and universities in Australia, New Zealand, the Phillipines and Canada are taking **training for rural health care** much more seriously than South Africa.

The issues of **equity and social justice** came through quite strongly. For this reason, it was agreed that we should address the ethics of international recruitment. Recruiting agencies from Australia and Canada are actively seeking more doctors for their under-served areas, but the rural doctors themselves nevertheless fully supported the view that it is not ethical for rich countries like theirs to recruit doctors from South Africa or other developing countries. Ian Couper and Steve Reid helped to draw up a code of practice for the international recruitment of health care professionals, which was presented to the conference as the **Melbourne Manifesto**, a key outcome of the conference. After input from the floor, during a working session, with rapid changes being made, it was presented to the participants in the closing session, and adopted *nem con* (one abstention, no opposing votes).

The conference focused heavily on the problem of the **recruitment and retention** of health professional staff in rural areas, possibly to the exclusion of other issues. One delegate felt that the conference was dominated by the medical discipline: even the gender issues dealt mostly with the female doctor in the rural setting. The level of attention to **health promotion** was low, which was surprising and disappointing to some. However in the keynote speeches it seemed that there was a reawakening to the issues of social responsibility and inter-sectoral collaboration.

The Australians are currently very preoccupied with what they call the 'indigenous' problem, which is the inequality in health status, and the level of services provided to the **Aboriginal people**. It has become a political monster, with increasing levels of funding being made to the services but very little impact being identified from the reallocation of the resources. It was surprising to discover that Aborigines were not given the vote until as recently as 1970, and there are relatively few Aboriginal doctors even now.

## PLENARY SPEECHES

**Ms Pat Anderson**, the Chair of the National Aboriginal Community Controlled Health Organisation, spoke on the issue of violence in the Aboriginal community. The effects of the "Lost Generation", when children were forcibly taken from their mothers by law and given to white foster parents to supposedly ensure a better upbringing, are still being felt in the next generation.

**Prof. Don Nutbeam**, Head of Public Health in the UK Department of Health, spoke of the initiatives in the UK to address inequalities of health in rural areas there. He frequently referred to the 'Acheson Report' and the NHS 2000 Plan, copies of which are available on the UK govt. website. This found that while health is improving overall, the gap between the rich and the poor in terms of health status is increasing.

He noted that policies which improve average health may have no impact on inequalities in health, and may even increase these. He also noted that the unequal effects on rural people may be masked because there are often socially excluded people living alongside the extremely affluent, who have moved into the country for a better lifestyle while still working in the cities. He made a strong appeal that health be seen from a collaborative view and all govt. ministers in the UK were asked to sign the health budget to ensure collaboration.

**Dr MK Rajakumar** from Malaysia, one of the senior statesmen of rural health and family practice, spoke powerfully but humbly about **rural health and global equity**. The one global market is pitching the ill equipped poor farmer against the highly equipped, mechanized farmers of the west. The effects are felt in all aspects of rural life. Since the cold war ended the world has entered a period of malignant neglect and there is talk of “compassion fatigue even before compassion has been exercised”. However rural physicians have the temperament, knowledge and skills to deliver on need. His challenge to us was to demonstrate that our tradition of caring goes beyond the consultation, and he began to phrase the values of the rural health movement, which have been implicit rather than explicit until now. He challenged those in rich countries who share the values of social justice to support those who do not have the resources to do what needs to be done in poorer countries, as opposed to the “glorified self-interest” of doctors who refuse to go beyond their immediate area of responsibility. There needs to be a new coalition of teachers, doctors, nurses and technologists to create a network of centres for rural health (cloning the good ideas), create links between family practices in developing and developed countries, and plans to assist doctors working with poor people. Because “in giving a bit of ourselves to help a stranger in a far away country we bear testimony to our own humanity and our own humane values.”

**John Thwaites MP** spoke on the health initiatives in the State of Victoria. There is a significant redistribution of funding towards the indigenous people. Incentives are being provided for rural health professionals so as to encourage their recruitment and their retention. He did stress that the government in Victoria was increasingly working more collaboratively on health matters.

**Prof. Florence Manguyu** from Kenya, former president of the Medical Women's International Association, spoke eloquently on gender issues in the provision of health services in rural communities. She nicely encapsulated the determinants of health as 4 'P's', which controlled women's roles; Providence (genetic), People (society), Politics (the policies in a given context), and Profession (the extent of health care available). She provided horrendous statistics on HIV/AIDS, TB and malaria. Women account for 70% of the 1.2 billion 'poor' of the world and 55% of the HIV cases in Africa.

**Dr Michael Boland**, President of Wonca spoke of his model of a rural health team comprising a doctor, a nurse, a community nurse and a pharmacist.

**Prof Roger Rosenblatt** spoke of the 'environment imperative' and 'Saving the Earth'. His presentation was fascinating and most thought provoking. He described a patient who had a fever, asthma, alopecia, thrust and scabies. The name of the patient was Earth and the symptoms were coming from the following problems:

Fever: global warming  
Asthma: air pollution  
Alopecia: deforestation  
Thrush: loss of bioversity  
Scabies: overpopulation, which he predicts will see the world population be 10 billion by 2010

His solutions were to control pregnancies, promote economic sustainable development and preserve natural habitats. And rural health professionals can influence their communities along these lines.

**Dr Helen Caldicott** terrified everyone in the room with her stark facts about the nuclear destruction possibilities in the world. She is a passionate advocate of nuclear disarmament, and founded the organization Physicians for Social Responsibility, which educates colleagues about the **dangers of nuclear power and nuclear war**. She has written a book, and made much reference to an article in The New England Journal of Medicine in 1962.

The most moving and inspiring address was given by **Mr James Fitzpatrick**, a medical student, poet, and Young Australian of the Year 2001. He spoke of 'A rural resurgence: walking together.' He and two friends travelled 30 000 miles across Australia in a bakkie and called on 40+ rural villages to speak to and work with the youth in those villages. They spoke in schools, at community centres, on radio stations, on TV, etc, but mostly they moved amongst the young people themselves and interacted with them. Called "**True Blue Dreaming**", the idea of the trip was to inspire young people to dream, to believe in themselves and to have hope for the future. He spoke of empowering from within with peace, equity, justice and health. They have in Australia a Rural Health Club in each region which is linked into a Rural Health Network. The young health professional students are encouraged to join and get experience in the rural areas.

**Senator Kay Patterson**, the National Minister of Health, spoke convincingly of her department's commitment to place Australians in the highest ranked health service in the world. She can do it because she believes it possible.

## PARALLEL SESSIONS

The themes of the conferences were recruitment and retention of doctors, gender issues, indigenous health and rural-urban interface.

### RECRUITMENT AND RETENTION

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.

None of the models presented were starting from the rural service providers with them/ 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, for any recruitment program to be a success, there needs to be a number of “joined up” activities which include the following:

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

### RURAL MEDICAL SCHOOLS

**James Cook University** is a new medical school in North East Australia that has grown out of work started several years ago in the University of Queensland. It has a specifically rural focus and is the most advanced in arranging for medical students to spend a very large proportion of their time actually training in small communities in remote rural areas. However, other medical schools throughout Australia are also recruiting far more students from rural areas (up from 8% a few years ago to 25% now) and are giving increased emphasis to training in rural areas. All medical schools have active “Rural Health Clubs” run by the students. The Commonwealth (Federal) government has a range of incentives to encourage students from rural areas to train as health professionals, and to work in rural areas after graduating. Some bursaries are linked to participation in the activities of a Rural Health Club.

There are a number of schools of rural health attached to different Universities in Australia and the **Monash school** is one of them. It has impressive facilities, a fair number of staff at Traralgon, and teaching practices in other sites in the state. In New Zealand the medical school in **Dunedin** reported very good experience and positive feedback from students who are doing much of their training attached to local doctors in remote rural areas. A representative from a new medical school in the southern **Phillipines** also reported good experience and positive feedback from students selected from and trained in a remote rural part of the Phillipines. In Canada the first new medical school to be set up in 20 years is the **Northern Ontario Rural Medical School (NORMS)**. It is busy appointing staff and will admit its first students in, apparently, 2003. Again the focus will be on recruiting students from rural areas and doing all the teaching in two small towns 1000km apart and in a number of very remote communities.

**The Carnavon Children's Fair.** Paper by a medical student in Perth. This was an excellent presentation, supported by other students and full of infectious enthusiasm. About three years ago the rural health club in Perth decided to try and improve the health of children in the small rural town of Carnavon several hundred kilometres North of Perth, and at the same time to expose students to the realities of life for aboriginal children growing up in a rural area. They have done this by organizing, for each of the last three years, a fair held over a weekend and run entirely by the students. They try to attract all the children of Carnavon but make a particular effort to draw in the children of the aboriginal families, plus any parents who wish to come. There are some health promotion activities and there may be some treatment for minor ailments, but the main emphasis is on promoting mental and social health by reducing the sense of isolation and alienation from mainstream Australian society.

The fair has grown from year to year and is now so popular that there is only space on the buses for less than half the students who volunteer to go. According to the report the fair has had a major educational impact on the students and has raised the morale and sense of self-worth of the children of Carnavon and their parents. This report highlighted how much can be done by students with enthusiasm.

## **RURAL ORIGIN STUDENTS**

### **Are Medical Students of rural origin more likely to become rural general practitioners than students of urban origin ? Australian and South African studies**

Many people believe that students recruited from rural areas are more likely to return to practice in rural areas. However, the evidence so far has been largely anecdotal or descriptive and has not been sufficiently strong to convince sceptics in faculties of health sciences. **Gillian Laven** presented the first rigorous epidemiological study in Australia to test the hypothesis, and **Elma de Vries** presented the results of a similar study in South Africa.

The Australian study is not yet complete but preliminary results show clearly that it is true that medical students from rural areas in Australia are more likely to end up practising in rural areas than students from urban areas. Being born, growing up and



attending primary school in a rural area, and marrying someone from a rural area, all influence people to return to a rural area. However, the single most important factor is attending secondary school in a rural area.

Elma de Vries' study has found the same in the South African situation. This has obvious implications for South Africa and our faculties of health sciences. Targeted recruitment of applicants from secondary schools in rural areas is likely to have a very positive effect on the future staffing of health facilities in rural areas. Although the Australian study focuses only on medical students and doctors, the same factors are likely to apply to all health professionals.

**The Friends of Mosvold Hospital scheme** was reported on by Andrew Ross of KwaZulu-Natal and was generally regarded by delegates from all countries as one of the most exciting papers presented to the WHO-WONCA pre-conference. He spoke about the scheme organised by this rural hospital to provide bursaries for students from local high schools to train as health professionals.

The first task has been to get the commitment of several faculties of health sciences that if up to a certain number of students from this rural district get specified symbols in matric, the university will admit them to the relevant courses. Hospital staff then visit local high schools to talk about the various health professions, what the work entails and the matric symbols needed to get into a faculty of health sciences to train in each. Students are told that if they get the required symbols, have the support of the local community and get admitted by a faculty of health sciences, they can get a full bursary from the hospital to cover all their study and living costs. Once they get a bursary, all they have to do is to report back regularly to their community, work every holiday in the hospital (for which they are paid R250 per week), and commit themselves to work as a trained professional in the hospital for at least one year for every year of bursary support.

So far, from the sub-district around that rural hospital, 12 students have been sufficiently inspired to get themselves into faculties of health sciences. They are receiving full bursaries, are working at the hospital in their vacations and are maintaining their links with their communities. The scheme is slowly spreading to other hospitals in the district and their local schools. The main rate-limiting factor appears to be funding for the bursaries, but the enthusiasm of Dr Ross and his staff at Mosvold are probably critical to the success so far. Other rural hospitals in South Africa could easily run similar schemes, and if the hospital staff are enthusiastic and can make the scheme work, then each province could easily direct some of its provincial bursary funds to support such a scheme.

One very interesting study was that presented by **Lexin Wang** from China which showed that the rural colleges of medicine were more effective in sending graduates back to serve in rural areas than the urban colleges were. Only 5 to 10% of graduates from the metropolitan universities went to work in the rural areas of China (regional cities) whereas 30 to 65% of graduates from the provincial regional city based universities worked in the rural areas. This would seem to support the concept that the place of teaching affects the aspirations and comfort of graduates in practice.

## **RURAL-URBAN INTERFACE**

It seemed that the issues of the rural-urban interface are the same all over the world as there were not many topics on this area. South African efforts in this area are comparable to other countries, for example, the flying ambulance and specialist outreach. It was interesting to discover a new category of health disciplines necessitated by telemetry. This is the so-called informatician with a computing and engineering background in the Faculty of Medicine.

### **Dr.Charles Boelen: Towards unity in health- the WHO approach**

This was an excellent presentation, covering many seemingly "obvious" things, many of which are already being implemented in the rural areas. The rural areas may in fact be able to take a lead in demonstrating the importance of team and multi-disciplinary work and the integration of both individual health care and public health care in caring for individuals who make up communities (Victor Fredlund has been involved in running a rural hospital at Mseleni, learning to do hip replacements as well as being involved a large scale water and sanitation project!) Dr.Boelen discussed the issues of quality of care and equity, which need to be held together with issues of relevance and cost efficiency, and all of these need to be based upon the needs of the individuals (& the people) being served. He also emphasized that all of those involved in broad health activities need to work in partnership (these need to include at least the following: policy makers, health professionals, health managers, academic institutions and communities) to ensure that any improvement in health care is done in the most cost effective manner. This type of approach will need shared values on behalf of all stakeholders/ partners and active research and development for its implementation as well as political and legislative support.

### **Fixing houses for better living: Mr Paul Pholeros**

This presentation outlined how "stopping people from getting sick" was used as a strategy for well being. Through community participation, creation of a healthy and safe home environment was identified as a key element to improving the health status of the indigenous people of Australia. 39 Indicators were agreed upon, used to assess the homes, however only 7 were used to declare the home not safe vs leaking pipes and taps, no water running water, no hot water, poor floors, poor water drainage, poor roofing and facilities for storing and preparing food. Should this be found the house was declared not safe and fixing would start immediately, with technical support from the Department of Housing. Benefits of the project were reduction in communicable diseases, upper respiratory tract infections, electrocution, diarrhoeal diseases, skin infections and improvement of nutrition. These practices can be adopted and adapted for our situation and be made practice for health promotion in collaboration with other sectors.

**Dr David Rosenthal**, comparing rural and urban health care in Australia, noted that the national doctor: population ratio is 245/100 000, the one for metropolitan areas is 306/100 000 and the ratio for rural and remote areas is 144/100 000. The average medical expenditure per capita is Aus\$145 for urban areas and Aus\$92 for rural areas. This is despite the major efforts in respect of rural health in Australia over the last decade.

## CONCLUSIONS

Responses of some of the South African delegates:

“It was pleasing to hear deliberations on **moral recruitment** of health personnel from the developing countries. I wish the governments in the world take these up. It seems, however, that the impressions about violence in South Africa have not been reversed from the publicity that went on when it was at its peak. This seemingly impacts on the attitude about on the country.”

“It is also heartening to see **how involved the [Australian] government was** in the conference. They had a stand and provide valuable literature on their efforts related to the conference themes.”

“The **core business** of the Governments, Health Care institutions and the academia according to the many views at the conference, is that of recruiting, training, providing opportunities for human resource development and retention of skilled human resources in all employment agencies. The outcome is the provision and maintenance of a **quality human resource pool**, to provide training and quality improved services for the entire population even in the rural or disadvantaged areas of any province or country. Unfortunately suitable qualified and skilled Doctors, Nurse Practitioners and Nurse Managers continue to leave at a rate greater than they can be replaced.”

“The trip was a demanding but worthwhile experience. The most important learning for me personally was the emergence of the **implicit values of the rural health** movement around the world, namely those of social justice and a concern for those who are marginalized and disadvantaged. It was significant to me to hear the unanimous support for the principles of the “Melbourne Manifesto” from every country regardless of the level of material resources. It was also important to forge links with other South Africans, with the Department of Health, and with other health professionals involved in rural health.

Lastly, the **focus on students** and encouraging them to consider careers in rural health, was a strong element of the main conference, and this confirmed for me the appropriateness and importance of my current position at the medical school.”

“South African faculties of health sciences that seriously wish to train health professionals for rural areas could learn a great deal from interacting with colleagues at the **rural medical schools**.”

“It was pleasing to see a good group of South Africans there. It is hoped that this will help to develop momentum with respect to rural health issues in South Africa.”

“In general, the conference was thought provoking, interesting and awakened the need to reinforce the existing channels and opportunities available for advancing rural health service awareness and development. I hope that the entire South African team will be committed to further drive the process of rural health improvement.”

## ACTIONS ARISING FROM THE CONFERENCE

The South African delegates met together briefly at the beginning and at the end of the conference, and put together the following plans for action back home following the conference:

- Encourage the formation of **Rural Health Clubs** at faculties of health sciences, and a Rural Health Network to link them
- Find funding for 2 or more students to attend the **Australian conference** of Rural Health Clubs 12-14 August 2002
- Establish **mentoring capacity**, particularly in rural South Africa, for all health professionals.
- Encourage Deans and others at faculties of health sciences to contact James Cook (Australia), Dunedin (NZ), NORMS (Canada) and SW Minadau (Malaysia) universities to learn about rural teaching
- Establish a forum for the presentation of research projects in rural health issues: an **Annual Rural Health Research conference**
- Advocate for **selection processes** at health science faculties that include a target of 25% of students from rural origin.
- Assist in **defining** what is meant by rural, for the purposes of planning and resource allocation
- Meet again at the **Rural Doctors Conference** in Mpumalanga 9-11 August 2002.

Further information regarding WONCA can be found at:

[www.globalfamilydoctor.com](http://www.globalfamilydoctor.com)  
[www.rural-wonca2003.net](http://www.rural-wonca2003.net)

Further information on the Rural Doctors Association of Southern Africa can be found at:

[www.rudasa.org.za](http://www.rudasa.org.za)