RURAL HEALTH AND HUMAN RIGHTS — SUMMARY OF A SUBMISSION TO THE TRUTH AND RECONCILIATION COMMISSION HEALTH SECTOR HEARINGS, 17 JUNE 1997

Steve Reid, Janet Giddy

Steve Reid and Janet Giddy are two family physicians who worked from 1986 to 1995 at Bethesda Hospital in Ubombo, Northern KwaZulu-Natal. This article, which has been adapted from their submission to the Truth and Reconciliation Commission (TRC) Health Sector Hearings on 17 June 1997, recounts their experiences as general medical officers with the KwaZulu Department of Health. Steve had been assigned to do community service for his religious objection to military conscription. Initially posted for 6 years, the husband and wife team served the hospital for 9.

THE REALITY OF RURAL HOMELANDS

In this submission we highlight the failure of the medical authorities to recognise and address the plight of vast numbers of 'forgotten' people who live desperately, on the edges of extreme poverty, in harsh environments. As rural doctors in a 'homeland' we provided care for people relegated to apartheid-constructed dumping grounds. On a daily basis we dealt with the ill health and disease suffered by large numbers of illiterate, poor and marginalised people. We would like to highlight the plight of those who are battling with the effects of preventable diseases such as measles, malaria, tuberculosis and AIDS, and those who continue to be marginalised even today.

RELATIVE LACK OF FINANCIAL AND HUMAN RESOURCES

In the time that we worked at Bethesda Hospital it was common knowledge that rural hospitals, especially in homeland areas, received approximately half the budget allocations granted to provincial hospitals of the same size in urban areas. Rural health services, conveniently out of sight and out of mind, were chronically underfunded relative to urban facilities.

A well-functioning health service needs to be adequately staffed by a team of health care professionals including doctors, nurses, physio- and occupational therapists, laboratory technicians, pharmacists and dentists. At no time while we worked in the Maputaland region was there ever such a team.

There was a permanent shortage of qualified nurses, which meant that the entire hospital was frequently covered by one professional nurse at night. Furthermore much of the work was done by enrolled nurses, compelled by circumstance to function far beyond their scope of practice. At one stage a dentist visited once a week for 6 months; otherwise the only dental care available was provided by the doctors, who taught each other to do extractions. No trained pharmacist was employed at the hospital. The laboratory was permanently understaffed, which had serious implications for diagnostic precision in a region where malaria, TB, bilharzia, typhoid and other serious infectious diseases are endemic. Finally, Bethesda Hospital had only one occupational therapist for one year in 1993, despite there being a significant number of disabled people in the community.

THE DOCTOR SHORTAGE

The uneven distribution of doctors in favour of urban areas, and at the expense of rural areas, is a well-known fact in this country. We raise this complex issue once again, not only because it was a significant factor in our experience at Bethesda Hospital, but also because it illustrates the failure of the health authorities and the medical profession to fulfil their duty towards rural patients and communities, namely to provide them with an adequate standard of health care.

While the vast majority of doctors live and work in urban areas for their professional lives, those few South African doctors who choose to work in rural locations are motivated by a variety of factors. Some are motivated by a missionary spirit; others are unable to get posts in cities; but a large number are foreign-qualified doctors. The foreign-qualified doctors who formed the backbone of the rural health service were frustrated by their insecure status in this country, in particular the difficulty they experienced obtaining full registration with the South African Medical and Dental Council. Despite their willingness to serve where South African doctors would not, and their often extensive skills, their status was not acknowledged by the authorities, and only a few dedicated individuals have remained at their posts for an appreciable length of time.

The Department of Health has never provided incentives for South African doctors to work in rural areas. Instead of the schemes used to attract foreign doctors to rural hospitals, the Department of Health could have provided attractive financial incentives to recruit South Africans to rural areas. Doctors who did remain in rural areas were given no specific acknowledgement or encouragement to serve for longer periods.

For certain doctors there were obstacles to working in KwaZulu. To the best of our knowledge there were no Zulu doctors working in rural hospitals in KwaZulu between 1986 and 1994, despite the fact that the University of Natal had been

33 Shuter Road, Glenwood, Durban
S J Reid, MB ChB, BSc (Med), MFamMed
J Giddy, MB ChB, DipPHC (Ed), MFamMed

graduating Zulu doctors since 1951. An important reason for this was the KwaZulu pledge, a requirement that all KwaZulu public servants sign an oath of allegiance to the KwaZulu government and its leaders. We personally knew of doctors who would have joined us if this pledge had not been an issue.

Another disincentive to doctors working in rural areas was the lack of academic support for rural medicine. The University of Natal medical school provided no specific professional support to rural doctors, and their medical undergraduate programme certainly did not produce doctors who saw rural service as a long-term career option. An undergraduate programme more attuned to the needs of the people, postgraduate programmes that supported rural doctors, and continuing medical education aimed at isolated rural practitioners, could have made a difference to this situation, as well as encouraging doctors to consider serving for a longer period of time.

While recruiting competent doctors to rural sites is a long-standing concern not only in South Africa but in other countries as well, little if anything has been done to address the situation here in a substantive way. In our experience the shortage of doctors resulted in long delays for patients waiting to receive treatment, inadequate emergency care, and unskilled operations, with associated morbidity and mortality. Unfilled posts created conditions of stress and overwork for remaining staff. A vicious cycle developed, as no doctor would choose to work in a hospital that was poorly staffed. Ultimately, health care for disadvantaged rural communities was compromised by this lack of action.

Human rights abuses of patients by doctors in rural areas

We are aware that a number of private general practitioners in our area operated racist practices. Separate entrances, waiting rooms and facilities for medical aid patients as opposed to cash patients effectively separated white from black. In the medical aid part of the practice facilities were conducive to privacy and a high quality of patient care, whereas the back door was normally used for cash patients and facilities and drugs were limited here to the bare essentials. These racist practices were defended on the basis that it was the only financially viable option for both the patients and the general practitioner. However, it was the cash patients who generated the income of private general practitioners in rural areas. At worst, this situation may be viewed as nothing less than racial discrimination in health care and the financial exploitation of disadvantaged rural people.

Another practice we were aware of was the widespread use of the intramuscular injection (*umjova*) for every patient, regardless of the complaint. Ethical issues around the exploitation of patients' ignorance in order to promote the doctor's perceived power through the indiscriminate use of the intramuscular injection were not considered, nor was this practice challenged. This practice led to the progressive disempowerment of patients by doctors, and was an abuse of human rights insofar as patients remained unaware and uninformed of the true value of the injection. At worst, we were informed of the intramuscular injection of sterile water instead of a drug, and the re-use of injection needles for numerous patients without sterilisation, both of which were completely unethical.

Human rights abuses of disabled people in rural areas

Disabled people have difficult lives in any situation, but particularly so in rural areas. A part-time district surgeons we were obliged to assess applicants for disability grants. The system was extremely inefficient and fraught with difficulties; in many cases there was even corruption on the part of Welfare Department officials. People with serious disability who were obviously eligible experienced endless bureaucratic problems in receiving their grants. In rural areas there were no schools for disabled children, no chronic care facilities for the severely disabled and no facilities providing intermediate care. Disabled patients discharged from the hospital after treatment of an acute problem would often find themselves back in a home situation which had caused their illness in the first place. Lack of resources led to patients remaining in hospital for months or years at a time, when they would have been discharged in an urban setting.

Even with wheelchairs and aids disabled people struggle in rural areas. Wheelchairs cannot move in soft sand, and life is often intolerable for people with serious disabilities. For example, Mr Frans Gumbi was a quadriplegic patient under our care for over 6 years. Following a spinal cord injury after a fall from a bicycle in 1979, he was left with no movement in his legs and only slight movement in his arms. Confined to a wheelchair, he was totally dependent on his mother. The family lived in a homestead made of sticks and mud about 10 km from the hospital. Mr Gumbi received a disability grant of R242 every second month. He was subject to urinary infections and bedsores that were difficult to manage at home because of the shortage of clean water, the distance to the hospital and financial constraints.

In any other situation Mr Gumbi might have expected access to resources and assistance in order to cope with the demands of his condition. However, because he was black and lived in a rural area where health services were totally inadequate he suffered far more than others with similar disabilities, and he died far sooner. That he did in fact live with dignity and inner strength despite the cruelty of his situation was a source of great inspiration to us, his able-bodied 'helpers'.

Conclusion

We have highlighted a number of situations where we feel that the medical profession and others responsible for the provision of health services have abused the human rights of

rural communities and individuals through neglect of their duties. We know of people who died prematurely and suffered immeasurably in obscure corners of South Africa as a result of these sins of omission. Their suffering was no less significant for its hidden and undramatic nature. It is our hope that by sharing our experiences and raising these difficult issues, the health of rural people in our country will be given the attention that it deserves. In many ways the health of rural people is a critical indicator of the extent to which the new government succeeds in its task.

ADDENDUM: RURAL HEALTH AND HUMAN RIGHTS — THE DURBAN DECLARATION

In an effort to address the challenges of improving health for all rural people, health professionals from around the world met at the Second World Rural Health Congress in September 1997 in Durban, South Africa.[1] 'For some it was the first time that they had encountered the sense of identity as a rural practitioner, while for others, it was a celebration of another success in putting rural health issues on the political agenda in this and many other countries.'[2] The Durban Declaration called for a combined effort to redress the historical inequities faced by rural and disadvantaged communities. Recognising significant contributions from several countries and organisations, the declaration expresses profound concern at the neglect of rural people.

The declaration cites the growing disparity in the distribution of wealth within and between rich and poor countries, and states that targets must be set in stages until the year 2020 to ensure the substantial reduction of all aspects of global poverty.

Health professions in South Africa contribute to the health and welfare of rural and disadvantaged communities. Training institutions should reformulate curricula and adopt other strategies to motivate students for rural practice. Professional organisations should form a strong lobby on behalf of rural health issues, and create continuing professional development programmes for rural health professionals. National government must devise and implement policy incentives for rural practice and initiatives to enhance the recruitment and retention of rural health workers. Local government must work together with the community and the health team in the assessment, analysis and development of health services responsive to community needs. Lastly, every health professional must examine his or her motives with regard to the provision of health care, noting how these affect the human rights of the people we claim to serve.

M de Villiers

Faculty of Medicine
University of Stellenbosch

References

1. Second World Rural Health Congress Special Edition. *South African Family Practice* 1997; **18:** 5.
2. Reid S. A positive approach to rural practice (Editorial, Second World Rural Health Congress Special Edition). *South African Family Practice* 1997; **18** (5): 1.

GENDER AUDIT OF HEALTH RESEARCH — 10 YEARS OF THE *SOUTH AFRICAN MEDICAL JOURNAL*

Miriam Hoosain, Rachel Jewkes, Simphiwe Maphumulo

Objective. To examine the extent to which gender bias, which has been identified as a feature of medical research internationally, is present in medical research published in South Africa.

Design. A retrospective review was undertaken of 789 articles, 106 letters and 266 editorials in 10 years of the *South African Medical Journal* (1986 - 1995).

Main outcome measures. These were gender of study subjects, proportion of women in the sample, and evidence of analysis of results according to gender of study subject.

Results. Forty-eight per cent of articles (377) and 98% of letters (104) did not mention the gender of the sample. Samples that included both genders had significantly fewer women than men, with 80% (297) of such articles and 93% (14) of such letters not presenting a comparative analysis of results.

Conclusions. These findings, similar to those of the international literature, indicate a predominant 'gender blindness' in published works. This precludes investigation of differences in the ways men and women experience disease and differential access to care.

S Afr Med J 1998; **88:** 982-985.

Gender bias occurs when there is a disproportionate focus on one gender, often because of lack of interest in the other or failure to consider gender differences due to an untested assumption that both genders are the same. Historically the direction of bias in research has usually, but not exclusively, been towards men. Researchers worldwide have drawn attention to gender bias in clinical research at conceptual, analytical and presentation stages, arguing that it has resulted in poorer access to health care for women and poorer clinical care.

Centre for Epidemiological Research in Southern Africa, Medical Research Council, Tygerberg, W Cape

Miriam Hoosain, BA Hons, MA
Rachel Jewkes, MB BS, MSc, MFPHM, MD
Simphiwe Maphumulo, BSc Hons