and its nearest district hospital, Zithulele (100 beds), in December prompted several veteran rural doctors to offer practical advice and academic textbooks to support the struggling Cosmos.

Solution on a plate

Mapham said he and his colleagues had presented Bisho with 'an almost complete human resources solution', by finding willing professionals to fill vacant posts. 'This is a solution that Ministers of Health must dream about,' he added.

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Wagner, who has won widespread respect among colleagues and academic institutions for her tireless work in the beleaguered province, said candidates for newly approved clinical posts started work on 5 January this year. Interviewed just days after her own appointment, she said she was already working on a human resources plan for the Eastern Cape for the next 5 years. 'I've just presented a framework to the University of the Transkei (Unitra) and they're very excited – I'll be working a lot with them,' she said.

Mapham, who teamed up with Wagner to 'sell' the Eastern Cape to various Deans of Medicine and delegates at medical conferences last year, said six Unitra medical students did their electives at Madwaleni over the first 2 weeks in December.

The long road to Madwaleni Hospital near Nelson Mandela's birthplace in the Eastern Cape. Picture: Chris Bateman

A United States-funded 'Mothers to Mothers-to-be' HIV assistance programme would also be setting up there this year while elective students and interns would continue to flow from the universities of Cape Town and Stellenbosch.

'We're the only accredited ARV site between Umtata and East London, so the USA programme will be a big boost with their specialist obstetrician/gynaecologist and a GP on hand,' he said.

Madwaleni had so far identified 10 patients as qualifying for ARV treatment and 56 community members were undergoing VCT training. Said Dr Ian Couper, Head of Rural Medicine at Wits: 'Rural hospitals represent and care for communities that are often invisible. Many people are born and die without birth certificates. This area's biggest problems are malnutrition, TB and HIV, all of which require primary health care that can only be delivered if there are professionals present'.

Madwaleni has also helped neighbouring Zithulele District Hospital recruit 5 doctors for the 50 km geographical radius that it serves, its two Cosmos having left in December.

As of mid-December, Madwaleni had three doctors (the Cosmos, supported by chief medical officer, Dr Patrick Nana-Akuako Nketiah, a former Ghanian), and 200 nurses living in 35 sparsely-furnished rooms.

Madwaleni is a 2-hour, good-weather drive from Umtata on patchy dirt roads. The Mbashe district is the birthplace of former President Nelson Mandela, who still maintains a home there, and of current president Thabo Mbeki, whose mother still lives there.

Chris Bateman

NOT 'CHARTERING' HER OWN WATERS – MINISTER

Rumours that she was unlikely to consult stakeholders on the Health Charter were 'puzzling and unfounded' because a widely representative task team was due to report to her early this year. This was said by Health Minister Dr Manto Tshabalala-Msimang in her closing speech at the government-convened and sponsored national health summit held at the Sandton Convention Centre on 2 and 3 December last year.

Tshabalala-Msimang said she was forced to revise an 'unrealistic' December 2004 target date she had initially set for the charter task team.

The framework of the Health Charter would emerge from the task team and be tabled for debate and discussion at her first regular meeting with her provincial counterparts (MinMEC).

'I'll then convene – and I say this very loudly – a national consultative forum to discuss the framework,' she added. She emphasised that this forum would consist of representatives of various stakeholders within the health sector

Health Minister, Dr Manto Tshabalala-Msimang, with her recently apppointed KwaZulu-Natal counterpart, Ms Peggy Nkonyeni, at the National Health Summit in Gauteng in December.

Picture: Chris Bateman

and be consultative but 'not a conference'.

'I don't know where these rumours come from, we get e-mails with people's faces just to threaten us – it's not helping create a climate of trust.'

When asked by *Izindaba* at a gala supper for detail about the 'threatening' e-mails, Tshabalala-Msimang said they were sent to her by a single person conducting a campaign, but stopped short at identifying the author. 'He attaches his picture to all the e-mails,' was all she would say.

However, she commended e-mail as a communication medium for stakeholders wanting to submit comments to the Health Charter task team, emphasising that the ensuing consultative forum would 'not be a negotiating forum'.

'It will collect all that you want to present to it and incorporate it into the framework – we've actually been very accommodating,' she told the summit.

Her comments came less than a month after a warning from Vic van Vuuren of Business Unity, South Africa, to the South African Medical Association's 'Solutions for Health Care Delivery' conference.

Van Vuuren said that doctors were being left behind in making contributions to the Health Charter, which he said was driven by government, in stark contrast to charters in other sectors.

The national health summit was attended by a wide variety of state and provincial officials, NGOs, private health care players and statutory health care bodies.

Equity 'underdone'

Tshabalala-Msimang expressed regret that more attention was not paid to equity in discussions on strengthening the health system, one of four broad themes concurrently explored. She said equity needed to be 'unpacked' within the context of values.

She took a defiant stand on the Millennium Development Goals, saying South Africans understood better than the international community what their needs were.

She took a defiant stand on the Millennium Development Goals, saying South Africans understood better than the international community what their needs were.

'It shouldn't just be about malaria, TB and HIV – we have elderly and young people in this country developing diabetes, cardiovascular traumas, and who are victims of violence and accidents – where do we locate these in the reporting goals? We can add these to their agenda', she said of the United Nations Global Health Summit goals set in Mexico last year.

As soon as StatisticsSA had completed their work on the Millennium Development Goals, the figures would be presented to cabinet and then be passed onto the United Nations, who would do their usual rating.

While supporting the local focus on primary health care, Tshabalala-Msimang expressed doubt about shifting too many resources to this at the expense of the hospital revitalisation programme. Unless a healthy balance was maintained, hospitals would revert to 'the shambles they were in when we took over'.

'Our choice of words here is critical or else the minister of finance could just stop the revitalisation of hospitals,' she warned. She urged GPs to say explicitly what they wanted when it came to incentives. 'They must tell us what they want, we don't know what it is,' she added.

Participate or perish

Tshabalala-Msimang said provincial consultative forums would soon be established and urged people to participate, 'because if you don't come you will be violating the law of this country!'

Referring to the lone e-mail ranger, she concluded, 'Please no more e-mails with people's faces complaining that we're not consultative!'

Summit outcomes

Recommendations and observations adopted at the summit included (under *Strengthening the Social Contract*) that: representation on the Health Charter task team be reviewed in terms of process, health care stakeholders were diverse and needed inclusion on a central platform, the preamble to the charter was weak and not binding, its scope of application be widened to include local manufacturers, academic complexes and other government departments and that it include civil society, NGOs and traditional healers. It should include more private sector information, the minimum package of services be properly defined and the rights of health care workers and guidelines for public/private sector resource sharing be included.

The Charter needed to be more of a 'living document,' the delegates added.

Under *Strengthening the Health System* it was recommended that there be cross-subsidies of health insurance mechanisms, revenue retention policies be standardised across provinces, service gaps be made more visible with more service level audits, accountability be strengthened (ward committees at local health management level) and a 'continuum' of accountability be established, authority be decentralised, standard business-like and service-oriented operating manuals be developed and quality assurance processes be more widely used. Strategic roles of other stakeholders needed identifying and their players enrolled into supporting the national health system. Intersectoral co-ordination outside of the social cluster needed improvement while the private sector needed enrolling into providing support in rural areas.

Under the *Millennium Development Goals (MDGs)* it was recommended that national and provincial custodians of the MDGs be appointed for monitoring purposes, United Nations indicators be used, access to prevention of mother-to-child transmission be improved and children be followed-up on, all child-related programmes be co-ordinated at health facility level, the Enquiry into Maternal Deaths be reviewed, basic training on maternal labour be intensified and voluntary counselling and testing be strengthened. Pregnant women should be prioritised for ART and PMTCT in order to decrease child mortality rates.

Family planning needed to be prioritised, especially for teenagers and co-ordination of directly observable treatment among community health workers improved for the ART programme.

Under *Human Resources* it was suggested that community structures such as health and hospital committees, community-based organisations (CBOs) and NGOs be used to help mobilise and strengthen resources, legislation be more creative to recruit and retain workers, mid-level worker, scarce skill and rural allowance delivery be speeded up, levels at which posts were advertised be reviewed (no recognition for previous experience), professional nurses' career pathing be supported, the entry of foreign health workers into the system be eased, a national human resources database be created including staff expectations, aspirations and skills in order to radically enhance planning and management.

The interpretation of the scarce skills allowance should be standardised across provinces and the application of the rural allowance widened.

Chris Bateman

Editor's note: *Such National Health Summits are an excellent idea. However, serious consideration needs to be given to improved planning and organisation. The present summit informed potential delegates weeks before it was to take place and the agenda was not finalised until days before the meeting. As a result it was difficult for potential delegates to decide if they should attend or to obtain accommodation.*

The South African Medical Journal

100 years ago:

We have had reported to us an incident whicb, unless it can be explained, looks very discreditable. A woman in Cape Town had engaged Dr. A. for her confinement. Dr. B., visiting the same collection of tenement dwellings, but not this woman or her family, noticed her condition, and then told her that he should be glad to attend her, his fee being two guineas. It may be mentioned that the fee of her own medical attendant was three. We cannot sufficiently condemn conduct of this kind as being not only unethical but indelicate. Unfortunately such touting based upon such ocular data is not altogether uncommon... Small wonder that the profession enjoys less public esteem than should be the case. If we do not respect ourselves, we can hardly expect others to respect us. In the SAMJ of the following month: With reference to a passim note in last month's issue referring to a Cape Town medical man "touting" for a midwifery engagement, we have been assured by a gentleman who conceives himself to be the party referred to, that the statement is untrue. He absolutely denies having made any approach to the patient, but says that she did approach him, as he happens to be M.O. to a club of which she is a member, and that, without knowing that the patient had engaged any other practitioner, he simply mentioned the club rate of fees. He imagines that the whole thing was a device on the part of the patient to induce the other practitioner to reduce his fee, and this we think a very probable explanation.

50 years ago: Blood groups and the clinician

In 1950 the authors of a standard work could still observe that, maternal-foetal differences apart, there was no evidence that those of any given blood group were particularly susceptible to any disease... Several recent papers have suggested some of the possible advantages and limitations of belonging to particular ABO groups. Aird and his colleagues showed in 1953 that subjects of group A seemed to be significantly more liable to carcinoma of the stomach than those of group O. But the tribulations of the O subjects are not confined to blood-giving, and in the following year Aird's team showed that bearers of group O were apparently very appreciably more prone to peptic ulcer than those of other groups. Pike and Dickens brought forward evidence to suggest that this was also true of toxaemia of pregnancy. Aird et al. found no relation between the ABO groups and the incidence of carcinoma of the colon, rectum, bronchus and breast. Further work will clearly be necessary... but there seems no doubt that real differences in disease incidence between those of different blood groups have been demonstrated; and that more will be found... Probably it is only one of many factors which act in this way. The blood-group studies now being undertaken are of obvious clinical interest; but they promise also to contribute something, however indirectly, to our understanding of the mechanism of human evolution.