innovative models is delaying financing reform,' he said.

Letlape said that SAMA was 'not in the business of having 38 million people without access to health care'.

Mr James Ngculu, chairman of Parliament's Health Portfolio Committee, reading a speech for ANC General Secretary, Mr Kgalema Motlanthe, said South Africa's modern economy produced the bulk of wealth while the underdeveloped economy contributed little to the GDP. The former was infrastructurally disconnected from the latter, which was incapable of self-generated growth, while the one serviced the other. 'The question is how we generate resources from one to impart to the other,' he said.

ANC concedes

Motlanthe conceded that management and governance of hospitals was poor and expressed a resolve to 'accelerate and strengthen' the government's HIV/AIDS strategy. 'Without better infrastructure our professionals will go away and without our professionals, better infrastructure will look hollow,' he noted.

The ANC was committed to halving unemployment and poverty within 10 years. Letlape said that SAMA was 'not in the business of having 38 million people without access to health care. It won't fix itself. It requires us to put our self-interest aside. Apartheid in health should die now and not in 15 years' time. If we transform the paradigm there will be work for all doctors,' he said.

Chris Bateman

MIRACLES IN THE LAND OF NON-ACCOUNTABILITY

Children at their remote Bulungula River mouth home in the Eastern Cape.
Picture: Chris Bateman

A small band of energetic community service doctors in harness with a 'fixer' colleague in the Eastern Cape health department are performing deep rural health care delivery miracles in the face of corrupt, careless and dysfunctional administration.

An *SAMJ* visit to the remote Zithulele and Madwaleni district hospitals in the idyllic Coffee Bay region in October revealed four young doctors squaring up to professional challenges on every front – and revelling in the after-hours beach lifestyle.

By networking, sharing makeshift solutions and calling on the astute, newly appointed Dr Rolene Wagner (Director, Strategic Support, office of the Superintendent General), they are making a difference and winning vital patient trust. Shopping expeditions to the local general dealer store find Zithulele doctors Rebecca Smith and Thandi Wessels, and Madweleni duo, Will Mapham and Sebastian de Haan, jovially jostled to the front of the check-out queue by their outpatients.

Knocks on the front door of their spartan hospital digs after hours can equally signal a dire emergency or a grateful patient bearing a pumpkin, mealie or live chicken.

Absent management

All four doctors are firm friends and share Wagner's passionate commitment to making an impact, in spite of seemingly insurmountable odds – odds like oxygen or electricity cutting out in the midst of a C-section, diesel for the back-up generator not ordered, water taps running dry or dirty, telephone lines down 3 - 4 days per week, using their private cell phones to run the hospitals, an absentee medical superintendent, Umtata ambulances taking 4 - 8 hours to arrive, district health managers who are virtual strangers, nurses cramped 30 to a small living unit, sharing one toilet and bathroom, and having to get up at 4.30 am to make their 7.30 am shift.

'The nurses are incredible – I wouldn't stay there for one minute. Without them we simply wouldn't be a hospital,' says Mapham.

Zithulele's Rebecca Smith sums up the reality check that deep rural doctoring delivers: 'I came here thinking I could change the world. I'll leave knowing I've left it at least better for the next people'.

After-hours paradise

The community service medical officers' (Cosmo's) biggest achievement outside of their immediate environment has been to alter the resistant and fearful

mindset of young medical students and newly qualified colleagues about deep rural doctoring. Mapham and Wagner have collaborated to aggressively market Eastern Cape deep rural doctoring, with unprecedented success.

Zithulele's Rebecca Smith sums up the reality check that deep rural doctoring delivers. 'I came here thinking I could change the world. I'll leave knowing I've left it at least better for the next people'.

The two former UCT friends worked the national conference circuit and medical campuses this and last year, and now have people lining up to do electives or community service. Mapham extolls the virtues, joys and satisfaction of the rural doctoring recreational lifestyle, using a visually seductive Power Point presentation of the idyllic 'Transkei' coastline. He addresses security fears by using the example of the female-only Cosmos at Zithulele Hospital jogging after work and enjoying an incident-free stay among the rural folk. Wagner complements this with an outline of the new doctor support systems she has set up across the province.

Support improved

These systems vary from orientation and induction, reimbursable skills development courses, career-pathing and basic Xhosa learning, formal mentorship and telemedicine, to conditions of service. There are also 10 new 'corporate service centres' spread across the province.

Stellenbosch University, which has a world-class rural medicine unit, sends students to the Eastern Cape for 1-month electives, while UCT students visit for a fortnight.

Explains Wagner, 'I noticed that the Western Cape had about 160 internship posts, but only about 87 Cosmo posts, so the obvious question was where do the other 73 go?' She seized on the 'surplus' and quickly strategised.

Having just recently persuaded the Health Professions Council (HPCSA) to re-instate the Eastern Cape as an accredited internship province, Wagner took Mapham in tow and visited the deans of medicine at Stellenbosch and UCT. The combination of her provincial role as then-Acting Director of Academic Health Complexes and Regional Hospitals and her committed community service colleague swayed the deans. They entered a service level agreement with the Eastern Cape from June 2004.

Says Wagner, 'They now send us 20 fourth- and fifth-year students twice a year. We give them a positive experience of the Eastern Cape, hopefully putting them in place for further down the line when they do their community service.'

Some of Mapham's 'scariest' solo rural challenges have turned out to be his most enlivening – like being forced to stitch back a woman's face sliced off in a panga attack.

She works closely with the Rural Support Network, a student organisation of six universities that focuses on voluntary work for students, and she tours clinics with Junior Doctors Association of South Africa (Judasa) representatives. Wagner is constantly seeking out and forging strategic problem-solving relationships.

Making a difference

Interviewed while shuttling back and forth between a telemedicine planning meeting and training three Deputy Directors how to strategically plan for special projects, Wagner reflects for a moment when asked what motivates her. 'I love empowering people, it gives me a thrill. Driving in the rural areas and seeing an old woman crossing the road with a can of water on her head

Rebecca Smith at the entrance to her Community Service home near Coffee Bay in the deep rural Eastern Cape.
Picture: Chris Bateman

and knowing I can help her – that is it,' says the mother of 6-year-old twins. Of her own evolution she says, 'I've been building teams my whole life, played softball for Border and was player/coach for them'.

Mapham comes from the same mould, having helped create the now-much-loved underdog Quaggas and Bushpig hockey teams (8th and 9th) as a player/coach at UCT. Of the medical interns who now visit Madwaleni he says, 'the longer they stay the more useful they become'.

Some tough challenges

Some of Mapham's 'scariest' solo rural challenges have turned out to be his most enlivening – like being forced to stitch back a woman's face sliced off in a panga attack. 'Her cheeks, nose and lips were gone but luckily she had the nose piece. I immediately contacted Umtata Hospital, but they had no plastic surgeon. I looked up the literature and did the best I could under local with the best suture materials I had, putting the muscle as close to the original position as I could. It worked – today she can breathe and smile. I made a difference that day.

Or saving a mother and child by doing a C-section for the first time, fresh from an obstetrics and gynaecology course in East London.

Mapham has not only enrolled physicians into working in the rural hospitals. His list includes Madwaleni's first-ever physiotherapist who rehabilitated one of his amputees, enabled a hospital matron to throw away her walking stick, and taught a cerebral palsied child to write and draw pictures. A lawyer friend came for 6 months, running business courses on a government grant, resulting in a cleaning lady now selling affordable food to overnight patients.

For the Cosmos one welcome difference from urban doctoring is the way the local hierarchy works. 'In town you have a medical hierarchy. Here it's social – when we hold our Wednesday forum meeting we're the youngsters among the cleaners, workmen, nurses and security staff,' he adds.

How it is

Madwaleni Hospital has three doctors (the Cosmos are supported by chief medical officer, Dr Patrick Nana-Akuako Nketiah, a former Ghanian), 230 beds and 200 nurses living in 35 sparsely furnished rooms. Its patients drain from a radius of some 150 km and it is a 2-hour, good-weather drive from Umtata on patchy dirt roads.

Zithulele has four doctors – the two Cosmos, a senior (foreign-qualified) medical officer and a medical superintendent (who hadn't been seen in 3 weeks), 100 beds, 36 nurses, a well-equipped laboratory and a gateway clinic. Patients drain from a radius of 50 km, it is newly built, is being extended and has three anaesthetic machines, one of which is state-of-the-art. None can be used, however, due to a myriad of technical reasons like faulty oxygen lines or non-existent oxygen supplies.

Only because of close social connections with Madwaleni's Cosmos did Rebecca Smith find out that Umtata has an emergency helicopter rescue service – which promptly began saving lives during fine-weather daylight hours. The local rubbish tip, frequented by pigs, dogs and goats, is about 10 metres from the back door of Smith and Wessels' kitchen.

TV entertainment is restricted to reception on the MNet open channel only between 5 pm and 7 pm because they cannot persuade any official to pay the Bisho-authorised DSTV bill. 'Nobody seems to be accountable...for anything!' says Smith. Mapham says of his own accommodation, 'I challenge any business person to live and work in their office for a year – it's very personal. Any problem that affects the business is yours. You don't have much space'.

Dr Rolene Wagner, Eastern Cape Director, Strategic Support in the office of the Superintendent General of Health, with Ms Khepukazi Mjamba, Deputy Director, Special Projects (front), and her two assistant directors, Ms Dumo Kwelita (back left) and Ms Lungi Maziko. Picture: Chris Bateman

'We've got the biggest problem you can get – poverty. We're working in a corrupt environment with a different culture and a different language in an area where any management consultancy would be afraid to tread. If we can make a difference here, we can succeed anywhere!'

Innovation

He's learnt how to fix geysers (or find alternative heat sources), repair water supply lines, and has driven patients to Umtata himself. The depth of the poverty was brought home to him when he caught a patient throwing prescribed pills out the ward window so that he could stay sick and in hospital.

De Haan once drove a pregnant woman with complications to Umtata himself but the mother and child died en route. It's a problem his female colleagues at Zithulele are familiar with.

His colleague, Sebastian de Haan, thrives on creative medical solutions and has invented a simple nasal oxygen prong to overcome the lack of oxygen masks. De Haan tells the story of an 8-year-old in respiratory distress with congestive cardiac failure and pulmonary tuberculosis. 'The oxygen ran out and we finally located another cylinder but saturation levels had dropped. I called Umtata (Nelson Mandela Hospital) on my cell phone and left a message saying we had a critically ill child and asking the paediatrician to call back.'

Six hours later, he did.

De Haan had correctly followed all the treatment protocols that he quickly read up *in situ* – but 4 hours later the child took a turn for the worse and died.

De Haan once drove a pregnant woman with complications to Umtata himself but the mother and child died en route. It's a problem his female colleagues at Zithulele are familiar with. 'I've had cases where we send patients to Nelson Mandela Hospital, and the staff there ask me to send oxygen, suture material and oxytocin,' he adds, shaking his head. He once completed stitching up a C-section using a laryngoscope light when the electricity failed.

Seeing results

Mapham's recreational lifestyle marketing is, however, bearing fruit beyond just extra interns and Cosmos. Next year he's expecting two married doctor couples, each physician with on average 6 years' experience, to come

and settle for '6 - 10 years', and an overseas psychology professor. The academic will work with sangomas, researching methods of healing. Mapham has already enrolled him into working with the hospital's administrative staff – in a bid to motivate them and increase efficiency.

Paid incapacity, carelessness

Interviews with selected administrative staff at these and other deep rural Eastern Cape hospitals (granted on grounds of strict anonymity) revealed common themes. One supervisor summed up administrative incapacity as 'Bisho putting square pegs in round holes'. He said Bisho's turnover of senior staff was 'too much – just when you've developed a working relationship with someone, he's transferred elsewhere. *Ad hoc* teams are everywhere, everybody's acting in this or that capacity'.

One foreign-qualified doctor with 10 years on site ascribed health care delivery failures to 'the unholy alliance of administration, infrastructure and staff'.

'We hardly ever see our district manager here, we have no medical superintendent. I've developed hypertension and am completely demotivated,' he admitted.

One foreign-qualified doctor with 10 years on site ascribed health care delivery failures to 'the unholy alliance of administration, infrastructure and staff'.

Asked what he would change if he had a magic wand, the doctor replied 'mentality and attitude'. 'It's pathetic. Staff couldn't care what happens to their fellow citizens. They think

Will Mapham savours the perks of rural doctoring.

freedom means not having to work and getting a salary at the end of the month. It's almost everywhere. After 10 years of democracy they should let bygones be bygones and look to the future!'

If it was up to doctors alone, the future of Eastern Cape health care delivery would probably lie somewhere on the continuum between youthful optimism and disillusioned experience.

Chris Bateman

BISHO'S UNCODED MALADIES

Eastern Cape Health MEC, Dr Bevan Goqwana, backs his new Superintendent General, Lawrence Mbuyiselo Boya. Picture: Chris Bateman

Four years ago Eastern Cape Health MEC, Dr Bevan Goqwana, blinking in the glare of exposés about corruption in his province's drug distribution system, boasted of an impending bar-coding system that would virtually eliminate fraud.

The bar-coding system is still pending – and the glare has become brighter.

In September this year, the Scorpions uncovered a R12.5 million scam at the province's two main drug depots and arrested 6 people, including the Umtata depot chief.

In the meantime, millions of Rands worth of vitally needed or inappropriately despatched state drugs continue to expire annually, and corrupt practices are still commonplace, albeit at the farther-flung clinics and hospitals.

In July 2000, when confronted with the litany of corruption and inefficiency in the drug distribution system, Goqwana told *Izindaba*, 'All drugs in future will be bar coded according to their hospital or clinic destination'.

Two years later, an *Izindaba* progress check seemed to offer hope: a tender was finally being put out for a public/private partnership for both the drug coding and the proper management of the drug depots.

A further 2 years passed, and in October this year Goqwana burst the bar code/proper management tender bubble.

Things were 'not going well,' he admitted. He explained that the tender had been withdrawn. 'What's delayed it is that national treasury has to get a transaction advisor on public/private partnerships (PPPs) to check whether it will be cost-effective and to do a risk analysis. It's very frustrating, but fortunately the advisor has now been chosen.'

Adds his new Health Superintendent General, Lawrence Boya, brightly, 'We're evaluating the request bids, and a short list will emerge out of that. Then we'll engage with those companies. National has to evaluate how much risk is being transferred to the private sector.