



## RURAL HEALTH CARE DELIVERY SET TO COLLAPSE

### Remaining foreign doctor and conscript pillars looking shaky

Short of major intervention, our rural health care delivery capacity will collapse from 2008, when its existing life-blood supply of community service doctors is strangled and hundreds of non-renewable contracts of foreign doctors end just 12 months later.

The local conscript and foreign doctor corps is now the backbone of South Africa's already severely understaffed rural and district hospitals.

The community service doctor availability crisis will hit in 2008 when the new 2-year academic internship first impacts, reducing the pool of available, sufficiently qualified conscripts by 78% (from 1 390 to about 400) for that year, officials say.

Just as the situation rights itself the following year, the 3-year contracts of hundreds of foreign doctors will come to an end, progressively depleting the 2 250-strong foreign doctor work force each subsequent year unless willing new English-competent recruits are found.

***One rural doctor recruitment NGO reported 1 350 queries from 'designated' developing countries, adding, 'I want to cry when I see their excellent CVs'.***

***Unless there is a policy shift, the 'unintended consequences' will be dramatic.***

The national health department's human resources chief, Dr Percy Mahlati, confirmed that the State's plan to handle the looming crisis involved 'negotiations' with an unspecified number of unnamed foreign countries



*Khetive Mlambo, a registry clerk at the Foreign Workforce Management offices in Pretoria, with one day's appointment slips.*

*Picture: Chris Bateman*

to provide more doctors (Izindaba later identified Tunisia, Poland and possibly Russia).

Mahlati said catering for the 'capacity bump' would also involve 'tapping into the private sector by using (local) GPs, asking community service doctors (comserves) to stay on and all that'.

There are also an estimated 1 000 foreign nurses and 250 foreign pharmacists working in South Africa at present. The majority of foreign doctors are the generalists so sorely needed in rural hospitals, providing vital 'mentoring' for comserve doctors.

### Existing 'pull' measures fail

Generous State rural allowances and scarce skills incentives have failed to lure local physicians back from overseas and out of our cities as even those few rural hospitals revitalised into attractive modern, multi-facility options fail to market themselves.

One respected audit (now 5 years old) had 23 407 South African-born workers practising a medical profession

in Australia, Canada, New Zealand and the USA versus 11 332 doctors and 41 617 nurses working in the South African public sector.

***The rural hospitals Izindaba visited were running at 30% or less of their doctor complement with only half the professional nurse posts occupied.***

Three quarters of GPs in South Africa serve just over 25% of the population (private sector).

With no active foreign recruitment strategy except for existing country-to-country agreements with Cuba (149 of 535 original recruits left) and Iran (33 with 103 to come), government is pinning short-term hopes on a continuing stream of foreigners.

Excluded through a recruitment policy that currently prevents hiring doctors from any 'designated' developing country and puts a 5% cap on foreigner numbers in any given



discipline, are some of the better generalist-producing countries (e.g. Nigeria).

One rural doctor recruitment NGO reported 1 350 queries from 'designated' developing countries, adding, 'I want to cry when I see their excellent CVs'. Unless there is a policy shift, the 'unintended consequences' will be dramatic.

Come 2008, private schemes like the Durban-based Rural Health Initiative's foreign and local recruitment programme and Discovery Health's R100 million academic rural medicine sponsorship might translate into life support systems for government.

The shaky scenario emerged after a 3-week *Izindaba* tour of rural hospitals in KwaZulu-Natal and the North West Province, plus a visit to the health department's equally understaffed foreign workforce management programme (FWMP) (Directorate Workforce Management) office in Pretoria.

*Yet alarmingly, it is the foreign doctors who seem to have the hardest time and who could scare compatriots into staying away in future.*

### Running at half capacity or less

The rural hospitals *Izindaba* visited were running at 30% or less of their doctor complement with only half the professional nurse posts occupied. Professor Adri Prinsloo, head of Family Medicine at Free State University and chairperson of the Medical and Dental Board's Internship Committee, summed up the looming 2008 crisis thus: 'If they can just get over 2008 and bring in enough foreigners to cover the rural areas plus create incentives to get community service doctors to stay on, we might get through.'

She said the health department was warned of the impact of the 2-year



*The Iranian backbone of Swartruggens Hospital, North West Province: Dr Alireza Mahdaviifar, his wife Dr Niloofar Asgari and surgeon Dr Hossein Gharehbaghi.*

*Picture: Chris Bateman*

internship 3 years ago and doubted whether different sections in the department had worked together sufficiently since. 'You're going to have to treat your comserve doctors really well, so that they consider staying on,' she added, citing Kimberley Hospital, where a basket of incentives such as good accommodation, scholarships and paying off student loans (in return for continued service) proved successful. Nearly 100% of interns wanted to return there for community service and 100% of those comserves then wanted to stay on as medical officers.

Prinsloo expressed concern that South Africa would 'end up with many foreign doctors trained in certain domains in certain ways, and no locally appropriate generalists. This will be unfair to the public, foreign doctors and the juniors working under them, she warned.

The Cuban contingent consisted mainly of 'specialists', inappropriate to rural areas.

*Izindaba* spoke to national and provincial health officials, foreign doctors and some of the few remaining die-hard 'non-conscripted' South African physicians at rural hospitals.

To the single question, 'Can we deliver rural health care without foreign doctors in South Africa?' every person, from the national deputy minister of health, Nozizwe Madlala-Routledge, to senior provincial managers, hospital managers and doctors and nurses we spoke to, answered unhesitatingly, 'no'.

*Izindaba's experience of rural hospital managers is that they are so desperate to keep staff that they sometimes economise on the truth or deliberately withhold information.*

### Poor hosts to foreign partners

Yet alarmingly, it is the foreign doctors (whom government is relying on to deliver its constitutional obligation of progressive health care access for all) who seem to have the hardest time and who could scare compatriots into staying away in future. Foreigners I spoke to were torn between their reasons for coming here and the daily barriers to fulfilling their professional tasks plus worrying about travel, decent accommodation, timeous and proper payment and their children's schooling.



They come to glean invaluable clinical experience with HIV/AIDS, other lesser-known illnesses and for humanitarian reasons. Far too many experience difficult working conditions, mindless red tape, incompetent/careless administration and inadequate travel and schooling facilities.

All the coal-face workers (foreign and local) I spoke to proved indomitable and committed, 'making do' in adverse conditions, their trademark being the humanitarian values that mark medicine at its best. All said that what kept them going was the 'small difference' they felt they made against overwhelming patient numbers and HIV/AIDS-driven disease profiles.

### Neglecting the core providers

At Swartruggens District Hospital in the North West Province, I found Dr Alireza Mahdavifar, his wife, Dr Niloofar Asgari, and their children, aged 7 and 6, part of a group of 26 newly arrived Iranian doctors (country-to-country agreement). With them was fellow Iranian, surgeon Dr Hossein Gharehbaghi (accompanied by his wife and offspring of 15 and 19), and one South African doctor. Together they run the newly built district hospital that hosts an increasingly pressured 420-patient HIV/AIDS clinic.

***Swartruggens also echoes the cry of many a rural hospital: state of the art (in this case ultrasound) cold machinery with no warm bodies available or qualified to operate it.***

Just over a month in the job, they had yet to be paid, the local primary school did not teach in English and the promise of transport twice a week depended on unpredictable driver and vehicle availability. They were living on US dollars brought along 'just in case', and estimated that they would earn the



Refugee Catch 22 – pregnant dentist, Dr Heba Al-Agha and her Palestinian refugee husband, Dr Nadi Haddad.

Picture: Chris Bateman

equivalent of 1 000 US dollars less than back home, where they said they saved half their salaries.

They claimed that the cost of living in South Africa was 'two or three times' greater than back home, but their biggest worry was schooling and attendant transport. Said Niloofar, 'There's no suitable school here and my youngest is at the crucial starting stage. There is a good school in Rustenburg, 68 km away, but we cannot travel there twice a day. They must rather let us live and/or work in Rustenburg.'

Their official minders, including the hospital manager, quoted 'rules' saying they must live and work in the same place or forfeit their housing subsidy.

### Desperate hospital managers

Their Swartruggens manager told them there were no doctoring slots in Rustenburg, where most of their compatriots (many of them single) are posted, but Foreign Workforce Management in Pretoria flatly rejected this, citing seven funded open slots.

*Izindaba's* experience of rural hospital managers is that they are so desperate

to keep staff that they sometimes economise on the truth or deliberately withhold information.

Mahdavifar managed a pharmaceutical company back home and has 10 years' doctoring experience, much of it vehicle accident trauma, cardiovascular conditions and hypertension, which he describes as the classic Iranian presenting profile. He's also a computer programme writer, quality assurance and drugs management expert and has offered these scarce teaching skills to management, but is confined to seeing patients.

'Our education back home is excellent, we're feeling a little undervalued here,' he confesses, citing local nurses who cannot operate computer keyboards and underdeveloped HIV/AIDS management systems. He could link up the entire hospital's computer system for networking, streamlining admissions, discharge and patient histories, but reports little enthusiasm.

Swartruggens also echoes the cry of many a rural hospital: state of the art (in this case ultrasound) cold machinery



with no warm bodies available or qualified to operate it.

Gharehbaghi says he asked management whether one of them could be sent to Rustenburg to be trained in their own spare time to use it, but was refused.

I ask them about their 3-bedroomed living arrangements. They have the standard basics, including ordinary TV, but missing is aircon (they were given a 2-bar heater when they complained during a cold snap in August), and a washing machine. Also absent are landline phones and Internet connectivity.

### Host package found wanting

Nilofaar doughtily re-emphasises her bottom line, 'I can live with the minimal facilities, but I will not sacrifice my children's education'.

It's a far cry from their relatively luxurious Iranian homes, but then they were 'seeking adventure and wanting to make a difference for mankind anywhere'.

Hossein Gharehbaghi's 19-year-old daughter wants to study dentistry in Pretoria, but the province cannot meet his suggestion that they pay rental for accommodation there and post him closer so he can commute and keep the family together. 'We're isolated here, potentially from our children, from our compatriots and from keeping up with news back home,' he says. 'They (DoH) told us they would pay us 3 months' advance salary, but we've seen nothing since we landed on 15 August, over a month ago – we've been helping one another out. Your DoH also told us that your education was good.'

While this doesn't exactly qualify as hiring under false pretences, it's enough to put off other tentative collegial prospects back home – and therein lies the rub. Hennie Groenewald, Director, Workforce Management, told *Izindaba* that if the Iranians had 'no obligation or loyalty, they can leave at any time

if they don't want to complete their contracts'. He admitted however that in official discussions around foreign health care workers, 'the concern is that our whole system relies on them'.

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*Now it's Catch 22. No airline will let her fly at more than 8 months pregnant and she risks arrest, a holding cell and giving birth in circumstances beyond her control.*

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### A war refugee's tale

Palestinian paediatrician, Dr Nadi Haddad, who secured official refugee status and has worked at Welkom Hospital for the past 4 years, has dark blue rings under his eyes as he stands smoking alongside pavement vendors below the DoH building in Pretoria.

Every 2 weeks over the past 6 months he has travelled from Welkom to the FWMP offices to try to secure permission for his pregnant dentist wife, Dr Al-Agha, to join him. They married in the United Arab Emirates after he secured refugee status and HPCSA registration here.

While the complex web woven by the often-competing requirements of Home Affairs, the Health Department and the Health Professions Council has largely been replaced with a more workable system, Haddad's wife is mired in the sticky remnants. Her 3-month visitor's permit, issued by the South African government office in Palestine, expires in 2 days. She didn't realise she needed to apply for temporary asylum (3 months, extendable) in order to stay longer.

Now it's Catch 22. No airline will let her fly at more than 8 months pregnant and she risks arrest, a holding cell and giving birth in circumstances beyond her control.

Cell phone to his ear, Shaun-Allan

Smith, the FWMP's hands-on chief, rails at a Home Affairs official, telling them he has an official job offer for her and that the Dental Board will accept her to sit for an exam. But the Home Affairs official (also an expert in her field) will not budge.

The demure, attractive young dentist must approach their Welkom office and apply for temporary asylum, she says. That's proper procedure and the law. Approached by *Izindaba*, the nervous but obviously knowledgeable Home Affairs official gives me her department's Welkom office telephone number to pass on, apologising and insisting on the correctness of her legal interpretation.

### In the engine room

Smith shakes his head. It's a routine kind of day, but somehow he still seems to care as his phone rings incessantly and over 5 000 colour-coded 'live' foreign health worker files languish heavily on cold steel shelves in a small side-room. The files cover a broad spectrum, from applicants 'wanting to come in' to foreigners already in South African employ. A private company is compiling a comprehensive database, auditing all health councils, health departments, universities and Home Affairs files to create a single database of all health care professionals in the country.

The audit's been going just over a month and will take 3 years. In the meantime policies and plans take shape in the grey half-light of supposition and estimate.

Smith's staff, consisting of 6 casual workers paid by the hour, rush about following his instructions, collecting visitors from downstairs, hunting down files, answering phones and opening 50 - 70 foreign job application files per day. Job interviews are on Tuesdays and Thursdays. It's Friday and the passage benches are full of currently employed foreign doctors seeking official succour. 'Sometimes a whole week goes by and



I can't get to a file because I'm so busy answering phones,' one FWMP worker tells me. Although the team seems to (barely) cope, I confronted Smith about his obviously hopeless understaffing.

'We receive up to 4 000 faxes and postal items per week (applications, appeals, copies of required documentation, etc.). We don't necessarily have to overstaff on entry level,' he admits blandly, adding, 'there's no junior and middle management. We struggle to facilitate the workload appropriately but we have a new director and management looking into it.'

When I officially quiz the health department about this seemingly untenable situation, its acting director of communication, Bhungani Mzolo, responds: 'The department has restructured its establishment (2005) in line with its strategic plans over the next few years. Staffing needs are addressed within the current budget allocations.'

***The 'long-term' strategy, it turns out, is to 'decrease the dependency of the public health sector on foreign health professionals'.***

Dare I probe further? I try another tack.

Why can foreigners constitute no more than 5% of health care professionals in any discipline and why are you not more pro-active on foreign recruitment?

The 'long-term' strategy, it turns out, is to 'decrease the dependency of the public health sector on foreign health professionals. It will serve as a benchmark to facilitate other policies, such as the intended increase in the production of local skills.'

The department also 'does not use recruitment agencies'. It addresses 'critical needs' throughout all the provinces by advertising on a common website.



*Dr Alistair Bull, the senior doctor at St Appolinaris Hospital near Creighton, KwaZulu-Natal.*

*Picture: Chris Bateman*

Back in the private sector, human resource managers are hampered by regulations confining foreign doctors to the public sector while service rigidity in the SA Nursing Council puts foreign nurse recruitment into maddeningly slow motion. Some nurses have lately turned to lawyers to force basic responses from the council.

The Medi-Clinic hospital group had 60 Indian nurses lined up to begin in October this year but the nursing council's promises of 1 week's 'processing time' grew into 9, wearing thin the foreign nursing corps' patience and numbers. Most importantly, these capacity gaps and regulations leave the private sector with little or no alternative but to poach health care workers from the ailing public sector.

'In the last 6 weeks I've interviewed 15 local provincial pharmacists,' admits Johan Henning, MD of Medi-Rite, the group aiming to open 35 Checkers Group supermarket pharmacies countrywide in terms of new enabling legislation. He's looking for 100 additional pharmacists by the end of next year, a tall order.

Although foreign pharmacists must first complete a year's community service, they are then able to move to the retail sector, a gap that legislators will soon close.

Enough. I turn to the rare 'veteran' rural doctors I met with between 2 and 20 years' local rural experience who seem inured to bureaucracy and red tape – although this doesn't stop them depicting their reality.

### **Local rural veteran's story**

One such is local career rural doctor Alistair Bull, the only non-community service doctor at the 155-bed St Appolinaris Hospital near Creighton (KZN), where regional poverty stands at 75% and 60% of deaths last year were HIV-linked.

Bull bemoans the lack of active staff recruitment and says that for the past 5 years 'comserves' have formed the backbone of services they are able to deliver. 'But they have no skills. As the most senior doctor it's very draining and just when you've put down emotional roots and invested in them, they're gone.'

He's watched St Appolinaris' staffing drop from an inbuilt skills and support system of 4 experienced doctors (1996 - 1999) to just himself and 2 comserves this year (they have 16 medical officer posts vacant). 'Until 1999 everyone had post-grad qualifications and families and we were smiling. Then the first one or two comserves arrived and things changed from being primarily service driven to having a teaching component. But now the pendulum has swung to where comserves are the backbone of the medical staff.'

He says the imbalance between junior and senior staff means each person is less able to cope independently. Comserves were expected to be in two or three places at once, which proved 'stressful while on a steep learning curve'.

What was needed was to build the level of senior doctors who committed



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for 3 - 5 years, 'so that you can develop your systems'. He added: 'At present we're treading water, it's difficult to feel that the ship is moving forward.'

In spite of constantly advertising posts in South Africa, there had been no takers.

'They say the sad, bad and the mad come to work in deep rural hospitals like this – you just try and work out where you fit in!' he laughs. His wife Fiona makes four 15-km trips a day on rutted, potholed roads to the Creighton primary school where their children of 12, 10 and 7 are being educated. They live in a simple, comfortable brick home in stark contrast to their hospital manager who shares a 3-bedroomed

prefabricated park home with the finance manager and social worker.

Comserves share a communal 4-bedroomed 'digs' with 3 toilets/bathrooms. Plans for bachelor flats were recently approved, as were plans drawn up in 2001 for 2 more homes. The only visible manifestation of this is a series of half-dug trenches.

Says St Appolinaris hospital manager, Ntombifikile Thekiso, 'If they'd delegated the building authority to me those homes would be up and occupied by now'.

Mahlati says the staff recruitment and retention policy 'is there, but the tactics of how that is done is left up to the provinces because it's related to their

budgets'. He adds: 'they must make conditions conducive; some are able to, others are not'. He concedes only that 2008 will be 'difficult', but 'it's not a train smash'.

As for his own department's understaffing, 'we'll advertise some posts, but right across government understaffing is a problem. Once our practitioners become competent, they get taken by the private sector.' One wonders just where the buck stops.

I would celebrate being proved wrong on the overall rural health care delivery outlook, as would millions of country folk who deserve better.

**Chris Bateman**



## THE OTHER SIDE OF RURAL DOCTORING

There are few places in the world where a doctor can learn how best to ease the suffering of an AIDS-ravaged patient and deliver her baby HIV-free in the morning, then spend the late afternoon surfing or hang-gliding in breathtaking surroundings.

Or when a difficult shift is over, take the hospital motorcycle and escape onto the foothills of majestic snow-capped mountains, rod and reel on board in search of a promising trout stream or lake.

Alternatively, if they're not into a short drive down the tar and dirt road to a world-renowned game reserve boasting the big five, play tennis, basketball and squash in their backyard or simply lounge around the pool or watch TV.....all while being paid comfortable salaries (bolstered by scarce skills and rural allowances) that enable them, within a few short months of their tenure, to buy a car suited to their rugged environment and explore even further afield.

*The recreational lifestyle of a rural doctor in South Africa (besides the priceless pathology learning curve) is arguably and maddeningly the most valuable untold and undersold 'State secret', given our rural public health care delivery crisis.*

These are not lines written for some recruitment brochure (although they should be), but a description of three diverse deep rural South African hospitals visited at random by *Izindaba* over the past 6 months. They are the Eastern Cape's Zithulele district hospital perched on a hill above pristine, endless beaches, KwaZulu-Natal's St Appolinaris Hospital near the Drakensberg and Hlabisa Hospital, next door to the Hluhluwe Game Reserve.



Rural Health Initiative recruiter Tracey Hudson chats with Australian medical technologist Roger Smedley during an after-work tennis set at Hlabisa Hospital. The Smedley family have adopted a 9-month-old AIDS orphan at the hospital.

Picture: Chris Bateman

Sure, they are severely understaffed, often poorly run, with little medical supervision and deeply challenging of a clinician's innovative, creative side while shattering all preconceptions.

But the recreational lifestyle of a rural doctor in South Africa (besides the priceless pathology learning curve) is arguably and maddeningly, the most valuable untold and undersold 'State secret', given our rural public health care delivery crisis.

### NGOs step in

While those officially charged with staffing rural hospitals do little to highlight these magnetic attributes, the private sector, academia and the South African Medical Association (SAMA) have cottoned on and are starting to make a small impact.

Take the private sector-funded, non-profit Rural Health Initiative (RHI) which, backed by the Rural Doctors Association of South Africa (RuDASA), has helped place 78 foreign doctors in needy rural hospitals nation-wide since June last year.

The RHI's 'can-do' advisory/ placement team of Tracey Hudson and Dr Bayanda Mbambisa have another 117 foreign doctors awaiting registration, permit and job clearance, a formerly year-long process they've reduced to an average of 4 months.

With hands-on advice and excellent relationships with key people in the Health Department, Health Professions Council and Home Affairs, they not only expertly navigate the bureaucratic minefield, but also 'meet and greet' their incoming doctors.

Mbambisa books newcomers into a Johannesburg hotel, helps them open bank accounts, secure medical aid, insurance, hire or purchase a car, then hands them a road map where 'X marks the spot' and bids them farewell, adding a gentle reminder to 'keep left'.

When time and opportunity allow, she takes them to a nearby township hospital for a quick 'orientation' visit that begins the vital process of dispelling preconceptions, one she later mitigates by doubling as an 'agony



Aunt'. 'Government needs about ten of us,' says Hudson brightly, seemingly puzzled as to why such a blindingly obvious response to the crisis is not immediately taken up.

'We try and engender a spirit of caring and support with everyone we deal with, but we also critically need local hospitals and provinces to market themselves. They must tell us what their specific needs are. They can even identify and woo the doctors themselves, we'll get them in,' she says with near-missionary zeal.

### A few good men...

Like her Foreign Workforce Management counterpart, Shaun-Allan Smith, and the HPCSA's Danie Kotze, whom she describes as 'angels from heaven', Hudson's cell phone is seldom silent and she takes day-to-day doctor crises in her stride.

Hudson and Mbambisa have visited virtually every public hospital they recruit to, know the managers, admin staff and local clinicians. Their placement efficacy is testimony to their formidable networking and people skills. They are backed by a top-flight academic team (Professors Steve Reid, Ian Couper, Jannie Hugo and others) that provides ongoing academic and professional development.

The Durban-based Hudson proudly lays claim to 'her' doctors when I mention foreigners I've interviewed at Hlabisa, Nkandla and Ngwelezana hospitals. One of her first recruits, Magnus Johansson, a Stockholm-qualified paediatric registrar, and his ICU nursing sister partner, Anna Beneus, after 7 months of unsuccessfully trying to get into South Africa 'solo', were esconced in just 3 months.

Says Johansson: 'We had an incredibly tough start at Hlabisa. We noticed a huge crisis immediately we got here. Doctors were understaffed and overworked, morale was low and the medical manager and his wife had just resigned.' Their home was 'a shell', with leaky toilet and no hot water.



*The male ward at Nkandla Hospital.  
Picture: Chris Bateman*

Johansson was 'thrown into' the female medical ward (traditionally the busiest), with 'nobody to tell me the routines on TB forms and so on. It really was the deep end, but luckily I got support from colleagues, though I had to take the initiative,' he says.

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***The 340-bed Hlabisa Hospital (serving a drainage area of 240 000 people with 16 clinics) has recovered somewhat since the Swedish pair arrived; it now has 7 of its 23 medical officer posts filled.***

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They plan to stay for a year but are prepared to stay for the full 3-year permit period. Anna is only helping with local AIDS orphans, having heard of the nursing council bureaucratic nightmare of securing a full-time paid job.

The 340-bed Hlabisa Hospital (serving a drainage area of 240 000 people with 16 clinics) has recovered somewhat since the Swedish pair arrived; it now has 7 of its 23 medical officer posts filled. It is a Presidential Lead Project, making it currently one of the most

attractive rural hospitals to work at in terms of recreational facilities.

### Foreigners all

At Nkandla, the deep rural village put on the international map by dint of being the birthplace of AIDS-ignorant, acquitted rape trialist and ANC deputy president Jacob Zuma, I find a Dutch doctor couple, Clement Barends and Elles de Vrieze.

Just 10 of Nkandla hospital's 27 doctor posts are filled, mostly by foreigners.

Also RHI recruits, the Dutch pair thought so many vacant posts meant they would be working with 'at least 60' fellow clinicians. Says Barends, 'but we see patients you just don't see back home. The pathology is much more adventurous – you feel you can contribute and make the world a better place.'

They have their own telephone line, GPRS for internet, a MultiSave Spa supermarket at Melmoth, 45 minutes' drive away and love the outdoor lifestyle. 'We basically get the same pay here as we did in Holland. We're thinking of getting a bigger, more comfortable car to visit friends.'

De Vrieze says targeted recruitment for doctors with their kind of outlook is crucial.

It cost them 'about 750 Euros' each in 'admin' to finally get placement (including notary public, work permits and visiting the consul general in the Hague). 'Tracey gave us the FWFM programme papers up front and checked them all before sending them to the HPCSA, which Bayanda nagged for us,' she says.

They also had a 2-day RHI orientation programme in Johannesburg and are lavish in their praise of the RHI's induction process.

Like St Appolinaris, Nkandla was originally a Catholic mission hospital and still has nuns on site, one Sister Ellen (aka Dr Maria Lindner), runs a life-saving ARV outreach programme





for primary health care givers in a district where 97% of people live in poverty. Nkandla has 266 beds and its outpatients department processes about 70 patients daily.

Medical Manager Dr Sydney Okojie said he could 'start to meet local needs' (the 10 outlying clinics are seldom visited by any clinician) if he had his full complement.

'If I had a magic wand, I'd start with maternal and child health needs followed by HIV and then mental health, which is the silent, explosive pandemic here as more and more people lose their loved ones,' he said.

The other main doctor placement agency (mainly urban) is 'The Placement Project', part of the SAMA's Foundation for Professional Development (FPD). It began operating in July this year and has so far placed 10 doctors, referring 1 to the RHI, who in turn have sent 8 its way.

Complains the project's Veena Pillay: 'We're outnumbered by agencies helping South Africans leave the country. One in 5 community service doctors I speak to plans on heading overseas.'

A third NGO is the 'Home Coming Revolution' (HCR), dedicated entirely to assisting South Africans of all professions to 'come home'. They refer doctors to PP and RHI and their linked website has one of the highest hit rates in the country (8 000 per month).

The HPCSA is looking at a 1-year



*Nkandla District Hospital's doctors: foreigners from left, Clement Barends, Sydney Okojie, Elles de Vrieze and, in front, Sibusisiwe Makhanya, a South African community service conscript.*

*Picture: Chris Bateman*

moratorium on crippling registration back-payments and re-registration penalties, currently up to 5 times the annual rate – a deeply disturbing disincentive. This 'amnesty', proposed for next year, is being hailed by the recruitment NGOs as 'sensible and far-reaching'.

Says the HCR's Megan Woods: 'We'd actually prefer that if you can prove you're registered with a recognised foreign health council, you're exempt from the local re-registration fee'.

Observes local veteran Derek Barrett, Principal Anaesthetist at Ngwelezane Regional Hospital, Empangeni: 'When I did a locum in New Zealand years

ago, the medical staff officer at the hospital where I was to work handled recruitment and registration. I was working within 24 hours of landing. Our local hospital HR office here has no clue about registration, work permits or even how to pay salaries to doctors and put them on a post'.

It's enough to make you want to go fishing or hang-gliding.

Helpful websites:

[www.homecomingrevolution.co.za](http://www.homecomingrevolution.co.za)

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

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

[www.theplacementproject.co.za](http://www.theplacementproject.co.za)

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