



## PERSONAL VIEW

## The Phumula project

Chris Ellis

In 1998 we started a project that many of us had been discussing for years. Africa has been left with a legacy of Western medical health care that does not seem to fit the needs of Africa at ground roots level. Large impersonal hospitals, which are expensive and difficult to manage, cater for the treatment of broken bodily parts, almost in the way that a mechanic fixes a car. Bodies are operated on and repaired and infections are conquered using strong and expensive drugs on a conveyor belt of technical services.

How, then, to find an African model to deliver health care without detracting from the benefits and advances of modern Western medicine?

We decided that the hospitals and technical apparatus already in place would obviously continue their excellent work, but to make them more efficient and cost-effective it was important to relieve them of overcrowding, inefficiency and time constraints under which the overloaded staff worked. The general theme of the change in African health care delivery was to be, in those fashionable words, 'affordable and sustainable'.

One arm of the project is the home-based health care services which, in various forms, are taking African health care into the community, reaching into huts on distant hillsides and into the shacks of peri-urban squatter camps.

The other arm is the Phumula project. *Phumula* in Zulu means 'to rest'. We chose the name purposely because it is just that, a place of rest. We knew that we would receive many terminal AIDS patients as well as cancer patients and those with poverty-related disease, but we wish to maintain an ethos where patients may come and go as they please. There are very few walls to the buildings. We wish to avoid the reputation that it is a place where one comes to die. It has an ethos of healing and caring to complement the treatment and possible curative aspects of health care. It is a place of hope.

In our African Medical Renaissance mode we chose the hills of Emkhizweni outside Pietermaritzburg for our pilot project. Some Zulu elders and sangomas walked the hills with us and chose the place for its spirituality and for its clear views down the adjacent valleys.

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*The hills of Emkhizweni.*

The main central structure is a huge circular thatched rondavel. All the buildings are made of thatch and there is, at present, a resident thatcher with African builders and thatch cutters. All the buildings are circular and mostly open. Africa has a circular communal familiarity as opposed to the more square angular buildings of the West.

Around the four large central poles are the cooking fires with ducting to draw the smoke upwards through the roof. Radiating from this central area are patients laid on rugs on the earth floor. Relatives or mothers of children have rugs to sleep on next to the patients, for whom they cook, and whom they wash and feed.

We have been lucky in that this initial project has been sponsored by a multinational aid agency that supports our vision of a holistic, comprehensive African health care delivery system, incorporating the spiritual, emotional and social aspects of healing and medical care. Apart from the words 'sustainable' and 'affordable' the mission statement includes other fashionable words such as 'empowerment', 'employment' and 'choice'.

From the main rondavel at the top of the hill, further rondavels radiate out in concentric circles, providing small industries. There is a weaving hut, which is frantically trying to keep up with the demand for rugs and blankets as it gets cold in the winter. The bricks are made on site in another large rondavel, while a volunteer occupational therapist has set up a craft shop in another.



We have tried to keep the paperwork down to a minimum otherwise 'management' tends to take over the service aspect of the project. There are no charges, but donations from individuals and organisations are received (at times with immense sighs of relief).

This year we have extended the project to provide a school and accommodation for AIDS orphans and abandoned children, further down the hillside. Alongside this is a health and nutrition rehabilitation unit that involves both mothers and pregnant women with training in mothercraft, child rearing and nutrition, and we are currently building another large rondavel in this outer circle, which will be a school for community health educators.

There is also a sacred place, a large thatched semi-rondavel situated on a cliff with awesome views over the umbrella acacias in the valleys below. In the mornings you can hear the doves cooing at the rising sun and in the evenings the calls of villagers on the other side of the valley. All patients and

ministers of different religions and beliefs use the place for services or personal prayer or meditation. The project is aimed at an integration of Western and Traditional healing methods within the wider vision of an 'African hospital'.

We run on a mixture of paid and voluntary staff of nursing sisters, teachers, traditional healers, faith healers, and visiting doctors. The small industries are starting to be profitable and we have now started a gardening service, which everyone joins in. Tree planting is a communal occasion and involves much discussion, planning and many opinions.

Our holistic ethos has been further enriched by a musician, who plays the flute and guitar and works at the school in the day and plays at the main rondavel in the evening and at the sacred place. He works in conjunction with a story teller (*izinganekwane*) in a programme of revival of African music, drama and story telling.

The Phumula project is an attempt to bring together all aspects of human life in the care of the sick of Africa.

## MEDICAL EDUCATION

### Continuing professional development — where are we now?

V I McCusker

CPD was discussed for decades within the professions. The concept gained focus and clarity when the College of Medicine of South Africa published proposals in 1994. The Medical Association investigated and propagated the concept and passed a consensus resolution at a Federal Council meeting stating that the Medical Council should be involved to achieve compliance by the more reluctant members.

Workshops were arranged by the Interim and Dental Council

including the Medical and Dental Schools, the College of Medicine, the Academy of Family Practice and the Medical and Dental Associations. The basic principles were defined and the requirement of 50 hours per year was accepted as being in keeping with international standards.

Different categories of activities were defined and it was agreed that no more than 80% of points could be obtained in a single category. It was felt that even for the most isolated doctors some interaction with their peers is essential, currently at least 10 hours per year. In keeping with international thinking, a minimum of 2 hours per year related to human rights and ethics are considered essential.

CPD is compulsory only for doctors in clinical practice. A separate registration category for non-clinical practice was proposed, but the regulations for this have yet to be published by the Department of Health. The annual subscription will be lower, as these are not the practitioners responsible for the high costs of professional conduct inquiries to the HPCSA.

*Ivan McCusker, a general surgeon, practised in the private and public sectors. He served on the National Council of SAMA for two decades and has been president of three Branches and the Association of Surgeons. His involvement in CPD started as Chair of the SAMA Health Policy Committee and continues until the end of this year as Chair of the CPD Committee of the Medical and Dental Professions Board. He now farms in George.*