Chapter 1.1.5

ATTAINING RURAL HEALTH EQUITY IN AFRICA

Ian Couper
University of the Witwatersrand, South Africa
Jannie Hugo
University of Pretoria, South Africa

Introduction

Equity is defined as the absence of systematic inequality across population groups (1). Systematic inequality – or inequity – is a stark reality in Africa, as it is in many developing countries. While inequity between rural and urban areas is a worldwide phenomenon, it is often more extreme in poorer countries and in most of Africa.

Inequity is a complex issue and addressing it requires some understanding of systems theory and the interconnectedness between economics, politics, health, agriculture etc. It cannot be done by medical practitioners alone, yet it is critical that doctors understand and can respond to the issue of inequity, and, more importantly, are able to be advocates on behalf of the poor.

This is even more important in rural communities where doctors are often amongst the few voices ready and able to speak up on behalf of these marginalised and less powerful people. Rural training needs to take this into account. It needs to be developed in partnership with local communities, where the local people are involved in a way that improves development and equity.

Primary health care is fundamental to any approach to addressing the issue of inequity in health care (2, 3). Thus any approach to medical training that does not ensure the production of sufficient numbers of well trained primary care doctors within an understanding of a philosophy of primary health care, will do very little to address the issue of equity.

Universities which play a role in addressing inequity in society do so by accepting responsibility and accountability for social and distributive justice. This challenges the university to engage with communities in a way that leads to increased justice and welfare. Inequity in health and health care is a key issue to be addressed in health science faculties. In December 2010 a Global Consensus for Social Accountability of Medical Schools was produced through an eight-month process - involving about 130 organisations and individuals from around the world with responsibility for health education, professional regulation and policy-making - culminating in a conference in East London, South Africa (4). This represented a serious attempt to address the issue of inequity in health care through medical education

Medical education's role in reducing rural inequity

The question here is how medical education can influence equity, particularly in a resource-scarce continent such as Africa, where there is huge inequity between urban and rural health care, as well as private and public health care. By shifting attention to more rural, public health care, academic institutions can help to ensure that resources are given to these, and legitimise them as places of work and practice. Too often medical schools perpetuate and reinforce the inequity that exists, instead of being transformative with a view to changing it. Contributing to a decrease in health inequity should be seen as an integral part of undergraduate medical education (5).

Medical education can contribute to promoting equity through social accountability. This implies that the processes of designing, implementing and following up educational programmes entails that they are not only of high quality but are also relevant to the needs of citizens and society as a whole and are effective in improving the provision of national health care (6).

Development of learning activities in rural areas has the potential to address inequities – and the establishment of rural learning campuses can be the starting point of a rural development initiatives. The cost of illness and disease can be devastating for the economic survival of families in rural Africa as, even when free services are available (and in most countries, they are not), the costs of accessing care can still be high. Improving the health of the rural communities enables them to

avoid these devastating costs and optimises the chances of being economically active. If rural learning activities and the establishment of rural learning campuses can contribute to improving health care and health outcomes, they can also contribute towards the potential for economic development – including increasing local human capital by recruiting rural young people to undertake health care studies.

Developing rural campuses brings resources into rural areas and can be the catalyst of many other local developments. Resources that come in are financial and material, but also include skills, knowledge and people. The development of rural campuses should be done in a way that promotes local economic development – and care should be taken to make maximum use of local people to be involved in the development and maintenance of the facilities. In addition, student and staff accommodation could be provided by local people who rent it to the university and the staff and students.

Recruiting young people from rural areas to study health sciences is a long-term development process that addresses inequity. The challenge of selection is such that in one community in South Africa, we were unable to find sufficient students who were eligible for entry into medical school, and who would be able to participate in our rural scholarship programme (the Wits Initiative for Rural Health Education - WIRHE). To address this required the development of a life skills programme in high schools, working with learners in their final year to help them set goals, to discuss their future aspirations and to understand opportunities for future study. This led to a dramatic increase in applications for the scholarship, resulting in identifying a handful of suitable students.

Rural medical education is almost always more expensive than standard urban-based medical education. It is not a cheap solution. Yet this extra expenditure and allocation of resources is critical for equity; equality of outcomes requires unequal and preferential expenditure of resources. At the same time, there are innovative models that entail placing students in rural areas where the communities themselves become hosts for the students, and cater for their accommodation and nutritional needs because they see the value of the programmes, making it a cheaper option. (The question in terms of equity is why they should have to do that when urban communities do not!)

In Africa mid-level medical workers, or associate clinicians, play a crucial role in medical care in rural areas. In most countries these clinicians are trained in non-university settings. However, in South Africa a programme was developed where associate clinicians are trained in a three-year Bachelors programme in university health science faculties, based on similar programmes in the USA. Students are recruited mainly from poor rural communities and a large proportion of the training takes place in rural areas, preparing graduates for the context in which they are expected to work. Through the development of high quality medical training for associate clinicians, medical schools can contribute to reducing inequities in rural health care.

Addressing inequity is an underlying value in rural education and needs to be considered in all aspects of this work, especially in areas where inequities are significant. To achieve equity, additional resources including resources for medical education, must be allocated to those with sub-standard health status (7), such as in rural Africa.

What's the evidence?

There is clear evidence of the ills of inequity and the beneficial impact of primary care in terms of reducing inequity (2, 8, 9).

While direct evidence for the role of medical education is not clear, there is evidence for the effect of selection and training of students on where they practice (10).

An illustrative anecdote

When the University of Pretoria developed training sites in the rural areas of Mpumalanga in South Africa, full-time university-appointed family physicians moved into rural districts and provide training in these rural areas for final year medical students, residents in postgraduate family medicine, clinical associates (mid-level medical workers) and nurse clinician students.

In addition improvement projects in maternal and child health and the management of chronic illness create integrated activities in these districts – and university staff and students initiate interventions that lead to better outcomes. Ongoing interventions and evaluation of these projects are undertaken to improve health and health care and decrease inequities.

(A similar model is being used by the University of the Witwatersrand in North West Province in South Africa.)

Broader applicability

In order to achieve a sustained and significant reduction of inequity, similar activities are necessary in other sectors of society including other collaborative or parallel tertiary educational interventions. The concept of a rural campus needs to be extended to include multiple programmes and faculties.

Practice pearls

- The challenge of a resource-constrained environment requires innovation and creative ideas.
- Medical education can be a vehicle to drive change in the health service and to improve equity.
- A commitment to equity requires a complete re-orientation of the mindset of a faculty[1], towards social accountability.
- Standards for measuring social accountability are now available.

What not to do

Potential pitfalls to avoid include:
- assuming that rural medical education is cheaper or requires fewer resources!
- expecting immediate impact; be there for the long haul.

[1] Here, 'faculty' is an organisational unit within a university comprising a cognate collection of departments– e.g. a Health Sciences Faculty.

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World Organization of Family Doctors (WONCA)
12A-05 Chartered Square Building
152 North Sathon Road
Silom, Bangrak
Bangkok 10500
THAILAND

manager@wonca.net

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