Chapter 1.2.2

RESOURCING RURAL HEALTH – HOW TO START RURAL TRAINING WHERE NONE EXISTS

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Introduction

So, you have been given the go-ahead by your Dean to start a rural training programme in your faculty or school – but where, when, and how do you start? The aim of this chapter is to provide practical guidance on how to approach setting up a new rural medical training programme or a new rural clinical school for the first time, with limited resources.

Actually, it very seldom starts this way. If you have already received the go-ahead from faculty or school management, you have probably been engaged in the process for quite some time already. Developing a rural training programme requires lots of groundwork, developing relationships amongst role players being the most critical component. You need to have the passion and the ideas which you can reinforce and develop, supported by the extensive literature that now exists on rural medical training. The motivation for rural training, for instance, can be categorised into workforce benefits, educational advantages and health service impact[1] – but you need to bring other people on board in order for this to go anywhere.

Bringing people on board

Charles Boelen introduced the notion of the Partnership Pentagon (or Pentagram), referring to the key role players with whom we need to engage for any project aiming to meet people's health service needs to be successful. These are policy makers, health managers, health professionals, academic institutions and communities.[2] This Partnership Pentagram also needs to be engaged in developing rural training.

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Stellenbosch University Collaborative Capacity Enhancement through Engagement with Districts (SUCCEED) performed a scoping review on decentralised medical training that led to the development of a framework for effective distributed training in the health professions. The scoping review and the framework foreground relationships as being at the centre of effective rural training,[1] the goal being to create a win-win situation that enables everyone to buy into the plan. Describing the role players in the development of the parallel rural community curriculum, Paul Worley and colleagues refer to the need for symbiosis which encapsulates this notion of everybody buying in because they all get something out of it.[3] This is the critical work to be done in starting rural training.

Thus one needs to be talking to the health service managers, ensuring that they can see what rural training can offer them, as well as persuading urban-based academics in the faculty or school regarding the positive difference rural training can make. Rural health professionals who will be supporters and supervisors of students, and thus a vital resource, need to come on board early and can be fellow champions.

The local community is also a very important resource in terms of making students feel welcome, identifying accommodation, providing psycho-social support, etc. Students can play a very important role as advocates for the community and, while funding may be required for them to undergo rural training, they also substantially contribute to the health service, and often to the local community itself.

Policy makers and bureaucrats in the academic institution and amongst the health service partners also need to see what the programme can offer to them – but if you have all the others on board, the momentum may become unstoppable.

Funding

Establishing rural training can be expensive but creative ways can be considered to address resource issues. In many instances, there are ways of doing things that can help to save money and, if there are good partnerships with goodwill, many possibilities exist. Good examples of this are health services allocating to clinicians part of their work time for supervision of students, because they know that students add benefits to health care; they can also provide learning spaces for students within the health facility that can be renovated at a small cost by the academic programme.

Community-based accommodation, or the handing over of hospital-based accommodation that is no longer used, have also occurred. Using interactive communications technology to provide support to students and preceptors is obviously essential in this regard, and this does not require sophisticated infrastructure; indeed, we find that in low-bandwidth environments simple Skype or WhatsApp video calls often work better than any expensive platform – and can be just as effective.

It is important not to set up a programme based on substantial external grants, unless these are used solely for initial infrastructure development, as sustainability can become a major issue. Rather than starting big and having to pull back, it is better to do less and depend largely on goodwill – and then grow the programme over time, and slowly develop resources. Adding sweeteners to persuade staff members at any level to take this on creates an unfortunate precedent that should be avoided.

Evidence and experience

This chapter presents the collective experience of the authors in South Africa in planning and setting up rural training sites, based on three main sources.

Firstly, in 2011 Stellenbosch University (SU) established the first Rural Clinical School (RCS) in Southern Africa.[4] Secondly, the Centre for Rural Health at the University of the Witwatersrand was involved in setting up rural training for final year medical students in resource-poor settings.[5] Thirdly, we conducted a scoping review of distributed learning[1] which assisted with a process to develop a framework for effective distributed training; this, in turn, led to the publication of twelve tips for distributed health professions training.[6]

In addition, the authors have been involved in working with and/or evaluating other programmes across Africa and beyond.

Illustrative examples

The SU RCS was established in the town of Worcester in the Western Cape province of South Africa as part of the university's Ukwanda Centre for Rural Health (CRH). It was established for long-term placement of final year medical students comprising both a regional hospital rotational model and a district hospital-based longitudinal integrated clerkship model. Ukwanda CRH was fortunate because the university used various grants to build a campus in Worcester mainly for the use of the RCS.[4] Compared to anything equivalent in more developed countries, however, the RCS runs on minimal staff, relying on their passion and dedication.

Many of the things that have been learned through this process are currently being used in the development of what is potentially a new RCS in the much underserved area of Upington in the Northern Cape province, where a newly built regional hospital is struggling with human resources (the recruitment and retention of health professionals). An academic partnership has thus been enthusiastically welcomed by hospital management, health professionals and local community members, providing an excellent basis on which to build an RCS, starting in the hospital without any additional infrastructure. A commitment from Ukwanda CRH to provide ongoing, regular on-site and distance support is matched by a commitment from hospital management to designate staff time towards the project and to commit clinicians to supervising students during placements.

Another critical element has been to start with a variety of health professions programmes together – that is, not just with medicine but also occupational therapy and physiotherapy (amongst others). This makes it a truly collaborative venture which bodes well for economies of scale becoming possible.

The Centre for Rural Health at the University of the Witwatersrand set up rural training for medical students in the North West province of South Africa, with minimal resources.[5] Often in the turmoil of this significantly under-resourced setting, characterised by inadequate infrastructure and administration, it was easier to ask for forgiveness than permission!

Many district hospital sites were so appreciative of the contribution that students made to health services – in terms of patient care, quality improvement activities and staff morale – that they were willing to provide free accommodation for the students and, in some cases, even providing meals for them. Most importantly, they allowed nurse practitioners and medical officers to be involved in supervising students as part of their duties. Critical in this was not being presumptuous or abusing the relationship, but instead always making sure that the local management team was aware of students and the role they were playing, providing and receiving feedback, tailoring student tasks to support the work of the health service, and not burdening local staff with unnecessary administrative or assessment work.

Part of the ongoing relationship is being sensitive to the needs of sites. Examples include giving a site a break from students when local factors determine this (such as someone being on leave); and making sure that students are constantly placed in sites which prefer this to ensure the accommodation gets used only for its intended purpose and not for something else.

Broader applicability

Resourcing issues will differ widely across different contexts and countries. In some situations, initiatives will be supported by government funding (from the education or health sectors, for example), or there will be long-term grant funding – while in many places there are no additional resources available. Here rural training can only be introduced through the support of partners and by reprioritising and re-allocating funding, which is never popular. Internal subsidisation within systems to allow for such training is often needed, which requires courage and commitment.

We have experience of both well-resourced and poorly-resourced environments, and believe that the fundamental principles outlined are nonetheless the same. Without good relationships and without a common vision amongst the partners, the presence or absence of resources will not be a factor that prevents successful development of rural training. Successful rural training depends more on resourcefulness than resources – ideas, creativity and enthusiasm should underpin the development of training regardless of what resources are available. There are multiple factors that enable rural training to happen – as outlined, for example, in Page and Birden's article on what makes rural medical placements successful.[7]

Practice pearls

In SUCCEED we have developed a short list of Simple Rules that encompass these factors, following the Simple Rules concept developed by Eoyang and Holladay.[8] While developed more generally for distributed training, we believe these rules are equally useful for establishing and continuing effective teaching and learning in rural environments, as they facilitate planning not only for compliance, but also for coherence. They are listed under the next section on 'What to do'.

What to do

1. **Build and maintain relationships:** Many players are involved in rural training and all of them are important to the success of the programme. It is good to invest in relationships early and continuously.
2. **Move towards a shared vision:** All partners should understand and commit to working towards a shared vision for rural training across multiple levels and perspectives.
3. **Fulfil roles and responsibilities:** Each role player has specific responsibilities, and effective rural training requires them to agree to, and fulfil, their commitments to such.
4. **Balance needs and provide support:** Throughout the rural training process all role players should contribute to addressing the needs of others, and at the same time should receive support in terms of their own needs.
5. **Engage with learning:** Students' learning should be the primary focus for all facets of the rural training programme, with constant reflection on how to improve learning.
6. **Evaluate and provide feedback:** Feedback from, and back to, all role players ensures programme quality and continuous improvement.

What not to do

- Don't change your focus away from innovation to searching for funding.
- Don't promise lots of resources to make rural training happen, or set up a model based on external time-limited grant funding, or provide extra payments to role players in order to get things started.
- Don't expect everyone to be happy all of the time, but also don't ignore criticisms and complaints that arise, as well as unspoken expectations from role players.
- Don't expect to be thanked for the work you are doing – when it happens, celebrate!
- Don't think that you will not make mistakes as you set up your rural training programme; be ready to acknowledge them when they occur and to learn from them.
- Don't rely on volunteerism; while this will work in the short-term, everyone needs to be getting something out of the project in the longer term, although this could be very different from financial compensation.
- Don't plan short rotations; longer and longitudinal rotations have superior training effects.
- Don't forget to involve the students in planning, implementation and evaluation of rural training initiatives.

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