

Rural Health
Advocacy Project

CONNECTING PRACTICE, POLICY AND PARTNERS

Lessons for advocacy initiatives in rural health
from the Rural Health Advocacy Project (RHAP)

Dr Waasila Jassat

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The
A T L A N T I C
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ADVOCACY AND ACTION FOR SUSTAINABLE SOCIAL CHANGE AND HEALTH EQUITY

EXECUTIVE SUMMARY



Rural health has been neglected historically, with severe implications for poor communities, and with few safe places for doctors and other health care workers (HCWs) to voice their concerns about service delivery problems. Despite progressive post-democracy policies and gains made in terms of improving access to health care, rural people continue to face significant barriers to accessing health care. Good policies were designed but overlooked the rural context, perpetuating existing inequities in access to health care between rural and urban areas, and advocates of rural health were largely disregarded.

Rural provinces have the poorest access to health care professionals, and the most rural and deprived provinces also have the lowest doctor-to-patient ratios. HCWs choose to work overseas, in private sector and in public urban facilities, with severe impacts on poor communities, ranging from inadequate care, long waiting times due to understaffing, unnecessary referrals to higher levels of care and even avoidable deaths.

The Rural Health Advocacy Project (RHAP) was conceptualised when the Rural Doctors Association of South Africa (RuDASA) decided to establish an entity to coordinate a joint voice to improve access for rural communities and provide a hub for HCW advocacy. Along with AIDS Law Project — now SECTION27 — and the Wits Centre for Rural Health, RuDASA applied to The Atlantic Philanthropies for an initial grant for two years to investigate and develop an advocacy framework, and a structure to drive it.

RHAP was established in 2009 with Atlantic funding. It is informed by the voices of rural HCWs, rural health associations and communities on the ground, to facilitate self-advocacy, generate debate, monitor implementation of health policies in rural areas, and influence pro-equity decision-making in tune with local rural realities.

The RHAP leadership has years of activism experience, combined with a culture of rigorous reflection and critical thinking. RHAP's strategic operating model has been structured to position it as a rural health knowledge and action 'hub,' which further draws on skills, expertise, knowledge and support from its partners. RHAP serves as an urban, Johannesburg-based hub for a large network of HCWs and other stakeholders whose aim is to advocate for a flourishing rural health care system in South Africa.

RHAP provides an innovative, highly effective and cost-efficient way of creating a powerful voice for driving the pro-rural health improvements agenda in South Africa. Its team is small but highly skilled. Its partnership approach enables RHAP to deliver results efficiently and eliminates the need for RHAP to grow into a sizeable and costly organisation. RHAP enables a network of small, diverse and disparate organisations to work together to achieve far more than any could on their own.

RHAP has been acknowledged for its contributions to rural health. In 2012 RHAP was awarded the Wits Vice-Chancellor's Academic Citizenship Award for

Rural provinces have the poorest access to health care

Doctors and health care professionals were not able to voice their concerns about poor rural health care delivery

RHAP coordinates a joint voice to improve access for rural communities and provide a hub for health care worker advocacy

RHAP advocates for rural communities to access quality health care

RHAP provides a coordinated voice and safe place for rural health care workers to channel concerns about poor rural health services

RHAP enables a network of small, and disparate organisations to work together to achieve far more than any could on their own

its work as a team. The director was voted Best Leader at the Wits Management Development Programme in August 2011. She and a programme manager were both featured in the 200 Young South Africans publication in 2011 and 2014, respectively.

Rural proofing is an approach to the development and review of government policy and strategic planning that recognises that the needs of rural areas and communities are different to those of urban areas. RHAP's advocacy role has resulted in rural-specific inputs to policy development and implementation assessments. RHAP provided substantial input into the Human Resources for Health (HRH) strategy released in 2011 and coordinated joint National Health Insurance, HRH and Primary Health Care submissions. RHAP's Rural-Proofing Programme has involved looking at international good practices on rural-proofing and the organisation produced a discussion document on defining 'rural' for the purposes of health policy. In addition, RHAP has conducted a number of research projects aimed at producing evidence in support of advocacy activities.

RHAP has seen some progress in shifting thinking around rural health issues. The success of some of its efforts including the Rural-Proofing Programme guideline launch, RHAP's work with the Department of Health (DoH) on defining rural for assessment purposes, input on the Ward-based Outreach Teams policy, and support to rural district management teams in their self-advocacy for more resources, is testament to the strength of this work and its growing legitimacy with key stakeholders such as the DoH.

RHAP has nurtured good working relationships with some key government officials at all levels. It has now refocused its work away from the national level and towards the provinces where implementation of policies and budgets is supposed to happen. RHAP is advocating for the protection of critical health posts within the context of budgetary constraints; engaging with provincial budget processes; putting a spotlight on unmet need in rural areas, the role of the full PHC team, the need for task-sharing, and shifting and trying to influence mid-level decision making, particularly at district level.

RHAP has been involved in a growing movement calling for health professionals' education transformation, and for more targeted rural selection of health science students. There has been growing government and university support for the development of decentralised rural training platforms.

RHAP's output has been prolific in terms of publishing and information dissemination in its short five-year lifespan. The RHAP website continues to receive attention, and RHAP's Facebook page has a significant reach as shown by the numbers of likes, comments and shares of RHAP posts.

RHAP has assisted HCWs with addressing service delivery failures. It is a partner in the Rural Mental Health Campaign, Eastern Cape Health Crisis Action Coalition and Stop Stockouts Project, the latter assisting with surveillance and working with partner organisations in joint advocacy to resolve medicine stockouts.¹

¹ Medicine stockouts are defined as the absence of specified medication in the storage area of the health facility

RHAP has been acknowledged for its contributions to rural health

RHAP's Rural-Proofing Project (RPP) has looked at international good practices on rural-proofing

RHAP has seen some progress in shifting thinking around rural health issues and better health care delivery in rural areas

RHAP has nurtured good working relationships with the national DoH, and has now refocused on implementation in the provinces

RHAP has been involved in a growing movement calling for health education transformation and upgrading the advocacy skills of rural health professionals

The Voice Project was launched by RHAP to advocate for improved access to advocacy-competent HCWs in rural areas. This includes the transformation of their education, social justice orientation and performance so that they are informed of their rights and those of their patients; they develop as agents of change; receive support if they experience victimisation; and receive assistance for rural HCW associations in increasing their membership, networks and advocacy. Through these activities, RHAP envisages a gradual paradigm shift among HCWs from the existing fear and uncertainty in reporting on health care failures to their understanding and upskilling to advocate for change when patient rights are violated.

RHAP's work is strengthened through close relationships with complementary organisations and institutions. It launched the Rural Health Partners Network in 2014 to establish strong relations with rural patient and provider representative organisations, and other rural health aligned organisations. RHAP's mandate is to 'connect practice, policy and partners' and play a coordinating, facilitating, empowering, enabling and supportive role, which will enable the rural voice to be heard in a strategic and effective way.

RHAP has created a platform for rural health issues, giving more power and influence to membership-based rural HCW organisations than they would have alone. In coordinating the Network, RHAP's strategy is to develop and strengthen individual organisations, as is demonstrated in their organisational and advocacy support of Rural Rehab South Africa and the Professional Association of Clinical Associates of South Africa.

Core funding partners continue to support RHAP and its partner alliance. Whilst RHAP operates very much like an autonomous organisation, it is housed within the University of the Witwatersrand in terms of its legal status. RHAP's accountability line to the broader University flows via Wits Centre for Rural Health. RHAP reports to a Board with representation by its founding partners, centres for rural health, patient-rights organisations and rural HCW associations.

The Atlantic grant was RHAP's only one in its first three years of existence from 2009 to 2012. This seed grant, and subsequent core funding, enabled RHAP to grow into a highly effective organisation and do highly innovative work. It also enabled RHAP to raise funds from new donors.

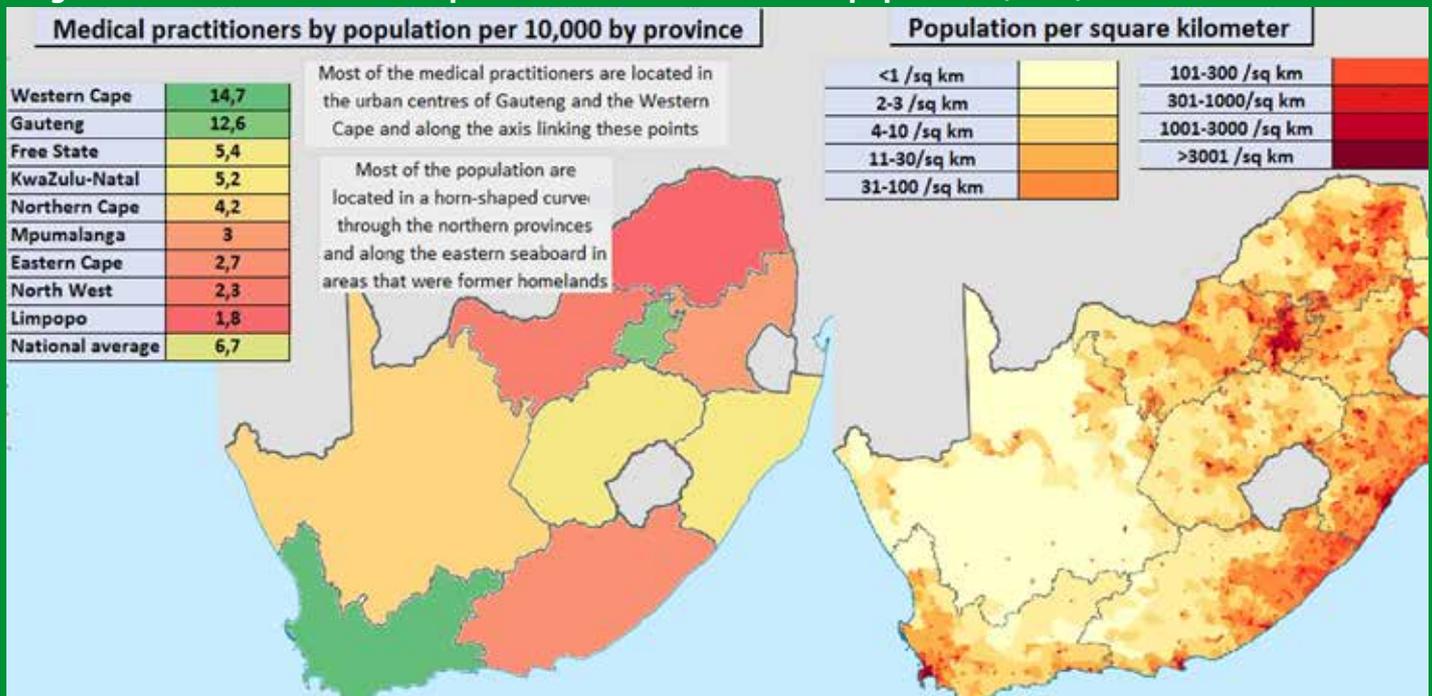
The Voice Project encourages rural health care professionals to act as agents of change

RHAP connects with other rural health care organisations in the Rural Health Partners Network

RHAP has given rural health care workers what they never had before — a platform to speak out

The Atlantic grant enabled RHAP to grow into a highly effective organisation and to raise funds from new donors

Figure 1: Distribution of medical practitioners in relation to the population (2014)



Sources: Based on HPCSA figures for registered medical practitioners and StatsSA population estimates for 2004

ACKNOWLEDGEMENTS

It has been my absolute privilege to have played a role in telling the story of the Rural Health Advocacy Project. I admire the energy, passion and drive of this small organisation and what they have been able to achieve in a short time through single-minded determination. I would like to acknowledge the staff and board members who so generously gave their time for interviews. The executive director, Marije Versteeg-Mojanaga, has been a strong supporter of this project and has contributed so much of her time, energy and ideas. My only hope is that the report does justice to the remarkable activities of RHAP.



Thanks to Marije also, as well as to photographer Thys Dullaart, for the RHAP photographs, which tell a story of their own.

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Finally, this process has enabled me to reflect on the role of funders in supporting advocacy organisations and my sincere appreciation is extended to The Atlantic Philanthropies for having the foresight and vision to invest in people and organisations in South Africa, with such remarkable impact.

Dr Waasila Jassat
July 2016

Photographs © RHAP

Pictures were sourced from RHAP and include pictures from:
Fjona Hill, Thys Dullaart, Karl le Roux, Rural Rehab South Africa and pictures taken by RHAP staff

TABLE OF CONTENTS

Executive summary.....	ii
Acknowledgements.....	v
Abbreviations and Acronyms.....	viii
Figures and Tables.....	x
Introduction.....	1
Purpose of the Report.....	1
Methodology.....	1
The Story of RHAP.....	2
The rural health landscape in 2009.....	2
The need for rural health advocacy.....	3
Formation of RHAP.....	5
RHAP’s theory of change.....	6
Who are RHAP’s staff?.....	7
Who are RHAP’s partners?.....	8
Who are RHAP’s funders?.....	8
Strengths, weaknesses, opportunities and threats.....	10
RHAP’s focus over time.....	10
Progress Against Objectives.....	13
1. Policy: Pro-Rural Reforms.....	13
1.1 Inputs to policy development.....	13
1.2 Rural-proofing policy and budget programme.....	14
1.3 Research: Informing policy advocacy.....	15
2. Evidence-Based Financing.....	16
3. Human Resources for Rural Health.....	16
3.1 The Voice Project.....	17
3.2 Undergraduate curriculum reform.....	17
3.3 Advocate for HR4RH strategy.....	19
3.4 Build advocacy competencies.....	20
3.5 Support HCPs.....	21
3.6 Support rural HCP member associations.....	22
3.7 Sustainability.....	23
4. Monitoring Implementation.....	23
4.1 Facilitating service provision.....	25
4.2 Rural mental health campaign.....	25
4.3 Access to medicines and the Stop Stockouts Project (SSP).....	26
4.4 Eastern Cape Health Crisis Action Coalition (ECHCAC).....	29
5. Building a Strong Organisation.....	30
5.1 Publications.....	30
5.2 Committees.....	31
5.3 Website and social media.....	31
Lessons About Partnership: The Rural Health Partners Network.....	33
Shared values.....	33
Areas of diversity.....	34
Roles of partners in the network.....	34
Strengthening member organisations.....	36
Strengthening the network.....	39
Coordinating rural partners to achieve impact.....	39
Solidarity and representivity.....	40

Legitimacy.....	41
Rural health advocacy	41
Challenges in maintaining the balance.....	42
Lessons about Advocacy Strategies.....	44
Choosing advocacy strategies	44
Informing the strategy.....	45
Leading from the front	47
Staying focused while remaining responsive.....	48
Shifts in focus	49
Getting government to respond.....	50
Lessons about influencing government	52
State of health.....	52
Health policy and reform.....	52
Implementation challenges.....	53
Changing the discourse	54
Climate for engagement.....	55
Lessons for Advocacy Groups	58
RHAP model.....	58
Strengthening the organisation.....	59
Pioneer leadership	60
Networks and alliances.....	60
Bringing the best possible mix of groups, capacities and strategies into play	61
Champions and facilitators	62
Advocacy style.....	62
Shifting focus	63
Using evidence and research	63
Targeting for greater impact	64
Managing attribution.....	64
Legitimacy.....	65
Enabling the voice.....	65
Being the voice.....	67
Mass-based movements	67
Change in policy, political and funding context.....	67
Universities	67
Government	68
Civil society.....	68
Funders.....	68
Sustainability.....	69
Lessons for Funders	72
Atlantic’s approach to grantmaking	72
Grantee selection.....	73
Grantee cohesion	73
Core funding	74
Enabling growth and strengthening organisations.....	74
Leveraging grants to secure funding	75
Relaxed oversight and control	75
Enabling innovation and adaptability	76
Grantee accountability	76
Understanding the long-term impacts of funding social change advocacy.....	77
References.....	78

ABBREVIATIONS AND ACRONYMS

AHP	Africa Health Placements
AIDS	Acquired Immunodeficiency Syndrome
ALP	AIDS Law Project
AP	Atlantic Philanthropies
ART	Anti-retroviral treatment
ARV	Anti-retroviral
CHEER	Collaboration of Health Equity through Education and Research
CHW	Community Health Worker
CME	Continuing Medical Education
CPD	Continuing Professional Development
CRH	Centre for Rural Health
CSO	Community Service Officer
DCST	District Clinical Specialist Teams
DDG	Deputy-Director General
DENOSA	Democratic Nursing Organisation of South Africa
DoH	Department of Health
EC	Eastern Cape (Province)
ECHCAC	Eastern Cape Health Crisis Action Coalition
EDP	Essential Drugs Programme
EMS	Emergency Medical Service
GP	General Practitioner
HCP	Health care Provider
HCW	Health care Worker
HIV	Human Immunodeficiency Virus
HOSPERSA	Health & Other Services Personnel Trade Union of South Africa
HPCSA	Health Professions Council of South Africa
HPSF	Health Professional Support Framework
HR4RH	Human Resources for Rural Health
HRH	Human Resources for Health
HRPM	Human Resources Programme Manager
KZN	KwaZulu-Natal (Province)
M&E	Monitoring & Evaluation
MDG	Millennium Development Goal
MDR-TB	Multi-Drug Resistant Tuberculosis
MEC	Member of the Executive Committee

Mol	Memorandum of Incorporation
MoU	Memorandum of Understanding
MPH	Master of Public Health
MRC	Medical Research Council
MSF	Médecins Sans Frontières
NDHSC	National District Health System Committee
NEHAWU	National Education, Health and Allied Workers Union
NGO	Non-Government Organisation
NHC	National Health Council
NHI	National Health Insurance
NHRC	National Human Resource Committee
NIMART	Nurse Initiated Management of Anti-retroviral Treatment
NRHTT	National Rural Health Task Team
NSP	National Strategic Plan
NW	North West (Province)
OPD	Outpatients Department
OSD	Occupational Specific Dispensation
OSF	Open Society Foundation
OT	Occupational Therapist
PACASA	Professional Association of Clinical Associates of South Africa
PHASA	Public Health Association of South Africa
PHC	Primary Health Care
PHM	People's Health Movement
PM	Programme Manager
PMTCT	Prevention of Mother-To-Child Transmission
RHAP	Rural Health Advocacy Project
RHPN	Rural Health Partners Network
RHTT	Rural Health Task Team
RPP	Rural-Proofing Project
RuDASA	Rural Doctors Association of South Africa
RuNurSA	Rural Nursing South Africa
RuReSA	Rural Rehab South Africa
RWOPS	Remunerated Work Outside of Public Service
SAHR	South African Health Review
SAHRC	South African Human Rights Commission
SAMA	South African Medical Association
SOP	Scope of Practice
SSP	Stop Stockouts Project

TAC	Treatment Action Campaign
UKZN	University of KwaZulu-Natal
VESP	Voice Enhanced Support Programme
WBOT	Ward-Based Outreach Team
WCRH	Wits Centre for Rural Health
WHC	Wits Health Consortium
WHO	World Health Organization
WIRHE	Wits Initiative for Rural Health Education
WISN	Workload Indicators of Staffing Need
Wits	University of the Witwatersrand
WMA	World Medical Association
WONCA	World Organisation of Family Doctors

FIGURES AND TABLES

Figure 1: Distribution of medical practitioners in relation to the population (2014)	iv
Table 1: RHAP's current organogram (July 2016).....	7
Table 2: RHAP's funders	9
Table 3: RHAP publications, 2009-2016	30
Table 4: Website homepage news item hits	31
Table 5: Facebook likes, comments and shares	32
Table 6: Priority-setting tool	48

INTRODUCTION

Since its inception in 2004, The Atlantic Philanthropies' Population Health Programme (PHP) in South Africa has awarded more than 100 grants, totalling more than 1 billion ZAR, with a collective goal of improving access to quality health care for all and to reducing health inequities across South Africa.

As Atlantic exits the funding stage, the focus of attention has moved to evaluation, with a commitment to capture the learnings through a variety of means, including high-level evaluations, individual reviews, case studies, and targeted assessments of individual grantees, all with a view to locating outputs of long-term value to the field.

PURPOSE OF THE REPORT

As part of Atlantic's commitment to giving voice to the underprivileged and marginalised, it funded key advocacy, primary health care and human resources programmes within the Population Health Programme. One of the beneficiaries was the Rural Health Advocacy Project (RHAP), funded from 2009 to 2016.

Atlantic has commissioned a series of individual case studies aimed to showcase the impact of grants to its beneficiaries. This RHAP case study sought to address the following major questions:

1. Was RHAP's strategic approach, as funded by Atlantic, appropriate and effective?
2. What can be learned from this strategic approach and programme achievements?
3. What is the likelihood of RHAP's sustainability beyond Atlantic funding?
4. What challenges, barriers and opportunities are there in making further progress?

METHODOLOGY

This case study was developed using a mixed method approach, drawing from theoretical frameworks including outcomes harvesting. A range of methods was employed including document review, observation, questionnaires, secondary quantitative data analysis, focus group discussions, and key informant interviews.

1. Document review of available materials related to the Atlantic grants and RHAP's activities and achievements
2. Observation of RHAP's key meetings and engagements
3. Administering a questionnaire to RHAP senior leadership to ascertain information on operations, structure, finances, capacity building, advocacy activities, key successes, challenges, and opportunities
4. Secondary quantitative analysis of data that has been collected by the organisation to demonstrate outcomes/ impact
5. Key informant interviews from senior managers, board members and staff of the organisation

Data from document reviews and interviews were analysed and key information extracted on objectives, implementation experience, challenges, and success factors.

Key lessons from the case study were presented at the following conferences in 2015:

- Public Health Association of South Africa, panel discussion: 'Advocacy to strengthen health systems'
- South African Monitoring and Evaluation Association, panel discussion: 'Lessons learnt by civil society and government from citizen-based monitoring of medicine stockouts'
- The material was also used to prepare a publication for a journal targeting lessons for funders: *The Foundation Review*, 'Enhancing funders' and advocates' effectiveness: The processes shaping collaborative advocacy for health system accountability in South Africa'

The material may be adapted for other journal publications, opinion pieces, advocacy briefs, etc. It is also intended that the recipients of Atlantic grants will be brought together in thematic groupings to explore learnings from their common experience that can shape further advocacy work. This will be facilitated by the case study researchers.

THE RURAL HEALTH LANDSCAPE IN 2009



Rural areas have vastly under-serviced health facilities

Historically, rural health care has faced enormous challenges in South Africa. Even post-democracy, and despite progressive policy and some gains being made in terms of improving access to health care, rural health has been given little attention. Policy did not take rural care into account, and there actually seemed to be anti-rural decision-making. There was no rural health strategy in place nationally or provincially and no Human Resources for Health (HRH) plan for rural health. Specific issues of rural health and rural health care were consistently neglected in decision-making, policy formulation and drafting of legislation. There was little space for rural advocates to be included in policy making structures at any level.

In terms of health financing, inequitable funding formulae resulted in *provinces with the greatest health*

*burdens, the least economic resources and the largest populations receiving the smallest share of national public health care funds.*² In times of fiscal constraint, budget cuts were made across the board, without reflecting the particular fragility of already under-resourced rural hospitals. Rural health facilities' budgets were based on previous years' budgets; and there was recurrent overspending due to rolling debt.

Inequities in human resource distribution exist between the private and public sectors and between rural and urban areas. About 60% of the nurses and 40% of the doctors serve 85% of the population using the public health sector. The poorest access to health professionals is found in rural provinces. Vacancy rates are the worst in rural provinces, with the three most rural provinces having the lowest doctor-to-patient ratios. Inequities existed within rural provinces and districts, with wide variations in staffing levels between facilities, leading to inefficient use of scarce health care workers (HCWs). The impact on poor communities has been severe, ranging from long waiting times, unnecessary referrals, poor quality of care, and even avoidable deaths. Government interventions which have tried to address the HR crises have often compounded the challenges. For example, Occupational Specific Dispensation (OSD), introduced by government in 2009 to improve remuneration of health workers, rewarded interns and specialisation at much higher levels than ordinary medical officers. This had the unintended consequence of incentivising specialisation, which is not possible in rural facilities, rather than encouraging career pathing in rural areas.

Rural health has been given little attention, with severe impact on poor communities, and no safe place for doctors and HWCs to voice concerns about service delivery problems

Human resources disparities that plague the South African public health sector have an even more damaging impact on rural areas. Freezing of critical posts and moratoria on staff recruitment cripple health services in already under-resourced rural areas. In 2009, there were no staffing norms in place and rural health workers were still not sufficiently financially recognised. Despite clear evidence to support university selection that favours rural origin and decentralised training in rural areas as means of retention, there were no clearly defined rural recruitment and retention strategies until the release of the HRH plan and few rural-based health training facilities.

² Stuckler D, Basu S, McKee M. 'Health care capacity and allocations among South Africa's provinces: Infrastructure inequality traps after the end of apartheid'. *American Journal of Public Health*. 2011;101(1):165-172

This had resulted in a breakdown in service delivery. In 2009, rural health issues were not heard and not known at policy level due to the isolated nature of rural HCWs. There was furthermore no safe place for doctors and other health care workers to voice their concerns about service delivery problems.

THE NEED FOR RURAL HEALTH ADVOCACY

The Rural Doctors Association of South Africa (RuDASA) was formed in 1996 and succeeded in bringing together a network of doctors from southern Africa around the common issues faced by them all. Under the banner of Inspiring others towards rural health, RuDASA's vision is for all rural people in southern Africa to have access to quality health care. In order to achieve this, RuDASA strives for the adequate staffing of rural health services by appropriately skilled medical staff and to be a voice for the rural doctor regarding training and working conditions.

RuDASA activities include an active committee, an annual conference, a website (www.rudasa.org.za) and an e-mail discussion group. RuDASA has supported the African section of the international journal *Rural and Remote Health* (www.rrh.org.au). They also established cooperative engagement with the Treatment Action Campaign, the Southern Africa HIV Clinicians Society (Clinicians' Society), and the South African Medical Association (SAMA); and maintained links to international organisations such as the Working Party on Rural Practice of the World Organisation of Family Doctors.

RuDASA found it increasingly difficult to be effective in fulfilling its mandate. The RuDASA committee consisted of a small number of dedicated individuals working voluntarily after hours. There were no full-time employees and no central office. The budget arising from membership fees was small, and only covered seed money for the annual conference and monthly committee meetings by teleconference.

Despite this lightweight approach, RuDASA managed to establish a national profile, and consistently punched above its weight. It has credibility in the national Department of Health (DoH) and has contributed to a number of documents and policies, primarily concerned with human resources for health. It attracts 200 to 400 delegates to its annual conferences.

However, the reality was that when an issue arose that needed attention, there were limited resources to deal with it apart from statements in the media, a letter written by the chairperson, or at most, a once-off delegation sent to meet with the people concerned. This was not sustainable as demands increased and members were unavailable to increase visibility and involvement. The situation was as follows:

- Advocacy was done by RuDASA members who felt passionate about a particular issue and had the time to take it up and could rally some support from fellow members;
- Information about pending policy making or amendments did not always reach RuDASA members with enough time to make well-coordinated, valuable submissions;
- RuDASA members could not always travel to make policy submissions due to their location far from urban centres as well as their hospital workload;
- RuDASA members and other rural health care professionals were victimised for speaking out negatively on rural health issues;
- Rural citizens had no voice in guiding rural health care service provision (both in terms of quality and access); and
- Other civil society organisations concerned with health issues did not put the specific needs of rural health onto their agendas.

Advocacy was ad hoc, not well-coordinated, of poor quality, and sometimes not timely enough to be included at all in policy considerations. In addition, due to its ad hoc nature individuals who spoke out were targeted by authorities as they did not have the support from other voices. In short, advocacy was reactive, issue driven and responsive. A spark for action came in the form of the KwaZulu-Natal (KZN) antiretroviral (ARV) issue.

CHALLENGING DISCIPLINARY ACTION AGAINST MANGUZI DOCTOR

'The ghost of AIDS denialism: Manguzi Hospital and dual loyalty' by Marlise Richter and Donna Knapp van Bogaert, SA Journal of HIV Medicine, 2008

'In July 2006, the World Health Organization (WHO) released its new guidelines on Prevention of Mother-To-Child Transmission (PMTCT), which recommended the use of dual therapy where indicated. Despite advocacy efforts to urge the national DoH to revise its PMTCT guidelines in line with WHO recommendations, the 2002 guidelines remained in force. In the public sector, scores of pregnant women with HIV/AIDS therefore received the less efficacious monotherapy.

[Dr Colin] Pfaff, Chief Medical Officer of Manguzi Hospital, as well as other concerned doctors in the province, investigated national and international PMTCT programmes, noting that in KZN 23% of women with HIV/AIDS on the existing single-therapy PMTCT programme transmitted HIV to their infants. This was in contrast to, for example, a less than 5% transmission rate in the Western Cape province where dual therapy had been in use since August 2004. Gravely concerned, in May 2007 Pfaff and his colleagues wrote to the KZN DoH requesting permission to start rolling out dual therapy in the Manguzi PMTCT programme: "We cannot sit in silence any longer."

When the provincial DoH failed to keep its promises concerning dual therapy implementation, Pfaff and his colleagues took the initiative and raised funds from an international donor in order to purchase dual therapy. In August 2007, Pfaff began to implement the 2006 WHO dual-therapy programme at Manguzi Hospital. Six months later, on 25 January 2008, the national DoH released its new PMTCT guidelines.

During the same month as the revised PMTCT guidelines were announced, Pfaff was threatened with suspension. Disciplinary action was taken against him in January 2008 because, as it was stated, he had 'allegedly acted beyond his authority in accepting a donation and implemented a (PMTCT) dual therapy to pregnant mothers and newborn babies without prior permission of his superiors.'

'Drop doctor's misconduct charges' –by Kerry Cullinan on 9 February 2008 in Health e-news³

'Pfaff was sent a letter from the Manguzi Hospital CEO asking him to respond to the charge that he 'wilfully and unlawfully without prior permission of (his) superiors rolled out [PMTCT] dual therapy to the pregnant mothers and new-borns. Pfaff has contravened policy. We are not against dual therapy treatment for HIV-positive babies, but it is not something that has been implemented yet. We have not yet budgeted for it and we do not have the capacity yet for it.' He was disciplined by the then KZN Member of the Executive Committee (MEC) for Health.

RuDASA, SECTION27 (then AIDS Law Project) and Wits Centre for Rural Health (WCRH) cooperated to challenge his unfair suspension. TAC issued a statement on disciplinary action against Dr Colin Pfaff, on 18 February 2008

"Dr Colin Pfaff and other medical doctors working in Manguzi Hospital have put patients before the process. The AZT he used was donated by Manguzi Mission Fund, so the provincial hospital incurred no cost for the HIV infections prevented by Dr Pfaff.

Ms Nkonyeni's statements contradict government policy, particularly the HIV & AIDS and STI Strategic Plan for South Africa 2007-2011, National Strategic Plan (NSP), which explicitly provides for the implementation of dual antiretroviral prophylaxis for PMTCT.

We demand that the Manager of Manguzi Hospital and the KZN DoH withdraw disciplinary action against Dr Pfaff. We also demand that Ms Nkonyeni apologise for her inflammatory statements. We call for the speedy implementation of dual antiretroviral prophylaxis.

The department then withdrew charges against Pfaff, but a few weeks later the MEC again accused Pfaff and colleagues of being 'opportunists' who had engaged in 'wanton behaviour' and 'anarchy'.

³ <http://www.health-e.org.za/2008/02/09/drop-doctors-misconduct-charges-rudasa/>

FORMATION OF RHAP

There was a growing feeling amongst health care providers, especially RuDASA members, that the ongoing neglect of rural health was unacceptable and that a stronger, more concerted rural voice was needed. The Manguzi case was a milestone which brought together a mini-coalition focused on rural health issues and served as a stimulus for action. (Executive Director, RHAP).

Following this incident, RuDASA identified the need to advocate more actively for the rights of rural communities to access decent health care. This was not achievable with their current structure and limited resources.

Rural doctors were busy, had full-time jobs and lacked advocacy skills and experience. They believed advocacy was important but often came away from government consultation feeling deflated as they were not properly prepared and didn't have sufficient expertise to engage on policy issues. (Board Member, RHAP).

RuDASA made a decision to establish an entity that could coordinate a joint voice for realising quality rural health care – to improve access for rural communities and to provide a hub for health care worker advocacy. Along with AIDS Law Project (ALP) — now SECTION27 — and Centre for Rural Health (CRH), RuDASA applied to Atlantic for an initial grant that gave them two years to investigate and develop an advocacy framework and a structure to drive such an advocacy approach.

The goal in the first 24 months of the grant was to develop a framework describing the purpose and function of a rural health advocacy unit. It was also intended that further proposals would be presented to potential funders. The long-term vision was to establish a rural unit within or alongside the ALP that included advocacy, policy analysis, support for rural doctors, media liaison, and information dissemination. Its focus would be much broader than just rural doctors. The advocacy unit would employ one suitably qualified person to tackle the issues systematically in a full-time capacity, initially for 12 months.



Rural stakeholder strategy meeting, 2011

The Rural Health Advocacy Project (RHAP) was established in 2009 to address specific identified high-priority issues in rural health in South Africa by systematically bringing them to the attention of relevant stakeholders to achieve measurable improvements in rural health services.

RHAP's Rural Health Advocacy Strategy would consist of sequential bite-size steps, tackling one discrete issue at a time and working out a systematic plan to deal with it. These issues would be identified by a group of stakeholders, and consensus would be reached on the top four or five issues that were most feasible to be tackled. These issues would be within the framework of access to health care for rural people and the lack of progress in relation to the United Nation's Millennium Development Goals, which lead to poorer health indicators in rural areas.

The seed grant from Atlantic Philanthropies allowed for the creation of RHAP and conceptualisation of a rural health advocacy approach

Over the long-term RHAP also aimed to establish a rural alliance that would bring together organisations with different rural health focus areas — both networks that have a grass-roots presence and core partners with which strategic alliances could be leveraged for achieving a greater voice.

The first seed grant from Atlantic therefore allowed for the creation of RHAP and conceptualisation of a rural health advocacy approach.

Within that timeframe RHAP was able to develop its theory of change and strategic framework which allowed us to get our head around long-term objectives. (Executive Director, RHAP).

RHAP'S THEORY OF CHANGE

RHAP provides a central place for advocacy for rural health, to represent the voice of rural HCWs and to influence policy processes to ensure they speak to the rural context. RHAP serves as an urban, Johannesburg-based hub for a large network of HCWs and other stakeholders whose aim is to advocate for a flourishing rural health care system in South Africa.

RHAP's strategic operating model has been structured to position it as a rural health knowledge and action hub with a small but highly skilled team that further draws on the skills, expertise, knowledge and support from its core partners, and other partners, to further its vision.

RHAP advocates for the constitutional right of rural and remote communities to have equitable access to comprehensive, quality health care.

VISION - Rural Health – Key to a Healthy Nation

RHAP's vision is based on the unwavering belief that South Africa can have a healthy nation only if rural health is central to health service planning and decision-making at both national and decentralised levels.

MISSION - Connecting Practice, Policy and Partners

RHAP's mission is to be a leading resource in the field of rural health advocacy that facilitates the translation of rural health needs and health care solutions into policy and decision-making.

AIMS

RHAP aims to advocate for rural communities to access quality and equitable health care, and to provide a coordinated voice and safe place for rural health care workers to channel concerns and recommendations regarding issues affecting rural health care.

RHAP hopes to achieve these goals through the following approaches:

- Facilitate self-advocacy, generate debate, monitor implementation of health policies in rural areas, support pro-equity government interventions, and influence decision-making that is in tune with local rural realities; and
- Facilitate building a strong, goal-focused advocacy platform for rural health, founded on research-based evidence, civil society alliance-building, and effective engagement with policy makers.

RHAP defined four strategic objectives which form the core of the organisational Theory of Change. These are to ensure that:

1. New and existing policies are rural-friendly.
2. Rural health care receives the financial resources to provide a quality, equitable service to rural citizens.
3. Every rural citizen has adequate access to caring, qualified health care teams (human resources for health).
4. Policies are implemented in effective and efficient rural health care systems.

WHO ARE RHAP'S STAFF?

Marije Versteeg-Mojanaga, then 32 years old, was employed as the executive director of RHAP in 2009. Under her dynamic and passionate leadership and stewardship, with the seed grant from Atlantic, the organisation grew greatly in its size, reach and visibility.

The addition over time of highly skilled programme managers (PMs) and researchers has resulted in a small but highly functional and productive team of individuals. Daygan Eagar was employed as a health budget specialist and PM for the Rural-Proofing Project (RPP) and Budgeting Programme in 2012; Prinitha Pillay as the PM for Human Resources for Health (HRH) and Policy Implementation in 2014; and Samantha Khan-Gillmore as PM Human Resources for Health from 2016. Mafoko Phomane, a Master of Public Health student in Rural Health, joined as an intern in 2014 and was appointed as researcher in 2015. Palesa Butler has been the administrative focal point since 2014. Although not employed by RHAP, Dr Richard Cooke has been working closely with RHAP since 2011 in developing rural-proofing strategies, while Bhekisisa Maqephula and Fikelephi Sithole have been seconded to the RHAP Rural-Roofting Programme by Treatment Action Campaign since 2014. Several interns joined RHAP for short periods of time, usually around six months.

The staff members have grown academically and developed their skills during their time at RHAP. Formal training opportunities have included a management skills course at Wits Management Development Programme, attended by the executive director. Daygan Eagar has attended a Principles of Management Course and has registered for a Master of Science (MSc) at Wits in collaboration with the Centre for Health Policy. His MSc research is embedded into the RPP work. Mafoko Phomane has integrated her MPH research project on rural health professionals' experiences with mental health care service delivery into RHAP's work. What is quite evident is that while there is a lean structure, RHAP has an exciting staff profile —young dynamic individuals who have drive, passion and dedication to the RHAP cause.

Table 1: RHAP's organogram (July 2016)

Staff category	Name	Age	Gender	Employed
Executive Director	Marije Versteeg-Mojanaga	38	F	2009 - current
Programme Manager: Rural-Proofing Policy and Budgeting Programme	Daygan Eagar	34	M	2012 - current
Programme Manager: Human Resources for Health	Samantha Khan-Gillmore	40	F	2016 - current
Researcher	Mafoko Phomane	37	F	2014 - current
Administrator	Palesa Butler	38	F	2014 - current
Clinical governance and policy advisor	Richard Cooke	47	M	2011- current
Community mobilisers RHAP/TAC	Fikelephi Sithole	42	F	2014 - current
Community mobilisers RHAP/TAC	Bheki Maqephula	31	M	2014 - current



WHO ARE RHAP'S PARTNERS?

The founding member organisations of RHAP were Rural Doctors Association of South Africa (RuDASA), University of the Witwatersrand (Wits) Centre for Rural Health (CRH) and AIDS Law Project (now SECTION27). Many other organisations have become formal partners through representation on RHAP's steering committee (which is now constituted as a Board); joining the Rural Health Partners' Network (RHPN); or developing coalitions with RHAP through local campaigns.



ECHCAC march to EC provincial government

RuDASA, as a partner organisation has served to provide RHAP with grass-roots information regarding the state of health care in rural areas. SECTION27 provides legal and advocacy expertise and initially housed RHAP in their offices. Wits CRH provides academic input and serves as RHAP's accountability line to the broader University.

Besides Wits CRH, the other rural academic partners include University of KwaZulu-Natal (UKZN) Centre for Rural Health, Stellenbosch Ukwanda Centre for Rural Health and the University of Cape Town Primary Health Care Directorate.

Rural health care provider member organisations such as RuDASA, Rural Rehab South Africa (RuReSA), Rural Nursing South Africa (RuNURSA)

and the Professional Association of Clinical Associates of South Africa (PACASA) give a voice to rural health professionals.

The TAC advocates for the rights of people living with HIV/AIDS. Africa Health Placements (AHP) provide sustainable and strategic solutions to human resources in health. Health-E shares office space with RHAP and works to identify and formulate responses to health crises on the ground using the media.

The Rural Health Partners Network includes RuReSA, PACASA, Ukwanda CRH, UKZN, CRH, AHP, RuNURSA; and rural health student clubs at UKZN, Wits, and the University of Cape Town.

Through the Stop Stockouts Project, RHAP has partnered with Clinicians' Society, Médecins Sans Frontières, SECTION27, TAC and RuDASA.

A number of organisations are represented on the Eastern Cape Health Crisis Action Coalition, including the Association of Concerned Specialists of the PE Hospital Complex, Black Sash, Budget Expenditure Monitoring Forum, Counsel for the Advancement of the South African Constitution, Democracy from Below, Democratic Nursing Organisation of South Africa, Health & Other Services Personnel Trade Union of South Africa, Igazi Foundation, Jubilee, Junior Doctors Association of South Africa, Keiskamma Trust, People's Health Movement, PACASA, Public Service Accountability Monitor, RuDASA, RuReSA, SECTION27, Sonke Gender Justice, South African Medical Association, TAC, Word Vision South Africa, and World AIDS Campaign.

WHO ARE RHAP'S FUNDERS?

Atlantic has been the most significant funder of RHAP since its inception, both in terms of the funding award amounts and the facilitating role the funding has played. The initial seed grant in 2009 allowed for the conceptualisation of the advocacy approach, the establishment of RHAP and the employment of its executive director. Atlantic provided core funding that enabled organisational growth. The second, more sizeable grant

from 2012 to 2014 provided funding for RHAP activities such as generating the evidence-based and rural-proofing health policy. The final award from 2013 to 2016 aimed at further strengthening the Rural Partners' Network and supporting specific activities such as advocating for pro-rural policy, implementing the rural health budget strategy and monitoring implementation of health care in rural areas.

The Atlantic criteria for matched funding required RHAP to seek other funders. Leveraging the Atlantic grant, RHAP was able to demonstrate to potential funders that their contributions would be supplemented by matched funds already raised. In this way the Raith Foundation funded the Rural-proofing Policy and Budget programme from 2014 to 2016. The Open Society Foundations (OSF) provided an annual grant from 2014 to 2016, co-funding the Voice Project from 2016. (The Voice Project aims to build advocacy competencies among rural HCPs and provide support to HCPs at risk or experiencing victimisation.) RHAP's work has been a good fit with OSF's strategic objectives, particularly of advancing civil society and promoting socioeconomic rights, around the interface of building active citizenship, and achieving universal access to health care. The Claude Leon Foundation has also come on board to support the Voice Project from 2016 to 2018.

The Atlantic funding for the Voice Project enabled RHAP to experiment with design and leverage further funding. The matched funding from OSF specifically for the Voice Project was initially an annual grant but has now been awarded for three years to ensure sustainability of the programme, with potential for increased funding in each year provided the programme is effective. More recently the Claude Leon Foundation, which funds predominantly social justice work, has allocated specific funding for the Voice Project. Despite this support from funders, the Voice Project remains underfunded due to the growing demand. RHAP realised that another human resources programme manager will need to be recruited to focus on technical HRH policy while the existing programme manager would focus on curriculum advocacy.

In the early years of its inception, RHAP received financial and in-kind contributions from partners such as RuDASA, SECTION27 and Wits CRH, which has been a game-changer allowing the RHAP to grow and build its reputation, which in turn facilitated independent fundraising. Médecins Sans Frontières awarded small grants in 2014 and 2015 for the Voice Project. RHAP also received the Wits Vice-Chancellor's Citizenship Award in 2012.

Table 2: RHAP's funders

Funder	Period	Purpose
Atlantic Grant 1	1/5/09 – 31/3/11	To develop an advocacy framework and a structure to drive such an advocacy approach
Atlantic Grant 2	1/1/12 – 31/12/14	To generate evidence-based and rural-proofing health policy
Atlantic Grant 3	1/7/13 – 30/6/16	To improve the flow of health resources in rural areas by advocating for and monitoring the implementation of pro-rural health policies and programmes
Open Society Foundations	1/11/12 – ongoing	Rural-Proofing Policy and Budgeting Programme Implementation of the Voice Project
Raith	1/4/14 – 31/12/16	Rural-Proofing Policy and Budgeting Programme: to identify and address barriers to equitable allocation of resources to the poor in rural areas; to develop rural-proofing policy guidelines that will provide government with an effective tool to properly plan for and deliver quality health care services; to rural-proof key health developments and advocate for interventions to cater for the needs of rural people; to improve awareness of and buy-in by government and civil society around the need to rural-proof budget and policies
Claude Leon Foundation	2016 – 2018	Implementation of the Voice Project
Médecins Sans Frontières	2014 & 2015	To support the development and rollout of the Voice Project
Vice-Chancellor's award	2012	Academic citizenship award recognised RHAP's commitment to human rights in relation to rural health care

STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

A SWOT analysis conducted in 2014-15 by the organisation as a process of self-reflection revealed the following:

RHAP's key **strengths** are its committed staff and its alliances and partnerships with like-minded organisations. RHAP also has a history of its affiliates (RuDASA members and rural health workers) speaking out for the rights of rural citizens and health workers. RHAP has earned external recognition and acknowledgement for the work they have done and the organisational brand is well known and recognised. RHAP is recognised for its informative publications and for developing an evidence-based approach.

The **weaknesses** identified stem from having a small, overstretched staff. This can affect the efficiency and effectiveness of internal coordination. Importantly, due to its small size, RHAP has to be focused in the issues it tackles and balance their passion for rural health issues with keeping a focused outlook on what they can achieve.

RHAP has identified **opportunities**, including a changing health care system with growth in the voices speaking out against system failures. RHAP has developed a better understanding of the DoH's agenda and so can better influence it through technical advocacy. RHAP's reputation for growing rural health is gaining traction. RHAP has recently had more meaningful engagement with Treasury.

The **threats** that RHAP perceives could affect them include weaknesses in partnerships, and potential or actual paranoia in government resulting in RHAP being ignored by decision-makers. In the current political and economic climate, rural health is not enough of a priority and government's attention is drawn away from service delivery and social justice. Other concerns are the shrinking of donor funding and the resultant threat to RHAP's sustainability.

RHAP'S FOCUS OVER TIME

Since inception, RHAP has seen an evolution and refinement in its strategic objectives. At the inception of the first grant from Atlantic and the establishment of RHAP, the first strategic framework of 2009-2012 stated its aim to address specific identified high-priority issues in rural health in South Africa by systematically bringing them to the attention of relevant stakeholders in order to achieve measurable improvements in rural health services

In the short-term (12 months), the goal was to develop an advocacy framework and structure to drive such an advocacy approach. This would be done through the appointment of a suitably qualified project director.

In the longer term (three to five years), the goals were to see the following as a result of this project:

1. Adoption of an appropriate national Rural Health Strategy by the national DoH and its implementation by provincial departments of health.
2. A process of policy analysis to ensure that all legislation being drafted recognise the needs of rural areas and are 'rural-proofed'.
3. Ongoing engagement with the Parliamentary Portfolio Committee for Health on proposed legislation.
4. Active recruitment of South Africa-qualified doctors and other health professionals into rural public service, including the retention of community service officers.

*RHAP
aims to bring
rural health issues
to stakeholders' attention
in order to achieve
measurable
improvements in rural
health services*

5. Revision of the policies and processes affecting foreign-qualified doctors and other foreign-qualified health care professionals.
6. Improved accommodation for health professionals in rural areas.

In the second grant period, from 2012-2014, the following grant objectives were proposed:

1. A strong, vibrant civil society organisation that actively advocates for staffing rural health facilities.
2. Health reforms are underway, such as the new primary health care approach and the National Health Insurance (NHI) are pro-rural.
3. A research-based credible body of knowledge on Human Resources for Health (HRH) is created and published.
4. Targets are set for staffing rural facilities in the revised human resources for health plan.

In the final grant period, 2014-2016, RHAP stated that rural health needs a strong, united voice to put further pressure on both national and provincial DoHs to 'put rural health first'. The following strategic goals were articulated:

1. Strategic alliances and networks with groups that have a grassroots presence and place the interests of rural communities at the centre of their work are strengthened.
2. Successful policy advocacy for human resources for rural health, manifest in pro-rural programmes and in the implementation plans of the NHI, Primary Health Care (PHC) Revitalisation and HRH strategy.
3. Existence of evidence base of rural health practices on the ground, built both through research and monitoring of health care implementation.
4. Strengthened capacity, resilience, and sustainability of RHAP to drive the country's rural health agenda through a strong and powerful alliance of pro-rural health groupings.

This would involve both programmatic and process advocacy:

Programmatic Advocacy involves:

- Implementation of the rural HRH Strategy, policy advocacy for, and monitoring of, an efficient and effective pro-rural NHI and PHC drive; and
- Continued advocacy for staffing norms, rural health education strategies, sound evidence-based rural policies, an annual HRH seminar, and monitoring implementation of rural health care.

Process Advocacy involves:

- Evidence-based research, and capacitating and expanding the alliance of rural health partners in order to:
- Conduct an intra-provincial comparison of policy adoption and implementation of four key HRH policies: community service medical officers, accommodation, transport, and overtime;
- Conduct research on the state of HRH distribution between urban and rural;
- Establish a sound evidence base regarding the failures to develop and implement pro-rural policies in the past (interviews and surveys);
- Implement rural health budget strategy; and
- Monitor implementation of health care in rural areas.

In its strategic framework, the RHAP set goals for 2016, some of which have received more emphasis than others, while new goals have been added in response to changing contexts and priorities. These are:

Policy to ensure that:

- Rural-proofing guidelines are being used by government and civil society;
- Health reforms are rural-friendly;
- Health policies have been amended to pro-rural; and
- All district governance structures have rural advocacy representation.

Financing to ensure that:

- A strong evidence base on rural health care financing is publicly available to all;
- Appropriate budgeting for the delivery of health care in rural areas occurs at national, provincial, district and facility level;
- Budget cuts take into account rural health realities; and
- Funds for rural health care are spent effectively and efficiently.

Human Resources for Rural Health (HR4RH) to ensure:

- Implementation of a new rural-friendly HRH plan;
- More effective planning for appropriately trained human resources for rural health;
- Implementation of a holistic set of rural recruitment and retention strategies;
- An equitable distribution of community service officers;
- Appropriate policies and processes affecting doctors and other health care professionals who qualify abroad; and
- A decrease in number of avoidable deaths.

Implementation to ensure:

- Implementation of key policy documents in rural areas;
- Availability of a strong body of public evidence on the state of rural health for all;
- Active participation of rural citizens in advocacy for their own rural health care; and
- An ongoing, sufficient supply of essential drugs in rural areas.

Strong organisation to ensure:

- The concerns of rural health care workers of different disciplines are heard and that joint advocacy for rural health takes place.



PROGRESS AGAINST OBJECTIVES

An external evaluation of RHAP conducted between September and November 2014 made the following conclusion:

In the five years of existence [RHAP] has operated in innovative, deeply collaborative ways to build a network of diverse relationships with partners, and, as a result, has had an impact way beyond what its size and period of operation would suggest There is clear evidence that the 2012-2014 objectives have been realised and, in many cases, exceeded. (External evaluation, 2014)

1. POLICY: PRO-RURAL REFORMS

Through its early work, a strong research-based conceptual framework has been developed, and significant work has gone into providing technical support to DoH officials at various levels. This hands-on technical support is mostly through RHAP staff and advisors who sit on various national committees and also through formal submissions, research and public advocacy with partners.

1.1 Inputs to policy development

Rural proofing is an approach to the development and review of government policy and strategic planning that recognises that the needs of rural areas and communities are different to those of urban areas. RHAP has continued to make rural-specific inputs to policy development and implementation assessments. RHAP provided input into the HRH strategy released in 2011 and coordinated joint NHI, HRH and PHC submissions.

RHAP has provided input and technical support to the PHC revitalisation strategy and engaged with the development of the national policy on ward-based PHC outreach teams. The deputy-director general (DDG) for PHC requested RHAP to review a draft of the policy and provide input on how it could better reflect rural contexts. Most of RHAP's input was retained in the draft published for public comment. 'Rural-proofing' has even been defined in the policy and outlined as an essential aspect of its development.

RHAP has also given feedback on the DoH's District Health Systems Strengthening document and published a position paper on the CHW's role in rural health, where they focus on the unmet need and critiqued the narrow DoH focus on prevention and promotion.

The NHI process, on the other hand, seems to have stalled, and a white paper has (at the time of this report) not been published. RHAP has made submissions on the development of the NHI system (including giving input to the Alternative Information Development Centre and Oxfam's review of the 2014-15 NHI budget) but otherwise has been unable to engage in the policy process as planned. Its work around the NHI has largely focused on other aspects of health system reform, such as Ward-based Outreach Teams (WBOT) policy, the Office of Health Standards Compliance and General Practitioner (GP) contracting, which are complementary to the broader reform process.

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There has been acknowledgement from decision-makers, particularly the national DoH and Treasury that looking at, understanding, and prioritising rural is important. Previously rural health was clearly off the agenda and government-developed universal solutions for urban and rural service issues. It is now understood by government that RHAP is not advocating for government to prioritise rural over

urban services and resources, but to approach it and plan for it differently. This newfound level of understanding is demonstrated through the establishment of the Rural Health Task Team (RHTT) by the NDoH. The RHTT provides a forum for more sustained engagement and despite its challenges, slow pace, and resistance by some people, there has been good buy-in from others, and firm resolutions have been taken at the highest levels to take decisions forward.

Furthermore, the inclusion of RHTT in the National District Health System Committee and the documented resolutions from this body to support the rural-proofing approach is a really good sign that there is buy-in at senior management level at the national DoH.

1.2 Rural-proofing budget and policy programme

The Rural-Proofing Project (RPP) has involved a desktop review of international good practices on rural-proofing and produced a discussion document on defining rural for the purposes of health policy. RHAP developed rural-proofing policy guidelines that were launched in January 2015. The launch was a significant success, having the DDG providing a keynote speech and robust participation during proceedings from representatives from the DoH at the national, provincial and district levels, as well as national Treasury. The event was well supported by key partners.

In March 2015 RHAP presented the guidelines to a meeting of the National District Health System Committee, which took a resolution to support the guidelines at the district level and actively identify ways to ensure their use in strategic planning.

RHAP successfully rural-proofed the GP contracting scheme through the development of the Health Provider Support Framework. The guidelines are also being used within the Rural Mental Health Campaign as a tool to assess policy and strategic planning for mental health services in rural settings and then to develop evidence-based advocacy messaging. A rural mental health care task team has been established.

There are numerous indications that the language and concept of rural-proofing are being used more and more both by health care professionals (HCPs) and government officials and that progress has been made in shifting language and thinking around rural health issues.

Government has been engaging more with evidence in recent years. The DoH has accepted that there is a need to develop a fit-for-purpose/operational definition of rural for policymaking and service delivery planning. The RHAP discussion document on defining rural is being used by the DoH Directorate of Integrated Planning, to assist the DoH in determining possible approaches to identifying districts as rural or urban. RHAP also collaborated with the directorate to write a chapter on RPP in the *South African Health Review*.

RHAP has set ambitious goals for the RPP but these are not unrealistic. RHAP is fortunate to have funders who have been cognizant of the fact that a lot is out of our control and cannot necessarily be influenced by us. RHAP may not meet short term goals but there has been some significant movement over two and half years. To show actual material change is quite difficult over a short period (PM, RHAP).

RHAP acknowledges that it is difficult for any transformative project to demonstrate change over a short period. There are genuine constraints within government to address issues they have been highlighting.

RHAP is not advocating for government to prioritise rural over urban services and resources, but to approach it and plan for it differently

The current negative situation has been created by many influencing factors which require a range of actions and shifts in many areas. To influence rural-proofing, DoH may agree in principle but don't have the money; Treasury agree rural-proofing is necessary but have competing priorities. We need to make a case to them on why and how they should prioritise our issue (PM, RHAP).

Treasury have been engaging with, and responsive to, requests by RHAP and do not deny that there are historical inequities that need to be addressed, but it has been more difficult getting them to commit to make actual changes. Treasury support the underlying principles but have been in some respects critical of the approach. RHAP has been engaging with them to refine the approach, making inroads into presenting something with the aim of influencing their thinking, which has already had their inputs. The lesson has been to make arguments that are convincing. At the conference of the Public Health Association of South Africa in September 2015, Dr Mark Bletcher, chief director for Health and Social Services in the Treasury, stated that civil society is often not aware what impact it has behind the scenes. He gave the example of actuaries within his department now looking into ways of accounting for rural in the equitable share formula.

1.3 Research: Informing policy advocacy

RHAP has conducted a number of research projects aimed at producing evidence in support of advocacy activities. Academic projects include a longitudinal study on the distribution of human resources for health between urban and public areas (with the Centre for Health Policy); costing of Community Health Worker (CHW) service delivery in an urban vs rural setting, with the Medical Research Council (MRC); desktop research into defining rurality and international best practices in rural-proofing; a rural budget mapping project; rural implementation assessment; and a Delphi research project identifying priorities for RHAP. RHAP has also conducted action research involving fact-finding such as the HRH surveys for the Eastern Cape Health Crisis Action Coalition. RHAP was requested by the emerging HRH Alliance to lead on the identification of overall HRH research gaps – this will be done in collaboration with the academic partners. RHAP plans to conduct a rapid assessment of the malfunctioning of the Health Professions Council of South Africa (HPCSA) and the South African Nursing Council.

RHAP has prioritised knowledge management — production of a body of knowledge, disseminating that knowledge and popularising research through factsheets, opinion pieces, and publications. The organisation will commit their efforts to growing their evidence base for advocacy through various popular and academic contributions to esteemed journals, for example, the *South African Medical Journal* and the *South African Health Review (SAHR)*. Some of the recent RHAP publications include:

- Peer-reviewed international publication on the key challenges for rural health care in South Africa;
- Chapters on HRH and the right to rural health care in *SAHR*;
- Rural Health Factsheet which is now becoming an annual publication;
- Chapter on Equity in the District Health Barometer 2012/2013;
- Three Rural Health Updates around the themes of rural health financing, rural mental health and the role of rural rehab professionals; and
- Concept papers that outline the concepts of 'rurality' and health, pro-rural health policy and rural-proofing HR health policies

RHAP documentation is being used in teaching HCPs, in ongoing professional development with HCPs and, to some extent, by government officials in policy development and implementation.

2. EVIDENCE-BASED FINANCING

Significant gains have been made in RHAP's work on rural health financing. Desktop research in rural health financing has been conducted into international best practices as well as research of macro-economic trends in South Africa. RHAP developed an approach to analysing expenditure that more explicitly accounts for the rural context. This served to conduct an assessment of the DoH's budget and strategic planning documentation with regard to planning and resourcing for the implementation of the NHI. RHAP concluded the mapping of the budget cycle in two rural districts. They were also involved in budget monitoring that consisted of an analysis of budget and expenditure issues over a number of months both for the Northwest DoH and to provide initial analysis for the South African Human Rights Commission (SAHRC) emergency medical service hearings in the Eastern Cape. This budget and expenditure analysis approach has also assisted RHAP's partners driving the Free State Health Crisis campaign using the data for presentation at the people's health inquiry in July. RHAP's Daygan Eagar co-authored the Equity Chapter in the District Health Barometer of 2013.

3. HUMAN RESOURCES FOR RURAL HEALTH

RHAP has developed a set of activities focused on implementation of a new rural-friendly HRH plan and more effective planning for appropriately trained human resources for rural health. For rural communities to access quality health care, change is required at both production and service delivery level.

Medical practitioners have an ethical duty and a professional responsibility to act in the best interests of their patients. This duty includes advocating for patients, both as a group (such as advocating on public health issues) and as individuals. (World Medical Association's Statement on Patient Advocacy and Confidentiality).

Shortages of HCPs and their vulnerability to victimisation due to being isolated in rural and remote areas make them reluctant to speak out. Whilst HCPs can be agents of change, many lack the motivation, knowledge, confidence, and/or skills to navigate and problem-solve specific challenges within the health system.

South Africa needs a critical mass of confident, health-rights-based thinking HCP advocates. This can be achieved by 'growing' HCPs who are informed of their rights and those of their patients. They should be confident and well-equipped to defend those rights strategically by using internal and external reporting tools and strategies. This includes collaboration with community-based structures, as well as local and national advocacy groups that can advise, support, defend and work with them to address health system challenges in a strategic and effective manner.



Rural health care service

3.1 The Voice Project

The Voice Project has been developed by RHAP in partnership with the Rural Doctors Association of South Africa (RuDASA), Rural Rehab South Africa (RuReSA), Professional Association of Clinical Associates of South Africa (PACASA), Médecins Sans Frontières (MSF), the Clinicians' Society and SECTION27. It aims to serve as a catalyst for long-term systemic change. The Voice Project's objectives are to:

- Advocate for the transformation of health professionals' education, including advocacy for the development of HCP change-agents;
- Advocate for implementation of the DoH Human Resources for Rural Health strategy;
- Build advocacy competencies among in-service rural HCPs in collaboration with communities and civil society structures;
- Provide support to HCPs at risk or experiencing victimisation; and
- Support the rural HCP associations in increasing their membership, networks and advocacy.



RHAP Voice workshop to Clinical Associates attending a PACASA symposium, KZN, 2016

The Voice Project intends to achieve the progressive realisation of the rights of rural people to access quality health care through:

- Universities producing more graduates that choose to work in rural areas due to changed selection and education practices;
- Improved distribution of existing HCPs in rural areas;
- Increased numbers of rural HCP change agents in rural areas;
- A powerful rural health network protecting and promoting the right to rural health; and
- Improved access to quality health care in rural areas through strategic and safe advocacy by a sufficient number of HCPs who work in partnership with communities, civil society structures, government bodies and other role-players.

3.2 Undergraduate curriculum reform

There is a fundamental problem not only in the way HCPs are distributed but also in the manner in which they are selected and educated. Selecting the right students and ensuring they receive appropriate educational experiences are crucial factors in addressing inequities in access to HRH. In South Africa, there is a growing movement calling for health education transformation, organised through the Collaboration of Health Equity through Education and Research (CHEER) network. This network consists of University Rural Health Centres that use softer advocacy approaches to effect health education transformation. While this network has achieved some successes, such as changes in the HPCSA accreditation criteria for Medical Schools, overall progress is painstakingly slow.

One of RHAP's objectives is to advocate for the transformation of health professionals' education, including advocacy for pro-rural admission criteria and education practices. RHAP and its co-founder Wits CRH have been involved in advocacy within Wits for a number of years for more targeted selection criteria of rural origin and intent health science students. RHAP advocated for the inclusion of rurality in the selection criteria of health science students. Data was made available with evidence of the impact of rural selection. In 2014 Wits changed its admission criteria and from 2015, 20 percent of students accepted to study medicine will be of rural origin. Tracking of graduates will be required to tell if they are likely to stay rural after three, five and 10 years. There has been growing government and university support for the development of decentralised rural training platforms.

Rural health clubs at universities continue to be supported by RHAP. Support for these clubs is needed to:

- Build future leaders who will lead the rural health associations;
- Increase their relevance and visibility at universities;
- Involve them in the new momentum to review the curriculum; and
- Engage them with the Voice Project and its integration into the curriculum.

Universities should produce HCPs with skills in ethics, problem-solving and advocacy

RHAP will increase the pressure for change by playing a public watchdog role in close collaboration with the CHEER network, the individual Centres for Rural Health, and rural health students' clubs. Emphasis will be placed on the type of HCPs that universities produce, ensuring that the non-bio-medical competencies such as ethics, problem-solving and advocacy are part of the education they receive. This will address 'the evolving role of doctors and other health professionals' so that graduates can be competent and active in broader advocacy and health reform.

RHAP is working with CHEER and other partners on the development of a public scorecard for the eight health science institutions in terms of their social medical accountability in relation to selection and education practices for rural health. This scorecard will include the following indicators:

- The nature of admission criteria and the extent to which these institutions facilitate the enrolment of a higher numbers of students of rural origin and from previously disadvantaged backgrounds;
- The extent to which the Faculties of Health Sciences track their graduates to demonstrate whether they are producing graduates that meet the needs of the country; and
- The extent to which advocacy and medical ethics are covered in the curriculum.



RSSP and KZN RuDASA Rep, Dr Indira Govender with Dr Richard Cooke (Wits CRH), and Prof Steve Reid (UCT) at a rural health partner network meeting, organised by RHAP, 2015

While the scorecard aims to achieve long-term systemic change in the health professions education system, the Voice Project guest lectures will also be used to demonstrate the need and value of such training and to start building a new paradigm and practical advocacy skills among the future health workforce. It is envisaged that there will be measurable positive improvements among health science students participating in various Voice Project activities regarding their knowledge, attitudes and practices towards HCP advocacy.

RHAP has contributed to Health Sciences curriculum reform through integration of advocacy training for undergraduate students.

RHAP has begun to engage with universities and higher-education bodies around the need to incorporate advocacy in the medical curriculum. It is not sufficient to integrate it into rural health, public health, patient centredness, ethics or PHC blocks. What is required is to mainstream advocacy across years and tracks... The CRHs have been identified as the first point of engagement. These ideas have been presented to learning and teaching committees... Wits University has done an assessment on advocacy in the curriculum. At [the University of Cape Town], a potential space to integrate advocacy is in the 'health in context' block. The existence of PHC as a platform cutting across all training tracks is an opportunity. At Stellenbosch University the family medicine department runs a longitudinal module 'doctor as change agent' in the fifth and sixth years which provides an opportunity to embed advocacy training. UKZN [University of KwaZulu-Natal] has been the biggest success. There is high level of buy-in and ownership, and the dean is supportive. They have conducted a review of who is teaching what in terms of advocacy, developed a definition of advocacy and a tool for assessing how universities are teaching advocacy. A workshop is planned with faculty to conduct a situational analysis in planning for an advocacy track. The UKZN has also created spaces for RHAP to present to the Academy of Science and at the Health Education Reform meeting attended by all [South African] universities. (Programme Manager, RHAP).

RHAP has succeeded in introducing the Voice Project to management, lecturers, and students across a number of Faculties of Health Sciences across the country, and a strong interest has been established in most cases, which now needs further nurturing and translation into tangible changes to the curriculum, sensitising staff and students to its relevance in universities.

3.3 Advocate for HR4RH strategy

RHAP has focused on advocacy for implementation of the DoH Human Resources for Rural Health (HR4RH) strategy with an emphasis on staffing norms, recruitment, and retention. RHAP and its rural partners advocated for the inclusion of Chapter 8 on HR4RH in the national HRH strategy (2011). RHAP has used both soft and harder advocacy approaches to pressure government to fully implement Chapter 8 and is now reviewing the extent of Chapter 8 uptake in order to develop further strategies during the next few years.



To date, implementation of Chapter 8 has been slow, as has the implementation of the overall HRH plan. A National Rural Health Task Team has now been formed (co-chaired by the DDG of PHC and the DDG of HRH) of which RHAP is a member. RHAP also has a standing invitation to the National Human Resources Committee (made up of all the provincial DDGs) and the District Health Systems Committee that fall under the Technical Advisory Committee of the National Health Council.

Under this objective RHAP undertakes to put measures in place to drive progress in all of the five strategic objectives of the HRH Plan, with an emphasis on a selected set of priorities, including:

- An increase in the number of community service officers placed in rural and other underserved areas;
- Meeting the national staffing norms in rural areas through sufficient resource allocation, redistribution of the health workforce and upscaling of production through health professions education transformation; and
- A discontinuation of staffing moratoriums in facilities that already function below the minimum staffing norms.

RHAP has contributed to defining rural staffing targets and been involved in meetings with the DoH Workload Indicators of Staffing Need (WISN) team, attending two high-level stakeholder sessions. RHAP provided inputs to the WISN tool and process. However, there has been little consultation or local inputs requested from WHO and the guidelines have not been rural-proofed.

Retention in rural areas is an important focus for RHAP and its partners. The RHTT has committed to a review of rural allowances and to further discuss accommodation and Continuing Professional Development (CPD) for those in rural service.

The DDG Primary Health Care requested RHAP to coordinate a review of the *District Hospital Package of Services* and also requested RHAP to support the drafting of the Ward-based Outreach Teams (WBOT) policy prior to public consultation. RHAP advocated for the inclusion of a structured support and retention programme for contracted GPs as part of the terms of reference for the tender. RHAP will contribute to structuring a capacity-building programme to help districts support the GPs that are contracted to join the PHC teams. Equitable distribution of these contracted health practitioners will also be watched closely by RHAP.

RHAP hosted a session on HRH as part of the Wits CRH Rural Health Week where they presented the stock take progress. They also supported RuDASA in hosting a small strategic session with key influential HRH role players. Attending organisations were Democratic Nursing Organisation of South Africa (DENOSA), Health & Other Services Personnel Trade Union of South Africa (HOSPERSA), RuDASA, RuReSA, PACASA, and the People's Health Movement (PHM).



ECHCAC march to Bisho, handing over a memorandum calling for interventions to fix the Eastern Cape health system.

RHAP has been represented on the EMS hearings in the Eastern Cape by the SAHRC. Dr Prinitha Pillay was the only external member on the panel. RHAP was asked by the SAHRC to coordinate a HRH sub-committee.

RHAP's constructive engagement with and support for PACASA in advocacy training to a young association is a good example of an HRH advocacy success. Due to the advocacy efforts by PACASA, RHAP and others, the Scope of Practice (SOP) for Clinical Associates was finally promulgated by the Minister in May 2015. This scope of practice is critical as the first graduates in 2010 entered the health system as long as four years ago, and it has been difficult to integrate into the existing health teams without a defined scope of practice.

RHAP also worked closely with Treatment Action Campaign (TAC) in their Free State CHW campaign. In August 2014 TAC, RHAP and other organisations supported over a 100 CHWs charged with 'illegal gathering', for a peaceful protest against their non-renewal of contracts. RHAP

has been vocal in support of CHWs, working with key civil society partners on drawing attention to the issues, briefing consultants working on WBOT policy to try and influence policy as well as broader reach through media statements and media coverage (print and internet). RHAP and its partners have embedded the CHW issue within a broader HRH crisis and the need for a united front to voice concern for poor HRH planning and implementation. RHAP brought together, on behalf of RUDASA, key stakeholders to form a united front on key HRH issues. Attendees included RuDASA, RuReSA PACASA, RuNurSA, South African Medical Association, DENOSA, National Education, Health and Allied Workers Union, PHM, HOSPERSA, SECTION27, and the Community Health Worker Forum.

RHAP has integrated the Voice Project as part of broader campaigns such as in the Eastern Cape province with the Eastern Cape Health Crisis Action Coalition (ECHCAC) and in the Free State in order to facilitate strategic collaboration between HCPs as active citizens with eyes and ears on the ground and local and national civil society structures, thereby providing a powerful alliance to advocate for the right to health.

In addition, to address the lack of systemic, district-based data on the maldistribution of the health workforce in South Africa, RHAP will implement an innovative longitudinal HRH distribution research project.

3.4 Build advocacy competencies

RHAP and its partners run workshops, CPD-accredited lectures, and an intensive Voice Enhanced Support Programme (VESP) across various sites in the country, reaching more than 500 HCPs. Workshops are demand-driven and, in many cases, take place as part of broader campaigns such as in the Eastern Cape province with the ECHCAC and in the Free State. This facilitates strategic collaboration between HCPs as active citizens with eyes and ears on the ground and local and national civil society structures thereby providing a powerful alliance to advocate for the right to health.



The Voice Project targets students, staff and management to the level of Heads of Schools at Faculties of Health Sciences

across the country to integrate advocacy competencies into the formal curriculum of health science students. RHAP staff members have given various guest lectures and taught on the Wits MPH Programme (on Advocacy and Rural Health); and the Graduate Entry Medical Programme (GEMP) (on Advocacy). CPD accreditation has been secured. The Voice Project workshops have been held with facility-based health care workers, at conferences, and through lectures to students, reaching more than 800 students. The Voice Project has delivered CPD accredited talks/workshops to more than 500 participants to date since January 2015. Facility workshops are led by RHAP trainers and SECTION27 legal researchers/attorneys.

RHAP has found that it does not currently have sufficient capacity to meet the demand for further Voice Project workshops and needs to investigate other options and models for increasing the reach of its training.

The Clinicians' Society has incorporated the Voice Project as a regular Continuing Medical Education (CME) activity. A milestone has been the achievement of ethics accreditation (participants receive six ethics points for attending a Voice Project workshop) which has been a significant pull factor to attract doctors to attend. SECTION27 have also run about five workshops using the Voice Project material.

There has been a varied spectrum of HCPs attending the Voice Project workshops from low-level CHWs, allied health professionals to medical super-specialists, professors, managers as well as some from the private sector. There has been a good reception of the material covered. Participants have noted the need for this in their training — the practical skill of how to be a change agent is a critical skill missing. They also recognise they need a lot of support while in the health system. Many participants across the lecture series had not heard of current civil society or patient-led advocacy initiatives that impact on their work e.g., SSP, ECHCAC, SECTION27. However, most participants had witnessed examples of health care failure.

RHAP has engaged openly with DoH management, sharing information about workshops, providing copies of the Voice Project manual. Clinical managers have attended workshops. There has been no attendance by district managers or political leadership. Many HCPs who have been through the Voice Project workshops have expressed the desire for RHAP to come to their facilities and speak to their managers. There is also demand for printed booklets for them to share with their managers.

In conducting the Voice Project lectures for undergraduate students, RHAP observed that most of these soon-to-be doctors had no knowledge of the content of the Voice Project manual, some had never read the South Africa Constitution, few had heard of the national complaints management protocol, or they were not aware of the process for contacting district managers. Few knew of the SSP, even though most had observed stockouts of medicines but did not know what could be done about it. A small number of final-year medical students had never heard of the Treatment Action Campaign.

The project aims to be in a position to demonstrate the impact of the Voice Project trainings to in-service HCPs through changes in knowledge, attitudes and practices towards advocacy in general and specifically regarding the reporting of health care failures.

3.5 Support HCPs

One of the project's key resources is a guide written for HCPs to identify, problem solve and report health care challenges. RHAP has developed the Voice Project manual that outlines the principles and tools for reporting health care challenges by HCPs. The project seeks to inform and equip health care workers to ensure that danger to patients' safety, corruption, malpractice, and any act that is prejudicial to public interest is reported. In addition, it seeks to create and inspire agency in individuals.

The Voice Project was developed as a response to people approaching RHAP saying we don't have enough doctors, there is no clean linen, the community and HCPs have complained about a clinical manager that we can't do anything about... RHAP does not have the capacity to

respond to each of these individual challenges but had the vision that it would be more effective to empower HCPs, supporting in-service isolated rural HCPs. (Programme Manager, RHAP).

RHAP provides advice and support to HCPs who face victimisation for reporting on patient and HCP rights violations. The Voice Project promotes 'safe and responsible' reporting. There is however a reasonable risk that some HCPs will nonetheless face victimisation. Where cases of victimisation occur, RHAP will provide a help desk and referral function to ensure that individual HCPs are supported through legal, moral, public and technical means. RHAP's close partnership with SECTION27 is critical in this instance as is the development of the Rural Health Partner Network, which would provide a shield around the affected HCP.

RHAP Researcher Mafoko Phomane, rural radiographer Sokwakhana Mavume, RHAP Programme Manager HR4H, Samantha Khan-Gillmore, RHAP Board chairperson Desmond Kegakilwe, and RHAP Executive Director Marije Versteeg-Mojanaga after a Voice training workshop.

VESP consists of a longitudinal support programme in two rural pilot sites with the aim of supporting health teams to address specific health care delivery challenges at their facilities over time through mentorship, guidance, partnership-building (for example, with community activist groups and local community structures), and technical support.

Through these activities, RHAP envisages a gradual paradigm shift among HCPs from the existing fear, uncertainty and perceived unlawfulness of reporting on health care failures to an understanding of and upskilling of HCPs to advocate when patient rights are being violated. This will lead to improvements in patient care through specific actions taken by HCPs; such as reporting staffing crises that result in interrupted patient care; broken equipment that leads to avoidable infant deaths and mismanagement such as abuse of Remunerated Work Outside of Public Service (RWOPS).

**RHAP
envisages HCPs
moving from a position
of fear, uncertainty and
perceived unlawfulness of
reporting health care failures,
to HCPs who advocate for
patients' rights when
these are violated**

It is intended that rural health care providers will organise themselves to build sustainable networks and well-staffed health services and conduct joint advocacy. HCPs will be empowered to seek advice and protection from the Protected Disclosures Act if they have been unlawfully disciplined and/or victimised for whistleblowing.

3.6 Support rural HCP member associations

South Africa has a number of volunteer-run rural health care provider associations that are unique for their patient-centred approach and that aim to provide local support networks to their members. RHAP supports these associations in building their membership in rural areas. This is done through the Rural Health Partners Network and by promoting the associations among students and in-service HCPs during all Voice Project activities. The growth of membership and local support networks are important strategies to addressing local challenges. Joint HCP advocacy will lead to greater influence, and therefore effectiveness. A local support structure through association membership also provides a first safety net when HCPs engage in advocacy and encounter challenges.



In the current climate, it is difficult to effect change unless strong alliances are formed between like-minded groups and a critical mass of patient-centred rural HCPs is reached. Together, these groups have a powerful voice that can effectively serve to realise the right to health and defend the democratic principles of government accountability, freedom of speech and freedom of association.

The Voice Project aims to achieve a 10% annual increase in membership numbers among the individual associations of RuDASA, RURESA and PACASA. It will also support the newly formed RuNuRSA. CPD accreditation has been a drawcard as well as an important mobilisation tool for rural health partners' associations' membership.

3.7 Sustainability

Building an active citizenry role among rural HPCs, that extends their functional role of disease prevention, treatment and rehabilitation, is a critical piece of the puzzle in civil society's efforts to promote, protect, and realise the right to health. The Voice Project builds on various initiatives and partnerships with a wide range of organisations and networks. This promotes the long-term sustainability of the project and also reduces risks to the sustainability of the project if faced with funding constraints.

The Voice Project is structured to achieve systemic impact that will last beyond the project's life cycle. For instance, once the advocacy competencies are formally integrated into the curriculums of the Faculties of Health Sciences, there will be less need for HCP in-service workshops, and by building the rural HCP associations, RHAP's advocacy and support role will become less necessary as this will be done by the associations themselves.

An article entitled 'Doctors should champion the cause of poor people' by Jimmy Volmink, issued the following call, published on 1 October 2015 in *Business Day Live*⁴

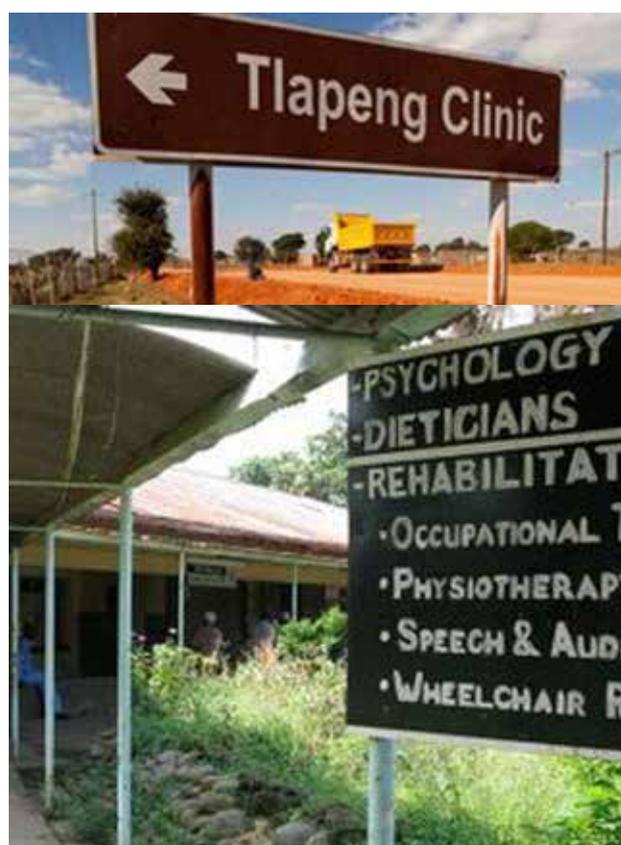
We need an 'upstream health professional' movement to break down the divide between clinical medicine and public health. Furthermore, given that health is the legitimate domain of health professionals, they can be considered the authentic champions of the right to health that is enshrined in the Universal Declaration of Human Rights and also embodied in SA [South Africa]'s Bill of Rights... Doctors are held in high regard in society. As such, their voice, whether individually or collectively, is more likely to be heard than that of others. Doctors must not neglect to use their formidable social capital in the struggle for health and equality in SA. By serving as advocates for the poor, we will make SA better for everyone, including ourselves and our children. (Prof Jimmy Volmink, Dean of the Faculty of Medicine and Health Sciences, Stellenbosch University).

The Voice Project intends to contribute to building this movement, from curriculum reform to in-service HCW advocacy training providing practical tools on how to do this.

4. MONITORING IMPLEMENTATION

RHAP has seen its strategic focus evolve to include a greater emphasis on monitoring and in turn, supporting implementation of policy at local levels. RHAP conducts a stock take of the implementation of the rural chapter of the HRH plan, which includes the DoH performance in terms of freezing of posts, unfilled critical posts, etc. The DoH proposed to integrate the stock take into the agenda of the RHTT going forward. There is also now a standing invitation to the rural health partners to attend the National District Health System Committee meeting and the National Human Resource Committee (NHRC) meeting where they have also been asked to present to the stock take. This is a significant milestone. The RHTT partners have further ensured that rural-proofing will be a standing item at these committee meetings. DoH will request the DG's approval to establish a Rural Health Sub-Committee of the Technical Advisory Committee of the National Health Council (NHC). RHTT has requested access to the provincial HRH plans.

⁴ http://www.sun.ac.za/english/Documents/newsclips/Volmink_Business%20Day.pdf



In the Eastern Cape (EC), the submission from rural communities to the SAHRC signals an important use by communities of the institutions meant to investigate violations of their rights to access EMS. It also is important that civil society uses the Chapter 9 institutions and strengthens their ability to safeguard the rights of all vulnerable communities affected by the same issues. The hearings provided testimony that was evidence-based around the numbers of ambulances, condition of ambulances, planned budget and expenditure, and the proportion of the budget for planned patient transport. RHAP was represented on the panel and also coordinated meetings with senior provincial officials to discuss the EC's short- and long-term response to the HRH crisis.

RHAP spearheaded a civil society response to austerity measures in North West (NW) Province following drastic budget cuts of 600 million rands for that financial year. RHAP did a rapid assessment of HCW experiences, and issued a press release, followed by a formal letter to the NW DoH in partnership with RuDASA, TAC, SECTION27, RuReSA, PACASA, and the Wits Initiative for Rural Health Education (WIRHE) Coordinator. They also held meetings with government officials, including NW Health and Treasury, with participation in a joint workshop on the freezing of posts.

RHAP received a request from TAC to participate and support the People's Commission of Inquiry into the Free State health system. They were tasked with providing financial analysis of the budget vs expenditure and obtaining health care worker testimonies. These testimonies speak of poor working conditions, medicine shortages, and victimisation of HCWs.

Firstly I started working at this hospital since 2013, there were no problems back then, the problems started late last year when we were told about financial problems that the DoH is having, which now seem to have resulted in medication shortages and stock outs. (Doctor, Free State).

No one will speak out, they are afraid, there is fear that the MEC will hunt you down. (Pharmacist, Free State).



4.1 Facilitating service provision

There are many examples of individual cases where RHAP assisted HCWs in addressing service failure:

UNBLOCKING OUTREACH SERVICES

For many months, an East London clinic-based doctor requested the District Office to release her to conduct outreach support visits to nurses providing Nurse Initiated Management of Antiretroviral Treatment (NIMART) in remote clinics. Her request was not successful. The clinics did not receive any doctor visits, which impacted adversely on patient care, driving up costs of patients with more complicated cases who now had to travel to referral centres. RuDASA asked RHAP for assistance. RHAP used existing networks to raise the matter at the provincial level.

Two weeks after RHAP intervention, the doctor received approval to conduct support visits. This enabled the doctor to start visiting five clinics, ranging from 30 to 90 kilometres outside East London — all serving rural communities. The Great Kei area has a population of 45,000. At the time, there was one full-time GP, one part-time GP, and one doctor at Komga Hospital, who did not do outreach. The Great Kei had more than 1,000 patients on anti-retrovirals (ARVs) and a number of clients with multi-drug resistant tuberculosis. The outreach doctor was now able to see about 450 to 500 patients a month. These consultations included reviews of chronic medication (including ARVs), management of acute patients and seeing complicated clients on ARVs who were referred by NIMART nurses. The doctor also trained nurses during these visits and received calls up to four times a day from nurses seeking advice.

RHAP has also worked in collaboration with other partners to address rural health care issues:

4.2 Rural mental health campaign

The health of persons living with mental health-related challenges has long been neglected by the public health care system in South Africa. Services offered have largely been modelled on institutional care and have lacked elements that promote social inclusion, empowerment, hope and independence. Services have been centralised in tertiary hospitals in the main cities of South Africa, while most people living with mental health-related issues in smaller towns and rural settings are confronted with unsupportive and inadequate mental health care services.

Rural health partners have launched a Rural Mental Health Campaign. RHAP coordinated the collection of testimonies from mental health users and HCWs' stories in Limpopo, KwaZulu-Natal (KZN), NW and EC.

RURAL MENTAL HEALTH: A CALL TO ACTION

The Rural Mental Health Campaign was started in 2014 by a group of organisations at the Rural Health Conference that were deeply concerned about the lack of progress made in the implementation of the National Mental Health Policy Framework.

Rural mental health care services are still largely inadequate. The *Rural Mental Health Campaign Report* is about the challenges that people living with mental illness face in rural areas.⁵

The testimonies of mental health care users from rural areas in the EC, KZN, Limpopo and the NW echo through the Rural Mental Health Campaign's findings and recommendations. The report portrays how mental health is neglected in rural settings and demonstrates why rural mental health must be prioritised. It explores how the budget for mental health care services can be mobilised to produce resources that equally benefit rural populations. The report highlights how

⁵ The Rural Mental Health Campaign Report: A call to action (2015)

stigma and discrimination remain significant barriers to accessing mental health care services. An assessment of the shortage of health care workers in rural areas supports the need for a human resources strategy that improves the quality of mental health care through the support of health care workers. Furthermore, the report highlights the importance of investing in community-based mental health care services in rural areas. Medication stockouts have also been discussed as hindering a person's quality of life and their right to health and dignity.

A further publication 'Mental Health: Real People Real Stories' was launched during Mental Health Awareness month in October and disseminated widely.

4.3 Access to medicines and the Stop Stockouts Project (SSP)



Problems with the supply chain, procurement, and projections are largely driving ARV and TB medicine stockouts. Stockouts are defined as the unavailability of specified medicines from the health facility stores. The DoH is well aware of the issue and has been working with partners on pharmaceutical systems strengthening. Despite the awareness and technical assistance, the situation is not improving, and inconsistent access to ARVs seriously compromises HIV and TB management. RHAP's experience with access to essential medicines demonstrates how they work in informal and formal partnerships with HCPs, communities, government, and other organisations.

During RHAP's inception period, its role, when alerted to stockouts by rural health providers, was to advocate to the appropriate health system managers who frequently took rapid action resolving stockouts within days. RHAP would also act if there was no immediate resolution, by alerting partner organisations for mounting a joint response.

LEVERAGING CONTACTS AND RELATIONSHIPS TO ADDRESS SYSTEMS BOTTLENECKS: IMMEDIATE ACTION FOR THE EC DRUG DEPOT

In November 2011, the Eastern Cape were faced with looming TB drug shortages in the depot due to a blockage at airport customs. Doctors from a rural hospital asked RHAP for assistance. RHAP contacted the DDG Strategic Health Services at the DoH. The DDG intervened and TB drugs were delivered four days after RHAP was contacted.

The impact was considerable. The hospital in question diagnosed 900 patients a year with TB, on average, about four new patients per day. With treatment lasting six months or more there were roughly 450 people on treatment at any one time. If the hospital was out of stock for a week, an estimated 20 people would not be able to start treatment and as many as 100 would have had a life-threatening treatment interruption. Missing even one week of treatment is a major problem as it undermines the TB 'don't miss a day' message. It could further lead to drug resistance (especially if the patient only returns a month later) and in the new patients on treatment, sometimes every day counts. When considering the number of hospitals served by the depot, the negative consequences would have been considerable.

RHAP's collaboration with RuDASA also played a critical role in highlighting problems through rural health workers and raising attention to the challenges resulting in the Mthatha Depot Intervention by MSF and TAC in 2013-14.

COLLABORATING FOR DECISIVE ACTION: TAKING OVER THE MTHATHA DEPOT

RRuDASA's doctor members first highlighted that the Mthatha medicines depot, serving more than 300 medical facilities in the rural Eastern Cape Province, was experiencing a staff strike. Furthermore, the depot had suspended those staff who were striking and was no longer supplying clinics with medicines. More than 100,000 patients on anti-retrovirals faced treatment interruption. RHAP took it up with TAC and SECTION27. Together they wrote complaints repeatedly to the national and provincial DoHs, which did not respond, but TAC ultimately managed to broker permission to intervene. On 7 December 2012, TAC took over the running of the depot under the guidance of Médecins Sans Frontières (MSF), an international group that has played a leading role in modelling HIV treatment in South Africa. With MSF funding, TAC deployed more than 20 volunteers to assist in packing and sending medicines to the various clinics and hospitals. Thousands of patients received their HIV and TB drugs within two weeks. TAC continued working there, with the support of a few nursing students until 1 March 2013, when 15 newly appointed staff took over. In addition to facilitating the handover, TAC contributed to a report with recommendations to the national DoH.

It was in this context of increasing awareness of system failure that RHAP, in partnership with the Southern African HIV Clinicians' Society, RuDASA, MSF, TAC and SECTION27, formed a coalition to jointly address the growing problem of drug stockouts.

COALITION TO MONITOR AND ADDRESS DRUG STOCKOUTS: THE STOP STOCKOUTS PROJECT (SSP)

RHAP, in partnership with the Clinicians' Society and SECTION27, conducted a needs assessment on the top reasons for drug shortages/stockouts and the development of a list of essential medicines to routinely monitor. They shaped the language of 'stockouts' as a shorthand that would capture public and political attention for the broader health crisis – a standardisation of language that is a sign of a network consolidating itself.

This developed into a system to collect routine information on drug stockouts. The proposed goal of the programme was to develop 'sentinel surveillance sites' at key hospitals and clinics in largely rural provinces and to monitor drug and medical supply stocks and any shortages that arise. The stockout reporting programme grew into the SSP.

In 2013 RHAP, in partnership with the Clinicians' Society, RuDASA, MSF, TAC, and SECTION27 formed a consortium organisation – the SSP. The goal of the collaboration is to help ensure reliable availability and access to medicines and medical supplies in South Africa by monitoring and reporting medicine shortages and stockouts when they occur.

By pooling resources, the consortium was able to hire project staff and engage in a full-time effort. The project is funded and supported by all five organisations; each organisation is represented on the SSP board and the Clinicians' Society provides in-kind support of office space. The project's focus is on monitoring and reporting medicine stockouts across the country. Any patient or health care worker can report stockout of a medicine via telephone, email, SMS, or WhatsApp and project staff will investigate the report with the clinic, depot, and provincial and national health departments, if necessary.

RHAP has encouraged HCPs to report stockouts to SSP when they happen, and several HCPs have registered to serve as 'sentinel surveyors', which means they indicate whether any essential medicines (based on a predefined list) have been out of stock in the previous month. These data will help provide a picture of medicine stocks at sentinel clinics and hospitals across the country. The project quickly established a working relationship with the Essential Drugs Programme (EDP) at the DoH and works in partnership with national and provincial staff to resolve stockouts.

SSP Process:

The project's focus is on monitoring and reporting medicine stockouts across the country. It has two processes of surveillance. The first reaches out through all its member organisations to health providers and community service users – including to the formal clinic committees where community members have representatives – providing a system for them to alert the SSP of a stockout using free mobile phone numbers and WhatsApp. This is a critical innovation given the poverty of most consumers who could not afford to pay when reporting stockouts. Once alerted, SSP staff follow-up at clinic level, escalating their queries upwards until they are resolved. These individual alerts provide early warning of potential national stockouts resulting from supplier problems.



The second surveillance system is a national telephonic questionnaire survey asking facility respondents (head nurse/matron or pharmacist) to identify the magnitude of drug stockouts, and producing a report on the number of public health facilities that had reported a stockout or shortage of ARVs and/or TB medicine in the preceding three months.

In late 2013, the SSP shared the findings of the first survey with the national DoH and provincial Heads of Pharmacy and also released its report, on which Health-e reported, as did other media.

In an article by Laura Lopez Gonzalez, published in Health-e on 29 November

2013 entitled 'Widespread stockouts of HIV, TB meds "a national crisis"',⁶ it was stated that:

More than ten percent of all health centres in the country have experienced stockouts of HIV and TB medicines in the last three months, jeopardising the health of millions of South Africans. The findings are part of a new report released 28 November by a civil society coalition ... under the banner of The Stop Stockouts Campaign. Between October and September 2013, the campaign interviewed about half of all health facilities in the country. One-in-five health centres surveyed reported shortages of HIV and TB medicines in the last three months. The Free State was the worst affected province, with more than half of facilities surveyed reporting stockouts.

⁶ <http://www.health-e.org.za/2013/11/29/widespread-stock-outs-hiv-tb-meds-national-crisis/>

Responses from government:

The first survey was met with hostility by the minister of health, who held press conferences and issued statements in response denying the extent of the crisis, attacking TAC for dishonesty and placing blame on manufacturers. SSP however found that only 20 percent of stockouts reported during the survey were manufacturing related and that poor planning, management, and coordination was behind the bulk of stockouts. Nevertheless, the SSP learnt from this experience. Partners further tightened the methodology of the second survey while also working hard at building relationships with the DoH. They negotiated an 'escalation protocol' that gives the DoH two days to respond to a stockout query from SSP at each level (clinic, district or province). If the problem is not addressed, SSP goes to the media.

It didn't start on a good footing, but when we set up the escalation protocol, it worked better. It is benefiting government because it is working closely with the very patients we serve – we have a shared interest and we appreciate that. Going forward we need to understand what society is saying and how they think the process can be improved, instead of a top-down approach. (Acting Director, Medical Supplies Depot, Gauteng Province).

SSP has also developed more constructive engagement with provinces on the findings of the survey. The HoD and MEC Gauteng sent out a circular to facilities to cooperate with SSP. There has been some engagement with North West, Mpumalanga, and Limpopo but the relationship with Free State has been fraught.

SSP was recently invited to meet the Eastern Cape Head of Pharmaceutical Services. Their agenda was to understand the work of the SSP. The main issues raised by the EC DoH include:

- Absence of clear introduction of SSP at provincial level;
- SSP has no formal permission to speak to DoH facility staff and conduct the survey; and
- Province would prefer once weekly email summarising stock out reports.

SSP maintains a delicate balancing exercise between continued positive engagement with those provinces that submitted action plans to reduce stockouts and political engagement with the minister around his denial of the problems.

In the first SSP report of 2013-2014, we did not pay sufficient attention to the rigour of the methods, the quality of the data and the interpretation of the findings. Some involved don't have the same rigour in critically appraising evidence, e.g., a case study was included in the report of someone who ran out of medicines, but we didn't review the report critically enough as clinicians to comment that this particular drug shortage would not necessarily have affected this particular patient. The DoH took particular objection to the society because of its role in the consortium. While this was a valid piece of work it needed to be re-done with a far more hands-on approach, evaluating critically what was really important in the report. For the current report the society has been more involved with the content and SSP has put together a good report. Whereas the first report was seen to be critical of government the subsequent report provided greater rigour in describing the methods and the interpretation of results. SSP has held meetings with key DoH managers of the national HIV and pharmacy programmes who now see the SSP as one measure the DoH can use to determine what's happening on the ground. It has become a much more collaborative process. (Board Chairperson, Clinicians' Society).

4.4 Eastern Cape Health Crisis Action Coalition (ECHCAC)

Recognising the Mthatha Depot situation as being the tip of the iceberg, TAC, RHAP, RuDASA, and SECTION27 held two 'dialogues' in April 2013, with representatives of communities, NGOs, and health care professionals and on 9 June 2013 they founded the Eastern Cape Health Crisis Action Committee (ECHCAC), which has grown to 25 member organisations. RHAP was asked by ECHCAC to coordinate the secretariat until early

2014, after which the overall coordination of the campaign was handed over to the elected chairperson of TAC Eastern Cape but funded by SECTION27.

TAC and SECTION27 released a damning report on the Eastern Cape Health Crisis called 'Death and Dying in the Eastern Cape' as a result of which one doctor was suspended by government for leaking information, and then later reinstated due to efforts by SECTION27 and RHAP. RHAP contributed two chapters to the report.

Backed by this report, in September 2013 the Coalition held a protest march in the province's capital to deliver a memorandum to the Eastern Cape's MEC but he was 'unavailable'. The new head of department accepted the memo and promised 'engagement', but none of the coalition's efforts to engage bore fruit. EHCAC have made submissions on emergency medical services (EMS) to the South African Human Rights Commission where personal testimonies were shared. The head of department was subpoenaed to attend the hearings.

The national DoH sent a fact-finding mission around the allegations on state of health services in the Eastern Cape. In November Parliament called it to report on the situation and EHCAC used that opportunity to also report to parliament on the health crisis. Some of the recommendations from the fact-finding mission were implemented, and a provincial committee was mandated to continue the work. In addition, after the May 2014 national elections, the provincial MEC was replaced and since then the provincial department has recognised EHCAC as a legitimate body advocating for change and has established mechanisms for cooperation and rapid response teams to address specific crises.

Relations between EHCAC and the health leadership improved in 2014, but many promises made have not been followed up and the state of health care remains in crisis. At the latest meeting in November 2015, EHCAC made resolutions to reconsider litigation and to hold a people's Provincial Health Assembly on the continuing crisis. A Memorandum of Understanding (MoU) was submitted to the EC DoH, giving EHCAC members the mandate to report delivery failures to local district management and escalate further if no improvement is seen. This MoU has never been signed.

5. BUILDING A STRONG ORGANISATION

5.1. Publications

RHAP has in five years established a presence and credibility as a rural health advocacy body and despite their infancy, small size and structure, have been prolific in publishing and disseminating many outputs.

Table 3: RHAP publications, 2009-2016

Type of Publication / Forum	Number
Peer-reviewed papers	4
Book chapters	2
Guidelines	2
Training materials	2
Policy briefs	3
Discussion documents and public policy submissions	10
Media articles and published opinion pieces	65
Press releases	20
Presentations at conferences, seminars, workshops and panels	83
University lectures (as part of curriculum)	10
Presentations to practitioners	> 20
Presentations to government/ policy makers	> 20
Presentations to NGOs	> 20
Expert meetings	> 20

5.2. Committees

RHAP staff members have also served on various committees, task teams and commissions:

- RuDASA executive
- DoH Rural Health Task Team
- NHI General Practitioner Steering Committee and Research Sub-Committee
- Budget Expenditure Monitoring Forum Steering Committee
- TAC National Council
- NSP Review Editorial Board
- NEHAWU Health Sub-Committee (now dormant)
- South African Human Rights Commission Section 5 Committee (Health)
- Stop Stockouts Project Steering Committee
- ECHCAC Steering Committee

RHAP is a founding or important member in the following consortiums:

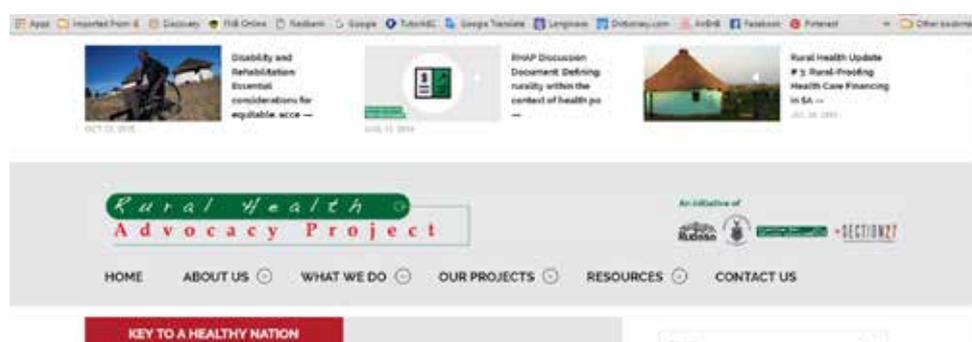
- Stop Stockouts Project (co-founder)
- Rural Health Partner Network (co-founder)
- ECHCAC (co-founder)

5.3. Website and social media

RHAP has had a website since 2011 and since 2014 has expanded its presence to Facebook and Twitter. RHAP's Facebook page has a significant reach as evidenced by the numbers of likes, comments and shares to RHAP posts. The RHAP website continues to receive very good attention as the following table demonstrates:

Table 4: Website homepage news item hits

Title	Views
Press Release: Stop Stockouts Project urges emergency response to chronic drug shortages in SA, June 11	1,574
Rural Mental Health Factsheet, July 27	940
TAC's GS on the Elephant in the Room at #SAAIDS2015, June 11	867
Know the Facts! Rural Health Factsheet 2015, Sept 29	667
Exploring Corruption in the South African Health Sector, Sept 30	584
Global Health Action Special Issue on Transforming Nursing in South Africa, July 29	542
Improving access to anti-retrovirals in rural South Africa – a call to action, Aug 3	519
Press Statement: Support for health care workers working in precarious situations is needed not vilification, July 23	477
Press Release: Mental Health Day: Report finds SA rural mental health care services to remain largely inadequate, Oct 10	460
Disability and Rehabilitation: Essential considerations for equitable, accessible and poverty-reducing health care in South Africa, Oct 23	360
Developing an approach to accounting for need in resource allocations between urban and rural district hospitals in South Africa, Oct 23	188



RHAP has also been featured in one video documentary by One Africa in 2012 and appeared in interviews in various documentaries and news items, for example, Health-E's documentary on EMS in the EC (2015).

Table 5: Facebook likes, comments and shares

Title	Reach	Post clicks/ likes, comments and shares
RHAP stands in solidarity with the student movements calling for a halt to fee increases	2,038	216/66
RuDASA Press Statement: Support for health care workers working in precarious situations is needed not vilification	1,185	42/21
Why did we march today? This is why. Billions of rands disappear in the provincial departments of health.	1,078	32/28
Government job freeze alarms health professionals Groundup	929	59/23
RHAP developed a fact sheet on mental health in South Africa	863	28/20
Rural Reflections. There is a problem.	749	49/5
Rural Health Factsheet 2015	720	29/19
The SAHR 2014/15 was launched last night! The rural voice is well represented in this year's edition	690	16/13
Rural Health Update 3: Rural Health Financing in SA	576	20/12
Developing an approach to accounting for need in resource allocations between urban and rural district hospitals in South Africa	444	14/5
On Wednesday Daygan presented in Parliament to the Finance Committee on RHAP's submission on the Medium-Term Budget Policy Statement 2015.	420	15/16



LESSONS ABOUT PARTNERSHIP: THE RURAL HEALTH PARTNERS NETWORK

The Rural Health Partners Network (RHPN) was launched formally in 2014 and aimed to establish strong relations with rural patient representative organisations and other rural health aligned organisations.

SHARED VALUES

A network is a highly effective way of enabling small, diverse, and disparate organisations that share a common concern to collectively achieve far more than they ever could on their own. The following unifying elements characterise developmental partnerships:

- Shared visions, values, and purpose;
- Shared notion that change and transformation are implicit and desirable;
- Striving for a high degree of trust, mutual accountability and responsibility;
- Demonstration of interdependence in relationships which gives rise to higher-level functions than 'getting the work done';
- Production of tangible and intangible benefits to both beneficiaries and partners;
- Possessing the potential to overcome fragmentation; and
- Maintaining a redistributive agenda.

A stronger collective rural health care voice is expected to emerge through a strengthened network, driven by the following common core values:

- Passion for rural health care;
- Commitment to access to health care for rural communities;
- Belief in equitable health care for all;
- Promotion of a holistic approach to rural health care delivery;
- Regard for rural health care patients;
- Common assessment that a lack of human resources besets the rural health care system;
- Policy and systemic focus;
- Primary health care lens;
- Unwavering belief in PHC as the underpinning philosophy of individual and joint work as network partners, with functional referral systems to higher levels of care;
- Patient-centred ethos; and
- Need for a policy and systemic focus in advocating for lasting improvements in access to health care.

Partner organisations noted the following shared goals:

- Improved health care for rural patients;
- Accessibility to — and equitable distribution of — rural health care services;
- Sufficient human resources for rural health care;
- Rendering rural health care attractive by motivating for retention of health care professionals and promoting improvement of their working conditions;
- Addressing the difficulties faced by those practitioners working in the rural health care system; and
- Advocacy for rural health.



AREAS OF DIVERSITY

Although carrying a common values foundation and a set of shared goals, the network partners also bring unique characteristics and a measure of diversity to enhance the network's reach and depth. The main points of diversity identified run along the following lines:

- Advocacy positioning: some partners are able to play an active, upfront advocacy role while others play a more supportive, informative role;
- Direct provision of rural health care or support to those providing rural health care: Some partners provide health care services, while others provide services to health care workers;
- Organisational structure: Some partners are membership-association-based organisations, whilst others are individual, intermediary organisations; each implies different levels/forms of governance; and
- Organisational identity: Some partner organisations' membership is comprised of health care students, whilst others include qualified health care professionals.

Other areas of diversity include the following:

- Most partner organisations are multi-disciplinary whilst others cohere around one discipline;
- Most partner organisations incorporate applied rural health care research into their activities, whilst others have a specific academic emphasis; and
- Some organisations are based on university campuses and some are in offices, while others operate virtually.

ROLES OF PARTNERS IN THE NETWORK

The RHPN is a group of aligned organisations as opposed to an informal network or formal alliance. This means that partners:

- Work together strategically without a memorandum of incorporation (MOI) and logo;
- Maintain their individual identity while being part of the partnership;
- Adhere to key principles and clarify roles and distinct activities as members of an aligned network;
- Identify themselves as members of the network, and there is regular communication across the network;
- Endeavour to strengthen the network by sharing, consulting and supporting network efforts;
- Show loyalty and support for each other's campaigns and issues and, where strategic and viable, have a joint voice on agreed issues; and
- Participate in an annual network meeting where joint goals and activities are planned.

Each of the partners in the network plays a different role, with the Centres for Rural Health and the University of Cape Town Primary Health Care Directorate leading on research and transformation of health education, the membership-based HCP association growing local membership and providing an ongoing voice from the rural coalface, and students exercising their legitimate voice on the changes they want to see in health training and health care delivery.

Membership-based organisations are critical for the legitimacy of the network's activities as they bring:

- A broad active membership base that is able to provide inputs, support campaigns, serve as an early warning system, and represent rural issues locally;
- First-hand and real-time experience and expertise from rural health care workers in terms of rural health issues that need to be advocated for as well as recommendations and solutions;
- Access to information and evidence on what is happening at the local level;
- The experience and voice of patients and community members; and
- More organisational capacity to give input to policy advocacy and to organise the power and voice of its members in a joint response.

Other network partners with specific positioning and expertise play the following roles:

- Providing a patient voice;
- Providing a health care worker voice;
- Developing a joint and informed voice on rural health;
- Rural alliance building;
- Advocacy and legal support; and
- Media coverage of the work of RHAP and the RHPN.

RHAP's mandate is to 'connect practice, policy and partners'. They therefore play a coordinating, facilitating, empowering, enabling and supportive role that will enable the rural voice to be heard in a strategic and effective way. At times RHAP may lead at the front, and at others times support behind the scenes with others at the front. This is all context-dependent. RHAP's role has involved the following:

- Stimulate dialogue;
- Maintain knowledge on what is happening in partner organisations and within the political arena;
- Convene annual meetings with network partners;
- Facilitate actively the exchange of expertise and rural health advocacy positions amongst alliance partners;
- Transform experience into advocacy;
- Joint policy submissions, seminars, fact sheets, media interviews, public hearings and government meetings;
- Clarify policy advocacy issues and engage with communities and media;
- Assist with knowledge implementation as well as the coordination of research;
- Provide support to partners in becoming stronger organisations, building their capacity and their voice; and
- Cover some of the costs for these partner organisations (joint advocacy, material, leadership retreat).

RHAP brings the following expertise and resources to the network:

- Advocacy expertise and experience;
- Credibility as a rural health advocacy organisation;
- Existing platform for engaging DoH through Rural Health Task Team;
- A small team of dedicated staff with a diverse skill set;
- Coordination capacity;
- Networks and contacts;
- Research skills and time; and
- Funding.

RHAP manages to go beyond the capacity that they have. They have time, contacts and insight to pick things to follow up on and sustain interest on important issues. Through good communication with partners they have coordinated resources in the network to mount a response. RHAP has the headspace to come up with appropriate strategies, where member organisations like [Rural Rehab South Africa] ... don't have capacity. RHAP has given some thought to the theoretical framings of partnerships in order to make sense and more clearly articulate what it is that they and their network of partners are managing on a day-to-day basis. RHAP's strategic leadership has been important for all of us... we make contributions, they bring it together. They have an established advocacy voice and platform... which can be used for that purpose. (Chair, Rural Rehab South Africa).

RHAP has chosen a very relationship-based approach in which its role is primarily consultative, facilitative and mandate-orientated. RHAP's relationship and consensus-based modus operandi is one of its greatest strengths.

Network support with partners adds a lot of value to the work we are doing. You don't find it very often... the way we partner with RuDASA, PACASA, [Rural Rehab South Africa], the Centres for Rural Health is an intimate and unified partnership where we play a clear coordination and advocacy role. (Executive Director, RHAP).

RHAP has made a decision to remain a hub rather than a membership-based organisation. Its role within this network of rural health organisations is even more complex than simply being a hub. In coordinating the network, RHAP has created a platform for rural health issues giving more power and influence to member organisations than they would have alone.

RHAP seeks to be a lever for change through strengthening rural membership-based organisations and coordinating the rural movement. They have facilitated people coming together who have a common agenda, who feel that their isolated voices are feeding into a common stronger voice for advocacy issues. (Programme Manager, RHAP).

RHAP
has created a platform for rural health issues, giving more power and influence to member organisations

STRENGTHENING MEMBER ORGANISATIONS

RHAP has planned the network funding allocation in a way that would strengthen the individual organisations and the rural health movement overall. RHAP has served to strengthen new fledgling partner organisations, channelling funds to them to enable organisational growth and development, thereby creating the space for them to focus on strategic priorities. Through Atlantic, RHAP has provided funding and/or organisational development and logistical support to RuDASA, Rural Rehab

South Africa (RuReSA), and PACASA and the student Rural Health Club at Wits. They have facilitated organisational development sessions and as a result, these organisations now all have a three-year strategic plan. In addition, RHAP has financially supported the leadership retreats for RuDASA and RuReSA where they were able to focus on succession planning, financial sustainability and membership management and growth.



At left, from top:

Abigail Dreyer from Wits Centre for Rural Health

Wits Rural Health Student Club

Marije Versteeg-Mojanaga (RHAP) with Anele Yawa (TAC) and Sasha Stevenson (SECTION27)

Main photo: Ben Gaunt and Dr Karl le Roux from RuDASA in Eastern Cape.



RHAP's commitment to development and strengthening of individual organisations is a key part of their strategy and is demonstrated in their organisational and advocacy support of RuReSA.

Rural rehabilitation

GIVING VOICE TO RURAL REHAB: RHAP SUPPORT TO RURESA

Rural rehabilitation refers to the provision of rehabilitation services in rural areas by Physiotherapists, Occupational Therapists, Speech Therapists and Audiologists. The work of rehabilitation professionals in these underserved areas faces a number of challenges. DoH seems to lack interest and understanding of the importance of channelling funds to rehab services in rural areas, resulting in lack of posts, inadequate remuneration, and shortages of equipment and transport in the rural setting. Rural rehab practitioners face similar struggles to those of rural doctors and nurses, except that they are years behind in terms of mobilising, having a credible voice and establishing political clout on their own.

At the rural conference in 2011 a rehabilitation track was held for the first time, attended by 20 to 25 people. RuReSA was formed to represent physiotherapists, occupational therapists (OTs), speech therapists, audiologists, orthotists, prosthetists, and mid-level workers.

RuReSA strives to be a voice for therapists working in rural areas. It aims to create a network of personal and professional support for rural therapists, including the sharing of information relevant to the disability, rehabilitation and public health fields within and outside South Africa. RuReSA represents rural rehabilitation on professional bodies and to the DoH, with regards to developing rural-friendly policies. They lobby for appropriate working conditions for therapists in the public sector in rural areas, including staffing norms, service delivery strategies and recommended resources.

RuReSA formed in 2011 and took some time to register as a non-profit organisation and obtain a bank account. At inception there was no funding at all and RuReSA members had no time for fundraising. They would pay from their own pockets when attending meetings.

RHAP played an important role in strengthening RuReSA as an organisation. RHAP made an allocation from their Atlantic grant to RuReSA which allowed us to hire a coordinator part time, create organisational structure and put systems in place. RHAP also funded RuReSA's annual strategic planning retreat. This investment created a stable base and freed up core people to be strategic and attend key meetings. RHAP put us in a position to grow and allowed us to sustain what we are doing. We have been impressed by RHAP... they have done a lot for us. (Chair, RuReSA).

RuReSA noted that health planning initiatives around HR, NHI and PHC re-engineering were not considering rural when developing policy. A good national rehab policy was released in 2009 but it was never implemented. Rehab officials in government have little voice and rehabilitation is a silo programme that is not given much priority. RuReSA realised that advocacy was needed but would not have known where to start. Their policy and advocacy work has grown due to support from RuDASA and RHAP. RHAP also played a critical role in developing the fledgling rehab association in terms of their skills, experience and capacity to advocate for rural rehab issues.

We were included by RHAP in meetings on staffing norms, where we would have never been invited on our own as RuReSA. We came into policy discussion on the back of their contacts. RHAP helps to give us context and background information where we don't know and understand the policies. RHAP brought us in, included us as part of the team. They served as role models, mentors, supporters... we learned from watching how they did things and how they approached policy engagement. Rehab people are trained as clinicians and have no experience with advocacy in the policy space. RHAP included us, giving voice to rehab aspects. (Chair, RuReSA).



Another particular success has been the support of PACASA.

SUPPORTING A FLEDGLING CLINICAL ASSOCIATES' MEMBERSHIP BODY: RHAP GUIDES PACASA

Clinical Associates are an important new mid-level category of health care providers in South Africa. They are trained to assess patients, make diagnoses, prescribe treatment, and perform minor surgery under the supervision of a physician. The Clinical Associates Programme is currently in its sixth year, with the first group of students having graduated in 2010. Being a young cadre that did not exist until a few years ago, they did not have a framework or any resources. The first graduates formed the Professional Association of Clinical Associates of South Africa (PACASA) in 2012. RHAP stepped in to support PACASA, who needed a lot of support with defining their strategies, as well as with basic advocacy skills such as how to write a letter.

Scope of practice:

Through intensive advocacy efforts by PACASA, RHAP, and others, the scope of practice for clinical associates was finally promulgated by the minister on 25 May 2015. This scope of practice is critical as the first graduates in 2010 entered the health system as long as four years ago, and it has been difficult to integrate into the existing health teams without a defined scope of practice. At the RHTT meeting, the DDG District Health Services indicated that there will be a task team that will work with the universities on the future planning for this new cadre.

Posts:

The newly graduated clinical associates had been complaining of a lack of posts. This was identified by RHAP as an advocacy point: that posts should be created for rural areas and provinces should facilitate their employment in these settings.

The delay in appointing clinical associate graduates in rural provinces (and urban Gauteng) in 2013 and 2014 plagued this new profession. Our expectation was that provinces would plan accordingly and ensure that 1) posts at district hospitals are created; and 2) funding for posts was ensured. This planning is possible as provinces already know how many students have bonded scholarships and the number of graduates from universities are also easily available. On the 17th and 18th of November we supported PACASA in writing to DDG Dr Terrence Carter at DoH and the relevant provinces [Mpumalanga, Eastern Cape, KwaZulu-Natal, Free State] to alert them to avert such a situation in 2015 and to strengthen any advocacy in the future. In response to PACASA, Dr Carter wrote that he would 'write to all provinces regarding the posts for next year'. In 2015 there were no significant delays in appointments. There were also no reports of clinical associate graduates out of work at the beginning of 2015. Having such posts filled in understaffed rural hospitals will naturally make a big difference on the health of individual rural patients. It is also a good example of the partnership approach of RHAP. (Executive Director, RHAP).

This support in advocacy training to a young association with a constructive engagement in advance (rather than reactive) is a good example of an HRH advocacy success. The letters to national and provincial DoHs were successful as they used available evidence on numbers of graduates and posts to make the case objectively. This was likened to a 'pre-emptive strike' of advocacy so that provinces could be told that the evidence had already been presented to them ahead of the start of the new year when posts should have been created.

[Clinical associates] have grown, are now standing on their own feet. Many of them are as young as 21 years old. There are very few of them, but they all have the instinct to do good. (Programme Manager, RHAP).

STRENGTHENING THE NETWORK

RHAP believes that the partnership approach with other civil society organisations remains more critical than ever, as does working strategically with and through others, in a combined effort to turn the crippled health system around. Faster change in the HRH field is anticipated through the combined forces of the health unions, health provider associations, patient groupings (e.g., Treatment Action Center) and coordinating bodies like RHAP and SECTION27. RHAP needs an active and agile (quickly reactive) group of individuals all tied together to form a strong movement that lends weight, action and power to rural campaigns.



RHAP has identified the skills needed to strengthen the network. More capacity is required to strengthen and support the associations in the implementation of their mandates and also for joint planning and execution of network strategies. Continued legal support from and partnership with SECTION27 is seen as crucial to the rural alliance effectiveness. The network needs to develop stronger relationships with other organisations within the network and with other strategic partners.

As RHAP is relatively small in size and budget, they are a sustainable initiative, more so due to their alliance-building approach. Several of RHAP's partners are also funded through Atlantic and working with them creates powerful synergies. This is reflected, for instance, by the resolution by the Treatment Action Center to appoint a rural rep (although this has not yet got off the ground) and RHAP's inclusion on SECTION27's health team. As organisations they bring different strengths and skills to the table and together can achieve more to address the persistent inequities in rural health.

COORDINATING RURAL PARTNERS TO ACHIEVE IMPACT

RHAP's modus operandi has been to represent, facilitate, and coordinate the voices of RuDASA, RuReSA and other rural partners in RHAP-driven policy and alliance-building work. In this way RHAP coordinated joint NHI, HRH, and PHC submissions; facilitated the representation of RuDASA in national bodies (e.g., SANAC Health Professionals Committee); and continue to link health professionals to other powerful advocacy organisations (e.g., TAC and SECTION27). RHAP coordinated a Rural Health Partner Stand at the National AIDS Conference in June 2015, which demonstrated the issues of rural health being promoted by a credible network of stakeholders.

A number of joint projects and areas of collaboration have arisen due to the coordination role of RHAP. With SECTION27 and TAC, areas of joint work include advocacy for CHWs and the Eastern Cape Health Crisis Action Coalition. Through the SSP, RHAP is able to connect people who were separately concerned about the issue of stockouts. Through this they have built momentum, played a key facilitative role, built alignment, and done research that was a valuable source of information for government.



RHAP Researcher Mafoko Phomane, rural radiographer Sokwakhana Mavume, RHAP Programme Manager HR4H, Samantha Khan-Gillmore, RHAP Board chairperson Desmond Kegakilwe, and RHAP Executive Director Marije Versteeg-Mojanaga after a Voice training workshop.

WORKING TOGETHER TO BRING ATTENTION TO LOCAL ISSUES

The head of orthopaedics at Rob Ferreira Hospital in Mpumalanga, a dedicated clinician, loyal and committed to serving the public sector, created a registrar programme because it was difficult to get qualified orthopaedic surgeons to stay and work in public sector hospitals. He submitted a report in 2014 to the superintendent of the hospital detailing how services were falling apart due predominantly to shortages in staff, equipment, and theatre time. Many initiatives to address these challenges were not supported by hospital management.

The initial response to the report was handled poorly by the DoH. RHAP took it up, publicly supporting the doctor and his complaint, and engaging with RuReSA and RuDASA members in Mpumalanga who contributed their experiences and case studies. Health-e picked up the story and provided media coverage on the plight of these HCPs and the impact on the health system. The Mpumalanga DoH was pressured into providing a more constructive and engaging response.

In 2014, we worked with RHAP to highlight Mpumalanga's orthopaedic crisis. RHAP helped us understand not only budget issues behind the dire shortage but also the impacts on the health system. We were able to tell a story that was essentially one of poor financial and human resources management through the stories of patients, doctors affected by the crisis. The story won a regional award and helped change the way we report on health in rural provinces and the kind of questions we ask. (Health-e).

This was an example of member organisations and partners getting behind an issue and together mounting an effective coordinated response.

Interestingly, the issues sparked the interest of the MEC of Health in Mpumalanga who was very vocal thereafter about the orthopaedic challenges in the province and also asked RuDASA and the University of Pretoria for support at a meeting in October 2015. The Province has subsequently taken a decision not to freeze critical posts in Health and Education.

SOLIDARITY AND REPRESENTATIVITY

RHAP works with multiple stakeholders on different levels and often finds itself working with the same individuals or partners in the board as well as in the RHPN or one of the coalitions that have been formed. This is partly by need and not by design; and according to the executive director has thus far not presented a challenge, probably because of the partners' solidarity and shared vision. This potential conflict of interest has now however been explicitly stated, and managed, in the new board governance structure, launched in November 2015.

There is quite a bit of solidarity in the rural health movement... we need to and want to do this together... through a team approach... and these are shared values that most of us have. (Executive Director, RHAP).

A steering committee provided strategic oversight from 2009 to 2015 constituted by representation of key stakeholders. As founding members, RuDASA, Wits CRH, and SECTION27 have been represented since inception on the Steering Committee, along with AHP and Wits University Faculty. The CRHs from other universities were also added. Later member organisations such as RuReSA were invited as it was agreed that voices of other health care professionals needed to be brought in to move away from being doctor-focused. The steering committee has since November 2015 been constituted as a board.

It was not a requirement at the beginning [i.e., the start-up phase] but later we did aim for representation. I've been taking a representation approach to ensure that we have different voices on the board. (Executive Director, RHAP).



LEGITIMACY

One of the most important considerations for advocacy is legitimacy and credibility. RHAP has however found it difficult to ensure adequate rural health care users' voice representation, something the executive director believes is pivotal.

The board needs to have representation from rural voices to hold RHAP accountable to its mandate. (Executive Director, RHAP).

The reality however is that there are not many mass based movements that exist in South Africa. Despite a groundswell in citizen-led protest predominantly around failing service delivery, this has not been harnessed in a constructive way to give voice to citizen's needs. TAC and SECTION27 have been forced to direct much of their resources on the survival of TAC. Should they have to close due to lack of funds this will also have consequences for RHAP's work. TAC is one of the very few grassroots citizen-led movements for social justice in the health sector and is therefore an important partner to RHAP.

Currently there is cohesion... and a shared agenda and message ... but it will be good to bring new voices, new perspective, and new angles to the discussion. (Executive Director, RHAP).

When the Steering Committee dissolved in November 2015 and a formal board was appointed, RHAP used this as an opportunity to strengthen its health care user voice on the board. TAC nominated its National Chairperson from deeply rural Giyani (Limpopo Province) and World Vision's Voice Coordinator also joined; both represent health care experiences of rural communities and patients. Further representation would be sought in 2016.

RURAL HEALTH ADVOCACY

The RHPN's greatest strength is its ability to provide ears and eyes on the ground to raise and channel rural health workers' and citizens' issues. It has become an important priority for RHAP to build professional membership-based networks of HCPs. The growth of membership and local support networks are important strategies to the resolution of local challenges. Joint HCP advocacy will lead to greater influence, and therefore effectiveness. A local support structure through association membership also provides a first safety net when HCPs engage in advocacy and encounter challenges.

For RHAP to deliver on its mandate, it needs a strong rural voice from the ground – both in terms of quality input and quantity and numbers. It needs access to health care workers, to patients, to an evidence base so that it can make timeous input into campaigns and policy submissions. (Executive Director, RHAP).

RHAP and the RHPN can only represent the voice of rural health workers if they have a strong membership base to draw from. It is therefore recognised that there is a need for each partner organisation to increase its membership. This would result in a wider spread of members and an increase in numbers to make members feel sufficiently comfortable to speak out on issues regarding their working environment.

Whilst there is a need for the membership to grow, this should not be at any expense. The most important thing remains to build and grow a membership base of patient-centred health care workers with high ethics. The aim is not to recruit members for numbers only – whoever joins should share the patient rights outlook.



Representation as in the scale of unions is not our or RuDASA's goal — but you need sufficient numbers to ensure you get a balanced and representative picture of the rural health care context, challenges, needs, opportunities... RuDASA is not so much interested in growing numbers per se — it's also about a specific calibre of doctor that RuDASA wants to attract — the patient-centred, ethical doctor, not just any doctor. We have been having discussions about this recently — RuDASA as a community of practice of doctors sharing similar values and ideals. (Executive Director, RHAP).

CHALLENGES IN MAINTAINING THE BALANCE

Alliances and networks serve as a source of resilience and capacity – the commitment to coalition building highlights the way in which RHAP sees the strategic significance of the work it has done to build a culture of interdependency with its partners. Partnership-based networks become more than the sum of their parts because of the collectivism, mutuality, and relational power that the network holds. For this to be effective there needs to be very conscious choice-making about levels of autonomy and reciprocity in how the network operates.

What needs to be recognised is that increasingly diverse and interdependent relationships bring with them increasing levels of complexity – which require time, input and careful management. Part of what needs to be managed is difference in style, approach, values, and strategy amongst partners. There is the risk of alienating those who are not willing participants in a consensus-building process; an inevitable consequence of this is that partners and funders align themselves with some aspects but are hesitant about other aspects of the network 'bouquet'. The RHPN acknowledges and is aware of this and has countered the potential risks by maintaining a 'loose' network with shared values, agreement and commitment to 'principles' but no commitment to joint action in every area.

For RHAP it is critical that balance must be maintained:

- Holding structure and activity in balance: playing a fulsome 'following and supporting' and coordinating role to member organisations as well as being a strong, central organisational axis for the network.
- Holding a balance between strategic autonomy and a converging perspective: freedom not to have to seek endorsement from the network for their every individual action. At the same time, clear processes need to be set in place to facilitate a converging perspective for the network to be able to take decisions for collective action.



Rural-proofing Project (RPP) working group meeting, 2014

- Holding a balance between effecting shared impact and providing benefits to belonging to the network: joint actions and the demands of being an active network member are balanced with network partners receiving the benefit of connectedness to a supportive group of like-minded organisations that will (in most cases) lend their voice to their issue when strategic and possible. Other benefits to Network partners include the coordination of efforts to have a larger voice and avoid duplication, not working in isolation of each other (in silos), feeling supported and part of a larger collective.

To further the need to balance far-reaching solidarity with specific criteria for affiliation, the boundary can be maintained in a number of ways through:

- Structure, where a network coordinating partner organises meetings according to criteria for participation.
- Difference, where membership is only open to specific organisations who have a common focus, but who may be part of a broader network.
- Coordination, which should be undertaken both in the 'middle' and 'across' the network. If there is central coordination this means that all joint activity and communication between members is centralised. If decentralised, this affords the opportunity for network members to participate with other network members who share a common interest; and not with everyone through central coordination only. If coordination is distributed across the network through organic flows of information, such as in social media practice, this is an example of networking by interest.

In mobilising partners and stakeholders around issues of shared concern, one particular lesson has been that the network is only effective if there is sustained coordination and support and if members are committed to action. In 2014 RHAP, on behalf of RUDASA, brought together stakeholders to form a united front on key HRH issues. Attendees included not only network members i.e., RuDASA, RuReSA, PACASA and RuNuRSA but also broader partner organisations and stakeholders, South African Medical Association, Democratic Nursing Organisation of South Africa, National Education, Health and Allied Workers Union, Health & Other Services Personnel Trade Union of South Africa, PHM, SECTION27, and the Community Health Worker Forum. This group met only once, and there was poor follow-up and response to the agreed actions.

What made the RHPN progress while this forum stalled?

RHAP's director believes a combination of factors had a role to play in making the rural network effective. There is a historical relationship, i.e., the rural partners already worked together previously, with a high level of trust, but now formalised their collaboration; and the organisational mandates are very closely aligned. The HRH forum was a new initiative, bringing together a broader range of organisations that have an interest in HRH and some of whom have not previously worked together. Its inability to be effective can be explained by over-committed partners, different priorities, and poor commitment on the part of others. This does not mean it would not be possible for such a forum to be effective; it would require one organisation to commit to playing a stronger coordination role (such as with the Eastern Cape Health Crisis Action Coalition secretariat), with regular calls for input and joint campaigning. The question is whether it is essential to have a 'formal HRH forum' in place, or given the broad range of organisations involved, one would aim at strengthening relations and 'voice' through joint campaigning on a case-by-case basis, around specific issues, such as the frozen posts matter, as some partners already do.

Alliance-building in itself brings up new challenges, such as the inclusion and exclusion criteria for membership of the RHPN and ensuring the focus of the network remains strategic and beneficial to the founding partners. The current gaps across the network, which could possibly affect its advocacy impact include:

- Insufficient coordination of research initiatives and insufficient evidence-based rural health care research being undertaken;
- Improved avenues for sharing of knowledge and 'intelligence' or information from the ground;
- Need for a stronger nursing presence in the network, though RuNuRSA is still in its infancy; and
- RHPN has not reflected sufficiently on continuity of organisational involvement in times of leadership changes.

CHOOSING ADVOCACY STRATEGIES

RHAP has learned that as an advocacy organisation, it has many options of advocacy strategies when confronted with a call for action:

- Gather more information;
- Commission a study;
- Build capacity – networking, support, training;
- Media – issue public statements;
- Initiate a campaign;
- Input to policy – ‘rural-proofing’;
- Legal route – pre-litigation;
- Litigation – letter of demand – course of action; and
- Practical assistance.

The types of issues and nature of the scenario will justify what course of action is taken:

- Issue – perennial, multifactorial, intersectoral.
- Problem – non-urgent, persistent, requires a response.
- Crisis – pressing (needs addressing in weeks or months), requires priority attention.
- Emergency – urgent (needs addressing in days to weeks), needs practical responses, cannot wait.
- Disaster – official declaration, can be local, provincial or national level, requires intersectoral response.

Other parameters that determine the way advocacy takes place are:

- Single issue vs complex issue?
- Capacity and feasibility to respond?
- Speed of response possible?
- Supportive vs critical response?
- Synergy with other organisations?
- Short-term actions vs long-term goals?

Developing the appropriate advocacy strategy has always been a collective effort with strong involvement, assistance, guidance, and advice on strategy through the board. A response to a crisis may take the form of writing a letter, convening a meeting, engaging the media or involving other organisations. RHAP’s executive and the board try always to think about advocacy more systematically and consider the effect and impact of different choices made... balancing the pros and cons. As RHAP have accumulated more experience, it is able to make better calls on which strategy to pursue and which would be most effective. (Board Member, RHAP).

RHAP as an advocacy organisation has explored and considered the use of the full range of advocacy activities including both soft (technical support) and hard (accountability) advocacy strategies; both working from inside, providing support to government, as well as outside, holding them accountable to action and performance.

RHAP combines softer style of advocacy (e.g., rural-proofing policies) building on its organisational foundation of collaboration and relationship-building; and harder styles of advocacy such as media campaigns, public campaigns with partners and even litigation. (Executive Director, RHAP).

RHAP has learned that there is no 'one-size-fits-all' approach, but that there are advantages in remaining small, nimble, and agile in identifying and addressing what are perceived to be the main issues. This will allow them to be well placed for identifying issues the organisation wants to take on, developing appropriate strategies, consulting with partners, responding to shifts and changes as they emerge while also documenting, monitoring and evaluating work being done.

The strategy thus far seems to have been that certain partners in its network and alliances, with less at stake in confronting the DoH, adopt a more public role while other partners who prefer a softer approach play a more technical and information-gathering role. The combination of technical support, research and more overtly political styles of advocacy is an ongoing and inevitable tension within the work of RHAP. It requires finding a balance between holding civil servants accountable and being seen as an ally in realising change for rural people.

RHAP maintains that balance by using what it describes as a 'problem-focused, values-driven' mission. However, the risk of focusing on problems is that one's voice becomes strident. A best practice, assets-based approach can be used alongside problem-based methods. This has resulted in RHAP taking a technical supportive stance on some projects and more adversarial accountability advocacy on other projects.

RHAP's theory of change has been developed based on the notion of a continuum that exists between rural-friendly policies and the realisation of improved health care. Its theory of action outlines the layered, complex, and diverse arenas within which its work takes place. Depending on the issue at hand, advocacy could be directed at one or more levels, e.g., national, provincial, district or community. RHAP's targets for advocacy have included the executive, judiciary, and legislature; public and private sector; rural citizens, students, HCWs, and professional associations. The hierarchy of scope also determines whether action will be directed at individual, local, district, provincial, or national level. RHAP has been successful in raising rural health's profile at all levels:

- National level: In 2011 RHAP assisted the DoH in drafting the rural HRH chapter of the national HRH strategy. The chapter was adopted, and the rural partners were asked by the DoH to develop an implementation plan, which they did in 2012.
- Provincial level: In 2013 RHAP was involved in coordinating the response to the Eastern Cape health crisis and was a founding member of the Eastern Cape Health Crisis Action Coalition.
- Rural health facility level: In 2013 RHAP supported a doctor at Tintswalo Hospital who was being victimised.

INFORMING THE STRATEGY

'A case of sick clinical management at Mpumalanga's Tintswalo Hospital', an article by Mandy de Waal published in the *Daily Maverick* on 14 March 2013, described the case of poor management of a rural hospital and the victimisation of a doctor who challenged the mismanagement.⁷ Through the Tintswalo case, RHAP learned of the need to train and empower health care workers with a voice for escalating their challenges.

VICTIMISATION OF A DOCTOR AT TINTSWALO

Tintswalo Hospital, a 423-bedded acute hospital, sees some 500 patients a day with a catchment area of about 1.5 million people. For years, people have complained and protested about poor hospital management, and the shortages of doctors, resources, and equipment. Despite the dysfunction, deaths, injuries, community action, lawsuits running into millions of rands, and the stream of talented medical staff regularly lost, nothing had been done about the situation.

⁷ <http://www.dailymaverick.co.za/article/2013-03-14-a-case-of-sick-clinical-management-at-mpumalangas-tintswalo-hospital/#.Vnz0GE3ovIU>

Dr X was a doctor running the HIV clinic in Tintswalo Hospital. His relationship with the hospital manager deteriorated over time, resulting in him being removed from his position and placed instead at the Outpatients' Department (OPD), a clear act of bullying and victimisation.

I am an HIV specialist in an area which has amongst the highest number of patients. I was appointed as the clinical head of the unit, and then for no reason was demoted to go and work in the outpatient unit. Currently there isn't a full-time doctor in the HIV unit, which means that the patients in that unit are suffering. It is such a crisis, but ... nothing is done about the problem. (Dr X, Tintswalo Hospital).

The RHAP executive director was quoted in the media saying that the doctors are divided, scared of being victimised, and have been threatened by the manager, who is allegedly protected by political allies and feared by hospital staff.

As a result, specialists and doctors are resigning in high numbers, which is incredibly problematic because it is difficult to recruit for this area, and this infringes on patient's rights to quality health care. (Executive Director, RHAP).

The Health Professions Council of South Africa (HPCSA), a statutory body that governs the health professions in this country, confirmed that a complaint was lodged against the manager with the council at the beginning of that year and that there had been complaints in the past.

SECTION27, the public interest law centre, detailed further incidents of misconduct by the manager. The letter from SECTION27's executive director, Mark Heywood, addressed to the National Health Minister, Dr Aaron Motsoaledi, indicates that between 2010 and 2011, the manager was suspended from Tintswalo Hospital for financial impropriety and then reinstated. It further alleges that in 1998, the manager was reprimanded for continuing to practice as a doctor despite having had his licence revoked in 1993.



RHAP made representation to the national and provincial DoHs, and visits were made by the MEC of Health and Social Development. The manager eventually got suspended and after many letters and continued follow-ups by RHAP and SECTION27, the manager was found guilty of misconduct by the HPCSA in a preliminary investigation. A disciplinary inquiry into the misconduct was planned in April 2016 where RHAP had been asked to make representations.

The situation at Tintswalo improved after the clinical manager left. In May 2014 RHAP received the following report back from one of the hospital doctors:

Tintswalo is doing well at the moment. We have an excellent, extremely diligent clinical manager at the moment from Tunisia. We have also been having students from the GEMP programme at Wits University since 2011 and have received our first community service doctors from that group of students — we got 6 from Wits and [the University of Cape Town] as well as 5 doctors from the UK, so we have a much stronger core at the moment. Paediatrics is doing pretty well... The district health team for our district has a very dedicated paediatrician, who regularly travels up from Nelspruit to support the paediatric team.

The efforts by RHAP, SECTION27, and the health care workers involved to report the matter to the HPCSA started in 2013. It is only in 2016 that the hearing was taking place, which would not have taken place at all were it not for the efforts of RHAP and partners.

In trying to help this doctor, RHAP learned much more about the processes for escalating grievances and reporting challenges to higher levels. Some of the gaps they identified were that often in such situations not much has been documented by the victimised party and there has not been much coalition building with other doctors. RHAP realised that before stepping in to assist the plight of individual health workers in such situations it needed to better understand the dynamics in order to enable HCWs to take the first steps informally dealing with their issues. Since RHAP and any other organisation would never have the capacity to assist every HCW individually, they needed to support HCWs to do more themselves, by giving them the tools and understanding. This led to the development of RHAP’s Voice Project.

LEADING FROM THE FRONT

RHAP has become a strong vibrant civil society advocate. Reports indicate that RHAP has become the key go-to structure for civil society, government, and various other stakeholders when it comes to issues of rural health. This has led to RHAP staff and partners being asked to play a role in establishing and sitting on various committees and coalitions. RHAP is also regularly approached to make presentations, give input in discussions, make policy-related statements, and endorse partners’ positions.

RHAP spearheaded the formation of the Human Resources for Rural Health (HR4RH) task team jointly chaired by the DoH Chief Directors for PHC and HR. The task team has held a number of meetings attended by both chairs and various resolutions have been adopted. The DoH has adopted WISN to determine staffing norms. RHAP and its rural partners were invited to attend a national consultation on the guidelines for WISN implementation and have developed a position paper on its implementation.

RHAP’s achievements have been in supporting other health advocates (HCPs, rural citizens, civil society and media) as well as direct advocacy. The most useful strategies RHAP has employed are presentations to inform policy; presentations to practitioners (through the Voice Project), and the use of social media to spread awareness of their work and positions. In terms of informing policy, RHAP have identified the areas where they perceive they have had a strong influence, including the CHW Policy and National HRH Strategy for the Health Sector.

Whereas RHAP does not aspire to have a presence in all districts of the country or to function as a community help desk, they do believe that the community voice needs to inform their work. This has been done to date in various ways (e.g., through the community dialogues in RPP, alliance formations such as the Eastern Cape Health Crisis Action Coalition and community reporting in SPP) and needs to continue.



Daygan Eagar presenting at a RPP Stakeholder Meeting on “Protecting Critical Posts in Health at Times of Austerity”, 2015, attended by civil society partners, health and treasury representatives.

STAYING FOCUSED WHILE REMAINING RESPONSIVE

Reflecting on the 2014 external review and their own experiences, RHAP believes that it is critical to be very selective in what issues to take up in order to ensure the organisation makes best use of its available resources, within the mandate and current context of their work, to derive maximum impact for rural communities. RHAP has experienced, over the years, the inherent danger in attempting to be responsive to too many rural health challenges, which dilutes its focus and undermines its ability to see things through and to show end results. Some concern has been expressed that RHAP has ‘over-committed’ in their deliverables.

There is a concern that RHAP takes on too many issues and is therefore losing a sense of sharpness and cutting-edge relevance in its advocacy style. This may also have led to the organisation spreading itself too thinly. (External evaluation, 2014).

Due to the magnitude of the rural health crisis, RHAP is at risk of spreading itself too thinly and needs to ensure that it stays focused on its core mandate. The external evaluation suggested that RHAP decide on a clear and specific ‘button’ it wants to press in realising the Theory of Change and the Theory of Action that have been developed. If necessary, they should work ‘narrow and deep’ rather than too broadly and superficially. It was also recommended that RHAP approach new initiatives with caution. Despite new developments such as the Voice Project and the Mental Health Programme having enormous potential, the external evaluation cautioned that new work, new funding, and new people adds to the complexity of their work.

The RHAP leadership and staff felt that all four strategic objectives remained relevant and critical as part of the Theory of Change. In response to recommendations from the external review and in an effort to sharpen their strategic focus, RHAP developed a priority-setting tool that will help them decide which issues to take up. It includes a set of criteria to inform the decision-making process:

Table 6: Priority-setting tool

	Yes	Some-what	No
IMPACT (HRH, Policy, Financing and Implementation issues)			
• Does it have a potential to make a large impact in relation to our vision? Will a solution to this issue result in real improvements in rural health systems and rural people’s lives?			
• Does it have a potential snowball effect?			
• Is it a provincial issue?			
• Is it a crisis, emergency or disaster? (circle one)	Crisis	Emergency	Disaster
• Is it an issue that can, realistically speaking, be resolved?			
ORGANISATIONAL FIT AND RESOURCES			
• Does it have a strong link to the existing commitments?			
• Can it be rural-proofed?			
• If it can be rural-proofed, is this issue particularly suitable to create awareness and buy-in to the need for rural-proofing?			
• Does it have a human resources component to it?			
• Does it have a financial resources component to it?			
• Does it help build and sustain alliances and partnerships that are important for driving change in rural health?			
• Is it an issue that our partners/other stakeholders are well suited to take up/drive?			
• Could action be postponed to next year/a later time			
• Can we tackle this issue with the resources available to us?			
• Will this issue help us put in practice our mission ‘To be a strong, vibrant civil society organisation that functions as a rural health hub connecting policy, practice and partners’			

Emphasis is placed on those issues that cut across levels, are rural-specific, are not likely to be taken up by other organisations, and that are expected to make a large impact if addressed. In this manner the RHAP identified the new 'critical posts strategy' as an urgent matter that meets all criteria. The Voice Project also feeds into all four strategic objectives and shows interrelatedness between different objectives.

After selecting priorities, the next step is to 'advocacy-proof' the chosen priorities in terms of advocacy strategies, targets, and tracking outcomes in a more systematic way.

SHIFTS IN FOCUS

RHAP has realised the importance of refocusing their work away from national and towards the provinces where implementation of policies and budgets is supposed to happen. Advocacy at provincial level was always a primary objective but in the beginning it was believed that shifting the policy context at a national level would give legitimacy to what RHAP would be doing at the provincial level. It is easier to shift thinking at national than provincial level but RHAP does recognise that if it wants to change things over time, the organisation must look at realising change at provincial level. RHAP's experience has been that where they have been able to convince the national DoH and achieve some shifts in policy focus, they have encountered barriers in the form of constitutionally mandated separation of powers, whereby provinces have authority to set their own priorities and agendas to an extent.

RHAP took the decision to focus on the resourcing of provincial departments, engaging with their budget processes, and trying to influence mid-level decision-making, particularly at district level. They are working with districts to support them in making arguments for resources and strategic plans in ways that suits the local context. RHAP has assisted districts with the language of rural-proofing that they have expressed an interest in. In so doing RHAP has tried to influence strategic planning and budgeting from the bottom up. RHAP helps provide districts with the technical arguments and evidence for HR needs and to frame them in ways that are more convincing to people in provincial Treasury and DoH. More recent work in the Rural-Proofing Policy and Budgeting Programme saw some shifts towards their advocacy with partners. Whereas the emphasis in 2013-14 was on building the evidence for advocacy, 2015-16 saw an increase in engagement with partners, policymakers, and influential stakeholders on the uptake of the evidence base. stakeholders on the uptake of the evidence-base.

RHAP needs to stay focused on its core rural-specific, mandate, and influence strategic planning and budgeting from the bottom up



RPP Stakeholder Meeting, discussing rural-proofing of policies, with RHAP staff and representatives from Health and Treasury, 2014

GETTING GOVERNMENT TO RESPOND

RHAP uses an insider/outsider approach, which requires balancing technical and accountability advocacy; a difficult tension to manage. A hard stance in one area of work – e.g., a public critique of a provincial government to freeze posts – may influence relationships in another – for instance when RHAP supports government in the rural-proofing of policies and budgets at district level. However, RHAP has navigated this tension well.

We don't make decisions on what we pursue or don't pursue due to fear of losing connections with officials. Most people we work with in government are well aware that we are an advocacy organisation and that includes taking a critical stance on government's performance when necessary. With most officials, there has been a healthy tension though yes, there have been times where an official has pulled back and hasn't wanted to work with RHAP... This tension is a risk but it is one that we manage, in terms of how we package things and how we engage with particular issues. So far, we have not framed our public advocacy in a way that it is personalised. This does not mean it may not be necessary to do so in future. (Executive Director, RHAP).

An example of this is the action in the North West province where RHAP spearheaded a civil society response to the austerity measures following drastic budget cuts of 600 million rands for that financial year. RHAP issued a press release, followed by a formal letter to the North West DoH in partnership with RuDASA, Treatment Action Center, SECTION27, Rural Rehab South Africa, PACASA, and the Wits Initiative for Rural Health Education (WIRHE) Coordinator. Despite using very strong language to highlight the violation of rights by the NW DoH and sending letters to the media around these issues, RHAP has not jeopardised their channels of communication with the province and are confident that they can still meet with officials and offer their support. This is because they are careful to ensure there is no personal criticism but a consistent focus on raising the challenges in an objective way supported by evidence.

Our approach seems to be working and we have not burned too many bridges. At the end of the day some officials at national and provincial levels understand and appreciate our role, others don't. I think it mostly depends on whether the government leader shares the ultimate vision and commitment to realising access to health care and whether he sees a role and benefit of an independent civil society in achieving that vision. (Executive Director, RHAP).

RHAP has received formal constructive responses from government, particularly around the reports of the SSP and also the Eastern Cape crisis. It is a significant achievement to have government engaged with an issue that has been brought to their attention through advocacy efforts and then also make some positive steps to address the challenge.

A recent example of partner collaboration and constructive engagement with government was a matter raised by a doctor at a District Hospital in Eastern Cape.

RESPONDING TO DOCTORS AND ENGAGING GOVERNMENT: EASTERN CAPE DOCTOR SHORTAGE

In late August 2015 RHAP received, through the RuDASA discussion group, an email from a doctor about critical medical staff shortages in a district hospital in the Eastern Cape.

The hospital which currently has a bed occupancy capacity of 169... is operating with only one Medical Officer and two community service doctors... Between these three medical doctors they have to attend to a hospital that offers a wide range of services to the community of well over 120,000 people, and an influx of patients from several feeder clinics and health centres... these doctors have to cover an OPD, Maternity,

TB ward, Casualty, Female and Male Surgical, Female and Male Medical, Paediatrics, High Care Ward and a Gender Based Violence Centre situated at the hospital. The burden on these people is heavy and is taking a toll on them. (Dr Y, Eastern Cape).

On the same day RHAP responded to the doctor and coordinated a response with SECTION27, TAC, and the Eastern Cape Health Crisis Action Coalition (EHCAC) to send a letter to the HoD for Health, Eastern Cape. The next day the doctor provided feedback that the member of the executive committee had given a directive to the district manager to handle the matter and report back on plans of actions undertaken. A meeting was held with stakeholders from surrounding hospitals and district representatives, including the district manager herself and immediate resolutions were agreed to remedy this crisis.

On 2 September, the superintendent general responded formally to EHCAC, reporting a number of actions that had been taken including the availability of four sessional doctors and lifting of suspension of a clinical manager, appointment of a medical officer to start in October, and placement of three doctors through Africa Health Placement. In the interim the DoH had seconded a doctor until the new recruits assumed duties. He also confirmed that the DoH was looking into the problem of doctors' accommodation at the hospital and that an infrastructure project was underway.

The next day the doctor responded to confirm that these new appointments were underway, that the seconded doctor was providing some relief to the workload of the doctors, and that the hospital was indeed working on doctors' accommodation.

They are indeed trying to find a way to speed up the response in addressing this matter. There are other commitments, interventions and plans on the cards... There has been a response and something is being done to address the issues we had raised... I would like to thank your office as well as SECTION27 in partnership with the EHCAC for your work and efforts to assist us in this hospital to bring health care service order back to this hospital and the community. (Dr Y, Eastern Cape).

In early December RHAP received the good news that two additional medical officers, three community service medical doctors, and one community service dentist were due to join the facility in 2016. A final word from the doctor in question in December 2015 to RHAP:

It's because of the work that you guys do that we are able to push on. Your support together with that of RHAP's affiliates has been unwavering and I have felt it right across the board. Thank you for giving an amplifier to this young voice, you have fanned the flame and it will continue for a really good while. Together with you and all other stakeholders we are going to keep fighting for patient rights everywhere. (Dr Y, Eastern Cape).

This case study illustrates some very important lessons to draw for advocacy groups. Through RHAP's responsiveness and collaborative action to hold government accountable for service delivery, strategic partnerships were leveraged for resolving an urgent issue; immediate improvements were secured for patient care; and, importantly, a rural health care worker felt morally supported in his quest to address critical issues in his workplace.

By listening, advising, referring, defending, and connecting, the health care worker does not have to feel he/she is standing alone in confronting such a major challenge, which could lead to a sense of despair and apathy. Instead such support is just what is needed to support a health care worker in following his social consciousness. (Executive Director, RHAP).

STATE OF HEALTH

In South Africa, constitutional health rights are not realised for rural communities and rural areas continue to experience severe staffing shortages and health system failures. There is government pressure on the DoH to improve people's access to affordable health care and various transformative programmes are being introduced. On the one hand, this provides an opportunity for advocacy, but on the other, fiscal constraints and limited resources slow down the pace of transformation. The separation of powers between the national and provincial spheres of government, coupled with a lack of sustainable, good leadership in most provinces are other factors that impact on access to health care. The Free State is a well-known example where the top leadership is facing corruption charges while hospitals struggle to provide adequate services.

Rural communities do not have constitutional health rights, and rural areas continue to experience health system failures

The national leadership has introduced innovative strategies to improve health outcomes, and to counter inequities, yet the shortage of senior management in key portfolios (such as HRH) at national level, and the concurrent powers between national and provinces, means that the national DoH has very little capacity or control over the provincial implementation of health strategies. This has implications for RHAP's ability to inform policy and hold provinces accountable to implement services.

RHAP is deeply concerned about the instability of the health system and the lack of firm leadership to see good policies implemented. These developments have consequences for RHAP's advocacy. While the use of softer advocacy approaches, such as technical support, will remain a core element of our work, a harder stance on certain areas appears unavoidable in the near future. This will need to be approached sensibly, in a manner that will enable us to continue, as far as possible, our technical work such as the roll-out of the rural-proofing guidelines to provincial and district management. In this context, a partnership approach with other civil society organisations remains more critical than ever, as does working strategically with and through others, in a combined effort to turn the crippling health system around. (RHAP Board Report).

A lot of lip service has been paid to equity, health systems strengthening and HRH, but weak national leadership, a politically tense environment, and failing provincial health systems has led to chronic health care crises for rural people and health care workers on the ground. There has been little real improvement across the board besides inspirational individual facility stories and good practices. The lack of vision and urgency on the part of DoH, provincial crises, and funding constraints are the major stumbling blocks for effective advocacy work.

HEALTH POLICY AND REFORM

New health reforms and interventions though well informed, face challenges in implementation. There are few fully constituted district clinical specialist teams in rural areas. The DoH recently outsourced further contracting of GPs to service providers without a strict clause on adherence to the Health Professional Support Framework model. DoH's delays in finalising a policy and change of approach signify a half-hearted commitment to the CHW cadre's role in PHC delivery. WISN has some serious shortcomings.

While the roll-out of decentralised care, through the PHC Strategy, continues to be a priority for the DoH, its focus is too narrow and is unlikely to make the much anticipated and hoped for impact in improving access to comprehensive health care for rural people.

Important reforms associated with the NHI may in fact widen the equity gap between urban and rural if rurality is not foregrounded in planning and implementation. In December, the NHI white paper was released. In its earlier submission to the NHI green paper (pre-consultative process leading up to a white paper), RHAP and its partners expressed the grave concern that if NHI is not properly rural-proofed, NHI could draw further resources to urban areas at the expense of rural health. This is due to the concentration of health care workers and private-sector facilities in urban areas. An NHI therefore needs to incentivise a redistribution of resources based on need and not current status quo.

The white paper has now identified rural communities as a group that needs to be given priority in the next phase of implementation, which will last for a period of five years and at which residents will be issued NHI cards to visit designated facilities. Whereas this points in the right direction, RHAP is most concerned about the available resources to deliver on the stated intentions of NHI and other related interventions such as the HRH Strategy, NHI, and PHC re-engineering. The national Treasury has not increased the health budget beyond inflation in 2014, nor has the health leadership made a convincing plea for such an increase in allocation. At a provincial level, such as in North West Province, health budgets are hugely insufficient to maintain the status quo, let alone expand services. The North West provincial health budget was cut in 2015 to deal with the accrual problems, whilst inflation increased the cost of the compensation of employees. This and other reasons have in turn led to staffing moratoria, also known as 'freezing of posts'. Ultimately, health is not a political priority.

IMPLEMENTATION CHALLENGES

There are specific areas where RHAP can demonstrate impact on the ground that can be attributed to their alliance's collective efforts, but this is mostly undermined by the governance, financial, and HRH crises in numerous provinces.



The DoH has introduced good initiatives yet implementation remains sketchy. The willingness to improve HRH is present amongst the senior leadership, but the DoH is plagued by insufficient senior management capacity to plan, coordinate, and monitor as well as by insufficient funds to adequately improve access to HRH. There is a shortage of senior management in key portfolios (such as HRH) at the national level. Weak provincial governments slow down and sometimes undermine rural health care improvements. The separation of powers between provincial and national governments without a strong rural voice is a critical challenge.

The situation on the ground is not improving sufficiently and, in some provinces, is deteriorating. This is further compounded by the current financial crisis faced by provinces, with many provinces being placed under administration by national Treasury due to poor financial management. In 2014 the Mpumalanga Health Department was placed under administration, preceded by Limpopo in 2011, and there is general consensus among activist organisations in the health sector that the health system in the Free State is in collapse.

The rural staffing challenge exists due to poor planning, monitoring, and management of HRH. There is poor allocation and monitoring of community service officers to rural areas, although this has recently improved, particularly in the Eastern Cape; absence of tracking systems for where graduates are over time (by HPCSA, DoH, and academic institutions); lack of rural consideration in WISN; frozen posts — moratoria continue with the national DoH doing little to intervene in provincial budgeting; there are no recruitment and retention committees in some provinces; the funding of rural campuses and rewarding outputs through the funding formula are not clear; there is limited rural exposure in undergraduate and postgraduate training; the range of skills and CPD support for rural practitioners has not yet been reviewed; there have been delays in conducting a review of OSD and rural allowance allocations; and there has been inadequate integration of clinical associates as a vital new cadre.

CHANGING THE DISCOURSE

Despite RHAP highlighting the issues of rural health and widespread knowledge existing of the evidence around the challenges in rural areas and their implications for health, urban development continues to receive explicit fiscal policy priority while rural development is limited to land reform and agriculture. The government's approach to the resourcing of rural areas continues to lack nuance and an understanding of historical neglect, higher costs of delivering services in a rural context and rural-urban linkages. The current levels of inequity continue to mirror the old apartheid geospatial boundaries. The most deprived districts today are all rural and fall within the boundaries of the former homelands. The poorest quintile of districts (mostly rural) has the greatest share of health needs but receives the smallest share of benefits (public and private).

Within the public sector, resources still tend to flow disproportionately to the least-deprived district, particularly those located in urban centres. This is a pattern that continues from apartheid-era budgeting and has been sustained by budget processes based on historical and incremental allocations and not on an assessment of need. Within the current tight fiscal climate, there are many developmental priorities that need resources from the same constrained national budget.

This is not something that can be quickly eradicated, and it requires a long-term advocacy commitment from RHAP and its partners and stakeholders. What RHAP has achieved to date is the development of a more nuanced and accessible evidence base, demonstrating the nature and causes of the persistent inequities described above, informing stakeholders and partners, and proposing solutions. These have been documented in a number of publications, including:

- RHAP 'Rural-Proofing for Health: Guidelines', January 2015. <http://www.rhap.org.za/wp-content/uploads/2015/02/2015-01-13-RHAP-Rural-Proofing-Guideline-A4-Email-1.pdf>
- Eagar, D. 'International best practice and rural health financing: Opportunities for the South African context': Version 2: 2014
- Eagar, D. 'Re-imagining rural: the state of rural health 20 years into democracy'. PHASA Newsletter. 28 May 2014, <http://www.phasa.org.za/re-imagining-rural-state-rural-health-20-years-democracy/>
- Eagar, D. 'Rural-proofing Policy International Best Practice', 02 November 2013

There are good indications that the discourse is changing and that government is looking into new ways of dealing with these structural challenges. Progress has been made in shifting language and thinking around rural health issues. The success of the RPP guideline launch, RHAP's work with the DoH on defining rural for assessment purposes, and input on the WBOTs policy is testament to the strength of this work and its growing legitimacy with key stakeholders such as the DoH.

The NHI white paper (released December 2015) identifies poor rural communities as vulnerable groups that have to be prioritised in the NHI process and Treasury's review of rurality as an indicator in the equitable share are illustrative. Change is however not fast enough, and RHAP will need to continue to exert pressure, with the greatest challenge ahead being the shift from evidence base on structural neglect to changes in policies and budgets.

In the short term, RHAP has been influential in securing Treasury agreement to create a portal of information that civil society can access. It would be important for a wide range of actors to access the information and use it to grow a credible evidence base for advocacy.

In the medium term, barriers to equity in rural health have been identified, such as filling posts in rural areas. One of the levers that need to shift is getting Treasury to adopt the practice that, in times of austerity when budgets are under constraint, provinces cannot blanket freeze critical posts. RHAP

would like to see Treasury taking a more nuanced approach to rural health challenges. RHAP believes it has a clear basis for advocating for this and will probably get the support of DoH.

In the long term, RHAP would like to see Treasury allocating resources between provinces or within provincial departments in a way that factors in rural and achieves greater equity in rural health.

CLIMATE FOR ENGAGEMENT

The state of the health system in general and the broader socioeconomic, fiscal and political developments in the country are a key challenge to advocacy efforts. Increasing numbers of corruption scandals and political leadership battles are diverting focus away from service delivery.

The political, regulatory and socio-economic environment in which RHAP operates has a direct bearing on our advocacy work. The DoH as an institution overall is volatile, from national down to district level, with frequent leadership changes and an increasingly closed climate. Symbolic of this is the Minister of Health's changed policy on media relations; with Minister [Aaron] Motsoaledi no longer accepting direct calls but now working through his spokesperson. (RHAP Management Report to the board).

Where progress has been made with individuals at national or lower levels, it remains a concern that the current receptive climate of advocacy may not last if there is a change of political leadership.

There has been a gradual clampdown on civil society space and rights. Participatory democracy is under threat. Increasingly civil society movements face greater scrutiny, with some going as far as to suggest that spyware has been used on the phones of senior civil society activists. (Programme Manager, RHAP).

RHAP has been able to nurture good working relationships with some key government officials at all levels. RHAP has identified good people within the DoH who serve as champions in creating the space for RHAP and its partners to highlight rural health issues. RHAP has been fortunate that over the past two to three years there has been a constant group of people that they have been able to engage with. There is an open culture of engagement with some officials who value RHAP's work, although there are still some who are less convinced of the need for sustained engagement.

RHAP also continues to develop good relationships with key role players at national Treasury, who in principle accept their approach though this still needs to translate into reforms. RHAP has engaged with Treasury on the RPP, advocating through initially building a technical evidence base, and now being in a position to use that evidence base more effectively to persuade non-rural partners to advocate for rural health and directly advocate to Treasury to change funding formulae to needs-based budgeting.

RHAP has presented to the National Parliament on a few occasions. The chair of the Health Portfolio Committee was in agreement with the evidence presented by RHAP and committed to a number of follow-up actions, although there have not been any responses thereafter. There are different views regarding the effectiveness of advocacy at this level. Many board members believe that it would not achieve any impact, but some argue that it is a necessary step in ensuring all avenues have been employed through advocacy before litigation is adopted as an approach.

RHAP has good working relationships with key government officials at all levels, who create the space for RHAP and its partners to highlight rural health issues

A significant risk in trying to influence policy and shift funding is political will. Efforts in health around transformation emerge then fail because of political change. The efforts in engagement with the current establishment and individuals will bear little fruit if political change results in the appointment of new Ministers and officials. RHAP cannot predict or control this and therefore continues to advocate around consistent objectives to a wide variety of government stakeholders at national, provincial and district levels.

RHAP believes that its 'softer' advocacy efforts in developing and implementing pro-rural policies can only be effective if DoH officials are receptive. RHAP's level of agency in achieving this objective is tied to the DoH's willingness to act as a partner and agent in this work. RHAP believes that where there is little responsiveness from DoH, the 'harder' advocacy approaches must be employed such as the public calls with TAC around CHWs and publishing the HRH scorecard.

With the establishment of the Rural Health Task Team (RHTT), it has been a positive development that the structure is in place and an important step forward, but so far it has met only once a year and many of the task team's resolutions are not followed up. There is still a lot of effort required to make this structure truly functional. RHAP has learned that incremental steps are required to achieve its vision and that patience and perseverance are important for an advocacy organisation in making progress in formal engagement with government. The appointment of a new chief director HR is an opportunity for moving the structure forward and making it more effective.



While the establishment of the RHTT is a major step forward, there needs to be greater ownership and commitment from government officials to the task team's resolutions. DoH should be the guardians of monitoring the implementation but this will require stronger leadership.

We have learned from our engagement with DoH that we need to try to get things into policy while there is an opportunity, so that it will be difficult to undo later, therefore getting a task team formed and pushing for documented resolutions rather than verbal commitment is an important advocacy win. It is also the best way to get around political issues and agendas, having rural health issues addressed in government's own documents. (Executive Director, RHAP).

While there does seem to be a culture of embracing evidence-based planning at a national level the experience with provinces has been variable. KwaZulu-Natal (KZN) has been making great strides forward with many new programmes based on best practices and doing things based on what is working in their own context. An example is the CHW programme that has been strengthened for many years before the adoption of PHC re-engineering and the national policy around WBOTs. RHAP has engaged closely with the KZN's DoH's Health Research and Knowledge Management Unit, which has been very responsive.

You don't get the sense that these managers are held back by fears from their superiors that they shouldn't be engaging. It seems like it's more of an organisational culture where there is space to engage. (Programme Manager, RHAP).

Where progress has been made in working with districts, it is most often due to a strong district manager with a particular interest in research or evidence-based planning. Positive engagements have been experienced with Sedibeng (Gauteng) and Umzinyathi (KZN) districts. However, RHAP has also encountered managers at all levels who have strong personal interests that do not create space for effective engagement.

Through the experience of the SSP, RHAP has learned about the balance in engaging provinces and holding them accountable. In the initial year, the SSP report was received very defensively from

government. In successive years, a more sustained process of engagement around the findings of the report as well as the opportunity for government to provide responses allowed for a more constructive engagement.

Our relationship with government remains ambivalent, which is natural for an advocacy organisation. On the one hand, we provide technical support with the aim of effecting pro-rural change and on the other hand we have a critical public voice when necessary, which is not always appreciated. Overall, our relationship can be described as positive. (Executive Director, RHAP).



Below: Rural people speak out at a rural health imbizo (gathering), held in Dr Ruth Segomotsi Mompati District, North West Province, in May 2016. The imbizo was hosted by RHAP and RuDASA.



RHAP MODEL

RHAP's strategic operating model has been structured to position it as a rural health knowledge and action hub with a small but highly skilled team that further draws on the skills, expertise, knowledge and support from its core partners to further its vision. RHAP's work is further supported and strengthened through close working relationships with complementary organisations and institutions.

RHAP's innovative model enables it to create a powerful voice for driving pro-rural health agendas in South Africa

RHAP's model is an innovative, highly effective, and cost-efficient way of creating a powerful voice for driving the pro-rural health improvements agenda in South Africa. The model eliminates the need for RHAP to grow into a sizeable and costly organisation and enables a network of small, diverse, and disparate organisations that share a common concern to work together to achieve far more than any could on their own.

In the six years of its existence, this model has enabled RHAP to operate in innovative, deeply collaborative ways to build a network of diverse relationships with partners and achieve impact way beyond what its size and period of operation would suggest.

RHAP's model is one which could be used in other countries facing similar challenges in the delivery of health care and other social challenges in rural areas, provided there is a high level of involvement and collaboration between implementing and supporting partners and access to people on the ground who can act as the voice of the rural poor.

Another remarkable feature is that RHAP started small with just a director in place in the first year, growing from within another well-established organisation (when it was housed by SECTION27). The founding organisations Wits Centre for Rural Health, RuDASA, and SECTION27 provided institutional support and in-kind contributions initially, but as RHAP grew they transitioned to being fully grant-funded. Credit is due to these early partners who sustained RHAP's early growth through commitment of resources. The way RHAP was conceptualised brought the three founding partners together in a sustainable way, helped to grow RHAP, and later bring other partners on board. Even though RHAP had only one staff member in its first year, it could point to its founding partners for organisational strength.

RHAP operated in collaborative ways to build networks of partner relationships and achieved impact way beyond expectation

However, the decision by RuDASA to use the Atlantic grant to establish an independent advocacy organisation rather than strengthening RuDASA to play that advocacy role has had some consequences. RHAP has grown while RuDASA is having some financial challenges, the same challenges faced by other volunteer-driven, membership-based organisations.

STRENGTHENING THE ORGANISATION

RHAP has moved from the pioneering (or 'storming and norming') phase into the consolidation phase, where impact and sustainability are the main focus areas. This is a new, more organisationally mature phase (or 'performing phase') in which outputs and programmes become increasingly central. There is a high level of conceptual and organisational coherence that is regularly developed and refined by RHAP.

The period from 2012-2015 has seen significant growth in the team. Adequate funding has been secured until the end of 2016 and there has been positive interaction with and feedback from primary donors. However, there is an urgent need for fundraising for 2017 and beyond.

RHAP has grown in its visibility and reach. The RHAP Facebook page currently has 459 page likes. The Voice Project Manual, on the projects page of the website, received 1,334 hits.

In the first three years, from 2009 to 2012, the Atlantic grant was the only grant we relied on. It has greatly capacitated a young team to grow an organisation and do highly innovative work. The seed grant and subsequent core funding provided us with much flexibility to explore and try out new approaches. In the first four years, the foundation of the organisation was laid from which we were in a position to raise funds from new donors. As such, the Atlantic grant has functioned as a catalyst for organisational development and contributed significantly to the professional development of middle and senior management who have grown into upcoming leaders in their fields of work. (Executive Director, RHAP).

An increasingly competitive donor funding environment has prompted RHAP to consider alternate strategies to resolve capacity constraints rather than growing into a sizeable and costly NGO. RHAP has remained quite small with a very clear development of approach, doing a lot of work with good focus. There is good coordination and teamwork between the staff members. In choosing to remain lean it has as a result limited operational capacity to engage with all the major advocacy needs nationally and on the ground, and relies to some extent on its rural partner organisations to play their distinct roles.

The external review in 2014 pointed to some shortcomings with its governance structure.

While the fiduciary and legal governance provided by the WHC [Wits Health Consortium] has worked effectively, the Steering Committee seems to need some reflection and review. RHAP's partnership approach has led to a steering committee that is unwieldy and at times not as effective as it could be due to its size. (External review, 2014).

RHAP's financial management systems are housed in WHC, which provides the Faculty of Health Sciences at the University of the Witwatersrand (Wits) with a legal framework within which to operate the research and other activities necessary to support its academic objectives. In terms of financial oversight, the WHC has in place an audit committee which is a sub-committee of the board and which approves the financial statements on an annual basis.

Strategic oversight is provided by RHAP's board, consisting of the founding partners and additional members including the UKZN Centre for Rural Health, the Ukwanda Centre for Rural Health, the University of Cape Town Primary Health Care Directorate, TAC, and Rural Rehab South Africa (RuReSA).

RHAP was one of five finalists of the 2012 One Africa Award. ONE is a campaigning and advocacy organisation of nearly eight million people around the world taking action to end extreme poverty and preventable disease, particularly in Africa. The ONE Africa Award is an annual \$100,000 USD prize which celebrates the innovations and progress being made by African civil society towards achievement of the Millennium Development Goals. With entries from 250 organisations across Africa, this was a significant achievement. The One Africa Team conducted a due diligence visit to the RHAP offices, and visited one of the rural facilities that RHAP works closely with. The One Africa website and blog posted the following:⁸

While its offices may be in downtown Johannesburg, RHAP works for the rights of South African's rural citizens to access affordable, quality health care in their home districts. In its short existence, RHAP has become the de facto source for the most innovative policies

⁸ <http://www.one.org/international/blog/announcing-the-2012-one-africa-award-finalists/>



and practices to improve rural health care and while at it, has given a voice to rural health workers that they never had before... RHAP has made 'rural proofing' a new buzzword in the advocacy world – they give rural health practitioners the ability to speak out. (Nealon DeVore, ONE).

**RHAP
has given
rural health
workers what they
never had before - the
ability to
speak out**

PIONEER LEADERSHIP

One of the successes of RHAP has been the high-quality pioneer leadership of the executive director who employs a collaborative style, balancing and managing contrasting views and approaches to health, rurality, and advocacy. Another key feature is the rigour with which key elements of the organisation's unique identity, advocacy style, and organisational ethos have been established, nurtured and developed.

The first grant from Atlantic enabled us to employ Marije. This has been the key to unlock the whole potential of RHAP. She has sustained the organisation, made something that really worked from initial humble ideals. She has exceeded expectations and taken RHAP to beyond what could have been imagined. (Board Member, RHAP).

RHAP's leadership model and ethos has epitomised a collaborative, interdependent style.

The high quality of pioneer leadership provided by RHAP's founding director, juxtaposes having a meticulous sense of what the organisation is and how it should function with a spirit of collegiality, consensus-building, interdependency and generosity. (External evaluation, 2014).

The board complements this with both its diversity and its consensus-building decision-making style. The RHAP leadership have years of activism experience, combined with a culture of rigorous reflection and critical thinking. The founding RHAP leaders are seen as wise elders who impart a wealth of experience. The new board has also brought new young leaders to the mix; bringing new voices, ideas and networks to the governance structure.

In 2012 RHAP was awarded the Wits Vice-Chancellors Academic Citizenship Award for their work as a team. The executive director believes it is the combination of people and the way their skills and personalities complement each other that contribute to the unique mix of staff at RHAP. Individuals at RHAP have also been recognised for their contributions to rural health. The director was voted 'Best Leader' by fellow management development trainees at the Wits Management Development Programme in August 2011. She and a programme manager were both selected for the '200 Young South Africans', in 2011 and 2014 respectively, Health Section – a list of 200 people aged 35 and younger 'who are truly helping to set a new agenda for South Africa'. Editor Nic Dawes wrote in June 2011 that they were chosen 'for their impact, their creativity and the resonance of their values with the project of building the South Africa that we all want to live in: vibrant, prosperous, equitable, diverse and hungry for the challenges of growth and change'.

NETWORKS AND ALLIANCES

The defining characteristics of RHAP's partnership with other organisations have been the commitment to consultation, collaboration, and joint decision-making, while employing a smart combination of partner roles, and at times alternating between soft and hard advocacy strategies.



RHAP has served to represent, facilitate, and coordinate the voices of rural partners in policy and alliance-building work. RHAP has learned that it needs an active and agile (quickly reactive) group of individuals to form a strong movement that lends weight, action and power behind their campaigns.

One of the strengths of the RHAP model is its ability to connect people, partners, practice, policy, research as well as connecting close partners to other valuable, non-rural specific, advocacy groups and vice-versa. Alliance building by RHAP has strengthened some membership-based organisations, e.g., support to RuReSA has worked well and based on their feedback it has been of great help. (Executive Director, RHAP).

The lessons from building coalitions and alliances stem from RHAP's experiences with SSP and the Eastern Cape Health Crisis Action Coalition (EHCAC). RHAP learned from its experience of the first SSP survey which resulted in a confrontational adversarial relationship with government. In the second SSP survey the working relationship with DoH improved, with SSP requesting and receiving inputs into the survey methodology and sharing results with DoH ahead of publishing the report. In addition, the report included responses from provinces on how they could address the issues identified.

EHCAC provides a model that could be replicated in other provinces. The convening of public hearings and provincial health consultative forums, meetings with provincial managers, and engaging DoH to develop an MoU that allows for mechanisms for HCWs to escalate problems, are all processes which other provinces can employ to great effect.

RHAP has found that there is not enough capacity for local action to influence national policy. RHAP has focused their activities on such projects as the Voice Project to enable a bottom-up approach through which HCWs themselves can influence implementation on the ground. RHAP's support for students also empowers them to advocate for transformation of education. Ultimately it is leadership at local level that can effectively promote rural and HRH issues.

While access to volunteering and/or organised HCWs that can represent the rural voice, and organisational position (whether RHAP's or that of its partners) in national policy developments has grown, there are inherent challenges to the involvement of rural-based health care workers in national policy initiatives. Most members of the rural health partners are employed full time as health care professionals and have little time available to support and build membership and then also to represent their issues at a national level. It is thus imperative for RHAP to continue to work with partners on growing the quality and quantity of the rural health associations' membership so that the 'load' can be spread and for RHAP to depend less on a few committed and available rural health care workers.

BRINGING THE BEST POSSIBLE MIX OF GROUPS, CAPACITIES AND STRATEGIES INTO PLAY

The conceptualisation of RHAP from the onset as a partnership initiative helped greatly in building RHAP's reach and standing. The continued alliance approach ensures voice, legitimacy, and sustainability. Acknowledging the shared mandate across the organisations to advance access to rural health care, and the existing informal collaboration over many years, the network partners committed to strengthening their collaboration to progressively realise the right to rural health care.

The in-kind technical and organisational support from core partners, especially in the early days of RHAP, and being associated with reputable organisations as founders has helped build RHAP's own name and influence.



A network is a highly effective way of enabling small, diverse, and disparate organisations that share a common concern to collectively achieve far more than they ever could on their own. Although carrying a common values foundation and a set of shared goals, the network partners also bring unique characteristics and a measure of diversity to enhance the network's reach and depth.

RHAP's close relationship with SECTION27, for example, has made a tremendous impact on the organisation. RHAP was based at SECTION27's offices in the first few years of its existence which benefited the fledgling organisation in growing and nurturing the staff's skills and capacity; and also in defining the organisation's ethos. SECTION27 was far more assertive and, at times, willing to be more politically overt and adversarial than RuDASA might have been and this shaped RHAP's approach to advocacy and its early lessons on what strategies to apply in varying circumstances. More recently, in partnering on the Voice Project, SECTION27 (being the only legal medical advocacy organisation) provided RHAP with an understanding of the Protected Disclosure Act and legal frameworks that are fundamental foundations of the Voice Project.

CHAMPIONS AND FACILITATORS

At a national level, RHAP has been able to identify good people within government, who serve as champions in being willing to highlight rural health issues. In provinces and districts on the other hand visibility and legitimacy are important. It is always a challenge gaining an entry or foothold and making contact in provinces and districts. Sometimes RHAP will present at a meeting attended by the district manager or other senior official and the contact will be made. At other times, the need is identified and then an avenue for engaging is identified. RHAP has done this through existing NGO contacts and more recently through health care professionals working in the districts. The CRHs have been important in making those connections, directing RHAP to the right people and RuDASA members also have been very helpful in identifying which managers have been responsive in the past. Another entry point has been the District Clinical Specialist Teams (DCSTs). On the ground, intelligence has always been beneficial.



Marije Versteeg-Mojanaga with a representative of the Office of Health Standards Compliance at the rural health imbizo (gathering) in Ganyesa, NW Province June 2016.

ADVOCACY STYLE

Identifying issues the organisation wants to take on, developing appropriate strategies, consulting with partners, responding to shifts and changes as they emerge, while also documenting, monitoring and evaluating work being done, makes every day of work multi-faceted, complex, and demanding. RHAP has learned that there is no 'one-size-fits-all' approach, but rather one of remaining small, nimble and agile in identifying and addressing what are perceived to be the main issues affecting rural health.

The combination of technical support, research and more overtly political styles of advocacy is an ongoing and inevitable tension within the life of work of RHAP. It requires finding a balance between holding civil servants accountable and being seen as an ally in realising change for rural people. RHAP balances the insider-outsider approach well.

While the use of softer advocacy approaches, such as technical support, will remain a core element of their work, a harder stance on certain areas appears unavoidable in the near future.

In the RHTT, RHAP employs a soft style of lobbying. Progress has been slow and success is sometimes defined as getting things on the agenda. But if RHAP were to issue press statements



critical of the task team and the lack of commitment from DoH, we would risk alienating ourselves. However, we still must take a firm stance or else we won't be taken seriously. We are reaching that point where we have exhausted soft strategies. We are grappling with decisions on how to proceed. We will possibly publish the stock take, give them a chance to comment then make it public. We are also considering whether other partners should continue on the task team while RHAP takes an outside role. For now, though RHAP has been driver and coordinator of the RHTT and there may not be anyone else to step in to do this. (Executive Director, RHAP).

SHIFTING FOCUS

Following an external review that made critical recommendations around RHAP's need to sharpen their strategic focus, RHAP developed a refined Priority-Setting Framework that will help them decide which issues to take up and in what manner. They have made the decision to approach new initiatives with caution and will consider the clear and specific 'button' that they want to press in realising the Theory of Change and the Theory of Action that have been developed. They have seen the need to work 'narrow and deep' rather than too broadly and superficially.

Initially it was easier to engage with national-level decision-makers, but they had limited ability to influence what happens at provincial levels. RHAP feels that greater attention therefore needs to be given to influencing decision-making within the policy and budgeting areas at national, provincial, and district level.

USING EVIDENCE AND RESEARCH

RHAP realises that research can support change, but is seldom a catalyst for change in itself. Despite this, evidence is required to inform their activities, to motivate for policy change, and to raise awareness of local issues. In the beginning RHAP relied on more anecdotal evidence of individual HCW case studies. That approach made sense in the project's infancy as RHAP was trying to raise the profile of rural health challenges as a moral call for action. As it grew in capacity and reach, RHAP has done or commissioned more research, even though it is not a research institution.

We don't see ourselves as a research institute, but we were compelled to conduct research due to the gap in evidence that was available. If there was sufficient research, we could spend more time on accountability advocacy. (Executive Director, RHAP).

RHAP's strategic model is to empower voices from the ground to inform their advocacy efforts. With HCP training and support and by working with partners like RuDASA, RuReSA, and PACASA, RHAP is able to understand what is happening on the ground through individual stories combined with broader quantitative evidence such as HR statistics.

In the Free State where the rural health movement traditionally have not had a good membership base, PACASA representatives were able to help RHAP document testimonies from HCWs that were presented at the Free State peoples' health enquiry in July 2015. Where research processes may not be able to generate quantitative and qualitative evidence immediately, such testimonies serve as powerful evidence of the state of health in a specific province.

RHAP has learned that an inventory of evidence is required not just at a national level but by province. The synergistic effect of having provincial health leaders use this evidence in advocating at the level of the National Health Council (NHC) while advocacy groups are also making the case through structures at DoH and in the media would be highly effective.

TARGETING FOR GREATER IMPACT

We are small... if we had 40 people there would still be enough work for us. When there is a crisis in a rural province you feel compelled to do something, as it is our responsibility to address rural issues... If we don't say anything and are silent it is as if we don't care... But the reality is that we can't always respond to everything, it dilutes our focus and impact. The need vs focus is a continuous tension that we face, that we probably all face in the social justice sector. (Executive Director, RHAP).

RHAP believes it has had a great impact with the groundwork of advocacy and increasing the visibility of rural health issues. A shared problem definition now exists among rural partners, and more people who buy into RHAP's Theory of Change. There have been some positive policy outcomes, such as the Rural Health chapter in the HRH Strategy and strategic rural content included in the CHW/WBOTs policy. Increased data and analysis through the RPP programme, and the newly initiated HRH research has led to an increased evidence base for rural health. RHAP now has increased access to participation and influence, sitting on a few policy structures and civil society structures. Some impact has been seen in areas of research, alliance building with rural HCWs and in profiling and highlighting the experience of rural HCWs and civil society coalitions.

In re-thinking RHAP's strategy for the next few years, the following questions have arisen:

- **In moving from policy to implementation**, how should RHAP balance internal resource allocation? For example, the RPP has been important in building the evidence base, but now the impact on implementation needs to be seen.
- **In making health, and rural health, a renewed political priority in the current context**, how should RHAP best represent the interests of those most affected by lack of access to rural health care? How should RHAP retain and build formal and ongoing linkages with grassroots constituencies and facilitate and support self-advocacy against the continued inequities in accessing health care in rural areas?
- **In balancing technical advocacy with accountability advocacy**, how should RHAP hold government accountable to policy implementation? In what way can they best amplify the voices of rural communities? Which additional partnerships are needed in creating a groundswell demand for rural health?
- **Should RHAP's overall goal be about improving health outcomes or should it be about ensuring equity for rural communities?**

It can take several years for the transfer of research into policy and practice. The potential impact that RHAP anticipates for future work includes:

- Filling of vacant posts – an end to the practice of 'freezing critical posts' in rural areas during times of financial constraints;
- Changes in the manner in which rural health is budgeted for and more equitable resource allocations;
- Growth in rural health associations through increase in membership numbers;
- Growth in advocacy competent rural HCWs who self-advocate for a better health care system;
- New policies that are rural-friendly; and
- More equitable distribution of HCPs between urban and rural.

MANAGING ATTRIBUTION

The eclecticism of RHAP's work is one of its greatest strengths but also a challenge when it comes to measuring the change its advocacy has catalysed. Advocacy can at best be described as contributing to change rather than being attributable. The slow progress is partly due to the long timeframes of advocacy work, e.g., the number of years it takes to see actual policy implemented and leading to better access and improved health outcomes.

You know intuitively it works... because your actions are drawing attention to particular issues. We have also been successful in changing the language around rural proofing... Though there is always the issue of attribution. Even when it seems clear an advocacy strategy has worked, it is difficult to get acknowledgement that your advocacy group was the push factor to get action, for example. in our experience with SSP, government initiated many new interventions but won't admit SSP played a role. But we know that SSP's spotlight on the stockouts certainly created an internal drive to improve and show results. (Executive Director, RHAP).

With other forms of advocacy such as litigation it is possible to show attribution quite easily.

With RHAP there is a lot of incremental work that we do. While major policy change is not always demonstrable, we can explain and demonstrate other ways where the organisation was influential and engaged in informing the policy process. (Executive Director, RHAP).

RHAP has found that such funders as Atlantic understand this particular challenge.

Funders we have had like Atlantic are all very well aware of the attribution issues and they don't require scientific studies that demonstrate percentage change directly related to the money that has been spent. RHAP has been fortunate in that sense... showing direct attribution has not been an expectation by the funders. (Executive Director, RHAP).

LEGITIMACY

Rural communities' right to health provides the moral compass for RHAP's work. Ultimately accountability is to citizens who are voters, and it is therefore vital to build demand from the ground up. RHAP serves with the legitimate mandate of advocating for accessible, comprehensive quality health care for rural people.

Enabling the voice

For RHAP to deliver on its mandate it needs a strong rural voice from the ground – both in terms of quality input and quantity/numbers. It needs access to health care workers, to patients, to an evidence base, and to timeous input into campaigns and submissions. RHAP grapples with the challenge of how to give voice to health care users.

Rural communities are by nature dispersed, they have no single issue or rallying point... it is impossible to come together. RHAP has to literally speak on behalf of communities that don't otherwise have a voice on issues that affect them. The issues that RHAP raises come through partner organisations; rural doctors have contact with people on the ground and know first-hand of health problems. [Rural doctors] are a huge area of RHAP's credibility and legitimacy as they have a good understanding of rural community challenges on the ground. (Board Member, RHAP).

RHAP's mandate is to improve access to health care in rural communities. Working in the social justice advocacy arena inherently means giving voice to users, making sure health care users influence their agenda. In 2016 RHAP plans to hold a round of community accountability meetings across rural provinces, providing feedback on RHAP's progress, challenges, and priorities from 2009 to 2015, asking for critical feedback, endorsement if and guidance for the next five-year strategic framework.



We need to raise some dedicated funds for this, but I believe it's critical and donors would support this. (Executive Director, RHAP).

RHAP's vision is that rural associations should grow and engage provinces more constructively and where there are problems, solicit the assistance of RHAP. It is these local rural voices that carry legitimacy while RHAP could provide support when there is need for a harder voice.

One of the philosophies at RHAP's inception was that it would be a central place where HCPs could bring issues to people's attention for advocacy without facing victimisation. This places us in a precarious situation... we are not a movement ourselves, we are an advocacy project. With time, what we should be doing is building the movements on the ground and assisting them in representing themselves. RHAP should play a coordinating role. This is what motivated the focus on alliance building. (Executive Director, RHAP).

RHAP would prefer to play a coordinating advocacy role and drive change from behind the scenes, where possible and appropriate, while rural membership-based organisations such as RuDASA, RuReSA and PACASA are at the forefront.

We are not a mass-based movement and cannot be in every district and have eyes and ears on the ground... we have been using different strategies to try and address that, such as working with [Treatment Action Center] for patient, health care user and community activism representation in our work.



We have also been drawing on research findings that reflect views and opinions of users. We have formed or joined coalitions and consortiums working together with other groupings that represent health care users, such as SSP and ECHCAC. None of us can achieve the end goal alone, we do really need each other, more now than ever, with the provincial crises and extent of the problem, gap between policy and implementation. (Executive Director, RHAP).

The need for the Voice Project arose as a response to the challenges RHAP faced in trying to respond to need identified. RHAP realised that it could not help every individual HCP in rural areas, and should build more advocacy competency among individual HCPs to self-advocate to think smartly before raising issues. The Voice Project empowers them to generate documented evidence of efforts made to raise the problem through internal mechanisms that didn't yield any results. The Voice Project further advocates to HCWs to support their patients in their self-advocacy, to use the complaints mechanisms to report problems, and to use all channels available to them. RHAP also urges HCWs to strengthen local complaints systems and to advocate and contribute to functional clinic committees and hospital boards. The Voice Project confirmed with HCPs that the end responsibility is towards their patients and not management whether they need to expose corruption, bad leadership, or their colleagues for abuse of overtime.

Being the voice

RHAP also realises that many people share the same concerns but do not have the personality or inclination to protest and that while RHAP should be encouraging activism amongst HCWs it also acknowledges individual differences among HCWs. The Voice Project therefore is about self-empowerment while RHAP maintains the willingness and positioning to step in, raise issues, and defend individual HCWs when the need arises.

Even though RHAP's goal is to strive towards self-empowerment of HCWs, mass membership, and growing a mass movement on the ground, they will still fulfil the function of being at the forefront and

raising challenges where there is a need to be the voice where HCWs cannot do it themselves. Often HCWs prefer RHAP to be at the forefront and feeding them information confidentially so RHAP will still have the dual role.

I think we do what we say we do 'connecting policy, practice and partners' with the aim of improving access to quality health care as promised by the Constitution. We don't pretend to be a 'citizen-led movement'. We do ensure we are guided by the experiences of, and support the voices of, health care workers, and health care users. For instance, we have been selective in choosing to support citizen-led movements and strategies with a strong health care user voice, e.g., EMS, SSP, EHCAC, and Mental Health Campaign. In the RPP we have two [Treatment Action Center] community advocates on the ground seconded to RHAP, who organise community meetings and provide grassroots input into RPP's work. We have improved and are still improving community representation on our board. For me the central question is: Are there ways in which we, taking into account RHAP's model, can better amplify the voices of rural communities, can we identify new/other partnerships that could generate a groundswell demand for rural health? I see this as the central discussion to have. (Executive Director, RHAP).

Mass-based movements



RHAP recognises the importance of the positioning of an organisation like Treatment Action Center (TAC). They have the membership numbers that gives them legitimacy, and they have single issues with which they can enter the political arena. Unfortunately, there is only one TAC in the country, which RHAP believes is a real limitation to the advocacy movement. The country needs more mass-based movements. TAC is currently plagued with their own challenges in funding and capacity constraints. They also need to maintain their own priorities and cannot advocate for everything.

The real problem is finding organisations on the ground that represent people's opinion. There is a need to invest in strengthening TAC... they are their own advocates. Funders need to continue supporting them, supporting citizen-based, party-political independent movements as a matter of priority. (Executive Director, RHAP).

CHANGE IN POLICY, POLITICAL AND FUNDING CONTEXT

Universities

The current student protests have been a fertile ground for curriculum change advocacy. #FeesMustFall is a student led protest movement that began in mid October 2015 in response to an increase in fees at South African universities. Protests rapidly spreading to most universities across the country. The '#Feesmustfall' campaign has accelerated the discussion on the transformation of universities in a meaningful way that expedites changes structurally. Curriculum transformation has been on the agenda for a while now and is not a new area of focus for rural health. Some universities have realised the benefits of targeted admissions criteria and decentralised training in addressing the needs of rural communities. This has resulted in a very good submission by the Consortium of Health Education and Equity Research (CHEER) to the National DoH for support on: 1) changing selection criteria; 2) shifting academic orientation to Primary Health Care; and 3) training in rural contexts. Recent changes to adapt selection criteria to include rural origin are significant. Despite promises from government and despite good progress advocated by rural health centres, commitment has been slow and the CHEER proposal has not yet been tabled at the NHC.

The student movement has also provided another window of opportunity for RHAP to have a presence in the transformation discussions at Universities. There have been good initial signs of uptake of the Voice Project by Faculties of Health Sciences based on the interest expressed by senior managers, invitations to key fora and access to decision-makers at a time when transformation is a top priority.

Government

A positive climate began when Dr Aaron Motsoaledi became minister of health, which generated hopeful energy amongst civil society, which believed this was fertile ground for advocacy work and that the political context would be more favourable and bring about real transformation. The early spirit of engagement gradually deteriorated, and relationships with government became more difficult. In a climate of poor leadership, corruption, leadership battles, and career deployment, provinces began falling below the minimum requirements without adequate intervention from the DoH, and with devastating consequences when Treasury intervened.

Despite this deterioration, RHAP has gradually managed to claim more recognition, space, and visibility. The rural voice is more visible and heard, both in civil society and government. Rural health issues are more recognised, evidenced by the formation of technical committees in the DoH focused on rural health issues, the change in language around rural issues as well as a growing rural health movement. However, the impact is not as great as it could have been because of the general deteriorating health system. Rural health is not sufficiently on the political agenda, but health in general does not seem to be either.

DoH does not seem to buy into the need for general HR4RH investment and growing the base of HCPs. Instead it has focused on individual stand-alone projects, targeting cadres such as the CHW programme and the establishment of DCSTs. There seems to be no vision for increasing the number of doctors in district hospitals.

RHAP finds that there is still receptiveness from DoH, with DDGs open to the message and willing to engage. There has been some institutionalised change, e.g., Chapter 8 in the HRH Plan and the adoption of the definition of rurality. However, RHAP has learned that effecting change is dependent on individuals and their agendas.

Service delivery breakdown seems in part to arise from concurrent powers or the separation of national and provincial powers, which is legal and constitutionalised. Provincial leadership feels it doesn't have to account to national leadership. This has informed RHAP's shift in focus to implementation and advocacy at provincial level in order to effect change on the ground. Shifts in leadership however, take time to translate into shifts at policy level, budgeting, and practice on the ground.

Civil society

In the recent Lancet series, it was proposed that the success in the fight against HIV would rely not only on the UNAIDS key 90-90-90 goals, but also requires the growth of global activism. Despite this, the rural advocacy space has become increasingly threatened, and a lot of paranoia is emerging. There have been comments from government about foreign-funded NGOs with foreign agendas and even the possibility of formal investigation of five local NGOs (including SA Litigation Centre). RHAP believes that this tension will worsen in the coming years with political changes underfoot. There is a concern that government will seek to discredit NGOs based on the source of their funding, and the make-up of their boards and senior executive staff.

Funders

International donors are withdrawing, and there is more competition for funding. Funders are less inclined to give money to organisations that struggle to demonstrate impact. As a result, there is a tendency

for narrow sorts of NGOs being funded: those involved in service delivery rather than advocacy. These organisations are often not working towards social transformation and are not representative of people's interests on the ground.

This is veiled as fiscal accountability — if you can't show that you are using funds effectively and efficiently in a mechanistic way, donors are very reluctant to fund you. The issue that TAC faced... the nature of the organisation is that it is staffed by activists who don't have financial training but have intuitive experiential sense of what needs to be done and what is effective. This may not necessarily align to neat log frames and theories of change. (Programme Manager, RHAP).

SUSTAINABILITY

The risks to the sustainability of RHAP include dwindling donor support in the sector, a shifting and fracturing political system, a fragile health system that will take years to bring to a point of functionality, and the vulnerabilities that partner organisations are currently facing. (Executive Director, RHAP).

According to RHAP's executive director, the most important sources of resilience and sustainability are the people. The relationships RHAP has with staff, the board, and various partners are its greatest asset. Core funding partners continue to support RHAP and the partner alliance. RHAP has also received financial and in-kind contributions from partner organisations including Wits CRH which previously funded a technical advisor providing support to RHAP and other partners such as UKZN co-funded a seminar.

Strategically, remaining part of a network and being open to reciprocal flows of resources and support seem to make the most sense. Tapping into the resources and opportunities that its networks have to offer is a wise and prudent strategy. RHAP has explored the options of implementing cost-sharing principles within the network and adopting affiliation fees. RHAP has signed MoUs with RuDASA and RuReSA regarding financial support from membership income to RHAP after 2016. It would be a long-term benefit to grow the membership of RuDASA, RuReSA, and PACASA so that membership fees can become a source of income for RHAP in the future.

Members may in future be asked to make a financial contribution to support RHAP's advocacy work in return for the benefits of membership including attending the HRH seminar and rural representation and advocacy. However, this will work only if the associations become stronger and much better resourced.

If RHAP closes down for whatever reason, the network will move on... playing a coordinating role. It is vital to grow ownership for the network among other partners for it to be seen not as RHAP's network, but as a network that belongs to all its partners. All partners should make decisions together about how we move forward. (Executive Director, RHAP).

A crucial component of RHAP's success has been the partner organisations. RHAP can't function completely on its own. It needs information and credibility from the ground. It is fundamentally important for RHAP to make partnerships work. People come and go, organisations have their own dynamics, with weak and strong periods. Having the right structure, being light centrally, while relying on partner organisations, is the tactic that RHAP has pursued. The success of the alliance model depends on the extent to which partner organisations see the need for advocacy, and pitch in and play their part. (Board Member, RHAP).

One positive feature for sustainability is that the network has a majority of members who are in essence a new generation of rural health advocates with predominantly a very young leadership.

RHAP is in good financial health. It is funded by three main donors and, through the efficiency of its small team and partnership approach, is able to deliver results in a cost-effective manner. It remains lean by maintaining a small staff component.

RHAP has accumulated institutional knowledge and despite its small size it is better off than other institutions. If resources are available, RHAP should carry on as there is a need for the work that they do and because their overall goal is unlikely to be reached for a long time given that change happens over a long period... Thanks to RHAP's governance structures and knowledge management, the work of RHAP will continue even if current staff leave. (Executive Director, RHAP).

Strategic oversight is provided by RHAP's board, consisting of the founding partners and additional members, including the UKZN Centre for Rural Health, the Ukwanda Centre for Rural Health, the University of Cape Town Primary Health Care Directorate, TAC, and RuReSA.

RHAP's financial management systems are housed in Wits Health Consortium (WHC). WHC provides the Faculty of Health Sciences at Wits with a legal framework within which to operate the research and other activities necessary to support its academic objectives. In terms of financial oversight, RHAP is designed to receive institutional support from the WHC that enables the organisation to account for money and show the impact of spending. WHC has in place an audit committee that is a sub-committee of the board and which approves the financial statements on an annual basis.

To ensure sustainability RHAP has taken the decision to remain under the auspices of the Wits CRH. If funding were to become too scarce for RHAP to continue in their own right, being absorbed into a university structure might be a way to ensure the sustainability of a pared-down version of RHAP.

Donor funding accounts for most of RHAP's income each year. Until 2014, the remaining income included cash contributions from RuDASA, SECTION27, Wits Centre for Rural Health, and a Vice-Chancellor's (VC) Award. New relationships with the Open Society Foundations and the Raith Foundation have added to financial resilience in the short-to-medium term. Atlantic has been the major contributor to RHAP since its inception, but this reliance on Atlantic has decreased over time. Whereas the seed grant from Atlantic in 2009 was the only funding RHAP had, by 2014 RHAP received less than 30 percent of its funding from Atlantic. The grant requirement from Atlantic for RHAP to obtain matched funding assisted the organisation to attract funding from Open Society Foundations(OSF) and Raith Foundation. OSF has funded the RPP and the Voice Project. The Voice Project has also received some funding from a new grant through the Claude Leon Foundation for three years. Elma Philanthropies have shown interest in funding RHAP.

RHAP reflects that Atlantic created the space for funding what the organisation determined was the need, and this funding model worked for RHAP. RHAP staff also feel it is unfortunate that a funder like Atlantic as a limited life foundation is closing down entirely by 2019 as they were one of the few funders that allowed grantees to seek funding in response to the need vs what funders wanted them to do. These are for now long-term concerns, and RHAP is starting to deal with the material sustainability of the organisation.

RHAP is firmly focused on strategies to ensure sustainability beyond the current grants, which include proactive fundraising, exploring opportunities for income generation, and generating more significant organisational reserves.

The ongoing fundraising programme targeting corporates and donors will consider funders such as the National Lottery Fund. RHAP is also considering requesting respected individuals who have been involved in rural health to serve as fundraising activists, inviting donations and submitting applications for relevant organisational awards. They will request to be considered as an event beneficiary for sporting and other cultural events.

A crucial component of RHAP's success has been its partner organisations

In the past two years, RHAP has committed funds towards building a contingency reserve fund to cover four months operating costs. It also intends to include a line item in grant budgets for reserves, but RHAP recognises that in order to build reserves, unrestricted funding is required. RHAP has tried to engage donors to commit a small percentage of the total budget to its reserve fund, or to donate a proportion of unspent funds at the end of the grant period to the reserve fund, provided good project progress is made. Donors thus far have not been enthusiastic about these suggestions – but RHAP believes this is a valid ask that funders should reconsider in supporting and sustaining the social justice movement in South Africa at this critical time.

RHAP has considered various options for income generation, including short courses and workshops, consulting, and speaking on rural health or NHI at a cost. They are in a position to offer RHAP’s budget analysis and training skills as a resource that can generate income and enable greater financial sustainability. But, overall, it is difficult for social justice NGOs to make significant income from fees for services. It risks diverting attention from the core priorities. If there are good income-generation examples of how others have done this successfully and ethically, RHAP would explore these further. RHAP and its partners are considering fundraising, not as individual organisations but as a network.

There is a good understanding of how we work together given finite resources, with a commitment not to compete. Fundraising is needed as a network and the RHPN should consider applying for funding together for specific projects. The more experienced fundraisers in the network can support the organisations to apply for funding. (RHPN member).

Health care workers at a Voice workshop

Ganyesa, North West Province, 21 May 2016



LESSONS FOR FUNDERS

There are many lessons for donors who may be interested in funding advocacy movements. The following lessons are extracted from a publication, co-written by the author of this report.

ATLANTIC'S APPROACH TO GRANTMAKING⁹

Zola Madikizela, the programme executive responsible for Atlantic's public health programming in South Africa describes how the impetus for the advocacy grantee portfolio came from the political context of shrinking civil society organising, as funders shifted their funds towards government and many change-makers had moved into government; yet it was a period of AIDS denialism that needed advocacy. Its first grants were to the TAC and the AIDS Law Project (that became SECTION27) which were already leading the challenge against denialism. Funders needed to invest resources in such organisations as SECTION27 that held government accountable to the constitution and were involved in constitutional advocacy and monitoring corruption. Atlantic was one of few funders that had the foresight to do this.

Atlantic began funding Health-e when their initial donor withdrew funds at short notice, possibly because government were unhappy about Health-e generating media outrage against AIDS denialism. In contrast, Atlantic began funding the Clinicians Society when it had no legal status and was operating from a garage. Its incoming president knew and approached Madikizela, arguing that with big funds they could be making an impact within a couple of years both in influencing government policy and in providing Atlantic's advocacy grantees with scientific evidence.

This aligned with [Atlantic]'s approach – focusing on strong people whose perspectives aligned with ours, and taking big bets – having confidence in people to make a difference and giving them big funds that allow them to do so; supporting groups that punch above their weight. (Programme Executive, Atlantic).

In contrast to the case of RHAP, Madikizela approached the voluntary and virtual organisation RuDASA, thinking that they could be making a bigger impact, and offered them funds to do a feasibility assessment. They came back and said they would prefer to stay voluntary but proposed that Atlantic fund the establishment of RHAP as there was a need for a group to generate and use academically rigorous evidence to advocate for a change in conditions facing rural health providers and users. Atlantic accepted their proposal, and RHAP was born.

Atlantic is a very different funder. It does not accept unsolicited proposals but goes out looking for people. For example, Atlantic approached UKZN and interviewed a number of people, asking 'What would you really like to do differently if money wasn't a problem?' No funder had asked that before. Atlantic made grants that allowed grantees to develop ideas to their fullest. Some worked and some didn't, but Atlantic allowed grantees to make their own mistakes and really grow. (Board Member, RHAP). RHAP respects the funding strategy of Atlantic and finds good alignment of Atlantic's focus on HR with the vision and mission of RHAP. They believe however that the impact of Atlantic funding, while significant, could have been greater given a better functioning health system.

Atlantic goals were realistic and not too broad, but nobody foresaw that we would be where we are now in South Africa, with such a dysfunctional government and health system. The impact could have been greater if the broader environment had been more fertile ground for the work of the grantees. However, this was not something that Atlantic or its grantees could have prevented. (Executive Director, RHAP).

⁹ Klugman B, Jassat W. Enhancing funders' and advocates' effectiveness: the processes shaping collaborative advocacy for health system accountability in South Africa. *Foundation Review*, 2016 (In press)

GRANTEE SELECTION

One of the reasons why Atlantic was able to select an effective mix of grantees is that it had in-country staff with long histories of work and relationships in this sector. Hence, they were continually reading the terrain – both political context and civil society capacities. Mansbridge (2014) argues that the most effective form of accountability lies in selecting the people and organisations who are most motivated and committed to particular goals – the better the selection, the less likely are the individuals or groups to go off track or to fail to pursue the intended goals. This accountability results from effective selection and trust, rather than relying on post-action sanction. Hence donor investment in having staff or consultants in-country or at minimum an effective network of embedded informants over a long period of time increases the likelihood of selection success.

GRANTEE COHESION

The Atlantic programme staff argue that one of the weaknesses of their strategies was that they did not bring grantees together to learn about each other's work and hence Atlantic played no role in facilitating collaboration or scaling up of effective interventions. While it is true that not all of its grantees are aware of each other's innovations in training public health leadership, or in strengthening health service delivery, this is not the case with the groups it supports to do advocacy. They initiated their own connections with each other without Atlantic's prompting or assistance. In fact, in the SSP it is interesting that Atlantic is actually funding five out of the six consortium partners. While this was certainly not by design in initiating SSP, this talks to the care of Atlantic's approach in so far as its selection of grantees recognised the mix of capacities needed.

RHAP feels there could have been more space for engagement between grantees. This community of reformers could be a convening process to bring grantees together, which though it did not happen during the life of the grant, it would align with the purpose of ensuring the legacy of grantmaking in the grant closure period.

What they didn't do, which they could perhaps have done, was be a little more directive about collaboration between grantees. Many organisations that are Atlantic grantees naturally came to work with one another, though this had not been a requirement. It would have been great to perhaps once a year bring grantees together, especially those working on HR. (Executive Director, RHAP).

Atlantic did not issue instructions or create forums that forced collaboration; rather it recognised 'the hidden networks already embedded in the civil sector'¹⁰. Many partnerships have failed because they have been forced from the top down, often by well-intentioned funders. Hence part of the art of grantmaking is selecting for the values and competencies that would favour collaboration over competition and then trusting groups to collaborate when strategically necessary. Advance prediction by any grantee of who it should work with on what issues would prevent it from finding synergies as needed.

¹⁰ Plastrik P and Taylor M (2006). *Net Gains: A handbook for network builders seeking social change*.

CORE FUNDING

RHAP and other Atlantic grantees could only achieve what they did because they had 'core' or 'general' support funds that allowed them to read the terrain and adapt accordingly. For example, as they identified the need for the SSP, they were able to fund it without having to wait for the next funding cycle to put it into a logical framework and raise funds specifically for it. Lynn (2014) notes that 'power over resources' is one of the issues that shape a field. The experiences of RHAP and its partners in SSP illustrate how by giving organisations funds they could allocate as needed, the donors ceded power to the grantees, who in turn chose to collaborate rather than compete and pooled resources of knowledge, expertise and money to make a stronger impact. Selection-based accountability lends itself to a different kind of reporting – not against outcomes committed in advance but against actual outputs and outcomes.

ENABLING GROWTH AND STRENGTHENING ORGANISATIONS

Atlantic funded the inception of RHAP. This funding and support enabled RHAP to professionalise the organisation and significantly expand its programmatic activities. With Atlantic support, RHAP has grown into a strong, sustainable organisation, trusted by health care workers, government, and partner organisations to provide an important voice on rural health issues.

Atlantic as a funder was a dream. Their grantmaking functioned on the basis of trust. The whole history of the first seed grant to form RHAP, then a second grant to implement, and finally a grant to expand further has enabled the organisation to become established.... RHAP would not have been here without the seed funding from Atlantic and without being given that flexibility to test and try for two years and come with a proposal for the future of RHAP... the growth and strength of RHAP can be attributed to Atlantic. (Executive Director, RHAP).

Atlantic also helped RHAP to put some of the basics in place including the Monitoring and Evaluation (M&E) framework and sustainability plan.

They kind of walk with you... their interest was more than just delivering our contracts but they seemed to have an interest in growing and sustaining RHAP. (Executive Director, RHAP).

RHAP has high regard for Atlantic's guidance of the fledgling organisation and its support for their sustained organisational capacity.

Zola [Madikizela] protected us... often young organisations get too much money and cannot sustain that growth. Atlantic helped to ensure the correct funding flow to RHAP to ensure the systems were growing alongside the strategic work we were doing, while we were strengthening our base of support and alliances. (Executive Director, RHAP).

The support from Atlantic also developed the staff of RHAP individually. As a young group of people, all in their 30s, Atlantic funding helped to grow their personal skills and create a young vibrant organisation with young leadership.

On a programmatic level and a personal level, the relationship between RHAP and Atlantic and particularly with the Population Health Programme Director Zola Madikizela, has been very constructive.

We have a very pleasant relationship with him where we always feel we are on equal footing... we don't feel nervous going into meetings with them. (Executive Director, RHAP).

Atlantic's belief in our work, support and flexibility throughout the funding period has been awesome. (Programme Manager, RHAP).

LEVERAGING GRANTS TO SECURE FUNDING

Atlantic's approach to matched funding enabled RHAP to secure funding from other funders, helping to convince OSF and the Raith Foundation that half of the budget had already been secured.

It can be said that the intention of this approach was successful in that it indeed assisted us to become more sustainable. Today we have established relations with two additional donors that together fund more than half of our annual budget and interest from further donor partners is also evident... Thanks to the addition of other funders through the matching grant requirement we will sustain ourselves when Atlantic leaves. Would we have secured that funding if they had not pushed us through a 1:1 grant matching requirement I am not sure. It forced us to think about sustainability from the beginning. (Executive Director, RHAP).

The funding model worked. Having a funder that part funded and required grantees to find matched funding, provided an automatic advantage that helped RHAP secure funding from Raith and OSF. Some may see it as a constraint but it opened doors for us to other funders. (Programme Manager, RHAP).

RELAXED OVERSIGHT AND CONTROL

Atlantic, compared to other funders, does not have onerous reporting requirements and having to submit a short annual progress report each year was a very welcome feature for RHAP. Atlantic was relaxed in oversight and control, which worked well for RHAP.

Once a year reporting does help... preparing reports requires a lot of your time and takes you out of work. (Executive Director, RHAP).

Our experience with other funders is that donor reporting requirements can be a key obstacle to accelerating change. Atlantic have been different in that. (Programme Manager, RHAP).

One observation though was that RHAP did not receive much feedback when submitting a grant proposal or report.

There was not much engagement about the content of reports so we always assumed they were happy with the report... so this was not a problem for us. We are self-driven and identify what we need to do and happy when they approve that. (Executive Director, RHAP).

A further reflection from the grantees was that Atlantic did not require visibility and acknowledgment like other funders do. They seemed to operate in the background influencing key developments in the South African public health sector over the past 15 years.

ENABLING INNOVATION AND ADAPTABILITY

One of RHAP's lessons from advocacy work has been that you learn constantly and make adjustment as you go, but that not many donors allow for such flexibility. As a funder, it is important to identify organisations that have the clear mandate, legitimacy, credibility, and capacity to meet their objectives. An understanding is needed that influencing policy is complex and requires innovation and adaptability.

Health policy is not made in a logical linear fashion from evidence to policy and at times it seems arbitrary. You need to build trust relationships with partners, develop a sphere of influence so that you can be part of important decisions. (Board Member, RHAP).

GRANTEE ACCOUNTABILITY

A funder's grantmaking approach needs to be based on careful selection followed by trust because it is not possible for effective advocates to commit in advance as to what strategies or activities they will use. Grantees all describe Atlantic as an effective funder because its staff gave them the leeway to use funds as needed, based on their shared overarching goal of the right to health. Some of their other donors require reporting against results predicted often a year or longer before the actual actions will be taken, and the grantees fear failing to deliver these results even when they are no longer the most strategic results to aim towards. This form of sanctions-based accountability is based on grantees' fear that failure to check the agreed boxes may result in denial of future funding, even when from a strategic point of view, flexibility in funding allows the groups to initiate more innovative approaches that constantly adapt to shifting contexts. Authors characterise this as 'indicator blindness'.

The fundamental difference from other funders is that organisations don't have to pander to Atlantic, the basis of their funding is that 'we support you'. Atlantic created the space for funding what organisations determined was the need. It is unfortunate that Atlantic is pulling out of [South Africa]. In discussions with partner organisations I have often heard complaints around other funders... trying to push on grantees an agenda that they want to see achieved, while being disengaged from the work. I have never heard anything like that about Atlantic and have only ever heard positive reports of experiences with Atlantic. (Programme Manager, RHAP).

A fundamental problem is that some of the donors who choose to fund advocacy groups are actually motivated by the desire for civil society groups to take on roles of government (such as elements of service provision) given constraints in government budgets and capacities, which is why they require quantitative predictable deliverables. At the very moment of funders selecting these advocacy groups, there is a mismatch in goals and hence tensions around reporting.

Also, funders who expect outcomes in the very year of their grant misunderstand that advocacy is taking place in a highly complex terrain, where building recognition of the issues, building trust and collaboration between groups, reaching a point that the public expresses dissatisfaction, and decision-makers feel forced to act all take time. It is impossible to know in advance which of multiple strategies deployed will be most effective. In addition, lessons learnt over time strengthen relationships between civil society groups and strengthen the quality of their advocacy and effectiveness. Similarly, tight controls over what funds can be spent on would have precluded the pooling of funding for collective campaigns.

We were the ones determining to a large extent the agenda of RHAP instead of submitting to a pre-conceived plan from the funder. Atlantic did not interfere much in our work but provided broad outcome areas which we were comfortable with and believed in. (Executive Director, RHAP).

UNDERSTANDING THE LONG-TERM IMPACTS OF FUNDING SOCIAL CHANGE ADVOCACY

RHAP was most appreciative that Atlantic took a long-term view and had a good understanding of advocacy work. The funder understood that one cannot effect change in a short period and that RHAP needed flexibility in adjusting project strategies. Atlantic knew that it had a short window in which it would be doing grantmaking in South Africa but wanted to leave a legacy.

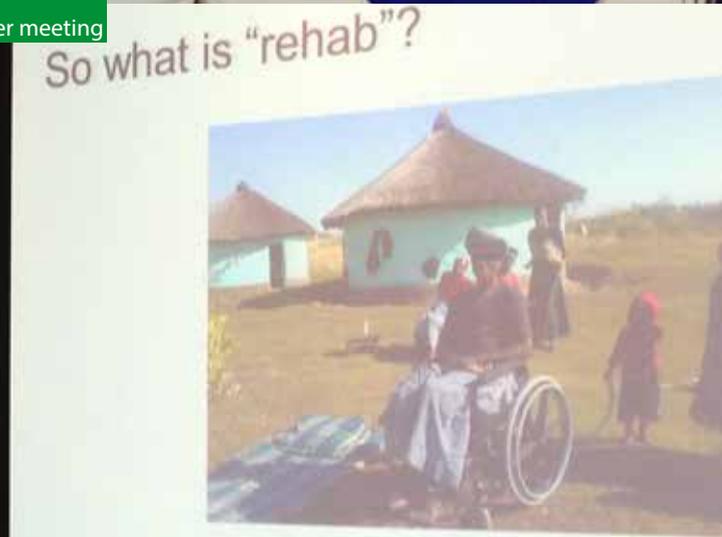
RHAP has reflected that in its experience with other organisations that have worked with other donors, not all of these donors would or even should fund advocacy work. What was needed was a donor that understands the dynamics and changing context of advocacy work.

It is important for RHAP to identify donors who understand the goal is longer-term influence and not short-term evidence. They prefer to work with such donors as Atlantic who have a focus on long-term impacts such as working towards an equitable health system.

With Atlantic support, RHAP has become a strong, sustainable organisation, trusted by health care workers, government and partner organisations to provide an important voice on rural health issues



Above: RuDASA student representative at Rural Health Partner Network Meeting 2015
Below: RuRESA Chairwoman Kate Sherry, presenting at RHAP rural-proofing stakeholder meeting



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