RURAL-PROOFING FOR HEALTH: GUIDELINES

A GUIDE TO ACCOUNTING FOR RURAL CONTEXTS IN HEALTH POLICY, STRATEGIC PLANNING AND RESOURCING

Rural Health Advocacy Project

Founded by:

Rudasa + SECTION27 Centre for Rural Health
## RURAL-PROOFING HEALTH POLICY AND STRATEGIC PLANNING A SYSTEMATIC PROCESS

### Define the Issue: Think Rural
- Think about your policy or strategic plan’s purpose and objectives
- Think about the current situation in rural areas where implementation will take place and list the factors that may influence how your policy or strategic plan is implemented and how services are accessed

### What Do You Want to Achieve
- Consider what it is you want to achieve by rural-proofing.
- List what the outcomes of a rural-proofed policy or strategic plan should be

### Systematically Review Your Policy Through a Rural Lens
- Use the attached rural-proofing toolkit to systematically review your policy or strategic plan for rural appropriateness
- Identify specific areas or interventions that need to be revised to account for rural implementation

### Decide on Rural-Proofing Actions and Make Adjustments
- Decide on the specific adjustments that need to be made to your policy or strategic plan to ensure that it is rural-proofed
- Identify options for how these adjustments could be made and select those that are most appropriate
- Make the necessary adjustments

### Monitor Implementation and Adjust Where Necessary
- Monitor the implementation of your policy or strategic plan and its impact on service delivery and access in rural areas
- If something is not working make adjustments where necessary

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**JANUARY 2015**

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Over the last few years the South African health care sector has been undergoing an important phase of reform. We have seen a renewed commitment to the revitalisation of Primary Health Care through initiatives such as ward based outreach teams, school health teams, district specialist teams, and most recently the contracting in of private General Practitioners (GP) to public facilities. There is no doubt that these all have great potential to improve access to healthcare for all who live in South Africa.

Fixing health care in this country is no easy task though. Our health system is struggling to overcome the legacy of apartheid and the consequent inequitable distribution of resources based on factors such as race, class and geographic location. This is particularly apparent in rural contexts where historical neglect, high levels of material deprivation, longer distances to facilities over difficult terrain, a lack of infrastructure and equipment, and a chronic shortage of critical health care and well-skilled support personnel requires contextually appropriate solutions to improving access to care.

As rural health care providers and advocates for the rights of our patients we are all too aware that what works in Johannesburg or Cape Town will not necessarily work in Lusikisiki or Manguzi. While this may come as little surprise to you, addressing the specific rural health context in policy design, budget allocations and implementation plans is not yet a standard process in South Africa.

The rural-proofing guidelines in front of you have been developed to assist with this task; to ensure that “the rural health context” is addressed adequately when new policies and budgets are drawn up and implemented in the beautiful rural parts of our country.

As rural health partners we are very excited about this development and many of us have actively contributed to the design of these guidelines. It is important to note that addressing rural health does not mean neglecting any other area of health. As rural health partners we stand for “health for all!”. What it does mean is that the specific rural context is taken into account in the policy and implementation processes. This is a critical step if we are to support and achieve our national goals of improving the nation’s health and eradicating the persistent inequities between urban and rural, public and private health care.

We would like to offer our voices and experience to this process and become active partners in rural-proofing for health.

DR DESMOND KEGAKILWE,
Chairperson of RuDASA

On behalf of the Rural Health Partners:

Rural Doctors Association of Southern Africa (RuDASA)
Rural Rehab South Africa (RuReSA)
Professional Association of Clinical Associate South Africa (PACASA)
Rural Health Advocacy Project (RHAP)
Wits Centre for Rural Health
UKZN Centre for Rural Health
Ukwanda Centre for Rural Health
The rural health student clubs at WITS and UKZN
Africa Health Placements (AHP)
Introduction

Approximately 40% of South Africa’s population reside in rural areas, which constitute more than 85% of the country’s landmass. Not only are rural areas significant in terms of population size and land mass they also play a vital role in South Africa’s economy, particularly in terms of agriculture, mining and tourism. Historically, rural areas have been central to social and political struggles against colonial and apartheid oppression.

Despite their obvious importance to the country’s social, economic and political landscape, rural areas continue to suffer from the effects of historical neglect in terms of development and social investment. Rural communities remain the most impoverished in the country and have the least access to basic social and economic necessities. In terms of health, this means that rural communities in South Africa carry a disproportionate burden of disease and can expect to have significantly less access to care than their urban counterparts.

One of the major contributors to the continued neglect of rural communities in general, and particularly with regard to health, is that little attention has been paid in policy and service delivery to explicitly address inequities between urban and rural contexts. This has meant that there have been few coherent strategies that target rural communities and address their needs within the rural context.

Currently there are no standards or methods for accounting for rural in the policy making process in South Africa. This means that critical elements of what makes rural different- geographically, economically, socially- are often not fully considered when designing programmes and interventions; there is no systematic method for avoiding unintended consequences for rural areas in the design of policy; policy is sometimes inappropriate for the rural context; and in some cases it entrenches inequities between urban and rural settings.

One of the difficulties in accounting for the rural context in policy development and strategic planning is that there is little guidance on how this could be done. For many it is not clear which aspects of a policy or strategic plan need to be adjusted to meet the service delivery needs in a rural setting nor is it clear what specifically could be done to ensure rural contexts are treated appropriately and equitably.

The Rural Health Advocacy Project (RHAP) has developed these guidelines in an effort to assist health policy makers and those responsible for strategic planning at the National, Provincial and District to engage with policy development, policy review and strategic planning processes in ways that will allow them to methodically consider the impact that interventions will have on rural contexts and account for rural factors in the design and implementation of policy. More specifically the guidelines have been designed to:

- Ensure that the rural context is explicitly considered in the design, review and implementation of policy.
- Assist with the identification of possible barriers to policy implementation in rural areas.
- Help with the assessment of rural needs and specific rural factors during the design of policy.
- Elicit possible policy solutions to meet rural need and overcome barriers to implementation.
- Promote the development of rural appropriate policy interventions that are effective, efficient and sustainable.
- Ultimately, to make sure that rural areas are treated fairly in policy and its implementation.

TIP

Training on these guidelines and the rural-proofing of health policy and strategic plans is available from the RHAP at no cost. The RHAP is also able to assist with the rural-proofing of specific policies and strategic plans.

For more information on how to obtain assistance you can make contact with the RHAP at info@rhap.org.za
What is rural-proofing?

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 their urban counterparts.

**KEY CONCEPT**

Rural-proofing may be defined as a process which ensures that all relevant executive policies are examined carefully and objectively to determine whether or not they have a different impact in rural areas from that elsewhere, because of the particular characteristics of rural areas; and where necessary, what policy adjustments might be made to reflect rural needs and in particular to ensure that as far as is possible public services are accessible on a fair basis to the rural community (DEFRA, 2002: 2).

There are several different approaches to rural-proofing that are currently being implemented in countries such as England, Canada, Finland, Mexico and China (see Good Practice 1). While these approaches may differ in many ways, the broad principles of rural-proofing are generally the same. These principles are:

- It is a systematic approach to accounting for rural factors in policy and strategic planning processes.
- It is a process of mainstreaming rural into policy as well as developing targeted rural policy.
- There is a statutory body - government department or committee - that oversees rural-proofing and coordinates activities between line departments.
- There is often legislation that makes rural-proofing mandatory and guides its implementation.
- There are toolkits and guidelines that assist policy makers with the implementation of rural-proofing.
- It includes the rural-proofing of budgets to ensure that policy changes that affect rural areas and communities are funded.
- There are a set of clear indicators that are used to monitor progress in implementation.
GOOD PRACTICE 1: RURAL-PROOFING IN PRACTICE:
THE ‘NEW RURAL PARADIGM’

Recognising the many weaknesses of uncoordinated rural policy approaches, there has been a shift internationally since the early 1990’s, particularly within countries that make up the OECD, towards re-thinking how rural regions and communities are approached in terms of both policy and governance. This has been driven largely by the recognition that rural is not synonymous with agriculture and that single sector policy is wholly inadequate to deal with the complexity and heterogeneity of rural areas (OECD, 2006: 56). As part of its ‘New Rural Paradigm’ the OECD has advocated for cross-sectorial approaches to rural development that focus on infrastructure, economic development, public service provision and the “valorisation of rural amenities” (natural and cultural) (OECD, 2006). A number of countries within the OECD have sought to introduce new rural policy approaches that seek to promote equity and sustainable rural development that are in-line with the OECD’s general approach of mainstreaming rather than the development of stand-alone rural policy.

Rural-proofing in the United Kingdom (UK): more than 20% of people in the UK live in rural areas, with this population steadily growing. Recognising the importance of appropriately catering for this population, the UK has been developing and fine-tuning its approach to rural-proofing since the mid-1990s. In 2000 the government established the Department for Environment, Food and Rural Affairs (DEFRA) as the statutory body to oversee rural development and rural-proofing. Since then rural-proofing has become mandatory for all policy processes. DEFRA has also developed a set of guidelines that can be used to mainstream rural into policy and planning.

Canada’s rural lens approach: about 90% of Canada’s land mass is considered rural and rural Canadian’s have higher than average levels of deprivation and poor access to basic services such as education and healthcare. Like the UK, Canada has been implementing rural-proofing since the mid-1990s. They have a Rural Secretariat as a statutory body that oversees rural-proofing across government departments. To assist with rural-proofing of policy, a Rural Lens tool has been developed to provide technical guidance for policy-makers.

The Mexican micro-regions strategy: about 23% of Mexico’s population is considered rural, of which 60% are living in extreme poverty. In 2001 Mexico enacted the Law on Sustainable Rural Development and in 2002 formed an Inter-Ministerial Commission to oversee the implementation of the law at the state, district and local government levels. While the law has been enacted at the national level, authority on how it is enacted is delegated to the local level to ensure rural-proofing considers local contextual factors fully. A unique feature of the strategy is the development of a rural budget that identifies and monitors the resources being allocated to rural interventions.

More examples of where rural-proofing is being implemented can be found in RHAP’s ‘Rural-Proofing: International Best Practice’ report, which is available on the RHAP’s website (http://www.rhap.org.za/international-best-practice-and-the-rural-proofing-of-policy-opportunities-for-the-south-african-context/) or directly from the RHAP (info@rhap.org.za)
The relationship between poverty, poor health and healthcare outcomes has been well established; not only do poor people experience higher burdens of disease because of various social determinants, they also have less access to care (Peters et al., 2008). Globally research continues to show that this is particularly acute for rural populations, which tend to carry a disproportionate burden of both communicable and non-communicable diseases and across almost all indicators experience worse health outcomes (Smith et al., 2008). The South African context is no different.

RURAL REMAINS A SIGNIFICANT PART OF THE SOUTH AFRICAN LANDSCAPE

According to figures provided by the World Bank (2013), approximately 38% of South Africa’s population are considered rural. This population is not spread evenly across the country though and there are five provinces where the rural population exceeds 50% of the total (see Table 1).

### TABLE 1: RURAL POPULATION BY PROVINCE

<table>
<thead>
<tr>
<th>EC</th>
<th>FS</th>
<th>GP</th>
<th>KZN</th>
<th>LP</th>
<th>MP</th>
<th>NC</th>
<th>NW</th>
<th>WC</th>
</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>20</td>
<td>4</td>
<td>53</td>
<td>88</td>
<td>59</td>
<td>29</td>
<td>55</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: Kok & Collison (2006)

RURAL POPULATIONS EXPERIENCE HIGH LEVELS OF RELATIVE DEPRIVATION

The provinces with the largest rural populations are also those with the highest levels of relative deprivation (Graph 1).

### GRAPH 1: RELATIVE DEPRIVATION BY PROVINCE (1= MOST DEPRIVED; 5= LEAST DEPRIVED)

Source: District Health Barometer 2013/14
In fact, the 10 most deprived sub-districts in South Africa are all considered rural (Table 2).

### TABLE 2: RELATIVE DEPRIVATION BY LOCAL MUNICIPALITY

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>DISTRICT</th>
<th>LOCAL MUNICIPALITY</th>
<th>POPULATION WEIGHTED AVERAGE RANK OF WARDS IN THE LOCAL MUNICIPALITY (WHERE 1 = MOST DEPRIVED)</th>
<th>NATIONAL RANK (WHERE 1 = MOST DEPRIVED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>KwaZulu-Natal</td>
<td>uMzinyati</td>
<td>Msinga</td>
<td>176</td>
<td>1</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>Alfred Nzo</td>
<td>Ntabankulu</td>
<td>280</td>
<td>2</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>OR Tambo</td>
<td>Port St Johns</td>
<td>304</td>
<td>3</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>Ugu</td>
<td>Vulamehlo</td>
<td>383</td>
<td>4</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>Ulembe</td>
<td>Maphumulo</td>
<td>388</td>
<td>5</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>Alfred Nzo</td>
<td>Mbizana</td>
<td>395</td>
<td>6</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>OR Tambo</td>
<td>Ngquza Hill</td>
<td>399</td>
<td>7</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>uMkhanyakude</td>
<td>uMhlabuyalingana</td>
<td>400</td>
<td>8</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>Chris Hani</td>
<td>Engcobo</td>
<td>449</td>
<td>9</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>Uthungulu</td>
<td>Nkandla</td>
<td>453</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: District Health Barometer 2013/14

It is also important to recognise that rural deprivation is highest in those areas that formed part of the former homelands and in these areas historical inequalities and neglect are still pervasive (Noble et al, 2012). These areas tend to have large rural populations that have little access to basic necessities such as water, sanitation, electricity, education and adequate nutrition.

**RURAL POPULATIONS RELY ON THE PUBLIC SYSTEM**

Rural districts also generally have the lowest levels of medical scheme coverage, which means they depend most heavily on the public health system for healthcare (Graph 2).

### GRAPH 2: MEDICAL SCHEME COVERAGE IN MOST RURAL DISTRICTS

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>DC</th>
</tr>
</thead>
<tbody>
<tr>
<td>uMzinyathi</td>
<td>DC24</td>
</tr>
<tr>
<td>Capricorn</td>
<td>DC35</td>
</tr>
<tr>
<td>Zululand</td>
<td>DC26</td>
</tr>
<tr>
<td>Harry Gwala</td>
<td>DC43</td>
</tr>
<tr>
<td>RS Mompatti</td>
<td>DC39</td>
</tr>
<tr>
<td>T Mofutsanyana</td>
<td>DC19</td>
</tr>
<tr>
<td>C Hani</td>
<td>DC13</td>
</tr>
<tr>
<td>uThukela</td>
<td>DC23</td>
</tr>
<tr>
<td>Joe Gqabi</td>
<td>DC14</td>
</tr>
<tr>
<td>OR Tambo</td>
<td>DC15</td>
</tr>
<tr>
<td>uMkhanyakude</td>
<td>DC27</td>
</tr>
<tr>
<td>A Nzo</td>
<td>DC44</td>
</tr>
</tbody>
</table>

Provinces: EC, FS, GP, KZN, LP, MP, NC, NW, WC

Percentage (Source: Modelled from Stats SA GHS)

Source: District Health Barometer 2013/14
THE CONSEQUENCES OF OUT OF POCKET (OOP) EXPENDITURE FOR HEALTHCARE ARE GREATEST FOR RURAL PATIENTS

The consequences of having to pay for healthcare at private or public facilities and providers are greatest for rural populations where OOP is often catastrophic for rural households (Table 3).

**TABLE 3. CATASTROPHE OOP EXPENDITURE BY LOCATION TYPE**

<table>
<thead>
<tr>
<th>Variable</th>
<th>OOP transport to outpatient care</th>
<th>OOP Outpatient</th>
<th>OOP Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5-9% &gt;10%</td>
<td>5-9% &gt;10%</td>
<td>5-9% &gt;10%</td>
</tr>
<tr>
<td>Rural</td>
<td>22.4 15.3</td>
<td>2.9 2.1</td>
<td>11.5 54.1</td>
</tr>
<tr>
<td>Informal-Urban</td>
<td>8.6 10.6</td>
<td>1.7 1.3</td>
<td>16.6 30.7</td>
</tr>
<tr>
<td>Formal-Urban</td>
<td>6.7 5.0</td>
<td>1.4 0.7</td>
<td>8.6 14.4</td>
</tr>
</tbody>
</table>

Adapted from Harris et al. 2011

*Expenditure is catastrophic if it exceeds 10% of a household’s monthly income

ACCESS TO FACILITIES TAKES LONGER AND IS MORE COSTLY FOR RURAL POPULATIONS

Research (e.g. Harris et al, 2011) has shown that accessing services in rural areas generally takes more time and is more expensive than in urban centres (Table 4).

**TABLE 4. COST AND TIME OF TRAVEL BY AREA TYPE**

<table>
<thead>
<tr>
<th>TB</th>
<th>ART</th>
<th>CEOC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>Urban</td>
<td>Urban</td>
</tr>
<tr>
<td>COJ</td>
<td>CT</td>
<td>BBR</td>
</tr>
<tr>
<td>Mean costs of travel (ZAR)</td>
<td>2.11</td>
<td>3.77</td>
</tr>
<tr>
<td>Mean travelling time**</td>
<td>40.1</td>
<td>41.8</td>
</tr>
<tr>
<td>Proportion of total costs of use***</td>
<td>100%</td>
<td>95.4%</td>
</tr>
</tbody>
</table>

Figure 1: cost of transport urban and rural patients (both ways) * costs collected in 2008/9 ** to and from facility *** other costs including food, child care and air time. Source: Harriss et al, (2011)

HISTORICALLY URBAN AREAS HAVE BEEN FAVOURED WHEN IT COMES TO HEALTH EXPENDITURE

Research has shown that provinces that are the most deprived and with the least developed health systems have historically received the smallest share of healthcare funds. This has been explained as the ‘infrastructure inequality trap’, where provinces with comparatively well-developed health infrastructure...
and human resourcing compliments tend to receive a larger share of available resources (Stuckler et al., 2011).

Over time this pattern has started to shift and there is some progress in achieving vertical equity between quintiles. In terms of total per capita District Health System expenditure median per capita expenditure in the least deprived districts (quintile 5) in 2005 was R686 while median expenditure for the most deprived districts (quintile 1) was R926, a difference of 34%. In 2013 median per capita DHS expenditure for quintile 5 has increased to R1261 while median expenditure for quintile 1 has increased to R1783. This represents a difference of 41% in favour of the most deprived districts (District Health Barometer, 2013/14). This trend changes, however, when we consider per capita Primary Healthcare (PHC) expenditure in relation to deprivation quintiles. Per capita PHC expenditure is an indicator of Department of Health Services (DHS) expenditure excluding expenditure on district management and district hospital services. In this instance, quintile 4 (second least deprived) had the highest median expenditure of R927 in 2013, while quintile 3 had the lowest median expenditure of R927. Quintile 5 districts had the second highest median per capita PHC expenditure of R856, while quintile 1 median district expenditure was R20 less per capita at R836 (District Health Barometer 2013/14).

In some instances intra-provincial inequities are greater than inter-provincial inequities. In the Eastern Cape for example the two metros Nelson Mandela Bay (R1069) and Buffalo City (R980), which are the two least deprived districts in the province, have per capita PHC expenditure that is substantially higher than Alfred Nzo (R516) and OR Tambo (R647), the two most deprived and rural districts (District Health Barometer, 2013/14).

THE DISTRIBUTION OF HUMAN RESOURCES FOR HEALTH (HRH) IS SKEWED IN FAVOUR OF URBAN CONTEXTS

The equitable distribution of HRH remains one of the most persistent challenges confronting access to healthcare for rural populations in South Africa. The number of HRH per 10,000 population is lowest in provinces with large rural populations. For example, the North West Province, a largely rural province, has less than half the HRH per 10,000 population than the Western Cape (Table 6).

<table>
<thead>
<tr>
<th>Province</th>
<th>EC</th>
<th>FS</th>
<th>GP</th>
<th>KZN</th>
<th>LP</th>
<th>MP</th>
<th>NC</th>
<th>NW</th>
<th>WC</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>44.83</td>
<td>52.01</td>
<td>69.21</td>
<td>58.83</td>
<td>48.83</td>
<td>45.24</td>
<td>55.53</td>
<td>33.06</td>
<td>74.08</td>
<td>55.67</td>
</tr>
</tbody>
</table>

Source: NDoH Human Resources for Health Strategic Plan (2011)

The differences become particularly stark when one considers the difference in the number of doctors between largely rural and largely urban provinces. The Western Cape, for example, has nearly three times as many doctors working in the province as Limpopo (Table 7).

<table>
<thead>
<tr>
<th>Province</th>
<th>MEDICAL PRACTITIONERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>2008</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>17.9</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>34.7</td>
</tr>
<tr>
<td>Limpopo</td>
<td>17.4</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>18.3</td>
</tr>
<tr>
<td>North West</td>
<td>14.1</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>35.7</td>
</tr>
<tr>
<td>Free State</td>
<td>23.2</td>
</tr>
<tr>
<td>Gauteng</td>
<td>32</td>
</tr>
<tr>
<td>Western Cape</td>
<td>37.9</td>
</tr>
<tr>
<td>South Africa</td>
<td>26</td>
</tr>
</tbody>
</table>

Source: Health Systems Trust 2013
These inequities are repeated when it comes to pharmacists. In this instance the Western Cape has four times as many pharmacists working in the province as Limpopo (Table 8).

<table>
<thead>
<tr>
<th>Province</th>
<th>PHARMACISTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>2008</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>2,9</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>5</td>
</tr>
<tr>
<td>Limpopo</td>
<td>4,5</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>4</td>
</tr>
<tr>
<td>North West</td>
<td>3,1</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>5,7</td>
</tr>
<tr>
<td>Free State</td>
<td>3,7</td>
</tr>
<tr>
<td>Gauteng</td>
<td>4,2</td>
</tr>
<tr>
<td>Western Cape</td>
<td>8,7</td>
</tr>
<tr>
<td>South Africa</td>
<td>4,5</td>
</tr>
</tbody>
</table>

Source: Health Systems Trust 2013

The pattern shifts with nursing where the spread of nurses between rural areas appears to be more even. In fact, rural provinces tend to have more professional nurses than largely urban provinces (Table 9).

<table>
<thead>
<tr>
<th>Province</th>
<th>PROFESSIONAL NURSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>2008</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>114,2</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>136,3</td>
</tr>
<tr>
<td>Limpopo</td>
<td>127,5</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>102,9</td>
</tr>
<tr>
<td>North West</td>
<td>81,1</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>155</td>
</tr>
<tr>
<td>Free State</td>
<td>94,5</td>
</tr>
<tr>
<td>Gauteng</td>
<td>111,7</td>
</tr>
<tr>
<td>Western Cape</td>
<td>123,4</td>
</tr>
<tr>
<td>South Africa</td>
<td>116,6</td>
</tr>
</tbody>
</table>

Source: Health Systems Trust 2013

There are a number of factors that contribute to difficulties in recruiting and retaining healthcare professionals in rural settings. Research has revealed that these include both push and pull factors: difficult working conditions; inadequate accommodation; lack of employment opportunities for partners; shortage of schooling for children; few opportunities for career development; and social and cultural isolation (WHO, 2013).

RURAL POPULATIONS TEND TO HAVE WORSE HEALTH OUTCOMES THAN THEIR URBAN COUNTERPARTS

All the factors described above mean that rural populations tend to have poorer health outcomes than their urban counterparts. For example, TB treatment success rates in the most deprived districts in South Africa, while improving, tend to be lower than in the least deprived districts (Graph 3).
Key facts and figures: rural health in South Africa

One of the challenges in ensuring that rural is fully considered in health policy, strategic planning, resourcing and service delivery is that there is a lack of technical clarity on what needs to be addressed in these areas to ensure that rural health receives a fair deal.

**WITH COMMITMENT AND FOCUS, RURAL AREAS NEED NOT EXPERIENCE POORER HEALTH-CARE AND HEALTH OUTCOMES THAN URBAN COUNTERPARTS**

South Africa’s prevention of mother to child transmission (PMTCT) programme is a prime example of where, with proper resourcing, planning and commitment, achieving outcomes can benefit both rural and urban communities alike.

Since 2008 there has been a decline in the percentage of polymerase chain reaction (PCR) that tests HIV positive for infants under two months decline from 8.4% (with a range from 3.2% to 18%) to 2.2% in 2014 (range between 0.7% to 3.5%). The rates for quintile 1 (2.1%) and quintile 5 (2.5%) are now virtually the same (Graph 5).

---

**KNOW THE FACTS**

For additional statistics and indicators for rural health you can access the RHAP’s rural health fact sheet, which is available at [http://www.rhap.org.za/know-the-facts-rural-health-factsheet/](http://www.rhap.org.za/know-the-facts-rural-health-factsheet/).
An important feature of rural-proofing is that it should be based on clear evidence of why one needs to distinguish between rural and urban contexts in the development of policy, strategic planning or the allocation of resources. In an ideal world there would be a single definitive definition of rural that could be used for any purpose. We do not live in an ideal world, however, and how we conceive of rural and urban really depends on the policy intentions or what we hope to achieve with policy.

**HOW IS RURAL DEFINED IN SOUTH AFRICA?**

One of the challenges with accounting for rural in health policy and strategic planning is that rural has not as yet been clearly defined for the purposes of healthcare provisioning in South Africa.

There are government departments and agencies that do define rural for the purposes of policy and strategic planning. These definitions are generally based on a number of approaches that include:

- **Everything that is not urban**: in many instances rural is not defined at all but is rather assumed to be everything that has not been designated as urban.
- **Deprivation**: in some instances, particularly in research, relative deprivation is used as a socioeconomic proxy for rural.
- **Demographics**: rural and urban is often defined based on population size, density and settlement types.
- **Function**: in some instances rural and urban are defined based on how space is conceived and used based on factors such as how the land is used (e.g. farming or industry), economic factors, and travel times to economic centres and/or government services.
- **Political considerations**: some areas have been identified as rural based on discretionary and political considerations rather than on technical elements.

Most definitions, however, use a combination of these approaches and include socioeconomic status (deprivation), demographic (population size, density or settlement type), functional and political factors. The underlying feature of all definitions used in South Africa is that they are meant to achieve a particular end and are designed to be “fit-for-purpose”.

**DEFINING RURAL FOR THE PURPOSES OF RURAL-PROOFING HEALTH POLICY**

### COURTESY OF AFRICA HEALTH PLACEMENTS
GOOD PRACTICE 2: SOME APPROACHES TO DEFINING RURAL FOR POLICY AND SERVICE DELIVERY PURPOSES IN SOUTH AFRICA THAT ARE FIT-FOR-PURPOSE

Centre for Scientific and Industrial Research (CSIR): The CSIR is committed to generating scientific knowledge, and thus has developed its typologies to suit this purpose. For example, the CSIR has developed the functional urban and rural typology that classifies areas on a continuum of nine “space types” that range from functional urban nodes to dispersed rural settlement areas. These space types are determined based on a number of criteria, including: employment opportunities, economic potential per sector, travel times and access routes (Huysteen et al, 2009).

Department of Water Affairs (DWA): This department has its strategic focus on service delivery including to those living in areas with poor service delivery. They have mapped settlements, according to their own settlement delineation criteria, which include economic activity, population density and settlement type.

Department of Social Development (DSD): The DSD needed to define rural for the purpose of staff deployment and remuneration. The CSIR helped to identify areas where social workers qualify for a rural allowance in order to attract and retain social workers to areas classified as difficult to live and work in. The definition combines an assessment of living and working conditions with a geospatial analysis of distance to the nearest town, transport infrastructure, and socioeconomic status of communities in each area.

Department of Basic Education (DBE): The DBE does not explicitly define rural but works off the assumption that due to the legacy of apartheid and separate development, schools that fall into the most deprived population quintiles (1-3) are mostly rural. This means that interventions aimed at rural education will largely be based on quintile classification in combination with discretion around specific inclusionary and exclusionary factors (DBE, 2014).

The Municipal Infrastructure Investment Framework (MIIF): The Department of Provincial and Local Government (DPLG) in partnership with the Development Bank of SA (DBSA) has developed the Municipal Infrastructure Investment Framework (MIIF), with various categories: metro, four categories of local municipality, and two categories of district municipalities. In this categorisation, two of the local municipalities and two of the district municipality categories are considered rural (Development Bank South Africa, 2009).

MIIF Typology

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Large urban complexes with population over 1 million and accounting for more than 50% of all municipal expenditure in the country (urban)</td>
</tr>
<tr>
<td>B1</td>
<td>Local municipalities with large budgets and containing secondary cities (urban)</td>
</tr>
<tr>
<td>B2</td>
<td>Local municipalities with large town as the core (urban)</td>
</tr>
<tr>
<td>B3</td>
<td>Local municipalities with small towns, with relatively small population and significant proportion of urban population but with no large town as a core (rural)</td>
</tr>
<tr>
<td>B4</td>
<td>Local municipalities which are mainly rural with communal tenure and with at most, one or two small towns in their area (rural)</td>
</tr>
<tr>
<td>C1</td>
<td>District municipalities which are not water service authorities (rural)</td>
</tr>
</tbody>
</table>

WHAT WOULD A “FIT-FOR-PURPOSE” DEFINITION OF RURAL FOR HEALTHCARE LOOK LIKE?

There is no simple answer to this question and how one chooses to define what is rural really depends on the policy and interventions that are being worked on. That said, there are elements or factors that should be considered when looking to use an operational definition of rural for the purposes of policy or strategic planning and resourcing.

A review of definitions of rural for healthcare internationally, for example, found that departments of health often adjust broader typologies to fit health specific policy purposes. It is frequently necessary for these departments to select health specific factors - such as utilisation, burden of disease and unmet need - that are most appropriate and relevant for the department, policy or intervention and combine them with factors such as population density and socioeconomic status to develop operational definitions for policy purposes (Humphreys, 1998).

These operational definitions of rural used in health, often referred to as rural health indices, have become increasingly popular internationally because they offer a technically rigorous approach to fostering both efficiency and equity in health system planning and the allocation of resources (Humphreys, 1998).

While the list of factors that are used as measures of rural in various indices can be fairly extensive, these factors can be grouped into the following five broad categories (Humphreys, 1998; McGrail and Humphreys, 2009 and Penno et al., 2013):

1. **Measures of health need**: measures of need can include utilisation, clinical, and epidemiological measures as well as demographic measures that act as proxies for need at the population level such as age, sex and socioeconomic status.
2. **Measures of geographical remoteness**: remoteness can include measures such as average distance and travel time to various levels of care for defined communities as well as average distance for inter-facility transfers.
3. **Population measures**: these measures can include both the size of a designated population and the population density of a particular area.
4. **Some measure of specific circumstances that affect particular communities**: these measures are usually based on policy decisions to focus on historically neglected groups (based on race, ethnicity, gender) that may contain high levels of unmet need.
5. **Measures that account for variations in service delivery**: costs between urban and rural settings associated with the effects of diseconomies of scale, governance costs and additional supply chain costs due to longer distances.

The factors chosen as the measure for each of these categories, and the relative importance given to each measure, really depends on what the operational definition will be used for. The factors that are chosen, however, should at least meet the following criteria:

1. Measures something explicit and meaningful (precisely and clearly defined, using criteria which are meaningful to the task at hand).
2. Be replicable (able to be copied or duplicated with the same results).
3. Be derived from available high quality data.
4. Be quantifiable and not subjective (can be measured or counted, and not dependent on the particular person doing the measuring).
5. Have on-ground validity (be able to measure what it is supposed to measure).

When rural-proofing your policy or strategic plan it may not always be possible to develop an operational definition to meet your needs. It is important though that you consider the context in which your policy or strategic plan will be implemented and to have evidence at hand that can demonstrate the rural factors that would need special attention.

Choosing factors that accurately describe what makes implementation in rural settings different from urban settings will allow you to design your policy or develop your strategic plans to effectively and efficiently account for the needs and circumstances of rural settings.

**RESOURCE: DEFINING RURAL FOR HEALTH IN SOUTH AFRICA**

For a detailed discussion on how to define rural for policy purposes and for some guidance on how this could be done for healthcare in South Africa you should read the RHAP’s Discussion Document on Defining Rural within the context of health policy, planning, resourcing and service delivery. This document is available at:

RESOURCE: KEY DATA SOURCES FOR RURAL FACTORS

Measures of health need: The Health System Trust (HST) publishes a number of health indicators that could be used as proxies of health need. These can be found:
• On their website at http://www.hst.org.za/content/health-indicators
• In the annual District Health Barometer at http://www.hst.org.za/district-health-barometer-dhb-2

Measures of geographic remoteness: The CSIR collects some of this data

Population measures: Population measures can be obtained from Statistics South Africa (StatsSA) that publishes census data as well as population survey data. www.statssa.gov.za

Measures of cost differentials: Health unit cost data in South Africa is limited and not much is publicly available. The Department of Health (DoH) is collecting some of this data but you could also try one of several research institutes that collect some cost data. These include:
• The UCT Health Economics Unit
• The Health Economic Epidemiology Research Office http://www.heroza.org/
• The Health Economics and HIV and AIDS Research Division www.heard.org.za/
• PRICELESS SA http://www.pricelesssa.ac.za/

Policy level factors: These factors depend on your priorities and are often more qualitative in nature and difficult to measure. You may want to include factors such as the impact of apartheid and then identify measures that could be used here.
Rural-proofing is a process that involves looking at policy and strategic planning through a rural lens. It asks policy makers and planners to first think about the impact a policy or intervention will have in a rural context and then how that policy or intervention can be designed to ensure that rural populations are treated fairly and enjoy equal opportunities to access services as their urban counterparts.

Rural-proofing of a policy or strategic plan can be achieved by taking the following broad steps:

### Define the Issue: Think Rural
- Think about your policy or strategic plan’s purpose and objectives
- Think about the current situation in rural areas where implementation will take place and list the factors that may influence how your policy or strategic plan is implemented and how services are accessed

### What Do You Want to Achieve
- Consider what it is you want to achieve by rural-proofing.
- List what the outcomes of a rural-proofed policy or strategic plan should be

### Systematically Review Your Policy Through a Rural Lens
- Use the attached rural-proofing toolkit to systematically review your policy or strategic plan for rural appropriateness
- Identify specific areas or interventions that need to be revised to account for rural implementation

### Decide on Rural-Proofing Actions and Make Adjustments
- Decide on the specific adjustments that need to be made to your policy or strategic plan to ensure that it is rural-proofed
- Identify options for how these adjustments could be made and select those that are most appropriate
- Make the necessary adjustments

### Monitor Implementation and Adjust Where Necessary
- Monitor the implementation of your policy or strategic plan and its impact on service delivery and access in rural areas
- If something is not working make adjustments where necessary
Before setting out on the process of rural-proofing your policy or strategic plan it is important to first be clear on what you intend to achieve with that policy or strategic plan.

- Describe the purpose of the policy or strategic plan
- List specific objectives outlined in the policy or plan
- List intended interventions or activities contained in the policy or plan
- List targets (if available) that you want to achieve and their time-frames

Then develop a list of the characteristics of rural areas that could possibly have an impact on how your policy or strategic plan will be implemented and how people will access those services. At this stage all you need to do is consider rural factors that may be of importance. Where possible list key statistics for the factors you choose.

The following questions are provided to guide your thinking. They may not be exhaustive and it may be necessary to consider other factors that shape the rural context that are of relevance to your issue.

- **Are there geographic factors that need to be considered?** Consider factors such as remoteness (e.g. distance and longer travel times), topography (e.g. mountains and rivers) and infrastructure (e.g. quality of roads and availability of transport) that need to be considered in terms of both delivery and access. Think about how these affect service delivery in rural areas.
- **What is the need for services in rural settings and does this differ from urban settings?** Consider factors like utilisation patterns, clinical measures and epidemiological measures. All this information should be available to you through the District Health Information System (DHIS), research institutions such as the HST or the Medical Research Council (MRC) and secondary resources such as StatsSA and the CSIR.
- **Are there population characteristics that may be important?** Consider factors such as socioeconomic status (deprivation), demographic profiles (age and sex), population numbers and density that need to be considered. Key resources here included StatsSA, CSIR and the District Health Barometer.

- **Are there other social and historical factors that would have an impact on both delivery and access?** Think about how apartheid has shaped health infrastructure and access to services and how this relates to the rural landscape.

Finally, clearly articulate how rural contexts have not been adequately considered in earlier versions of the policy or previous strategic plans. This should be done by considering the rural factors you have described above and listing how earlier versions of your policy or strategic plan have or have not addressed these factors.

**TIP: DEVELOP A RURAL SITUATIONAL ANALYSIS**

It may be useful for you to develop a rural situational analysis that addresses the questions provided above and that can be used to guide your thinking while you rural-proof your policy.
Once you have identified why and how defining rural is essential to your policy or strategic plan it is important to start establishing priorities for rural-proofing. This is a process of identifying what you aim to achieve with rural-proofing. Broad priorities should include:

- Improved access to services for people living in rural areas, which should include both availability of services and the means, such as affordable and readily available transport, to get to where services are being provided.
- Greater equity in the provision of services between urban and rural settings.
- Greater efficiency in how services are accessed and delivered in rural settings.

A vital step in setting priorities for the rural-proofing of your policy or strategic plan will be to consult with rural stakeholders. This should be done to ensure that whatever is included in the rural-proofing process is relevant and acceptable for those who will be directly affected by the policy or strategic plan. Important stakeholders include:

- Provincial and district health officials
- Facility managers
- Healthcare workers such as nurses, doctors, allied professionals, and community health workers
- Patients and patient groups
- Community representatives
- NGOs working in rural settings or rural health issues

Grant Difford courtesy of Africa Health Placements
Rural-proofing is a systematic approach to accounting for rural factors in policy and strategic planning and as such benefits from a structured framework to guide the processes. While there are many possible frameworks that could be used as a guide, it is important that whichever one is selected makes sense within the broader health system policy making and strategic planning frameworks. This is important for ensuring that rural-proofing becomes part of general policy and planning processes rather than being in addition to these processes.

RHAP has chosen the WHO Health Systems Framework (HSF) as the underlying structure for the rural-proofing tool that forms part of these guidelines. This is because the framework is well structured and already being used by the DoH in South Africa to guide much of its health system reform.

The WHO framework describes health systems in terms of six core components or ‘building blocks’ that contribute to key health system (improved efficiency and effectiveness) and population level (social and financial risk protection and equity in access) goals and outcomes (Figure 1).

**KEY CONCEPT: MAINSTREAMING**

An underlying principle of rural-proofing is that it is fully integrated into policies and strategic plans. While targeted stand-alone rural policy is often necessary it is important that rural-proofing should ensure that rural is included as an integral component of all policy and planning processes. In this way rural-proofing is mainstreamed.

**FIGURE 1: WHO HEALTH SYSTEM FRAMEWORK AND BUILDING BLOCKS**

<table>
<thead>
<tr>
<th>SYSTEM BUILDING BLOCKS</th>
<th>OVERALL GOALS / OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERVICE DELIVERY</td>
<td>IMPROVED HEALTH (Level &amp; Equity)</td>
</tr>
<tr>
<td>HEALTH WORKFORCE</td>
<td>RESPONSIVENESS</td>
</tr>
<tr>
<td>HEALTH INFORMATION SYSTEMS</td>
<td>SOCIAL AND FINANCIAL</td>
</tr>
<tr>
<td>ACCESS TO ESSENTIAL MEDICINES</td>
<td>IMPROVED EFFICIENCY</td>
</tr>
<tr>
<td>FINANCING</td>
<td></td>
</tr>
<tr>
<td>LEADERSHIP / GOVERNANCE</td>
<td></td>
</tr>
</tbody>
</table>
While these building blocks do not address social determinants of health, they are important in understanding how health systems could practically contribute to achieving the highest attainable standard of physical and mental health within available resources as described in the International Covenant on Social and Economic Rights and articulated in Section 27 of South Africa’s constitution.

For the purposes of rural-proofing, this framework provides a useful way of structuring the rural-proofing process. Once we have thought through and clearly articulated what it is about our policy and/or intervention/s that is rural and then established what we hope to achieve with rural-proofing, using the framework we can systematically go through our policy or strategic plan with a rural lens to make sure we are rigorous in our approach.

The remainder of these guidelines are structured into six sections that form part of the rural-proofing tool, each of which covers one of the WHO building blocks and is set-out as follows:

1. Description of the building block.
2. List of possible inputs, processes, and/or outputs for each building block, which can be supplemented or expanded based on contextual considerations.
3. Tables that are used to elicit key rural-proofing questions for each of the inputs, processes, and/or outputs, and then require you to list or describe how these components should account for the rural context.
4. Space to describe priorities for each building block and what practical revisions or additions need to be made to integrate these into your policy or strategic plan and how you would measure their success.
5. Suggested sources of information, statistics and best practice examples to assist you in identifying possible ways to rural-proof each building block.

Using the tool:

1. Start by deciding which building blocks are most relevant to your policy or strategic plan: this may mean you use all building blocks or that you only use one. For example, a policy on Primary Healthcare (PHC) re-engineering would require that you use all building blocks, as it is a system wide reform. If, however, you are developing a HRH strategy, you may only need to consider the Health Workforce building block.
2. Review the policy or strategic plan by assessing its contents against the critical questions listed next to each component of each of the building blocks you have chosen to use. Make note of the answer to each of these questions on the table provided. This will ultimately provide you with a list of rural issues or gaps in the policy or plan that will need to be addressed with specific strategies or adjustments to existing interventions.
3. List specific actions that will be taken to adjust the policy or strategic plan so that it addresses the rural specific factors or issues you listed for each component of each building block used. This should give you a list of things that should be adjusted in your policy or strategic plan and could also provide detail on how these elements should be adjusted.
4. Then list what the intended outcomes of each of these adjustments will be in your policy or strategic plan to account for rural factors. Where appropriate you could also list specific targets that if achieved will contribute to achieving your stated objectives for rural-proofing of your policy or strategic plan.

TIP: USING THE TOOL WITH YOUR SITUATIONAL ANALYSIS AND OBJECTIVES

It is important that when using the tool you have your rural situational analysis and documented rural objectives with key outcomes at hand. These should always inform how you approach rural-proofing with regard to specific policy and planning issues.
5. Once you have completed steps one to four make necessary adjustments to your policy or strategic plan in line with your stated rural-proofing actions that will address the rural issues or policy gaps you identified for each component of each building block you have chosen to use while rural-proofing.

6. The success of rural-proofing in achieving your intended objectives should periodically be assessed. You may find that there are things in your approach that could be adjusted or changed to improve implementation. This will require that adjustments to your policy or strategic plan are made over time and when the service delivery environment changes. Rural-proofing is a continuous process of fine-tuning and readjusting policy and planning to meet the needs of rural communities.

**TIP: CREATE YOUR OWN TABLES AND CUSTOMISE YOUR APPROACH**

You may find that you need to adjust the rural-proofing tool to suit your needs. This may be because you would like to add components and critical questions that are not included or simply because the tables provided do not provide sufficient space to complete the task. It may be worthwhile to create your own tables in programmes such as Excel or Word that provide you with necessary flexibility.
This building block speaks to how services will be delivered and accessed. At its core it is about how the health system links with the patient, how the patient receives care, and what the quality of that care is like.

For this building block it is important that you think about rural communities and rural patients, how they currently link to the health system and how they move through it. What is different about how people in rural settings access services and how those services are delivered?

Some important aspects of service delivery that you will need to consider are:

- **Availability:** Are services currently available in rural areas? Are all rural populations currently covered by the service/s as part of your policy or strategic plan? Is infrastructure adequate to ensure services are available?

- **Accessibility:** How and where would people access the service in rural settings? What are some of the possible barriers that relate to geography (distance and topography), cost of transport to access facilities and inappropriate service delivery approaches?

- **Continuity of care:** how will the policy or strategic plan address continuity of care across services, health conditions, levels of care and across the life-cycle of the condition?

- **Coordination:** how will the policy ensure coordination of services between providers and levels of care (e.g. Community Health Workers, clinics and hospitals)?

- **Quality of care:** how will this policy or strategic plan contribute to ensuring that services are of a high quality i.e. are they safe, effective and based on the patients’ needs in rural settings?

- **Efficiency of services:** how will this policy ensure that delivery of services is efficient with the least wastage of resources? Efficiency in service delivery in rural areas may differ from urban areas.

**KEY QUESTION**

What specific adjustments to your policy or strategic plan need to be made to overcome the barriers to accessing services in rural areas and improve the quality of care rural patients receive?
<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>CRITICAL QUESTIONS</th>
<th>RURAL ISSUE OR POLICY/PLOTTING GAP</th>
<th>RURAL-PROOFING ACTION</th>
<th>INTENDED OUTCOME/TARGET</th>
</tr>
</thead>
</table>
| Availability | • Are services included in the policy or strategic plan currently available in rural areas?  
• If they are not available or only partially available what are the factors that explain this gap (e.g. lack of infrastructure)?  
• How can your policy address coverage gaps in rural settings? | |  | |
| Accessibility | • Where will services be accessed in rural settings?  
• How will rural people access those services?  
• What are some of the potential barriers to access (e.g. transport infrastructure or cost)?  
• What are policy overcoming access barriers? | |  | |
<table>
<thead>
<tr>
<th>Component</th>
<th>Questions</th>
<th>Intended Outcome/Target</th>
<th>Rural-proofing Action</th>
<th>Planning Gap</th>
<th>Rural Issue or Policy</th>
<th>Critical Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuity</td>
<td>What is the continuity of care between providers within rural settings?</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How can these barriers be addressed?</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How can policy decisions help overcome these issues?</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

**Coordination**

- Within the health system, is there coordination across levels of care between rural and urban contexts?
- What are some barriers to effective coordination?
- How could policy decisions help overcome these issues?
<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>CRITICAL QUESTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>What are some of the challenges in rural settings with ensuring services are delivered in a manner that is effective, safe and responsive to patient needs?</td>
</tr>
<tr>
<td></td>
<td>How could the policy account for these issues and contribute to the progressive improvement in the quality of services?</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Where are areas of inefficiency and wastage in the delivery of services in rural settings?</td>
</tr>
<tr>
<td></td>
<td>How can the policy deal with inefficiency and wastage through improved supply chain processes and service delivery methods?</td>
</tr>
</tbody>
</table>
GOOD PRACTICE 3: RURAL-PROOFING SERVICE DELIVERY: USING TRANSPORT VOUCHERS TO IMPROVE ACCESS TO ANTENATAL CARE

Geographic inaccessibility and the cost of transport are one of the biggest challenges pregnant women in rural areas face in accessing health institutions for antenatal care and childbirth. There is evidence to show that improving access to health institutions and skilled care professionals can significantly reduce maternal and infant mortality.

Unfortunately, in most contexts only supply side factors are being addressed to improve service delivery at facilities without adequate consideration for demand side factors such as distance, the availability of transport, and cost.

There are relatively cost-effective options to overcome access barriers related to distance and cost of transport. In some low- and middle-income contexts, such as Bangladesh, Uganda, Nicaragua and India the provision of vouchers to pregnant women that cover the costs of transport for antenatal check-ups and delivery have proven to be effective in improving maternal and infant outcomes.

For example, in 2007 the Bangladesh government piloted a voucher scheme in 16 rural sub-districts to determine if this kind of intervention could result in improvements in access for poor women.

In 2009, an evaluation of the programme (Hatt et al., 2010) was undertaken to compare access in the 16 pilot districts with 16 control districts. The impact during the two year pilot programme was compelling:

- The rate of deliveries attended by a skilled health professional was more than double in the pilot sub-district (64%) compared to control district (27%).
- Rate of deliveries in facilities was also double in pilot sub-districts (38%) when compared to control sub-districts (19%).
- Women in the pilot sub-districts were significantly more likely to have at least 3 antenatal visits than in control sub-districts (58% vs. 37%).

KEY RESOURCE

For more information on improving access to care in rural areas read the RHAP’s, “International best practice and rural-proofing policy”.

This can be found at http://www.rhap.org.za/international-best-practice-and-the-rural-proofing-of-policy-opportunities-for-the-south-african-context/ or directly from the RHAP.
All health systems depend heavily on the skills, motivation and distribution of healthcare workers for the effective delivery of health services. A lack of human resources, an inappropriate skills mix and the inequitable distribution of human resources are amongst the most significant threats to the successful implementation of any health policy or strategic plan.

When considering this building block in terms of your policy or strategic plan it is important to think about the current state of the healthcare workforce in rural areas (numbers, skills mix, distribution, turnover, working conditions, pull factors and push factors) and what is needed to effectively meet your policy objectives. It is also important to consider each of the following aspects of this building block as it relates to other building blocks, such as service delivery, and your policy or strategic plan objectives:

- The type of healthcare workers (HCWs) needed in rural areas.
- The number of HCWs needed in rural areas.
- The number of HCWs currently in place in rural areas.
- How could HCWs be recruited to rural settings.
- How could retention of HCWs be improved in rural settings.
- What sort of training would HCWs need to improve service delivery in rural settings.

**KEY QUESTION**

What are the push and pull factors that influence recruitment and retention in rural areas? How do these factors sustain inequities in HRH numbers between rural and urban areas and how can these be overcome?
<table>
<thead>
<tr>
<th>COMPONENT CRITICAL QUESTIONS</th>
<th>RURAL-ISSUE OR POLICY/PLANNING GAP</th>
<th>INTENDED OUTCOME/PLANNING GAP</th>
<th>RURAL-PROOFING ACTION</th>
<th>CRITICAL QUESTIONS</th>
</tr>
</thead>
</table>
| Recruitment of HCWS         | How many more are needed?          | How many HCWS are needed and number currently in place         | How are the number 
HCWS needed and ... |
| Type of HCWS                | Are the type of HCWS with necessary skills available in rural settings? | Are the type of HCWS with necessary skills available in rural settings? | Are the type of HCWS with necessary skills available in rural settings? |
| Recruitment of HCWS         | How many more are needed?          | How many HCWS are needed and number currently in place         | How are the number 
HCWS needed and ... |
| Type of HCWS                | Are the type of HCWS with necessary skills available in rural settings? | Are the type of HCWS with necessary skills available in rural settings? | Are the type of HCWS with necessary skills available in rural settings? |
| Recruitment of HCWS         | How many more are needed?          | How many HCWS are needed and number currently in place         | How are the number 
HCWS needed and ... |
| Type of HCWS                | Are the type of HCWS with necessary skills available in rural settings? | Are the type of HCWS with necessary skills available in rural settings? | Are the type of HCWS with necessary skills available in rural settings? |
| Recruitment of HCWS         | How many more are needed?          | How many HCWS are needed and number currently in place         | How are the number 
HCWS needed and ... |
| Type of HCWS                | Are the type of HCWS with necessary skills available in rural settings? | Are the type of HCWS with necessary skills available in rural settings? | Are the type of HCWS with necessary skills available in rural settings? |
| Recruitment of HCWS         | How many more are needed?          | How many HCWS are needed and number currently in place         | How are the number 
HCWS needed and ... |
| Type of HCWS                | Are the type of HCWS with necessary skills available in rural settings? | Are the type of HCWS with necessary skills available in rural settings? | Are the type of HCWS with necessary skills available in rural settings? |
### Rural-proofing Action

#### Component: Retention of HCWs

<table>
<thead>
<tr>
<th>Critical Questions</th>
<th>Intended Outcome/Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the reasons HCWs leave rural areas?</td>
<td>• What are some strategies that could be used to deal with push factors?</td>
</tr>
<tr>
<td>What is needed for policy implementation?</td>
<td>• What sort of training is needed to ensure implementation in rural settings?</td>
</tr>
</tbody>
</table>

#### Component: Training of HCWs

<table>
<thead>
<tr>
<th>Critical Questions</th>
<th>Intended Outcome/Target</th>
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<tbody>
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</table>
GOOD PRACTICE 4: RECRUITMENT AND RETENTION OF HCWS IN RURAL SETTINGS

The recruitment and retention of HCWs across all categories remains one of the most significant barriers to the provision of care to rural communities. In South Africa, while 38% of the population live in rural areas only about 12% of doctors and 19% of doctors work in rural settings.

There are a number of factors that contribute to the difficulties in recruiting and retaining healthcare professionals in rural areas. These factors include: the availability of decent accommodation; professional and personal isolation; safety; career development and advancement; access to basic amenities such as schooling for children; and workload, to name but a few (Lehman et al., 2008).

In most contexts the response to recruitment and retention of HCWs in rural areas has been to provide financial incentives such as the rural health allowance in South Africa. The problem with this approach is that it only deals with one of many push and pull factors (it is not necessarily even the most important factor).

Based on an assessment of what works in the recruitment and retention of HCWs in rural areas, the WHO (2010) recommends targeted interventions in the following areas to improve recruitment and retention:

- **Education**: targeting the enrolment of students from rural backgrounds; locating training institutions outside of major cities; clinical rotations in rural settings; introduce rural specific curricula; continuous professional development for rural practitioners.
- **Regulation**: introduction of enhanced scope of practice in rural settings; introduce different kinds of health practitioners in rural settings; compulsory service in rural and remote areas; subsidized education for return of service.
- **Financial incentives**: the introduction of rural allowances and rural practice incentives.
- **Professional and Personal support**: improve living conditions; provide outreach support; provide career development programmes; development of professional networks; adopt public recognition measures.

KEY RESOURCES

For more information on improving the recruitment and retention of HCWs in rural areas you can read the WHO’s ‘Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations. Geneva: World Health Organization’ available from [http://whqlibdoc.who.int/publications/2010/9789241564014_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241564014_eng.pdf)


Information is a critical enabler for evidence-based decision making in all areas of the health system, including rural contexts. The absence of reliable and timely data on all aspects of health system functioning including input, process, output, and outcome measures means that services will not be responsive to the needs of rural populations. The effective development and revision of policy and strategic plans require that we think carefully about our specific health information needs.

This includes considering issues such as:

- The type and level of data needed: what are the key indicators that could be used in setting priorities and measuring impact?
- Sources of data: What are possible sources of data for each of these indicators? Are they available from within departmental systems or do you need to source them from external institutions?
- Analysis of data: How can available data be analysed to generate an understanding of the impact of rurality on the issues the policy or strategic plan is addressing?
- Packaging of data: How should the data be packaged to ensure it is useful for policy and planning processes?

**KEY QUESTION**

What information and data is needed to ensure that an accurate picture of rural health and rural need is developed? Are systems to collect this information in place?

Grant Difford courtesy of Africa Health Placements
<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>CRITICAL QUESTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROCESSING and planning</td>
<td>How should the chosen or policy be developed to ensure the policy is suitable for rural context?</td>
</tr>
<tr>
<td>RURAL ISSUE OR GAP</td>
<td>HOW AND WHAT DATA IS NEEDED?</td>
</tr>
<tr>
<td>RURAL-PROOFING ACTION</td>
<td>WHAT ARE THE KEY RURAL INDICATORS THAT COULD BE USED TO SET PRIORITIES AND MEASURE IMPACT?</td>
</tr>
<tr>
<td>INTENDED OUTCOME/ RURAL-PROOFING ACTION</td>
<td>WHAT ARE THE POSSIBLE SOURCES OF DATA FOR EACH OF THESE INDICATORS?</td>
</tr>
<tr>
<td>RURAL ISSUE OR GAP</td>
<td>HOW CAN AVAILABLE DATA BE ANALYSED TO GENERATE AN UNDERSTANDING OF THE IMPACT OF RURALITY ON THE POLICY OR STRATEGIC PLAN?</td>
</tr>
<tr>
<td>CRITICAL QUESTIONS</td>
<td>HOW SHOULD THE DATA BE PACKAGED TO ENSURE IT IS USEFUL FOR POLICY AND PLANNING PROCESSES?</td>
</tr>
<tr>
<td>SOURCE OF DATA</td>
<td>EVIDENCE BASED PLANNING AND IMPLEMENTATION</td>
</tr>
<tr>
<td>TYPE AND LEVEL OF DATA NEEDED</td>
<td>STRATEGIC PLANNING TOOLS AND METHODS TO BE USED TO ENSURE THAT POLICY AND PLAN ARE BUILT ON RURAL KNOWLEDGE AND NEEDS</td>
</tr>
</tbody>
</table>

GOOD PRACTICE 5: USING CELLULAR TECHNOLOGY TO CONNECT RURAL HEALTH

Reliable and readily available health information is essential for planning and management of health services. The problem, however, is that information system infrastructure is limited in rural settings, resulting in the slow flow of information from facility level, inaccurate data or the total absence of health information from rural areas.

In the long-term, the development of cheap and reliable information systems and information technology in rural contexts must be prioritised. There are, however, innovative strategies that can be deployed in the short to medium term to improve the flow of information from and to rural facilities, HCWs and patients.

Over the last decade mobile cellular technology has become ubiquitous even in some of the most remote rural settings across the globe. This technology is not limited by fixed infrastructure beyond cellular masts and handsets have become commonplace in many households. Cellular technology not only offers voice connectivity but also allows for data connectivity and Internet access.

In South Africa a mHealth programme was introduced in 2011 to support the rapid capturing of data as part of the governments HIV Counselling and Testing Campaign (HCT). The system used cellular technology to immediately capture patient data and feed it into a surveillance system. Subsequently this system is being piloted in ward based outreach teams to facilitate real-time capturing during home visits into the District Health Information System (DHIS).

In India, a Mother and Child Tracking System that uses a mobile platform that is provided to community health workers to register pregnant women in rural areas is being used to ensure that these women and their babies receive all basic health services (antenatal check-ups, postnatal visits and vaccinations). A similar system is being piloted in Uganda, which uses simple SMS technology to ensure that all births are registered and tracked on government information systems by community health workers (Labrique et al 2013).

Kenya was the first country in sub-Saharan Africa to introduce a completely online health information system online. Since 2011 all health districts and many facilities have been connecting to the system using mobile technology including cell phones. After the first year, reporting rates for monthly forms was above 90%.

KEY RESOURCES


For health system data and statistics visit the HST [http://www.hst.org.za](http://www.hst.org.za)
BUILDING BLOCK 4: ACCESS TO ESSENTIAL MEDICINES

Access to essential medicines is most often a basic component of a health intervention. We have seen with HIV and TB the absences of medicines or their irregular supply can have dire consequences for patients. Medicines are therefore a foundational aspect of access to healthcare. As with other aspects of service delivery, rurality may pose a number of challenges to the supply and accessing of medicines.

When considering access to essential medicines it is important that you understand this building block in relation to others. In terms of service delivery, for example, think about how medicines are provided to patients and the barriers that rural patients face in accessing these and adhering to treatment. In terms of governance, you could consider what role supply-chain management plays with regard to ensuring the predictable supply of medicine to rural clinics and hospitals. For example:

- **National policies, regulations and guidelines:** do these medicines’ policies and guidelines consider the rural conditions and needs?
- **Procurement, supply and storage, and distribution systems:** what factors in rural settings could result in delays in the procurement and supply of medicines and what are the factors that could result in leakage and waste?
- **Support for rational use of medicines:** what are the factors that would affect adherence to treatment in rural areas?

**KEY QUESTION**

What are the main barriers to reliable access to medicines in rural areas? Are these problems as a result of the supply chain or how patients access where medicines are provided?
<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>CRITICAL QUESTIONS</th>
<th>RURAL ISSUE OR GAP</th>
<th>RURAL-PROOFING ACTION</th>
<th>INTENDED OUTCOME/TARGET</th>
</tr>
</thead>
</table>
| Medicine’s policy, standards, guidelines and  | • Do relevant medicine’s policies and standards explicitly account for rural conditions or need?  
• If not, what do you think is missing?                                                                                                             |                   |                        |                        |
| regulations                                    |                                                                                                                                                                                                                  |                   |                        |                        |
| Accessibility and availability of medicines   | • What do you think could be some potential difficulties patients face in accessing medicines in rural settings?  
• Does your policy or strategic plan currently account for these barriers (e.g. distance to hospitals)?  
• How could it improve accessibility for rural patients?                                                                                         |                   |                        |                        |
<table>
<thead>
<tr>
<th>Component</th>
<th>Critical Questions</th>
<th>Intended Outcome/Target</th>
</tr>
</thead>
</table>
| Procurement, supply and storage of medicines (availability) | • What are potential risks to the adequate supply of medicines to rural facilities?  
• Are there deficiencies in the storage and management of medicines within rural facilities?  
• What are the causes of these weaknesses that could lead to leakage and wastage? |  |
| Patient support and adherence |  
• Are there systems or structures in place to promote adherence to treatment in rural settings?  
• If so, what is working and what is not?  
• If there are no systems or structures in place, what could be done to support better adherence? |  |
GOOD PRACTICE 6: CENTRALISED PACKAGING FOR DE-CENTRALISED PROVISIONING

Access to basic medicines remains one of the most significant barriers to good quality healthcare in rural settings. On the demand side, distance and cost of transport can make it difficult for rural patients to access points (facilities and pharmacies) where medicines are provided. On the supply side, weaknesses in supply chain management processes in rural settings often render the supply of medicines unreliable and can result in stock shortages of even the most basic supplies.

Difficulties in accessing medicines are felt particularly by rural patients receiving antiretroviral therapy (ART). Patients on ART are often required to refill scripts on a monthly basis and are required to travel long distances to health facilities to make collections. Any delays in the provision of these medicines could have potentially catastrophic consequences for rural patients.

In response to difficulties associated with the supply of ARVs to rural patients, a district hospital on the Wild Coast in the Eastern Cape started a process of pre-packaging ARVs for each patient in the service area of the hospital at a central location before sending them to clinics for collection by patients. As part of this process, not only are ARVs pre-packaged, but pharmacists at the hospital also include all of the patient’s chronic medications so that they don’t have to make multiple trips to a facility to collect repeats of different scripts.

The advantages of pre-packaging are that patients simply need to collect their packages from their preferred clinic and do not need to wait for processing at the facility. Nurses no longer have to process patients and are able to attend to other work and patients no longer needed to wait for a pharmacist to package their medicines.

Centralised packaging also helps to ensure consistency and reliability in the supply of medicines to patients. Decentralised provisioning then helps to improve access for patients who can predict when their medicines are available and can trust that they will be at the facility when needed.

KEY RESOURCES

For more insight into some of the challenges in supplying and accessing medicines in rural areas go to http://www.stopstockouts.org
Financing and budgeting are amongst the most important features of ensuring the successful implementation of any policy or strategic plan. Without sufficient resources and the appropriate management of these resources a policy cannot be fully or effectively implemented. This is particularly relevant in the case of policies or strategic plans that will be implemented in rural contexts. Owing to the fact that the financial and cost factors associated with implementation in rural settings have not been fully considered in the past, implementation in rural settings tends to be under or inappropriately funded.

Key factors that you should consider when designing a policy or strategic plan with the rural context in mind are:

- **Rural cost of the policy or strategic plan and its components**: have the costs of implementation in rural settings been considered during design? Are potentially higher costs due to the effects of geography (distance and longer travel times) for patients (e.g. cost of transport), health workers and supply chain considered? Are higher per patient costs associated with diseconomies of scale in rural areas factored in during design?

- **Integrating rural into budgets for implementation**: are the higher costs associated with policy implementation factored into departmental budgets at all levels? Are there alternative service delivery methods for critical components of the policy/strategic plan that could save costs (improve efficiency) while maintain/ improving access and effectiveness?

- **Expenditure of budget**: Are there mechanisms in place that can determine if expenditure for implementation in rural settings is equitable, effective and efficient? How could this information better be integrated into information and governance systems?

**KEY CONCEPT: DISECONOMIES OF SCALE**

In the context of rural health financing diseconomies of scale refers to a situation where the per capita cost of providing services in rural areas increase as outputs increase. This is because it takes more resources to achieve the same outputs in rural areas as it does in urban settings. This is due to factors such as longer distances to facilities and lower population densities.
<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>CRITICAL QUESTIONS</th>
<th>RURAL ISSUE OR GAP</th>
<th>RURAL-PROOFING ACTION</th>
<th>INTENDED OUTCOME/TARGET</th>
</tr>
</thead>
</table>
| Rural cost of policy and its components | • Have costs of implementation in rural settings been considered during design?  
  • Have patient costs associated with access in rural settings (e.g. transport) been considered?  
  • Have health worker costs been factored in to account for factors such as outreach?  
  • Have costs associated with rural HCWs allowances been considered?  
  • Have additional supply chain costs associated with distance to facilities been accounted for?  
  • Have diseconomies of scale been considered? | | | |
### Rural-proofing for Health: Using World Health Organisation (WHO) Health System Building Blocks as a Guide

<table>
<thead>
<tr>
<th>Rural Issue or Gap</th>
<th>Critical Component</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural-proofing for health interventions</td>
<td>Budget on policy</td>
<td>• Have rural costs been factored into departmental and facility budgets?</td>
</tr>
<tr>
<td></td>
<td>Expenditure of budget</td>
<td>• Are there alternative service delivery arrangements where there is budget leakage and inability to deliver, resulting in increased costs?</td>
</tr>
<tr>
<td></td>
<td>Expenditure effectiveness</td>
<td>• Is expenditure between districts/sub-districts equitable?</td>
</tr>
<tr>
<td></td>
<td>Expenditure efficiency</td>
<td>• Is expenditure effective?</td>
</tr>
<tr>
<td></td>
<td>Expenditure of policy components</td>
<td>• Are there budget constraints and critical departmental factors that have resulted in rural-proofing of action?</td>
</tr>
</tbody>
</table>

**Intended Outcome:** Improved, accountable, efficient, and effective delivery, with minimal costs where used to reduce the costs of health policy interventions.

**Target:** Rural-proofing for health.
GOOD PRACTICE 7: ACCOUNTING FOR RURAL IN POPULATION BASED FUNDING FORMULA

There are many examples of health systems that are currently implementing or developing population-based formulas as a mechanism for allocating resources between health authorities (e.g. health districts) and/or facilities. While all of these use population size as a basic component they tend to vary in structure, complexity and the number and type of demographic, utilisation, need and cost adjustment factors.

Included amongst the many various examples of population-based formula being implemented in low- middle- and high-income settings around the world are a few good examples of formulas that include factors that explicitly attempt to address differences between urban and rural health settings in terms of need and/or cost.

Kenya: The Kenyan government uses a resource allocation formula that includes variables that are weighted for factors of rurality. These factors include, amongst others, poverty rates, under-5 population, number of women of reproductive age, area of the district (sq. km.) and for fuel costs to account for distances for outreach (Chuma and Okungu, 2011).

India: In India the National Rural Health Mission (NRHM) has advocated for the increase in government spending on PHC infrastructure in rural areas by developing and supporting the implementation of an allocation formula where the division of revenue for health service delivery between states is weighted in favor of those with relatively poor health indicators. In some states this formula has resulted in a three-fold increase in government spending on rural infrastructure (Durairaj and Evans, 2010).

Zambia: Zambia makes use of a deprivation index to ensure greater equity in the allocation of resources. This index includes variables that account for differences between urban and rural including measures of poverty, disease burden, access to basic services and a measure of the availability of healthcare personnel per capita.

KEY RESOURCES

For more detail on accounting for rural in financing and budgeting you can access the RHAP’s ‘International best practice and rural health financing’ here: http://www.rhap.org.za/financing-rural-health-international-best-practice-options-south-african-context/
BUILDING BLOCK 6: GOVERNANCE AND LEADERSHIP

The implementation of policies and strategic plans that achieve intended goals and objectives are often determined by the strength of governance systems and the quality of leadership. Governance and leadership encompasses planning, decision-making, oversight, performance management and relationship building (between institutions, stakeholders, communities and individual patients). Critically, governance and leadership is a crosscutting component and should be understood in relation to all other building blocks.

When considering this building block in terms of rural contexts, you should think about the following areas:

- **Delegation of authority:** Is authority to make decisions delegated to the right level? Is it necessary to have different delegations for rural and urban districts/sub-districts/facilities?
- **Oversight:** Are effective oversight systems in place? Is it more difficult to provide oversight in rural settings (e.g., supply chain management processes)? How could oversight be improved where facilities are far apart?
- **Performance monitoring:** Are performance-monitoring systems in place? Are there factors that affect performance that are specific to rural settings that need to be addressed in particular ways?
- **Stakeholder engagement:** Are stakeholders such as patient groups, civil society and other departments consulted during planning and are they part of governance and oversight structures (e.g., clinic committees)? Does stakeholder engagement differ in rural settings from urban settings?

KEY QUESTION

Is governance and oversight more difficult in rural settings than in urban settings? Are greater distances to facilities in rural areas from administrative centres a factor? Could decentralisation and the delegation of authority help overcome these barriers?
<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>CRITICAL QUESTIONS</th>
<th>RURAL ISSUE OR GAP</th>
<th>RURAL-PROOFING ACTION</th>
<th>INTENDED OUTCOME/TARGET</th>
</tr>
</thead>
</table>
| Delegation of authority (who is responsible) | • Is authority to make decisions delegated to the right level?  
• Is it necessary to have different delegations for rural and urban districts/sub-districts/facilities?  
• How would the delegation benefit/hinder processes in rural settings? | | | |
| Oversight responsibilities | • Are oversight systems and processes currently in place effective in rural settings?  
• How could oversight of processes (e.g. supply chain) and service delivery be improved in rural settings? | | | |
<table>
<thead>
<tr>
<th>Component</th>
<th>Critical Questions</th>
<th>Intended Outcome/Target</th>
<th>Rural-Proofing Action</th>
<th>Rural Issue or Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement and stakeholder engagement</td>
<td>- Are performance-monitoring systems in place and functional in rural settings? &lt;br&gt; - Do performance-monitoring systems exist and are they functional in rural settings?</td>
<td>- Are stakeholders such as patient groups, civil society, and other groups involved in rural contexts? &lt;br&gt; - Does stakeholder engagement differ in rural settings from urban settings?</td>
<td>- How could performance-monitoring systems be improved in rural settings?</td>
<td>- How could stakeholder engagement be improved in rural settings?</td>
</tr>
</tbody>
</table>

*Health System Building Blocks as a guide*
GOOD PRACTICE 8: COMMUNITY PARTICIPATION IN DECISION-MAKING AND OVERSIGHT

South Africa’s National Health Act (2003) provides for the establishment of clinic committees to give effect to the principles of community participation in health system governance and oversight at the district and facility level. The Act requires that legislation be passed at the provincial level that outlines the specific role and functioning of such bodies. While this legislation has not been enacted in most provinces, clinic committees are in place in many facilities. The absence of clear regulations on their functioning and a shortage of resources to support their work have meant that many are dysfunctional (Glattstein-Young, 2010).

Overcoming weaknesses with the functioning of these committees, which includes clear guidelines and resourcing, could have significant benefits for rural health. Research has shown that community participation in rural healthcare in structures such as facility committees has been beneficial in rural contexts in the UK, Europe, Asia and Australia (Kenny et al, 2013). Benefits have been particularly significant with regard to:

- Communication and awareness raising around services offered at facilities
- Greater accountability in the management and use of available resources
- Redesign of service delivery methods and options to better suit community needs
- Improved social support for healthcare workers
- Engendering as sense of ownership of the local health system within the community

With PHC re-engineering under way and health system reform high on the agenda in South Africa, clinic committees provide an important structure to assist in local level planning, oversight and awareness raising within the local context.


Glattstein-Young, G. S. (2010). Community health committees as a vehicle for participation in advancing the right to health.


### Introduction

**What is rural proofing?**

**Key facts and figures: rural health in South Africa**

**Defining rural for the purposes of rural-proofing health policy**

**How to rural-proof health policy**

**Define the issue: think rural**

**Set priorities: what should rural-proofing achieve**

**Rural-proofing for health: using World Health Organisation (WHO) Health System Building blocks as a guide**

- **Building block 1:** Service delivery
- **Building block 2:** Health workforce
- **Building block 3:** Health information systems
- **Building block 4:** Essential medicines
- **Building block 5:** Financing and budgeting
- **Building block 6:** Governance and leadership