# Innovations that have transformed the health system in South Africa

## EXECUTIVE SUMMARY

### The contribution of The Atlantic Philanthropies Population Health Programme to Primary Health Care and Human Resources for Health from 2004 to 2016

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## Background

South Africa is a middle-income country of 55 million people that has been characterised for generations by extreme contrasts of wealth and poverty, racial diversity and health status. Despite having gained political freedom for the majority of its people in a peaceful democratic transition in 1994, South Africa remained in a state of tension and conflict because of persistent disparity.

In the early 2000s, South Africa was gripped by quadruple epidemics: (1) escalating HIV and AIDs infections and deaths; (2) maternal and child disease; (3) non-communicable conditions and diseases such as cardio vascular disease, cancer and mental illness; and (4) deaths from injuries.

To make matters worse, the overall performance of the health system in the ten years since the democratic transition had been poor despite the development of good policy and relatively high spending on health (8.5% of GDP). For a variety of reasons, services remained disproportionately fragmented between the public and private sectors, which served 84% and 16% of the population respectively. This maintained the sharp inequalities in health experienced by the poor, primarily because the private sector was well funded in relation to the public sector.

The country was also plagued by a shortage of health professionals trained and willing to work in rural areas where many South Africans lived. In addition, the health system in South Africa was crippled by weak management at all levels, including the district level where primary health care services are most often delivered.

The Atlantic Philanthropies, which had been working in South Africa since 1994, launched a population health programme in 2004. Atlantic's goals were to secure the fundamental right to health for all citizens and to improve the health and well-being of the most vulnerable. To do so, Atlantic focused its investments on:

- Improving human resources in health. Funding supported key institutions that would train and place a cadre of health professionals to work in the areas that needed them most, especially rural South Africa or informal settlements. Atlantic sought to improve the training, distribution and retention of health professionals, particularly nurses, in the health sector.
- Developing primary health systems. Atlantic's funding sought to strengthen primary health care at the district level where most of South Africa's health care is delivered.
- Amplifying the voices of disadvantaged and vulnerable populations in the health system. Grants supported the monitoring of the implementation of health care policies to ensure that the government adhered to the promises of the country's Constitution.

Over more than a decade, Atlantic invested R1.7 billion ($177.9 million) supporting over 100 initiatives through its population health programme.

## Impact Evaluation

Atlantic commissioned an impact evaluation to share lessons and encourage innovation. This study involved the use of quantitative and qualitative methods. Most of the projects included had also been independently evaluated and this has provided a particularly rich source of information. Predominantly, however, participatory action research was undertaken using an appreciative inquiry approach involving key informant interviews combined with desk top review of annual reports and available information.

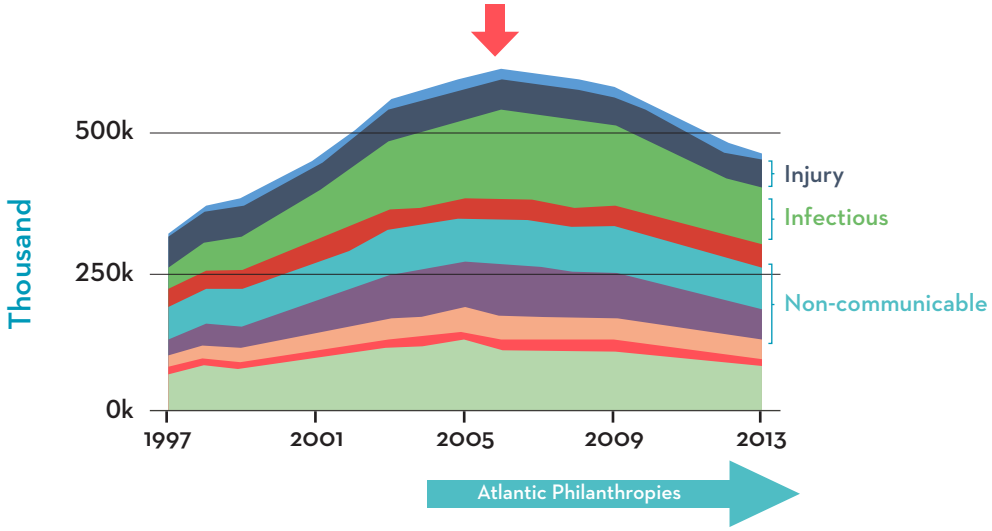
1 Friedman I. *Innovations that have transformed the health system in South Africa: Executive Summary,* Atlantic Philanthropies, New York, 2019 www.atlanticphilanthropies.org

## Overall Findings

Findings from the evaluation reveal an extraordinary turnaround in the health of the country over little more than a decade as is shown in the following figure. The rising mortality which reached its peak in about 2006 began to fall. Many interconnected factors led to these changes, including the actions of the South African Government as well as those of a range of support agencies. While it is not possible to attribute these changes to the interventions funded by The Atlantic Philanthropies, there is little doubt that it made an important contribution. Perhaps the use of the word "transformative" with health services might sound too optimistic suggesting that all is now well with the health system, which is far from the case. But as the mortality trends below reveal, disaster has been averted and progressive realisation of improved health should be possible.

# Mortality trends (2013)

**The Quadruple epidemics: (1) HIV/AIDS (including tuberculosis); (2) non-communicable conditions (3) injury and (4) maternal and child disease that had been increasing since 1997 began reversing**




*Source: Stats SA*

The evaluation investigated more than twenty new replicable, scalable and sustainable primary health care and health workforce interventions funded by Atlantic. These revealed many examples of successful health promoting advocacy and programme interventions which have undergone much innovative testing, revealing considerable evidence of profound policy reform and system-wide changes. They are certainly a legacy of programmes here upon which continuous progressive change can be built.

The following figure shows diagrammatically how Atlantic's 'big bet' of investing in a population health programme aimed at improving human resources for health, public health care and giving voice to the marginalised in South Africa resulted in three streams of activity. These in turn led to a synergistic stream of approaches and a matrix of outputs that have addressed many of the deeply systemic challenges to the national health system. The possibility of building a National Health System to provide universal health care for everyone has emerged as a realistic prospect and could be part of the legacy left by the Atlantic investment.

The rest of this report examines in more detail each of the individual interventions as contributions to this legacy.

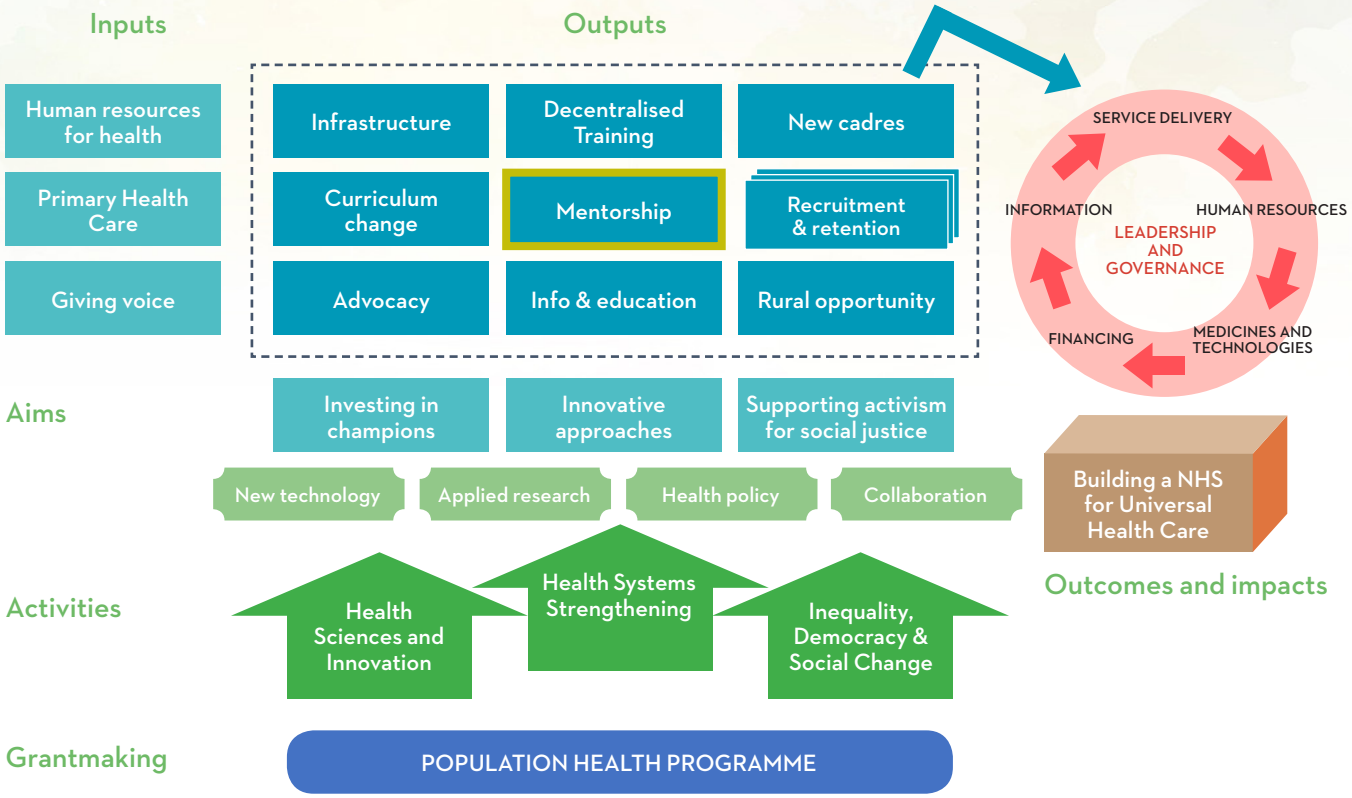



*Figure 1: Summary Input, Activities, Output and Impact Matrix for The Atlantic Population Health Programme (2004-2016)*

## Improving Human Resources in Health

### Nursing education and scholarship—strengthening the backbone of the health workforce

Professional nurses have always provided the backbone of the health workforce in South Africa but for a variety of reasons the production numbers declined and the competencies of new recruits to this critically important health cadre fell short of expectations in the first decade after 1994. In addition, nurses were leaving South Africa in droves for better opportunities, exacerbating the nursing shortage.

The Democratic Nurses Organisation of South Africa (DENOSA), the Nursing Education Association (NEA) and The Forum for University Nursing Deans in South Africa (FUNDISA), working with nursing colleges and university nursing departments throughout the country, have shown in a range of settings that innovative teaching can strengthen nursing education, thus strengthening academic scholarship as well as the production of nursing graduates.

Much of Atlantic's focus in nursing sought to strengthen universities and nursing colleges often located in rural and poor areas that were experiencing severe shortages of nurses. Atlantic's investments funded new facilities, nursing programmes, curriculum development, faculty positions, and community-based training programmes.

As an example, prior to Atlantic's funding, South Africa had few programmes dedicated to providing undergraduate degree that trained nurses to work in primary health care, and in particular rural areas. Most of nurse training had previously mainly focused on hospital-based care with perhaps the odd module devoted to community-based care. The influence of Atlantic helped to shift the emphasis of larger groups of nurse training institutions towards a population-based approach, including an emphasis on community-based primary health care.

Atlantic supported the Durban University of Technology to create South Africa's first four-year nursing primary care training programme. Nursing students train out of a campus that serves rural communities and get much of their experience working in community-based health centres. The programme also seeks to produce independent thinking professionals who can work in primary care in areas where there is a shortage of primary care doctors. Some 375 nurses graduated between 2013 and 2016.

In South Africa, before a new educational programme can receive government funding it must provide a two-year track record of effectiveness as well as accreditation. With Atlantic's support to prove the effectiveness of this approach, government began funding the undergraduate nursing programme in 2012. The programme is also serving as a model for other nursing programmes.

The number of nurses in South Africa increased dramatically by 44% between 2005 and 2011. Fulfilling Atlantic's hopes to make a meaningful contribution, its nursing sector grantees produced about half of all new nurses. In terms of the official South African Nursing Council records, the growth of nurses continued at an encouraging rate with a further increase of 16% over the five-year period from 2012 to 2016.

Although the evidence regarding mass emigration of nurses discussed above is equivocal, by the end of 2016 only 2,158 of registered nurses requested verification letters from South African Nursing Council, which are needed to secure employment outside of the country. This suggests that less than 1% of nurses had left South Africa to work in other countries.

Perhaps the most specific outcome of this work was increased government funding and commitment to nursing education. While not all of this change can be attributed entirely to Atlantic, there is strong evidence that its work contributed to the government's decision to provide an additional US$120 million to the sector from 2013 to 2017 to further develop nursing colleges and build homes to house nursing students. This was a multiplier effect of almost four times the magnitude of the amount spent by Atlantic.

## Effectively recruiting and retaining health personnel

Recruiting and retaining a competent health workforce to serve in rural and marginalised public health settings has been one of South Africa's most challenging issues.

African Health Placements (AHP) developed an effective, efficient and replicable model for recruiting foreign qualified and local private sector health professionals and placing them in the rural public health sector.

In just over a decade, 4,097 health workers were recruited and placed, which resulted in an estimated 30 million consultations. Despite challenges, the value of the placements was evident in that 75% of facilities judged the placements as excellent, good or satisfactory. In addition, AHP's retention programme, aligned with the Department of Health's human resources policies, addressed some of the underlying causes of high attrition rates in rural hospitals and ultimately this helped to create a more sustainable workforce in rural South Africa. Since 2014, AHP has equipped over 14,000 managers to improve their retention of health workers.

## Cultivating a passion for science & maths

In the past, most poor rural students found the sciences daunting, and few were able to gain entry into competitive health professional training programmes.

The Unizulu Science Centre provides a lively interactive learning centre and outreach programme to foster science and maths for science educators and secondary school learners in mainly the poorest northern districts of KwaZulu-Natal (KZN) Province, where poverty and health inequality have been endemic. This has provided an important stimulus to inspire rural students to undertake careers in the health sciences. The Unizulu Science Centre was able to reach about a quarter of KZN's education regions which consisted of about 550 secondary schools.

## Ensuring high success rates among rural undergraduate health science students

One of the most challenging areas in developing the health workforce has been finding a way to increase the number of health professionals who are committed to working in rural communities over a number of years. Training young people from such rural areas could be an ideal way to nurture a locally-grown workforce that will remain and serve their communities for years to come.

The Umthombo Youth Development Foundation, working in roughly the same area as the Unizulu Science Centre, demonstrated the remarkable synergy between two Atlantic initiatives. Umthombo is a rural health recruitment, mentoring and financial support programme to enable young rural tertiary students to qualify as health professionals. It does this by recruiting high school graduates into careers in the health sciences and then comprehensively supporting them through their entry to higher education until graduation and beyond, helping many disadvantaged rural students to succeed in fulfilling their dreams of becoming health professionals. Many of those students participated in the Unizulu Science Centre programme when they were in secondary school. This demonstrates the potential that community-based science teaching could play in encouraging disadvantaged students to take up careers as health providers in their own communities.

Umthombo showed that with the appropriate undergraduate mentoring and support, rural and disadvantaged health science students could achieve exceptional results in a wide range of tertiary health science settings including notably medicine and nursing. Some 93% of Umthombo's students graduated from tertiary health science institutions, all of whom came from disadvantaged backgrounds (compared to national graduation averages below 50%).

Encouragingly, some 70% of these graduates then subsequently returned to work in their sponsoring rural hospitals, which were desperately in need of their services. In a period of only 14 years Umthombo added 218 health science graduates (57% women) working in 15 different disciplines. There was a profound lesson to be learned from what they discovered – mentorship and comprehensive support were the cardinal interventions to achieving high levels of professional education success.

The impact of the programme has been substantive. The 218 graduates of Umthombo have provided sufficient staff for nine rural hospitals and sufficient doctors for five rural hospitals.

## Rural-trained doctors competent to serve in disadvantaged settings

Most medical schools follow conventional, teacher-centred, hospital-centric curricula that have a long history of producing graduates equipped to work in affluent settings rather than disadvantaged communities. These programmes are costly to scale up and as a result there has been a chronic shortage of doctors in South Africa.

The Health Sciences Faculty of the Walter Sisulu University (WSU) in the Eastern Cape Province has demonstrated that a problem-oriented learning/community-based education (PBL/CBE) approach to medical education was not only feasible but that it could readily be scaled, even in resourced-constrained settings. PBL/CBE are contemporary, best-practice student-centred medical education pedagogies in which students learn about a subject through the experience of solving an open-ended problem found in material designed to grab a learner's interest. Ideally this work takes place in a community setting similar to that in which the student may one day work as a practitioner. Early in its funding approach to strengthen the health system in South Africa, Atlantic recognised this approach as the most appropriate method for its investments in medical and health sciences education.

The results have been encouraging. The WSU has increased its output of doctors since its inception as a new rural medical school in 1990. Of the 935 doctors who have graduated since inception, only 111 did so on the traditional medical curriculum track in the first five years (1990-1996), the remaining 340 (a 206% increase) graduated on the innovative PBL/CBE 6-year curriculum (1997-2004); and 484 (a 42% increase) doctors on an even more innovative and integrated PBL/CBE 5-year curriculum (2004-2013). Given South Africa's shortage of doctors and the need to send medical students to study in Cuba, these findings vindicate Atlantic's conviction that supporting the alternative problem-oriented learning/community-based medical education approach was important.

## Clinical Associates provide health professionals where there are insufficient doctors

In the face of persistent shortages of doctors to work in the public health system, mid-level workers have been proposed as a solution to the problem. Given that a mid-level worker could be more quickly and inexpensively trained and less likely to emigrate than doctors, training such a cadre of professionals could assist in making better quality professional care available in rural and other marginalised communities.

The Water Sisulu University (WSU) Clinical Associates Programme and the Wits Centre for Rural Health (WCRH) district rural health campus for multi-professional training were given grants to develop this new cadre of mid-level worker, which are similar to physician assistants. Both have shown the potential of these new cadres to render professional health services in areas where there are insufficient doctors. All 23 (100%) of the first intake of WSU Clinical Associates, trained in rural settings in the competencies necessary to manage uncomplicated conditions, graduated with bachelor degrees, obtained posts supervised by medical practitioners and were well accepted in clinical practice, resulting in significantly replacing the need for doctors in outpatient departments and health centres.

The WCRH developed a similar rural multi-professional learning site in the North West Province. Their training approach added a further 34 Clinical Associates students. Further encouragement can be drawn from the establishment of The Professional Association of Clinical Associates in South Africa to advocate on behalf of Clinical Associates in South Africa.

## Schools of public health train health activists and public health personnel

Important as the role of clinicians in hospitals and clinics has been, the most significant gains in health awaited the development of public health personnel trained to address the powerful social determinants of health, which when correctly implemented, have the dramatic potential to promote health and prevent illness on a massive scale. To enable South African academic institutions to enrol more students in their schools of public health, expand research capabilities and generate knowledge to inform government policies and public health programmes, Atlantic invested in four schools of public health.

The stories of the University of the Western Cape School of Public Health (UWC SoPH), a newly emerging School of Public Health, and a traditional centre of excellence, the Wits Schools of Public Health (WSoPH), are illustrative.

The grants to UWC's School of Public Health enabled the university to build a state-of-the-art building and attract new teaching staff, which increased the faculty from four permanent posts to a team of nearly 100 people.

The UWC SoPH student numbers expanded in tandem to the growth of the staff and by 2012, there were 218 Masters and 27 Ph.D. students enrolled—the largest number in South Africa – as well as 3,000 public health managers who had completed short courses. By 2016, some 12,000 participants from South Africa and other African countries, mostly sponsored by their health services, had attended Winter or Summer Schools, probably the largest continuing public health education programme in Africa.

The Wits School of Public Health (WSPH) located in Johannesburg also achieved notable outcomes in terms of not only building a new school of public health but transforming the demographic profile of its senior academics in favour of black women, significantly contributing to the emerging cohort of a new generation of public health leaders and professionals.

They also established a fellowship programme for health leaders, developed a formal mentoring system for district health managers, enhanced the capacity of clinic committees and hospital boards and undertook advocacy for the recognition of public health as a core requirement for employment as a district manager as well as increasing the enrolment in a master's degree in epidemiology programme.

A Legacy Student Programme increased the throughput of public health trainees seeking their master's degrees who, for one reason or another, had not made significant progress to completing their qualifications. In 2014, a third of all their post-graduates were made up of this previously underperforming group.

## Boost in the output of executive health managers

As in all sectors, the competence of management has the greatest potential to optimise the performance of the public health system. At the time of Atlantic's investments in South Africa, local and district health systems were receiving substantial funds from the national government for primary health care but lacked the management experience to make effective use of these funds.

Two programmes, the University of Cape Town's Oliver Tambo Fellowship (OTF) and the Albertina Sisulu Executive Leadership Programme in Health (ASELPH) made significant strides in partnership with the national and provincial departments of health, strengthening the role of senior and middle management within the health sector.

The OTF Programme, which offered a Post-Graduate Diploma in Health Services Management, established a highly reputable track record with over 200 alumni. Between 2012 and 2014, it had 28 graduates, which an independent evaluation reported were demonstrating commitment to applying what they learned in the field by participating in a community of practice and sharing both a common ethos and approach to dealing with similar challenges in the workplace. The graduates developed leadership skills as well as specialisations in particular areas of management, guided by the principles of health as a human right.

Similarly, ASELPH offered formal executive leadership training by the University of Pretoria and the University of Fort Hare, which provided practical evidence of the potential of the three academic partner institutions, supported by the Department of Health working at great distances from each other, to collaborate effectively to offer an interesting pedagogical approach. The approach combined an interactive teaching model which stressed vigorous participation, group work and feedback with a distance learning approach

Initial throughput rates for the programme have been sound. Between 2013 and 2015, in its first three annual cohorts, ASELPH had enrolled a total of 178 trainees. Of the first cohort of 48 Fellows, 90% successfully completed the Post-Graduate Diploma in Health Services Management offered by the University of Pretoria.

Just over two thirds (68%) were "emerging" Fellows with "executive" Fellows comprising the balance (32%). This meant that twice as many of the leaders being developed by the programme were at the emerging level, consistent with the strategic gap in the system. A total of 193 Fellows and 48 graduates have been produced in 49 health districts of all nine of South Africa's provinces – evidence of an extensive outreach programme. Together the OTF and ASELPH programmes have offered health managers advanced technical skills to develop high quality management and build a new generation of inspired leaders to transform the South African health system.

# Developing Primary Health Systems

## Re-engineering primary health care

Primary health care has long been recognised as the most critical foundational philosophy underpinning the provision of universal health coverage. Despite rhetorical commitment to primary health care in policies and despite the mandate provided for within the National Health Act (2006), in practice primary health care was inadequately implemented in the first decade and a half since 1994. It was broadly understood that the reason for this was not the lack of policy, but of an implementation framework that required a much more radical coordinated commitment of multiple stakeholders.

This was the situation which existed when the current National Minister of Health, Dr Aaron Motsoaledi, assumed office in May 2009. Committed to the transformation of health action at the highest level of government, he was aware that achieving this would depend on a collective commitment not only of the National Minister of Health, but colleagues heading national and provincial departments.

Recognising the important opportunity for galvanising national health transformation, a collaboration between The Atlantic Philanthropies, the Henry J. Kaiser Family Foundation and the Health Ministry led to an innovative development programme for health politicians, provincial legislators, national executive managers, provincial heads of departments and other thought leaders.

In 2010 Atlantic partnering with the Kaiser Foundation took a high–level delegation for a 10–day study visit to Brazil, led by South Africa's Minister of Health. What they learned was eye-opening. On their return, they committed themselves to a sustained process of health systems reform, which was named "the Primary Health Care Re-Engineering Programme". This has since led to a profound change in health system policy and a recommitment to the process of revitalising primary health care in the country.

## Building rural capacity for excellent teams

Although South Africa made rapid progress after 1994 in providing improved physical access to health services, the resistant challenge remained the quality of care provided.

The Centre for Rural Health (CRH) at the University of Kwa-Zulu Natal provided excellent examples of best practices in helping rural teams to make notable achievements in providing primary health care and improving hospitals in under-resourced, rural settings. They have shown that to achieve this, a range of complementary health system strengthening actions need to be simultaneously implemented at the district level.

One good example of such systems-wide interventions was the "Learning Complex" project, which set out to develop and stimulate a culture of learning within the health service in three rural health districts. A total of 46 managers divided into groups of 5 to 6 managers met approximately every six weeks, which provided a protected space for reflective practice through action-learning around issues that the participants identified. Through this process, the participants worked on some of the most intractable issues they faced and came away with a renewed sense of confidence that no challenge was too great to tackle.

## Strengthening district health teams

The overall performance of the National Health Service since 1994 has been disappointing despite the early development of good policy and relatively high spending on health (8.5% of GDP). By focusing on strengthening the health system at the district level, which oversees much of the provision of health care services, Atlantic believed the entire health system could benefit.

The Health Systems Trust (HST) demonstrated the considerable additive impact of collaboration between itself as an NGO, research agencies, government and private sector to strengthen district activities such as building the capacity of managers to work with communities.

As just one example of best practice in collaboration, *HST assisted the North West Province to successfully introduce many system-wide improvements.* Those improvements included maintaining an active register of pregnant and postnatal women, improving their links with the closest public health clinic and community health workers and following up with them regularly to increase the number of antenatal and postnatal visits. HST also helped the district implement a system to identify people with chronic illnesses such as tuberculosis, HIV, diabetes and mental illness who needed to attend clinics regularly as well.

## Health reviews informing practice

National, provincial and district managers have often struggled to implement services in the absence of useful and valid information.

*HST was also able to demonstrate the potential of information to inform practice.* As just one of many innovations HST introduced the District Health Barometer (DHB), a publication whose purpose was to enable managers and health care professionals to measure, monitor and understand the changing health profile, improve primary health care and forecast future circumstances.

In the four years of its evolution, the DHB developed from a pilot concept in 2003/04 using 15 health indicators with simple, basic descriptions into a much more mature publication, providing rigorous, comprehensive cross-sectional analyses using 30 indicators to cover 53 health districts, 6 metropolitan areas, 13 rural nodes and 9 provinces.

It also offered unique deprivation indices for all the districts, providing a sound basis for beginning to address the social determinants of health. In an evaluation of its impact, the evidence showed the DHB had been demonstrably valuable, even if not perfectly used, by South African health managers at the national, province and district level. Encouragingly, the Department of Health itself made extensive use of the DHB over the four-year project period in a number of areas, including developing new policy, strategic and operational planning as well as providing information for local, regional and international presentations.

## Strengthening electronic information systems at the primary health care level

Paper-based systems for recording, retrieving and managing patient records have been hugely problematic in health facilities.

The Africa Centre for Health and Population Studies investigated whether an interactive and integrated electronic primary care information system (PCIS), implemented at six public primary care clinics in the Umkhanyakude District in collaboration with the KwaZulu-Natal Provincial Department of Health could improve the situation. They tested the feasibility of introducing a simple primary care information management system for staff with little or minimal previous computer experience.

They found that while it was possible to do this with a small, low-cost server and a combination of electronic fingerprinting and wireless networking there were still challenges in doing so with complete reliability. Thus, while introducing a more efficient, low maintenance PCIS in a rural primary clinic setting showed some early promise and was feasible, it was not yet ready for large scale implementation. Disappointing though this may have been for the innovators, it showed that while not every big bet pays off, there is much value to be gained in the lessons learned.

## Improving health systems referral

Effective rural two-way referral of patients has been a hugely vexing and challenging issue for the health system resulting in lost information and mismanaged patients.

The Benguela EOH project tested the concept of using a custom-designed Referral Telephony System in combination with improved paper documentation to improve referrals. A pilot project implemented with the support of the Valley Trust (a health and development nongovernmental organization) and the KwaZulu-Natal (KZN) Department of Health provided evidence that modest improvements in the referral system were feasible though challenging to implement.

The system allowed free communication between health personnel using their own cell phones but without cost to themselves. The underlying concept was that there should be consultation before referral. Such consultation necessitated easy communication with senior staff who could advise (and thereby generally manage cases competently at that service level) or, if referral was needed, provide instant authorisation for an upward referral to be made. In these cases, the referrals were vigorously monitored and reviewed.

Despite some areas of improvement, overall the new referral system proved difficult to institutionalise. Although the system had been widely tested and could have had advantages if revised protocols were formally adopted by the Department of Health, this was not done. The lesson that emerged was the central role of the Department in driving a structured change management process and ensuring that it become institutionalised and sustainable. Once again, while the intervention may have fallen short of intentions of the innovators many valuable lessons were learned.

## Developing sustainable community-based organisations to deal with HIV/AIDS

The critical role of thousands of community-based organisations in countering the spread and impact of HIV and AIDS has been widely recognised.

The AIDS Foundation of South Africa (AFSA), based in Durban in the KwaZulu-Natal Province located at the global epicentre of HIV and AIDS pandemic, was able during the period being reviewed to develop a robust training, mentoring and monitoring approach that saw their supported nongovernmental organizations (NGOs) and community-based organizations (CBOs) emerging more capable and sustainable than other comparable organisations receiving routine support by the Department of Social Development.

The limited evidence available suggested that there had been increasingly valuable effective and efficient services offered both in terms of the total number of beneficiaries as well the increasing scope of services provided. Although the hope had been that enhancing the performance of the CBOs would lead to a gradual shift towards government funding for CBOs and long-term sustainability, this proved not to be the case.

For a variety of reasons outside of the control of AFSA, primarily because of the economic recession and poor management in government departments, funding remitted by government to AFSA CBO partners declined 39% from 2008 to 2009. The result was that fewer community care workers (CCWs) and CBO personnel posts were either fully or partially funded by government grants leading to larger numbers of CCWs working purely on a voluntary basis or receiving very meagre, indeed token stipends, funded with grants from private donor contributions providing the continuing primary source of support.

## Amplifying the voices of disadvantaged and vulnerable populations

### Listening to peoples' views about health transformation around universal access

While the importance of community participation remains a fundamental pedestal for implementing primary health care, it is an idea honoured more in deed than word. Given that about 85% of the population depends on the publicly-funded health care system in South Africa, direct input into influencing policy-making processes is critical.

*The Black Sash's convening of provincial workshops* between May 2010 and June 2011 in all of South Africa's nine provinces provided a simple model of a process, that, at the very least, ensured provincial community consultations with many civic society groupings on health reform including soliciting their views on National Health Insurance.

The majority of participants across all nine provincial consultations supported the introduction of a tax to fund National Health Insurance on condition that it provided a substantially improved and quality health care system accessible to everyone. They also listed their leading priorities for other areas of health reform action including:

- Continuing to address inadequate access to health care facilities, especially in some rural areas
- Overcoming persistent shortages of medications
- Providing staff with adequate skills and competent levels of performance
- Improving ambulance services
- Facilitating community participation in health facilities
- Recognising the role of users in health decision-making
- Improving support to community health workers, community care workers and home-based carers
- Ensuring access to education as it pertains to realizing the right to health
- Enhancing monitoring and evaluation to assess the extent of the attainment of the promised levels of health care services.

## Strengthening advocacy for rural health care

Despite much rhetoric within the public health system, the quality of health care in rural areas has always been inferior to that in urban areas.

The Rural Health Advocacy Project (RHAP) conceptualised in 2009 by the Rural Doctors Association of South Africa along with AIDS Law Project - now SECTION27 - and the Wits Centre for Rural Health has done much to improve the joint voice of rural communities and provide a hub for health care worker advocacy.

In its short five-year lifespan, RHAP's output has been prolific in terms of publishing and information dissemination. Its work resulted in rural-specific inputs to policy development and implementation assessments. These include the Human Resources for Health strategy, the National Health Insurance scheme and the Primary Health Care Reengineering Programme, especially in regard to the Ward-based Outreach Teams policy. There has been a shift in thinking around rural health issues, including refining the concept of joint rural assessments with the Department of Health.

One of RHAP's notable successes has been the assistance given to health care workers in preventing service delivery failure. An outstanding example of this was the participation of RHAP in a multi-organisation campaign called the "Stop Stockouts Project", which sought to apply pressure to resolve the perennial challenge of medicine stockouts (supplies of medicines running out) in clinics throughout the country.

RHAP did this by being an active participant in the second annual national stockouts survey, conducted in 2014, which provided the most comprehensive data gathered by that time on the frequency, prevalence and impact of stock outs in the health system in five of the nine provinces (Mpumalanga, North West, Limpopo, Free State and Eastern Cape). It used the findings to advocate for change arguing that with more than one in three health facilities reporting a stockout of at least one anti-retroviral treatment or TB medicine during the three-month survey period, urgent action needed to be taken by the Department of Health, which did result in notable improvements. The Acting Director of the Medical Supplies Depot in the Gauteng Province acknowledged their role as follows:

*"[RHAP] is benefitting 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."*

RHAP thus earned itself growing legitimacy with many key stakeholders including importantly the Department of Health.

## Advocacy for equitable treatment

The right of people infected by HIV to adequate and lifesaving care has been one of the most bitterly contested issues since the advent of democratic South Africa.

Faced with increasing denialism about the effectiveness of anti-retroviral treatment (ART) in the midst of an exponential increase in AIDS-related mortality, which manifested in the deaths of hundreds of thousands of young people each year, The Treatment Action Campaign (TAC) is credited with having coordinated one of the most important life-saving and exemplary advocacy campaigns in history. The TAC and its alliance partners were ultimately able to force the South African government to provide universal access to ART.

TAC's strength has been its membership base which has used information and negotiation to build actions. Strategic mobility has been its hallmark, working with decision-makers where possible but naming and shaming when no headway was made. The TAC has successfully built powerful alliances and networks into a social movement for the right to treatment in the context of a failing health system and in the face of denialism, cynicism and stigmatisation. Its advocacy has led to the widespread introduction of ART, saving hundreds of thousands, perhaps even millions of lives. It has pushed local production of low-cost generic medicines, itself stimulating the growth in the economy.

## Health news reporting to promote equity

The health behaviour of populations depends critically on access to accurate information. Similarly, effective advocacy requires supportive mass media.

Between January 2005 and December 2014 *Health-e News* wrote 1860 stories; of these 650 were written by citizen journalists. Between January 2005 and December 2012, Health-e supplied South African Broadcasting Corporation radio stations with 664 stories. Health-e's television unit was established in 2008 and has produced 74 TV programmes. Health-e has thus consistently been on the cutting edge of identifying issues relating to health rights and then working closely with the advocacy groups such as the TAC to get the Department of Health to address these issues – thereby making a major contribution to improve the health of the nation.

## Offering clinical excellence to the world's largest HIV and AIDS programme

With more people living with HIV in South Africa than any other country in the world, (estimated to be 6.8 million HIV-infected individuals in 2014 - equivalent to 18% of the global HIV burden), the competence of professional staff managing HIV and AIDS was crucial, particularly given that debate around the pandemic was politicised and marred by ongoing controversy, notably by AIDS denialism and official mistrust of anti-retroviral drugs.

The South African HIV Clinicians Society (SAHIVCS) played a leading role in supporting the widespread adoption of HIV best practice through a variety of activities, including continuing professional development; formulation of better practice guidelines on specific aspects of HIV treatment and care; online discussion groups; and establishing a scholarship programme for doctors and nurses.

The Society had been instrumental in developing curriculum and accreditation procedures for a College Diploma in HIV management. As with other grantee organisations, the contribution of Atlantic in helping the Society to achieve its goals is a powerful illustration of its strategic grant-making in the form of thoughtful, large, 'big bets'. Commencing in 2006, Atlantic was the first significant donor of the Society. This financial support enabled the Society to gain administrative and organisational capacity, secure office space, professionalise the organisation and expand its information technology and website capacity, which significantly increased its programmatic activities.

These included expanding its continuing professional development-accredited branch meetings, issuing and distributing the Society's publications (the *SAJHIVMED* journal, *Transcript* and *HIV Nursing Matters*); developing HIV clinical management guidelines; and financing Society conferences including a skills-building programme and provision of bursaries for Society members. Atlantic's requirement for matched funding attracted the attention of other donors, especially the pharmaceutical industry, and facilitated the Society's efforts to draw the government into the consultation process.

In just over a decade the Society has grown into a substantial organisation and an important voice in combatting the AIDS pandemic in South Africa - providing expert, knowledge-based information at a time when this was seriously needed. The big bet investment has paid off and the young fledgling idea is now a well-established and self-sustaining professional organisation.

## Conclusions

For more than a decade, although only one of many intervention efforts, Atlantic's population health programme made a remarkably significant contribution to improving the public health system in South Africa both through specific local impacts as well as some key national impacts. The brief list on the following page summarises just a few of the key national impacts of the Population Health Programme.

While not an exhaustive list, the following are illustrative of the profound impacts that have transformed the South African health system:

- Recommitment to revitalising primary health care, the philosophical basis of the national health system – a profound change in policy following a 10-day study visit to Brazil, led by South Africa's Minister of Health
- Primary health care re-energized, health systems have been strengthened & advocacy galvanised
- Health science teaching enhanced: Schools of public, nursing and other health science educational institutions enhanced; clinical associates established as a successful new cadre
- Health workforce issues are being tackled with renewed vigour - nurse numbers increased by 44% between 2005 and 2011
- South Africa's leading disease burden caused by HIV and AIDS turned around. In 2004, very few patients people had access to antiretrovirals in the public health sector; by 2013, 2 million people were receiving treatment, arguably the largest global programme.
- 80% of all pregnant women receiving antiretroviral medication, resulting in a 70% reduction of perinatal transmission of HIV/AIDS between 2010 & 2012
- An amount R1,24 billion (US$120 million), larger than the total Atlantic investment, was leveraged from South Africa's Treasury for the revitalisation of nursing colleges

## Contribution of The Atlantic Philanthropies

Atlantic have recognised that with so many role players involved in making improvements in the health system over the past two decades, it is impossible to attribute success (or failure for that matter) to specific institutions or individuals. Contribution is a far more valuable way of expressing the multiple, synergistic and subtle beneficial ways that Atlantic's grantmaking has facilitated. The lessons from Atlantic summarise the views of numerous grantees regarding its approach.

- ✓ **Visionary leadership – investing in champions**
- ✓ **Careful identification and assessment of grantees**
- ✓ **Preparing grantees – working with them to develop proposals**
- ✓ **Flexibility and modest proposal and reporting requirements**
- ✓ **Synergy of efforts creating more than the sum of its parts**
- ✓ **Fearless advocacy – speaking truth to power when required to ensure that action is taken when needed to include people who are marginalised, socially disadvantaged or discriminated against.**
- ✓ **Lack of bureaucracy, trust and focus on creativity**
- ✓ **Global cooperation with international partners to achieve equity**
- ✓ **Emphasis on participation, democracy, justice and equity**
- ✓ **Willing to be a contributor without need to ascribe "attribution"**
- ✓ **Concentration of resources over a relatively short time**

*Figure 2: Valuable lessons from The Atlantic Philanthropies Population Health Programme*

**While only one contributor among many, encouragingly, it appears that the legacy left by Atlantic's exit, is potentially sustainable from within the country's own resources**

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