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# Access to Health Care

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## Community Approaches

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### EXECUTIVE SUMMARY

In October 2016, an ambulance was placed for the first time in Nqileni Village in the Eastern Cape to serve the Xhora Mouth Administrative Area. The ambulance rests on the rolling hills of the Wild Coast waiting for an emergency. At night it is secured in a structure built by the community, it is guarded by community members and the Emergency Medical Services (EMS) staff can rest in a 100% community owned lodge, the Bulungula Lodge. The availability of an ambulance here is a success story. But how the ambulance got here shows a tale of battered victims of avoidable tragedies and of a community – guided by strong traditional leadership – who have become aware of their human rights and who are empowered to complain, to make demands, and to commit even their own resources to realise the right to health care. It is also a story of collaboration between the community and the Bulungula Incubator (BI) with civil society, SECTION27 in particular, and the South African Human Rights Commission (SAHRC) and one of collaboration, confrontation and eventual partnership with the government.

The right of access to health care remains unrealised for members of the Xhora Mouth Administrative Area. For one of the poorest areas in the country – where the need is great – the nearest clinic, if you are healthy, is a 2.5 hour walk away (one way) and includes crossing a river and climbing significant hills! We need so much more human solidarity to address the challenges to realise the right of access to health and we will continue to work with civil society, the SAHRC and government to realise this right. But we must pause, reflect and celebrate our victories and having an ambulance on our hills is a victory. The paper hopes to share the journey of this victory so that other similar communities can learn from us and learn how to unlock the potential of collaboration across many sectors so that they too can advance the right of access to health care.

In general, communities will have varying resources and potential partners available. The first step is therefore to map your landscape and identify your allies and supporting factors and what your barriers to progress are. Other lessons based on our experience include:

1. Utilise existing community structures: this could include for example your traditional leadership or local ward counsellor depending on your assessment as to who will be



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your best ally, who will provide you with the necessary support and who will unite the community to support your cause. NGOs and activists should also take guidance from communities concerned to see who they think best represents them.

2. Create a leadership structure to drive the issue: For example, create a committee to be in charge of addressing the issue. Make sure that the committee has the support of the leadership in the community and that its membership includes some of those leaders; this will give it the necessary power to make decisions and drive the process forward.
3. Collaborate and partner for resources: the community's partnership with the Bulungula Incubator (BI) is one such example of a symbiotic relationship that was needed to make this a success. The BI employees were on the health committee and they provided guidance, leadership and the necessary infrastructure to make organising possible (such as access to internet, copiers, phone-calls, setting up community members and assisting with the communication between other partners etc.).
4. Collaborate and partner with allies: this could include partnerships with NGOs, public interest organisations and/or Chapter 9 institutions such as the South African Human Rights Commission (SAHRC). It could also include people within government or certain government departments.
5. Rights are no substitute for political struggle: know and understand your rights in the Constitution and government's obligations. But, do not think that because we have a "right to..." anything that we can stop the struggle. These constitutional protections or obligations cannot be a substitute for political struggle and we need to find the necessary partners who will be vigorous advocates for the poor.
6. Have a broad strategy: that includes a media, political, legal and cultural strategy as well as a strategy in relation to partners.

There is no one right approach. With sufficient partnerships and engagement, you should be able to create an approach that suits your community.

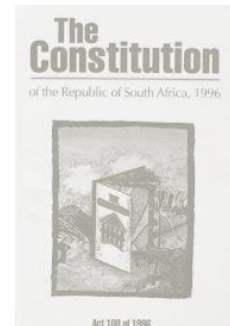


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### INTRODUCTION

“No one may be refused emergency medical treatment” – a clear, bold demand nestled in section 27 of our Constitution, a sound and unambiguous message to government and to private providers of health care. The Constitution guides our understanding of what we can expect and what we can demand, and this section is supposed to “provide reassurance to all members of society that emergency departments will be available to deal with the unforeseeable catastrophes that could befall any person, anywhere and at any time”.<sup>ii</sup>

In 2015, Mr MN who has lived in Xhora Mouth for 70 years explained to the South African Human Rights Commission (SAHRC) that he has never seen or heard of an ambulance in the area. For the first 20 years of democracy, section 27(3) of the Constitution – the right that no one may be refused emergency medical treatment – has been a lie to the people of the Xhora Mouth Administrative Area in the Eastern Cape.



### BACKGROUND

In 2004 (10 years into democratic South Africa), Dave Martin first moved to the area to start a developmental tourism project jointly with the community (the Bulungula Lodge is now 100% owned and run by the Nqileni community). He was the only person with a car in the region and it did not take long for people to start coming to him to get them to hospital with all sorts of chronic medical emergencies: stab wounds, child birth, people dying, burn victims, and stroke victims are just some examples. On treacherous “roads”, Dave essentially provided a free ambulance service for 8 years; sometimes he would do as many as three separate trips to the hospital through the night.

However in 2012, he stopped providing this service for a number of reasons. First, in 2010 a proper road was finally built into the region, secondly in 2012 two additional community members got their own cars who could potentially also provide this service but most importantly, he began to understand the obligations of government better, and realised that the failure of government to budget for and provide ambulances to this area was a blatant violation of the Constitution. He discussed with the community that he was no longer going



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to be providing a free ambulance service to the area but, as a representative of the community, he would write a complaint to the SAHRC. In March 2013 a complaint form was filled out and sent to the SAHRC. This was the first complaint letter ever submitted by the community.

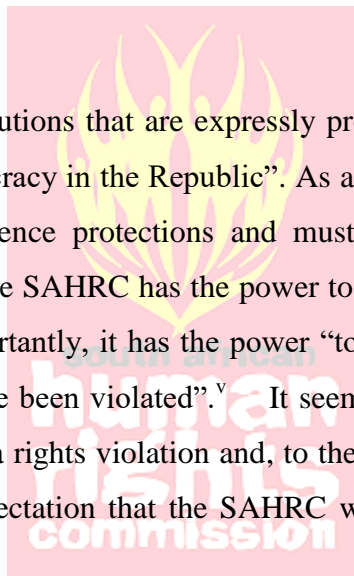
The complaint was described as follows:

“The complaint raised a number of allegations, including the fact that no ambulance service is available to the Xhora Mouth area, as well as other rural areas in the Province. The lack of medical transportation in the area meant that those in need of medical assistance would have to make use of public transportation at personal cost, and during times that public transportation is unavailable private transportation would need to be found, normally at an average cost of R700.00 per trip. Often faced with desperate situations, families may be forced to walk up to 30km to the nearest hospital, or to make use of wheelbarrows or donkey carts in order to acquire medical attention, whilst the delay caused in obtaining treatment often results in severe complications, permanent disability and loss of life.”<sup>iii</sup>

Although the initial complaint was filed by Dave in his personal capacity on behalf of the community, it was quickly integrated into the Bulungula Incubator’s work on improving access to healthcare.

### THE SAHRC

The SAHRC is one of the institutions that are expressly provided for in the Constitution to “strengthen constitutional democracy in the Republic”. As a result of this mandate it is given profound powers and independence protections and must exercise those powers without “fear, favour or prejudice”.<sup>iv</sup> The SAHRC has the power to investigate and report on human rights violations but, more importantly, it has the power “to take steps to secure appropriate redress where human rights have been violated”.<sup>v</sup> It seemed so obvious that there was an implicated right, that there was a rights violation and, to the community – now that they had complained – there was an expectation that the SAHRC would do something about it and quickly.





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To its credit the SAHRC came and did a community visit shortly after receiving the complaint letter. At this initial meeting the community listed their grievances and this was the start of the SAHRC engaging directly with the community on the lack of access to health care and emergency services in the area. But it quickly became obvious that the SAHRC was not going to do what it needed to do without extensive support and lobbying and it also quickly emerged that the complaint could not be properly investigated or addressed in isolation of the entire Eastern Cape Province. What does the law require? What are the regulations for Emergency Medical Services? What are the national standards and policies relating to emergency care? What are the obligations of the State? What does international law require? What has been planned for? What has been budgeted for? What are the accessibility challenges in rural communities? And most importantly: what needs to change?

### **A STROKE OF LUCK – A SYMBIOTIC RELATIONSHIP**

The enormous task of answering these questions or pushing for the right questions to be asked so that the correct answers could be found, could not have fallen to us alone, a deep rural community, with limited resources. Fortuitously, SECTION27, a well-resourced public interest law centre, was simultaneously participating in a broader campaign under the Eastern Cape Health Crisis Action Coalition (ECHCAC). They had identified nine key weak areas in the Eastern Cape health system that required urgent intervention; the lack of emergency health services was one of those pillars.

We came across the ECHCAC campaign and informed SECTION27 about our complaint. Shortly afterwards SECTION27 representatives came and conducted a workshop with our home-based carers (Community Health Workers) who again raised the issue as one of extreme urgency. After being notified of the complaint and learning how important EMS services were to our community (and other communities similarly situated), SECTION27 decided to throw all their energy behind making the SAHRC process a success and chose to design their campaign around EMS services in particular. Thus was the start of a strong symbiotic relationship between a well-organised deep rural community (supported by the BI) and a civil society organisation largely based in Johannesburg.



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### **THE COMMUNITY STRUCTURES**

As the amount of effort required to make this a success mounted, the community got more organised. The community in the Xhora Mouth Administrative Area very quickly put together a Health Committee that included Chief NoOfisi Gwebindlala, and the sub-headmen from the different regions, and various other members of different social class and standing. The BI's Health Programme Manager, Bulelwa Ganca and the Project Assistant Manager, Bongweza Sontundu are also members and provide essential infrastructural support and organisational leadership.

This Committee has met countless times over the last few years (with members often having to walk 2 hours to meetings). They meet outside, some members sitting on the floor and others on chairs and then each member, man or woman, is afforded an opportunity to speak. They meticulously plan, prepare and strategise for their encounters or meetings with SECTION27, the SAHRC and/or government.

Through the work of this Health Committee, Fikile Boyce of ECHCAC and Mluleki Marongo of SECTION27 were able to go around the villages, consult with community members and collect the haunting accounts of avoidable catastrophes. SECTION27 carefully collected information, put together an extensive analysis of the gaps in the area and submitted a lot of evidence to the SAHRC. However, given the vastness of the problem, SECTION27 decided to encourage the SAHRC to host a public hearing in the hope that that would provide a strong foundation for making recommendations to the Eastern Cape Health Department (the Department).

### **SAHRC HEARING**

The SAHRC resolved to investigate, access and monitor the provision of EMS services in the Eastern Cape based on the “scale of recorded challenges”<sup>vi</sup> and in March 2015 the SAHRC held a public hearing on the issue. Although it took two years after the initial complaint was filed, the hearing proved to be a powerful show of participatory democracy. Each statement from the community influenced the hearing and the magnitude and impact of the hearing on the final report was because of the traditional leadership facilitating community input.



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On 2 October 2015 the Commission's report was published. They found that the Eastern Cape Health Department has an insufficient number of ambulances, Planned Patient Transport and Inter-Facility Transport vehicles and qualified emergency service personnel to meet the need. Following this broad finding, a series of recommendations were made to the Department. In particular, the report highlighted the importance of community engagement and explained that the Department is obliged to engage with communities and to solicit participation in their planning and implementation of their health plans, policies and programmes.<sup>vii</sup>

For almost a year following this report little changed for our community. The Health Committee continued to meet regularly. Since starting this process they had heard many promises, and had been waiting patiently and were becoming frustrated with the fact that nothing had changed. Emails were sent to the Health Department in May, June, July and August and no responses had been received. In September the Chief wrote another letter to the Department explaining that she had been trying to meet with the Department since May.

And then a welcome surprise . . . With a few days' notice, the community was invited to a meeting with the Department in Bisho. Everyone was incredibly excited and proud of themselves. The Health Committee, on their own accord and without reaching out to better resourced partners, went to each household asking for R20 to cover the cost of transport to Bisho. For them it was important that this was a community owned process and this contribution of R20 guaranteed that the whole community was invested in this; an example of thriving rural democratisation.

The meeting was attended by the Department Clinical Director, the Deputy Director and various high-level EMS staff. The community again complained of the lack of EMS services and the lack of access to a clinic in their area. The community reiterated previous offers to offer the Department land to build a clinic (an offer which has stood since 2005) as well as provide a site to keep their ambulance safe and secure.





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At the end of the meeting the EMS staff promised to come to visit the region the very next day and promised that there would be an ambulance for us by the end of October. As for the clinical staff, they promised to come later in the year to view the proposed site.

The community had prepared two sites for the EMS staff to view (plan A and plan B). On arrival, the EMS staff raised concerns about accessing signal for emergency phone-calls, having a guarded and covered site for the ambulance, a place for their staff to rest in quiet periods and having access to water to wash the ambulance with. With each concern raised, the community offered careful solutions. The idea that government must just “provide” was not even entertained, the community wanted to ensure that this was a success and were willing to share even some of their own resources to guarantee this. Government quickly went from our adversary to our partner.

The Bulungula Lodge, which is 100% community owned, was eventually chosen as the site for the ambulance and the ambulance arrived on 1 October 2016. This is an example of the real implementation of a policy that requires the decentralising of ambulances to ensure that resources are relocated close to communities. The response time goal for rural areas is 40 minutes, which is now a possibility for the members of the Xhora Mouth Administrative Area. Community members who spent 70 years having never seen an ambulance, now see the yellow stripes on their hills.<sup>viii</sup>



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### LESSONS

#### 1. Use existing community structures

For those working tirelessly to advance access to social justice, the story of our ambulance ought to show that traditional leadership can be an essential ally. The traditional leaders in the Xhora Mouth Administrative Area have their leadership positions based on a birth right but they live in our communities, share schools and resting spaces with fellow community members and their families are accountable to the community for their entire lives. In our area, our traditional leadership also shares the struggles of a lack of access to health care and EMS services and cares deeply about the same issues that their community members face. The traditional leadership has led and supported this entire process and without them, the community would never have felt the connectedness and support that is required to complain and demand more from government.

In other areas, the local ward counsellor may be the more reliable form of leadership to work with. The lesson is that one should not import one's own biases about traditional leadership or governance structures and take the time to ascertain who the community feels best represents them and to work closely with that entity. This approach is also an important way to access community members and mobilise support. The existing leadership structures very often already have the respect of its members, they know the terrain, the history, the needs and, with their support on a project, the community members feel more empowered to participate.

#### 2. Create a leadership structure to drive the issue

We created the Health Committee and feel that such a structure is a good foundation for productive community organising. The expectations and powers of decision-making for the committee ought to be determined by the community as a whole. This creates clear lines of accountability, manages expectations and allocates the responsibility of pushing the issue on a distinct and recognisable group of people.

#### 3. Collaborate and partner for resources



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South Africa is rife with disempowered communities who accept their current lot and where governmental failures have become normal and acceptable. Through collaboration and partnerships we have awakened our community to demand action for change. There is a synergy that has emerged “through processes of collective action and alliance building”.<sup>ix</sup> This synergy is being used to prioritise the needs of the poor in a deep rural area.

Part of finding the right partnerships, is derived from knowing your strengths and weaknesses and knowing how you can contribute to the partnership. Rural communities can organise easily, they know their challenges and know the terrain better than anyone. They can also obtain community stories easily. Use these stories. This is credible and powerful information to hold government accountable and upon which evidence based debates can start.

We are lucky in that the BI is an integral part of the community and was able to provide necessary leadership and infrastructural support to this campaign. Although there is uniqueness to the way the BI operates, communities ought to be able to find an NGO or other entity that could provide at least the infrastructural support for their cause.

#### 4. Collaborate and partner with allies

In terms of complex analyses of the law or policy documents, find partners in public interest law firms such as SECTION27, Equal Education, the Child Law Centre, the Legal Resources



*SECTION27's John Stephens visiting our ambulance*

Centre, Lawyers for Human Rights or the Socio-Economic Rights Institute. Push organisations like the SAHRC to use the full extent of its powers and to inject the necessary urgency into government actions. They have the potential to be powerful if they realise the full breadth of their capabilities.

Start from the point that



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government is an ally, not an adversary and be prepared to work with government to ensure that projects are successful.

### 5. Rights are no substitute for political struggle

Know and understand your rights in the Constitution and government's obligations. NGOs must vigorously pursue constitutional literacy to ensure that this is the case for communities. Mass political mobilization in the 1980s and early 1990s led South Africa to the negotiation table and laid the foundation for what was to be the most progressive constitution in the world. Many presumed the hard work stopped once the rights were secured; unfortunately they could not have been more wrong. Obtaining rights, as constitutional guaranteed protections or obligations, is no substitute for political struggle.<sup>x</sup>

We need to reinvigorate the “extrajudicial political coalition that led to the recognition of rights in the first place.”<sup>xi</sup> Organisations like the SAHRC needs to be vigorous advocates and partners with the poor. Only through this process will a culture of human rights and empowerment be possible. And only through seeing results will people “develop respect for the law”.

In addition, we need to remember that the struggle is never over. Sadly, despite the arrival of our ambulance SECTION7 is of the view that very little has changed regarding access to emergency services across the Eastern Cape. It is likely that litigation will have to be pursued to force the government to account to some of the poorest and most vulnerable communities.

### 6. Have a broad strategy

Start with consciousness building, build an advocacy strategy and find your allies. Be able to admit when your allies become your adversaries and – in an ideal world – when they become your allies again.



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### CONCLUSION

From writing a complaint letter, to participating in hearings, to writing letters and attending meetings, this process – and the learning that has happened through our partnerships - has inculcated a culture of human rights in a deep rural setting. Our community members talk strongly about their rights and how they have been violated.

This is a story of empowerment. Our community members once felt dejected and confused about what to do and waited for government to (maybe) do something. They now know how to ask questions and find out what to do, how to advise others about what to do, how to use complain services are poor and most of all what it feels like to achieve something and get something done.

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<sup>i</sup> Thanks in particular to our Health Programme Manager, Bulelwa Ganca; Project Assistant Manager, Bongezwa Sontundu; and our general everything person, Dave Martin and to our partners at SECTION27 in particular John Stephens and Tim Hodgson (formally employed by SECTION27) for providing information, documents and comments on the draft.

<sup>ii</sup> Original quote is from Sachs J in *Soobramoney v Minister of Health (Kwazulu Natal)* [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1996 at para 51 but quoted with approval more recently in *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33; 2016 (1) SA 325 (CC); 2015 (12) BCLR 1471 (CC) at para 56.

<sup>iii</sup> “Access to Emergency Medical Services in the Eastern Cape: Hearing Report” South African Human Rights Commission Report dated October 2015.

<sup>iv</sup> See Chapter 9 of the Constitution.

<sup>v</sup> Section 184(2)(b) of the Constitution.

<sup>vi</sup> South African Human Rights Commission letter address to Dr Phumza Dyantyi of the Eastern Cape Province dated 15 April 2015.

<sup>vii</sup> “Access to Emergency Medical Services in the Eastern Cape: Hearing Report” South African Human Rights Commission Report dated October 2015 at 97-98.

<sup>viii</sup> One story that was sent to the SAHRC was: “Mr MN has lived in Xhora Mouth for 70 years and has never seen or heard of an ambulance in the area”. Today, an ambulance has been deployed to our area.

<sup>ix</sup> John Gaventa *Finding the Spaces for Change: A Power Analysis* IDS Bulletin 2006 Vol 37(6) 23 at 24.

<sup>x</sup> Mark Tushnet ‘Rights: an Essay in Informal Political Theory’ *Politics and Society*, Dec 1989 Vol 17(4) 403 at 409.

<sup>xi</sup> Id at 413.