

**PLACE IN THE SUN:
REFLECTIONS ON RELATIONSHIPS, RULES AND RURALITY**

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Prior to moving to the North West province, he worked at Manguzi Hospital in KwaZulu-Natal for nine years. He was active in the formation of the Rural Doctors Association of Southern Africa in 1997 and chaired the international Working Party on Rural Practice of the World Organization of Family Doctors from 2007 to 2013.

His research interests include rural health, human resources for health and health professions education. He has authored or co-authored over 100 peer-reviewed articles and book chapters. He is the editor of the African section of the international journal *Rural and Remote Health*.

After being a member of two World Health Organization Guideline Development groups, he is currently serving a second term in the World Health Organization Guidelines Review Committee. He was a member of the national task team to establish the clinical associate programme in South Africa. He has supported health professions education initiatives in a number of African countries. He has held visiting appointments at Monash and Flinders universities in Australia and the University of Washington in the USA.

PLACE IN THE SUN: REFLECTIONS ON RELATIONSHIPS, RULES AND RURALITY

BACKGROUND

I worked for nine years at Manguzi Hospital, serving the rural community of KwaNgwanase in the far north of KwaZulu-Natal. A 67-year-old male patient of mine, a retired teacher who was an *induna* in the local tribal council, had been seeing me over quite a number of years for problems including hypertension, diabetes mellitus and osteoarthritis. He then developed chronic kidney failure, for which the only real therapy was dialysis. This was not available locally. I discussed the possibility of sending him to Durban, where a family member lived, with the idea of him spending most of his time there, coming home periodically for weekends. He gave this brief consideration before rejecting the plan. He was clear about the implications of his decision but also about his reasons against going to Durban. He said that, for him, living in the city, away from his home, community and environment, was not a life worth living. He argued that the quality of life that he experienced, because of his connectedness to and his relationship with the people in that place, would make up for any shortening of his life that would likely result from his decision. He requested me to do the best that I could to enable him to carry on for as long as possible. Together I think we were able to achieve that; despite a subsequent hip fracture in a car accident, he passed away at home and at peace, about 10 years later.

This experience has always spoken to me more eloquently than any theory about rurality and rural health. The relational heart of it informs the discussion that follows, which reflects on theories in relation to rurality, rural health and health professions education, but also the implications of these for policy and interventions, particularly in the healthcare and education systems.

RURALITY

Rural communities are unique. There are often clear cultural differences between rural communities and urban centres, as well as among rural communities, leading to the saying, "If you have seen one rural community, you have only seen one rural community". Within these communities, there is often a strong feeling that they are different from the cities, with their own special qualities: Relationships are seen as personal and enduring, unlimited and unspecified in their demands and imbued with a strong sense of loyalty to both friends and relatives, as well as to the community and its members.^[1] Alongside this, there is often a clear sense of behavioural norms, seen in community views of social roles and functions of various members of the community, often

undergirded by tradition and/or religious practices. People in rural communities often place high value on self-sufficiency, self-reliance and independence.^[1]

A duality can frequently be observed in our understanding of rurality. On the one hand, what comes to mind is the rural idyll, involving scenes of happy people living tranquilly in beautiful environments sustaining themselves from the land and free from the pressure and stress of the city. On the other hand, the idea of rural often goes hand in hand with the backward, traditional, conservative and underdeveloped. Dichotomies such as rural innocence and urban corruption, rural naiveté and urban sophistication, rural ignorance and urban enlightenment have long histories,^[2] but the reality is of course a complex mixture of the two images, and much more.

The report by the Nelson Mandela Foundation titled "Emerging voices: A report on education in South African rural communities" offers a poignant insight into being rural, under the heading "Being there":

As the sun breaks over the furthest rim of hills at Bizana, it illuminates a world apart, an idyll in the city dweller's mind of quietude, of lowing cattle, smoke rising in the still morning air, vivid bird calls in the waking bush, a river, gleaming and silent.

Being there is different. Being there is not romantic. To be there is to be engaged in a struggle to live, and to hope. Money and jobs are scarce, the land itself harsh and demanding, and the schools, which straddle the old rural routines and the glittering prospect of a different life heralded by political and economic change in the far-away cities, are often ill-equipped, under-resourced and poorly staffed. Rural people know this.^[3]

Therefore, rural people also experience a duality, but this is a real, lived experience that is encountered daily, and is fundamental to the place they call home.

Place is important. We need a theory of place in order to understand the importance of rurality. Through this theory of place we can understand what the key features of 'rural' or of 'being rural' are and how place or geography links to a range of factors that influence how people live, with relationships being central to that.

Any epistemology of rurality must connect geographical and existential realities, and the relationships between

them. Even health professionals, however temporary the association with rurality may be, describe some of these relationships in their reflections on why they choose to practise in rural areas.^[4]

ON DEFINITIONS

With the socio-economic demands in South Africa and increasing urbanisation, it is not too surprising that more attention and resources have been given to urban communities. The proportion of people living in urban areas around the world rose from 33% in 1960 to 54% in 2016, with particular growth in Asia and Africa, and similar changes occurring in South Africa.^[5] The resultant decline in the sustainability of rural communities is a major concern. Despite this urbanisation, the current estimates are that approximately 35% of South Africa is rural,ⁱ which still represents a significant sector of the population. We therefore need a specific focus on rural communities.

What is a rural community? We have struggled for years to establish universal or even national definitions of rurality and have not succeeded in reaching consensus. The rationale for needing a definition is so that we can focus on addressing the needs of rural communities. I would argue that it is not the lack of a single unifying definition that holds us back. Rurality is a lived experience, a matter of perception, or a state of mind, whereas governments and other agencies construct definitions to provide a basis for policy decisions and resource allocation. The Rural Health Advocacy Project reviewed the issue of defining 'rural' and concluded that each sector or department defines the term in its own way according to the issues related to that sphere of activity.^[6] We can therefore define rurality for a particular need or context in order to achieve certain goals.

It is important that we do not approach this from a deficit perspective. In other words, it is very tempting to define rural areas by what they are not. Stats SA initially defined rurality as 'non-urban', but changed in 2003 to an urban/rural classification dichotomy.^[7] It is always unacceptable to define people by what they are not.

It is not only in the health sector that we have been struggling to define rurality – across fields such as education, sociology, geography and rural studies (which brings together a number of different disciplines) the issue of definition has been widely discussed. Balfour et al.^[8] note that the rural is often defined as the 'passive attendant' to the urban, as highlighted above, pointing out that definitions are used not only to describe, but also to disempower. Masinire et al.,^[9] writing about

education for rural development, argue against a deficit perspective, but then define 'rural' as space that sustains human existence and development outside the jurisdiction of urban authorities!

Gieryn^[10] argues, from a sociological perspective, that there are three components required in any definition of place, namely geographic location (a unique spot in the universe), material form (a compilation of tangible things) and investment with meaning and value (places are named, interpreted, felt, understood). The latter component (meaning) is emphasised by Inge,^[11] who, in discussing place from a theological perspective, makes a distinction between space and place, indicating that space is about three-dimensionality or distances between fixed points, whereas places are 'storied spaces', with historical meaning, that provide continuity and identity to people. Therefore, place is fundamental to human experience,^[11] particularly if one considers the centrality of the human search for meaning described by Victor Frankl;^[12] 'being rural' is inseparable from 'rural', and it is only through lived experience that one can realise this, which has significant implications for rural healthcare.

Halfacree^[13] proposes a complex model of rural space, which incorporates three interrelated facets, namely 'rural localities', with distinctive activities resulting from socio-economic processes linked to production or consumption; 'representations of the rural', which embodies how rural is seen in relation to the wider world; and 'everyday lives of the rural', which describes how individual and social elements are incorporated into behaviours and beliefs, even if rural people are no longer located in a rural space.^[13, 14] The latter is illustrated in the desire for many rural South Africans working in the cities to return home to die,^[15] and may transcend generations, manifesting in an ongoing rural affinity.

Is the definition of 'rural' really an issue? It seems it is often an excuse to avoid the problem. The substance – the significance of place, the meaning of rurality and the relationships between these – should be our focus.

RESPONDING TO RURALITY

Why do rural areas deserve our attention? Firstly, they demand attention because of the need for equity, defined as "the absence of avoidable, unfair, or remediable differences among groups of people".ⁱⁱ This is fundamental to any discussion on rural communities anywhere, but particularly in South Africa, both because of constitutional mandates and because of our historical struggle for justice. Secondly, there is a need to preserve such areas for the sake of all

ⁱ The World Bank Data. Rural population (% of total population). <https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS>; 2016.

ⁱⁱ World Health Organization. Health equity. http://www.who.int/topics/health_equity/en/; c 2018.

humanity and the environment. Unless we pay attention to rural communities, the trend towards urbanisation and centralisation will not stop and will lead to rural communities becoming extinct. This motivated a recent call in the journal *Nature* for more rural scholars who can focus on issues such as resilience, land consolidation, cultural heritage preservation and poverty alleviation in order to improve rural livelihoods.^[5] Thirdly, rural areas deserve our attention simply because such communities exist and have the inalienable right to be there.

What does giving attention to such areas mean? I will discuss this from a general perspective and then focus on rural health in particular. In establishing policy and interventions, we need to look at their impact on rural communities. There is a tendency, internationally, for policymakers to develop programmes that address city issues and concerns without considering the consequences in rural areas, which may be quite negative, albeit unintended. A well-known example of this in the South African context is the roll-out of antiretroviral therapy for patients with HIV/AIDS. Initial policies required patients to be assessed and prescribed treatment by a suitably qualified doctor only and for the medication to be dispensed by a designated pharmacist. This essentially excluded large numbers of rural patients from receiving treatment. Rural practitioners took the initiative to develop decentralised models for providing such treatment to patients through clinics; they demonstrated significant success despite not adhering to policy. The policy was progressively changed so that patients can now access HIV care in almost every rural clinic, provided by nurse clinicians, and receive ongoing treatment in the form of pre-packaged drugs delivered to their nearest decentralised dispensing site.

In the same way that we require an Environmental Impact Assessment for new developments, so should we require Rural Impact Assessments for any new policy. This has been called ‘rural proofing’, which requires using a rural lens to proof policy and interventions,ⁱⁱⁱ but the term ‘Rural Impact Assessment’ seems clearer. Just as Environmental Impact Assessments require planned projects to assess the possible environmental consequences (positive and negative) prior to a decision to move forward, based on a prescribed set of rules, so would Rural Impact Assessments have similar requirements regarding all proposed legislation, policies and projects in or affecting rural communities. Components of such a systemic approach would include legislation to make it mandatory, establishment of a body to oversee the process, guidelines for carrying out assessments and indicators for monitoring and evaluation

of progress. Variations of this approach are in effect in both developed countries, including England, Finland and Canada, and developing countries, such as Mexico and China.^[16] South Australia requires all legislation to undergo regional impact assessment.^{iv}

The context of South Africa is that rural communities have been left behind in the struggle for a new society. While there certainly has been progress in some areas, particularly in relation to infrastructure such as electrification, by and large the areas that missed out most in terms of development since 1994 are the former homelands, which make up the major component of rural communities in South Africa. This was acknowledged by former president Nelson Mandela in 2005:

I have often said that the most profound challenges to South Africa’s development and democracy can be found in its rural hinterlands. These areas, systematically and intentionally deprived of the most basic resources under apartheid, continue to lag behind the rest of the country in the post-apartheid era.^[3]

Spatial analyses of multiple deprivation^[17] and of poverty^[18] have demonstrated the striking overlap between such markers of inequity and rural former homeland areas. For many such communities they have not been accorded a place in the sun, despite the importance of their place in the struggle for a democratic South Africa. I would argue that their struggle for liberation must continue. We have seen some of that play out in the land debates that are currently taking place – land being critical to the soul of rural communities.

The first significant investigation into rural livelihoods by the Carnegie Commission of 1932 saw unplanned urbanisation as a white Afrikaner problem, ignoring the hidden majority of rural poor.^[2] It took more than 70 years before a second considered perspective on rurality in South Africa was produced, in the form of the “Emerging Voices Report” (2005), which focused on rural communities, schools and development.^[2] Policy generated in South Africa has largely served an urban elite, with the report describing policy frameworks as “insufficiently sensitive”.^[3] This is the challenge for rural South Africa going forward, and why Rural Impact Assessments should become the norm.

RURAL HEALTH

Now turn to the issue of rural health. The establishment of the Ukwanda Centre for Rural Health in 2002,

ⁱⁱⁱ The Rural Health Advocacy Project has produced an excellent guide to rural proofing in the South African context: *Rural-proofing for health: Guidelines. A guide to accounting for rural contexts in health policy, strategic planning and resourcing*. <http://rhap.org.za/rural-proofing-health-guidelines-2/>.

^{iv} Paul Worley, personal communication.

the first of its kind in South Africa, was based on the understanding that rural communities, which then made up about half of South Africa’s population, were generally underserved, and that the health status of people living in these communities is often poor. Little has changed. Rural communities are among the most disadvantaged in terms of accessing quality healthcare, with consequent poor health outcomes. Poor rural households in a Mpumalanga district spend up to 60% of their monthly income on repeated healthcare consultations, mainly due to travel,^[19] and a national survey found that financially catastrophic transport costs occurred in 15.3% of rural households accessing healthcare.^[20] Rural South Africans have higher rates of HIV/AIDS and TB mortality and increasing rates of mortality due to non-communicable diseases.^[21] There is a high burden of stroke in rural communities, which account for about half of stroke deaths in South Africa annually.^[22] Rural–urban inequities in maternal health are growing.^[23] A child living in the rural Eastern Cape is more than twice as likely to die in its first year of life than a child from the Western Cape, while a person with TB in mainly urban Gauteng has a 19.9% higher chance of being cured than a similar person in the predominantly rural North West province.^[24] Other developing countries show similar inequities in urban–rural health outcomes.^[25] We therefore need a specific focus on rural health.

In order to make a difference to rural health, we have to think broadly. Rural health is a broad concept with multiple dimensions, including social determinants of health and a comprehensive or biopsychosocial-spiritual approach to care. However, what is the theoretical framework that we can use in discussing and researching rural health? Despite extensive work in this area over the last few decades, there is a lack of a theoretical basis for our discourse.

Why do we need theory? A theory offers an analytical tool to assist us in understanding and explaining a field of study in a systematic way. Bourke et al.^[26] argue cogently for the need to develop a theory of rural health to provide a more comprehensive understanding of the field, and how and what should be studied, to articulate key assumptions and to systematise knowledge to enhance transferability.

A group of international rural medical educators has offered a framework for our understanding of rural health in terms of the context in which we work as a basis for discussion.^[27] Acknowledging a shared set of values and principles, we see these being shaped by the rural context, rural determinants of health, rural health systems and rural clinical practice, within which relationships we pursue our work as rural medical educators (see diagram).

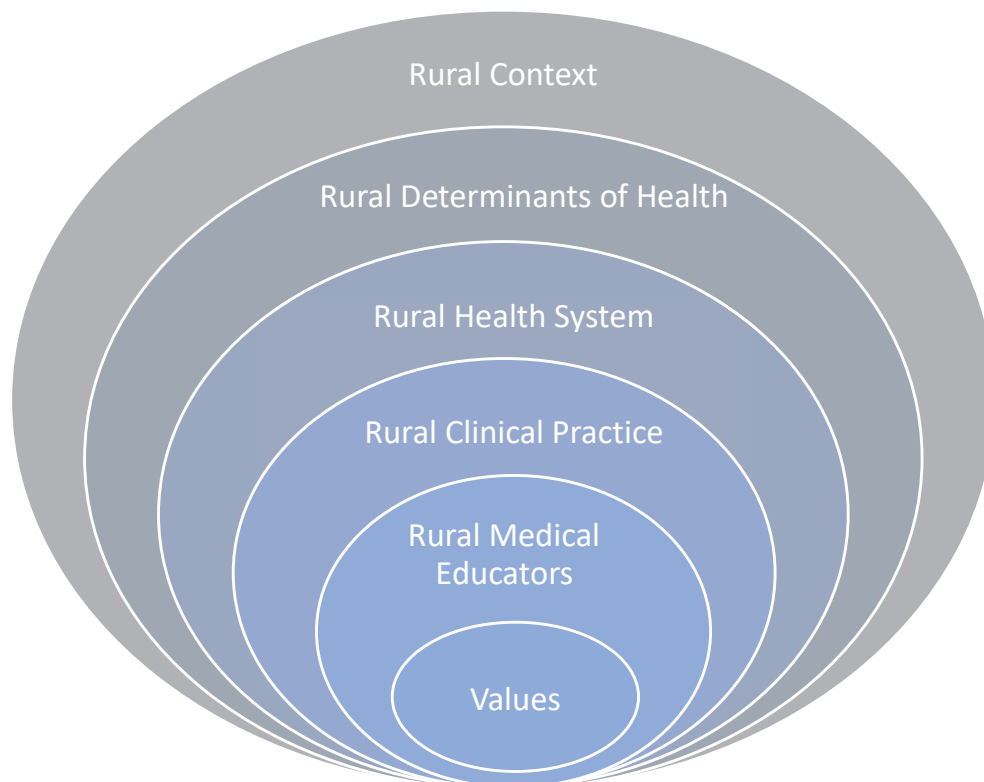


Diagram: Framework of relationships in rural medical education (from Reid et al.)^[27]

Going further, Bourke et al.^[28] undertook the development of a theoretical framework for analysing rural health in Australia. They brought together a team of rural health practitioners, academics and public servants from diverse disciplines (geography, public health, medicine, health policy, social work, community development and sociology) to participate in an iterative process consisting of a series of workshops and syntheses of relevant literature. At the outset, the definition of 'rural health' was used to indicate not only "the health status of individuals and communities physically, mentally and socially in rural and remote areas but also the organisational, social and cultural arrangements that create the health of individuals and communities in rural and remote areas".^[28]

The resulting framework for rural and remote health is comprised of six interconnected concepts:^[28]

- (i) Geographic isolation (rural space)
- (ii) The rural locale (social relations in the space)
- (iii) Health responses in rural locales (local services and programmes, shaped by location, local actors and broader systems)
- (iv) Broader health systems (organisations and political structures that influence rural health priorities, decisions and funding)
- (v) Broader social structures (including structural constraints resulting in health inequalities and the poor status of rural health)
- (vi) Power (facilitating or constraining action in relation to rural health services, care and outcomes).

This framework seems relevant for South Africa and therefore offers an opportunity for research to assess its applicability and usefulness in our context. It does highlight the fact that any action to improve rural health will involve complex processes at multiple levels and cannot be considered simplistically in siloes.

IMPLICATIONS FOR EDUCATION

One gap in the above framework is the role of rural health professions education, although it is embedded in it implicitly and to some extent explicitly. (It is central in the framework of Reid et al.)^[27] It may be that this is because the role of health professionals in influencing rural health, as opposed to delivering healthcare, in the light of social determinants of health, is quite limited. However, I now want to focus on education, because without a health workforce, policy is impotent, but without appropriate education, the workforce is weak and therefore part of the problem rather than the solution.

I have given attention to the issues of rurality and rural communities to highlight the importance of understanding context for health professions education. Context is critical in education. Unfortunately, education in general, and health professions education in particular, is often seen to be context-neutral. Certainly the notion of training medical students in tertiary academic health centres has been based on the idea that what is learnt there is applicable in all situations that students will face, because the knowledge and skills gained are independent of context. However, the reality is very different. It is increasingly clear that context is critical for learning – that has been a major thrust within the decolonisation movement – and that students need to be supported to learn in multiple contexts in order to be able not only to apply the theory they are learning at all levels of the healthcare system, but also to learn a wide range of appropriate knowledge, skills and attitudes that are determined by a particular context, such as approaches to common presenting problems, patient-centred care, applied epidemiology, etc.

Dewey wrote: "We are not explicitly aware of the role of context just because our every utterance is so saturated with it that it forms the significance of what we say and hear."^[30] Therefore, context is embedded in education, but if it is not examined, we will remain unaware of its influences – positive or negative. This has been highlighted in decolonisation discourses.

Gruenewald notes that the role of context has largely been addressed in the literature in two ways: critical pedagogy and place-based education.^[31] Critical pedagogy is focused on imbalances of power in education, addressing questions of how ways of seeing and believing become internalised to the point that those being educated no longer aspire to question or change the way they are living.^[32] Denying the role of context, educational institutions colonise the thinking of those being taught, so that they come to believe their lived experience to be irrelevant to learning. Paulo Freire challenged this approach, stating:

People as beings 'in a situation', find themselves rooted in temporal-spatial conditions which mark them and which they also mark. ... Human beings *are* because they are in a situation. And they *will be more* the more they not only critically reflect upon their existence but critically act upon it.^[33]

It is interesting to note, as a relevant aside given the focus of this paper, that critical pedagogy grew out of the literacy campaigns of Paulo Freire among peasants in rural areas of Brazil and other developing countries, although much of its focus has since been on urban contexts.^[34] Place-based education, on the other hand,

brings together a range of educational approaches that are concerned with context and that recognise the value of learning from and in specific places or communities.^[31]

Bringing these together, McLaren and Giroux^[34] argue that a critical pedagogy must be a pedagogy of place; recognising that the power imbalances and assumptions of the classroom reflect those of the society in which the education occurs, it must address the experiences and histories arising from place that have formed the understanding of the learners. Therefore, Gruenewald^[31] proposes a *critical pedagogy of place*, which challenges educational practices that disregard place, and which focuses on “learning more socially just and ecologically sustainable ways of being in the world”. Reid^[35] proposes that such an approach provides a theoretical framework for a distinct rural pedagogy.

Returning to health professions education, according to Bates and Ellaway, the contexts for our training “are largely invisible to those embedded in them, and become visible only through investigation of their profound influence on our programmes, our teaching, and our students’ and trainees’ learning and eventual practice”.^[29] Failing to recognise this leads to the situation that is all too common, in which a hidden curriculum that is urban-biased and tertiary hospital-focused dominates. Noting the many studies on the effects of context on learning, Koens et al.^[36] propose a model for examining learning tasks that considers three different dimensions of context: a physical dimension (the learner’s environment), a cognitive dimension (linking the knowledge of the learner with the contextual information) and a commitment dimension (aspects of context that affect a learner’s motivation). All of these are important to where we place our students, and speak to the need to challenge our traditional practices by examining the role of context in all learning tasks.

Bates and Ellaway^[29] note that current practices are informed by three ways of thinking about context: context as coincidence, where it is assumed that there is equivalence across contexts; context as mechanism, where context is seen to be an active and transformational influence; and context as outcome, where there is a focus on changing the contexts within which training takes place in addition to any other outcomes, particularly seen within the framework of social accountability. It is important to be cognisant of these factors in seeking to distribute health professions education across different contexts, and particularly in the drive to ensure sufficient exposure of students to rural contexts and communities. These perspectives

emphasise that there are advantages that go beyond the necessary curricula for educating health professionals, but these require articulation in order to make them explicit, and assessment if they are to be valued.

RURAL HEALTH PROFESSIONS EDUCATION

Having spelled out the importance of context for education, and for exposing students to a range of contexts during training, including rural contexts, I will touch on the specific motivations for addressing rural health professions education.^v These play a major role in our understanding of the value of distributed learning more generally, which is not surprising given the results of our scoping review of the literature on decentralised medical education: Of 58 articles in which the physical placement of student rotations was specified, 38 (65.5%) were described as rural, 4 (7.0%) as urban and 16 (27.5%) as both rural and urban.^[37]

The educational motivation, which links to the notion of context as mechanism, is based on evidence that students trained in rural sites have been shown, inter alia, to develop the skills and personal qualities required to practise in areas of need^[38] and a more complex sense of professional identity,^[39] to feel prepared to become doctors,^[40] to gain more clinical and management skills and knowledge of social determinants of health,^[41] and to adopt professional practices that influence patient outcomes.^[42] Rural students see more patients and perform a greater number of procedures than their urban counterparts,^[43] experience comprehensive care and forge strong relationships with health services,^[44] and grow in teamwork and understanding of different cultures.^[45] In a nutshell, context counts in training health workers for rural and remote areas.^[46] Achieving such outcomes requires orientation of training towards work in rural settings and curricula aimed at preparing health professionals to work in underserved areas.^[47]

The literature highlights the development of such context-specific competencies as a critical component of promoting social accountability,^[48] thereby linking context as mechanism and context as outcome. A workforce motivation is a major component of social accountability. This is based on mounting evidence that the context for the training of health professionals has a significant impact on where they will choose to practise. The World Health Organization (WHO) recommendations, “Increasing access to health workers in remote and rural areas through improved retention”, advocate for four types of interventions to address access to healthcare for rural people, namely

^v Elements of the discussion in this section arise out of my work in the Stellenbosch University Collaborative Capacity Enhancement through Engagement with Districts (SUCCEED) project. I gratefully acknowledge the contributions of the following SUCCEED colleagues to iterations of these arguments: Professors Marietjie de Villiers (principal investigator), Susan van Schalkwyk, Julia Blitz and Athol Kent.

educational interventions, regulatory actions, financial incentives and personal and professional support, with the strongest evidence being available for the educational interventions.^[49] Our review of critical interventions to address the inequitable distribution of health professionals indicated that selection of students from rural areas and location of training in rural areas had the greatest impact on future rural practice^[50] – findings that have been consistently documented around the world.^[51-54] A more recent systematic review of strategies to recruit primary care doctors^[55] also found evidence to support rural placements and recruiting from rural areas, while a review of evidence pertaining to low- and middle-income countries found that rural background, community-based training in rural areas, early exposure to the community and rural location of a medical school motivate medical students to work in rural areas upon graduation.^[56]

An additional motivation is the contribution that students make to healthcare, an important element of service learning, and another aspect of context as outcome. Community-based education of health professionals, particularly in rural contexts, leads to improved service delivery and patient care, increased access to service for patients and increased quality of care.^[57, 58] Academic involvement is a source of motivation for local health services^[59] and hospital culture becomes more positive and interprofessional with the presence of students.^[60] In a study we conducted across 10 countries in Africa, students in decentralised settings were perceived by healthcare providers to strengthen healthcare by having a positive effect on job satisfaction and workload, introducing evidence-based approaches and contributing to improvements in quality of care, patient experience and community outreach.^[61] We have confirmed similar findings across the distributed training sites of the Stellenbosch Faculty of Medicine and Health Sciences,^[62] as has a recent study on undergraduate student placements in three rural sub-districts of the Western Cape province.^[63]

A critical aspect of educational interventions is student selection. Consistent evidence from around the world, including South Africa, demonstrates that selecting students from rural areas will increase the numbers of health professionals in rural areas because they have a greater likelihood of deciding to work there.^[50, 56, 64] Selection of rural students has been a recurring recommendation of the WHO,^[47, 49, 65] and was included as a principle in the South African national human resource plan.^[66] This goes beyond the outcome, however, to the intertwined issues of access and equity – for a host of reasons, rural learners have much greater difficulty in accessing higher education, even if they are fortunate to be informed about the possibilities open to

them^[67] and are much less likely to achieve the criteria for entry into faculties of health science. Our previous research suggests that the proportion of students from rural backgrounds in health professions training is much lower than that in the general population;^[68] although we do not have current data, there is no reason to believe that this has changed dramatically. What we therefore require, in addition to rural training tracks, is targeted selection of students from rural areas. In addition, we also need to provide support for such rural cohorts to ensure that they achieve the same as their peers – learning is not decontextualised,^[69] as I have been arguing, and the transition for rural students to urban-based university training is even greater than for other students.^[70]

BEYOND EDUCATION

If we take the idea of a critical pedagogy of place seriously, we need to go beyond these educational interventions. The very notion of critical pedagogy includes addressing issues of power in the structures of society, including universities. This is central to the notion of social accountability, which focuses on the impact of health science faculties through the production of professionals who are equipped to respond to the challenges of healthcare in order to meet the needs of the community they serve.^[71] While medical education traditionally teaches students to conform, thereby maintaining the status quo of societal inequity in health,^[72] a socially accountable faculty can use critical pedagogy to equip students with the knowledge, skills and attitudes to play a role in transforming the inequitable system of healthcare.^[73]

At a basic level, in addressing social determinants of health, by which is meant that the conditions in which people grow, live, work and age are the result of political, social and economic structures,^[74] we need to have a rural perspective, or rural pedagogy.^[35] In other words, we need to consider how the various dimensions of rural communities impact on the health of people living there. Therefore, our response to rural healthcare needs must include dimensions of health policy, the structure of healthcare services and the nature of health professions education.

In terms of health policy, as already stated, there is a need to review every policy emanating from national or provincial departments of health using a rural lens to assess the rural impact. For many years we struggled to persuade the national Department of Health to develop a rural health policy. The response has frequently been that its policies already address rural health issues, citing specifically the approach to district health services. However, one of the problems with the implementation

of district health services has been failure to recognise the difference between urban and rural environments. A case in point is community health workers, including the issues of their scope of practice, what training they receive for their role given, the lack of resources in rural communities, and how many households need to be seen by each community health worker. Another example is the role of the district hospital, which has constantly shifted in relation to district structures, instead of understanding the hospital as a resource for rural districts and thereby ensuring its integration into the structures, although this may now be happening.^[75] There does not need to be separate policies, but rather a review of all policies in relation to rural impact, with specific people being given responsibility for ensuring this happens. This was one possible role of the Rural Health Task Team established by the national Department of Health approximately five years ago, but it has only had a couple of meetings. It is important to reiterate that separate can never be equal and therefore rural communities need to be integrated into any health policy, legislation or intervention, but that does not mean that specific and focused attention should not be given to the impact on these communities and how this can be addressed in order to ensure equity.

In terms of healthcare services, it is often said that *the rural healthcare issue internationally is access*;^[76] regardless of the level of resources of a country, access to healthcare for rural people is a challenge. Changing the financing of healthcare does not address the issue of access for rural people. I fully support the drive for universal health coverage, and therefore the proposed National Health Insurance (NHI) scheme for South Africa; whether NHI will deliver such coverage for rural people, however, remains a question. Simply building clinics and hospitals also does not address the issue of access, as important as it is to have healthcare service infrastructure close to people. The key to access is sufficient, appropriately trained and committed healthcare professionals who are retained in rural services and develop relationships with rural communities. This requires a complete mind shift that we have not yet seen in this country, and which is not part of current NHI documents. This shift includes an understanding of the importance of developing the health workforce as an investment in economic prosperity, rather than simply a cost.^[77]

In faculties of health sciences in South Africa and beyond, we cannot simply stand outside and throw stones, because we are equally culpable and are equally required to look at all of our policies and processes with a rural lens to see to what extent we are addressing the issue of equity. I am privileged and very proud to be part of the Faculty of Medicine and Health Sciences of

Stellenbosch University, and particularly to be director of the Ukwanda Centre for Rural Health, because of what has been achieved – we are indeed leaders in the field of rural health, as evidenced by establishing Ukwanda as the first such centre for rural health in Africa and in 2011 launching the first Rural Clinical School on the continent. However, there is much more that should still be done. Issues of student selection, exposure of students to rural training possibilities, curricular content and messaging, and budget allocations all need to be addressed.

More broadly, we need to be asking hard questions about our current training processes. How can we make training more accessible, more affordable and more appropriate? How do we ensure that our graduates are better trained for the context in which they are going to work? How do we deal with issues such as the fact that therapists who go directly into community service after graduation and often have to work in rural hospitals have little training in a major problem they will face in such communities, such as cerebral palsy,^[78] and that graduates across the health professions going into such contexts face health systems in crisis without the tools to understand the problems and facilitate improvement in the system in a collaborative way? Is it appropriate to be focusing so much time and energy on training medical practitioners for a minimum of six years plus two years internship, instead of putting more resources and energy into training clinical associates as mid-level medical professionals who can make a major impact in rural healthcare services?^[79-81] (It is disappointing that the Western Cape Department of Health refuses to support the training and employment of clinical associates, given the needs even in the rural Western Cape, but also tragic that the national Department of Health, which supported the development of the Bachelor of Clinical Medical Practice degree to train these professionals, has failed to provide leadership in ensuring the creation of posts and the effective utilisation of this cadre.) Similarly, what should be the role of rehabilitation workers at the community level, and how do we move past a siloed thinking that divides parts of bodies among different therapy approaches? Why do we impose a medical model on the training of community health workers in the face of social determinants of health? We need to apply a rural lens to our training programmes and to the statutory bodies that regulate them.

WHAT CAN WE DO?

So how do we respond? Let me start with the Ukwanda Centre for Rural Health. It has been exciting since I joined the faculty to work with a great team in Ukwanda towards developing a new vision for the Centre. We want to expand, extend and deepen undergraduate rural training in all the programmes in our faculty, building on the success of the Rural Clinical School; in this

regard, the new developments in the Northern Cape towards building training initiatives in Upington are very encouraging. However, we want to serve the faculty and the people of South Africa by driving a bigger vision to make a difference to rural communities, working along the whole pipeline, from admission through training at undergraduate and postgraduate levels to support for rural practitioners of all professional backgrounds; by way of example, our prototype Postgraduate Diploma in Rural Medicine is awaiting approval by national educational authorities. We want to grow our model of collaborative care and work together with communities to achieve better integration; our annual community partnership functions (there will be three this year) are a small part of this. We hope that we can increasingly engage with other faculties and work towards an institute that is truly multi-disciplinary in its interventions, based on our understanding of the breadth of rural health. Our vision also includes developing a research hub that will drive rural health research, with a focus on addressing equity but also working particularly in four areas, namely rural health professions education, collaborative care, the first thousand days of life and applied clinical research for district and regional hospitals. We also hope to become a resource for other faculties in South Africa and beyond in terms of developing training to impact on rural health, with a focus on South–South collaboration.^[82]

For this to happen, the support of the Faculty is needed. The Faculty's equity focus should drive decisions regarding budgeting and allocation of resources to ensure that we are appropriately addressing rural health issues, demonstrating the commitment to rural training by ensuring that a percentage of all student time is spent in rural areas with all students getting some exposure and some students gaining extended exposure to rural practice, and making specific decisions about the selection and support of rural students in collaboration with rural communities.

At a university level, addressing the issue of equity for rural communities should be a cornerstone of social impact activities, but, even more, relevant departments and divisions should be incentivised to extend themselves into these communities to support interventions that can make a solid difference that is needed to influence rural health. This is a call for high-level leadership in driving the development of a common approach focused on marginalised rural communities across the Western and Northern Cape and beyond, as part of Stellenbosch University's Vision 2040 aspiration to have an all-encompassing impact on social, financial and environmental well-being on a range of levels.

RELATIONSHIPS

I have deliberately chosen to return to the issue of relationships to end this paper, because they are so fundamental to rurality, healthcare and education

Rural communities are sustained through and by relationship. Any person who has grown up or lived in a rural community refers back to the relationships that made that community important. In the typical rural health facility there will be multiple relationships among staff at all levels (blood relationships, historical or clan relationships, marriages and friendships), among staff and patients, and within community governance structures – these can be a huge strength, but also need to be considered when dealing with patients and community-based issues. Health professionals who think at an individual level and respond to individual patients will be very limited in their capacity to assist. On the other hand, family relationships and community connections can be very powerful in addressing health needs.

Any intervention in a rural community has to take relationships into account. Rural areas are littered with the debris of failed projects that did not consider relationships. It is not surprising that words such as 'dialogue', 'love', 'hope' and 'humility' are scattered throughout *Pedagogy of the oppressed*.^[33] Rural healthcare has taught me some lessons about this.^[83] At a system level, relationships are at the heart of symbiosis, the model for rural community-based education proposed by Worley.^[84]

In the research that I have been involved with over the course of my career, the issue of relationships has come up repeatedly in different ways. Relationships are central to successful management of rural hospitals^[85] and to transforming rural health systems.^[86] The effectiveness of visiting doctors' contributions at clinic level is dependent on their relationships with the staff in the clinic, particularly the nurses.^[87, 88] Problems in relationships underline the need for changing organisational climate as a key priority in addressing rural healthcare needs in South Africa^[89] and were central to the differences in functioning observed in a case study of two clinics serving the same community.^[90]

Medical students in longitudinal clerkships learn clinical reasoning through their relationships with patients and preceptors,^[91] which also facilitate their transition towards being professionals.^[92] Doctors learn the language of the communities they serve through their relationship with patients.^[93] These support the notion that transforming clinical education through a relationship-based approach can assist in repairing society.^[94]

CONCLUSION

“We are realists, we dream the impossible.”^{vi} With international colleagues in rural health we have seen significant progress towards the impossible dream.^[95] We can therefore demand the impossible. The dream is that rural people will have their place in the sun; that rural healthcare will have its place in the sun. We will know we have reached that point when women giving birth are no longer more likely to die simply because they live in a rural area and that children under five years are no longer less likely to survive and flourish simply for the same reason. We will know when all policies, at any level of government, are reviewed in terms of their rural impact and include targeted strategies to address rural communities. We will know we have reached that point when students are based in rural areas for their entire health professional training, doing electives in the city on occasion, and rural students have equitable access to health professions training. We will know when there are sufficient posts for the right kinds of health professionals in rural areas and graduates are competing with one another for selection to those posts.

Celebrating rurality, working together in relationship and applying the rules of Rural Impact Assessment at all levels, based on the theory and motivations outlined, will ensure that equity for rural communities is achievable so that they can enjoy their place in the sun.

^{vi} This saying has been widely attributed to Che Guevara, but I could not find the original source. It was used on a poster, advertising books by Che Guevara, which is available in the collection of the Oakland Museum of California (<http://collections.museumca.org/?q=collection-item/2010548587>). It appears to arise from the 1968 slogan “Soyez realistes, demandez l'impossible” (“Be realistic: Demand the impossible”). Levitas^[96] describes the latter as a common slogan seen in graffiti and posters in France in May 1968, variously attributed to the Sorbonne and Censier.

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“I would love to live like a river flows, carried by the surprise of its own unfolding.” John O’Donohue

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