UNIVERSITY OF KWAZULU-NATAL ™
INYUVESI YAKWAZULU-NATALI

RURAL HEALTH CONFERENCE
PACASA • RuDASA • RuNurSA • RuReSA

RURAL HEALTH CONFERENCE 2019

Kapenta Bay, Port Shepstone, KwaZulu-Natal

PACASA
RuNurSA Rural Nursing South Africa
RuReSA Rural Rehab South Africa
RuDASA

INSPIRING GREATNESS

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About the Conference

The Rural Health Conference has been an annual event since 1996. Delegates often ask why do we always change province each year and have it in a small town? Well, the conference started with a small band of doctors working in remote and rural areas dealing with a multitude of problems with very little support. By sharing their experiences they started the rural doctors conference and were quickly joined by nurses and therapists working in rural areas who saw the conference as a means of meeting up and getting support. Historically people working for the Department of Health had very few opportunities to attend conferences during the week and did not get funding so the idea of meeting on a long weekend was born, and by rotating provinces it gave people the opportunity to attend something in their province instead of travelling to the traditional conference venues of Cape Town, Johannesburg & Durban. The conference has grown to include many of the universities and NGOs who are based in the cities – so we have to remind them that rural is a different world and so we always have the conference in a small rural town!

The conferences is now run by a partnership of RuDASA, RuReSA (Rural Rehabilitation South Africa), PACASA (Professional Association of Clinical Associates), and RuNurSA (Rural Nursing South Africa). We are guided by RHAP (Rural Health Advocacy programme) to ensure that the conference recognises the diversity of South Africa, the importance of advocating for better services and seeking presentations on innovations in care and service provision.

In 2013 the annual RuDASA Conference was renamed as the annual Rural Health Conference with Rural Rehab South Africa (RuRESA) and the Professional Association of Clinical Associates (PACASA) joining officially as annual conference partners. The overarching aim of the Rural Health Conference is to create a platform for rural health practitioners, partners and stakeholders across the country to connect, share experiences and challenges facing rural health care practitioners and communities, learn from one another, and advocate for good practice.

The conference usually takes place on a long weekend in September and consists of a 3-day programme of presentations, workshops, and AGMS, as well as evening meals and events. The conference rotates between the Provinces so that health workers have equal opportunities to be able to attend a conference. Moving Provinces also enables us to learn about the challenges in the different areas in South Africa and how people are meeting those challenges. Newcomers to the conference are amazed at the energy and commitment of the people there, as well as the multidisciplinary approach. We really try not to have silo's for each profession, but to come together to hear, debate and learn from each other. In addition we welcome various exhibitors and have an interesting Exhibition and Poster area.

For those of you new to the Rural Health Conference we hope you grow to love it as much as we do!

Conference Theme

Izwi lomphakathi wasemakhaya – The Rural Voice

The Rural Health Conference 2019 aims to be a space where the voice around rural health can be raised and amplified. Rural health – and rural people more generally – are underrepresented in the discourses and policy debates around how to achieve the goal of a long and healthy life for all. The Rural Health Conference will provide a vibrant space for a wide range of health care professionals, students, activists and community health workers to stimulate debate, explore innovative solutions and raise our voices!

Ukulalela izwi lethu– Hearing our voice:

We are looking for presentations from or about the community we serve so that we can contextualise their needs and develop service delivery and research practice for the future. This may include the work of students, community workers, traditional and faith based healers, as well as the broader community. Our Voice includes a reflection on what we have been saying, why it is important and whether anyone has been listening to what we say; as well as voicing concerns we have about ethical rural practice.

Ukusebenza ngezwi lethu – Acting on our voice:

There are many voices that guide the development of rural health services including government policy, rural advocates such as WONCA and RHAP, and WHO; but how is policy being translated into service delivery at the local level? We are looking for best practice ideas for building young professionals so they can survive & thrive, building dialogue with local communities and their healers, and solutions for good practice despite poor resources, and best practice for influencing service development and good practice.

Sponsorships

The Rural Health Conference 2019 is particularly indebted to the University of Kwa-Zulu Natal who provided generous support for our conference, this included:

The DRILL team: Nisha Nadesanreddy and Lungelo Khanyile, who provided us with much needed administrative support and good ideas throughout the year, and DRILL for sponsoring many delegates.

UKZN Corporate Relations who provided pro bono: graphic design and layout, photography, corporate gifts; and reduced fees for all the audio-visual equipment and recording & streaming of the conference.

UKZN Deputy Vice Chancellor Research: Professor Deresh Ramjugernath who provided generous sponsorship for all the audio visual costs.

In addition we are grateful for all our Gold sponsors who donated funds, Silver Sponsors who are exhibiting at the conference, and Bronze sponsors who provided funds to the value of R4000 or "goodies" for your conference bags.

PLATINUM:

UNIVERSITY OF KWAZULU-NATAL ™
INYUVESI YAKWAZULU-NATALI

Towards Research Leadership
DRILL
Developing Research Innovation, Localisation and Leadership in South Africa

The DRILL programme is supported by the Fogarty International Center (FIC), NIH Common Fund, Office of Strategic Co-ordination, Office of the Director (OD/OSC/CF/NIH), Office of AIDS Research, Office of the Director (OAR/NIH), National Institute of Mental Health (NIMH/NIH) of the National Institutes of Health under Award Number D43TW010131.

GOLD:

VULA

Discovery

lifecheq

SILVER:

BRONZE:

Welcome Note from the Organising Committee

Dear Delegates

Welcome to the 23rd Rural Health Conference. This conference has been an annual event since 1996. Initially started as a conference for rural doctors by RuDASA (Rural Doctor's Association of South Africa) it has grown into a vibrant meeting of doctors, nurses, therapists, clinical associates, students, NGOs and academics interested in improving health care in rural areas. The conference is now run by a partnership of RuDASA, RuReSA (Rural Rehabilitation South Africa), PACASA (Professional Association of Clinical Associates), and RuNurSA (Rural Nurses South Africa). We are guided by RHAP (Rural Health Advocacy Project) to ensure that the conference recognises the diversity of South Africa, the importance of advocating for better services and seeking presentations on innovations in care and service provision.

This theme for this year's conference is ***Izwi lomphakathi wasemakhaya*** – **The Rural Voice**. Rural health – and rural people more generally – are underrepresented in the discourses and policy debates around how to achieve the goal of a long and healthy life for all. At this conference we aim to address this and provide a platform to hear the voices of people who are historically not heard at academic health conferences, including community healthcare workers, traditional healers, students and traditional leaders. Delegates will be treated to a wide array of workshops, oral discussions and poster presentations, with topics ranging from snakebites to portable vision screeners.

On a personal note, I would like to welcome you to the beautiful province of KwaZulu-Natal and specifically the sunny and friendly south coast region. We hope you get to spend some time strolling on the nearby beach, looking out at the warm Indian Ocean and perhaps spying a pod of dolphins gliding past. I would like to thank the Conference Organising Committee who represent the four professional bodies for all their work, as well as the wonderful team from the University of KwaZulu-Natal's Developing Research, Innovation, Localisation and Leadership in South Africa (DRILL) programme – who provided significant administrative, logistical and technical support. A special thanks to all the sponsors and exhibitors without whom there would be no conference.

We thank all of our presenters for being willing to share their knowledge, experience and skills. This conference will provide a vibrant space to stimulate debate, explore innovative solutions and raise our voices. You are all established or emerging experts in health, with rich practical and research experience in some of the most marginalised communities in South Africa. This is a relatively small conference, without hierarchies or inter-professional rivalries, where many people give up what little leave they have to seek solutions to some of the most pressing issues in rural healthcare. Please take the time over the next three days to renew old friendships, get to know people you have not met and enjoy the hospitality and variety of experiences KwaZulu-Natal has to offer.

Thank you for joining us at the 2019 Rural Health Conference. We look forward to hearing all of your voices.

Siybonga kakhulu

Saul Cobbing
Chair: Organising Committee
2019 Rural Health Conference

Rural Health Conference 2019 Committees:

Organising Committee

Saul Cobbing (Chair)

Stephanie Homer (RuReSA)

Martene Esteves (PACASA)

Bernhard Gaede (RuDASA)

Tumi Ndweni (PACASA)

Heather Coombe (RuReSA)

Lungile Hobe (RuDASA)

Thabisa Ngcakaza (RuNurSA)

Nisha Nadesan-Reddy (DRILL)

Scientific Committee

RUDASA

Victor Fredlund

Indira Govender

Bernhard Gaede

RuRESA

Kate Sherry

Maryke Bezuidenhout

Anthea Hansen

Saul Cobbing

PACASA

Tumi Ndweni

RuNurSA

Guin Lourens

UKZN Discipline of Family Medicine

Cyril Nkabinde

Andrew Ross

DRILL

Velisha Ann Perumal Pillay

Verusia Chetty

Varsha Bangalee

Khathutshelo Percy Mashige

Pam Pillay

Sherika Hanley

Shelley Wall

Desiree Govender

Alvin Munsamy

Euphemia Mbali Mhlongo

Diane van Staden

Thiloshini Govender

The Conference Partners

RuDASA

The Rural Doctors Association of Southern Africa (RuDASA) is a membership-based organisation actively working towards better health care in rural areas. RuDASA strives for the adequate staffing of rural health facilities by appropriately skilled medical staff; and to be a voice for rural doctors regarding training and working conditions.

Our Vision

For all rural people in Southern Africa to have access to quality health care.

Our Mission

RuDASA strives for the adequate staffing of rural health services by appropriately skilled medical staff and to be a voice for the rural doctor regarding training and working conditions.

RuDASA aims to inspire health workers to work in rural areas, and support and empower those committed to making health care available to all South Africans. Our network provides an opportunity for members to connect, share concerns, challenges, good practices and innovative ideas, through a variety of forums. Members can share ideas and request assistance from others.

RuDASA is involved in a number of initiatives to lobby for and address the needs of rural doctors and has also taken on a prominent advocacy role in terms of pushing for improved health in rural areas in general, as well as addressing specific topics, such as the availability of posts in rural hospitals and drug shortages. We aim to be a resource of rural expertise to the South African Government and other stakeholders. From time to time RuDASA has issued open letters and press statements, often with partner organisations, to create awareness of the plight, challenges and successes of rural doctors and other health professionals.

Find out more and join us:

- info@rudasa.org.za
- www.rudasa.org.za
- www.facebook.com/ruraldoctors

RuReSA

Rural Rehab South Africa (RuReSA), is a multidisciplinary organisation of professionals committed to providing and improving rehabilitation services in rural communities.

We are passionate about creating positive change through rehabilitation which will:

- **Prevent** disability,
- **Empower** the disabled through early intervention,
- **Promote** healthy and active lifestyles after disability,
- Enable the disabled to participate fully within their communities, thereby fulfilling the Government goal of, "***a long and healthy life for all South Africans.***"

Why Rural?

Nationally there is approx. 1 therapist per 750 disabled individuals. Most of these therapists are lost to the Private Sector. Therefore, the prevalence of disability is higher in rural areas due to:

- Immense poverty
- Poor access to all health services
- Lack of resources for both the people with disabilities and the therapists

Our Vision is that rehabilitation services are provided within a PHC framework to all rural communities, and are high-quality, comprehensive, appropriate, accessible, and equitable.

Our Mission

- To ensure rehabilitation is integrated into health policy and planning at all levels
- To develop and share best practice models for high-quality, appropriate, accessible, acceptable, and effective rehabilitation services
- To disseminate information and research on: the health needs of rural people, rural rehabilitation, and health policies
- To provide support to recruit, retain and inspire rural therapists.
- To influence the actions of the service delivery community.

We are working with our rural partners, the professional associations, universities and policy makers to ensure this happens.

Find out more and join us:

- www.ruresa.com
- www.facebook.com/ruresa
- ruralrehab@gmail.com

RuNurSA

Rural Nursing South Africa (RuNurSA) is a membership based network focussed on access to quality healthcare for all. We are inspired by the courageous commitment of nursing professionals in the face of rural health realities and challenges. We seek to influence the change required to improve rural health nursing care.

Nurses are called upon to lead in healthcare, especially in rural environments by stepping forward and becoming a voice to lead and champion nursing issues which will positively affect the health of communities in this country. Nursing leadership has the potential to changes lives, forms teams, build healthcare organisations, and impact communities.

RuNurSA was selected by the International Council of Nursing (ICN) as a voice to lead nursing in achieving the sustainable development goals. We must build on that legacy for rural nurses to have a voice in decisions that affect their practice and to ensure quality healthcare.

Our Vision

Strengthening rural nursing leadership.

Our Mission

To be a voice to lead in the South African health system in addressing leadership, management and governance.

To advocate for quality healthcare political will; appointment of public service managers with the right skills, competencies, ethics and value systems; effective governance at all levels of the health system including rural areas; appropriate management systems; and citizen involvement towards accountable public officials.

Find out more and join us:

- ruralnursingsa@gmail.com
- www.facebook.com/ruralnursingsouthafricarunursa

PACASA

Clinical Associates as a profession started out in South Africa with the first undergraduate group being admitted to the Walter Sisulu University (WSU) in the Eastern Cape in 2008. There are now three institutions that offer the Bachelor of Clinical Medical Practice, namely the University of Pretoria, University of the Witwatersrand and Walter Sisulu University. Soon after the first graduates were deployed, it was realised that they needed a representative voice in order to receive recognition and to proactively build the profession.

The Professional Association of Clinical Associates in South Africa (PACASA) was established on 10 April 2012. An interim executive management committee was nominated to manage the initial organisational structuring of PACASA, and to develop sound governance principles for the future.

Our Vision

Be a credible representative body and advocate for the recognition and development of clinical associates whilst in partnership with likeminded organizations to provide patient-centred quality healthcare for the general public.

Our Mission

To empower and unite Clinical Associates to provide accessible, equitable and quality healthcare in South Africa.

PACASA is dedicated to

- Strengthening the professional identity of Clinical Associates;
- Strive for a patient centred healthcare system through empowering our members;
- Build healthy, productive, mutually beneficial relationships with the people of South Africa;
- Network with allied professions and organisations;
- Carry out and/or participate in research of the profession and other health related topics

Find out more and join us:

- pacasamedia@gmail.com
- pacasamembership@gmail.com

KEY NOTE SPEAKERS

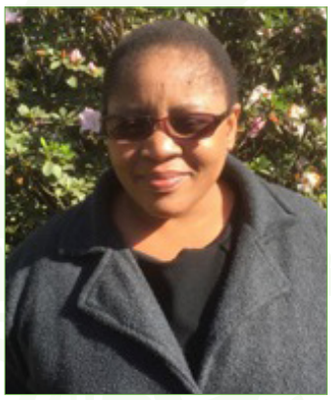
Ungakwenza kwenzeke – You can do it – it is possible

RuReSA Key Note Speaker: Bongiwe Zuma

Hearing the voice of the community we serve

Bongi has a powerful message to health professionals about her own and other parents experience of the health system as parents of children with a disability. This will cover the experience of trying to find out what is the problem with your child, what is understood and how it feels when the health professional gives the message "your child is disabled", why parents may not understand what has been said or be able to follow the recommendations of the health care professionals, and how much counselling is really needed throughout the child's life and not just when a diagnosis is given. Bongi will also describe her experiences as a CREATE staff member working with hospital staff on "Breaking Bad News" to people. Although she speaks from the framework of disability these tips will be useful for health professionals working with chronic, rare or terminal illnesses.

Biosketch:



Bongiwe is from rural Estcourt, KZN, is disabled herself as well as being the mother of a child with a disability. She trained as a Community Rehabilitation Facilitator (CRF) at the Institute of Urban Primary Care (IUPHC) for 2-years during 1996 – 1997. She joined Sarah Rule in Pietermaritzburg in 1999 as the 1st CBR trainer and has worked for CREATE for 20 years. She had wide experience in training CRFs until 2006, when training was terminated by the Health Professions Council of South Africa (HPCSA). In 2000 she was involved in developing the CBR training manual for community health workers and facilitators at Valley Trust, KZN as well as a 3-month training for the National Alliance for Child Care Workers (NACCW) to work with children with disabilities. Her work on training for human rights based on the Convention on Rights of Persons with Disabilities (CRPD) started in 2008. She has been involved in enabling mainstream NGOs in KZN to shift from CBR to disability-inclusive development since 2012. She has had a focus on training traditional leaders in access to justice for people with disability, gender-based violence, inclusion of children with disability in Early Childhood Development (ECD) as well as supporting groups of parents of children with disabilities. Bongi is the Deputy Chairperson of the Disability Forum in the Msunduzi Municipality and is about to graduate as a Paralegal Officer. Her present work as the Senior Advocacy Officer at CREATE includes the Impendulo (meaning to answer) project focused on access to justice for people with disability in traditional courts in rural areas, and the Khulumani Collective focused on land and health rights for people with disabilities.

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Nursing and Social Accountability

RuNurSA Key Note Speaker: Mrs Gcina Radebe

Acting on the voice of the community we serve

This paper focuses on nursing and social accountability simply because the South African department of health committed to the implementation of the National Health Insurance (NHI) and Primary Health Care is considered to be the heart -beat of the this NHI. Primary Health Care in South Africa unlike other countries is nurse driven. They have the support and coverage from other health professionals.

The purpose of this paper is to stimulate an open conversation on issues of social accountability that were not raised in my time of training and socialization as a South African and particularly KwaZulu Natal nurse (1975 to 1981). Will it be correct for me to claim that the South Africa was not a democratic country then? This claim comes from the saying that social accountability is an important feature of democracy and one understands that this country only became a democratic country in 1994.

Biosketch:

Mrs Noxolisa Gcina Radebe is with the KZN Provincial Department of Health as a Director Primary Health Care. She holds a degree in B.A. CUR, a Master's in Advanced Community Healthy Nursing and a Master's in Public Health. She started her career as a professional nurse at Edenvale hospital shares the same experiences as many nurses working in a rural clinics without electricity.: 'We used candles and a gas lamp for lighting in the evenings when we had to tend to patients. I remember an incident where I was about to deliver a baby and the lamp burst. I had to use a candle and during the procedure the candle burnt out. I had to complete the delivery in the dark and then transferred the mother and child to a hospital for a check-up. Mrs Radebe spent time at Edendale Nursing College as a Primary Health Care Trainer. In 2003 she was appointed as a District Manager for Sisonke Health District now known as Harry Gwala District. Then, in 2014, she joined the Provincial office as a Director Primary Health Care. The Primary health Care Directorate has a number of innovative ideas such as Ward War room which meets once a week for feedback. War rooms include the ward councillor, community leaders and various governmental departments. In this way, each household receives holistic services ensuring the well-being of all individuals within the community. Another example of lateral thinking is to work in partnership with Cotlands and Mondi to give children in remote villages in Mtubatuba access to early learning play-based opportunities.

The Role of Traditional Leaders in Health Care

PACASA Keynote Speaker: Inkosi Muziwenhlanhla Ngcobo

Acting on the voice of the community we serve

Abstract

The provision of basic health services has been and continue to face stumbling blocks in the health status of rural communities. This emanate from different forms of challenges ranging from seldom or poor infrastructural develops of health facilities, alienation of these facilities from the general community, power management and staff shortage. However, these challenges can be addressed if the culture of health practice is promoted such as dietary guidance, regular checkups and other forms of close medical attention. This culture of health practices can be adopted in light of minimal resources possessed by local communities especially in rural areas. It is at this point where traditional leadership with its authority over and for the people can play vital role. The ability of Amakhosi to influence and instigate any form of culture in communities under their jurisdiction is a great opportunity to either advocate for this culture of health practices and or canvas for better health infrastructural development funds. This apolitical structure continue to be stronger and relevant in rural areas of this country and therefore remain as an ideal structure to channel any form rural development. The involvement of relevant stakeholders at local level can possibly create effective delivery of basic health together with active involvement of local community members promoting sense of ownership and accountability. At core is the effective participation and communication of these structure. It is this view that local governance should be the main focus for the provision of basic health services. It's close proximity to local populace automatically test the effectiveness of government in the delivery basic services as one of basic rights.

Biosketch:

Inkosi Ngcobo is currently an executive member of ILembe Local House of Traditional Leaders. He is also a Chairperson of Nyuswa/Mlamula Development Trust. He completed Bachelor of Social Science (Political Science and Development Studies) in 2012 at University of Kwa-Zulu Natal (UKZN). He went on to do Bachelor of Social Science Honours Degree (Public Policy) and completed it at UKZN. In 2016, he completed Master of Science: Public Policy in UKZN. He then went on to enrol for PhD in Political Science at Western Cape University.

His title of Inkosi (Chief) has not stopped him from being a humble man of the people. He is passionate about community development. This is seen through various social development initiatives (mention a few) the Nyuswa Council has facilitated for young boys and girls. He is a firm believer in the Zulu saying "inkunzi isematholeni" which can be loosely translated to mean that tomorrow's leaders are amongst today's youth.

His legitimacy as a leader is not drawn only from his birth right, but also his dedication to educating himself and developing his leadership skills through education, his passion for community development, general humility as a person and love and dedication to the development of his community.

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Mental health system costs, resources and constraints in South Africa: a national survey and case study for universal health coverage

RMHC Key Note Speakers: Sumaiyah Docrat & Donela Besada

Hearing the voice of the community we serve

The inclusion of mental health in the Sustainable Development Goals represents a global commitment to include mental health among their highest priorities for health and development investments.

Low- and Middle-Income Countries, such as South Africa, contemplating mental health system scale-up embedded into wider universal health coverage-related health-system transformations, require detailed and locally-derived estimates on existing mental health system resources and constraints; the absence of which has led to limited scale-up efforts to address the growing burden of mental disorders in most LMICs.

The speakers will also be sharing their proposal for and reflections on a new and related phase of work towards building the case for investment in mental health in South Africa and the explicit inclusion of mental health in the UHC and NHI agenda.

Between January and October 2018, Sumaiyah and Donela, with support from the National and Provincial Departments of Health, conducted a national survey to quantify public health system expenditure on mental health, and; evaluate the constraints of the mental health system for SA.

They will share the findings of this study, which for the first time, offers a nationally representative reflection of the state of mental health spending in South Africa and reflects on inefficiencies and constraints emanating from existing mental health investments in SA.

The speakers will also be sharing their proposal for and reflections on a new and related phase of work towards building the case for investment in mental health in South Africa and the explicit inclusion of mental health in the UHC and NHI agenda.

Biosketch:

Sumaiyah Docrat is a health economist and researcher at the Alan J. Flisher Centre for Public Mental Health. She holds a masters in public health from the University of Cape Town, specialising in health economics. From 2013 to 2017, Sumaiyah was involved in a collaborative research project entitled the: "Emerging mental health systems in low- and middle-income countries" (Emerald) Project, as a health economics researcher. Her work includes the development of research methodologies and the analysis of data across the six low-and-middle income country sites of the Emerald Project. Sumaiyah is currently pursuing a PhD focusing on economic costs, impacts and financing strategies for mental health in South Africa.

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Donela Besada is a senior scientist at the Health Systems Research Unit (SA Medical Research Council). She holds a masters in public health rom the University of Cape Town, specialising in epidemiology and biostatistics and a diploma in health economics. She is currently a PhD candidate at King's College London's Institute of Psychiatry, Psychology and Neuroscience, where her research will focus on developing an adapted methodology to assess the cost-effectiveness of multi-sectoral interventions and its application to community-based service delivery for people living with severe mental health disorders and intellectual disabilities in South Africa. She has worked with the Medical Research Council for approximately six years focusing on multi-country evaluations of programmes. More recent work has focused on assessing the cost-effectiveness of decentralised MDR-TB care and supporting the Department of Health in understanding the resource implications and health system benefits of the formalisation and scale up of the national CHW programme through an investment case.

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South Africa and HIV in 2019: What is rural medicine to make of all this?

RuDASA Key Note Speaker: Professor Francois Venter

Acting on the voice: Best rural practice

Rural delivery models paved the way for decentralised antiretroviral care. New drug choices are revolutionising the field and becoming widely available within even the South African state sector at breakneck speed. The discussion will be an update on HIV care, and how the new guidelines and research directions may influence rural health workers.

Biosketch:

Willem Daniel Francois Venter FCP (SA), PhD (Wits), Dip HIV Man (SA), DTM&H (Wits)

Professor Venter heads Ezintsha, a sub-syndicate of the Wits Reproductive Health and HIV Institute at the University of the Witwatersrand, Johannesburg. He leads multiple antiretroviral treatment optimisation studies, and has an active interest in public sector access to HIV services. He is currently working on new first and second line antiretroviral options, patient linkage to care interventions, and HIV self-testing projects. He has led large PEPFAR-funded HIV programmes in South Africa, including one that focuses on truckers and sex workers. He has been represented on South African and regional HIV guidelines for over a decade, having done almost all his training within South Africa. He is an advisor to the South African government, ACTG, Southern African HIV Clinicians Society, UNAIDS and WHO. He has been involved in several human rights cases involving HIV within the Southern African region, and has an active interest in medical ethics. His major research currently focus on combinations of newer drugs to improve the resistance and potency while lowering the cost of first and second line antiretrovirals, improve early diagnosis of HIV, facilitate access to pre-exposure prophylaxis, as well as using patient information to drive improved linkage to care after diagnosis. He supervises multiple local and international Masters and PhD students, and is the convenor of the regional Diploma in HIV Medicine and Diploma in Sexual Health and HIV for the Southern African Colleges of Medicine.

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PLENARIES AND PANEL DISCUSSIONS

PLENARY: THE EXTENT OF PATIENT AND COMMUNITY ENGAGEMENT IN ENSURING PARTICIPATORY APPROACHES IN THE DELIVERY OF RURAL HEALTH SERVICES

NCEBA GQALENI

The concept of patient and community engagement in health care settings is a contested terrain and has several meanings based on where the locus of power is located. In South Africa, where inequality has been well-defined it is necessary to interrogate in the context this conference to interrogation how the voices of rural patients and communities served make into the health delivery and policy space. This paper will explore what patient and community means to healthcare workers and rural communities who receive services.

Presenter's Biosketch: Science Engagement Research Fellow at the Africa Health Research Institute

Nceba Gqaleni obtained a masters at the former University of Natal and a doctorate at the University of Strathclyde in Scotland. He is an Honorary Professor University of KwaZulu-Natal and an Adjunct Professor at the Durban University of Technology. He is a member of the Interim Traditional Health Practitioners Council of South Africa.

He previously served as leader of the Traditional Medicine programme, Director of the Centre for Occupational and Environmental Health, Operations Director of the Doris Duke Medical Research Institute and Deputy Dean of Nelson R Mandela School of Medicine, University of KwaZulu-Natal. In 2007 he was appointed the DST/NRF Research Chair in Indigenous Health Care Systems.

He has been a member of the Presidential Task Team on African Traditional Medicine, Deputy Chairperson of the KwaZulu-Natal Provincial Council on AIDS, and the WHO (African Regional Office) expert committee on Traditional Medicine. He is among 20 best authors globally on integration of traditional medical practices into 'mainstream' medical care selected by an international committee of experts from the Inter-Academy Medical Panel and other renowned international scholars. Currently, he serves on the SA HIV and TB Think Tanks.

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ORAL PRESENTATIONS

TITLE	Are Tindzhaka and Tuberculosis the same illness?: Working with Traditional healers in rural Bushbuckridge
AUTHOR/S	**Ryan Wagner**, Carolyn Audet
BACKGROUND	Tuberculosis (TB) in South Africa (SA) has increased significantly in the last 30 years, with an annual incidence rate near 1%. In Bushbuckridge, SA, Tindzhaka is a common condition for which people seek the services of a traditional healer. Tindzhaka is an ailment that affects the lungs and can eventually lead to death. There is suspicion among clinicians that Tindzhaka and TB are the same illness; increased understanding about the causes, symptoms, treatment, and expected outcomes associated with Tindzhaka can be used to engage healers to support testing of suspected TB patients.
METHODS OR DESCRIPTION	In 2015, we completed 27 in-depth interviews and 133 surveys with a simple random sample of traditional healers in rural Bushbuckridge. Healers were mostly female (77%), older (median = 58 [IQR: 50-67 years]), with low levels of education (median = 3.7 [IQR: 3.2-4.2]) years). Seventy-three percent of healers claimed to treat Tindzhaka (while less than 10% claimed to treat TB).
RESULTS OR LESSONS LEARNED	Traditional healers acknowledged that Tindzhaka and TB have overlapping symptoms such as: coughing, difficulty breathing, loss of body weight, fevers and, ultimately – if there is no treatment – death. However, healers maintain that these are two distinct illnesses with differing pathogeneses: social transgressions in the case of Tindhzaka and Myobacteria in the case of TB.
CONCLUSIONS OR WAY FORWARD	With 11% mortality among those who contract TB in SA, it is important that health care practitioners (both traditional and biomedical) work together to prevent poor patient outcomes. Understanding traditional views of disease through further engagement with traditional healers is required.
PRESENTER'S BIOSKETCH	Dr Ryan Wagner is research fellow based within the MRC/Wits Agincourt Research Unit, School of Public Health at the University of the Witwatersrand, Johannesburg. His research interests included epilepsy, cognition and rural health care delivery, including the role of traditional healers. Ryan lived and worked in rural Bushbuckridge for more than a decade (where he completed a MSc by research and a PhD looking at epilepsy) before moving up to Johannesburg to undertake clinical training as a medical student at Wits, class of 2021.
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TITLE	Assessment of the Availability and Accessibility of Rehabilitation Services in a rural district of South Africa
AUTHOR/S	Qhayiya, Magaqa
BACKGROUND	The Right to rehabilitation services for people with disabilities has been articulated in key international documents including the Convention on the Rights of Persons with Disabilities, and locally in the plans for introducing the National Health Insurance in South Africa. However, people with disabilities in rural South Africa continue to have high unmet needs for rehabilitation services such as physiotherapy, prosthetics and speech therapy, to name a few. The objectives of this research are to assess the availability and accessibility of rehabilitation services as it relates to people with disabilities in a rural district, for the purposes of informing the implementation of the National Health Insurance.
METHODS OR DESCRIPTION	This study approaches the assessment of rehabilitation service provision for people with disabilities from a health policy and systems research perspective. First, national and sub-national policies relating to disability and rehabilitation are reviewed for the extent to which they facilitate access to rehabilitation services. Second, drawing from the policy review, the current implementation gap between the policy directives and the provision of rehabilitation services is described. Third, interviews with people with physical disabilities illuminate their experiences of both accessing and not accessing rehabilitation services.
RESULTS OR LESSONS LEARNED	Preliminary results point to an important policy-practice gap as it relates to how people with disabilities access rehabilitation services in a rural district. Further, this gap is multi-factorial and described in terms of resource allocation and priority setting practices, health facility service provision and rehabilitation human resources in the Eastern Cape.
CONCLUSIONS OR WAY FORWARD	The results of this study will be important for informing the effective implementation of the National Health Insurance as it relates to rehabilitation services and a traditionally marginalised population in South Africa, namely people with disabilities.
PRESENTER'S BIOSKETCH	I am a physiotherapist and doctoral candidate at the University of Oxford. My research explores how the health system may best respond to the rehabilitation needs of people with disabilities in rural South Africa, and within the context of universal health coverage plans.
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TITLE	Community healthcare worker response to childhood disorders: Inadequacies and needs
AUTHOR/S	**Pragashnie Govender**, Deshini Naidoo
BACKGROUND	Community Healthcare workers play a vital role in linking health facilities and communities where there is a prevalence of childhood disorders. However, there is a limited literature on whether this cadre of worker is adequately prepared for this task. Aim: This study explored the priority training needs of community healthcare workers (CHWs) working in the field of childhood disorders and disabilities to improve future training of CHWs and service delivery.
METHODS OR DESCRIPTION	**Method:** This qualitative study used purposive sampling to recruit 28 CHWs and four key informants working in health facilities in one district of KwaZulu Natal. Data were collected via semi-structured interviews and focus groups. Interviews were conducted in the first language (isiZulu) of the CHWs. Data was analysed thematically. Ethical clearance was obtained from the University Research Ethics Committee.
RESULTS OR LESSONS LEARNED	**Results:** There was an evident lack of knowledge and skill in managing childhood disorders and disabilities by CHWs. Enablers and restrictors affecting service delivery were highlighted, namely staff shortages, lack of transport, supervision, passion and roles of other stakeholders. The training of CHWs that is offered by the ministry of health appears to not include childhood disorders and disabilities resulting in a lack of confidence and demotivation of CHWs.
CONCLUSIONS OR WAY FORWARD	**Conclusion:** Training of CHWs in childhood disorders may assist improving CHWs competence and confident in the field which may enhance service delivery at this level of care, which may have positive spinoffs towards ensuring optimal health care for children.
PRESENTER'S BIOSKETCH	Associate Professor Pragashnie Govender Experienced Lecturer with a demonstrated history of working in the higher education industry. Skilled in Clinical Research, Research Design, Lecturing. Strong education professional with a Doctor of Philosophy (Ph.D.) focused in Health Sciences from University of KwaZulu-Natal.
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TITLE	Community Participation: What? Why? So what? and What Next?
AUTHOR/S	**Steve Reid**, Hoffie Conradie
BACKGROUND	Community participation is an ideal that is seldom fully realized in practice in rural areas. There are often attempts to involve community members in the planning and delivery of health services, but they are characteristically not sustained over time. They also tend to be dependent on specific individuals who purportedly represent the whole community, without thorough processes of representation. Communities and health workers often become disillusioned with these attempts, and this lack of sustainability seems to be a recurring pattern.
METHODS OR DESCRIPTION	We ask the question WHAT? What is the current state of community participation in rural health services in South Africa? What do we actually mean by community participation? And what do we actually mean by the terms community responsiveness, involvement, or accountability? Secondly, we ask the questions WHY and SO WHAT? Why is community participation important? In what ways does it make a difference? Why should we spend time and effort on involving communities in how services are delivered, beyond satisfaction surveys? What are the underlying set of assumptions that drive this process? How does it relate to political realities and processes?
RESULTS OR LESSONS LEARNED	Finally, having made an analysis of the situation, we wonder WHAT NEXT? How could this become a two-way process, a dialogue, and a continuous process of adaptive action? What are the next steps that we need to take individually and collectively in order to make this happen? What needs to happen at a community level in order for this to be sustainable?
CONCLUSIONS OR WAY FORWARD	This paper will be based on the ideas, reading, and reflection on the authors' experiences of community participation over many years of rural practice in South Africa, stimulated by the question of what would make community participation sustainable and meaningful in our context.
PRESENTER'S BIOSKETCH	Rural family physician from Obonjeni; now academic at University of Cape Town; head of Primary Health Care at UCT. Supporter of RSN and RUDASA; Board member of RHAP, SHAWCO and Tekano. Also a musician and involved in the medical humanities.
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TITLE	Community stakeholders' perspectives on the role of occupational therapy in primary healthcare
AUTHOR/S	**Deshini Naidoo**, Pragashnie Govender
BACKGROUND	Primary healthcare (PHC) is central to increased access and transformation in South African healthcare. There is limited literature about services required by occupational therapists in primary healthcare. Despite policy being in place, the implementation of services at grassroots level does not always occur adequately. Objectives: This study aimed at gaining an understanding of the challenges of being disabled and the services required by occupational therapists in rural communities to better inform the occupational therapy curriculum.
METHODS OR DESCRIPTION	**Methods:** An exploratory descriptive qualitative design was implemented using purposive sampling to recruit 23 community healthcare workers from the uGu district. Snowball sampling was used to recruit 37 members of the uGu community, which included Persons with disabilities and caregivers of Persons with disability. Audio-recorded focus groups and semi-structured interviews were used to collect data, which were thematically analysed. Ethical approval was obtained from the University Research Ethics Committee.
RESULTS OR LESSONS LEARNED	**Results:** Two main themes emerged namely: firstly, the challenges faced by the disabled community and secondly appropriate opportunities for intervention in PHC. A snapshot of the social and physical inaccessiblity challenges experienced by the community was created. Challenges included physical and sexual abuse, discrimination and marginalisation. Community-based rehabilitation and ideas for health promotion and prevention were identified as possible strategies for occupational therapy intervention.
CONCLUSIONS OR WAY FORWARD	The understanding of the intervention required by occupational therapists in PHC was enhanced through obtaining the views of various stakeholders' on the role. This study highlighted the gaps in community-based services that OTs should offer in this context.
PRESENTER'S BIOSKETCH	Deshini Naidoo is currently a lecturer within the Discipline of occupational therapy, in the School of Health sciences at the University of KwaZulu Natal. Research interests includes health professions education, primary healthcare and rehabilitation.
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TITLE	Effectiveness of ICT-enabled Community Oriented Primary Care
AUTHOR/S	Sanele Ngcobo
BACKGROUND	In low-resource settings, CHWs are frontline providers who shoulder much of the health service delivery burden. Increasingly, mobile technologies are developed, tested, and deployed with CHWs to facilitate tasks and improve outcomes. In 2016 the Gauteng Department of Health engaged UP Family Medicine to provide education, training and information technology support for the phased scale-up of ward based outreach teams (WBOTSWBOTs) through information and communication technology enabled community oriented primary care (ICT-enabled COPC). AitaHealth is an electronic data and human resource management and support system for Ward Based Outreach team. **Aim** To assess data obtained through ICT-enabled COPC.
METHODS OR DESCRIPTION	We conducted a retrospective analysis, reviewing AitaHealth data collected by 4239 CHWs from Jan 2014 to June 2019.
RESULTS OR LESSONS LEARNED	It was found that, 4239 CHWs in 553 WBOTs used AitaHealth. During this period 930 000 people were registered onto AitaHeath, with 306 493 households assessed. In the households assessed, there were 85 755 individuals with chronic illnesses, 16 639 children with incomplete immunizations, 5097 women receiving post-natal care services.
CONCLUSIONS OR WAY FORWARD	AitaHealth has improved patient management in the community level, quality of data collected by CHWs, CHWs performance management and WBOT monitoring and evaluation.
PRESENTER'S BIOSKETCH	I am a Clinical Associate (29, male), currently working at UP as a lecturer with focus in COPC. I obtained DPH in 2014, MPH 2016 and currently a PhD Candidate at UP.
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TITLE	Expertise on disability needed on WBOTS
AUTHOR/S	Pam McLaren
BACKGROUND	RuReSA has long recognised that there is a lack of information and expertise on disability and the potential of rehabilitation for health workers employed as members of the ward-based outreach teams (WBOTs). There have been attempts at advocacy for a community disability/ rehabilitation worker to be included as part of the team.
METHODS OR DESCRIPTION	At a Community Orientated Primary Care (COPC) Conference in Durban, April 2019, a booklet shared 22 stories written by health workers from outreach teams in all 11 KZN districts. Documenting the work of WBOTs showed what positive changes they had brought about in people's lives. A significant number of the stories illustrated the need for more information on the different types of impairments that may lead to life-long disability in children, youth and adults.
RESULTS OR LESSONS LEARNED	CREATE (Community Rehabilitation for Education and Training for Empowerment), a non-profit organisation in Pietermaritzburg, has a long history of expertise in disability awareness and sensitisation. The organisation has been successfully training Community Caregivers (CCGs) from WBOTs in some districts of KZN with funding from the Finnish Evangelical Lutheran Mission (Felm) An evaluation of the CCG training identified a major shift in their motivation to engage with people with disabilities. Prior to the training they were nervous, in some cases afraid, to enter the homesteads where people with disabilities required intervention.
CONCLUSIONS OR WAY FORWARD	It is recommended that urgent attention is given to empowering CCGs. Providing them with information and training on disability and the potential of rehabilitation, as well as the rights of children, youth and adults with disabilities, will fulfill this need.
PRESENTER'S BIOSKETCH	Pam McLaren trained as an occupational therapist in 1971 but soon became an advocate for rural disability and a proponent of community-based rehabilitation (CBR) in northern KwaZulu. She became a disability researcher after obtaining a PhD in Community Health in 1991. Her passion is action research - she and Sue Philpott started DART (Disability Action Research Team) in 1995 and have been colleagues ever since.
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TITLE	Hearing the voices of patient/client families – are we listening?
AUTHOR/S	Professor Petra Brysiewicz
BACKGROUND	Involving families in patient/client care is not just better for patients/clients, it's crucial to success in today's healthcare landscape.
METHODS OR DESCRIPTION	This presentation will provide a synthesis of findings from a targeted body of research directed towards family focused care in the acute care setting (intensive care units and emergency departments) within Africa and South Africa. It will focus on the following questions ● Who is the family? ● What do the families experience? ● What can nurses do to improve their experiences?
RESULTS OR LESSONS LEARNED	There are challenges when engaging with families however there are a number of strategies which can be used.
CONCLUSIONS OR WAY FORWARD	Family members need to become active partners in decision making and care and this requires a change in the mind set of healthcare professionals.
PRESENTER'S BIOSKETCH	Professor Petra Brysiewicz is a full professor in the School of Nursing & Public Health at the University of KwaZulu-Natal, South Africa. She is currently involved in teaching Trauma/Emergency Nursing at undergraduate and post-graduate level as well as Qualitative Research Methods course at master's level. Professor Brysiewicz is an Executive Committee Member of various emergency care organizations and through these societies is playing an active role in the further development of emergency care in South Africa and Africa. She is the co editor-in-chief of the International Emergency Nursing journal.
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TITLE	Evaluating the implementation of the Standard Treatment Guidelines (STG) and Essential Medicines List (EML) at a public South African tertiary institution and its associated primary health care (PHC) facilities.
AUTHOR/S	Tashni Govender, Velisha Ann Perumal-Pillay
BACKGROUND	In order to reform a frail, resource-constrained health care system, the South African National Department of Health (NDoH) adopted the National Drug Policy (NDP), which allows for the provision of an Essential Medicines List (EML), guided by the Standard Treatment Guidelines (STGs), and is in the process of implementing universal health care, National Health Insurance (NHI). The STGs and EMLs serve as a guide to prevent irrational prescribing, promote cost-effectiveness and improve accessibility to medicines.
METHODS OR DESCRIPTION	The purpose of this study is to evaluate the use and implementation of the STGs/EMLs by prescribers at a public tertiary institution and its associated PHC facilities in the uMhlathuze subdistrict in the King Cetshwayo district of KwaZulu Natal. The study aims to provide feedback and make recommendations to policy makers to improve the use and implementation of the STGs/EMLs and to inform NHI policy development. An observational quantitative research design will be used. A survey will be conducted and questionnaires will be utilized to collect data from nurses and doctors to evaluate the utilization of the STGs/EMLs and the rational use of medicines.
RESULTS OR LESSONS LEARNED	To be completed and presented at conference
CONCLUSIONS OR WAY FORWARD	NHI is a single financing system that will provide citizens with essential healthcare, thus will rely on the STGs/EMLs as guiding policies. As South Africa moves toward improving health outcomes through NHI, this study will provide a grassroots picture of how the STG/EML is being used and implemented. The research this study provides may inform policies involved in the development and implementation of NHI or provide novel recommendations for improvement of the current Essential Medicines Programme.
PRESENTER'S BIOSKETCH	Bachelor of Pharmacy, UKZN, pursuing a Masters degree in Pharmacy. Currently employed as a clinic pharmacist at Ngwelezana Hospital, KZN.
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TITLE	How Do We Create an Enabling Environment for Healthcare Workers to Advocate in South Africa?
AUTHOR/S	Karessa Govender
BACKGROUND	The purpose of this presentation is to critique the current environment in which healthcare worker advocacy takes place, to what extent this environment supports or hinders advocacy and provides recommendations on how these conditions can be addressed going forward in order to create an environment that supports healthcare workers when advocacy is indicated.
METHODS OR DESCRIPTION	This presentation has been influenced by RHAP's experiences with healthcare worker advocacy; a) as providers of advocacy training and b) supporting individual healthcare workers during their advocacy efforts. Our experiences reveal that a number of different conditions are required for healthcare worker advocacy to be effective. This includes robust policy and legislature and its implementation, strong statutory and regulatory bodies, working and academic environments that support current and future healthcare workers and lastly, adequate training on healthcare worker advocacy are all necessary factors that contribute towards effective healthcare worker advocacy.
RESULTS OR LESSONS LEARNED	We will investigate each of the above conditions to determine to what extent it supports or hinders healthcare worker advocacy. We will then go on to provide recommendations based on best practice available. The presentation will include critical analyses of advocacy efforts (case studies) by healthcare workers in an attempt to draw conclusions on what constitutes effective and ineffective advocacy by this population.
CONCLUSIONS OR WAY FORWARD	Thus far, healthcare workers have been lambasted both when they choose to speak up and when they choose not to. Subsequently, commentary has focused solely on the healthcare worker with very little discussion on the environment in which healthcare worker advocacy takes place. It is intended that through this presentation, critical discourse around healthcare worker advocacy will be stimulated and active steps be taken to create an environment that supports healthcare worker advocacy through reforms in policy and legislation, training institutions and health facilities, statutory and regulatory bodies.
PRESENTER'S BIOSKETCH	Karessa Govender is a project coordinator at the Rural Health Advocacy Project. An occupational therapist by profession, she has worked in the public sector for close to 7 years before moving into civil society. She is passionate about healthcare worker advocacy and citizen voices in realising the right to health. She holds a masters degree in occupational therapy through the University of the Witwatersrand. Her core work includes coordinating a learning site in a predominantly rural district in the Eastern Cape; OR Tambo District, in addition to supporting the organisation's HRH programme and training healthcare workers and health science students on how they can effectively advocate for their patients in the public health system.
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TITLE	Hybrid Clinician-Managers – Combining Clinical and Managerial Worlds to make rural healthcare work
AUTHOR/S	Jacobus (Koot) Kotze
BACKGROUND	In rural district hospitals, clinicians shoulder enormous responsibility, not just for managing the care of individual patients, but also developing staff and services at primary and hospital level, and contributing to wider decision-making around health care priorities and resource allocation." (Rural Health Advocacy Project, 2017) Throughout primary and secondary healthcare in rural South Africa, clinicians are relied upon to take up managerial responsibilities and roles. In doing so, they "hybridize" their clinical roles with managerial roles. The "hybrid clinician-managers" (HCMs) are expected to occupy clinical roles as well as adapt to leadership and management expectations, but evidence suggests that not all are able to make this transition equally well. Clinicians adopting the role of HCM "willingly", "reluctantly" or "incidentally" have an impact on the quality of the service they can provide. The success or failure of rural clinicians in taking on managerial roles has important consequences for our ability to act on rural voices.
METHODS OR DESCRIPTION	Several theoretical frameworks have been used to understand the process by which clinicians engage in management roles, including that of trait theory, identity transition, moral leadership influenced by professional background, distributed leadership, and more. Combining the insights of these myriad viewpoints may offer a more complete perspective on how clinicians take on management roles and combine this with clinical work.
RESULTS OR LESSONS LEARNED	This talk will explore and summarize the current literature around the combination of clinical and managerial roles in both developed and developing contexts. Furthermore, we will discuss the processes which have been identified as facilitating and hindering this combination. We will consider the implications of these findings for rural healthcare in South Africa.
CONCLUSIONS OR WAY FORWARD	We will also present the unanswered questions from the literature, as well as experiences in South African rural healthcare, and propose a strategy to answer these and advance rural health.
PRESENTER'S BIOSKETCH	South African medical doctor, DPhil student at the University of Oxford, Department of Primary Care Health Sciences.
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TITLE	Izwi Labazali: sharing the work of CREATE with parents of children with disabilities
AUTHOR/S	Bongiwe Mbona
BACKGROUND	This presentation begins with a description of CREATE, an organization based in Pietermaritzburg which is involved with promoting disability-inclusive development in rural districts of KwaZulu-Natal.
METHODS OR DESCRIPTION	Goals of the work with parents of children with disabilities are outlined, as is the training and support offered to them by CREATE. The processes of work with parents are described, including setting baselines, fabric mapping and workshops. There is identification of the impact of the engagement with parents by CREATE as well as what staff of the organization have learnt from it. Principally this is that "parents are strong".
RESULTS OR LESSONS LEARNED	The presentation will conclude with two parents sharing their personal experiences of involvement – around the questions of what has changed, the impact that CREATE's input has had on them and what they are planning to do going forward.
PRESENTER'S BIOSKETCH	Mrs Bongiwe Mbona joined CREATE in September 2017. She has an Adult Basic Education and Training (ABET) qualification from the University of South Africa (UNISA). She has experience in community work previously being employed by Red Cross as a home-based carer. She conducts workshops with parents of children with disabilities, enabling them to form support groups and savings groups in rural areas. She trains community care givers (CCGs) deployed by the KZN Department of Health in the Ward Based Outreach Teams (WBOTS) on inclusive health which includes an orientation to disability rights and an explanation of the different forms of impairments that may result in disability in children, youth and adults. Her work also covers access to health, land and justice for women with disability in rural areas.
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TITLE	Identification of baseline information about sexual health problems of learners in a selected high school in Mamelodi, Gauteng Province.
AUTHOR/S	**Roinah Ngunyulu**, FM Mulaudzi, MD Peu, O Khumisi, M Sethole
BACKGROUND	The highest rates of pregnancies worldwide are in low to middle income countries, including South Africa. The Stats SA General Household survey report, which focused on schools revealed that 99 000 teenagers fell pregnant in 2013. Amongst the 99 000 the highest teenage pregnancy rate is in the provinces of Kwazulu Natal (26 468), Eastern cape (20 698), and Limpopo (13 941). In 2018 Stats SA reported that 97 143 teenagers gave birth. In the selected high school in Gauteng, there was 18 learners who were pregnant during the time of problem identification in 2018. Teenage pregnancy comes with many complications. In addition to emotional and financial strain for the mother, pregnancy at a young age carry risk of complications that can lead to mortality of both the young mother and her baby.
METHODS OR DESCRIPTION	Purpose: The study aimed at identification of baseline information about sexual health problems of learners in a selected high school in Mamelodi, Gauteng Province, with the intention to promote sexual health, improve psychological well-being and prevention of pregnancy. Research design: A qualitative research design was used. The learner and educators were purposefully selected for the study. Two (one with the learners and one with the educators) focus group discussions were used during data collection. Content analysis was used during data analysis.
RESULTS OR LESSONS LEARNED	Three themes: learner's sexual health needs, contributory factors to teenage pregnancy and strategies to address health needs, and sub-themes: parental involvement in sexual health issues, free condom contribution, sex education in schools, homes and churches, use of technology and stepping stones approach were identified as strategies to reduce the rate of teenage pregnancy.
CONCLUSIONS OR WAY FORWARD	It is concluded that the researchers should work in collaboration with the parents and Life Orientation educators to address the high rate of teenage pregnancy and substance abuse which are the main health problems amongst the learners. Other sustainable interventions to curb the identified problems should be explored to promote the sexual health of learners.
PRESENTER'S BIOSKETCH	Senior Lecturer at the University of Pretoria, PhD in Nursing, Advanced Community Nurse, Advanced midwifery and neonatal nursing science
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TITLE	Knowledge, attitudes and practices about nutrition and child development in mothers with under 5-year-old children in a district hospital in KwaZulu-Natal, 2017.
AUTHOR/S	Nonjabulo Ndaba, Dr Stephen Knight
BACKGROUND	Child malnutrition is a leading public health concern globally resulting in substantial mortality, morbidity and disability. Poor childhood nutrition is associated with poor cognitive, neurological, physical and socio-emotional developmental outcomes in children. According to the World Health Organization, there are many interlinked factors that contribute to child malnutrition, which are common in low- and middle-income countries such as South Africa. Few studies have looked at the influence maternal factors have on child malnutrition and development in these countries. This study aims to determine whether there is a connection between what mothers of under 5-year-old children understand about nutrition and a child's development, in a district hospital in KwaZulu-Natal in 2017.
METHODS OR DESCRIPTION	An observational analytical unmatched case control study design was used. The study participants were mothers with children under the age of five presenting at the paediatric care sections of Northdale District Hospital. The mothers of children who had developmental delays were the cases studies; and the mothers of children who were well developed were the controls.
RESULTS OR LESSONS LEARNED	Pre-tested questionnaires were administered to 144 mothers of children under 5 years old. There were 48 cases with delayed developmental milestones and 96 controls (2:1) with normal development. Statistically significant risk factors for developmental delay were living in an informal area (adjusted odds ratio (aOR) 2.5; 95% confidence interval (CI) 1.0 to 6.2; p=0.046); maternal illness (aOR 2.7; 95% CI 1.0 to 7.0; p=0.042); and the risk of developmental delay in children was nine times higher amongst mothers who did not practise good nutrition (aOR 8.7; 95% CI 1.5 to 49.5, p=0.015).
CONCLUSIONS OR WAY FORWARD	Maternal sociodemographic characteristics and their child nutrition practices play a role in the normal development of children in this community. Health professionals caring for children need to be aware of these risk factors; implement relevant community based interventions and encourage interdisciplinary collaboration in practice.
PRESENTER'S BIOSKETCH	BSc in Occupational Therapy (UCT); Masters in Public Health (UKZN)
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TITLE	Kopano Ke Matla – In Unity there is Power
AUTHOR/S	**Michelle Flowers**, Gillian Saloojee
BACKGROUND	Despite excellent legislation and inclusion policies, as well as government-based health workers, private health care practitioners and non-profit organizations, the majority of South African children living with disabilities. are still not receiving the health care and rehabilitation services they require and deserve. This gap in service provision is intensified in rural communities. The growing number of non-profit organisations serving children with disabilities, whilst offering excellent services, are often limited in their reach and impact relatively small numbers of children with disabilities. What would happen if more collaboration between various organisations, including community members existed?
METHODS OR DESCRIPTION	In 2018 Malamulele Onward and Shonaquip Social Enterprise partnered together to address the quality of life of children with disabilities living in rural areas of the Eastern Cape, Kwa-Zulu Natal and Lesotho. Malamulele Onward is a Johannesburg based non-profit organization. They recognize that in order to improve a child's quality of life, one cannot work in isolation. Malamulele Onward has trained roughly forty mothers of children with Cerebral Palsy who are equipped to support caregivers from their communities using a practical, problem-solving based approach. There are five Parent facilitators based in rural areas in Lesotho and they have named their program "Kopano ke Matla," which means, "In unity there is power," an apt title for this presentation.
RESULTS OR LESSONS LEARNED	Through these Parent Facilitators, relationships with local therapists, and funding from ELMA Philanthropies, Shonaquip and Malamulele Onward worked together to change the lives of 56 children in Lesotho through the provision of assistive devices whilsttheir caregivers and the local Parent Facilitators were trained in seating and technical repairs of devices.
CONCLUSIONS OR WAY FORWARD	Using this case study of collaboration in Lesotho, this presentation paints a picture of what teamwork between organizations can achieve, and the lessons learned along the way.
PRESENTER'S BIOSKETCH	Occupational therapist Augmentive and Alternative Communication (UP 2012), Post-graduate Diploma in Palliative Medicine (2016), NDT trained. Worked at MO and Shonaquip amongst other rural settings with children with severe disabilities.
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TITLE	Marked increase in antiretroviral therapy initiation in a rural KwaZulu-Natal community, after implementation of the universal test and treat guidelines at Bethesda District Hospital
AUTHOR/S	Dr Thandaza Cyril Nkabinde, Dr Jienchi Dorward, Mr Siyabonga Mkhize, Mr Nhlanhla Gwala, Mr Mbongiseni Thabethe, Dr Nompumelelo Gloria Mfeka-Nkabinde, Dr Kelly Gate
BACKGROUND	In September 2016, Bethesda District Hospital implemented the South African National Department of Health guidelines to provide universal treatment for all people living with HIV, irrespective of CD4 count. We aimed to evaluate whether removal of CD4 count thresholds resulted in large increases in antiretroviral therapy (ART) initiations in this rural community setting, which has a high burden of HIV and tuberculosis.
METHODS OR DESCRIPTION	We analysed routinely collected clinical and laboratory data from Bethesda Hospital and its 8 primary care clinics in rural uMkhanyakude District, KwaZulu-Natal, South Africa. All non-pregnant patients, aged >15 years initiating ART between Jan 2015-June 2018 were included in the analysis. We assessed trends in ART initiations as well as the mean CD4 count and proportion with tuberculosis at ART initiation.
RESULTS OR LESSONS LEARNED	Overall 5524 patients were initiated on ART in the study period, of which 3607 (65.3%) were female, 1917 (34.7%) were male, and median age was 32 years (interquartile range [IQR] 26-39). There was an increase of 53% from 342 to 522 ART initiations in the quarter when universal treatment was implemented, compared to the previous quarter. However, there was a subsequent decrease to pre-universal treatment levels (Figure). Mean CD4 count before universal treatment implementation was 302 cells/mm3 (standard deviation [SD] 192) compared to 402 cells/mm3 (SD 265) after universal treatment. The proportion of patients with tuberculosis at ART initiation was 8.6% (95% CI 7.5-9.9) before universal treatment, and 5.2% (4.5-6.0) afterwards.
CONCLUSIONS OR WAY FORWARD	In this rural South African district, implementation of universal treatment was associated with an initial rise in ART initiations, sustained increase in initiation CD4 count, and decrease in the proportion with tuberculosis. This supports the rollout of universal treatment to combat the HIV and tuberculosis epidemic in this high prevalence rural community
PRESENTER'S BIOSKETCH	Qualifications: MBChB (UKZN), MMed Family medicine (UKZN), FCFP (CMSA). Dr Nkabinde is a Family Physician currently employed at the University of KwaZulu Natal, department of family medicine as a lecturer/specialist. He has a masters degree in Family medicine, and his masters research focused on the internship training program in KwaZulu Natal, to see if it adequately prepared South African medical graduates for community service. He worked in a rural district hospital for 4 years as a Family Physician prior to joining the university, thus has a special interest in rural medicine. He is the academic coordinator of the undergraduate final year rural block, which places final year medical students for 6 weeks in rural district hospitals across KwaZulu-Natal. He is also very interested in experiential learning in rural district hospitals, hence he is currently working on his PHD around this topic, exploring how doctors learn in a rural environment. He is also involved in other research projects focused on malnutrition in rural communities.
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TITLE	Men, Media and Society
AUTHOR/S	Nokwanda Khanyile
BACKGROUND	The idea of being a man or a woman transcends the biological composition of a person and is mainly rooted in constructs given by societies. The most common definitions of what it is to be a man or masculine involve being a provider, aggressive, competitive and instrumental as opposed to being feminine which includes traits such as being cooperative, passive and expressive. The definition of what it is to be a man is evolving, in the age of social media and mainstream media new constructs are being added to the definition of being a man.
METHODS OR DESCRIPTION	Theories such as symbolic interactionism within the field of sociology assert that people choose their line of behavior and thought as they interact with a given situation while the cultivation theory suggests that what we consume through media will influence how we act. This is because people have minds and selves which allow them to choose their line of behavior.
RESULTS OR LESSONS LEARNED	Using data collected through individual interviews from a sample of seven (7) homosexual male participants from the Gay and Lesbian Network in Pietermaritzburg, this study sought to answer the questions of whether or not men find it hard to act according to societal standards of masculinity. Moreover, whether or not the definitions that the participants had were rooted in the media or society.
CONCLUSIONS OR WAY FORWARD	From a thematic analysis done from the results obtained, the study found that participants regardless of their non-conformity to the hegemonic masculinity ideal will still construct their identities around the hegemonic masculinity, even though the media has some influence on how they define being masculine the society and community in which they reside will have a greater influence.
PRESENTER'S BIOSKETCH	I am Nokwanda Nomzamo Khanyile, a Sociology Honors Degree holder from the University of KwaZulu Natal. My areas of interest include Education, Public Health, Mental Health and Rural Development.
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TITLE	Nutritional support in HIV infected patients: perceived knowledge and practices among nurses working in a district hospital in KwaZulu-Natal
AUTHOR/S	**Simphiwe Andreas Mabaso**, Nomaxabiso M. Mooi
BACKGROUND	Adequate nutritional support contributes significantly in the recovery of HIV infected patients. Nurses, as primary care providers require appropriate knowledge, skills and guidelines to integrate nutritional support in the management of HIV infected patients. Purpose: The aim of this study was to assess perceived knowledge and practices of nurses working at a district hospital in KwaZulu-Natal pertaining nutritional support in HIV infected patients.
METHODS OR DESCRIPTION	This study followed a quantitative and descriptive research design. A 38-item questionnaire was used to collect the data. Data was analyzed using Statistical Package for Social sciences, version 25. Ethical clearance was granted by the University of KwaZulu-Natal Humanities and Social Sciences Research Ethics Committee and the KwaZulu-Natal Department of Health Research and Knowledge Management committees, reference numbers HSS/1375/017M and HRKM Ref:348/17, respectively.
RESULTS OR LESSONS LEARNED	A total of 259 questionnaires were distributed and all returned yielding a response rate of 100 per cent. Nurses' perceived knowledge pertaining nutritional support for HIV infected patients were adequate (61.8 %), but their practices were vastly poor. Factors associated with nurses' knowledge were nurses' age (p=0,003), type of training institution (p=0,034) and nursing category (p=0,002). Nurses' practices were associated with type of nursing qualification (p=0,019), nurses' gender (p=0,038) and availability of nutritional protocols.
CONCLUSIONS OR WAY FORWARD	Nurses' knowledge pertaining nutritional support of HIV infected patients was satisfactory, however, their practices were poor attributable to the scarcity of formal nutritional training and the lack of standardised nutritional guidelines and protocols in the healthcare institution. This study recommends a formulation of standardised nutritional support protocols pertaining nutritional support for HIV infected patients and continuous in-service training of nurses.
PRESENTER'S BIOSKETCH	Originally from Ladysmith Matriculated from Emhlwaneni High School Bachelor of Nursing from UKZN Recipient of UKZN Talent and Equity Scholarship Master of Nursing Research from UKZN Community Service 12 Months King Dinizulu Hospital Currently Working as Registered Nurse at Primary Healthcare, Isiboniso Clinic
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TITLE	Palliative Care- An Integral Component of Universal Health Coverage Implications for Rural Communities
AUTHOR/S	Thilo Govender, Andy Gray
BACKGROUND	The World Health Organisation (WHO) defines Palliative Care, "as an approach for patients and their families facing problems associated with life threatening diseases, through the prevention and relief of suffering, the early identification and impeccable assessment and treatment of pain and other distressing symptoms, physical, psychosocial and spiritual". As South Africa) strives to achieve Universal Health Coverage (UHC), to ensure access to health services for all citizens without financial hardship; Palliative Care remains a neglected component. Despite being a signatory to the World Health Assembly (WHA) declaration of 2014 which mandates member states "to strengthen Palliative Care as part of comprehensive services throughout the life course", progress is slow.
METHODS OR DESCRIPTION	The study utilised the Walt and Gilson Health Policy Analysis framework which includes stakeholder analysis, process mapping and document analysis to describe the context, content and actors formulating health policy. The National Policy Task Team was chaired by the Minister of Health for KwaZulu Natal, Dr Dhlomo, with participation from the non-governmental sector, academia and allied government departments. Broad stakeholder engagement was pivotal in policy formulation.
RESULTS OR LESSONS LEARNED	The first South African Palliative Care policy was launched in KwaZulu Natal in May 2018. Implementation at provincial and district level has been hindered by limited resources and competing health priorities. While partnering with the Hospice movement has the potential support the public health system, many hospices are closing due to funding constraints and few are located in rural areas. Improving in-service training programs, use of telemedicine and online learning opportunities while adapting the undergraduate and postgraduate curricula in parallel is needed to rapidly upskill healthcare workers in urban and rural communities. Health Policy analysis plays a central role in health sector reform. Policy goals must be clearly articulated, adequately resourced with feasible implementation plans.
CONCLUSIONS OR WAY FORWARD	Palliative Care is largely absent in the public health sector service package, training curricula and budget allocation and more so for rural communities. Initial tentative steps may falter if not adequately resourced and attention paid to underserved areas.
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TITLE	Place in the Sun: Reflections on Rurality
AUTHOR/S	Ian Couper
BACKGROUND	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 are the key features of "being rural", and how place links to a range of factors that influence how people live, with relationships being central to that.
METHODS OR DESCRIPTION	A review of the published and grey literature was undertaken to explore the issues of place and space in relation to rurality, and the meanings of this for rural communities, as part of preparation for an inaugural lecture.
RESULTS OR LESSONS LEARNED	We have struggled for years to establish universal or even national definitions of rurality, not only in the health sector but also across fields such as education, sociology, geography, and rural studies. However, rurality should be seen as a lived experience. Conceptions of place and space include multiple dimensions that need to be explored. Rural areas demand our attention not because of how we define them but because of their meaning in the lives of people, their historical significance and their future hope.
CONCLUSIONS OR WAY FORWARD	Is the definition of 'rural' really an issue? It may be 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.
PRESENTER'S BIOSKETCH	Director, Ukwanda Centre for Rural Helath and Professor of Rural Health, Department of Global Health, Stellenbosch University
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TITLE	Portable digitised timesaving paediatric vision screener for South Africa
AUTHOR/S	Naimah Ebrahim Khan
BACKGROUND	Competent vision screening during early childhood is integral to early intervention and a favourable prognosis. Vision screening occurs at some schools in South Africa, however screening in rural schools is irregular as there are insufficient optometrists to meet the human resource demand for this activity. An ecologically valid digital vision screener, BONA (Basic ocular ngane assessment) in the form of a software program was developed, that can be used by non-optometrists to conduct vision screening in primary schools in KwaZulu-Natal (KZN). BONA is comprehensive and conforms to the standards set by the Health Professions Council of South Africa (HPCSA).
METHODS OR DESCRIPTION	The design phase involved identifying the school screening protocol via a review of HPCSA documents, planning the design and implementation with a software engineer, modifying traditional tests by incorporating ecologically valid targets and digitising, program development and pilot testing proof of concept, grading using a technology readiness level indicator, translating the program interface into isiZulu and the development of English and isiZulu instruction manuals. The second phase involved a logistic applicability exercise in the community to compare BONA to the traditional testing method on 355 primary school learners (grade R – grade 3) in rural schools.
RESULTS OR LESSONS LEARNED	BONA, when compared to traditional vision screening tests showed minimal differences in pass/fail results. BONA was preferred by 78 % of the participants compared to the 16 % who preferred the traditional screening protocol. It takes an average of 5.30 ± 0.9 minutes to administer BONA and an average of 10.30 ± 1 minutes to screen via the traditional method. Research participants indicated that BONA was more fun, quicker and easier.
CONCLUSIONS OR WAY FORWARD	BONA uses an e-Health platform and can screen children for vision problems in all communities. It can be translated into any language and is a comprehensive visual screener that non-optometry personnel can be trained to use.
PRESENTER'S BIOSKETCH	Naimah Ebrahim Khan is a Lecturer in the Optometry Department at the University of KwaZulu-Natal. She holds a master's degree and is currently completing a PhD in Optometry. She teaches both undergraduate and postgraduate students. Her specialties are contact lenses, dry eyes, digital optometry, optics and paediatric vision. She believes that South African researchers should work on local challenges and her research has focused on dry eyes in KwaZulu-Natal, contact lenses and contact lens practice in KwaZulu-Natal, improving optometry teaching practice at the University of KwaZulu-Natal and vision screening in KwaZulu-Natal. She has presented her research locally as well as internationally at the World Conference of Optometry in Hyderabad, India in 2017 and the Global health forum in Beirut, Lebanon in 2018. She balances her academic career by spending time with her daughter and son, reading, painting and has established a local online modest wear clothing range.
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TITLE	Quality improvement project aimed at better understanding and addressing challenges of running an efficient triage system in a deeply rural district hospital
AUTHOR/S	Andrew Wilkins
BACKGROUND	South Africa has some of the busiest emergency centres in the world. In a resource limited setting, with poverty, high burden of disease and staffing shortages, an effective triage system could help to improve patient waiting times, quality of care, and healthcare practitioners experience of providing a necessary service. Nurse driven triage systems can be effective and sustainable especially in a rural setting. In 2015, the South African Triage scale was introduced as a triage tool, along with several other interventions, to improve the triage system of Madwaleni District Hospital in rural Eastern Cape. Many challenges have hindered the efficient outworking of that triage system as shown in a Quality improvement project conducted by medical students from Walter Sisulu University in 2018. Some challenges obstructing the triage system are high turnover of staff, undertrained and poorly supported nurses, and administrative difficulties
METHODS OR DESCRIPTION	The science of quality improvement helps to offer insights into systems with multifaceted problems, first to better understand and secondly to approach formulating effective, sustainable interventions. We applied this science through a quality improvement project aiming to better understand our current system, as well as nurses' and patients' experience and understanding of triage.</ p> <p>By gaining understanding, we achieved a better grasp on the challenges of running an efficient triage system. It became clear that there were tools we could develop and changes we could make to improve our triage
RESULTS OR LESSONS LEARNED	We implemented a package of proposed interventions including a dedicated professional nurse and doctor allocated to overseeing triage for a 3-month period, a 'triage handbook' with helpful triage tools, and training sessions with nurses to improve support and understanding system.
CONCLUSIONS OR WAY FORWARD	We share insights on this process of understanding and then developing creative, informed solutions to these many challenges, giving a voice both to our community and our healthcare workers.
PRESENTER'S BIOSKETCH	Medical Officer exploring rural medicine at Madwaleni District Hospital in the Eastern Cape. Special interest in Emergency Medicine
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TITLE	Red Flag Early Identification Tool
AUTHOR/S	Cathy Mather-Pike
BACKGROUND	Siyakwazi's programmes are implemented amongst the poorest and most under-resourced areas in KZN where many factors prohibit development, one being the average annual household income of R14 600 which is half the amount for KZN. These issues are likely to lead to children being delayed in their development namely physically, emotionally, intellectually and socially.
METHODS OR DESCRIPTION	We have taken up this critical opportunity to provide specific interventions for children under the age of 7 to learn holistically, resulting in more children being ready to learn, as well as enhancing success early on in a child's educational career. In this way, Siyakwazi is providing a foundation for all future learning and supporting no child being left behind. Previously, our team have identified children who display barriers to learning either through observation, teacher referral or parental enquiry. We found this strategy to be inadequate in catching all children at risk of falling behind.
RESULTS OR LESSONS LEARNED	In February 2018 we developed and started implementing a new, standardised tool, called the Red Flag Early Identification Tool, to support screening all children under the age of 7, in ECD Centres from the age of 2 to 5 years and in schools, grades R and 1. This ensured early identification and enabled relevant interventions to be implemented within a full calendar year, enhancing maximum learning and support. There are 9 different activities targeted to measure success in all the different areas of a young child's development. The tool is implemented in small groups of 5 children and indicates whether a child can or cannot do a certain activity. We have intentionally lowered the screening tool so that the children who most need support are identified.
CONCLUSIONS OR WAY FORWARD	Our work is an example of unique interventions towards inclusive practices, support for all children to learn holistically and ensure no child is left behind.
PRESENTER'S BIOSKETCH	Qualifications: FDE Special Educational Needs (Stellenbosch University,1999), Honours in ECD (UNISA, 2013), Master of Education (UKZN, 2018) Designation: Siyakwazi Director
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TITLE	Primary Health Care and Patient-Centered Care: The Challenge of the Nurses, Case Study of Southwest Nigeria
AUTHOR/S	**Monsurat Adepejuu Lateef,** Dr Mhlongo EM
BACKGROUND	In Southwest Nigeria, manpower resource is a huge challenge to the nursing profession, quality healthcare service delivery, patient and the implementation of patient-centered care. Primary Health Care setting is the grass root level of the health system of all the nations that require a lot of attention for the nation to achieve sustainable health for all. This has undermined nurses effort to reduce the burden of disease and prevent certain illnesses among the people. This is not peculiar to Southwest Nigeria, as evidence from studies conducted in other developing countries revealed a similar problem. This is interfering with nurses efficacy and effectiveness in the PHC. Therefore, the objective of this study is to explore nurses' healthcare service delivery regarding patient-centered care in the Primary Health Care setting.
METHODS OR DESCRIPTION	The study was qualitative participatory action research. Data collection was through individual interviews and focus group discussions with the nurses in the Primary Health Care in Osun State, Southwest Nigeria. Data analysis was done using thematic content analysis.
RESULTS OR LESSONS LEARNED	The result of this study highlighted nurses acceptability of patient-centered care, inadequate manpower of nurses in the Primary Health Care setting. This leads to work overload and poor quality of healthcare service delivery in the Primary Health Care setting.
CONCLUSIONS OR WAY FORWARD	Manpower resource is indispensable at all levels of the healthcare system. Since manpower is a challenge to the nurses, the nursing profession, to patients and the healthcare service delivery as a whole. Therefore, the employment of more nurses in Primary Health Care is pivotal and it requires urgent attention from the government and other stakeholders. Thus, patient-centered care will be implemented optimally.
PRESENTER'S BIOSKETCH	Ms Lateef M. Adepeju is a PhD candidate in the Discipline of Nursing, School of Nursing and Public Health, University of KwaZulu-Natal. She is a professional and specialized nurse by training. Her research interest is in healthcare service delivery for Primary Health Care. She has 5 years of clinical experience in a teaching hospital, Primary Health Care center and holds a Masters in Nursing Research. Lateef works as a free lancing screener for the Systematic Review Services, University of KwaZulu-Natal, assisting with timeous completion of high quality systematic reviews.
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TITLE	Reflections on the experience of Nelson Mandela Fidel Castro (NMFC) collaboration medical students during their reintegration in the South African health system in KZN.
AUTHOR/S	**Hoffie Conradie,** Dr Gloria Mfeka, UKZN
BACKGROUND	During this presentation five of the 2018 cohort of NMFC collaboration students who are placed in KZN will reflect on and share their experiences and challenges in returning to South Africa especially with regards to their rural family medicine rotation in a rural district hospitals. Each student will give a short reflection on different aspects of the rotation e.g. work-placed-based learning, team work, community engagement and quality improvement projects.
METHODS OR DESCRIPTION	The Nelson Mandela Fidel Castro (NMFC) collaboration gives the opportunity for rural scholars to study medicine in Cuba. The majority of students are selected from rural disadvantaged communities and are fully funded to study medicine in Cuba. For the first year in Cuba the students are required to learn to speak Spanish and do basic science courses. They then spent five years at a medical school in Cuba and work in the Cuban health system both at community and primary care level and in hospitals. On their return to South Africa they are required to do 18 months as final year medical students at a South African medical school. Once they have completed their internship there are required to return to their communities of origin to work there as community service doctors and primary health care practitioners.
RESULTS OR LESSONS LEARNED	Some of the main challenges the students face on their return to South Africa, are: • a language problem as they studied in Spanish and now have to communicate in English • adjusting to a different burden of disease especially HIV/AIDS and TB • working in a mainly hospital centred curative healthcare system were in Cuba they worked in a community-based primary health care system with the main emphasis on promotion of health and prevention of disease • adjusting to South African protocols and guidelines for disease management • acquiring multiple new practical skills.
PRESENTER'S BIOSKETCH	Hoffie Conradie, MB ChB, DCH, M Med (Fam Med), FCFP (SA). He worked for more than 25 years as a rural doctor and family physician in the Eastern Cape. From 2003-2015 he was a rural family physician and medical educator, responsible for the rural training program for undergraduate medical students and post graduate family medicine for the Stellenbosch University in Worcester. In 2009 he became director of the Ukwanda Centre for Rural Health. From 2010 he was the Founding Director and part of a team that established the first Rural Clinical School (RCS) in sub-Saharan Africa in Worcester. As from January 2016 he is employed as a distributed learning facilitator for the Stellenbosch University Collaborative Capacity Enhancement through Engagement with Districts (SUCCEED) project in collaboration with Walter Sisulu University in the Eastern Cape and as from October 2018 the University of KwaZulu Natal (UKZN).
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TITLE	"Rural-proofing" the primary care literature in South Africa
AUTHOR/S	Dr TC Nkabinde and Adam Asghar
BACKGROUND	As the healthcare landscape changes, and medical education resources move towards an open access model, established journals are being challenged to redefine themselves, in order to remain relevant to the community of practice they serve. The South African Family Practice Journal (SAFPJ) has recently announced a new editorial board, and whilst moving with the sea of change, has prioritised hearing the voice of rural health primary care practitioners, by maintaining RuDASA representation on the board. This acknowledges that this community of practice has unique professional and academic development needs.
METHODS OR DESCRIPTION	This oral presentation will review the professional and academic development needs of rural healthcare practitioners, by summarising relevant literature from the past ten years, and relevant discussions held on the RuDASA forum from the past five years. These findings will be juxtaposed with the current editorial trends of the SAFPJ.
RESULTS OR LESSONS LEARNED	By presenting and contrasting the evidence-base, with anecdotal accounts of the learning needs of rural healthcare practitioners, this presentation will initiate the debate of how the SAFPJ can assist the community of rural practitioners to optimise their professional and academic development, in order to better serve the communities in which they work.
CONCLUSIONS OR WAY FORWARD	The intention is to develop the material presented, and the discussion held after the presentation, into a workshop to be held at the Rural Health Conference 2020. The workshop will provide an opportunity to explore how the SAFPJ can maintain and develop relevance to rural healthcare practitioners.
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TITLE	Sinezwi 'We have a voice'
AUTHOR/S	Cathy Mather-Pike
BACKGROUND	The presentation will introduce Siyakwazi, a community-based organisation founded in 2013 who support children with disabilities and barriers to learning under the age of 7 within rural communities in the Ugu District, KwaZulu-Natal.
METHODS OR DESCRIPTION	The two main areas of Siyakwazi's operation will be briefly unpacked, namely inclusion and school readiness. The presentation will then focus on the role Siyakwazi plays in supporting parents/ caregivers of children with disabilities. Programmes including; home support visits, therapy sessions, psychosocial support, access to resources through Siyakwazi's toy library and resource centre.
RESULTS OR LESSONS LEARNED	A parent will present their testimony on the impact having a child with a disability has on their day to day lives and some of the challenges they are faced with especially in a rural context. The importance of disability awareness will be highlighted, so that barriers and stigmas can be broken, and more people can realise that "disability is not a curse". A brief overview of a new programme will be included which focuses on teaching new skills to parents with disabilities.
CONCLUSIONS OR WAY FORWARD	The presentation concludes how Siyakwazi's programmes address these challenges and how this ultimately empowers parents impacting their relationship and care for their child with a disability or barriers to learning.
PRESENTER'S BIOSKETCH	Cathy Mather-Pike is the Director and Founder of Siyakwazi, a community based NPO that supports children with a range of disabilities and barriers to learning. She was trained as a Special needs teacher at the University of Stellenbosch and taught in the UK in special schools as well as mainstream. She has also gained an Honours Degree in early childhood development and a Master in education and development, with a special focus on participatory ways of enhancing development within school readiness. She has a special interest in supporting all children in rural settings through early intervention and prevention. She envisions this model of inclusion to spread to other areas within Ugu and KZN.
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TITLE	Surgical Skills Training in Primary Health Care: How to be on top of the game?
AUTHOR/S	**Hans Hendriks**, Professor Parimalaranie Yogeswaran
BACKGROUND	Surgical skills training in the Family Medicine (FM) Registrar Program at decentralised or District Hospital, is a challenging exercise. Barriers to training come from infrastructure constraints, geographical location (rural) and workload at training hospitals. Since hospital services tend to develop according to provider availability and skills, surgical care at these hospitals is shaped by the availability and skills of the doctors.
METHODS OR DESCRIPTION	Walter Sisulu University (WSU), FM Registrar program, used an innovative new digital surgical tool (Incision Academy) to enhance the training. Incision Academy is a surgical education program that bridges the gap between knowing the theory of surgical procedures and doing the procedures. It provides 350 high quality filmed procedures (in 2D and 3D) with animation overlays highlighting anatomical structures. Theoretical knowledge (anatomy, pre-and postoperative considerations and self-tests) provided with each procedure. Incision Academy is accredited by the Royal College of Surgeons of England and endorsed by the European Society of Surgical Oncology.
RESULTS OR LESSONS LEARNED	Incision Academy developed an individualised online program for FM registrar training, grouping 25 regular (compulsory) and seven extra (optional) courses together ("course" referring to a specific taught procedure). Certification for the successful completion was a pre-requisite for the Registrar to achieve before entering examinations at the end of the 2nd year. The list of procedures taught through Incision Academy was guided by the College of Medicine of South Africa clinical domain logbooks as well as needs identified at FM training sites.
CONCLUSIONS OR WAY FORWARD	The use of Incision Academy proved to be an invaluable tool in teaching surgery to FM registrars in the rural setting of Eastern Cape, South Africa. It helped bridge some of the gaps preventing registrars from gaining the needed surgical practice and experience as well as giving them the confidence to perform procedures at their training sites.
PRESENTER'S BIOSKETCH	Senior Lecturer, Family Medicine, Walter Sisulu Hospital and Zithulele Hospital
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TITLE	The discourse of silence about HIV risk and HIV testing among people living in rural areas in South Africa
AUTHOR/S	**Betty Chebitok**, Dr Mary Van der Riet
BACKGROUND	Notwithstanding the scaled up HIV testing services in South Africa, the dominant HIV discourse still identifies youth as resistant to HIV testing uptake. Finding a way to encourage youth to undertake early and routine HIV testing is a significant step in responding to the epidemic in South Africa.
METHODS OR DESCRIPTION	A discursive qualitative and exploratory study on a university campus in South Africa examined students' discourses about HIV risk and HIV testing, and how they located themselves in the broader risk and protective discourses available to them. Convenience, purposive and snowball sampling techniques were used to recruit 20 students (5 men and 15 women) aged 18-24 years.
RESULTS OR LESSONS LEARNED	The majority of participants distanced themselves from the risk of infection and viewed it as something for others. They described the various categories of people in relation to HIV risk. This presentation addresses one aspect of their views, which is constructions of 'rural people' as vulnerable to HIV risk and less engaging with HIV testing. The 'rural people' were constructed as underprivileged in terms of education, health facilities, media, and schools, thereby lack knowledge about self-protection, HIV testing and decision-making power. Complicating 'rural people's' vulnerabilities further is the silence about HIV risk, HIV testing and sex-related topics in some homes, attributing it to cultural norms linking non-marital sex with promiscuity and sexual experimentation. Thus, if youth were to initiate talks about HIV risk and HIV testing, it would be taken to mean that they are reporting their sexual behaviours to their parents and/or identifying themselves as HIV-infected. While it seems as if these constructions position rural people as the problem, the discourses deployed construct underprivileged people as passive and innocent victims of the epidemic.
CONCLUSIONS OR WAY FORWARD	The majority of student participants came from rural areas and so these othering processes may provide an alternative framing of youth's vulnerability to HIV suggesting that they assume multiple identities or positions at various points in time and within specific contexts. However, this discursive framing of HIV risk as other people's problem is partly attributed to the myths and stereotypes about the epidemic and people who become infected. Therefore, while participants were confident that HIV could be eliminated in South Africa, interventions should focus on personification of HIV risk among youth, which can in turn influence actual change in HIV testing behaviour and risk reduction.
PRESENTER'S BIOSKETCH	Betty Chebitok is currently in her 2nd year of study towards Doctorate in Psychology at the University of KwaZulu-Natal (UKZN) on the Pietermaritzburg Campus. Her research is looking at the social construction of HIV risk and HIV testing among sexually active youth aged 18-24 years at UKZN, Pietermaritzburg Campus. Betty is a member of two professional organisations namely; Health Professions Council of South Africa (HPCSA) and Teachers Service Commission (TSC) in Kenya. Her career goals are to contribute to research in the fields of HIV risk and HIV testing among youth, work as a researcher in psychology, pursue lecturing opportunities, supervise students, and practical experience in psychology.
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TITLE	The Distributed Apprenticeship, up-scaling the training of doctors in rural spaces
AUTHOR/S	Francois Coetzee
BACKGROUND	The Faculty of Medicine and Health Sciences of Stellenbosch University has embarked on developing a new curriculum for the MBChB program for various reasons including: The HPCSA recommended several changes to the current curriculum; ● a reduction in factual overload, ● better use of the distributed platform ● "Enhanced roll-out of the lessons learned from the rural clinical school to the main stream curriculum including the longitudinal student-intern clerkship The New MBChB curriculum therefore includes a comprehensive approach to the training of medical professionals that will be well equipped to practice within the South African Health Care System. One of the principles that is re-introduced into the training of medical professionals, is that of apprenticeship. This will entail medical students working alongside healthcare professionals with the focus on acquiring the necessary skills to practice as a doctor. This process will start at the beginning of the program and the final year (the Distributed Apprenticeship) will be dedicated to mastery of the required skills and applied knowledge.
METHODS OR DESCRIPTION	A new curriculum program committee was formed in 2017 and 9 module leads were appointed. For the past two years the module leads have been working in teams to develop their modules and have presented their work to the committee. During this process module leads were involved in several workshops hosted by internal and external experts.
RESULTS OR LESSONS LEARNED	The New Curriculum Program Committee has developed the 9 modules for the revised curriculum and have arranged an expo to invite comment and suggestions. The final year module will entail placing the whole MBChB class in rural / peri-urban hospitals.
CONCLUSIONS OR WAY FORWARD	This presentation will give an overview of the new MBChB curriculum and will then focus on the final year module of the new curriculum, the distributed Apprenticeship.
PRESENTER'S BIOSKETCH	Francois Coetzee is a family physician and he is a program coordinator Worcester Rural Clinical School (WRCS) in South Africa. For 12 years he practiced as a rural clinician in a 70 bed hospital and in 2013 he joined the Worcester Rural Clinical School team. He has published 3 research articles and 5 book chapters since his appointment at Stellenbosch University. In 2017 Francois took over the coordination of the longitudinal integrated clerkship and the rotation based programme at the WRCS. Current clinical duties include doing outpatient clinics. Francois is a bi-lateral amputee and enjoys hiking, mountain biking and swimming in the sea. He is currently involved with: A research project that comprises tracking of the WRCS graduates and documenting their intentions to practice rurally or in urban settings. The re-designing of the final year of the new medical curriculum at Stellenbosch University
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TITLE	The impact of training Health Professionals, Healthcare Workers and Traditional Healers on the Early Warning Signs of Childhood Cancer in the Rural Areas in South Africa, The outcome thus far. Where to from here?
AUTHOR/S	**Agie Govender**, Adri Luddick
BACKGROUND	SA should diagnose between 2500 new cases of childhood cancer per annum. However between 1000 – 1500 new cases are reported per annum. In developed countries there is a recovery rate of between 80 – 90% and in less developed countries the survival rate is below 55%. Two thirds of children with cancer never reach a treatment centre and the majority of those who do, present with an advanced stage of the illness.
METHODS OR DESCRIPTION	In 2011, in partnership with the national Department of Health, CHOC embarked on a campaign to train health care professionals and workers and traditional healers on the St Siluan Early Warning Signs of childhood cancer. During 2017-2018, we focused specifically on KZN and worked closely with DOH in empowering health care professional with knowledge before proceeding with community awareness.
RESULTS OR LESSONS LEARNED	We are able to see a positive growth in new diagnosis as well as an increase in the beneficiaries we serve. We will present statistics on our community engagement thus far.
CONCLUSIONS OR WAY FORWARD	Our aim is to create awareness and to reach children at the early stages of diagnosis and to train health care professional and workers to detect early warning signs of childhood cancer. This is to ensure early diagnosis and better prognosis. Beyond this our aim is to enter communities and partner with similar NGO's and CBO's to train and empower the general public. Since 2011 we have reached more patients, however we continue to see children who present at an advanced stage of the disease and we continue to miss nearly half of those children who should be diagnosed
PRESENTER'S BIOSKETCH	I am the Regional Manager of CHOC KZN. I have my Masters in Social work and 32 years in counselling and in community work from hands on to management. For the past 18 years I have focused my attention strictly on child care at various levels i.e. from Children at risk, to children confined and lastly with children with life threatening illnesses.
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TITLE	The incidence of drug induced liver injury and nephrotoxicity in HIV/TB co-infected patients in a regional hospital in the Ugu district of KwaZulu Natal
AUTHOR/S	**Serisha Ramasir**, Dr F Oosthuizen, Dr V Bangalee, Dr S Chetty
BACKGROUND	South Africa has one of the highest rates of HIV/TB co-infection in the world. Tuberculosis is a leading cause of death in people infected with HIV. In both these conditions adherence to the treatment regimen is a major issue. Adverse drug reactions (ADRs) impact treatment adherence which subsequently affect the outcomes of patients. Overlapping toxicities of anti-tuberculosis and antiretroviral medication result in an increased potential for patients to experience ADRs such as drug-induced liver injury (DILI) and nephrotoxicity.
METHODS OR DESCRIPTION	The main aim of this study was to establish the incidence of DILI and nephrotoxicity in HIV/TB co-infected patients in the Ugu district in KwaZulu Natal, South Africa. A retrospective analysis of patient data was conducted in a regional hospital.
RESULTS OR LESSONS LEARNED	Data was collected from 01 January 2016 to 31 July 2018. A low incidence of nephrotoxicity and DILI (1%) in HIV/TB co-infection was found. The majority of patients were admitted for an average of 10.44 days with 55% of patients being down referred to lower levels of care following discharge. More patients were cured compared to those who demised. There were minimal submission of ADR reports (1%) with focus mainly on ART associated ADRs. The compliance to guidelines was 48.4% and 59.1% for DILI and nephrotoxicity respectively. Lack of standardization in the management of patients with DILI and nephrotoxicity is apparent with poor compliance to guidelines.
CONCLUSIONS OR WAY FORWARD	Documentation of ADRs is extremely poor as reflected by the minimal number of completed ADR forms. The study of TB is important especially considering the rapidly developing resistance leading to an increasing number of multidrug resistant and extreme drug resistance cases. Factors that impact the development of resistance is adherence. As previously noted ADRs impact adherence. Through effective monitoring and patient counselling early identification and effective management can limit the impact of the ADRs.
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TITLE	The musculoskeletal impact of cranial loading porterage among rural Africans
AUTHOR/S	**Terry Ellapen,** Y Paul, M Barnard, D Opperman
BACKGROUND	Cranial loading porterage is a habitual longstanding method transporting fundamental nutrition and domestic items among many rural African communities. A literature precis' reviewing the prevalence of musculoskeletal related pathology among African female porters will be presented.
METHODS OR DESCRIPTION	An electronic literature investigation adhering to PRISMA guidelines in Google Scholar, Sabinet and PubMed search engines was conducted. Key search words included were: cranial loading, head loading, Africa, musculoskeletal injuries
RESULTS OR LESSONS LEARNED	522 records were identified, which was reduced to seven, three of which were quantitative in nature, while the others qualitative. Two studies were comparative in nature with concurrent controls. The others were observational descriptive studies.
CONCLUSIONS OR WAY FORWARD	All evidence agree that cranial loading porterage does produce cervical intervertebral disc compression leading to pain, intervertebral disc prolapse and spondylolisthesis.
PRESENTER'S BIOSKETCH	I am biokineticist, who has being actively conducting research on impact of cranial loading among South African. My research has focused primarily injury
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TITLE	The PADI (People for the Awareness of Disability Issues) Voice in South Africa
AUTHOR/S	**Dr Dhanashree Pillay**, Ms Jenna Sher and Ms Sandy Heyman
BACKGROUND	Disabled people represent 10-20% of the population. There has been an increased focus on the rights and policies aimed at people with disabilities in SA. Healthcare professionals that encounter people with disabilities should be aware not only of the medical details of disabling health conditions, but also of the incorrect assumptions about disability that result from stigmatized views that are common within society. The PADI project aims to create public awareness of disability issues through corporate information workshops, student training and school workshops in urban and rural areas.
METHODS OR DESCRIPTION	The PADI project was established in 1987 by Sandy Heyman, as there was a need to educate Non-Disabled persons in all sectors of the community about disability. PADI conducts "Experiential Learning Life Skills Programmes" utilizing roll play exercises, depicting sensory disabilities. Facilitators, all whom are people with disabilities, conduct these workshops. There are PADI outlets in Johannesburg, Bushbuck Ridge and KZN.
RESULTS OR LESSONS LEARNED	The Speech-Language Pathology and Audiology (SPPA) department at the University of the Witwatersrand has partnered with the PADI project as students in 1st year are paired with an individual with a disability for 6 months. First year students are initially hesitant to engage with their assigned individual with a disability however towards the end of the process they gain a first-hand experience of how individuals with disabilities are able to navigate their way through the barriers in which society has created and the students become better advocate for their patients' rights. The inclusion of the SPPA partnership aids in transforming the curriculum in SA.
CONCLUSIONS OR WAY FORWARD	The aim of the presentation will be to highlight the role and benefit of including the PADI project within the tertiary curriculum of the healthcare profession. We (staff from the SPPA department and Sandy Heyman via a video recorded presentation) will be discussing the facilitators, barriers and benefits of the PADI project in rural and urban areas of SA. The voices of individuals with a disability will be a highlight of the presentation as Sandy Heyman will provide a detailed life experience of her journey as the director of PADI.
PRESENTER'S BIOSKETCH	Dr Dhanashree Pillay is an Audiologist who has worked in rural KZN and has been involved in the Red Cross Air Mercy Service outreach programs within Northern KZN. She is a board member of the PADI (People for the Awareness of Disability Issues) organisation in South Africa and she is a member of the Standards Division at the SABS (South African Bureau of Standards) where she is involved in the writing up of policies and procedures. Dr Pillay has published in scholarly journals and has presented at both national and international conferences. She is a reviewer for academic journals including Speech Pathology and Audiology journals. Dr Pillay's research interests focus around the areas of: Amplification, Spirituality, Religion, Traditional beliefs and practices, Sports Medicine and Noise. Dr Pillay is a senior lecturer at the University of the Witwatersrand.
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TITLE	The socio-economic impact of rural origin graduates working as healthcare professionals in South Africa
AUTHOR/S	**Andrew Ross,** G MacGregor, G Zihindula
BACKGROUND	Studies documenting the social-economic impact of education leading to employment of rural youth, specifically in healthcare professions (HCPs), are lacking. The Umthombo Youth Development Foundation (UYDF) is an NGO that provides financial support for rural students to train as HCPs as a way of addressing staff shortages at rural hospitals. The aim of this study was to understand the social and economic impact on the individual and their families of qualifying as a HCP and being employed at a rural district hospital.
METHODS OR DESCRIPTION	A mixed methodology was used to collect data from 40 graduates at eight district hospitals in rural KwaZulu-Natal Province. The research tools had qualitative and quantitative questions, with additional data being extracted from the UYDF database. The qualitative data was analysed thematically, with STATA software being used for the quantitative analysis.
RESULTS OR LESSONS LEARNED	The findings indicate that graduate household assets increased significantly, as did their socio-economic circumstances, compared to before they qualified as HCPs. Graduates attached high value to education that led to their employment, which provided them with money to afford assets. Having a permanent job and regular income also transformed their family's lives, as they were able to care for their siblings and extended family members.
CONCLUSIONS OR WAY FORWARD	Training rural youth for employment in scarce skills that leads to employment, such as a career in health science, boosts their socio-economic circumstances and that of their families. This contributes to the staffing of rural hospitals, job creation and the economic development of the country.
PRESENTER'S BIOSKETCH	Associate Professor, Department of Family Medicine UKZN
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TITLE	Theoretical Guidelines To Support Health Communication Messages Within An Integrated Marketing Communication (Imc) Approach: A Thelle-Mogoerane Regional Hospital Case Study
AUTHOR/S	Lucky Mawasha
BACKGROUND	Health communication has been instrumental in assisting with health efforts since the introduction of the first vaccine (Schiavo 2007). Child immunisation has been a successful attempt in eradicating and controlling threatening illnesses for the wellbeing of children in many African countries by health professionals (Schiavo 2007). But as for other health related issues and intervention that aim to change the public and convince parents to immunise their children against disease that might affect them later has utilised global multidisciplinary effort (Schiavo 2007). With campaigns such as small pox eradication; patriotic hygiene; public health breastfeeding in Africa, social aspects were not considered by NGO's and foreign donors that initiated these health campaigns (Lagerwerf, Boer & Wasserman 2009).
METHODS OR DESCRIPTION	Religious and cultural beliefs play a major role in how people assimilate behaviour. Introducing the adaption of a new behaviour such as healthy behaviour can be problematic because beliefs guide behavioural change acceptance (Lagerwerf et al 2009). This also leads South African policymakers and professionals to struggle with implementing the introduction and change of practices in support of better health communication (Lagerwerf et al 2009). Mass media as a distribution tool for health messages also experiences challenges. The example of this includes, when Intensive media coverage was used to create awareness on the spread of HIV/AIDS. Government denial that led to legal discussions to criminalising same sex relations, which may lead to imprisonment without access to condoms in countries such as Botswana and a lack of government support to anti-retroviral support programs were some of the highlighted challenges (Lagerwerf *et al* 2009).
RESULTS OR LESSONS LEARNED	Therefore, this study seeks to propose IMC theoretical guidelines to enhance health communication messages in health promotional campaigns from Thelle-Mogoerane regional hospital centralised around culture and the social context of the patients. The IMC theoretical guidelines will be formulated from the two literature reviews on health communication and IMC. The study adopts the qualitative research methodology with three data collection sources namely: semi-structured individual interviews with health promotion practitioners, focus groups with patients and content analysis from health campaign and planning documents, Facebook updates, newspaper articles, newsletters, posters and radio interview recordings between 2014-2019 time period. The study will use Tesch's (1992) eight steps to interpret and analyse data. Data collected from the prescribed documents uses direct qualitative document analysis. Direct content analysis is directed by a more organised method than in a standard approach (Hsieh & Shannon 2005).
CONCLUSIONS OR WAY FORWARD	The findings will only be generalised to Thelle-Mogoerane regional hospital.
PRESENTER'S BIOSKETCH	The main speaker is a masters student from the University of South who is health com-munication and Integrated marketing communication researcher, with over 6 years of experience in social research and a lecturer for the University of South Africa, Varsity and Rosebank college. The speaker is currently head of program for the faculty of humanities for IIE.
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TITLE	Therapeutic hypothermia (head-cooling) for neonatal encephalopathy at Mseleni Hospital January 2016 - July 2018.
AUTHOR/S	**Nilene Van Velden**, George Lawson
BACKGROUND	Therapeutic headcooling reduces mortality in high income settings. This audit reviews the feasibility of head-cooling at Mseleni, a rural district hospital.
METHODS OR DESCRIPTION	40 patients with possible hypoxic brain injury from January 2016 to July 2018 were identified from neonatal admission and therapy records. Those that underwent head-cooling were audited for compliance to guidelines, which included correct patient selection as per history and examination, appropriate head-cooling within 6 hours of birth, stable temperatures within the therapeutic window (330-350), and safe re-warming.
RESULTS OR LESSONS LEARNED	From a total of forty babies; two had head-cooling but insufficient records, one met inclusion criteria but did not receive head-cooling, fifteen did not have head cooling due to appropriate exclusion, and it was not possible to trace records for sixteen patients. Of the six eligible babies undergoing head-cooling with sufficient documentation all were initiated within 3 hours. One patient had more than one temperature outside of the therapeutic window. Length of head-cooling varied between 12 – 56 hours. Only one patient had documented rewarming. Four babies had a Thompson score greater than 10, one scored less than 10, and one did not have an initial score. Only one patient had a score greater than 10 after 24 hours of head-cooling. All survived to discharge and were neurologically intact at 18 months.
CONCLUSIONS OR WAY FORWARD	The audit suggests that head-cooling is technically feasible at the district level, however there are concerns about the accuracy of temperature monitoring, rewarming, and inclusion criteria not being met. Most staff were unable to say where the guideline was (it was hidden behind other equipment in nursery). Maintaining skills with high doctor turnover is a challenge for rural hospitals. Improved record keeping would allow a greater sample size, and possibly justifiable comment on efficacy and safety.
PRESENTER'S BIOSKETCH	Please contact Dr Van Velden for biosketch. Co-authored and submitted by Dr Lawson but will be presented by Dr Van Velden
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TITLE	Traditional health care services in Umkhanyakude District Municipality
AUTHOR/S	**Amos T**, Mthembu, Innocent Moyo
BACKGROUND	The traditional health practitioners play an important role in the delivery of health care services as many people use traditional medicine as the first line of medical care. There are various reasons which make people to utilise the services of traditional health practitioners which include their belief in the efficacy of traditional medicine and accessibility of traditional health services. There are efforts of integrating both traditional and biomedical health care services in South Africa but these systems still operate differently. The integration of traditional health practitioners into health care system in South Africa could also be enhanced when there is knowledge about the operation of traditional health practitioners. This study aims to provide knowledge by determining the geographical, ecological and social factors which play a role in the operation of traditional health practitioners and also relationships among traditional health practitioners as well as between them and biomedical practitioners in the study area.
METHODS OR DESCRIPTION	A sample of 52 traditional health practitioners was drawn from the study area. The questionnaires were used to elicit data from the traditional health practitioners
RESULTS OR LESSONS LEARNED	It was found that the age of the majority of healers ranged from 41 to 60 years. A large proportion of healers have been in the practice for more than 10 year. While healers provide services at home they also travel to other parts of South Africa offering services. There was a relationship between the healers themselves and also biomedical health practitioners.
CONCLUSIONS OR WAY FORWARD	The findings of the study will go a long way in the understanding of operation of traditional healers.
PRESENTER'S BIOSKETCH	Amos T. Mthembu is a lecturer in the Department of Geography and Environmental Studies at the University of Zululand
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TITLE	Using improvement science to better understand and address challenges in a deeply rural healthcare setting; sharing insights from an overbearing outpatients department at Madwaleni Hospital.
AUTHOR/S	**John-D**, Lotz, James Porter
BACKGROUND	The mountain of challenges faced in our historically neglected, deeply rural sub-district constantly threatens to overwhelm even the most enthusiastic healthcare worker. A struggling primary health care system overflows into inappropriate burdens on the local district hospital. High numbers of unreferred patients and unnecessary referrals consume valuable resources, stealing from more fruitful investments in doctor time that could arguably be better spent supporting and uplifting healthcare at a primary level. The science of improvement offers insights and methodology that provide a handle into first understanding, then systematically approaching these challenges in an objective, data-driven manner. We applied this science to a focal point of daily work at Madwaleni Hospital. By aiming to first understand the outpatient workload, it became not only possible to reduce the patient load and improve efficiency of work there, but also to better understand the challenges faced by our surrounding primary healthcare system through a rich sample of daily patients.
METHODS OR DESCRIPTION	We share insights in the process of developing a novel tool we use to better understand and monitor our work in an undifferentiated ambulatory outpatients department.
RESULTS OR LESSONS LEARNED	Being able to generate simple, meaningful, and accessible data has paved the way for directing multiple interventions into improving the quality of healthcare we can offer, while regular and engaging data feedback has provided an objective and inspiring barometer to track the efficacy of each of those interventions.
CONCLUSIONS OR WAY FORWARD	The science of improvement has allowed us to find creative and informed solutions to the unique arrangement of challenges we face, provided a keyhole through which to hear the objective voice of our community, and empowered us to make a better difference in response.
PRESENTER'S BIOSKETCH	Registrar in the Faculty of Family Medicine and Rural Health, Walter Sisulu University. Based full time at Madwaleni Hospital, where my wife and I have joined a team of like-minded enthusiasts since 2014. Our two daughters add to the fun.
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TITLE	What the elderly experience and expect from primary care in KwaZulu Natal, South Africa
AUTHOR/S	Keshena Naidoo
BACKGROUND	People aged 60 years and older are predicted to outnumber children under 5 years in South Africa for the first time by 2040 (Day et al, 2017). This will place increased demands on the health system to address geriatric health needs. However, there is scarce data on geriatric populations in sub-Saharan Africa. Health policy makers need to be informed of the expectations of the elderly regarding health services, especially at primary care level.
METHODS OR DESCRIPTION	Aim: The aim of this study was to explore the experiences and expectations of people aged 60 years and older regarding ageing and health services, and the factors that might improve the quality of primary care services to geriatric patients. Setting: This study was conducted at three public health primary care facilities in Kwa-Zulu Natal, South Africa, one of which was in a rural setting, one peri-urban and one urban. **Methods:** This qualitative study involved a purposive sample of 28 participants, aged 60 years or older. Four focus group discussions were conducted in either isiZulu or English, depending on preference of the participant. Using an inductive approach the data was analysed thematically. Ethics approval was obtained from the UKZN Biomedical Ethics Committee (BE 287/18)
RESULTS OR LESSONS LEARNED	Of the 28 participants, 18 (68%) were female. Five key findings emerged from the data: (1) long waiting times- participants were distressed by lengthy waiting times; (2) illness-centred care – participants felt that they were seen as diseases to be treated; (3) health professionals attitude – health providers were perceived to lack compassion; (4) pill burden – participants experienced adverse effects from prescribed medication and (5) need for priority care – participants wanted a separate queue for the elderly.
CONCLUSIONS OR WAY FORWARD	Training of health professionals should consider the need for empathy and special care of the elderly.
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TITLE	Whose voices are valued? Reflections on two evaluations seeking to amplify the voices of persons with disabilities
AUTHOR/S	Sue Philpott
BACKGROUND	The focus of this presentation is the question: How can evaluation be a means of amplifying voices that are usually silent? It uses as case studies two evaluations that the author has recently been involved with – one at a special school in rural KZN and the other in a community-based organization working with adults and youth with disabilities in the Eastern Cape. Contrasting with typical approaches which engage primarily with management and governance structures, processes used in these evaluations specifically sought out the views of children and youth with disabilities and parents of disabled children, raising the question as to whose truth are we seeking? Whose views and perspectives? Whose voices are being heard?
METHODS OR DESCRIPTION	This presentation includes a description of these alternative processes, and what is required to ensure that the voices often silenced are amplified, including within focus groups, home visits, individual interviews and Participatory Learning and Action. Reflection on the two evaluations from this vantage point reveals two critical themes viz. a lack of critical analysis and reflection of staff on the programmes that they implement and that monitoring processes often mask the impact of programmes.
RESULTS OR LESSONS LEARNED	The presentation concludes with identification of key lessons emerging in respect of evaluation processes including the need for safe spaces if alternative voices are to be heard; an external facilitation process may be necessary to enable articulation of opinions that contradict the dominant voices; the need for management to hear what is being said and commit to responding.
CONCLUSIONS OR WAY FORWARD	The evaluation process thus has the potential to be a catalyst for authentic dialogue and collective action within organisations.
PRESENTER'S BIOSKETCH	Sue is currently a post-doctoral candidate at UKZN. She is a disability researcher and activist with a particular interest in inclusion of children with disabilities in early childhood development
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TITLE	Why should we send our students away? An exploration of the transformative nature of learning in a decentralized clinical training placement.
AUTHOR/S	Penelope Flack, Mershen Pillay
BACKGROUND	This paper describes a model for decentralized clinical training in a primary health care context, introduced into the curriculum for the Bachelor of Speech Language Therapy at the University of KwaZulu-Natal. This model has developed from our 30 year history of focus on community based education, in a curriculum that recognizes that health cannot be understood in isolation from community and, in developing countries especially, without looking at poverty. It is an attempt to move clinical training into a more realistic context, to ensure relevance. This placement is introduced as a service learning module in the final year.
METHODS OR DESCRIPTION	The aims of this module include: to develop skills for the facilitation of sustainable services in a resource constrained, community context, to develop therapeutic skills for working with individuals with communication and swallowing disorders within a community-based setting, and to understand changing models of service delivery, particularly for rehabilitation. Students spend six weeks in a community approximately 175 Km from their home campus, working in district level hospitals, primary health care clinics, schools and at household level. They live and work with students from other disciplines, as well as from other universities, within an IPE framework.
RESULTS OR LESSONS LEARNED	In an attempt to answer the above question, the academic coordinators explore what and how students learn during this placement by analysis of students' reflective journals/ blogs, exam responses and both students and educator module review. The focus is particularly on what students have learnt about themselves, about the other professionals, about service delivery, about the reality and challenge of meeting the patients' primary needs in a context of poverty.
CONCLUSIONS OR WAY FORWARD	This paper therefore explores how this placement transforms students' thinking and learning, and ends with a reflection on the lessons learned and the proposed way forward to ensure continued relevance of the curriculum.
PRESENTER'S BIOSKETCH	Penelope Flack is a lecturer in Speech-Language Pathology at the University of KwaZulu-Natal. Her research interests are language learning disability, and health science education, in particular community based education (CBE) and cultural and linguistic diversity. She holds a Bachelor's degree in Speech and Hearing Therapy (Witwatersrand), Master's in Linguistics (Stellenbosch) and a Doctor of Education (KwaZulu-Natal). Dr Flack's publications cover community based education, student retention, cultural diversity in practice and identity construction in children with language learning disability.
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POSTERS

Topic	Presenter	E-mail
AAC intervention in Children living in the Valley of 100 Hills	Casey Bieldt	caseyvs@hotmail.co.za
Child functioning and disability in children living with HIV in a semi-rural setting in KwaZulu-Natal, South Africa	Lindokuhle P Mthethwa	lindie800@gmail.com
Community Based Primary Healthcare Training for physiotherapy undergraduates: Perceptions of participating academics	Nomzamo Chemane	chemanen1@ukzn.ac.za
Community Health Workers putting in words our challenges to be heard.	CHW (Mamelodi)	Abigail.Dreyer@wits.ac.za
Cost-savings accruable to removing value added tax from antiretrovirals in the South African private health sector	Varsha Bangalee	bangalee@ukzn.ac.za
Developing Exercise Prescription Guidelines for Aged People Living with HIV in South Africa – A Study Proposal	Mr Levin Chetty	chettyle@ukzn.ac.za
Development of an Optometric isiZulu Paediatric Rate of Reading Test for isiZulu primary school children	Urvashni Nirghin	nirghinu@ukzn.ac.za
Efavirenz-induced hepatic injury in the "treat all" era	Sherika Hanley	hanley@ukzn.ac.za
Follow up of feeding methods in low birth weight infants discharged exclusively breastfeeding from Madwaleni District Hospital neonatal unit –A pilot study.	Michaela Lotz	drmichaelalotz@gmail.com
Let's Talk Disability	Michelle Flowers	michelle@shonaquip.co.za
Manguzi Gijima: Community orientated interventions for preventative medicine and breaking down barriers for people living with disabilities	Rael Sanzul	rsanzul@gmail.com
Mobile Clinic Toy Library Project	Irene Chetty	monicas@cotlands.org
Proposal For Implementation of Autonomous Drone Delivery During Stockout of Medicines	Damerrick Perry	dtperry2@illinois.edu
Role of antibiotics in uncomplicated appendicitis	MD Mukit-ul Islam	muksvipx1000@gmail.com
Sight to the unseen: An analysis of the delivery of comprehensive optometric services to rural KwaZulu-Natal by the Department of Health	Lungile Buthelezi	mafbuthelezi@gmail.com
The effect of mHealth and conventional awareness campaigns on developmental literacy	Courtney Brown	212518629@stu.ukzn.ac.za
UCT's Rural Support Network	Shandri Erasmus	Shan3.E@gmail.com
Voices of Primary Health Care Facility Managers Regarding Support And Supervision Of Ward Based Primary Health Care Outreach Teams In National Health Insurance Pilot Districts In Kwazulu-Natal	Mbali Mhlongo	mhlongoem@ukzn.ac.za
Walter Sisulu University health promoter establishes a rural Non-Profit Organization	Zimbini Madikiza, Karessa Govender (RHAP)	madikizazs@gmail.com

POSTER ABSTRACTS

TITLE	AAC intervention in Children living in the Valley of 1000 Hills
AUTHOR/S	Casey Bieldt
BACKGROUND	Interface- KZN is a non-profit organisation that actively promotes Augmentative and Alternative Communication (AAC), which can be defined as any technique, device or strategy that supports or replaces speech. Little or no functional speech results in isolation and providing a system of AAC strategies enables individuals to interact with their family, friends, peers and greater community in ways that are readily understood. AAC also enables communication, language development, learning and participation in life.
METHODS OR DESCRIPTION	A need has been identified to provide AAC intervention to the children/youth of the Valley of 1000 Hills, a semi rural area 45km west of Durban central and the outrech project began in October 2016. The project recognises the importance of early intervention and aims to ensure that AAC strategies and systems are familiar and developed before the child enters Grade One. Through the project the child is exposed to language development, play, communication and learning oppertunities which result in effective transition into schooling and overall, enables participation.
RESULTS OR LESSONS LEARNED	The presentation will outline the work that Interface-KZN has conducted in the Valley of 1000 Hills. This includes how the team has raised awareness of the real need for AAC services, the screening process and holistic team assessment and how AAC interventions used are either augmentative (support speech) or alternative (replace speech). Each child receives individual intervention as well as being part of a communication group and the structure of group sessions will be outlined.
CONCLUSIONS OR WAY FORWARD	The presentation will close with two case studies which illustrate the impact that AAC can make in a childs ability to communicate, learn and play.
PRESENTER'S BIOSKETCH	**Biosketch:** Casey Bieldt has an honours degree in counselling Psychology, Post graduate Certificate in Education (foundation phase) and Honours degree in Augmentative and Alternative Communication. Worked for Interface KZN since the inception of the Valley project and is project manger of the Valley project.
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TITLE	Child functioning and disability in children living with HIV in a semi-rural setting in KwaZulu-Natal, South Africa
AUTHOR/S	**Lindokuhle P Mthethwa**, Professor V Chetty, & Mrs S Lawler
BACKGROUND	South Africa faces the burden of children living with HIV experiencing impairments and often disabilities. Little is understood about these disabilities and their challenges. Furthermore, as the virus becomes a chronic episodic condition rehabilitation needs to be included in the fundamentals of care and medical management. This research project sought to understand the level of child functioning, disabilities and access of rehabilitative care in a semi-rural healthcare setting in South Africa in order to inform an integrated model of rehabilitation
METHODS OR DESCRIPTION	A care giver proxy questionnaire Washington Group/ United Nations International Children's Emergency Fund Module on Child Functioning was administered to caregivers of all children aged 5-10 living with HIV accessing care at semi-rural healthcare facility in Kwazulu-Natal Additional sociodemographic and medical data supplemented the questionnaire.
RESULTS OR LESSONS LEARNED	Forty-four children living with HIV and their caregivers were included in the study. There results showed 61.36% of children presented with physical impairments while cognitive and behavioural difficulties were reported by caregivers to be 77.27% of children. Many of the children were experiencing both cognitive and physical impairments. Although children were experiencing impairments only 22 were referred to rehabilitation professionals, many caregivers (84%) did not follow up with rehabilitative care following the initial assessment due to financial constraints as well as lack of time and transport restriction.
CONCLUSIONS OR WAY FORWARD	Disability screening would be beneficial at various points of care including primary healthcare facilities to promote early identification and timely referral to appropriate health care professional. Decentralizing rehabilitative care to homes and primary healthcare facilities could offer a possible solution to some of the reported barriers to accessing care.
PRESENTER'S BIOSKETCH	I am a Physiotherapist (B Physio) practicing in the government sector as a Chief Physiotherapist.
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TITLE	Community Based Primary Healthcare Training for physiotherapy undergraduates: Perceptions of participating academics
AUTHOR/S	Nomzamo Chemane, G Govender, Professor V Chetty, Dr S Cobbing
BACKGROUND	This project is aligned to a current need for healthcare within a South African context to address poor recourses in rural and peri-urban settings, shifting focus from an overserved urban region. Traditionally clinical education for undergraduate physiotherapy students has been centred around acute services in large teaching hospitals. Final year physiotherapy students requires active workplace and community engagement to learn practices and values essential for developing an independent practitioner. Currently there is a lack of an integrated model guiding clinical education for physiotherapy students in South Africa. **Aim:** To explore perceptions of physiotherapy academics on a novel community based primary healthcare approach to clinical education for students at a South African University in order to inform the rollout of an evidence-based model for physiotherapy education.
METHODS OR DESCRIPTION	A qualitative explorative approach using eight semi-structured interviews with eight physiotherapy academics at the institution was used to explore their perceptions of the community based primary health care training. Data was analysed using thematic analysis and was classified into themes and categories.
RESULTS OR LESSONS LEARNED	Four overarching themes emerged namely: curriculum review, constraints to decentralized learning, community based clinical education benefit and recommendations for learning platform. Academics believed that community based primary healthcare training was an approach that influences students to be socially responsive while addressing access to healthcare services such as rehabilitation in resource poor communities in SA.
CONCLUSIONS OR WAY FORWARD	The perceptions of academics was crucial in understanding the implementation clinical education of physiotherapy students in a Primary Health Care setting. The benefits of the community based primary healthcare approach included in the development of core competences of undergraduate students in preparation for independent practice as well as a call for students to be more socially responsive as future health care practitioners.
PRESENTER'S BIOSKETCH	Currently a lecturer at UKZN. Fourteen Years of experience as a clinician in public sector and rural hospitals at KZN
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TITLE	Community Health Workers putting in words our challenges to be heard.
AUTHOR/S	CHW (Mamelodi), Michelle Janse Van Rensburg
BACKGROUND	Based on the Community Health Workers (CHW) per household norm in the 2011 Ward Based Primary Health Care Outreach Teams implementation framework, the country needs 54956 CHWs to serve the entire South African population. In terms of the focus on health promotion and disease prevention within the scope of work of CHWs, their efforts are best applied to the poorer South African households since South Africans in higher income brackets have access to alternative health promotion media. CHWs work in defined areas with defined people and communities. Their work extends healthcare beyond the individual patient and provides services to people in their homes.
METHODS OR DESCRIPTION	This poster presentation will bring together the voices of CHWs working in Mamelodi, Soweto and Bushbuckridge. The challenges faced daily make the functioning in the WBOTS difficult.
RESULTS OR LESSONS LEARNED	The analysis of the findings show that CHWs have serious challenges in their aim to have a positive impact in taking healthcare to the people in their homes and communities. How can these challenges be addressed in order to support their optimal functioning in the team?
CONCLUSIONS OR WAY FORWARD	The presentation argues for the voices of CHWs to be heard and the challenges be addressed as a matter of urgency.
PRESENTER'S BIOSKETCH	Has been a CHW in the Mamelodi area as part of Tshwane Health District. First time conference attendee and representing the CHW group
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TITLE	Cost-savings accruable to removing value added tax from antiretrovirals in the South African private health sector
AUTHOR/S	Varsha Bangalee, Fatima Suleman
BACKGROUND	South Africa has one of the highest HIV/AIDS prevalence's in the world. Escalating medicine costs however, affect the availability, accessibility and affordability of essential medicines for a large percentage of the population. Despite the important role that medicines play in any society, all medicines, including those identified as essential, are uniformly subjected to 14% value added tax (VAT). This study aims to demonstrate the potential cost-saving attained from the removal of VAT from antiretroviral treatment in the private healthcare sector.
METHODS OR DESCRIPTION	An empirical analysis was undertaken to illustrate the potential cost-saving achieved by removing VAT from the Single Exit Price (SEP) and the dispensing fee of an adult fixed-dose combination first-line antiretroviral regimen as well as to a group of third-line antiretroviral medicines. Private sector prices (SEP's) for the originator and the lowest priced generic for each of the sample medicines as at 10 November 2015 were retrieved from the South African Medicine Price Registry. The SEP consists of the ex-manufacturers price, logistics fee and VAT (14%) - which is calculated from the sum of the two costs and added to them. The maximum dispensing fee, VAT inclusive, was calculated for each medicine, as per the price bands outlined in the amendments to the Medicines and Related Substances Act.
RESULTS OR LESSONS LEARNED	The potential saving for the lowest priced generic and originator first- line antiviral regimen accrued to ZAR 693.84 and ZAR 1085.04 over a year respectively. Regarding the third-line antiretroviral drugs, results yielded an annual saving of ZAR 1678.68 (darunavir), ZAR 5741.04 (maraviroc) and ZAR 159.48 (rilpivirine).
CONCLUSIONS OR WAY FORWARD	The study demonstrates that even small changes to the tax treatment of essential medicines, may affect the relative position of the poorest households in South Africa. Lobbying for the removal of VAT from the supply chain of medicines should be intensified.
PRESENTER'S BIOSKETCH	Dr Varsha Bangalee is a qualified pharmacist. She is a lecturer in the Discipline of Pharmaceutical Sciences, School of Health Sciences, at the University of KwaZulu-Natal and is responsible for supervision of post-graduate students. She additionally is a lecturer on the on-line Master's program in Pharmacoeconomics. She qualified with a degree in Pharmacy (2002) from UKZN. She completed her Masters degree in the field of Pharmacoeconomics, UKZN (2013). She obtained a Post Graduate Diploma in Business Management from the University of Natal (2003) and a Post Graduate Diploma in Pharmacovigilance and Pharmacoepidemiology from the James Lind Institute (2015). She recently graduated with her PhD (April 2017), UKZN. Her research was titled: "Evaluating the Pricing Interventions in the Private Sector of the South African Pharmaceutical Distribution Chain". She is currently a postdoctoral Fellow undertaking research on: "Reimbursement of health professionals and medicines as we move toward National Health Insurance"
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TITLE	Developing Exercise Prescription Guidelines for Aged People Living with HIV in South Africa – A Study Proposal
AUTHOR/S	**Mr L Chetty**, Dr S Cobbing, Professor V Chetty
BACKGROUND	The study will investigate the effects and adherence to exercise programmes in aged people living with HIV in South Africa, to develop exercise prescription guidelines for this population. The study will assess the acceptability, practicality, preliminary efficacy of exercise activity to improve interventions for disability among the aged living with HIV. The guideline will integrate exercise prescription and management tools as well as aim to improve identification, referral and linkage to care, with an intervention protocol that can be used by healthcare and trained lay health professionals.
METHODS OR DESCRIPTION	Phase one will inform the design of an integrated exercise rehabilitation programme for geriatric HIV care. The study will first undertake a formative exploration of the factors relating to integrating exercise rehabilitation within geriatric HIV services from the perspective of caregivers and health professionals. It will use qualitative methods, including in-depth interviews and focus group discussions. The knowledge from this phase will inform the design of the guideline in phase two and phase three will pilot the integrated exercise rehabilitation and geriatric HIV exercise prescription guideline at a study setting in South Africa. The pilot intervention will be formally evaluated.
RESULTS OR LESSONS LEARNED	The results from this study will determine whether the exercise prescription guide has potential for widespread application in South African geriatric HIV care and what further modifications may be needed.
CONCLUSIONS OR WAY FORWARD	It will inform South Africa's current efforts to strengthen interventions for people living with HIV and disabilities. It will be an important and critically needed step in the use of exercise rehabilitation to strengthen geriatric HIV care in the region.
PRESENTER'S BIOSKETCH	Mr Chetty is a qualified Biokineticist, and currently a Technician in the Discipline of Physiotherapy and part time lecturer in Sport Science, School of Health Sciences, UKZN. His duties include teaching and supervising research for both undergraduate and postgraduate students. He graduated with a Masters in Health Sciences 2015 and is currently registered for his PHD at UKZN. His research aims to develop and implement exercise rehabilitation interventions for older people living with HIV and other chronic diseases.
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TITLE	Development of an Optometric isiZulu Paediatric Rate of Reading Test for isiZulu primary school children
AUTHOR/S	Urvashni Nirghin
BACKGROUND	Rate of reading tests for children with associated standard scores are available internationally, yet limited nationally for educational and optometric use. Most of these tests are designed for English speaking children with none available in the isiZulu language. Furthermore, the identification of factors affecting reading rate are based on reading rate norms specifically established for the English speaking population. Such factors maybe generalised to children whose home language is isiZulu. Initiatives to improve the reading ability of South African children may therefore fall short when implementing this on the isiZulu speaking learner.
METHODS OR DESCRIPTION	**Aim:** To design an isiZulu Paediatric Rate of Reading (PRR) Test for normally sighted and low vision primary school children aged 6 to 12 years old. A qualitative method was used to develop the isiZulu PRR Test based on word selection from Grade One Level One reader as prescribed by the Department of Education. The item development of the tool, which included word selection, word placement on chart, visual acuity letter size, scaling of print, font type, contrast and background, design of pretest chart and recording sheet, was based on literature and the design procedure followed for the English PRR Chart. Twelve most frequently used words were identified using the NVIVO software package version 11. The random placement of words were typed in Quick Sand font typeface in lower cases using a programmed computer with assistance of a graphic designer.
RESULTS OR LESSONS LEARNED	A pretest chart, recording score-sheet and six versions (A, B, C, D E, and F) were designed corresponding to visual acuities 6/15, 6/19, 6/24, 6/30, 6/48 and 6/60 respectively.
CONCLUSIONS OR WAY FORWARD	The isiZulu PRR Test can be used to assess reading rate as well as establish reading rate norms for isiZulu speaking primary children age 6 to 12 years old.
PRESENTER'S BIOSKETCH	Urvashni obtained a Bachelor of Optometry degree from the University of Durban-Westville [now University of KwaZulu-Natal (UKZN)] in 1995. Her career started as a self-employed optometrist in Durban for 11 years, followed her involvement in primary eye care and community engagement with an NGO and Department of Health within KwaZulu Natal. In 2006 she decided to pursue her interests in academia at UKZN with her involvement in both undergraduate and postgraduate programmes. She has contributed to the optometry profession both nationally and internationally through publications and conference presentations. She completed an Advanced Certificate in Ocular Diagnostic (UKZN) in 2011, graduated in 2013 with a Master's degree (cum laude) at UKZN, completed the didactic component of Ocular therapeutics Certificate (UKZN and State University of New York) in 2015 and is currently completing a Doctoral degree (UKZN) with her focus growing in Paediatric Optometry.
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TITLE	Efavirenz-induced hepatic injury in the "treat all" era
AUTHOR/S	Sherika Hanley
BACKGROUND	Efavirenz (EFV) is widely used as part of first line combined antiretroviral therapy (cART) in low and middle-income settings. There is increasing evidence of a low grade non-specific EFV-induced hepatitis, particularly with concurrent viral hepatitis. A severe, life-threatening hepatotoxicity secondary to EFV is said to be rare. Published case reports describe females aged in their thirties with high CD4 counts who appear to be at higher risk for EFV-induced hepatotoxicity, and resolution occurs in 6-12 months. South African National Department of Health guidelines do not advocate routine monitoring of alanine transaminase (ALT) with EFV exposure. This case report describes an episode of submassive necrosis with prolonged time to recovery yet a favourable outcome.
METHODS OR DESCRIPTION	Case presentation: a 35 year old South African female of African descent was enrolled into a PMTCT randomised controlled trial. She expressed pill burden following 3 years of study drug, Lopinavir/Ritonavir and Truvada, and requested transition to standard of care FDC(EFV/Emtricitabine/Tenofovir). During this time she was virally suppressed with a high CD4 count. Four weeks following initiation of EFV, ALT increased to a grade 1 and hepatits B surface antigen was negative. ALT and clinical status progressively worsened, with other likely causes excluded following extensive work-up, and cART was discontinued.
RESULTS OR LESSONS LEARNED	She denied the use of traditional medication, alcohol and over-the-counter analgesia. Liver biopsy was indicative of a drug-induced submassive hepatic necrosis. Lopinavir/Ritonavir and Truvada were commenced following ALT levels 100iu/L, eighteen months from first elevated ALT. ALT levels returned to normal after just over 2 years.
CONCLUSIONS OR WAY FORWARD	The report describes the potential seriousness of Efavirenz-containing cART. With the rapid roll-out of cART under the Universal Test and Treat guidelines, vigilance is advised with the use of EFV in females with high CD4 counts, especially from 1-8 weeks following initiation.
PRESENTER'S BIOSKETCH	Dr Sherika Hanley is a qualified Research Clinician and specialist in Family Medicine who works for the Centre for the AIDS Programme of Research in South Africa (CAPRISA) based in the Umlazi clinical research site. She is a PhD candidate and participates as a leading and co-investigator in multiple clinical trials
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TITLE	Follow up of feeding methods in low birth weight infants discharged exclusively breastfeeding from Madwaleni District Hospital neonatal unit – A pilot study.
AUTHOR/S	**Michaela Lotz,** Sarah Wilkins
BACKGROUND	Breast-feeding is a key child survival strategy in resource poor settings. The Department of Health currently recommends exclusive breastfeeding for all infants for the first 6 months of life, with continued breastfeeding for at least 1 year, depending on the mother and child's HIV status. Breastmilk is preferred over formula feeding for all low birth weight (LBW) infants because of benefits related to infection and neurodevelopment. Specific conditions for safe formula feeding are rarely met in mothers delivering at Madwaleni Hospital, yet exclusive breastfeeding rates in a similar Eastern Cape rural population are only 22% by 3 months.
METHODS OR DESCRIPTION	Madwaleni Hospital has a 9 bed neonatal unit. In the last year, the multidisciplinary team has prioritised improving the rates of exclusive breastfeeding on discharge of LBW neonates, using an adapted clinical guide for cue-based transition to oral feeding in preterm infants. Discharge criteria include adequate weight gain with on-demand breastfeeding. Whether this has translated to sustained breastfeeding after discharge is not known.
RESULTS OR LESSONS LEARNED	In order to better support breastfeeding in infants who are discharged from the neonatal unit, a feeding follow up tool, facilitated by a speech and language therapist, has recently been added to the Madwaleni High Risk Baby Clinic (HRBC) program. The hospital-based HRBC aims to follow up growth and development in high risk neonates up to 1 year corrected age, but depends on caregivers being able to attend on set dates.
CONCLUSIONS OR WAY FORWARD	This is an audit of the HRBC feeding tool and initial newborn admission record, for each previously LBW child who attends the HRBC from May to July 2019, in order to describe current feeding methods, factors that affect ongoing feeding choices after discharge and barriers to breastfeeding in this group. This is a pilot for further research at this facility.
PRESENTER'S BIOSKETCH	Speech and language therapist/medical officer team with a special interest in neonatal care and a passion for supporting breastfeeding. Living and working at Madwaleni District Hospital in the Eastern Cape
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TITLE	Let's Talk Disability
AUTHOR/S	Michelle Flowers
BACKGROUND	Health workers have a duty of care to ensure that people with disabilities can access the support needed to participate fully in life's opportunities. Attitudes towards people with disabilities are tainted by myths, misinformation, preconceptions, prejudice and stereotyped thinking that compounds the other barriers which confront people with disabilities. With disability prevalence in South Africa higher than 15%, a platform is essential for people to come together to minimise discrimination and promote change. The importance of effective disability awareness programs has been given increasing attention in an effort to break down barriers and increase opportunities for everyone to contribute to creating a positive inclusive society. However, few have had an impactful conversation about the practical steps taken to reduce barriers and promote change within their communities.
METHODS OR DESCRIPTION	In response to this identified gap, the Shonaquip Social Enterprise has introduced a simple poster tool to facilitate productive group discussions in a program called "Let's talk Disability" (LTD). Each LTD brings various community members, people with disabilities, care-workers and other local stakeholders together. The objective is to talk about disability and to better understand how people perceive, talk and think about disability. What makes the LTD effective is that the community members themselves identify the barriers to inclusion that exist in their community and steps to overcome these barriers. "LTD" guides groups in community-driven action to address the obstacles that isolate and discriminate against people with disabilities and have undesirable outcomes for the community as a whole.
RESULTS OR LESSONS LEARNED	This poster will share the tool itself, how it is applied in practice and the lessons learned as community members engage with this tool in support of an inclusive society.
CONCLUSIONS OR WAY FORWARD	We hope to reflect the voice of the communities we serve and recognise the potential that exists within them to drive societal change.
PRESENTER'S BIOSKETCH	Occupational Therapist (2009 UCT) Bachelors in Augmentive and Alternative Communication (P 2013), Postgraduate Diploma in Palliative Medicine (UCT 2016)
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TITLE	Manguzi Gijima: Community orientated interventions for preventative medicine and breaking down barriers for people living with disabilities
AUTHOR/S	**Rael Sanzul**, Maryke Bezuidenhout
BACKGROUND	Non-communicable diseases (NCDs) are amongst the top ten causes of unnatural deaths in South Africa and contribute significantly to morbidity rates of those living with these diseases. Lifestyle modification such as participation in a regular physical activity programme and a healthy diet can prevent the development of NCDs and control their progression. The inclusion of people living with disabilities (PLwD) in physical activities is limited, especially in rural areas due to barriers which include, stigma regarding their abilities, accessible exercise equipment and appropriate advice from trainers or healthcare workers.
METHODS OR DESCRIPTION	The annual Manguzi Gijima is a community event created to promote physical activity in the Manguzi community, highlight and tackle barriers to inclusion of PLwD and promote health through alignment with the themes of National Nutrition Week and collaboration with community organisations. The organisers are made up of healthcare workers from Manguzi Hospital and members of community Disabled Peoples' Organisations within the community. The event requires multi-sectorial collaboration between the Departments of Health, Sports and Recreation, Education and various municipal structures including the local tribal leadership. Recently a relationship has been built with the South African National AID Counsel (SANAC).
RESULTS OR LESSONS LEARNED	Over 200 (57% disabled) people attended the 4th Annual event in 2018 which included 21km, 10km, 5km races, 3km and 100m wheelchair races and short races for mothers/caretakers of children living with disabilities. Local vendors provided food, and entertainment was on show by local school children and DJ. NCD and HTC services were on offer by PHC staff at the event.
PRESENTER'S BIOSKETCH	I am a qualified sport scientist and dietitian, currently working at Manguzi Hospital in KZN. I have been in public service since my community service at Manguzi Hospital in 2015. I am a strong proponent of preventative medicine through lifestyle adjustment and physical activity especially for those whom traditionally have significant barriers to this such as disadvantaged communities and people living with disabilities.
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TITLE	Mobile Clinic Toy Library Project
AUTHOR/S	Irene Chetty
BACKGROUND	Cotlands is a non-profit organisation providing vulnerable and marginalised children under five access to quality play-based early learning opportunities. Cotlands have been operating a toy library and mobile unit since 2008, and served more than 7 500 children through toy libraries. Cotlands recently extended the Cotlands mobile toy library trailer model to Kwamsane Clinic, Mtubatuba, KwaZulu-Natal in collaboration with the Department of Health.
METHODS OR DESCRIPTION	A toy library is a collection of educational toys, play materials, games and books aimed at improving children's school readiness. Briefly the project steps include: finding a space to set up the depot at healthcare facility, preferably close to where the mobile health clinics operate from. A trailer is hitched to the mobile health vehicle and the toy librarian accompanies the nurses on the mobile clinic. At the service point, the toy librarian sets up a play session that is conducted for 3 hours, and which promotes play-based early learning aimed at the holistic development of the under five year old children. In addition, the toy librarian does basic screening of children's health and psychosocial needs.
RESULTS OR LESSONS LEARNED	Once the play sessions are well supported, playgroups may be established in partnership with the Department of Social Development to provide a higher dosage of early learning. In addition parenting support sessions that encourages bonding and relationship building through mother/father/caregiver and baby playgroup may also be provided. The toy library depot becomes a resource to ward based outreach teams, mobile teams, ECDs, Phila Mntwana Centres and primary health care providers working in that area.
CONCLUSIONS OR WAY FORWARD	This model enables Health to deliver on their mandate as outlined in the National Integrated Early Childhood Development Policy (2015). Inter-sectoral collaboration is the cornerstone of this project providing solid foundations on which to sustain this initiative.
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TITLE	Proposal For Implementation of Autonomous Drone Delivery During Stockout of Medicines
AUTHOR/S	Damerrick Perry
BACKGROUND	According to a recent Stop Stockouts survey, over 200 health facilities in South Africa reported a stock out of medicines in 2017. For these facilities, factors such as deteriorated infrastructure and health service protests heightened the occurrences of these stockouts. In such cases, hospitals should be prepared to deliver vital medical supplies to patients even during times of crisis, or else the patients' lives become more at risk.
METHODS OR DESCRIPTION	Current solutions such as the Central Chronic Medicines Dispensing & Distribution system implemented by the National Department of Health are decreasing both the frequency and intensity of stockouts. But recently, autonomous drones have shown to be successful in further reinforcing the supply chain of health systems in countries such as Rwanda and Malawi.
RESULTS OR LESSONS LEARNED	This proposal presents a solution along those lines in the form of a hybrid combustion-electric drone and warehouse system in which health facilities can report low stock of medicines and have them delivered to the facilities immediately.
CONCLUSIONS OR WAY FORWARD	Overall, this proposed system of pre-positioning medicinal inventory should make the health care supply chain more resilient against circumstances of uncertainty such as those mentioned above.
PRESENTER'S BIOSKETCH	Damerrick Perry is currently an undergraduate student at the University of Illinois at Urbana-Champaign studying physics. Throughout his undergraduate career, he has been involved with organizations outside of his studies, one in particular being Entrepreneurs Without Borders. Through this organization, Damerrick has gained an abundance of experience traveling to other countries such as South Africa and Tanzania in order to learn about as well as teach entrepreneurship in subsistence marketplaces. He has also had the opportunity to carry out consulting projects with other students in these contexts. His experience with one organization, Silicon Cape Initiative, piqued his interest in the issue of logistics and supply chain efficiency in South Africa. He is currently seeking projects and approaches in which he can make a positive impact in this field as he looks forward to graduation next year.
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TITLE	Role of antibiotics in uncomplicated appendicitis
AUTHOR/S	MD Mukit-ul Islam
BACKGROUND	Appendectomy has remained as the standard of care in the management of appendicitis. However, this requires referral to a surgical centre. In rural South Africa, access to a safe surgical centre is challenging and time consuming. In recent years, evidence supports the use of antibiotics as conservative management. The aim of this retrospective study was to determine if antibiotic therapy is feasible for uncomplicated appendicitis in the Eden district.
METHODS OR DESCRIPTION	This study was a cross sectional analysis using the patient database in the Department of Surgery at George Hospital during the period of 2015 to July 2019. The target population was the Eden district in the Western Cape with referral to George hospital. Patients were selected with a discharge diagnosis of appendicitis and either receiving invasive or non-invasive management. The Alvarado score was completed using patient details retrieved from the electronic patient record. Successful antibiotic management included resolved signs and symptoms during hospital stay and no recurrence of signs and symptoms within 1 year of successful hospital discharge.
RESULTS OR LESSONS LEARNED	This section will be completed by the end of June 2019 and presented at the conference in September 2019.
PRESENTER'S BIOSKETCH	I grew up in the small town of Mafikeng close to Lomanyaneng. I am a final year medical student at the University of Cape Town. Currently doing my final year at George Hospital in the Eden district. I have a keen interest in surgery and rural health.
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TITLE	Sight to the unseen: An analysis of the delivery of comprehensive optometric services to rural KwaZulu-Natal by the Department of Health
AUTHOR/S	Lungile Buthelezi, Ms Nonkululeko Gcabashe, Dr Diane Van Staden
BACKGROUND	There are significant challenges for Eye Health Care (EHC) service delivery in South Africa, with the projected tripling of avoidable blindness globally. KwaZulu-Natal in distinctly rural in nature, with a population of 11.4 million people. Healthcare is found to be better in Urban Areas (UA) yet 51% of people reside in rural settlements. Currently, the KZN Department of Health (DoH) doesn't have a clear policy for EHC. Subsequently, optometric services are unevenly distributed resulting in inadequate service delivery to outlying areas. Previous research has neglected to analyse the capacity of all the KZN DoH resources for the delivery of comprehensive EHC services in KZN. The World Health Organisation (WHO) framework structures health systems in terms of six components for the achievement of equitable and sustainable health outcomes.
METHODS OR DESCRIPTION	This cross-sectional study sort to analyse human resource (HR) and infrastructure resource capacity of the KZN DoH for comprehensive optometric service delivery, guided by the WHO framework. Purposive sampling which included all KZN DoH optometrists was utilized. Data was collected by means of an online survey and equipment checklist which was distributed to each hospitals' eye clinic.
RESULTS OR LESSONS LEARNED	Most participants were based in rural areas (74%) where patients are required to travel to the nearest referral facility in UA (81%). Refraction was the most prevalent service provided and almost half of the respondents felt that equipment was inadequate for practicing the full scope of optometry. Furthermore, service delivery gaps were attributed to financial constraints and poor governance.
CONCLUSIONS OR WAY FORWARD	Optometrists commented that they felt undervalued as professionals and that policy makers are uninformed about EHC, as such, 50% of participants were seeking employment elsewhere.
PRESENTER'S BIOSKETCH	I am an early stage researcher with the hopes of building a career in research and community development in public eye health. I believe I possess the skills and potential to pursue further studies into my Post-Graduate research, with the goal of becoming a fulltime researcher and academic. I am in the process of completing my masters manuscript under the supervision of Dr Van Staden and co-supervisor, Ms Gcabashe, at the school of optometry at the University of KwaZulu-Natal Westville campus. I have gained some further training in research by serving as a research assistant for the PhD study of Mr Alvin Munsamy, under the School of Optometry. During this research I am conducting some clinical participant recruitment, data collection and data capturing. This project has given me insight into the field of HIV healthcare and neuro-ophthalmology. I've had a time to work along several departments such as neurology and radiology. This experience has revealed the importance of collaboration across disciplines, and the value this brings to the patients that we serve and the students we train. I have had the opportunity to present a poster at The African Forum for research and education in Health (AfreHealth) 2018 conference. In addition to my developing research training and experience I have acquired clinical teaching skills as a preceptor at the school of Optometry at the University of KwaZulu-Natal. I have thoroughly enjoyed the experience of training and enriching the learning experience of the students.
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TITLE	The effect of mHealth and conventional awareness campaigns on developmental literacy
AUTHOR/S	Courtney Brown
BACKGROUND	In the South African context, children in impoverished households face a multitude of risk factors that may impact early childhood development (ECD). Poor ECD could lead to many negative outcomes such as the continuation of the intergenerational cycle of poverty and fewer opportunities in life. This study aims to determine which form of awareness campaign, mHealth or conventional awareness campaign (paper-based), is most effective in improving caregivers' knowledge of ECD.
METHODS OR DESCRIPTION	Caregivers were recruited from a Primary Health Care Facility in Mamelodi. Once participants were identified, they were divided into three groups. mHealth; the conventional awareness campaign or the control group. The Knowledge of Infant Development Inventory (KIDI) was utilised to determine caregivers' knowledge of infant development before the caregivers were exposed to the awareness campaign. After a period of three months, during which the caregivers received the same information, the KIDI was performed again to determine the level of improvement.
RESULTS OR LESSONS LEARNED	The results showed that neither awareness campaign was more effective; as the results for both forms were similar to the control group's results. However, there was a significant improvement from pre-test to post-test. The common denominator between the three groups was a face-to-face engagement at the initial interview. The recorded improvement may be attributed to this factor and thus face-to-face interviews may be more effective than mHealth and conventional awareness campaigns.
CONCLUSIONS OR WAY FORWARD	Improved knowledge of ECD can reduce the prevalence of developmental delays and minimise the consequences of affected children. With improved knowledge of ECD, intervention may be sought earlier in the cases where intervention is required and consequently improving the possibility of a positive outcome.
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TITLE	The effects of Momordica balsamina methanolic extract on kidney function in STZ-induced diabetic rats: effects on selected metabolic markers
AUTHOR/S	Anelisiwe Siboto
BACKGROUND	Background The administration of bolus insulin in Diabetes mellitus is associated with sodium retention, hyperinsulinemic oedema and hypertension. Previous studies in our laboratory have showed that medicinal plants have hypoglycaemic and renoprotetive effects in STZ-induced diabetic rats. Studies suggest that Momordica balsamina (instungu) possesses hyporglycaemic effects. The effects of Momordica balsamina on diabetic complications such as DN however have not been established. Accordingly, this study seeks to investigate the effects of M. balsamina on kidney function in STZ-induced diabetic rats.
METHODS OR DESCRIPTION	The methanolic extracts (ME) of M. balsamina's leaves were used in this study. Short term effects of M. balsamina methanolic extract on kidney function and MAP were studied in individually caged rats treated twice daily with M. balsamina methanolic extract (250mg/kg), insulin (175µg/kg s.c.) and metformin (500mg/kg) for 5 weeks. Results M. balsamina methanolic extract significantly increased Na+ excretion outputs in STZ-induced diabetics rats throughout the 5 week experimental period without affecting urine flow and K+ excretion rates by comparison to STZ-diabetic control rats. Administration of M. balsamina methanolic extract significantly increased GFR in STZ-diabetic rats with a concomitant decrease in creatinine concentration and also reduced kidney to body ratio, albumin excretion rate (AER) and albumin creatinine ratio (ACR). Administration of M. balsamina methanolic extract significantly reduced MAP in STZ-diabetic animals by comparison with STZ-diabetic control animals. These results suggest that M. balsamina methanolic extract not only lowers blood glucose but also has beneficial effects on kidney function and blood pressure. M. balsamina methanolic extracts have the ability increase urinary Na+ outputs of STZ-induced diabetic rats and elevated GFR suggests up-regulation of renal function by this medicinal plant.
CONCLUSIONS OR WAY FORWARD	These finding suggest that M. balsamina may have beneficial effects on some processes that are associated with renal derangement in STZ-induced diabetic rats.
PRESENTER'S BIOSKETCH	I was accepted in UKZN to study BSC LES I majored with Biochemistry and microbiology and I obtained my degree in record time. I applied for my honours in human physiology and I was accepted. I worked under Proff Musabayane who as my supervisor and I was doing a study in malaria. I am currently a 1st year PhD student working on my proposal in preeclampsia and prediabetes.
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TITLE	UCT's Rural Support Network
AUTHOR/S	Shandri Erasmus, Kopano Marobyane
BACKGROUND	We are the UCT Rural Support Network (RSN), an entirely student-run society. RSN was formed in 1996 at the SAMSA general assembly. Our society aims to create awareness around rural health and encourage students at the UCT Faculty of Health Sciences to consider rural placements for their community service and/or internships. We would like to present at the Rural Health Conference 2019 to share the progress and success of our society, as well as to seek advice from others who may have insight on how we could further advocate for the decentralization of healthcare workers in a university-setting and raise awareness of the challenges faced in rural healthcare systems in general.
METHODS OR DESCRIPTION	One of RSN's most anticipated events of the year is a fully-funded rural placement at selected hospitals across South Africa. The students (from the first to final years, of all health sciences disciplines), shadow and assist healthcare professionals for two weeks, learning first-hand, what it means to work in a rural hospital. A qualitative study from our university, done by Mr James Irlam in 2014, showed positive results in the efficacy of RSN's placements in inspiring students to contribute to rural health in their futures.
RESULTS OR LESSONS LEARNED	Throughout the year we host panel discussions and workshops around topics related to rural health. This year alone has included discussions on multidisciplinary teams and mental health in rural regions, difficulties faced and lessons to be learnt from working at rural hospitals, advocacy channels to make use, and many more. RSN is currently looking towards ways of advocating for the inclusion of rural placements within the UCT Faculty of Health Sciences curriculums. This would something of note to discuss after our presentation.
CONCLUSIONS OR WAY FORWARD	We believe that students are not adequately prepared to work in rural areas, and are not encouraged to take up rural posts, when these regions need healthcare workers the most.
PRESENTER'S BIOSKETCH	Shandri is currently a 5th year MBChB student at UCT.
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TITLE	Voices of Primary Health Care Facility Managers Regarding Support And Supervision Of Ward Based Primary Health Care Outreach Teams In National Health Insurance Pilot Districts In Kwazulu-Natal
AUTHOR/S	**Mbali Mhlongo,** Dr Elizabeth Lutge
BACKGROUND	Human resource challenges jeopardise the South African health system, undermining the efforts made to reduce the burden of disease. There is a demand for a category of health workers to meet basic health needs of people at grass roots level to ensure accessibility and affordability of health care services. Evidence from many countries suggests that provision of home and community based health services, linked to care at fixed PHC facilities, is critical to good health outcomes. In South Africa, the Ward-Based Primary Health Care Outreach Teams (WBPHCOTs) are well placed to provide these services. Managers of PHC facilities ensure that WBPHCOTs perform their duties as required through training and supervision. The teams report to a PHC facility through their outreach team leader (OTL). The PHC facility Manager provides guidance and support to the OTL.
METHODS OR DESCRIPTION	The objectives of the study were ● To explore and describe the roles of the WBPHCOTS as per national policies and guidelines ● To explore and describe the roles of facility managers in supporting and supervising the WBPHCOTs This was an exploratory qualitative study. Data was obtained from interviews conducted with the PHC facility managers and the WBPHCOTs, at a sub-district level. Thematic analysis of data was done.
RESULTS OR LESSONS LEARNED	The study highlights some gaps in the supervisory and managerial relationship between WBPHCOTs and PHC facility managers. Issues such as high workload at clinics may undermine the capacity of PHC facility managers to support and supervise the WBPHCOTs. Supervision of WBPHCOTs in the field seems to take place only rarely. For those WBPHCOTs living far away from the clinic, any communication with the clinic manager may be difficult. The study further highlights issues around the training and preparation of WBPHCOTs for work in the field.
CONCLUSIONS OR WAY FORWARD	The supervision and training of WBPHCOTs requires attention, since there are currently important challenges experienced by both WBPHCOTs and PHC facility managers in this regard. The WBPHCOTs are an important component of National Health Insurance (NHI), and in order for NHI to be optimally implemented, the issues raised in this research should be addressed with some urgency.
PRESENTER'S BIOSKETCH	Dr Mbali Mhlongo is a lecturer in the Discipline of Nursing in the College of Health Sciences, at the University of KwaZulu-Natal. She is a community health nurse and has a strong Primary health care background having served under resourced communities in LMIC during her career life. She is a fellow for Developing Research, Innovation, Leadership and localization in South Africa, an NIH funded project and her passion is on health systems improvement. She is also a research supervisor for post graduate students in the College of Health Sciences
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TITLE	Walter Sisulu University health promoter establishes a rural Non-Profit Organization
AUTHOR/S	Zimbini Madikiza, Karessa Govender (RHAP)
BACKGROUND	Rural communities need to be equipped with essential knowledge and skills on how to take control and improve their health and access to equitable healthcare services. Ba Phakamise is an up and coming health promotion organization established in 2018, that seeks to be the leading organization for empowering rural communities to take ownership of their health and healthcare service delivery. Ba Phakamise is based in the rural parts of the Eastern Cape in the OR Tambo district and is run by a team of dedicated health promoters. These health promoters obtained their Bachelor's degree in Health Promotion at WSU. Despite the numerous benefits that health promotion offers, the HPCSA does not recognize it as a profession from an accredited university.
METHODS OR DESCRIPTION	This poster presentation will be used to raise awareness of health promotion as a discipline and its importance especially to rural communities. The WHO has shifted the definition of health promotion away from prevention of specific diseases or risk behaviors towards the health and well-being of the whole populations. In addition to healthcare workers diagnosing problems, the communities themselves determine health issues of relevance to them in their local communities. Ba Phakamise health promoters seeks to strengthen community participation for a collaborative responsibility of their society that has to be prioritized by organizations and the government in decision making.
RESULTS OR LESSONS LEARNED	Ba Phakamise's role in rural communities is to support communities to define their own health challenges. The organization with its dedicated team plan an appropriate intervention for addressing the challenges outlined and serve as mediators in advocating for the community to relevant NGOs and government departments. Phakamise believes that these are the best practices in acting on the rural communities' voice.
CONCLUSIONS OR WAY FORWARD	Ba Phakamise is in partnership with the WSU campus clinic and is currently working with RHAP on a community participatory project called WASH in Nyandeni sub district. The aim of this project is to equip the community with skills to conduct social audits on the state of water, sanitation and hygiene in their healthcare facilities.
PRESENTER'S BIOSKETCH	Zimbini Madikiza is a qualified health promoter from Walter Sisulu University (WSU). She is passionate about advocating and empowering rural community to take control of their health and improve access to quality health care. Born from the rural parts of the Eastern Cape, she established a rural health promotion non profit organization, called Ba Phakamise that is based in the OR Tambo district. She is also currently studying towards a masters of science degree in health promotion at WSU.
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WORKSHOPS

WORKSHOP	PRESENTER
Our voice: sharing the experience of community rehabilitation workers	Judith Mahlangu
Snakebite management	Christoff Bell
Photovoice exhibition at the rural health conference	Bernhard Gaede
Rural Seeds Cafe 2019	Bernhard Gaede
Healer, Heal Thyself	Suvira Ramlall
General Surgery by Generalist Surgeons	Steve Reid
Giving Children with Cortical Visual Impairment a Voice	Heather Coombe
Making decentralised learning work in a district hospital	Hoffie Conradie
Listening to your inner voice (LIVe)	Sarah Davids
Who wants to be a rural doctor?	Steve Reid
Social Accountability in training and service	Bernhard Gaede
Community engagement – are we doing enough?	Russell Rensburg
Developing a support and mentorship programme for community service health care workers.	Martin Bac
Performance management of community care workers: The ASK method	Guin Lourens
RuDASA Indaba Mentoring	Mosa Moshabela
RuNurSA Indaba	Guin Lourens
PACASA Indaba	Zuki Tshabalala
Thriving in Rural health through mentoring	Madeleine Muller & Dr Jenny Nash

WORKSHOPS ABSTRACTS

TITLE	Our voice: sharing the experience of community rehabilitation workers
AUTHOR/S	**Judith Mahlangu,** Saul Cobbing, Theresa Lorenzo, Pam Haynes
WORKSHOP DESCRIPTION	This interactive workshop will provide the unique opportunity for delegates to hear the voices of the unsung heroines of the South African public sector. Ten community healthcare workers (CHWs) will be given the platform to share their lived experiences of delivering rehabilitative care to South Africans living in rural areas. The workshop will be facilitated by Judith Mahlangu, herself a community healthcare worker, with assistance from three rehabilitation professionals and researchers. The workshop will focus on listening to these voices closely in order to collaboratively decide on innovative ways in which quality multi-faceted rehabilitation options are made available to all South Africans. Given the impact of the work done by CHWs in the fields of rehabilitation and disability, there will be a strong focus on how task-shifting strategies can be included in these options. It is hoped that a wide cross-section of delegates will attend this workshop, including members of disability groups, health advocates, rehabilitation and health professionals, rural health and rehabilitation activists, NGO representatives, and policy and decision makers at national and provincial level. We want this workshop to be as interactive as possible and request that all delegates add their voices and experiences in order to discuss rehabilitation requirements, community rehabilitation interventions that are currently working effectively as well as the potential barriers to the success of these programmes.
PRESENTER'S BIOSKETCH	Judith is a community worker, who has for many years dedicated herself to uplifting others and creating a positive change in various communities. She has worked at NGOs, started and been involved in community projects, assisted occupational therapy students on fieldwork placements, conducted research and been a research assistant.
E-MAIL ADDRESS	cobbing@ukzn.ac.za

TITLE	Snakebite management in the rural district hospital
AUTHOR/S	Christoff Bell
BACKGROUND	The WHO recognised snakebite envenoming as one of its priority neglected tropical diseases in 2017 estimating 100 000 deaths and 400 000 amputations or permanent disability globally each year. It affects the poorest in our country and is often poorly managed mostly due to a lack of knowledge. The workshop aims to address this lack of knowledge and will include an overview of the problem, but then focus on the practicalities regarding snakebite management in a rural district hospital setting with the aim to equip the audience to adequately treat snakebites.
METHODS OR DESCRIPTION	Practical Topics covered will include: First aid Different snakes and clinical envenomation syndromes Evaluation of the snakebite victim Deciding and administering antivenom Ongoing monitoring Complications
CONCLUSIONS OR WAY FORWARD	There will be clinical scenarios + discussion and a picture quiz at the end to test the audience knowledge.
PRESENTER'S BIOSKETCH	Christoff Bell is a medical officer committed to rural medicine. He completed his MBChB at the University of Stellenbosch in 2008, and did his internship at George Hospital in the Western Cape. In 2011 He did community service at Mseleni Hospital in the Umkhanyakude district, KZN. Afterwards he stayed on at Mseleni to pursue a career in rural health. In 2017 he moved to Mosvold district Hospital which is also located in the Umkhanyakude district. From a young age he showed a keen interest in nature, animals and snakes in particular. Working in rural KZN rekindled this love for snakes and he subsequently also developed a keen interest in snake bites, which is a common problem in the area. In 2013 attended the Swaziland Snakebite Symposium and later returned as a presenter at the symposium in 2018. He is currently a member of the National Snake-bite Advisory Group that assists medical personnel across the country with regards to managing snake bites. He also completed a snake-handling course with well known South African herpetologist, Johan Marais, in 2013 and since then frequently removes snakes from people's homes in the area. He has a passion to improve the management snakebites in South Africa as it most often affects the rural people which he has committed to serve.
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TITLE	Photovoice exhibition at the rural health conference
AUTHOR/S	**Bernhard Gaede,** Lebo Moletsane
BACKGROUND	As part of the rural health conference 2019, we would like to propose an exhibition of photos by participants of the conference. The theme of the exhibition will be "This is rural health"
METHODS OR DESCRIPTION	How to participate: How it will work: 1) Please take a photo depicting "what does rural health mean to you?" 2) Please write a short caption or paragraph (not longer than 50 words) that explains or reflects on the meaning of the photo. 3) Please send an email that includes both the text and photo attached to gaedeb@ukzn.ac.za BEFORE the 16 August 2019 to allow for the photos to be printed before the conference. 4) We want to exhibit all the photos with their texts at the conference for the duration of the conference at the conference venue as well as use them as screen savers between sessions in the venues. 5) At the END of the conference you will be able to take your printed photo with you (if you leave before the end of the conference, we will make a plan to send the photo to you).
RESULTS OR LESSONS LEARNED	**Rules:** 1) It should be a photo that you took yourself. 2) Save the photo in one of the following formats: JPEG, TIFF, GIF, BMP or PNG. 3) Only photos submitted by people attending the conference will be displayed 4) If any persons are depicted in the photo, written consent needs to be taken 5) Late entries cannot be displayed as they will not be printed.
PRESENTER'S BIOSKETCH	Dr Bernhard Gaede is currently the Head of Department of family medicine at UKZN. Prior to this appointment he was the director of the Centre for Rural Health at UKZN. He worked in rural settings for well over a decade prior to joining UKZN, the bulk of it in the Bergville area, KZN. He was deeply involved in the setting up of the ART program in the mid-2000's, working with traditional healers, homebased carers and community structures. He has also been actively involved in the Rural Doctors Association of Southern Africa and the Rural Health Advocacy Project. He competed his medical undergraduate studies at Wits University and qualified as a family physician from MEDUNSA in 2004. In 2014 he completed his PhD through the University of Pretoria, focusing on the experiences and challenges of health professionals working in the public sector bureaucracy. Areas of research and publication include health care systems, community-level care and medical anthropology. Recent interests include health professional education, decentralized training and community engagement and is currently the PI on the NRF grant Community Engagement in Training (ComET).
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TITLE	Rural Seeds Cafe 2019
AUTHOR/S	Bernhard Gaede
BACKGROUND	A Rural Seeds group was set up at the family medicine WONCA Rural Conference in Australia to organize and support students and young health professionals who are interested in working rural. The group is a global network and has organized regular virtual online 'Rural Seeds Cafe's' as well as meetings at many conferences and meetings since then. The Rural Seeds Cafe links students and young professionals with rural veterans to promote exchange on how rural-based curricula, transfer of rural knowledge and rural mentorship can be promoted and supported. Since 2017 we have held Rural Seed Cafe's at the South African Rural Conference which has brought students, young professionals and seasoned rural practitioners from all the participating professions to share and exchange views. In the past the sessions have been a vibrant forum for discussion and sharing of stories. The idea has been not only to give a voice to students and your professionals interested in rural health but also to stimulate dialogue and hear from some that have 'been rural' and some that are 'going rural'.
METHODS OR DESCRIPTION	At the 2019 Rural Seeds Cafe we hope to connect with international rural health champions, including members of the established Rural Seeds movement as well as some global leaders in rural health. The session is designed for students and young professionals.
PRESENTER'S BIOSKETCH	Dr Bernhard Gaede is currently the Head of Department of family medicine at UKZN. Prior to this appointment he was the director of the Centre for Rural Health at UKZN. He worked in rural settings for well over a decade prior to joining UKZN, the bulk of it in the Bergville area, KZN. He was deeply involved in the setting up of the ART program in the mid-2000's, working with traditional healers, homebased carers and community structures. He has also been actively involved in the Rural Doctors Association of Southern Africa and the Rural Health Advocacy Project. He competed his medical undergraduate studies at Wits University and qualified as a family physician from MEDUNSA in 2004. In 2014 he completed his PhD through the University of Pretoria, focusing on the experiences and challenges of health professionals working in the public sector bureaucracy. Areas of research and publication include health care systems, community-level care and medical anthropology. Recent interests include health professional education, decentralized training and community engagement and is currently the PI on the NRF grant Community Engagement in Training (ComET).
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TITLE	Healer, Heal Thyself! How To Heed The Inner Voice And Beat Burnout
AUTHOR/S	Suvira Ramlall
BACKGROUND	On 28th May 2019, 'burnout' was included in the 11th Revision of the International Classification of Diseases (ICD-11) as an *occupational phenomenon*- **not** as a medical condition. Defined in ICD-11 as 'a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed, it is characterized by three dimensions: feelings of energy depletion or exhaustion; increased mental distance/negativism/cynicism from one's job and reduced professional efficacy.' Globally, rates of stress, depression, suicide and, more recently, burnout among healthcare professionals are increasing at alarming rates.
METHODS OR DESCRIPTION	When the health of healthcare workers themselves is compromised by a 'non-medical' condition then the hope of a pharmacological antidote on the horizon is also snuffed out and healthcare faces a malignant paradox: carers are unable to take care of themselves! A paradigm shift in what constitutes health and healing is required if a collapse of our health services is to be averted. At this workshop delegates will be required to dive 'inward' to seek answers and antidotes to the growing burden of burnout among healthcare professionals. Dismantling the old and ushering in new meaning to health, healing and happiness, delegates will: ● Define and manage their core identity, mission and sources of 'energy' ● Discover their powerful inner world and learn how to use it to effectively manage the outer world ● Debunk the myths of stress and harness it for growth ● Design an achievable personal transformation plan to lead healthy and empowered lives.
PRESENTER'S BIOSKETCH	Dr Suvira Ramlall is a senior psychiatrist and academic who heads the clinical psychiatry unit at King Dinuzulu (formerly King George) Hospital Complex in Durban. She is a member of the Provincial Mental Health Advisory Committee and has served on provincial and national mental health and substance abuse task teams and forums. Her PhD, completed in 2014, focused on dementia and paved the way for her role in the first multi-disciplinary Memory Clinic in the province at Inkosi Albert Luthuli Central Hospital and her work with NGOs-TAFTA and the Bessie Makhatini Foundation. At the University of KwaZulu Natal, she is the Academic Leader of the Registrar Training Programme in the College of Health Sciences as well as a lecturer at the Nelson R Mandela Medical School. She is currently serving her third term as the Secretary on the Council of the College of Psychiatrists, College of Medicine of SA. She serves on the executive committee of the Public Sector division of the South African Society of Psychiatrists. In addition to presenting papers at local and international conferences, she has published articles in local and international scientific journals and textbooks and co-edited Talk Therapy Toolkit, a text on the theory and practice of counselling and psychotherapy in the South African setting. She co-founded the KZN Mental Health Advocacy Group in 2014 and opened the KZN branch of the South African Depression and Anxiety Group in 2018 where she now serves as a Director.
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TITLE	General Surgery by Generalist Surgeons
AUTHOR/S	Steve Reid, Kathryn Chu
BACKGROUND	A large proportion of surgical procedures are carried out not by specialist surgeons but by generalist doctors in district hospitals. This has been quantified to some extent in the past, and more up to date data on the surgical capacity of all 288 district hospitals in South Africa will be presented at the start of this workshop.
METHODS OR DESCRIPTION	The ongoing maintenance of quality of care, as well as the improvement of surgical skills in district hospitals however, is inconsistent and not standardized, and referrals to regional centres are consistently problematic. Global surgery is the science of improving equitable surgical care and the recognition that surgical care is an essential part of global health. Since 2015, global surgery has gained political traction with the passage of a World Health Assembly Resolution, the establishment of the Lancet Commission for Global Surgery, and the development of National Surgical Obstetric Anesthesia Plans (NSOAPs). Despite these efforts, global surgery remain a low global health priority.
RESULTS OR LESSONS LEARNED	This workshop aims to bring together those who are interested in supporting and developing surgery by generalist surgeons in district hospitals in order to: 1. Understand the current situation of surgical services in district hospitals in South Africa 2. Discuss the training needs of generalist doctors and how they could be met 3. Discuss how can specialists (surgeons, anaesthetists, O&G, orthopaedics) can best support surgical care at district hospitals 4. Plan how support could be provided through m-health platforms, e.g. whats app groups, vula referrals, online education, etc. 5. Plan for better communication between district and regional hospitals regarding transfer of surgical patients.
CONCLUSIONS OR WAY FORWARD	The experiences of the participants of the workshop as well as the authors will be engaged in order to answer these questions, and links with other groups working on generalist surgery in Africa will be made.
PRESENTER'S BIOSKETCH	Rural family physician from Umkhanyakude. Sakhe indlu emphakathini wase-Obonjeni. Naye uthanda ukucula. Now he is an academic at the University of Cape Town, in primary health care
E-MAIL ADDRESS	steve.reid@uct.ac.za

TITLE	Giving Children with Cortical Visual Impairment a Voice
AUTHOR/S	**Heather Coombe**, Casey Bieldt
BACKGROUND	Cortical Visual Impairment (CVI) is a congenital or acquired brain-based visual impairment, meaning that the visual problem lies within any of the visual processing centres of the brain, rather than with the eye. CVI is common in children with cerebral palsy or other neurological damage; and children with CVI often present with complex communication needs (CCN). Children with CVI and CCN require targeted interventions to develop functional vision which allows them to engage in meaningful interactions and communication, and to have the opportunity to learn and participate in daily life.
METHODS OR DESCRIPTION	The workshop aims to introduce the concept of CVI and CCN, The CVI Range and the use of low technology interventions which are suited to low resource environments. The CVI Range is a tool based on the ten visual characteristics and is used to assess, monitor progress and direct intervention for children. Intervention involves giving the child time to learn and creating visual environments where the child can develop their visual library. The nature of language input that children with CVI and CNN receive assists the, to interpret what they see and therefore the concepts of vision and communication are intertwined.
RESULTS OR LESSONS LEARNED	The workshop will focus on how health care workers can implement low cost interventions for children with CVI and CCN which are embedded into family routines which ensures that the child's vision and communication is frequently and repetitively supported in meaningful ways.
CONCLUSIONS OR WAY FORWARD	This gives the child a voice and promotes their participation in all aspects of daily life.
PRESENTER'S BIOSKETCH	Heather Coombe is an Occupational Therapist working in private practice with children with neurological and visual impairments.
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TITLE	Making decentralised learning work in a district hospital
AUTHOR/S	**Hoffie Conradie**, Professor Steve Reid
BACKGROUND	Distributed learning (DL) in district hospitals and sub-districts have become an essential part of medical education in South Africa. Tertiary training hospitals are unable to cope with the increasing numbers of medical students and returning Mandela Castro collaboration students and do not provide the health care context and the burden of disease that most doctors will experience on qualifying. Students at most medical schools in South Africa spend time at district hospital level varying from weeks to a full year. **Audience** Academic supervisors of DL, site preceptors and doctors and allied health workers working in district hospitals involved in student teaching and learning and students involved in DL.
METHODS OR DESCRIPTION	**Objectives** 1. The participants will be able to develop and enhance a learning culture at district hospitals and sub-districts. 2. The participants will be able to facilitate deeper learning of medical students in a primary health care and district hospital context using cycles of adaptive action
RESULTS OR LESSONS LEARNED	A short introduction will address the present extent of decentralised learning in South Africa. Participants will be introduced to the concept of adaptive action as developed by the Institute of Human Systems Dynamics. Participants will then work in small groups using the What, So what, Now what format: ● What to describe patterns in DL in their local context, ● So what to make meaning of these patterns and discuss options to enhance DL and ● Now what to decide on adaptive actions to enhance
CONCLUSIONS OR WAY FORWARD	After each "what" small group discussion, participants will report back to the larger group. The workshop participants will make recommendations for action to enhance DL.
PRESENTER'S BIOSKETCH	Hoffie Conradie, MB ChB, DCH, M Med (Fam Med), FCFP (SA). He worked for more than 25 years as a rural doctor and family physician in the Eastern Cape. From 2003-2015 he was a rural family physician and medical educator, responsible for the rural training program for undergraduate medical students and post graduate family medicine for the Stellenbosch University in Worcester. In 2009 he became director of the Ukwanda Centre for Rural Health. From 2010 he was the Founding Director and part of a team that established the first Rural Clinical School (RCS) in sub-Saharan Africa in Worcester. As from January 2016 he is employed as a distributed learning facilitator for the Stellenbosch University Collaborative Capacity Enhancement through Engagement with Districts (SUCCEED) project in collaboration with Walter Sisulu University in the Eastern Cape and as from October 2018 the University of KwaZulu Natal (UKZN).
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TITLE	Listening to your inner voice (LIVe)
AUTHOR/S	Sarah Davids
BACKGROUND	"Mental health and well-being are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life" WHO 2013. The recent inclusion of the burn-out syndrome in the ICD-11 May 2019, reiterates the place and importance of preventative strategies for health care workers in rural settings who have disproportionate access to services as compared with urban areas. "Burn-out is a syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed, characterised by feelings of energy depletion or exhaustion, feelings of cynicism and negativity in the work setting and reduced professional efficiency WHO May 2019.
METHODS OR DESCRIPTION	**Workshop aim** To invite participants to an experiential session to reconnect with their inner voice through activities and skills that can be proactively applied in their lives.
RESULTS OR LESSONS LEARNED	Session outline A participatory methodology will facilitate engagement and skills transfer for application in both personal and work spheres. It forms a continuum, yet separate to the session done in 2018**.**
CONCLUSIONS OR WAY FORWARD	Key outcomes for the participants by the end of the session: ● How to create a safe space to listen to your inner voice ● Practical application of the atlas of emotions ● Practical mindfulness and guided meditation techniques
PRESENTER'S BIOSKETCH	OT with Leadership and management experience. Prime focus is well-being of health care workers in public sector
E-MAIL ADDRESS	sarahdavidsngq@gmail.com

TITLE	Who wants to be a Rural Doctor? Defining the outcome skills and attributes of rural training programmes
AUTHOR/S	**Steve Reid,** Ian Couper
BACKGROUND	Most universities now offer rotations through rural training sites, either compulsory or voluntary, and varying in length from one week to a whole year. Since these programmes are relatively expensive, administrators are constantly asking for evidence to justify rural educational programmes. One of the major unanswered questions in planning rural health sciences education concerns the question: how long is enough? In other words, how long should the required minimum length of time be of a rural rotation in the compulsory curriculum, to achieve the desired educational outcomes for all students? This has major implications for planning and budgeting, and is the subject of a current research project.
METHODS OR DESCRIPTION	This question obviously begs prior questions, namely: exactly what are the desired educational outcomes that can be expected of a graduate from a rural rotation, and how can they be measured? This workshop seeks to answer these questions, by bringing together rural practitioners who not only have an interest in student training, but also have a stake in their outcomes. Each university in the country has a different approach and their rural programmes aim for a variety of outcomes, as these are not stipulated by the HPCSA. Many programmes aim to produce graduates who choose to become rural doctors, but career choice is only one of a number of possible outcomes, particularly when considering the impact of rural training on all graduates.
RESULTS OR LESSONS LEARNED	Participants in this workshop will be asked to identify and prioritize the most important skills, characteristics and attributes of medical graduates, that they could expect rural training programmes to achieve
CONCLUSIONS OR WAY FORWARD	A nominal group technique will be used to identify and prioritize the most important outcomes. This will then be fed into the research project on the minimum time required for compulsory rural rotations in medical curricula in South Africa.
PRESENTER'S BIOSKETCH	Family physician, founder member of Rudasa, Chair of Primary Health Care at UCT.
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TITLE	Social Accountability in training and service
AUTHOR/S	Lyn Middleton, Training for Health Equity Network, Bernhard Gaede, UKZN
BACKGROUND	Social accountability has become a central thrust for many health professional education programs throughout the world. Particularly new programs integrate social accountability de novo into the approach of how both training and service delivery link in a socially-accountable manner. However, in the case of existing services and training programs, the transition to more accountable approaches is often poorly understood.
METHODS OR DESCRIPTION	The workshop will cover: ● A framework to explore how social accountability can be understood ● Reflection on the challenges for introducing and supporting social accountability in existing services and training programs ● Exploration of opportunities for social accountability on the service platform and training programs
PRESENTER'S BIOSKETCH	Dr Bernhard Gaede is currently the Head of Department of family medicine at UKZN. Prior to this appointment he was the director of the Centre for Rural Health at UKZN. He worked in rural settings for well over a decade prior to joining UKZN, the bulk of it in the Bergville area, KZN. He was deeply involved in the setting up of the ART program in the mid-2000's, working with traditional healers, homebased carers and community structures. He has also been actively involved in the Rural Doctors Association of Southern Africa and the Rural Health Advocacy Project. He competed his medical undergraduate studies at Wits University and qualified as a family physician from MEDUNSA in 2004. In 2014 he completed his PhD through the University of Pretoria, focusing on the experiences and challenges of health professionals working in the public sector bureaucracy. Areas of research and publication include health care systems, community-level care and medical anthropology. Recent interests include health professional education, decentralized training and community engagement and is currently the PI on the NRF grant Community Engagement in Training (ComET).
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TITLE	Community engagement – are we doing enough?
AUTHOR/S	Russell Rensburg
BACKGROUND	It's been said repeatedly that for universal health coverage to be achieved, communities must be at the centre of health services. However, there is very little discussion on the actual mechanics of community engagement. The 'why' behind community engagement may be clear but the 'how' and 'by whom' seems to be missing from this discourse. Suffice to say, the paternalistic and transactional manner in which the health system treats and excludes communities in decision making activities persists to this day. As we transition towards a new health reform, this is an opportune time to critically dissect what community engagement means and how we (healthcare workers, health managers, civil society) engage with it.
METHODS OR DESCRIPTION	This workshop will take the format of an open discussion and is explorative in nature however we have drafted the following questions to guide the dialogue: What do we understand by community? 1. What exactly does community engagement mean? Does engagement include participation? 2. Whose responsibility is it to engage with communities? 3. How do we practically engage with communities and how do we measure it? 4. What policy reform can we advocate for that will aid community engagement? 5. Local case studies that worked? 6. What current platforms or arrangements exist that we can capitalise on to engage communities?
PRESENTER'S BIOSKETCH	Hailing from the Eastern Cape, Russell took up the position of Director of RHAP in January 2019, leading the organisation into the next decade of rural health advocacy. Previously, Russell was RHAP's Programme Manager for health systems and policy. Russell is an expert in health systems and policy and was a Commissioner of the Lancet High Level Commission on Quality Healthcare. He also manages RHAP's rural proofing programme which advocates for the equitable allocation of resources for rural health care delivery. Russell says "The right to health is enshrined in the Bill of Rights and as such places a significant responsibility on the state to ensure that everyone has access to the health care services they need. However access to health is not limited to the treatment of disease but is a critical enabler to human development. While elected officials are mandated to realising this right as responsible citizens we have a duty to participate in the governance of our health systems". It is this duty that drives Russell passion to support the strengthening of health user voices in the design and delivery of person centered health systems. Before joining RHAP, he worked with the UNAIDS supported Technical Support Facility, managing technical assistance to 19 focus countries across Eastern and Southern Africa. He holds a Bachelor of Commerce with majors in Management and Economics.
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TITLE	Developing a support and mentorship programme for community service health care workers.
AUTHOR/S	Martin. Bac, Victor Khanyile, Keith Michael, Jenny Nash
BACKGROUND	We want to organize a workshop to develop a programme that will assist and support all 2000 health care workers who do their community service every year. RudaSA, RureSA, RuNurSA, RHAP and PACASA can work hand in hand with the national department of Health and the NGO's participating in the Christian Alliance to develop such a programme. It is envisaged to compile a complete overview of all health care facilities that can accommodate community service workers and how many of each category.
METHODS OR DESCRIPTION	All facilities should identify suitable and experienced mentors and facilitators eg local staff that has a commitment to mentor and support young colleagues.
RESULTS OR LESSONS LEARNED	A manual should be developed to assist and guide all young professionals that start their community service each year.
CONCLUSIONS OR WAY FORWARD	At the start of each cohort of community service professionals there should be a proper orientation in each province or district.
PRESENTER'S BIOSKETCH	Senior lecturer Family Medicine UP, board member of CMF
E-MAIL ADDRESS	martin.bac@up.ac.za

TITLE	Performance management of community care workers: The ASK method
AUTHOR/S	Guin Lourens, Ruben Geweldt
BACKGROUND	South Africa's new National Strategic Plan (NSP) on HIV, TB and STIs presents a unique opportunity to start correcting the rudderless management of community health workers (CHWS) in the South African public healthcare system in recent years. "Community health workers need to be formalized as a cadre, appropriately trained and supported, and fully integrated into the health system."
METHODS OR DESCRIPTION	Ukwanda Centre for rural health has a student learning centre in Avian Park, an informal settlement in Worcester where they collaborate with Boland Hospice. The performance management system of the Western Cape Government Health and Stellenbosch University is similar and complex to navigate at community level.Performance appraisal is managed by the nurse in charge of the Avian Park learning centre in collaboration with the relevant nurse from Hospice. The ASK (Attitude. Knowledge' Skills) system was developed by Boland Hospice and applied for management of CCWs in the Ukwanda centre for rural health. Good governance would include suitable performance management of CCWs to mitigate any vicarious liability to any of the 3 stakeholders of having CCWs rendering services.
RESULTS OR LESSONS LEARNED	Given the vital importance of proper integration into the healthcare system and the need for the creation of decent jobs in South Africa, reliance on the employment of CHWs through NGOs may dwindle. If we value the work of CHWs and consider it indispensable to the move towards a preventative health system, as we purport to, CHWs must have a suitable performance management system, which can be integrated into future endeavours in state employment and the associated social and economic benefits.
CONCLUSIONS OR WAY FORWARD	This study renders an opportunity to explore a performance management system tailored for CHWs, describe the implementation and make recommendations in terms of viability in the broader healthcare system as a human resource management tool. A Qualitative, descriptive design: Focus group discussion, individual interviews and document review applied.
PRESENTER'S BIOSKETCH	PhD Public healthcare management
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TITLE	RuDASA Indaba: Building Mentoring Systems
AUTHOR/S	Professor Mosa Moshabela
BACKGROUND	Following on the Workshop "Thriving in Rural Health Through Mentoring" the Indaba will focus on developing a staged mentoring plan to create a doctor-to-doctor support system.
METHODS OR DESCRIPTION	The current challenges in professional development will be identified by the participants as well as the skills needed to build functional mentoring relationships and environments within rural practice.
RESULTS OR LESSONS LEARNED	Resources like learning centres, online access, support visits, rural champions, Rural Buddies, the Rural Seeds Cafe, SAMA, and the Vula App will be reviewed to lay the foundation for a best practice network.
CONCLUSIONS OR WAY FORWARD	The outcome of the workshop will be a cohesive business plan to submit to the Discovery Foundation.
PRESENTER'S BIOSKETCH	Professor Mosa Moshabela is the Dean and Head of School of Nursing and Public Health, College of Health Sciences UKZN. Prof. Moshabela is a specialist in Family Medicine, a leading national and international researcher in HIV/AIDS, previous key personnel leading the establishment of decentralized clinical training sites in the UKZN Medical Education Partnership Initiative (MEPI) programme and currently a multi-PI leading the HIV/AIDS scientific track of the National Institutes of Health (NIH), D43 training program (DRILL: Developing Research, Innovation Leadership and Localisation in South Africa). He is a young (under age of 40), dynamic leader with an established track record of publications in high impact journals and a commitment to strengthening the health system particularly in rural areas of KwaZulu-Natal.
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TITLE	Thriving in Rural Health Through Mentoring
AUTHOR/S	**Dr Madeleine Muller,** Dr Jenny Nash
BACKGROUND	The aim of mentoring is to help clinicians thrive in rural practice and to become trustworthy practitioners.
METHODS OR DESCRIPTION	What do we want to trust our rural doctor / nurse / therapist to be able to do competently in his or her e.g. district hospital? We need clinicians that are knowledgeable, safe, competent, efficient and effective, cost-effective and professional.
RESULTS OR LESSONS LEARNED	We will explore the concept of Entrustable Professional Activities as one approach to developing a "rural health curriculum" and are looking for input and contributions in this interactive workshop. A variety of approaches to mentoring will be debated including: one on one mentoring, mentoring groups, recommendations for clinical skills & development of professional skills.
CONCLUSIONS OR WAY FORWARD	From the participants we will gather examples of "best practice" and possible partnerships in developing a mentoring programme.
PRESENTER'S BIOSKETCH	Dr Madeleine Muller MBChB.MRCGP.HIV Dip Man Dr Muller qualified as a medical doctor from the University of Pretoria in 1995 and obtained her Membership with the Royal College of Practitioners (MRCGP) in 2003 in the UK. She worked as a GP in the NHS in the UK until 2006 when she returned with her family to East London South Africa. In 2009 she joined the NGO Beyond Zero and in 2010 was awarded a Certificate of Special Merit by Rural Doctors of South Africa SA for work in mentoring PHC clinics in Rural Eastern Cape. In 2012 she obtained her Diploma in HIV management and in 2016 passed her Advanced HIV Health Management Program (AHMP) through FPD / Yale cum laude. She has created and implemented a part-time adaptation of the Wits RHI Advanced HIV and TB course in the Eastern Cape and Limpopo and over 300 clinicians have completed the certification with more than a 100 doctors having passed the Diploma in HIV Management. In 2017 she joined Nkqubela TB hospital and has facilitated trainings in DRTB and TB in rural districts of the EC province. She has been mentoring and supporting the creation of the Butterworth Gateway outreach decentralised DRTB site. Dr Muller is the Eastern Cape representative of RuDASA, sits on the SAMA border council as the rural representative and is the HIV clinician society coordinator for East London. She is an examiner for the Diploma of HIV Medicine with CMSA. Dr Jenny Nash was awarded Doctor of the Year in 2014 and the SAMA Local Heroes Award in 2015. She is a Family Physician on the Amathole District Clinical Specialist Team, Eastern Cape. Jenny is driven to help the impoverished population and is an advocate for multidisciplinary teamwork. A passionate advocate for rural practice she declares her clinical skills are sharper because she see so many different kinds of patients and works in a team. Jenny also has a keen interest in HIV and helped co-ordinate the first district-based anti-retroviral programme at Mseleni Hospital KZN
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