

**22nd Rural Health Conference**  
**Henley-on-Klip Gauteng Province**  
**Friday 21st to Monday 24th September 2018**



**RURAL HEALTH  
CONFERENCE  
2018**



## **Building the Legacy of Rural Health: Leadership, Advocacy & Clinical Care**

We have a rich history from our “real health veterans” but now is the time to develop a new generation of rural health professionals to lead the rural health movement. The conference story line will start what is needed for young professionals to be attracted to rural and stay rural. This would include what knowledge and skills gaps there are, and build on the SAAHE Statement on Training from RHC2017. We then move to recognise young leaders and developing their leadership skills, as well as building clinical expertise for all rural health professionals. The current economic constraints will continue and we need to do more with less. This creates a number of stressors for rural based professionals. So how do we look after ourselves as well as our patients? How do we make it easier for us all to “stay rural” through learning how to manage rural stressors? The Final Day will draw together the various strands of the conference and develop “key take home” messages for delegates and identifying work that has to be done by organisations to create long term solutions.

### **Welcome Note from the Organising Committee**

We welcome all delegates and thank all of our presenters for being willing to share their knowledge, experience and skills. A special thanks to all the sponsors and exhibitors without whom there would be no conference. For those of you new to the Rural Health Conference we hope you grow to love it as much as we do! 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.

#### RHC2018 Organising Committee

Guin Lourens	Chair & RuNurSA
Abigail Dreyer	RuDASA
Martene Esteves	PACASA
Heidi Theron	RuReSA
Tumi Ndweni	PACASA
Sihle Nyawose	Student Rep
Gloria Maimela	WHRI & Scientific Chair
Daniel deSanto	Volunteer Scientific Committee
Stephanie Homer	Conference Office

# RURAL HEALTH CONFERENCE 2018

## Gold Sponsor



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Occupational Therapist



## RuNurSA Welcome Note

Welcome to the RHC 2018. We hope to see more nurses attending the annually and are proud to have our first keynote address by a nurse leader at the conference this year!

RuNurSA (Rural Nursing South Africa) aims to strengthen rural nursing leadership. 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.

A call for a metaphorical 'repair of fault lines' in the South African health system to ensure success of the proposed national health insurance system includes addressing the leadership, management and governance failures (Rispel, SAHR, 2016). This requires 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 to enforce laws; appropriate management systems; and citizen involvement and advocacy to hold public officials accountable. We embrace our rural health advocacy partners at the conference and look forward to joining forces.

Nurses are called upon to lead, especially in rural environments by having the faith of their convictions-stepping forward and becoming a voice to lead and champion nursing issues which will positively affect health of communities in this country. Good nursing leadership has the potential to changes lives, forms teams, builds 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 direct care rural nurses to have a voice in decisions that affect their practice and to ensure quality healthcare. We salute our rural nurse of the year for doing just that!

Kind regards

Guin Lourens

RuNurSA & RHC2018 Chair



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<b>11h00 - 14h00</b>	<b>Registration &amp; Open Exhibition 11.00 to 14h00</b> <b>Sight seeing - local Tourism stand</b> <b>Health Site Tourism</b> <b>Tea &amp; Coffee</b>
<b>14h00 - 18h00</b>	<b>Conference Opening</b>

<b>14h00 - 15h00</b>	<b>Welcome by RHC2018 Chair</b> <b>Introduction of RHC2018 Partners</b> <b>Blessing for the conference</b> <b>Opening Speech</b>
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<b>15h00 - 16h00</b>	<b>PACASA Key Note: Nwabisa Mgobozi</b> <b>Defining the Problem: Experiences of a Young Clinician</b>
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<b>16h00 -16h30</b>	<b>The Rural Determinants of Health: principles for theory (Reid)</b>
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<b>16h30 - 17h30</b>	<b>Parallel Sessions:</b>
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	<b>Venue A: Clinical Skills</b>	<b>Venue B: Health Care</b>	<b>Venue C: Advocacy</b>	<b>Venue D: Developing young professionals</b>
<b>16h30 - 16h50</b>	Workshop: Introduction to the Department of Health's Patient-centric Culture Code to improve patients' and colleagues' experiences (Pillay)	Workshop: Bavuse-Mobile mobilisation for a People's NHI (Munshi)	Workshop: Working towards "rehabilitation for all": Where are we now? (Cobbing)	Investigating the Skills needed by new Doctors in Rural Hospitals (Couper & Johnson)
<b>16h50 - 17h10</b>				Towards reaching the UNAIDS 90-90-90 goals in student-patient encounters (Conradie)
<b>17h10 -17h30</b>				Are Patients in Butterworth Hospital Casualty Department Adequately Assessed and Triageed? A Quality Improvement Project (Mawer)

<b>18h00 - 21h00</b>	<b>Late Registration &amp; Cocktail Platters</b>
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## PACASA Welcome Note

I would like to personally welcome each of you to this year's annual RHC 2018. It is an exciting time for PACASA as we continue to grow and adapt, remaining always adaptable, motivated and responsive to the challenges and accomplishments of Clinical associates in South Africa. Our organisation is confronting a time of many changes and we are meeting these changes during a time of nation-wide and global change. The world of *Rural Medicine* is an exciting area in which to work, study and play, and we will continue to bring and meet inspired people together in forums like this.

We at PACASA are transforming the way we operate to continuously improve our ability to provide support and education to all our members as well as those within the community. We are determined to fight against the negativity and expel all doubt and confusion about our profession whilst providing support to our fellow members that have continued to meet the challenges of our field and who have excelled despite setbacks. We should all be very proud of where we are today and excited about where we are headed.

In closing, I would like to thank each of you for attending the RHC 2018 and bringing your expertise to our gathering. You, as organisation leaders and fellow professionals, have the vision, the knowledge and the experience to help us pave our way into the future. You are truly our greatest asset today and tomorrow, and we could not accomplish what we do without your support and leadership. Throughout this conference, I ask that you stay engaged, keep proactive and help us shape the future of *Rural Medicine*.

*Thank you*  
*Zukisa Tshabalala,*

PACASA Chair



## Saturday 22nd September 2018

**7h30 - 8h30**

**Exhibition - Tea & Coffee Station**

**7h30 - 8h30**

**Conference & CPD Registration**

**8h30 - 9h30**

**Welcome to Day 2 : Building a Leadership legacy**  
**RuReSA Key Note: Maryke Bezuidenhout**  
**Rural Proofing the New Generation of Health Professionals**

**9h30 -10h00**

PANEL: The development of the rural health movement in South Africa (Reid)

**10h00 -10h30**

**Tea break**

**10h30 - 11h00**

**View Exhibition**

**11h00 - 13h00**

**Parallel Sessions:**

	<b>Venue A: Clinical Skills</b>	<b>Venue B: Health Care</b>	<b>Venue C: Advocacy</b>	<b>Venue D: Developing young professionals</b>	
<b>11h00 -11h20</b>	Early detection of developmental delays in vulnerable children by community care workers using an mHealth tool (van der Merwe & Mosca)	PACASA Indaba: Navigating Supervision of Clinical Associates in a Rural Health Setting (PACASA)	Workshop: Must-haves for good rural service (Khan-Gillmore)	Shifting and Transforming the Practice of Audiology: The Inclusion of Spirituality, Religion and Alternative Practices. (Pillay & Moola)	
<b>11h20 - 11h40</b>	Workshop: I can make a difference working with a child with severe disabilities (Krige)			Workshop: NHI: Friend or Foe? (Rensburg & Govender)	Developing leadership and advocacy skills in final year healthcare students: Community Assessment Projects (Statham & Engright)
<b>11h40 - 12h00</b>					Becoming the change we want to see: Cataract Outreach (Lo & Belisha)
<b>12h00 - 13h00</b>					Workshop: Distributed Clinical Training: So how can we get this right together? (Muller & Bezuidenhout)

**13h00 - 14h00**

**Lunch break & Exhibition**

## Saturday 22nd September 2018

**13h00 - 14h00**

**Lunch break & Exhibition**

Parallel Sessions:				
14h00 - 17h00	Venue A: Clinical Skills	Venue B: Health Care	Venue C: Advocacy	Venue D: Developing young professionals
14h00 - 14h20				Decolonisation of knowledge: What do we mean and what are the implications for research and clinical practice in rural areas? (Neille)
14h20 - 14h40	Workshop: Managing Burns Beyond the City: NOT as difficult as it seems (Moore)	Workshop: Mitigating stress and the risk of burnout (Davids)	VOICE workshop: A Guide to Reporting Workplace Challenges: Principles, Tools and Strategies (Khan-Gillmore & Govender)	What makes a clinic an 'island of good practice'? Characteristics of care in the South African health context (Watermeyer)
14h40 - 15h00				
15h00 - 15h20				
15h20 - 15h40				
15h40 - 16h00				
16h00 - 17h00				Workshop: Rural Seeds Cafe 2018 (Gaede)

**17h00 - 18h00**

**Tea break & Exhibition**

**17h00 - 18h30**

**Student Meet & Greet & AGM**

**19h00 - 22h00**

**Gala Dinner & Award Ceremony**

## RuReSA Welcome Note

Welcome to RHC 2018! This year I feel the theme is particularly pertinent, given the overwhelming challenges the public health sector is currently facing including recent policy development, monitoring, funding and implementation challenges. The RHC brings together passionate people from different backgrounds, professions and sectors across the generations. This makes this conference particularly relevant in discussing and addressing current issues in service delivery the underlying persistent inequalities.

The NHI has at least gotten South Africa discussing the concept of 'Health for All', and two particular statements from abstracts which I feel embody the need for rural proofing this initiative include 'welfare grants alone are insufficient to ensure reintegration and participation of patients within community' and 'the services your child with a disability accesses depends on where you live'. We all bring particular backgrounds and skills sets to the conference, and I encourage everyone to participate in the robust discussions around rural proofing the NHI so that comprehensive input can be submitted.

A number of presentations and workshops look at the broader, overarching needs and challenges, including the rural determinants of health, the critical impact that good communication and organisational culture has on health systems and perceived quality of care, and the pitfalls of trying to deinstitutionalise and decentralise services to support community integration without ring fencing and redirecting budgets to PHC level.

This year a lot of emphasis is being placed on training fit-for-purpose graduates through inclusion of advocacy within the health sciences curricula, identifying gaps in current syllabi affecting independent practice in rural settings, decolonisation of curricular and research, mentoring and addressing burnout as well as building and strengthening the interdisciplinary team. A student presentation has hit the nail on the head with the statement 'Be the change you want to see'. Training undergraduates is everyone's responsibility, and many of the presentations focus on addressing particular challenges faced at the coalface (aka the training platform).

I'm encouraging all to reach out and engage with different viewpoints and experiences that different sectors and professions bring to the table - together we can achieve a lot. Be the change you want to see!

Maryke Bezuidenhout  
RuReSA Chair



**Sunday 23rd September 2018**

**7h30 - 8h00**

**Exhibition - Tea & Coffee Station**

**7h30- 8h00**

**Conference & CPD Registration**

**8h00 - 9h00**

**Welcome to Day 3: Leadership & Advocacy**

**RuDASA Keynote: Dr Lungi Hobe**

**From Mentee to Mentor**

**9h00 -10h00**

**RMHC Key Note Carrie Brooke-Sumner**

**Remember Esidimeni: health practitioner advocacy for community-based services for severe mental illness**

**10h00 -10h30**

**Tea break**

**10h30 -11h00**

**View Exhibition & Posters**

## Sunday 23rd September 2018

**10h30 -11h00**

### View Exhibition & Posters

Parallel Sessions: Clinical Skills & Leadership				
	Venue A: Clinical Skills	Venue B: Mental Health Care	Venue C: Advocacy	Venue D: Developing young professionals
11h00 -11h20	Which type of Caesar do you want? (Viljoen)	Mental health in-patient intervention: Infrastructure and community focused (Lourens)		
11h20 - 11h40				Distributed training platform coordinators-voices from the other side of the mountain (Muller)
11h40 - 12h00			Building Momentum for the RuDASA Strategic Plan (RuDASA)	The value of a short practical training course for newly qualified therapists working with children with cerebral palsy in South Africa (Bakuwa)
12h00 -12h20	Workshop: Eish, A Paediatric Surgery emergency in the sticks! (Manickchund & Machaea)	Workshop: We cannot achieve health for all without investing in rural mental health (Morgan & Smith)		Are SA's most vulnerable communities benefiting from community service? (Govender & Rensburg)
12h20 -12h40				Advocacy in the Health Sciences Curriculum – A Student Enabler (Khan-Gillmore)
12h40 - 13h00				

**13h00 -14h00**

### Lunch break & Exhibition

## Sunday 23rd September 2018

**13h00 -14h00**

### Lunch break & Exhibition

**14h00 - 17h00**

### Parallel Sessions: Skills & Leadership

	<b>Venue A: Clinical Skills</b>	<b>Venue B: Mental Health Care</b>	<b>Venue C: Advocacy</b>	<b>Venue D: Developing Leadership</b>
<b>14h00 - 15h00</b>	Workshop: Making the most of technology: remote seating mentoring and support services (Giljam)	Workshop: Building resilience through community of care for rural health professionals (Kanda)	Workshop: The New National HRH Strategy – Setting Priorities for a Joint Submission (Versteeg-Mojanaga)	Workshop: Developing the leadership of a community disability-inclusive workforce (90 min) (Lorenzo)
<b>15h00 - 17h00</b>	<b>Poster presentations &amp; Judging</b>	<b>Poster presentations &amp; Judging</b>	<b>Poster presentations &amp; Judging</b>	<b>Poster presentations &amp; Judging</b>

**16h30 -17h00**

### Tea break & Exhibition

**17h15 - 19h30**

### Meet & Greet People & AGMs

	<b>Venue A</b>	<b>Venue B</b>	<b>Venue C</b>	<b>Venue D</b>
	<b>RuDASA</b>	<b>RuReSA</b>	<b>PACASA</b>	<b>RuNurSA</b>

**19h30 - 22h00**

### Informal Dinner & Social

## RuDASA Welcome Note

Dear Delegates,

It is my greatest pleasure to welcome you all to this the 22nd Rural Health Conference. The theme of building young professionals to be our rural leaders of the future is close to the heart of RuDASA.

Each of us walks a different path in rural health care, but this conference affords us an opportunity to offer support to each other, as we continue to serve and comfort our rural communities. We hope to learn from our youth about the challenges they face, and share the lessons learnt by the rural veterans so we can find ways to overcome these challenges.

We welcome the specialists who have joined us at the conference to pass on their skills so that we can provide a better service for our patients who often have long delays in getting quality care. We strive for good quality rural services, and this mission is never ending.

As we look forward to the goals for 2030 we need to debate the Human Resources for Health plans and the National Health Insurance plans to ensure that our rural communities get their fair share of services. We need to ensure the participation of RuDASA in these fora.

I should also send a special welcome to all of you members of RuDASA, and invite you to join the Indaba session to discuss how we how we can develop rural champions that will be resources and mentors for their rural colleagues.

We hope that our proposed plan for RuDASA will meet the approval of its membership body, as we embark on a journey to change to face of this association, whilst still preserving the ethos and values in rural health practice, the very thing that brings us all together.

sSincerely,

Mosa Moshabela

RuDASA Chair



## Monday 24th September 2018

**7h30 - 8h00**

**Tea & Coffee Station**

**7h30 - 8h00**

**Conference & CPD Registration**

**8h00 - 9h00**

**Welcome to Day 4: Building on the Advocacy Legacy**  
**RuNurSA Key Note: Daphney Nozizwe Conco**  
**Women's Empowerment in the Context of Chronic Poverty: Lessons for Health Professionals Working in Rural Settings**

**9h00 - 9h30**

Plenary : Considerations for a just State response to conscientious objection in South Africa and its impact on access to safe abortion in rural areas (Versteeg-Molanaga)

**9h30 -10h30**

Panel Discussion: Termination of Pregnancy Services in Rural Areas & Conscientious (Gonzalez)

**10h30 -11h00**

**Tea break**

**11h00 - 12h00**

**Parallel Sessions: Planning for the Future**

	<b>Venue A: Clinical Skills</b>	<b>Venue B: Health Care</b>	<b>Venue C: Advocacy</b>	<b>Venue D: Developing young professionals</b>
<b>11h00 - 12h00</b>	Workshop: Using the ICF framework to make collaborative patient care possible (Muller)	Workshop: How health care workers can report stock-outs to strengthen health care systems (Jankelowitz)	Workshop: Using Health Workers for Change (HWFC): The Quality improvement methodology to build advocacy legacy (Conco)	Workshop: The whole person - How to Look After Ourselves and Our Patients (Bac)

**12h00 - 13h30**

**Plenary: Reflections On Learning And A Way Forward**

**Critical ideas from the Key Note Speakers and Workshops  
(Organisation reps & delegates)**

**Building momentum: What can your organisation do to change rural health service for the better?  
(RHC Chairs & delegates)**

**Announcement of the Conference Prize Winners  
(Scientific Committee)**

**Key Take Home Messages from the Conference  
(RHC2018 Chair)**

**Conference Closing & Media Releases**

**13h30**

**Take a packed lunch & travel safely home!**

Day 3: Sunday Poster Session 15h00 - 17h00	Presenters
The Expectations and Perceptions of Final Year Medical Students of Clinical Associates	Michiel Koortzen, LW Biggs, Martin Bac, Liz Wolvaardt, & Astrid Turner
Impact of a Clinic Dedicated to Hypertension in Pregnancy at a District Hospital	Sr. N Nkosi & Dr. N Mthetwa
The LEAP for Quality Programme in Lesotho*	Dr Martin Bac, Prof Bob Pattinson, Prof Peter MacDonald, Dr. Anne-Marie Bergh, & Prof Jannie Hugo.
Overcoming Barriers to Inclusion of the Rural Child With a Mobility Disability	Margaret Linegar
Hypertension In Pregnancy Burden At A Regional Hospital In Kwazulu-Natal	Dr. T Mathenjwa & Sr. A Cezula
Strengthening South Africa's HIV-AIDS Response By Aligning Clinical Associate Education Programmes With National Prevention And Treatment Guidelines – A Curriculum Map Review	Scott Smalley
Non-Communicable Diseases in a Rural Setting	Dr. Brendan Bebington & Miss Martene Esteves
AwezaMed: Mobile speech-to-speech translation within the Midwifery and Obstetrics domain	Nina van Niekerk, Karen Calteaux, & Glenn Stein
My personal experience as a community liaison for students and a NGO worker	Judith Nomthandazo Mahlangu & Helga Elke Lister

# **Rural Health Conference 2018**

## **Conference Proceedings**

## Key Note Speakers

### **Advocacy for the future of rural health: Rural Proofing the New Generation of Health Professionals**

RuReSA Keynote Speaker: Maryke Bezuidenhout

Content: Building momentum: Taking the rural health movement forward

Twenty four years post democracy, South Africa remains one of the most consistently unequal countries in the world. 40% of South Africans (in 2015) lived below the lower bound poverty line, with the bottom 50% of households accounting for only 8% of incomes, 5% of asset values and 4% of net wealth. The poverty headcount remains higher in rural areas. Underserved populations typically struggle to access affordable and appropriate health care. Social, psychosocial, environmental and economic factors affecting these populations further create worse health outcomes. Despite an appropriate overall expenditure on health, the regulatory and funding disparities between public and private sectors have further contributed to inequities in health access and rural health outcomes continue to be sub-optimal.

South Africa has chosen a 'comprehensive' primary health care approach, adopting a biopsychosocial model which requires a trans-disciplinary approach and a coordinated, sustained inter-sectoral collaboration. Trans-disciplinary practice is not inherent, it requires a shared set of values as well as significant support, funding, mentoring and professional development; and South Africa is struggling with implementation of this approach across multiple platforms. This presentation looks at how curriculum planners and the Department of Health need to partner to create appropriate rural health professionals. Universities are considered responsible for producing graduates that are 'fit for purpose' within the underserved South African context. Currently our training does not meet the mark. Professionals working in the Rural Health arena struggle to cover the extensive skills sets required in unsupervised or poorly mentored rural practice.

Selection criteria, exposure and syllabus affect overall appropriateness of graduates for work in the South African public sector. There has been an effort to increase the selection of students from rural areas; training continues along professional and specialist lines with primary health care, multi-disciplinary collaboration and goal setting confined to theoretical exercises. The focus on acquiring professional clinical skills within an institutional environment overlooks the need for new graduates to have a working knowledge of the lived reality of rural health care either as a practitioner or patient. Whilst the need for students to be trained in PHC and experience health systems rural areas is supported in theory, there is minimal support in practice by the Department of Health and universities. Lack of appropriate PHC exposure and a lack of training in health systems hampers the production and retention of fit-for-purpose graduates. It is crucial that the Rural Health Movement is involved in creating appropriately trained graduates and rural mentors by enabling Universities to develop and support the following:

- Decentralised training platforms for primary and district health care
- Multi disciplinary and Trans-disciplinary learning platforms
- Key knowledge base and skills for "working rural"

We need to unpack the role of The Department of Health as a partner in training undergraduates for the future of rural health and providing budget support to ensure appropriate training can occur within the rural primary health care platform. A comprehensive package of care requires a comprehensive health team and it is critical that policy makers, health planners, human resource planners, budget holders and decision makers consult with Allied Health as well as doctors and nurses.

Biosketch:

Maryke Bezuidenhout graduated as a physiotherapist from the University of Pretoria in 2001. After a brief dabble in private practice, she has since firmly entrenched herself as far away from urban civilisation as possible - a move which she feels has given her a strong sense of justice and an excellent sense of humour. Maryke comes from a long line of incredibly stubborn people who feel life is not worth living unless it is packed to the max with activity and filled to the brim with challenges. When not tackling remote donkey tracks on her mountain bike or tempting crocodiles on her kayak, she is found heading the 22-strong multi-disciplinary rehab team at Manguzi Hospital in the remote north eastern corner of Kwa-Zulu Natal, where she has been working for the past 14 years. She considers herself incredibly fortunate to work with a passionate team, within an amazing community. Maryke also plays an active role in policy development and advocacy as chairperson of Rural Rehab South Africa (RuReSA) and serves as a committee member on the public sector rehabilitation forum and KZN Orthopaedic Manual Therapy committee.

## **Defining the Problem: Experiences of a Young Clinician**

PACASA Keynote Speaker: Nwabisa Mgobozi

Content: Building leadership legacy: What do young professionals want and need to know?

In rural communities there are often severe staff shortages and over the years at Canzibe hospital this has been a regular occurrence. In 2017 the doctors' shortage reached crisis levels dipping from 7 doctors to 2 then later to 1 doctor (the Clinical Medical Officer). I joined Canzibe Hospital during this crisis period and in this presentation I will identify the main contributions a clinical associate can make to the rural district hospital team and my experiences of being a team member. The work of Clinical associates often goes unnoticed and this need to be addressed at leadership level, together with PACASA we will outline the key messages that need to be used to market Clinical Associates to both Hospital CEOs and Health Planners.

Working rural at a Hospital like Canzibe means working off the beaten track. Coming off the main road from Mthatha, there is a further 26km of gravel, sand, dust, and hard driving before arriving at the entrance of the hospital. Many have turned away from this difficult and challenging road. The challenges for young professionals working in rural areas will be identified, such as working under pressure, managing emergencies, transport. The effect of these challenges on young professionals and factors that will encourage young professionals to "stay rural" will be explored.

Together with PACASA we will outline the key messages to attract health professionals to work rural and stay rural.

Biosketch:

Nwabisa Mgobozi is a young clinical associate originally from Hillcrest, Mthatha in the Eastern Cape. She graduated from the University of Witwatersrand and started working at Canzibe Hospital, EC in March 2017. Canzibe Hospital is far off the beaten track (literally & figuratively) and it has not been easy to navigate the change from being a student in a Metropolis to being a professional in a rural hospital; particularly for a young, energetic millennial.

Nwabisa joined Canzibe during a crisis period when there were only 2 doctors. Many would have turned away from this difficult and challenging road, but Nwabisa responded to the call of duty, despite many challenges such as: long queues of patients, managing emergency C/sections, travelling on public transport, and receiving no benefits for committing extra time served for rendering services to patients; she loves the fact that she is able to help people who are in desperate need of medical assistance. Having her around made a significant difference and Nwabisa adores the fact that she can do many functions of a doctor such as consulting, examining, ordering and interpreting investigations, giving a diagnosis and performing procedures.

Although her first year was difficult she has learned a lot from her rural experience; and the one thing that's still outstanding from her experience is that it wouldn't have been possible without a team with the same goal.

## From Mentee to Mentor

RuDASA Keynote Speaker: Dr Lungi Hobe

Content: Building on the advocacy legacy: How to look after ourselves and our patients?

The road travelled from being a mentee to becoming a mentor has numerous confusing and challenging curves. I was first introduced to the idea of mentoring in my first year of university when a senior student was allocated as my mentor. We had regular meetings, in which discussions about university lifestyle, coping with the work load and life in general were held. This mentor made sure that I hit the ground running at university and even though adjusting to city life was a challenge I knew I had someone I could relate to available to discuss issues with. We found that we shared similar principles in life and this strengthened our mentor-mentee relationship.

Towards the end of my second year I joined Umthombo youth development foundation, then known as friends of Mosvold which forced me to join yet another mentoring programme run at the time by the founder of the scholarship Dr Ross for the recipients of the scholarship. This programme was conducted monthly to a group of students that were at different levels of their studies. Dr Ross focused on academic performance and career paths, his favourite phrase was “you have to have to have to pass”, in these sessions we learnt to identify challenges that we wouldn’t have been able to identify on our own and also come up with solutions to these prior to the mentor having to come to our rescue, this developed a sense of ownership for our education and independence.

A time to toughen up came when I was left to fend for myself in my community service year, I yearned for a mentor but there was none, it was in this moment that I was certain I had chosen a wrong career path and needed to exit medicine faster than I had entered into it. Little did I know that somewhere in a little corner of south Africa, where only the brave hearted dared to venture lied an oasis for my career. It was in this hidden area of Mseleni, my birth place that I found one of the greatest mentors, without ever having to name the relationship we had he soon became a spiritual mentor, a father figure, a professional mentor and an advisor. It was after only a few years that this untitled mentor envisioned that my career should not end where it was at medical officer level. I was encouraged to head certain committees, to look for evidence for my practice (a then new skill that I have taken to my current practice), to present at conferences, to be innovative, to write up papers and publish (even though this never took off) and to reach for higher ground.

It is for this journey that I had at all these levels that I have taken mentoring junior doctors and students to heart and treat it as such a gem. However there are still numerous challenges when it comes to mentoring programmes and these are listed below as the main highlights to my presentation: the mentor-mentee relationship, expectations, supporting the programme (resources- time and human), assessing the impact.

Biosketch:

*Dr. Lungile Hobe:* as a child she often accompanied her mother, a nurse, to the local hospital in rural Mseleni; these childhood visits inspired her to become a doctor. Supported by Umthombo Youth Development Foundation (UYDF, formerly Friends of Mosvold) she trained at University of KwaZulu-NatalKwaZulu-Natal, graduated in 2006, and has returned to Mseleni to working the medical wards and High Care Unit. Dr. Hobe knows she is the main source of health care for this community and will often travel with fly with ZUMAT to remote locations where no doctors live or work. She completed her registrar training in family medicine in 2017 and is finishing off her MMED which aims to highlight the barriers of breastfeeding in mothers of infants less than 6 months of age.

In addition to her busy life as an MO she supports doctors in different departments within the hospital, supervises medical students from UKZN Department of Family Medicine and some international students who visit for their rural electives as well as offer support and guidance to the nurses at Mseleni. She is

committed to developing her role as a family physician in the community as a collaborator, a leader, a mentor, a supervisor, a capacity builder, an all-rounder who ideally should perfect their skills in a variety of areas to achieve an improved quality of life for her patients, her staff and the community at large.

## **Remember Esidimeni: health practitioner advocacy for community-based services for severe mental illness**

RMHC Keynote Speaker: Carrie Brooke-Sumner

Content: Building a clinical care legacy: Taking specialist care skills into rural areas

The Esidimeni tragedy shone a light on the gaping inadequacies in community care for people with severe mental illness in our country. Researchers and mental health service user advocates have been drawing attention to this for more than a decade. While the country has made rapid progress on deinstitutionalisation, resources have not been ring-fenced and redirected to the community level. In the absence of community-based services, service users discharged into the community reside most often with family. The provision of medication and disability grants is necessary but not sufficient to promote recovery and enable service users to integrate into community life. Families and community organisations alike are often ill equipped and unsupported to provide the care required.

Policy directives for the provision of community-based psychosocial rehabilitation exist at the national level within both the Departments of Health and Social Development. Still, coverage of this service is low, highly variable between provinces, particularly lacking in rural areas, and where available, is provided mainly through NGOs with insecure funding mechanisms. Health practitioners and managers from all levels of care have a key role to play in advocating for and planning provision of these services, to begin to address the repeated relapse and readmission common in the absence of community support. There are important benefits to be gained, not only for the rights and dignity of service users and families, but for reducing costs for in-patient care.

In this talk I will outline experience of the PRIME research consortium on building an intersectoral partnership between the Department of Health, Department of Social Development and community based organisations in the North West Province for provision of psychosocial rehabilitation. Advocacy requires planned action, and I will present a roadmap for action to operationalise this type of intersectoral work, based on challenges and opportunities identified in research with national, provincial and district representatives of these sectors.

### **Biosketch:**

Carrie Brooke-Sumner holds a BSc Honours Degree in Biochemistry and Microbiology from Rhodes University South Africa. She completed a Master's degree in Public Health (specialising in Health Promotion) at the London School of Hygiene and Tropical Medicine in 2007, and on returning to South Africa in 2008 worked as a consultant in health promotion for NGOs in the HIV sector. In 2012 she joined the PRIME-SA team at UKZN as a PhD candidate and is the first PRIME PhD candidate to graduate.

Her PhD focused on developing a community-based psychosocial rehabilitation programme for people with schizophrenia in the North West province. People with long term and severe mental illnesses remain some of the most marginalised in any society. Psychosocial support and medication are important for recovery. The programme involved the development, piloting, and initial process evaluation (including feasibility and acceptability) of the programme. The process evaluation showed people with schizophrenia had experienced improvements in illness knowledge, self-care, reduced social isolation and increased contributions to their household's chores.

## **Women's Empowerment in the Context of Chronic Poverty: Lessons for Health Professionals Working in Rural Settings**

RuNurSA Keynote Speaker: Daphney Nozizwe Conco (PhD)

Content: Building on the advocacy legacy: How to look after ourselves and our patients

Hunger and increasing poverty are major problems facing those living in impoverished South African settlements. Gender equality features significantly in the sustainable development goals as key to poverty and hunger reduction. Theory contends that only women's empowerment can address gender inequality. Yet, few research studies analyse the links between women's empowerment and poverty from the perspective of women living in such conditions. The paper presents insights from an in-depth enquiry into women's experiences and perspectives of household hunger and chronic poverty. Successful women's empowerment begins with awareness of socially constructed oppressive conditions and having sufficient agency power to make positive life choices.

The study found that women living in chronic poverty could not be empowered because in the process of staving off household hunger they constantly sacrificed social capital that had a potential to contribute to their empowerment. Their experiences of poverty are aggravated by poor access to basic services like proper shelter and electricity. Moreover they get excluded from mainstream anti-poverty strategies including social grants because of their limited literacy abilities. In brief life stories of women living in chronic poverty are full of complexities and inequalities in gender power relations and networks that would undermine efforts to empower them.

Optimal health is not possible where there is gender inequality and sexism. Sexism marginalises, exploits, and disempowers women, thus limiting their health opportunities. It is therefore imperative for health professionals to embody positionally and multiple perspectives, additional to paying attention to detail so as to address health issues that are important to women. What better way then, to transform health service delivery than adopting a feminist approach. Health professionals who adopt a feminist approach address sexism additional to critiquing all forms of partiality including rurality and poverty. They become aware of own positions of power and seek ways to manage such by making health care seekers central in their practice.

### **Biosketch:**

Dr Daphney Nozizwe Conco, a Public Health Specialist, is currently occupying a Senior Lecturer at the Wits School of Public Health teaching on Qualitative Research Methods and Designing Public Health Programs. She has worked mostly in deep rural areas of KZN, for various institutions including the government, non-governmental organisations, United Nations, a trade union and academia. Daphney also serves as the Treasurer of the Public Health Association of South Africa (PHASA) and a board member of the Rural Health Advocacy Project (RHAP) and Sexual and Reproductive Justice Coalition in South Africa (SRJC-SA).

Her research interests cover a range of topics including: social determinants of health, eradication of extreme poverty and hunger, promoting gender equality and women's empowerment, advocating for sexual and reproductive health, rights and justice; prevention and reduction of health inequalities, health system strengthening and management, leadership in health policy, and improving quality at the primary health care level.

## Plenaries & Panel Discussions

### **Considerations for a just State response to conscientious objection in South Africa and its impact on access to safe abortion in rural areas**

Presentation Type: Plenary Session

Author: Marije Versteeg-Mojanaga

Content: Building on the Advocacy Legacy: how to look after ourselves and our patients

There is ongoing debate and disagreement among stakeholders in South Africa, and elsewhere in the world, on whether or not, and under which conditions, conscientious objectors to abortion provision should be accommodated in the public health sector. I will present considerations for the South African democratic liberal state, with its own particular context, to take into account when seeking to respond to the impact of conscientious objection on patient health rights and outcomes. Abortion, under defined conditions, in the SA public health sector is legal and protected by the Constitution yet access is significantly restricted, partially due to the high number of conscientious objectors in the public health sector.

Lack of access disproportionately affects women and girls of deprived and rural backgrounds and leads to avoidable morbidity and mortality. Freedom of conscience is also a Constitutional right and an important primary good in a democratic liberal society. Conscientious objectors, for the most part, seek to protect their moral integrity. I will unpack the concept of moral integrity before presenting the views of conscientious objectors as well as those arguing against conscientious objection, or for limitations to this right, in the case of abortion.

I will argue that the democratic, liberal state should protect and promote tolerance of different belief systems and conceptions of the good life, however this is not without limitations. Reviewing various approaches to managing this conflict, I will present some principles and guidelines that I believe ought to inform a morally justifiable response by the State. This is an important discussion for the rural health movement, where opinions on the topic differ starkly, and a way forward needs to be found which protects women and girls lives, health rights and dignity, while acknowledging the importance of healthcare workers' moral integrity. A full paper on the presentation is available.

Biosketch:

Marije Versteeg-Mojanaga has been at the helm of the Rural Health Advocacy Project (RHAP) since its inception in 2009. Marije's expertise lies in health advocacy and social justice, organisational development and governance, coalition-building and partnerships for social change. She is currently working on issues relating to fair priority-setting of healthcare resource allocations, and the ethics of healthcare worker advocacy. Marije holds a Masters Degree in Culture, Organisation and Management from the Vrije Universiteit in Amsterdam and is studying towards a Masters in Applied Ethics with a focus on Bio-Ethics, at the University of the Witwatersrand, Johannesburg. She has spearheaded the development of the two flagship programmes of the RHAP, which are The Voice Project (Building a critical mass of advocacy competent healthcare workers) and the Rural-Proofing Policy and Budgeting Programme.

Marije has authored peer-reviewed and popular publications, provides regular presentations on issues affecting human rights and health in public fora, represents RHAP in a number of civil society coalitions and was one of the leading contributors to the NDoH National HRH Strategy chapter 8 on access to HRH in rural areas (2012-2016) and rural HRH task team member. She is a member of the Executive Committee of the Rural Doctors Association of South Africa and represents RHAP on the Treatment Action Campaign National Council

## **Termination of Pregnancy Services in Rural Areas & Conscientious Objection**

Presentation Type: Panel Discussion

Author: Laura Lopez Gonzalez

Content: Building on the Advocacy Legacy: how to look after ourselves and our patients?

In 2017, the Bhekisisa Centre of Health Journalism surveyed the 246 facilities provincial health departments said were designated to provide termination of pregnancy (TOP) services. Of the 236 facilities that could be reached, only 197 were offering TOP on the day on which they were surveyed. Services were most inaccessible in rural and inland areas.

This panel will focus on exploring how healthcare workers can expand access to TOP for women in rural areas by addressing main barriers to care. In doing so, the panel will discuss how doctors and nurses exercise their beliefs without limiting services for women. The panel will be comprised of rural doctors who have grappled with conscientious objection and its effects on patients as well as experts with more than two decades experience in training TOP providers and sexual and reproductive health.

The panel will also reflect on what needs to be done to create a more enabling environment in rural and inland areas. This will include what role management and rural leadership play in extending access to care in these settings. As the health department drafts new, updated guidance on refusals to treat, what needs to be included to provide women with a full range of sexual and reproductive health and rights, including TOP, in rural settings.

Panellists will include a conscientious objector who uses referral networks to ensure patients can still access care; a former objector who went on to draft the CTOP Act, a long-time trainer of rural health workers on TOP and a doctor who has spoken internationally on conscientious objection

Biosketch:

Lopez is the deputy editor of the Bhekisisa Centre for Health Journalism at the Mail & Guardian and has almost 15 years of health reporting experience in SA. In 2017, the centre compiled the country's first publicly available and searchable map of public abortion providers. The centre has trained nearly two dozen journalists on abortion reporting and published a recent reporting guide for media.

## **The Development of the Rural Health Movement in South Africa**

Presentation Type: Panel Discussion

Authors: Steve Reid, Ian Couper, Elma de Vries, Desmond Kegakilwe, Anja Morris-Paxton, Mosa Moshabela, Andrew Ross, Marije Versteeg-Mojanaga

Content: Building a leadership legacy: what do young professionals want and what do they need to know?

Before and during the apartheid era of race-based neglect of healthcare in the rural areas of South Africa, mission hospitals delivered most of the western medical services. Following democracy and implementation of the district health system after 1994, the aspiration of health for all in an inclusive health system became possible. The organised rural health movement in South Africa began formally with the establishment of the Rural Doctors Association of Southern Africa in 1996. Since then a number of government and non-governmental initiatives have given voice and impetus to addressing the health needs of rural people in the country.

An annual rural health conference was instituted in 1996, and the initial focus on rural medicine was subsequently changed to rural health. During the height of the AIDS epidemic, many non-governmental organisations in rural areas devoted themselves to mitigating the untimely deaths of thousands of young people, including an early stand against government policy regarding ARVs. After 2003 they refocused on getting as many people onto ARVs as possible, and rural districts led the way.

Some NGOs focused on the recruitment and retention of professional staff, while others focused on issues of advocacy and policy. Clinical associates, therapists and nurses working in rural areas have organised and joined a broader collective of rural health professionals to advocate for improvements in the health system. The collective has become an inclusive movement for all patient-centred rural health cadres reflecting the diversity of South Africa.

Government has responded to rural health needs in terms of policy initiatives but continued inequalities, quality and access challenges have given rise to various community and civil society protests and campaigns. This presentation will also indicate likely developments in rural health in the future, framed by the plans for National Health Insurance as well as the National Development Plan.

Biosketch:

All of the authors have lived and worked in rural areas, and have been involved in the development of the rural health movement for many years in different capacities. The presentation aims to 'hand on the baton' to the next generation of leaders.

## **The Rural Determinants of Health: principles for theory**

Presentation Type: Plenary (30 Minutes)

Author: Steve Reid

Content: Building Momentum: Taking the Rural Health Movement Forward

**Abstract** :The rural determinants of health include geography and topography in addition to the social, economic and political factors that result in ill-health in rural areas. Rural health needs to be based on a set of principles that guide our efforts in practice, teaching and research. It has not yet been described in theoretical terms because it appears to be more of a practical endeavour than an academic one. But underlying our efforts are a set of assumptions that we inevitably bring to bear on our priorities and ways of working that could be better informed by including ways of thinking outside of our default biomedical frameworks, in order to address some of the intractable challenges in rural health.

Apart from the clinical and public health disciplines with which we are most familiar, disciplines such as geography and sociology have developed a large body of literature on rural studies. Similarly, the medical humanities is a fast developing field in health sciences education, clinical practice and research, bringing medicine and healthcare together with history, literature, philosophy, education, anthropology, sociology, law and the arts amongst others.

Theories of place and space need to be integrated with diverse concepts of health and illness, in formulating appropriate theory. This presentation will explore a range of theoretical concepts that could frame rural health as an academic discipline in its own right, incorporating the knowledge and frameworks from various fields to conceptualise a set of principles for further discussion and development.

### **Biosketch:**

Steve Reid is a rural family physician from KwaZulu-Natal, now an academic at UCT, who is a teacher, researcher and an advocate for rural health. He is also a musician and a keen mountain biker, and often goes off on long rides for fun.

## Oral Presentations

### **Advocacy in the Health Sciences Curriculum – A Student Enabler**

Presentation Type: Oral Presentation

Authors: Samantha Khan-Gillmore, Marije Versteeg-Mojanaga, Richard Cooke, Julia Moorman

Content: Building on the Advocacy Legacy: how to look after ourselves and our patients?

The purpose of the advocacy manual is to provide educators with useful and practical tips on incorporating advocacy into the health sciences curriculum. There are many lessons to be learnt and many skills to be developed in the realm of advocacy particularly since it is now an HPCSA requirement for HCW's to be health advocates.

More than twenty years into democracy, the health system has many challenges and not much is known about how to tackle the health problems that manifest into and are linked to socio-economic ills. Healthcare workers are first hand witnesses to how health care is delivered at the coalface and this requires HCW's to be change agents for effective patient advocacy. Students should be taught about human rights, social justice and how to advocate for their patients. There is much to be learnt about how to advocate safely and lawfully for patients but these methods and techniques are not taught to students therefore many HCW's are without knowledge at a time when it is most pertinent.

The manual utilises the six-stage model of Kern (1998):

1. Problem needs identification and general needs assessment
2. Advocacy needs assessment of targeted learners
3. Coals and Objectives for advocacy
4. Educational strategies for teaching advocacy
5. Implementation – integration advocacy in the curriculum

The integration of advocacy is no longer a choice but an imperative to produce healthcare workers that can and want to meet patient healthcare needs and protect their rights.

Biosketch:

Samantha Khan-Gillmore is responsible for RHAP's knowledge management and communications work. Having managed The Voice Project for two years, she continues to lead on RHAP's Advocacy in the Curriculum work as well providing overall communications leadership and support to the organisation. Before joining RHAP she has managed education, workers' and human rights programmes for over a decade, in South Africa and across the African continent. Samantha has previously worked for the Discipline of Occupational and Environmental Health (DOEH) at the University of KwaZulu-Natal (UKZN), Durban, as well for local and international labour movements. She holds a post-graduate (Honours) qualification in Politics and an undergraduate Law degree from the University of KwaZulu-Natal in Durban. She is currently studying towards a MMedSci looking at advocacy in the health sciences curriculum.

## **Are Patients in Butterworth Hospital Casualty Department Adequately Assessed and Triageed? A Quality Improvement Project**

Presentation Type: Oral Presentation

Author: Dr. Andrew Mawer

Content: Building a clinical care legacy: taking specialist care skills into rural

Background: Butterworth Hospital is a busy rural hospital in the Eastern Cape with a high throughput of acutely unwell patients. Our aim is to improve the assessment and triage of patients on the basis of urgency

Methods: Data were collected retrospectively from clinical records (n=38) pertaining to the month of March 2018 to determine whether patients' vitals including heart rate (HR), oxygen saturations (SO<sub>2</sub>), respiratory rate (RR), blood pressure (BP) and temperature (T) were recorded. Following collection of baseline data the results were presented at local meetings, training was implemented and additional equipment was purchased. Data were re-collected in the month of June 2018(n=39) to determine whether there was an improvement.

Results: baseline data collection showed that 29 patients from a total of 38 (76%) had a documented HR, 27 (71%) a documented SO<sub>2</sub>, 26 (68%) a documented BP, 4 (11%) a documented T, 0 (0%) a documented RR. After our interventions, statistically significant (p<0.05) improvements were demonstrated in all of these domains. In June 38 patients (97%) had a documented HR, 38 (97%) a documented SO<sub>2</sub>, 37(95%) a documented BP, 20 (51%) a documented T, 14 (36%) a documented RR.

Conclusions: We have demonstrated an improvement in the assessment of patients presenting to Butterworth Hospital Casualty Department. However, this quality improvement project is an ongoing process. There is still much room for improvement in the recording of vital signs and there is ongoing work to train nurses to identify physical signs which warrant urgent review and to sort patients on the basis of their urgency as per the South African Triage Scale (SATS).

## **Are SA's most vulnerable communities benefitting from community service?**

Presentation Type: Oral Presentation

Authors: Karessa Govender, Russell Rensburg, Marije Versteeg-Mojanaga

Content: Building Momentum: Taking the Rural Health Movement Forward

**Background:** The Internship and Community Service Placement Guideline and the National Human Resources for Health South Africa, Strategic Priority 8 call for the prioritisation of rural and underserved areas for community service placement. One of Rural Health Advocacy Project's (RHAP) core programmes is to ensure rural communities have sufficient healthcare workers through community service placement.

**Objectives:** The Annual Community Service Allocation Update 'ACUTE' is one part of a broader undertaking by RHAP to address the inequitable distribution of community service officers. The goal of 'ACUTE' is to monitor and critically evaluate the developments with regards to the yearly community service allocations.

**Methodology:** The 2018 publication reviewed the allocation process across two provinces: Eastern Cape and North West. RHAP accessed data from NW and EC. This took the form of Excel spreadsheets which detailed the following information: health facilities that will be receiving community service officers and the number of posts allocated to each facility. Community service posts were analysed using two variables; the South African Index of Multiple Deprivation and rural/urban classifications.

**Results:** Despite some improvements, urban communities still largely benefit from the community service allocation process, to the grievance of rural communities.

**Conclusions:** The failure to place sufficient community service officers in rural further cripples health facilities in these areas. Regression of health services was observed in health facilities which did not receive community service officers for 2018. The community service programme, if implemented strategically, has the potential to alleviate HR shortages in South Africa's most vulnerable communities.

### **Biosketch:**

Karessa obtained her undergraduate degree in Occupational Therapy from the University of the Witwatersrand in 2009. She is currently completing a master's degree in occupational therapy with a specialisation in neurosciences. She has been committed to public service since the onset of her career and has served in four different public hospitals across KZN and Gauteng since 2010. During this time, she has actively contributed to improving the quality and range of services provided in the departments she has worked in. Karessa's involvement in the public sector has spurred her interest in social advocacy and the unique but often overlooked role of rehabilitation workers in advocating for social justice. She is currently working as a Project Officer working across multiple programmes with an emphasis on Human Resources for Health, the Rural Learning Site and the Voice Project.

## **Becoming the change we want to see: Cataract Outreach**

Presentation Type: Oral Presentation

Authors: Fatouma Moustapha Lo & Yuval William Belisha

Content: Building Momentum: Taking the Rural Health Movement Forward

**Problem :** The leading cause of blindness in the world is attributed to the development of cataracts, a disease known to arise most commonly due to senility or as a result of illnesses such as diabetes. The good news however, is that cataracts are treatable by a quick and simple operation performed by a qualified ophthalmic surgeon. But this fact begs a rather important question, why is it that a treatable condition results in such a high burden of morbidity? Furthermore, why is this trend quadrupled in rural communities, majority of which predominate South Africa. And lastly and more urgently, what can we as students do to help alleviate this burden?

**Approach:** To answer these important questions, we need to address various factors of rural healthcare and this needs to be done in depth. These factors include, the state of the public healthcare system, the level of unemployment and lack of education in South Africa and most importantly, the general accessibility to affordable quality healthcare. It is worth noting that often, the latter factor is listed as being separate, and we think that this could be a precipitating cause as to why cataracts continue to claim the sight of many.

**Action:** To go about answering these questions, we sat down and had lengthy discussions as to how we can take the action of literally becoming the change, we so badly want to see. And as such, we founded our own cataract outreach programme in the rural Eastern Cape, wherein we as students are key-players in the planning and execution of the outreaches.

**Outcome:** The project works. It is not easy organising the project, nor getting sponsors on board but there are people who are enthusiastic to be engaged. The outreach has enabled us, a student-run organisation to contribute in bringing about change. We have removed over 50 Cataracts and completed follow-ups on our own.

**Lesson:** Despite our successes, we have realised that we need to upscale our efforts in order to ensure sustainability of the project and realisation of our long-term goals.

**Biosketch:**

Fatouma Lo is a 19 year old, third year Medical Student at Wits University. Driven by the passion to advocate for equal access to quality healthcare for all, I chose to follow the health sciences path, and not just aim at being a good student but to become one who is involved in platforms that give the youth a voice. As such, not only am I a member of the Golden Key International Honour Society, but I am also the current chairperson of the Wits Rural Health Club as well as an executive committee member of Wits Friends of MSF (Doctors without Borders). I aim to complete my internship years and practise at a Rural hospital and I have made it my mission to work on educating fellow students to do the same.

## **Decolonisation of knowledge: What do we mean and what are the implications for research and clinical practice in rural areas?**

Presentation Type: Oral Presentation

Authors: Joanne Neille

Content: Building a leadership legacy: what do young professionals want and what do they need to know?

Calls for decolonisation practices in health, education and research have received increasing attention in recent years, and have largely been fuelled by the #rhodesmustfall and #feesmustfall movements. A number of studies into the prerequisite shifts for decolonisation have been conducted in countries such as New Zealand, Australia and the Americas, yet guidelines for the decolonisation of research in the South African context has remained limited. This raises questions regarding what it means to decolonise research, what steps need to be taken and by whom, and what the possible implications may be for practice.

This presentation will provide an overview of decolonisation of research, with a discussion on the relationships between decolonisation and the researcher's epistemology, choice of research methods, and research ethics. The implications of decolonising cross-linguistic and cross-cultural research will also be considered. Suggestions will be made regarding contextually and culturally relevant methodologies, specifically those based on the principles of Ubuntu, ethics of care, ethic of discomfort, and participatory action research. The presentation will conclude by considering the ways in which decolonisation of research may influence our clinical practice and how to avoid the potential pitfalls of further silencing voices on the margins of society.

Biosketch:

Joanne Neille is a senior lecturer in the Department of Speech Pathology and Audiology at the University of the Witwatersrand. She is passionate about rural work but has a specific interest in ethical issues and in protecting the rights of vulnerable populations.

## **Developing leadership and advocacy skills in final year healthcare students: Community Assessment Projects**

Presentation Type: Oral Presentation

Authors: Sue B Statham & Marlie Enright

Content: Building a leadership legacy: what do young professionals want and what do they need to know?

Introduction: A need was identified to develop students' ability to respond appropriately to changing healthcare environments and community needs. It has become necessary to expand on their clinical training in rural areas to teach them community assessment skills.

Methods: A module to teach and facilitate students on their community block was developed to implement a community assessment project. The project examines the contextual barriers experienced by specific target populations lack of inclusion in their community. The project was aligned with the Stellenbosch University's graduate attributes, specifically focusing on advocacy and leadership. The students were expected to interact with the given community through interviews with service providers and target populations. They had to complete an environmental assessment through community mapping and observations. At the end of module, the students had to complete a report advocating for appropriate changes. The students used reflective techniques facilitated by the DEAL model to consolidate their learning.

Results: A six-week module has been implemented for final year students while working in rural and other low socio-economic areas. They need to use tools to establish the contextual barriers of specific target populations such as wheelchair users, people with amputations and older population. Reports completed by the students are then sent to Department of Health and other stakeholders to advocate for appropriate changes in services and support. Students gave feedback on their experiences at the end of each module highlighting their learning and changes in attitudes as it relates to their professional, personal and civic learning.

Conclusion: This module facilitates student development in accordance to the graduate attribute outcomes for advocacy and leadership. Growing self-confidence in the students' ability to view the community as a whole was expressed through their reports and reflections. These skills will enhance the wellbeing and inclusion of all in the communities they serve.

Biosketch:

Sue Statham has extensive experience in community based training for students at Stellenbosch University in both peri-urban and rural settings. She also conducted numerous research projects on student learning and inter-professional education.

Marlie Enright has worked in rural setting in Eastern Cape and then joined the Stellenbosch University as a Clinical Educator, facilitating community engagement. She has conducted research on patient experiences in rural settings.

## **Distributed training platform coordinators: voices from the other side of the mountain**

Presentation Type: Oral Presentation

Author: Jana Muller

Content: Building on the Advocacy Legacy: how to look after ourselves and our patients?

**Background:** With the increase in student numbers and health science programmes on the distributed training platform (DTP) across South Africa there is a growing need for onsite coordination of learning. At Stellenbosch University Worcester Rural Clinical School local clinicians were employed on the DTP to supervise and coordinate student training, this presentation speaks to some of the facilitators and challenges they faced over the last 5 years.

**Methods:** An inductive analysis of semi-structured interviews held in 2017 was done with a purposively selected sample. 6 academic student coordinators from 4 different programmes, namely Occupational Therapy, Human Nutrition, Physiotherapy and Medicine, were interviewed by the researcher about the facilitators and challenges of being part of the development and maintenance of training at a distributed site.

**Results:** Benefits to identifying local clinicians as coordinators are prevalent, however the transition for these clinicians into their new academic roles was fraught with challenges. Issues regarding training, communication, roles, equipment, access and relationships were highlighted when developing and coordinating learning on a new DTP. The close working environment with other programme coordinators allowed for collaborative training and community engagement which provided rich learning opportunities in the community.

**Conclusion:** The findings of this study have been assimilated to optimise a best practice scenario for identifying and preparing coordinators on the DTP in the future. These ideas will be piloted by Ukwanda Centre for Rural Health during new site development in 2018. Important factors to consider and scenarios to prepare for when appointing a site facilitator are provided as a guide for the development of the DTP.

### **Biosketch:**

Jana Muller has been working on the distributed training platform as a coordinator for Stellenbosch University for seven years. She is a physiotherapist by profession and has facilitated clinical training for undergraduate student from seven programmes. She is also part of a collaborative team of professionals based at a distributed training site who all evolved into their current posts from being DoH clinicians in 2012.

## **Early detection of developmental delays in vulnerable children by community care workers using an mHealth tool**

Presentation Type: Oral Presentation

Authors: Ms Maria Neethling van der Merwe, Ms Renata Mosca, Prof De Wet Swanepoel, Prof Frances Page Glascoe & Dr Jeannie van der Linde

Content: Building on the Advocacy Legacy: how to look after ourselves and our patients?

**Introduction:** Developmental delays are increasing worldwide, as a result of exposure to environmental risk factors, such as poverty. Early detection services are often inaccessible in low- and middle-income countries (LMIC) due to limited human resources and a lack of knowledge regarding development. This study investigated an mHealth screening programme with community care workers (CCWs) facilitating early detection of developmental delays in children from underserved communities.

**Method:** An exploratory research design that was both qualitative and quantitative in nature was applied. CCWs, employed by a community-based non-governmental organisation (NGO), were trained to administer the Parents' Evaluation of Developmental Status (PEDS) smartphone application as part of home-based services offered to families affected by HIV/AIDS. After the training, they screened 138 children (mean=19.2 months, SD=11.1) in the community. Children who failed the screen were re-screened, and depending the outcome, were referred for diagnostic assessment. CCWs completed a questionnaire regarding their perceptions and experiences of community-based mHealth-assisted screening.

**Results:** The results indicated an overall referral rate of 49%. Older children (19-38 months old) had a significantly higher ( $p<0.05$ ; Chi-Square) referral rate (57%;  $n=39$ ) compared to those aged 0-18 months (40%;  $n=24$ ). The high referral rate may be attributed to the at-risk population sampled. Average screening time was 12.5 minutes and on average ten children were screened per day. CCWs perceived mHealth screening as valuable in terms of utility, outcomes and contribution to developmental knowledge for community members and CCWs. CCWs indicated that they were motivated to promote increased developmental surveillance in their community.

**Conclusion:** Community-based services are a promising platform for the implementation of mHealth-assisted early developmental screening programmes for improved access to early detection and surveillance for vulnerable children and their families.

### **Biosketch:**

Maria obtained her degree in Speech-Language Pathology in 2015 at the University of Pretoria. In 2016 she completed her community service year in Barberton, Mpumalanga. In 2017, she obtained her master's degree in Speech-Language Pathology, focusing on training and empowering community health workers to conduct developmental screening, using mHealth, in their community. While completing her master's, she also provided school-based speech therapy services in Pretoria. In 2018 she started with her PhD, continuing and building on the research done for her master's study. She is currently also appointed as a clinical lecturer at the University of Pretoria.

## **Investigating the Skills needed by new Doctors in Rural Hospitals**

Presentation Type: Oral Presentation

Authors: Ian Couper, Oliver Johnson & James Barnacle

Content: Building a clinical care legacy: taking specialist care skills into rural

Background: Many doctors recruited to work in rural hospitals have insufficient generalist skills for the extended range of practice required. The Ukwanda Centre for Rural Health is developing a Postgraduate Diploma in Rural Medicine, with the aim of preparing doctors for such work.

Initial impetus for this came from Africa Health Placements (AHP), which recruits doctors from abroad to work in rural hospitals in Africa. Many such doctors feel insufficiently skilled and complete courses in Tropical Medicine in the UK or the Netherlands, which often do not adequately prepare them for situations in Africa.

To understand better the needs of rural hospitals receiving such doctors, a survey was conducted to determine the skills needed and assist in drawing up specific aspects of the planned curriculum. The aim of the study was thus to determine the skills gap for overseas-trained doctors (OTDs) working in rural district hospitals in South Africa.

Methods: Nine rural hospitals in the Eastern Cape, KwaZulu-Natal and Mpumalanga were selected by AHP as hospitals which place foreign doctors. An online survey was developed asking about the key skills required when working rurally and where the weaknesses in these skills were for foreign doctors, as well as general questions related to the curriculum. The clinical manager and any European doctors placed by AHP working in each hospital were invited to complete the survey.

Results: Surveys were completed by 5 clinical managers and 19 OTDs. The top clinical skills identified in relation to specific domains will be presented, as well as the "top 5 overall clinical skills" selected by respondents. Responses regarding non-clinical skills and the most important gaps will be described.

Conclusions: Consistency amongst respondents clearly indicates the important skills focus areas. This study provides useful further direction for planning of the PG Diploma programme.

Biosketch:

Ian Couper is Director of the Ukwanda Centre for Rural health and Professor of Rural Health in the Centre for Health Professions Education, Faculty of Medicine and Health Sciences, Stellenbosch University.

## **Mental health in-patient intervention: Infrastructure and community focused**

Presentation Type: Oral Presentation

Author: Guinevere Margaretha Atilla Couldridge Lourens

Content: Building on the Advocacy Legacy: how to look after ourselves and our patients?

Renovating healthcare facilities is intricate and implementation takes high levels of energy, tenacity and perseverance from staff, patients and the community. Health leadership should bring quality to life through campaigning for quality assurance in implementation through meaningful engagement with research which provides evidence to support continued commitment to quality of care during such endeavours.

Psychiatric or mental health patients are a vulnerable group in the healthcare scenario, especially if they are admitted to a healthcare facility which is under construction for the purposes of upgrades. The WHO fact sheet of April 2016, titled Mental Health: Strengthening our response calls for strengthening of effective leadership and governance, as well as evidence and research for mental health. Ministries of health will need to take a leadership role guided by WHO to work with persons with mental disorders and enable them to participate in the reorganisation, delivery and evaluation of services so that care becomes more responsive to their needs.

A doctoral study critically evaluated the implementation of a hospital revitalisation project in Paarl, South Africa, which aimed to modernise and transform the infrastructure and health technology of the hospital whilst improving quality of care and access to public health care. This project included a phase for a Psychiatric unit. A drive by the National Department of Health in South Africa to improve the quality of health care through the National Core Standards calls on leadership in this health sector to facilitate initiative and change in practice. Research on quality of care in health thus fulfils a practical mandate to create information for use by nursing leaders to improve and inform practice.

The outcome of the study was the development of an innovative framework for project implementation, which was tried and tested in an intervention study against the needs of Psychiatric patients. A descriptive case study design, with qualitative research methodology was selected. The case study involved an intensive exploration of the circumstances, dynamics and intricacies of this public hospital project. The multi-method approach to data collection included focus group discussions; individual and pair interviews; as well as photographic and document review. Action research methodology was conducted with its intent of collaborative knowledge enquiry and sharing. The findings that arose during the main study were simultaneously used to develop a project implementation framework. By application of this framework, action was taken to improve project implementation in the planning and decanting stage of the Psychiatry clinical unit. The Psychiatry intervention included multi-sectoral collaboration with nurse leadership, engineering and architectural consultants and a local mental health non-profit organisation, whom established a healing garden for patients. This collaboration facilitated liaison with the community, chronic psychiatric patients in the community and the hospital.

The intervention study findings indicate that the proposed hospital revitalisation implementation framework reduces risk to client, staff and technical quality domains during implementation. This study found that nursing professionals need to be an integral part of hospital construction project planning. Nursing leaders must claim the space at the point around which community and other stakeholders pivot in the interest of best practice for psychiatric patients and healthcare providers involved in hospital renovation projects. The proposed implementation framework serves to inform of the risk management strategies for the infrastructure, health technology, and quality assurance deliverables of future hospital revitalisation projects where mental healthcare is delivered. Theoretical models are put forward to supplement project implementation in each specific component. Roger's (1983) theory on diffusion of innovation provides a broad

framework for the hospital revitalisation project innovation assimilation and implementation in the health service.

The framework also includes guidelines for hospital upgrade business case development; design considerations and the quality direction focus in the golden triangle of project stewardship. Nursing leaders stand to benefit from the framework in the interest of affordable (economically effective and efficient allocation of public resources), acceptable, appropriate, timely and good quality health for all.

This research could contribute to advancing hospital revitalisation policy implementation in practice by nurse leaders for the staff involved and their Psychiatric patients affected by re-engineering of operational health facilities. Such evidence-based decision-making could serve as sound recommendations to influence policy around hospital revitalisation.

The findings thus provide nurse leaders globally with innovative research, which has produced evidence-based practice strategies in the shape of a pragmatic, tangible framework for Psychiatric patient and staff safety; as well as risk management outcomes during health facility infrastructural upgrades.

#### Biosketch:

Guin Lourens is currently the clinical training platform manager and previous manager of the Ukwanda Centre for Rural Health at Stellenbosch University in the Faculty of Medicine and Health Sciences. She holds a doctorate in Public Management, a master's degree in Nursing, and qualifications in Health Services Management, Health Science Education, Primary and Occupational Health. With a clinical background in community Psychiatry and mobile clinic health service delivery on farms, she is invested in advocacy for quality rural healthcare access. Dr. Lourens lectures on 2 post graduate nursing programmes to develop nursing capital and serves on academic, public health facility and NPO boards in the Western Cape. A founding member and current chairperson of the Rural Nursing Network South Africa (RuNurSA), she is committed to strengthening rural nursing leadership.

## **Shifting and Transforming the Practice of Audiology: The Inclusion of Spirituality, Religion and Alternative Practices.**

Presentation Type: Oral Presentation

Authors: Dhanashree Pillay, Najeebah Moola, & Tshepang Serooe

Content: Building a leadership legacy: what do young professionals want and what do they need to know?

**Abstract** :Introduction: Science and Religion have been debated for centuries. Patient assessment and management have traditionally focused on the medical model of detecting and curing a disease, facilitating a narrow focus on the physical needs, without considering the patient holistically. Patient care operates both in the temporal and the spiritual spheres. Inclusive models of patient care are becoming favourable as the diversity of patients and health practitioners becomes more evident. We live in a diverse spiritual society therefore audiological care needs to shift its practices to include aspects such as spirituality, religion and alternative beliefs.

**Methods:** Data was collected from three studies that are interconnected to the topic of discussion.

**Study 1:** Narratives of 7 participants, who reported a supernatural healing of a sensorineural hearing loss, were recorded during an interview.

**Study 2:** Twenty-five Muslim adults completed a questionnaire pertaining to their perceptions and experiences with Hakeems. Four Hakeems were interviewed to obtain their perceptions of speech-language pathologists and audiologists.

**Study 3:** Forty-one audiologists in Gauteng were required to complete a questionnaire relating to their perspectives of traditional healers.

**Results:** Grief, distress and confusion are evident emotions that occurred after the diagnosis of a hearing loss. The belief in God, prayer and supernatural occurrences of healing were key concepts within these studies. The participants in study 1 and 2 indicated the frequent use of religious and spiritual care in conjunction with medical care. The audiologists in SA are willing to collaborate with traditional healers to share information however there was uncertainty with regards to the methods for the incorporation of spirituality and beliefs into the audiological practices.

**Conclusion:** There is a need to shift and transform the audiological practices to ensure that integrated and holistic care is provided to the dynamic and diverse population of South Africa.

**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 , a committee member of the Standards Division at the SABS (South African Bureau of Standards). Dr Pillay has published in scholarly journals and has presented at both national and international conferences. She is a reviewer for 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.

## Which Type of Caesar Do You Want?

Presentation Type: Oral Presentation

Author: Kobus Viljoen

Content: Building a clinical care legacy: taking specialist care skills into rural

The Saving Mothers Report flags a serious concern about the amount of maternal deaths that are due to cesarean section related complications. It is universally accepted among clinicians performing surgery, that adequate access is paramount – especially when things go wrong. Due to the emergency nature of the majority of Obstetric surgery, and the disproportionate amount of blood loss to be expected compared to other lower abdominal surgery, this is a critical issue.

Midline incisions are widely accepted to provide better access due to superior extendability. If every mother in South Africa had only one Pfannenstiel (or equivalent) incision this would hardly be an issue - but most mothers have two or three (in rare cases four).

It is during these repeat sections, often resulting in severe adhesions, that complicated surgery at a rural hospital becomes critical. Authorities suggest that an "experienced surgeon" should manage cases where severe adhesions are anticipated - but it is widely known that this is extremely difficult to judge pre-operatively. Even if it were possible, the question remains if there is enough surgical expertise within the average rural hospital in South Africa? The Saving Mothers Report would suggest "Not" .

Isn't it time that we reconsider how we train young doctors? Shouldn't they first be able to do a midline incision which is the go-to incision – even when an already transversely opened abdomen proves too difficult to access - and shouldn't rural hospitals reconsider making midlines their standard incision?

Biosketch:

Dr Kobus Viljoen studied medicine in Bloemfontein. After some time working in the private sector and overseas he arrived at Mseleni in 2002. He says he enjoys working in the rural areas; this is where you find the most vulnerable patients who have more social problems than medical, and that Health is the greatest wealth. Dr Viljoen was named as the RuDASA Doctor of the Year in 2013.

## **The Value of a Short Practical Training Course for Newly Qualified Therapists Working with Children with Cerebral Palsy in South Africa**

Presentation Type: Oral Presentation

Author: Takondwa Bakuwa

Content: Building a leadership legacy: what do young professionals want and what do they need to know?

Cerebral Palsy (CP) is one of the most complex disabling disorders in children that newly qualified therapists face in practice. Newly qualified therapists do not feel prepared to deal with complex conditions despite being expected to. Short practical training courses could potentially help bridge this gap in readiness.

A secondary analysis of therapists' course evaluation records from eleven short practical training courses was done. The aim of the study was to determine the tangible value of a practical training course on cerebral palsy to the practice of newly qualified therapists. The study established the ability of the course to meet expectations of course participants, change in their level of CP knowledge, aspects of the course deemed useful for cerebral palsy practice and change in cerebral palsy clinical practice attitudes and behavioural intents. These were studied from the data contained in the general information form, knowledge questionnaire and evaluation form generic to a specific CP training course.

Course expectations of 97.3% of the therapists were met, most of whom reported having also gained skills and confidence. There was significant change in the level of knowledge in various aspects of cerebral palsy after the course ( $p=0.000$ ). Aspects of communication and play therapy showed the most significant difference ( $p=0.0000$ ). Therapists appreciated the integration of theory and practical demonstrations, the holistic approach of the course and involvement of caregivers as part of the team in the course. They reported readiness to adopt more of active as opposed to passive CP therapies, work interdisciplinary and enhance creativity in practice.

A short practical training course is therefore valuable in addressing the perceived lack of readiness amongst newly qualified therapists working with children with CP. It is capable of improving their confidence in practice, improving their knowledge and changing their clinical practice and clinical behaviour intentions positively.

### **Biosketch:**

Takondwa Bakuwa is a Malawi trained physiotherapist pursuing a masters degree in community physiotherapy at the University of Witwatersrand. She has worked as a therapist and assistant lecturer for three years under the college of medicine in Malawi. Out of her Interest in rehabilitation service provision in rural and low resource areas, she has co-coordinated community-based rehabilitation training programs for undergraduate students for two years and volunteered physiotherapy services for a non-governmental organisation in a remote community health centre. She has seen the great difference that determined efforts of a few can make for rural rehabilitation service.

The challenges faced in all these activities and the potentially far-reaching benefits of community-based rehabilitation were both an inspiration for her to further her education in the area of community physiotherapy and public health. She did the current research project in partial fulfilment of the requirements of the master's degree. The research has provided insights into the crucial role of practical training courses in the continuing professional development of novice therapists. She believes that the insights may also have relevance to other areas of clinical practice.

## **Towards reaching the UNAIDS 90-90-90 goals in student-patient encounters**

Presentation Type: Oral Presentation

Authors: Conradie HOFFIE (SU), Porter James (WSU), Jikwana Akhona WSU) & Titi Vuyelwa (WSU)

Content: Building a clinical care legacy: taking specialist care skills into rural

Background: Medical students from Walter Sisulu University (WSU) in South Africa do a 20-week integrated longitudinal community clerkship (ILCC) in rural district hospitals with a high burden of HIV/AIDS disease (prevalence of 19.5% in age group 15-49 years).

Summary of work:

During the 2017 ILCC students were asked to work towards the UNAIDS 90- 90-90 goals (90% of people living with HIV to know their status, 90% of HIV positive people to be on anti-retroviral therapy (ART), and 90% of people on ART virally to be suppressed). A cell phone application was developed by the decentralised learning project of the Stellenbosch University Collaboration for Capacity Enhancement through Engagement with Districts (SUCCEED) who supports three of the rural district hospital. Students used the application to record in every student/patient encounter the patients HIV status, if HIV positive whether on treatment and if on treatment whether the viral load was suppressed thereby reminding them of the 90-90-90 goals and collecting data on reaching the goals. Thirty-three students at the three sites recorded student/patient encounters at the three sites using the web-based data collection tool on their cell phones. No personal patient details were recorded and ethical approval for the study was obtained from WSU.

Methods and results: Analysis of 7000 consultations showed that initially 83.3% of patients knew their status. This went up to 89.7% when students tested the patients whose status was unknown. Of the patients with known status, 90.8% were on ART. Of those with a known viral load, 71% had a suppressed viral load.

Discussion and conclusion: By using the application students reported an increased awareness of the importance of knowing their patients' status. Positive patients not on treatment were initiated on ART, viral loads were done on patients on treatment but not monitored and students engaged with patients with high viral loads to address adherence issues.

Biosketch:

Prof HOFFIE Conradie is an emeritus associate professor of family medicine at Stellenbosch University (SU). He has extensive experience of rural health care and is presently working as a decentralised learning advisor for the Stellenbosch University Collaboration for Capacity Enhancement through Engagement with Districts (SUCCEED) project in collaboration with Walter Sisulu University (WSU) supporting three rural district hospitals in the Eastern Cape.

## **What makes a clinic an ‘island of good practice’? Characteristics of care in the South African health context**

Presentation Type: Oral Presentation

Author: Jennifer Watermeyer

Content: Building Momentum: Taking the Rural Health Movement Forward

**Background:** Communication is at the heart of good health care, as is the relationship between patients and healthcare workers. There is a clear relationship between effective communication practices and outcomes for patients, health professionals and the institution, and an analysis of communication practices may have considerable value in understanding and improving care.

**Methods:** Using a success case method, this paper will describe findings from studies at five urban and rural healthcare sites where patients have identified care as being ‘good’. These sites – so-called ‘islands of good practice’ – display remarkable qualities of communication and care despite huge potential barriers and limited resources. Drawing on an extensive data set of interviews and focus groups with health professionals and patients as well as recorded health care interactions, this paper will examine some linguistic and non-linguistic features characterising ‘good’ care at these sites.

**Findings:** Eight features emerged as qualities of a caring institution, including attention to a broader model of care, leadership, the notion of atmosphere, continuity of care, patients as excellent consumers of service, community based models of service, creative management of temporal and spatial dimensions, and novel organisational routines, including the development of long-term partnerships. This paper will highlight and illustrate these features.

**Discussion:** The features of good care identified at these islands of good practice demonstrate humanisation within health care systems. There is space for care and it emerges when suffering is recognised and responded to. With regard to understanding overall effectiveness and quality of service, analysis suggests a need to look at broader indices that tap into the nuances of communication.

### **Biosketch:**

Jennifer Watermeyer is an associate professor in the Department of Speech Pathology and Audiology and the Health Communication Research Unit at the University of the Witwatersrand, South Africa. Her research focuses on communication processes in multicultural healthcare contexts.

## Posters & Oral Posters

### **AwezaMed: Mobile speech-to-speech translation within the Midwifery and Obstetrics domain**

Presentation Type: Oral Poster

Authors: Nina van Niekerk, Karen Calteaux, & Glenn Stein

Content: Building a clinical care legacy: taking specialist care skills into rural

One of the national challenges with service delivery is that citizens speak multiple languages. Language barriers are an everyday occurrence in South Africa, especially in health care situations where the health care provider (HCP) and patient often do not share a common language and only a low percentage of consultations are done in the patient's home language. Language barriers often lead to communication breakdowns which can have serious consequences.

The DoH's Strategic Plan (2014-2019), highlights maternal and child morbidity and mortality as one of the quadruple burdens of disease which it aims to address. It's National Service Delivery Agreement has Decreasing Maternal and Child Mortality as one of its four outputs.

The AwezaMed application will be a tool that has the potential to support the Department to realise these targets by enabling equitable access to healthcare in a patient's language of preference, improving the quality of the communication event, and by implication the quality of the healthcare received, and enabling more efficient healthcare provisioning.

AwezaMed is an Android-based mobile speech-to-speech translation application into which human language technologies (HLTs) such as automatic speech recognition (ASR – converts speech input in source language into text), machine translation (MT – takes ASR-generated text in source language and translates it into text of target language), text-to-speech (TTS – takes translated text and synthesises it to speech in target language), and natural language understanding (NLU – takes free form natural language user input and converts it into computer-readable data) are integrated.

The application will be developed as a translation system of medical terminologies and phrases from one South African language to another. The initial implementation will be for English, Afrikaans, isiZulu and isiXhosa. A phased approach will be used during the pilot stage to enable iterative development and improvements based on user feedback.

#### Biosketch:

Nina van Niekerk holds a BSc (Hons) degree in Molecular Medicine and Medical Biochemistry from the University of the Witwatersrand. Her diverse background includes laboratory diagnostics and scientific publishing. However, she also holds two qualifications in project management and is a Prince2 Practitioner.

Nina is a senior project manager for the Human Language Technologies Research Group and joined the CSIR in March 2011. She manages a variety of projects which range from research and development to implementation and commercialisation. She is passionate about the way in which speech and language related technologies can be created and applied to benefit the people of Southern Africa.

## **Impact of a Clinic Dedicated to Hypertension in Pregnancy at a District Hospital**

Presentation Type: Oral Poster

Authors: Sr. N Nkosi & Dr. N Mthetwa

Content: Building a clinical care legacy: taking specialist care skills into rural

Vryheid Hospital (Level 1) is situated in the sub-district Abaqalusi, district Zululand, Zone 4, KwazuluNatal. Its referral centre is Queen Nandi regional Hospital (QNRH) 250 kilometres away. Hypertension (HT) in pregnancy has been major contributor to perinatal and maternal mortality in Zone 4. Avoidable factors identified are administration related (distance to referral centre, transport factors and health worker shortages and turnover), patient related (late booking, late presentation, use of alternative medicine, lack of preconception and post-delivery assessment) and health worker related (poor recognition of risk factors, lack of a management plan, inappropriate management and referral).

As part of the RHINO (Rural Health Initiative in Neonatology and Obstetrics) project a clinic dedicated to HT in pregnancy has been set up at district hospitals. The clinic (Ubejane) is run at the hospital once a month. It sees non-emergency patients with HT in the present or past pregnancies (preconception, in the index pregnancy and after the postpartum period). It is run by a selected team under mentorship by a consultant from QNRH to ensure continuity and uniformity of care.

The poster is a preliminary presentation of results and impact of the initiative. Although PNMR has increased, the number of MSB and % of deaths from HT has decreased. The number of referrals has stayed the same but the number of elective referrals for HT has decreased from 50.1 % to 35.7%. This is a major advantage for patients who have to be transported 250 Km to QNRH and in most cases is a 3 day stay away from home. Whether this can be sustained can only be assessed over a longer period.

What needs to be included in the assessment is the classification of the HT, the number of hypertensive deliveries (to establish the PNMR due to HT) and the weight categorisation of babies delivered. Community factors such as access to health facilities, preconception and post-delivery evaluation of HT patients are to be addressed.

Biosketch:

Carol Elizabeth Nokuthula Nkosi is an advanced midwife who has experience at Vryheid Hospital. She is a ESMOE master trainer and genetics trained.

## **My personal experience as a community liaison for students and a NGO worker**

Presentation Type: Oral Poster

Authors: Judith Nomthandazo Mahlangu & Helga Elke Lister

Content: Building a leadership legacy: what do young professionals want and what do they need to know?

With the current move towards decentralised training, it is necessary to ensure that we learn the lessons from the past and plan accordingly for a more effective training programme of health care professionals. Community work principles are well-documented and existing training is supposed to prepare students adequately for their fieldwork, however there seem to be a lack of translation of the students' learnings into practice. There are many common preventable mistakes that are often repeated, impacting relationships with the community and thus the sustainability of the interventions.

This presentation is a reflection of the challenges experienced and lessons learnt from my work as a community liaison for students on fieldwork in the community and a community worker in various NGOs. I describe the context of the university requirements, the students' reactions and the resultant effects on community members.

Living in the communities that I have worked in, and being a student in community and health psychology, has offered me a unique perspective on understanding both sides of the partnership. Based on this, I offer some proposed solutions to the challenges described. This will then hopefully improve the practice of professionals working within communities.

### **Biosketch:**

Judith has always had a passion for working in the community. After completing matric, she started working in NGOs, first as a care-giver and then in marketing. She then worked for the University of Pretoria's Occupational Therapy Department as a community liaison. From here, she became a research co-ordinator for the Hammanskraal section of a nation-wide disability study. Following this, she moved back into NGO work for 5 years, before becoming a research assistant for a study in Mamelodi. She is currently enrolled as an undergraduate student in community and health psychology through UNISA.

## **Non-Communicable Diseases in a Rural Setting**

Presentation Type: Oral Poster

Authors: Dr. Brendan Bebington & Miss Martene Esteves

Content: Building a clinical care legacy: taking specialist care skills into rural

The President of South Africa has in his State of the Nation address for 2018, set out an agenda to focus on our South African health context with regards to non-communicable diseases – his speech states the following "We will also need to confront lifestyle diseases such as high blood pressure, diabetes, cancers and cardiovascular diseases. In the next three months we will launch a huge cancer campaign similar to the HIV counselling and testing campaign. This will also involve the private sector as we need to mobilise all resources to fight this disease."

With this being said, in this oral presentation we'd like to address the issues being faced by rural healthcare practitioners with regard to non-communicable diseases in South Africa, particularly cancer. As a specialist unit in private practice, we have the ideal conditions to treat these patients to the best of our ability and with this being said, we'd like to share our knowledge on how to screen for these conditions, how best to treat these conditions in a rural setting with a growing and ageing population, and how to adequately refer to a specialist centre using telemedicine.

Biosketch:

Brendan Bebington – MBChB; FCS(SA)

I am a specialist colorectal surgeon in independent private practice. Since 2010 I have been involved in the establishment of the WDGMC Colorectal Unit. Our aim as a private training unit, is to train the next generation of specialist colorectal surgeons. I oversee the training of at least 1 full time fellow, as well as a registrar from the Wits Department of Surgery. In addition to our regular patient consultation and surgical lists, we attend a weekly Oncology MDT meeting where we discuss individual patients to reach a group consensus regarding the treatment best suited to their diagnosis. We host a monthly pelvic floor MDT meeting together with gynaecologists, urologists, radiologists, physiotherapists & psychologists to discuss patients who present with complex pelvic floor disorders, and decide upon the best treatment approach. I am an active member of the executive committee SACRS (South African Colorectal Society).

Martene Esteves – BCMP, graduate from WITS, 2013

I am a Clinical Associate currently working with the WITS Donald Gordon Medical Centre Colorectal Unit. I focus most of my time on coordinating care for our patients with colorectal cancer. I have previously worked at Chris Hani Baragwanath Academic Hospital in Paediatric Surgery and Orthopaedics. I have a keen interest in surgery and enjoy working closely with multidisciplinary teams to ensure the best possible care for the patients we treat. I am an executive member of PACASA.

## **Overcoming barriers to inclusion of the rural child with a mobility disability**

Presentation Type: Oral Poster

Author: Margaret Linegar

Content: Building a clinical care legacy: taking specialist care skills into rural

In South Africa, 52% of the population and 75% of poor South Africans reside in rural areas. Access of a child with a disability to health care, education and social support is largely dependent on where the child lives. Children with disabilities in rural areas are known to be especially vulnerable, routinely being denied their rights to quality education, adequate social assistance, early intervention and protection against abuse, neglect and exploitation.

In the absence of appropriate, functioning assistive devices, people with severe disabilities are also greatly limited in their potential for participation. Despite SA policy commitment 15 years ago to the rights of the child to inclusive education, it was reported recently that over 500 000 children with disabilities countrywide remain outside the education system.

The Shonaquip Social Enterprise (SSE) targets the barriers affecting children with disabilities and their families which arise from a lack of personal mobility, poor access to wheelchair services and skilled rehab, challenging environments and isolating or stigmatising attitudes. People with disabilities may need support to participate fully in their communities which involves working with many different people throughout the child's ecosystem. For many years Shonaquip's outreach teams have implemented services to support the inclusion of children with mobility disabilities across rural parts of Southern Africa.

Their multifaceted outreach model goes beyond service delivery to include broad ranging, local capacity building, collaborative partnerships and the breaking down of barriers to inclusion which limit the prospects of a rural child with a disability. Of particular importance is advocacy, parent and caregiver empowerment.

This poster illustrates how SSE implements holistic outreach in a way that is sustainable in rural communities to support the child with a mobility disability to become a valued, contributing member of the community.

### **Biosketch:**

Margaret Linegar is an Occupational therapist currently supporting the rural outreach teams and a range of other activities of the Shonaquip Social Enterprise. Drawing on years as an OT working with people with physical disabilities, and many years of experience as an educator at UCT, she focus on staff development, the design of training resources and capacity building approaches in the social enterprise. She is also responsible for outreach trip reporting and contributed to the development of our impact framework for the social enterprise. She regularly contributes to policy affecting people with disabilities and was involved in the design of community disability surveys and the Uniform Referral Pathways training used within the Dept of Social Development. She supports Shonaquip team members to share their work experience through publications, presentations at conferences and training workshops across South Africa.

## **Strengthening South Africa's HIV/AIDS response by aligning clinical associate education programmes with national prevention and treatment guidelines – A curriculum map review**

Presentation Type: Oral Poster

Author: Scott Smalley

Content: Building a clinical care legacy: taking specialist care skills into rural

**Background and Objectives:** A critical lack of trained clinicians, especially in rural areas, undermines South Africa's HIV response. Existing training for health workers does not always include targeted, up-to-date lessons on HIV prevention and treatment, hindering care. With South Africa having the highest burden of HIV positive patients, health care response is essential. The National Department of Health (NDOH) established the Clinical Associates (ClinA's) cadre to fill human resource gaps, enable task sharing, increase efficiency and maintain a high standard of care. This study conducted an HIV Curriculum Map review to evaluate how well existing programmes are preparing ClinA students to provide HIV-related services.

**Method:** The universities conducted a curriculum map review workshop, developing a ClinA competency framework in August 2016. The workshop focused on development of competency-based curricula that incorporates national guidelines and best practices in HIV prevention and treatment.

**Results:** Each university developed HIV-specific course content across all years of ClinA training. The competency framework yielded an HIV curriculum map with milestones, assessment criteria, competency levels and compared this to the 2015 national HIV guidelines as well as the 11 exit outcomes and Clinical associate national exam. The study revealed that ClinA curricula at all the universities is in line with the NDOH's 2015 National Guidelines for HIV response. Areas of improvement in objectives, competency levels and assessment are needed.

**Conclusion:** ClinA training curricula, updated with current HIV/AIDS training modules and aligned with national guidelines, are well-suited for rapidly training mid-level medical workers fully capable of managing HIV-related prevention and treatment services. ClinA programmes should be scaled up, with specific inclusions in curricula, to help address South Africa's dire need for qualified health professionals, particularly in areas with high HIV burden. Efforts to deploy this cadre to underserved parts of the country should be ramped up.

### **Biosketch:**

Scott Smalley is the Academic Head of Division of Clinical Associates in the Department of Family Medicine and Primary Care, University of Witwatersrand. He graduated from the University of Vermont in 1991 with a BSc and Northeastern University Bouve College of Health Sciences in 2007 with a Masters in Science in Physician Assistant Studies in the United States. Scott has provided medical care and training as a Physician Assistant in the US, as a Clinical Officer in Kenya and as a Clinical Associate in South Africa.

He is on the Clinical Associate National Department of Health Task Team. He serves as Secretary and President-Elect for the International Academy of Physician Associate Educators (IAPAE). As Head of the Division of Clinical Associates, Scott coordinates the undergraduate and postgraduate Bachelor of Clinical Medical Practice (BCMP) degrees to train students to be registered as Clinical Associates. In addition, he is currently studying part time for the Postgraduate Diploma in Health Science Education at University of Witwatersrand.

## **The expectations and perceptions of final year medical students of clinical associates**

Presentation Type: Oral Poster

Authors: Michiel Koortzen, LW Biggs, Martin Bac, Liz Wolvaardt, & Astrid Turner

Content: Building a leadership legacy: what do young professionals want and what do they need to know?

Background: A clinical associate (ClinA) is a mid-level health professional that was introduced to address the strained South African health system. A ClinA may only legally practice under the supervision of a medical doctor. What is not known is whether medical students are aware of their future supervisory role, feel prepared to fulfil this legal obligation and are aware of what is allowable under the ClinA's scope of practice. This study explored these questions among final year medical students, at the University of Pretoria.

Summary of work: This descriptive cross-sectional study used a 9-item questionnaire. Final year medical students (n= 287) at the University of Pretoria are eligible to participate. Participation is voluntary and questionnaires are completed after each District Health and Community Obstetrics rotation (The study ran from March 2017 to March 2018). Data were analysed with Excel. Ethical permission was granted.

Summary of results: From the 117 responses: the majority (76%, n=89) had worked with a ClinA before and only 3 (2.5%) were unsure. Their impression of working together was generally positive (77%, n=72). Approximately half (49%, n=57) thought that ClinA's' scope of work similar to registered nurses and 45 (39%) thought it was closer to a doctor's. Few were aware that they had to supervise ClinA's (14%, n= 16). In this group that were aware of their supervisory role: 8 (38 %) felt adequately trained and comfortable with the responsibility, 8 (38%) were not comfortable and 5 (24%) had received training, but still felt uncomfortable. Participants identified actions they thought allowable within the ClinA's scope of practice (20 possibilities). The median score of correct answers was 12 (range 4 -20).

Discussion and Conclusions: Final year medical students have worked with ClinA's but seem unaware of their future legal obligation of supervision. Adequate clinical supervision is based on the knowledge of the scope of practice which was variable in this study.

Take-home Messages: Formal training on the scope of work of ClinA is needed to prepare future doctors for their supervisory role.

Biosketch:

Michiel Koortzen and LW Biggs are both fourth year medical students. Supervised by staff within the Clinical Associate program (Family Med) and School of Public Health

## **The Hypertension in Pregnancy Burden at a Regional Hospital in KwaZulu-Natal**

Presentation Type: Oral Poster

Presenters: Dr. T Mathenjwa & Sr. A Cezula

Content: Building a clinical care legacy: taking specialist care skills into rural

Queen Nandi Regional Hospital (QNRH) is a level 2 facility in Empangeni, Umhlatuze sub-district, King Cetshwayo District KZN. It is the referral hospital for 16 Level 1 hospitals from King Cetshwayo, Zululand and Amkhanyakude districts (Zone 4 KZN). There is no level 1 facility in Umhlatuze, so it also serves 22 district clinics.

Hypertension (HT) in pregnancy is a major contributor to maternal and perinatal morbidity and mortality. Because of the huge catchment area QNRH manages a large number of patients with this problem. The Rhino (Rural health initiative in Neonatology and Obstetrics) project which started this year has focused specifically on HT in pregnancy to in the long term decrease mortality and morbidity from this disease. This presentation is based on baseline data collected at QNRH to determine the burden of the disease at QNRH and to later assess if interventions put in place have had an impact.

QNRH receives referrals from 16 district hospitals and 22 Umhlatuze clinics. Data was collected for 86 days in 2018. The total number of patients was 4657 . Patients were categorised by type and severity of HT. Outcomes for mother and child were analysed and the perinatal mortality rate (PNMR) in HT patients is about 3 times higher than overall PNMR. Infant deaths were related to low weight. Facilities with high referrals have been identified and action plans have been instituted.

HT disease in pregnancy great burden resulting in significant maternal and perinatal mortality at QNRH. Administrative, patient related and health worker related factors have been identified and action plans instituted. The Rhino project which focusses on mentoring at district hospital and clinic level has been started.

A major focus is patient education via media and improving access to medical care. Effectiveness will be assessed by evaluating perinatal and maternal mortality rates as well as morbidity and results presented at future conferences.

Biosketch:

Sr Ayanda Cezula

Registered Midwife

Queen Nandi Regional Hospital Empangeni

Rhino champion for hypertension in pregnancy in high risk clinic.

## **The LEAP for Quality programme in Lesotho**

Presentation Type: Oral Poster

Authors: Dr Martin Bac, Prof Bob Pattinson, Prof Peter MacDonald, Dr. Anne-Marie Bergh, & Prof Jannie Hugo.

Content: Building a clinical care legacy: taking specialist care skills into rural

Background: Lesotho has a population of 2,2 million people and is served by 17 hospitals. The maternal and neonatal mortality in Lesotho have been high in the past decade despite a performance based financing programme by the World Bank.

Summary of the work: The World Bank contracted the SAMRC unit and the Department of Family Medicine at UP to conduct training for doctors and midwives in the Lesotho hospitals in order to improve the health outcomes. A programme was developed according to World Bank specifications, the Lesotho Action Programme (LEAP) for Quality. The first task at hand was to change the checklist that was used to measure the performance of the Lesotho hospitals that participated in the Performance Based Financing (PBF) programme. Based on that a master training was conducted with a focus on maternal and neonatal health (70%) and the rest was devoted to common causes of death such as prematurity, childhood infections, HIV/TB and trauma. A week long master training was done for 65 health care workers of district hospitals in March 2018. All 8 hospitals in the PBF programme will conduct weekly training and do fire drills. Based on their performance in maternal, neonatal, HIV/TB and emergency skills they will be financially rewarded by the World Bank.

Discussion: Maternal mortality in Lesotho is around 1000/100.000 and neonatal mortality 39/1000 despite good health care facilities and a regional referral hospital. In a twelve month period intensive training will be done of health care providers with material that is specifically developed for this purpose and will be very useful for all district hospitals.

Biosketch:

In the years that Dr Martin Bac worked at Gelukspan Community hospital he developed a keen interest in PHC and the most effective way to deliver health services to the community despite apartheid and poverty. Thereafter I worked at Medunsa in the nutrition unit and department of Family Medicine for 3 years. In 1990 we went back to the Netherlands and we had a family medicine practice in Leerdam until 2010. From 2010 I got a job at the department of Family Medicine at UP and my main task is the training of Clinical Associates and supervision of the district health rotation of the medical students. From 2017 I am involved in palliative care and developing CPD training and teaching material for district hospitals.

## Workshops

### **Bavuse: Mobile mobilisation for a People's NHI**

Presentation Type: Workshop (60 minutes)

Authors: Shehnaz Munshi & Catherine Fungiwe Mokotla

Content: Building Momentum: Taking the Rural Health Movement Forward

The People's Health Movement South Africa (PHM-SA) has called on civil society, communities and allies in health struggles to join in mass mobilisation and community action to realise health equity and the right to health for all in South Africa. A prominent example is PHM-SA's urgent campaign for a "People's NHI", which demands people-centred health services based on the principles of human rights, universality, social solidarity and social justice. PHM-SA is strategically using Bavuse! – an exciting new mobile health advocacy and mobilisation tool – to bring together community members and civil society groupings to establish a broad social movement for people's health.

As a communications and mobilisation platform, Bavuse! can help with self-organising and information-sharing in remote and rural communities – at little or no cost to community members. Bavuse! could reach potentially thousands of people through SMS, USSD, email and social media. It is a single platform that is interactive and easy to use, and can be adapted to people's access to specific forms of technology (basic phones, smartphones, tablets or computers). It can serve as a strategic tool that has the potential to change rural health mobilisation through:

- Mobilising our constituencies in different geographical areas around health advocacy and social justice campaigns
- Self-organising at grassroots level
- Public education on health issues
- Quick, large-scale information-sharing on developments happening on the ground

We will give an overview of how we have been using Bavuse! to mobilise for a People's NHI Campaign and for increasing people's voice about health issues – through initiating discussions, organising and bringing change. Bavuse! provides options to organise campaigns, call meetings, have votes, run polls, and integrate with petitions hosted through Amandla.mobi. Workshop attendees will have the opportunity to engage with the People's NHI Campaign via Bavuse! – using our free campaign dialling code: \*134\*1994\*333#. Thereafter, we will interrogate the merits of using mobile mobilisation techniques for mobilisation around health.

#### Biosketch:

Shehnaz Munshi is an occupational therapist who holds an MPH in Health Systems and Policy Research. She serves on the steering committee of the People's Health Movement. She is the Chairperson of the Junior Public Health Association of South Africa, is an Atlantic TEKANO fellow for health equity and a fellow of the Emerging Voices for Global Health for 2018. Her research interests include the political economy of health, gender, transformation and decolonisation of health sciences education, health advocacy, governance and leadership, creative arts and ability for equity, accessibility, acceptability, quality, availability, human rights, gender equality and social justice.

Catherine Fungiwe Mokotla is a member on the Steering Committee of the People's Health Movement.

## **Building Momentum for the RuDASA Strategic Plan**

Presentation Type: Workshop (2 hours)

Author: Dr Mosa Moshabela

Content: Building Momentum: Taking the Rural Health Movement Forward

This workshop will describe the progress from the setting of the RuDASA Vision & Mission and the decision at the RuDASA Indaba 2017 to focus on building the membership and strengthening the provincial networks, so that all delegates are on the “same page”. Participants will then work in small groups to look at the following sections and describe goals, specific actions, and timelines for these actions:

- Building the membership
- Building student and young professional membership and offering them support
- Creating effective Provincial – local networks of doctors
- Creating a responsive RuDASA: developing an advocacy policy with key health issues to focus on, developing key “RuDASA messages” e.g. on community service
- Strengthening the partnership with the Rural Centres at Universities to support rural proofing curricula & students as well as building a “rural best practice” information library/courses for rural doctors

### **Biosketch:**

Dr Mosa Moshabela (MBChB, MFamMed, Dip HIV (SA), PhD) is a public health scientist in health services, systems and policy research, and currently chief medical specialist and head of Rural Health at the University of KwaZulu-Natal (UKZN), South Africa. Prior to joining UKZN, Dr Moshabela was the regional health advisor for the Millennium Villages in West and Central Africa, based at the MDG Centre in Mali/Senegal, and affiliated with the Earth Institute at Columbia University, NYC as a Public Health Specialist. Dr Moshabela is a Wellcome Trust Research Fellow at the Africa Health Research Institute (AHRI) in South Africa, which collaborates with University College London (UCL) and the London School of Hygiene and Tropical Medicine (LSHTM). Dr Moshabela is currently based in London seeking to enhance his goal to effectively design, implement and evaluate complex interventions in public healthcare services and programs appropriate for resource-poor settings in sub-Saharan Africa.

## **Building resilience through community of care for rural health professionals**

Presentation Type: Workshop (60 minutes)

Author: Meba Aphonse Kanda

Content: Building on the Advocacy Legacy: how to look after ourselves and our patients?

Rural clinical practice occurs in a context of isolation with populations that are hard to reach because of their peripheral geographic and social positions. It is in this context of isolation that many rural health professionals find themselves to be witnesses of poverty, violence and suffering in their daily clinical practice. Such situations are a source of burnout with other forms of suffering among rural health professionals. The aim of this workshop is to facilitate the building of resilience of rural health professionals through the mobilisation of their diverse psycho-socio-cultural resources.

Based on a meaning centred existential anthropology, the workshop uses an experiential learning method with the help of personal and collective narratives to facilitate the discovery of the psycho-socio-cultural resources of participants and build resilience through a community of care, despite the adverse challenges. From literature, ethnographic studies of rural clinical practice, personal and collective experiences, the workshop creates a platform to examine various existential themes which relate to the following topics: different forms of suffering, the context of suffering, being a witness of suffering, and ways of engagement and living of participants.

This workshop is part of supporting the process of building resilience in rural clinical practice and wellbeing of rural health professionals using an experiential learning method with a meaning centred existential anthropology perspective. The resilience and wellbeing of participants as health professionals are critical contributing factors of the improvement of the quality of rural health care.

### **Biosketch:**

Dr MA Kanda is currently working in the community mental health unit of West Rand Health District in Gauteng/ South Africa as a Principal Medical Officer. He is mainly involved in the outreach programme of mental health clinics in West Rand District. He is also a clinical logo-therapy facilitator at the UNISA Centre for Applied Psychology and an e-tutor for the department of Anthropology at UNISA where his current studies as an Anthropology Master student focuses on the psycho-sociocultural interventions in clinical settings. His professional interests are centred on the interaction between medicine, anthropology and psychology, in other word interaction of health, culture and mind, with an existential approach.

## **Developing the leadership of a community disability-inclusive workforce**

Presentation Type: Workshop (90 minutes)

Author: Professor Theresa Lorenzo

Content: Building a leadership legacy: what do young professionals want and what do they need to know?

A community-based inclusive workforce is central to shifting the perceptions and stigma related to disability, so as to facilitate the participation of youth with disabilities and young parents of disabled children in opportunities for social and economic development. An inclusive workforce needs inner resources to manage their own wellbeing and cope with the emotional and mental challenges that arise in everyday work life. For sustained change, collaborative relationships between stakeholders that enable reciprocal learning and continuity of care is needed.

The workshop will share experiences of graduates of the Higher Certificate in Disability Practice. It will provide space to explore articulation for career development and their identified need to organise themselves to address employment benefits and conditions of services. Consideration will be given to their contribution to Primary Health Care and the Framework and Strategy for Disability and Rehabilitation.

The workshop will be 90 mins long and will be creative and participatory.

### **Biosketch:**

Professor Theresa Lorenzo is an occupational therapist who spearheaded the training of community rehabilitation workers while at Tintswalo Hospital in collaboration with University of Witwatersrand in the late 1980s/early 90s. She completed her MSC in Community Disability Studies at University of London. She has worked in the Department of Health and Rehabilitation Sciences, Faculty of Health Sciences, University of Cape Town since 1996.

Her PhD in Public Health focused on social and economic development of poor disabled women. She is currently PhD Programme Convenor in the Division of Disability Studies. Theresa's career has focused on designing disability-inclusive development programmes in collaboration with non government organisational and disabled people's organisations in rural and urban communities, with specific focus on livelihoods development of youth and women. Her passion is facilitating reciprocal capacity building of an inclusive community-based workforce. Her most enjoyable occupation is cycling.

## **Distributed Clinical Training: So how can we get this right together?**

Presentation Type: Workshop (60 minutes)

Authors: Jana Muller, Maryke Bezuidenhout, & Karl le Roux or Ben Gaunt (TBC)

Content: Building Momentum: Taking the Rural Health Movement Forward

Distributed Clinical Training (DCT) is the focus of many discussions and conferences themes across South Africa, with 8 medical schools in 7 provinces aiming to incorporate DCT into their curricula, hearing the voice from grass roots level is more important now than ever. In 2017 SAAHE released a consensus statement to support DCT as a potential 'gold standard' in health care education. In order of universities to collaborate with expert clinicians they have to engage with professionals at national, provincial and district levels of care. Each university has its own way of approaching and working with health care workers and communities for student placement, the results are either favourable or in many cases not. Relationships between clinicians and academia can be fraught with misunderstandings, which often leads to mutual disappointment and affects the standard of training students could benefit from in a real-life setting.

Over the years the RHC has attracted a larger number of practicing clinicians from all sectors of health care than Educators or Politicians. Using the principals of community engagement, a needs analysis needs to be conducted with clinicians across the country. This workshop aims to leverage off the experience and expertise of the RHC delegates to determine multi-site and multi-provincial experiences of DCT and establish recommendations as to how universities and rural health care professionals can better engage prior to student placement. Three facilitators, one allied health clinician, one academic coordinator and a doctor from three different provinces will facilitate the workshop using evidence from available literature on DCT. These recommendations will then be compiled into a report and made available to all universities and rural health bodies (RUDASA, RUNURSA, RURESAs) for comment.

### **Biosketch:**

Jana is an academic coordinator for collaborative distributed training from Stellenbosch University in the Western Cape, Maryke is chair of RuReSA and an experienced physiotherapy clinician working in Manguzi, KZN with years of student supervision during elective placements. Ben (or Karl) is an experienced rural doctor from Zithulele, Eastern Cape who regularly supervises medical students and is a long standing member of RuDASA.

## **Eish, A Paediatric Surgery emergency in the sticks!**

Presentation Type: Workshop (90 minutes)

Authors: Dr. Yashoda Manickchund & Dr. Sello Machaea

Content: Building a clinical care legacy: taking specialist care skills into rural

Aims and Objectives:

- Outline common paediatric surgery emergencies in the various age groups
- Help to enable doctors to recognise and diagnose paediatric surgery emergencies at district level
- Outline basic resuscitation and stabilisation of children with surgical problems
- Outline guidance for safe transfer of the neonate to tertiary level centre
- Give advice on elective minor procedures that can be performed at the base hospital

Format:

Powerpoint Presentation:

- Interactive with case presentations and discussions

Question and answer session:

- Questions from participants on Paediatric Surgery

Biosketch:

Dr Yashoda Manickchund completed her undergraduate studies in the University of Cape Town, 2 years of internship at King Edward VIII Hospital (KZN) and community service at Khayelitsha District Hospital (W.Cape). Thereafter she joined Doctors without Borders for 2 years, working in Pakistan, Iraq, Libya and Ethiopia. After working in a rural hospital in KZN, she undertook her post graduate training Paediatric Surgery at UKZN and completed her Masters in Medicine with a project on planning Paediatric Surgery Outreach. After voluntary work at a paediatric surgery service in Lilongwe, Malawi, she joined the Department of Paediatric Surgery in East London, Eastern Cape. Her interest is in providing Paediatric Surgery support to rural and underdeveloped areas in Africa and globally.

Dr Machaea obtained his medical degree from the University of Kwazulu Natal. He worked in Durban as an intern and in Limpopo as a Community Service MO. He then returned to Durban to join the General Surgical Training Program. He started as a Paediatric Surgery Registrar in East London in February 2015

## **How health care workers can report stock-outs to strengthen health care systems**

Presentation Type: Workshop (60 minutes)

Author: Lauren Jankelowitz

Content: Building on the Advocacy Legacy: how to look after ourselves and our patients?

The Stop Stock-outs Project (SSP) is working nationally monitoring medicine shortages and stock-outs in public health care facilities. SSP engages communities, civil society partners and both national and provincial departments of health to relieve the ongoing essential medicines stock-outs. Being a problem that affects the communities countrywide, it is urgent to evaluate the types and frequency of medicines stock-outs and their impact on patients. These include interruptions in care, economic burdens, healthcare burdens and subsequent death where patients default and are prone to further opportunistic diseases. It has become clear that stock-outs impact poor and rural based patients in particularly severe ways, forcing them to spend limited financial and time resources making additional unnecessary journeys to the public health facilities.

SSP is working to increase awareness and education on how citizens, civil society organisations and healthcare workers can be responsive to reporting stock-outs. Reported stock-outs are critical in advocating through the supply chain management to reduce stock-outs and help in understanding root causes of medicines shortages in public health facilities. These reports are escalated to the Department of Health (DoH) and other stakeholders in the interests of strengthening supply chain management and increased state accountability. Through deeper community engagement initiatives, SSP aims to increase the monitoring footprint of essential primary health care medicines and childhood vaccines with the training of healthcare workers, communities and civil society leadership on reporting stock-outs and shortages.

Biosketch:

Glenda Muzenda is the project manager of the Stop Stock-outs Project (SSP)

## **I can make a difference: Working with a child with severe disabilities**

Presentation Type: Workshop (90 minutes)

Author: Kabi Krige

Presenters: Lydia Ngwana, Ruth Mashe, & Tadenda Mashe

Content: Building a clinical care legacy: taking specialist care skills into rural

When children with Cerebral Palsy (CP) present with severe multiple disabilities, we often find ourselves stuck. This is because children with CP who are severely disabled often do not respond to typical treatment strategies. This often leads to feeling like we cannot make a difference in the child's life and therapy becomes viewed as irrelevant.

Malamulele Onward believes that ALL children with CP can grow, play and learn and that we CAN make a difference in this group of children. We will focus on facilitating movement, communication and play in GMFCS Level 4 and 5 children with CP who have associated visual, communication and eating and drinking impairments. We want to demonstrate the starting point to unlock their potential to grow, play and learn.

Looking at how you can pick up on the small things can help you to establish the child's current level of interaction, determine what you need to do to meet the child at that level: (i) manipulate the task, (ii) the environment or (iii) the requirement to the child's body, as to improve interaction.

The reality: The average child with CP living in a rural area receives 4-5 hours of therapy a year. These children are discharged when they are 6- 7 years old, as they are considered too old/ become difficult to transport. This means that you have 35hours to set a child and a family up for life with CP. How do we overcome this?

Helping a caregiver understand that this necessary interaction can be applied into daily life – How can a mother make that connection with the everyday things she does? Not an extra add on to her busy life, but a different way to do it, making everyday things we do therapeutic.

Biosketch:

Lydia Ngwana has extensive real life experience in caring for children with severe disabilities. She is the mother of a young gentleman (21 Years old) with Cerebral Palsy and has been working for Malamulele Onward for 12 years. She is a trained parent facilitator; this involves administering practical workshops on caring for a child with severe disabilities, supporting other caregivers with children with severe disabilities, assisting therapists (individual and group therapy) in the therapy room and on outreach visits (group therapy and home visits) at Malamulele Onward. Lydia's fun loving personality, understanding and love for what she does makes her an excellent teacher of how to connect with children with severe disabilities.

Ruth Mashe is the mother of Tadenda Mashe (7 years). She is also trained by Malamulele Onward as a parent facilitator. She is excellent in handling Tatenda and has a special way to communicate, connect and adapt to what he needs.

## **Making the most of technology: remote seating mentoring and support services**

Presentation Type: Workshop (60minutes),

Author: Megan Giljam

Content: Building a clinical care legacy: taking specialist care skills into rural

Shonaquip and UHambo Foundation are a hybrid social enterprise working together towards an inclusive society for all. Through the provision of appropriate posture support mobility assistive devices, Shonaquip aims to reduce barriers to inclusion. The devices are viewed as a tool to not only facilitate development of children with mobility disabilities but also to provide opportunities for optimal function and participation in everyday activities.

Over the last 25 years Shonaquip has been part of a group advocating for equitable and sustainable access to appropriate posture support wheelchairs as well as the essential supporting services. In South Africa, intermediate level seating is a post graduate course which requires not only attending a week long course but also working and gaining the appropriate clinical experience to be confident in working with posture support wheelchairs as well as wheelchair users who are more complex.

One of the major challenges which have faced this work over the years is that, although the products are now available on a national tender, the skills needed to work with them are still scarce. There are fewer therapists working in rural areas and fewer still who have the required training and experience to work with intermediate devices.

For many years, Shonaquip has been involved in the hands-on mentoring and support of therapists in rural areas as and when we can visit them. However, in recent years technological developments have allowed for a new avenue of mentoring that is not dependent on travel. In 2017, Shonaquip was involved in an international mentoring program which aimed to provide mentoring through an online platform.

In this presentation I would like to share our experience and learning over the years as well as our proposed way forward to incorporate this into the clinical mentoring services that we already offer.

Biosketch:

Megan Giljam is an Occupational Therapist working at Shonaquip and UHambo Foundation in Cape Town. She has been working at Shonaquip for almost 7 years and now heads the team that delivers seating and training services across Southern Africa. Before working at Shonaquip, Megan worked at Zithulele Hospital in the Eastern Cape where she developed a deep passion for working with people in rural areas and in particular the impact that the appropriate wheelchair has on function and participation of people with disabilities.

## **Managing Burns Beyond the City: NOT as difficult as it seems**

Presentation Type: Workshop 3 hours

Presenter: Dr Rachel Moore

Content: Building on the Clinical Care Legacy: taking specialist skills into rural

The thought of managing a burns patient is often terrifying, overwhelming, and WAY outside the health care professionals comfort zone. This applies across the board: doctors, nurses, professionals allied to health (PAMS). The workshop aims to debunk the fear factor and equip the participants with both knowledge and confidence in the management of burns. Our multidisciplinary team will go through the basics of theory and then engage participants in practical exercises to apply this theory, including the ethics of end-of life decision making and palliative care of the non survivable burn injury.

### **Biosketch:**

Dr Rachel Moore is a Specialist General Surgeon recently appointed as Head Acute Care Surgery (a new unit of the University of the Witwatersrand) at Baragwarnt Hospital where she was a Consultant for the Bara Burns Unit from 2013 -2017. She was Acting Head of Sebokeng Hospital Sept 2017 - Feb 2018) and is currently the Vice-President of SA Burn Society.

## **Mitigating stress and the risk of burnout: Looking after ourselves so we can better look after our patients**

Presentation Type: Workshop (2 hours)

Author: Ms Sarah Davids

Content: Building on the Advocacy Legacy: how to look after ourselves and our patients?

Background: Health care is one of the only remaining professions in which ignoring spouses, significant others, children and even ourselves are still considered to be socially acceptable (Wicks and Buck, 2013). Healthcare workers experience stressors of financial difficulties, typically being the main breadwinners, are exposed to violence and multiple bereavements, and often have thoughts and plans of resignation. They are at risk of burnout and secondary traumatic stress. The cost and impact of unhealthy practitioners ranges from an increased number of sick days to decreased quality of performance as well as employee resignations (Wicks and Buck, 2013).

Workshop Aim: To introduce participants to a range of skills and activities that can be proactively implemented within the rural health setting to mitigate the effects of stress and risk of burnout

Session outline

Using a participatory method and drawing on our extensive experience in implementing the WEL process, we will engage participants and inspire them to adopt strategies to mitigate the effects of stress and risk of burnout on their physical, emotional and spiritual lives in order to actively transforming their own and their patients' lives.

Key outcomes for the participants by the end of the session are:

Completion of a range of activities to mitigate rural stressors

Guided mindfulness and relaxation techniques

Introduction to the 'Five Agreements' as an alternative framework to strengthen relationships

Inspiration to decide to identify and address rural stressors and risks of burnout through a gender lens.

Biosketch:

Sarah Davids has formal qualifications in coaching, public health and occupational therapy. She has more than 25 years experience in supporting capacity development within the district health system and coordinates the Wellness for Effective Leadership project in Health Systems Trust.

**Must-haves for good rural service: Working in a rural community comes with many challenges. Some are technical, operational or social.**

Presentation Type: Workshop (60 minutes)

Authors: Samantha Khan-Gillmore & Marije Versteeg-Mojanaga

Content: Building on the Advocacy Legacy: how to look after ourselves and our patients?

According to the NHI White Paper, there will be two processes in assessing a provider's suitability to provide services under the NHI. The first, certification by the OHSC; the second, accreditation by the NHI. The OHSC certification will provide a regulatory measure of the minimum acceptable level of quality. The NHI accreditation will need to set standards for quality that provide a trajectory towards excellence for all providers in the NHI health system. It is recommended that there be recognised, accredited steps on the trajectory to enable providers to progress to excellence over time.

While the above might be true and structurally correct working in a rural community is not easy. Health professionals require different levels of social interaction in order to thrive in rural communities and to be that excellent service provider. We have over the years witnessed comm serve allocations being skewed in favour of urban facilities compared to their rural counterparts. We are aware that rural communities have less human, technical, and operational resources than urban areas. Young graduates are often challenged by the lack of readily available resources in a rural setting. We therefore understand and appreciate that there are many factors that contribute to HCW's being excellent, proud and willing to work in rural communities.

HCW's voices (past and present who have worked in rural communities) are important to facilitate a better understanding of coping mechanisms and processes. This is a workshop to explore what are the top three "must-haves" that new, young health professionals cannot do without in rural communities or that could potentially be a deal-breaker to remain in a rural area. How and what can be done to assist with these challenges?

Biosketch:

Samantha Khan-Gillmore is responsible for RHAP's knowledge management and communications work. Having managed The Voice Project for two years, she continues to lead on RHAP's Advocacy in the Curriculum work as well providing overall communications leadership and support to the organisation. Before joining RHAP she has managed education, workers' and human rights programmes for over a decade, in South Africa and across the African continent.

Samantha has previously worked for the Discipline of Occupational and Environmental Health (DOEH) at the University of KwaZulu-Natal (UKZN), Durban, as well for local and international labour movements. She holds a post-graduate (Honours) qualification in Politics and an undergraduate Law degree from the University of KwaZulu-Natal in Durban. She is currently studying towards a MMedSci looking at advocacy in the health sciences curriculum.

## **NHI: Friend or Foe?**

Presentation Type: Workshop (60 minutes)

Authors: Russell Rensburg, Karessa Govender, Marije Versteeg-Mojanaga, & Samantha Khan-Gillmore

Content: Building Momentum: Taking the Rural Health Movement Forward

The release of the NHI Bill is an important milestone in the country's path to the achievement of universal access to health. The Bill is silent on the full spectrum of services to be covered nor how the fund will be financed. However, the Bill does provide some insight into how the NHI Fund will be constituted, how it will be governed as well as some insight into the various technical committees that will shape how the fund will operate. Additionally, it also provides some insight into the role of the various spheres of Government particularly the role of provinces and district health offices. Sustained calls have been made for an extension of submissions to the Bill. It is critical that rural stakeholders have their voices heard as the NHI can benefit or harm equitable rural healthcare.

In this workshop, we present some thoughts on how the NHI will likely impact on the provision of rural healthcare by providing an overview of the proposed NHI Fund and its governance, strategic purchasing, the impact of the proposed purchaser / provider split, the proposed contracting units for primary care and the role of provinces, private sector under the NHI. We will seek inputs by rural health movement partners and stakeholders, inviting critiques and ideas, with a view of developing a joint submission.

Biosketch:

Russell Rensburg is RHAP's Programme Manager for health systems and policy. His work includes managing RHAP's rural proofing programme which advocates for the equitable allocation of resources for rural health care delivery. He is a Lancet Commission member looking into aspects of quality of health care for rural communities, and works closely with various civil society organisations on budget justice. Before joining RHAP, Russell 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.

## **PACASA Indaba: Navigating Supervision of Clinical Associates in a Rural Health Setting**

Presentation Type: Workshop (2 hours)

Author: Zuki Tshabalala

Content: Building Momentum: Taking the Rural Health Movement Forward

Clinical Associates play a vital role in service delivery in poorly resourced areas but the role of this new cadre is not well understood by doctors or the decision makers in the Department of National Health. This workshop aims to unpack the scope of practice for Clinical Associates and discuss the role of clinical associate versus doctor, and the requirements for supervision by doctors in the clinical sites. The Issues facing these young professionals as identified in the PACASA Keynote address will be analysed and we will develop key messages to promote the profession of Clinical Associates to the Department of Health so that we are well prepared for the new Department of Health National Strategic Plan for Human Resources.

### **Biosketch:**

Zuki Tshabalala is a U.S. trained Physician's Assistant. She received her Bachelors in Biology from the University of Georgia, thereafter working as a Medical Assistant for a group of pulmonologists. Zuki's original plan was to pursue a Medical Degree, however after learning of Physician Assistants, she felt that a mid-level healthcare provider would be an asset to a free South Africa.

Zuki went on to complete her Masters of Medical Science at Emory University becoming a certified PA. In 2004 Zuki attended a conference in South Africa, where the possibility of developing a mid-level medical worker was being explored. She moved back to South Africa and began working on getting national and university-level approval for the introduction of such a cadre into the South African District Healthcare System. Zuki began working with the University of Witwatersrand, and assisted in the development of the Clinical Associate curriculum there. She was instrumental in getting this curriculum approved by the Faculty Board and has since moved to the University of Pretoria, where she now serves as Academic Coordinator for the Clinical Associate Program.

## **Rural Seeds Cafe 2018**

Presentation Type: Workshop (2 hours)

Authors: Dr. Bernhard Gaede

Content: Building Momentum: Taking the Rural Health Movement Forward

Rural Seeds group was set up at the WONCA Conference 2017 in Australia. Rural Seeds aims to grow and support students and young health professionals who are interested in working rural. This world network hopes to raise awareness about the rural issues students and young professionals face and provide guidance in coping. It recognises the 2-way relationship between young professionals and rural veterans and that both can be involved in the promotion of rural based curricula, transfer of rural knowledge and developing rural mentorship.

At RHC2017 we held our 1st Rural Seeds Cafe and aimed to bring students, young professionals and seasoned rural practitioners in all health fields together to share rural experiences around “culture shock”, “building teams” and “best rural experiences”.

Based on the Cairns Call For Action, to establish effective social media platforms to build networks and share stories and discussions, our Rural Seeds 2018 Cafe will review how Rural Seeds sessions have been run internationally and explore some of the possibilities for linking students, young professionals and rural veterans (as community role models) in together in a South African social media mentor programme.

If there is sufficient time then other aspects of the Cairns Call for Action such as the “students role in rural health”, “rural health education and practice” and interdisciplinary practice and education” will be discussed in order to plan the Rural Seeds 2019 workshop.

### **Biosketch:**

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 and worked in the Bergville area in KwaZulu-Natal for well over a decade prior to joining UKZN. He has also been actively involved in the Rural Doctors Association of Southern Africa and the Rural Health Advocacy Project. Recent interests include health professional education, decentralised training and community engagement and is currently the PI on the NRF grant Community Engagement in Training (ComET).

## **Introduction to the Department of Health's Patient- centric Culture Code to improve patients' and colleagues' experiences**

Presentation Type: Workshop (60 minutes)

Author: Stacey Ann Pillay

Content: Building on the Advocacy Legacy: how to look after ourselves and our patients?

To effectively deliver National Health Insurance, the National Department of Health (NDoH) has invested heavily in initiatives such as National Core Standards and the Ideal Clinics model to define and monitor quality standards. The NDoH believes these standards should be found in all public health facilities in South Africa. However, these initiatives do not articulate 'how' front line health workers should meet the emotional needs of their customers, be it internal (colleagues) or external (patients). There is no measurable target for the behaviour of healthcare facility staff, such that organisational culture aligns to the values and mindset desired to produce high quality care.

In 2015, AHP, in partnership with USAID and Frances Baard DoH, defined and codified an appropriate organisational culture to positively impact the values and attitudes of staff in public healthcare facilities across South Africa. The resulting NDoH Patient-Centric Culture Code aligns all staff behaviours with those required to deliver an experience where colleagues and patients 'felt cared for'. The measurable behaviours (I connect, I analyse, I inform, I deliver and I learn), articulate NDoH's purpose to achieve its vision of 'a long and healthy life for all', and to improve access to and quality of healthcare delivery in a sustainable way. To date, this project has been implemented across three districts and over 30 public health facilities across South Africa. During its workshop slot, AHP seeks to a) onboard RuDASA conference attendees on the patient-centric culture code; and b) host a debrief session with participants to reflect on key learnings. Through this workshop, AHP aims to build participants' awareness of the Patient-Centric Culture required to deliver a positive customer experience.

Biosketch:

Stacey Ann Pillay has been at AHP for seven years, and has recently been appointed as the organisation's CEO. In 2015 Stacey was one of 25 participants from six African countries selected by the University of Cape Town's Graduate School of Development Policy and Practice for the 'Leading in Public Life' Programme.

Stacey has supported hundreds of doctors in their transition to serving in underserved areas in Africa, and manages relationships with a range of key stakeholders including existing and potential donors, government and healthcare regulators. Stacey has led diverse teams of people and continues to mobilise her team and others around AHP's mission.

## **The New National HRH Strategy – Setting Priorities for a Joint Submission**

Presentation Type: Workshop (60 minutes)

Authors: Marije Versteeg-Mojanaga, Russell Rensburg, Samantha Khan-Gillmore, & Govender

Content: Building on the Advocacy Legacy: how to look after ourselves and our patients?

The Department of Health is working on a new National Strategic Plan for HRH: 2019/20 to 2024/25, within the context of the 2030 SDGs, global developments in HRH, the National Development Plan and the National Health Insurance. Reducing inequities, prioritising the worst-off in achieving healthcare for all, and an emphasis on healthcare for disadvantaged rural communities is part and parcel of the language. As rural health partners we developed Chapter 8 on rural HRH of the previous chapter; what were the successes, what are the gaps, what needs continued advocacy, what is new, is there low-hanging fruit? We call upon all stakeholders including RuRESA, RuDASA, RuNURSA, PACASA, PHASA, Academic Rural Health/PHC Centres and the Student Clubs to be part of the process and make input. We need all hands-on-deck! This workshop will deal with 3 broad components: 1) Process of working together, 2) Content, 3) Advocacy strategies.

Biosketch:

Marije, Russell, Samantha and Karessa are members of the Rural Health Advocacy Project team. The Rural Health Advocacy Project is a leading health advocacy initiative, based in Johannesburg, advocating for equitable access to quality health care for rural communities in the whole of South Africa.

Informed by the voices of rural healthcare workers and communities on the ground, partner organisations, stakeholders and research, RHAP conducts advocacy, generates debate, monitors implementation of health policies in rural areas, supports pro-equity government interventions, and rural-proofs policies to ensure that they are in tune with rural realities. RHAP's vision is a health system where rural communities access equitable, quality health care services.

## **The Voice Project: Building healthcare worker competencies for safe, strategic, ethical advocacy and reporting on patient rights violations**

Presentation Type: Workshop (2 hours)

Authors: Samantha Khan-Gillmore, Marije Versteeg-Mojanaga, Mafoko Phomane, & Karessa Govender

Content: Building on the Advocacy Legacy: how to look after ourselves and our patients?

The Voice Project is an initiative of the Rural Health Advocacy Project. It aims to educate and inform HCWs from all levels of the public health system on how to identify, problem solve and report health system challenges in a manner that is ethical, strategic and within the applicable policy frameworks. The overall goal of The Voice Project is to increase the active engagement of HCWs in addressing health system challenges by taking strategic and effective steps that contribute to a strengthened, equitable health system for all South Africans.

A 2-3 hour workshop is presented using a manual titled "Voice: A Health Care Providers Guide to Reporting Health Care Challenges: Principles, Tools & Strategies" to facilitate the workshop. Prior to the workshop commencing a Pre-Workshop Survey is used to assess knowledge of participating healthcare workers, a post workshop survey is administered at the end of the workshop. The Voice Project trainings have reached a varied number of HCW categories within the public health system.

Brief overview of presentations in the session and likely outcomes

1. What is advocacy and the different roles of health care providers
2. The Constitutional mandate for healthcare worker advocacy
3. Using internal and external mechanisms to report health care issues, raising concerns in order to improve health standards
4. The Protected Disclosures Act; what am I protected against?

Workshop Outputs

- Knowledge of applicable laws and policies to support advocacy and reporting
- Knowledge of the four doors of a protected disclosure
- Knowledge of advocacy processes, strategies and principles
- Feel inspired by the work of other health advocates
- Feel more confident to advocate knowing your rights and duties
- Ask questions and be part of the discussion on the way forward for healthcare worker advocacy

Biosketch:

Samantha Khan-Gillmore is responsible for RHAP's knowledge management and communications work. Having managed The Voice Project for two years, she continues to lead on RHAP's Advocacy in the Curriculum work as well providing overall communications leadership and support to the organisation. Before joining RHAP she has managed education, workers' and human rights programmes for over a decade, in South Africa and across the African continent.

Samantha has previously worked for the Discipline of Occupational and Environmental Health (DOEH) at the University of KwaZulu-Natal (UKZN), Durban, as well for local and international labour movements. She holds a post-graduate (Honours) qualification in Politics and an undergraduate Law degree from the University of KwaZulu-Natal in Durban. She is currently studying towards a MMedSci looking at advocacy in the health sciences curriculum.

## **The Whole Person - How to Look After Ourselves and Our Patients**

Presentation Type: Workshop (60 minutes)

Authors: Dr Martin Bac

Content: Building on the Advocacy Legacy: how to look after ourselves and our patients?

In this workshop we will look at how we see and treat people. Are we mostly clinicians who treat complaints, try to make a clinical diagnosis and then treat the disease with the most up to date and evidence based medication?

In Family Medicine there has been a strong movement to look at the patient as a person and to practice in a patient centred way by using the 3-stage assessment and paying attention to individual and contextual factors that have an influence on the patient's management and well-being.

To which extent do health care workers include personal, contextual and cultural aspects in the care for their patients? Is there anything we can learn from each other? We will share examples of different approaches to patients with chronic and non-communicable diseases or cancer.

Is this whole person medicine or are there other aspects in a person's life that a health care professional should explore and assess the patient's needs? What is the role of the patient's world view and faith? Is that a factor to be reckoned with when you treat people?

We will explore the following questions and statements:

- Good clinical evidence based medicine is sub-standard medical care.
- Good health care should always respect the patient's wishes and culture.
- Traditional healers, faith healers and pastors should all be involved in patient care.
- If you omit spirituality in patient care you only treat 1/3 or at the most 2/3 of a person.
- Can spirituality and faith make a positive or negative contribution to clinical outcome?
- Has whole person medicine a place in rural health?

Biosketch:

I am born in the Netherlands in a rural village and studied medicine at the University of Rotterdam from 1969 to 1975. As preparation to work in a developing country I did one year surgery and six month obstetrics. In 1976 my wife Mies and I decided to go and work in Gelukspan hospital. This was at that time still a mission hospital but by the time we arrived at the hospital it was handed over to the homeland government.

When I started in the hospital I was the only full time doctor and I was overwhelmed by the amount of work in this hospital with over one thousand beds. I found more than 300 TB patients who stayed for 6 months in the hospital and who were referred from a very large area in the Western Transvaal and Northern Cape. These patients were mostly managed by the nurses with a visit once a month from a TB doctor from Johannesburg. Then there was an institution with disabled people and a general hospital. I had to learn a lot, both from nurses and the few doctors who did sessions in the hospital!

## **Using Health Workers for Change (HWFC): The Quality improvement methodology to build advocacy legacy**

Presentation Type: Workshop (60 minutes)

Author: Daphney Nozizwe Conco (PhD)

Content: Building on the Advocacy Legacy: how to look after ourselves and our patients?

The aim of this workshop is to introduce: "Health Workers for Change, A Manual to Improve Quality of Care" and to explore appropriate ways of applying the HWFC methodology in rural health settings.

### **Workshop Description:**

The workshop will entail facilitating a process that enables participants identify factors that pose as barriers in delivering quality care and will provide them with a platform in which they can brainstorm ways to remove barriers to providing quality care. It will also induce willingness among the participants to make changes within their control where possible. By going through some aspects of the HWFC methodology, the participants will gain an insight on what HWFC methodology can do.

The participants will also be engaged in discussions on how the HWFC methodology can be applied in the rural health settings. Dr Tore Godal from the World Health Organisation had this to say in 1995 "...the methodology is effective, it is realistic and practical to implement and has a positive impact on how health workers see their jobs and their interactions with clients, especially women." The HWFC methodology was developed in a rural setting with the staff of Agincourt Health Centre by Makhosazana Xaba and Sharon Fonn. It was tested in Uganda, Senegal, Zambia and Mozambique and published by WHO in 1995. A multi-centre study in Nigeria (2), Tanzania (2), Ghana (1), Kenya (1) and Argentina (1) was conducted to establish its impact and published in 2001 by Onyango-Ouma et al. Since then the HWFC methodology has been used widely in South Africa, in the African region and beyond and for different contexts.

### **Biosketch:**

Dr Daphney Nozizwe Conco, a Public Health Specialist, is currently occupying a Senior Lecturer at the Wits School of Public Health teaching on Qualitative Research Methods and Designing Public Health Programs. She has worked mostly in deep rural areas of KZN, for various institutions including the government, non-governmental organisations, United Nations, a trade union and academia. Daphney also serves as the Treasurer of the Public Health Association of South Africa (PHASA) and a board member of the Rural Health Advocacy Project (RHAP) and Sexual and Reproductive Justice Coalition in South Africa (SRJC-SA).

Her research interests cover a range of topics including: social determinants of health, eradication of extreme poverty and hunger, promoting gender equality and women's empowerment, advocating for sexual and reproductive health, rights and justice; prevention and reduction of health inequalities, health system strengthening and management, leadership in health policy, and improving quality at the primary health care level.

## Using the ICF framework to make collaborative patient care possible

Presentation Type: Workshop (60 minutes)

Author: Jana Muller

Content: Building a clinical care legacy: taking specialist care skills into rural

Primary health care in South Africa has been reported to consist of isolated, fragmented health care services and impersonal patient care leading to dissatisfaction and health care worker burnout (Saba et al., 2012). This is even more challenging to overcome in a country where the health care worker to patient ratio is exacerbated by urbanisation, distance and culture (Bhorat & Westhuizen, 2012). The World Health Organisation (WHO, 2010) defines collaborative health care as a system where multiple health care workers working together with the patient, families, carers and the community are united in providing comprehensive service of the highest quality across all settings. This sounds utopian – is it possible?

Inter-professional practice requires moving beyond a working culture that separate health workers, and has become an essential part of training health professionals to keep pace with the change in approach to health care delivery. However, working together across the boundaries of professions that define medical care can be challenging because of time, opportunity, power dynamics and difficulties with trust and respect, which have been shown to have a direct impact on patient experience (McDonald et al., 2012). Inter-professional training is encouraged by the WHO (2010) not only so that professionals learn about one another's roles, but more importantly so that improvements in health care delivery and quality can be achieved.

This workshop aims to introduce health care workers to a practical and simplified version of the WHO's International Classification for Function, Disability and Health (ICF) to foster multidisciplinary assessment and intervention. Challenging case studies collected from rural practitioners will be used to collaboratively identify health, environmental and personal barriers and facilitators in each case and learn how to tailor their inter professional approach accordingly.

### Biosketch:

Jana is an academic coordinator for collaborative distributed training for the Ukwanda Centre for Rural Health, Stellenbosch University. She runs a collaborative home visit project where inter-professional teams evaluate complex patient cases and do home visits to gather sufficient data to make appropriate referrals to optimise holistic patient care. She has experience of practically using the ICF in the clinical setting and has facilitated both students and clinicians adopt the ICF framework to improve patient outcomes.

## **We Cannot Achieve Health For All Without Investing In Rural Mental Health**

Presentation Type: Workshop (90 minutes)

Authors: Shannon Morgan & Gabrielle Smith

Content: Building a clinical care legacy: taking specialist care skills into rural

The South African Stress and Health (SASH) study found that only one in four South Africans living with mental disorders have access to treatment. The most deprived districts in the country are still all rural and largely mirror the former homelands under apartheid. These rural communities are prone to social and economic disadvantages, which are risk factors for depression (SAHR 2012/2013) and do not have equitable access to mental healthcare services. The combination of “high risk” and “low resourced” communities create enormous challenges for rural health professionals.

This workshop, presented by Rural Rehab South Africa (RuReSA) and the Rural Mental Health Campaign, aims to enable participants to raise challenges they may have in developing mental health services and gain insight into the current challenges facing mental health service users in rural areas. A problem solving approach using presentations, case studies and discussions will be used to equip participants with appropriate plans and practical skills to develop mental health care services in their area.

### **Biosketch:**

Shannon Morgan is an Occupational Therapist who has been working in a rural health for 9 years. She was the chairperson of the Rural Mental Health Campaign for 4 years and has a special interest in rural mental health and community based inclusive development (CBID). Shannon has been developing a CBID programme where she has been working with Community Disability Workers since 2014.

Gabrielle Smith is an Occupational Therapist who graduated from the University of the Witwatersrand in 2016. She did her community service year at Zithulele Hospital in the rural Eastern Cape in 2017 and was able to stay on as a permanent staff member from 2018. Gabrielle has been part of developing the mental healthcare services in the OT department at Zithulele and brings this practical experience and passion to this workshop.

## **Working Towards “Rehabilitation For All”: Where Are We Now?**

Presentation Type: Workshop (60 minutes)

Authors: Saul Cobbing

Content: Building Momentum: Taking the Rural Health Movement Forward

This is a follow-up workshop to the workshop held in Taung in 2017 titled: Working towards “rehabilitation for all”: how to maximise service delivery to rural communities. This interactive workshop will encourage members of disability groups, rehabilitation and health professionals, rural health and rehabilitation activists, NGO representatives, and policy and decision makers at national and provincial level to ensure that quality multi-faceted rehabilitation options are made available to all South Africans.

Evidence on this topic and feedback from discussions between the author and the stakeholders will be briefly presented to workshop participants. Thereafter participants will be requested to discuss ways in which a new cadre of general mid-level rehabilitation worker (GMRW) can be realised and the practicalities and information required to implement the training of this cadre. Evidence on the piloting of the Ward-based outreach teams will also be presented, with participants asked to discuss how best rehabilitation (either via the GMRW cadre or rehabilitation professionals) can be included in this initiative.

### **Biosketch:**

Dr Saul Cobbing is a qualified Physiotherapist and Biokineticist, and currently is a senior lecturer in the Discipline of Physiotherapy, School of Health Sciences, UKZN. His duties include teaching and supervising research for both undergraduate and postgraduate students. He graduated with a PhD in Physiotherapy in April 2017 and is currently a fellow on the College of Health Science's Developing Research, Innovation, Localisation and Leadership in South Africa (DRILL) Programme. He has been a key driver of his department's Decentralised Clinical Training programme, ensuring that undergraduate physiotherapy students live and receive training in rural communities. His post-doctoral research aims to develop and implement community interventions for the rehabilitation of people living with disabilities and chronic diseases, in resource-poor communities.