# RURAL HEALTH CONFERENCE

PACASA · RuDASA · RuNurSA · RuReSA

Emerald Vale Farm, Chintsa

14th - 16th September 2023

# Celebrating Rural Service

## *Abstract Booklet*

# Table of Contents


About the Conference 2
Conference Theme and Sub-themes 3
Greening the RHC 4
Sponsors 5
Welcome Note from the Organising Committee 6
Committees 7
The Conference Partners 8
  RuDASA 8
  PACASA 9
  RuReSA 10
  RuNurSA 11
The Key Note Speakers 12
Keynote Presentations 14
Plenaries 18
Oral Presentations 19
Posters 69
Workshops 82
Sponsors 99

# About the Conference

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

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

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

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

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

# Conference Theme and Sub-themes

## Celebrating Rural Service

It is time to showcase the amazing rural services we have developed. We want you to tell your story about what you are doing that is working. The idea is to share how rural health workers cope with rural challenges, how they adapt interventions and services, and the stories they tell to colleagues. If you have done research - Great! If you haven't done research we still want to hear what you are doing.

At this conference we will have a chance to share our accomplishments and be inspired by others.

## Sub-themes

### Building Rural Inter-professional Teams

- Developing undergraduate teamwork & multi disciplinary teams to achieve UHC
- Innovative ideas on "Who is the team?" and alternative human resources to achieve NHI & UHC
- Developing team leadership and team management within the NHI
- Trans-disciplinary teams for rural facilities
- Building an insightful workforce
- Mentoring, accountability and supervision of students and young professionals within the team
- Strengthening WBOT in rural areas
- Best Practice in Teamwork
- How the multidisciplinary team improves health outcomes

### Health Systems Management

- The gap between urban & rural: population health & disability demographics, rural social determinants of health, human resources, service delivery in rural areas
- Working in resource constrained environments yet still giving quality care
- Reforms to get better outcomes, and socially relevant and responsive services to achieve UHC
- Capacity building to develop good services & retain staff in rural areas
- Setting priorities to ensure access to care for those currently disadvantaged in health care
- Problems & solutions on issues such as access to service, budgets, human resources, quality facilities
- Litigation & costs related to poor service delivery and poor quality of service
- Holistic vs specialist care, best use of specialists and access to specialist care in rural areas
- Developing new Service Delivery Packages to ensure UHC
- Best practice in PHC
- Best practice global surgery

## Community engagement & end users voice

- Working with traditional  healers and leaders
- The voice of hospital & clinic boards
- The voice of patients  and their family parents
- How we can all be health advocates

## Policy & Practice

- What is Universal Health Coverage and how does NHI provide UHC?
- Sustainable Development Goals agenda 2030
- How to use the policy framework /operationalising policy to improve services in the district
- Innovative practice that makes health care equitable
- Good practice in adverse conditions
- Unpacking DoH policy and practice for private practitioners
- Health finance, health worker distribution and user access to health services
- NDoH prioritised Health Infrastructure projects
- Technology to resolve rural issues
- Social accountability:
- Climate Change
- What the News tells us about social determinants of health
- Role of the university:  training undergraduates to to be ready for NHI
- Inter-sectoral work

## Greening the RHC

Being green means using resources wisely and we urge you all to share accommodation and travel! Please do not book “accommodation units” just for yourself. Monitor the “Share the Drive” posts on the facebook page nearer to the  start of conference to look for lifts or offer space in your car.

## Sponsors


RURAL HEALTH CONFERENCE

# Welcome Note from the Organising Committee

Welcome to the Rural Health Conference, hosted for 2023 in the beautiful village of Chintsa, on the East Coast in the Eastern Cape. The RHC is organised by four organisations supporting rural health care workers in Southern Africa including RuDASA (Rural Doctors Association of Southern Africa), RuReSA (Rural Rehabilitation Association of South Africa), PACASA (Professional Association of Clinical Associates SA) and RuNurSA (Rural Nursing Association of SA). One of the best aspects of the rural health conference is the extraordinary clinicians, academics, advocates and organisations that it draws together each year, all united in their passion and dedication to rural health care delivery. It is our delegates that makes this conference, and we look forward to you presentations, interactions and conversations over these three days.

The theme for this year is Celebrating Rural Service and we wish to recognise the extraordinary service of our health care professionals to health care delivery in rural areas. We honour and celebrate our doctors, nurses, clinical associates, occupational therapists, physiotherapists, speech therapists & audiologists, dieticians, pharmacists, counsellors, community health care workers and more. One of the most important emotions that informs intrinsic motivation, is that of transcendental purpose. Doing a job that serves a higher purpose is a key aspect of loving one's profession, decreasing burn-out and giving a clinician an experience of having found their calling. When clinicians provide health care in rural or isolated areas, they transform people's lives every single day, but this is often forgotten. It is easy to become overburdened by the challenges and frustrations of the daily grind, and not see the enormous impact they are making on people's lives.

With Celebrating Rural Health we want to create an opportunity to remind health care clinicians of their enormous value to patients, to families, to communities and to the overall public health in rural areas. A good example is the one-year community service provided by clinicians. Often this is viewed as a year to 'survive', and many young health care professionals fear the time they will be forced to spend at a rural facility. What is not always recognised is that rural health care in South Africa is based on the foundation of a continuous flow of these community service clinicians and that this year of service is an invaluable gift to our communities. We appreciate and salute you!

We are honoured that our conference will be opened by Dr Rolene Wagner, the Head of Department of Health for the Eastern Cape, and that Dr Sibongiseni Dhlomo, the deputy minister of Health, will be one of our keynote speakers. Prof Khaya Mfenyana, a family physician and leader in health professions education, will be presenting a tribute to our rural health care workforce in celebrating rural health service. The RHC2023 program includes an exciting collection of oral presentations, posters and workshops that will encourage the sharing of best practices and building closer rural networks.
We hope you enjoy RHC2023 and will join us in celebrating the contribution of rural health care professionals to rural health care delivery in South Africa.
Dr Madeleine Muller
Project Lead RHC2023 Committee.

# Committees

## Organising Committee

Madeleine Muller Conference Chair
Asafika Mbangata RuDASA
Jenny Nash RuDASA
Nicholas Fine RuDASA
Nthabiseng Sibisi RuNurSA
Thabisa Ngcakaza RuNurSA
Tina De Freitas RuReSA
Helena Fine RuReSA
Nolubeko Xuma-Soyizwapi RuReSA
Cameron Reardon RuReSA
Nompumeleo Mahlambi PACASA

## Conference Office

Lou Billet (Administration)
Stephanie Homer (Web & Finance)
Abigail Dreyer RuDASA (Bank)
Erika Bostock RuReSA (Finance approval)

## Scientific Committee

### RUDASA

John-D Lotz
Graeme Hofmeyer
Ben Gaunt

### RuRESA

Kate Sherry
Thandi Conradie

### RuNurSA

Nthabiseng Sibisi
Thabisa Ngcakaza
Nomana Ntshakaza
Warren Hansen
Silingene Ngcobo

### PACASA

Nompumeleo Mahlambi
Thabang Sepiroa
Melissa Olifant
Sherilee Naidoo

# The Conference Partners

## RuDASA

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

## Our Vision

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

## Our Mission

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

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

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

Find out more and join us:
info@rudasa.org.za www.rudasa.org.za
www.facebook.com/ruraldoctors


# PACASA

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

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

## Our Vision

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

## Our Mission

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

PACASA is dedicated to

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

Find out more and join us: pacasamedia@gmail.com
pacasamembership@gmail.com

## RuReSA

118-079 NPO

Rural Rehab South Africa (RuReSA), is a multidisciplinary organisation of professionals committed to providing and improving rehabilitation services in rural communities. We are passionate about creating positive change through rehabilitation which will:

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

## Why Rural?

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

•Immense poverty

•Poor access to all health services

•Lack of resources for both the people with disabilities and the therapists

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

## Our Mission

•To ensure rehabilitation is integrated into health policy and planning at all levels

•To develop and share best practice models for high-quality, appropriate, accessible, acceptable, and effective rehabilitation services

•To disseminate information and research on: the health needs of rural people, rural rehabilitation, and health policies

•To provide support to recruit, retain and inspire rural therapists.

•To influence the actions of the service delivery community.

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

## Find out more and join us:

info@ruresa.org.za

www.ruresa.org.za

www.facebook.com/ruresa

RURAL HEALTH CONFERENCE

## RuNurSA

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

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

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

## Our Vision

A voice for rural nurses

## Our Mission

To advocate for rural nursing aligning with the current South African healthcare system.

## Our Objectives

1. Advocate for the needs of the rural communities and its nurses through influencing policy makers, the South African Nursing Council, the National Department of Health, and other Governmental Sectors.
2. Collaborate with civil society and relevant stakeholders for health equity and social justice.
3. Link rural nurses with resources to enhance advocacy in the health care delivery system.
4. Promote continued education, and mentorship for pre-service and in-service rural nurses.
5. Provide a platform for rural nurses to belong.

Find out more and join us: ruralnursingsa@gmail.com

https://www.facebook.com/RuralNursingSA/

## The Key Note Speakers

### RuNurSA Keynote: Judiac Ranepe

Biosketch: I am Comprehensive District Health Nurse trainer and an abortion provider in the Southern/Western substructure of the Department of Health in Cape Town South Africa.I have BTECH Degree in Primary Health care and practiced as a clinical nurse practitioner & assessing, examining, diagnosing, treating, and referring patients with acute and chronic diseases. Obtained a Master degree in Nursing specializing in Nursing Education from the University of the Western Cape 2020. I am master trainer for Comprehensive &Abortion Care with the Leading Safe Choice program of the Royal College of Obstetrics & Gynaecology (London). I am Comprehensive District Health trainer specializing in maternal & child health care. I am a Global Atlantic Fellow for Health Equity based at & Tekano South Africa and my work in the fellowship is focused on access to healthcare for vulnerable rural communities, working with them by facilitating conversation, education around healthcare & amplifying their voices towards receiving accessible, acceptable, affordable, effective, reliable, and equitable health care services. My work on healthcare access is in Mnceba clinic in Ntabankulu, EC.

### RuReSA Keynote: Gift Tshaka


**Biosketch:**

Gift Tshaka is from a small town called Nqamakwe in Kotana administrative area. He matriculated from St johns in 1993 where he was active in sport and choral music. He did his junior degree in Bsc Occupational Therapy with the University of the Western Cape and graduated in 1996. He furthered his studies in 2001 with the same university doing Masters in Public Health which he obtained in 2004 at the same time with his Diploma in labour Law and the latter was obtained from Institute of Global Business Solution in EL. In 2021 he enrolled with the National school of Government and obtained the following certificates; Nyukela Public Service SMS pre- entry programme, Project Khaedu: Field Assignment and in Methods and Perspectives.

## RuDASA keynote: Jenny Nash

### Biosketch:

Dr Jenny Nash is a Specialist Family physician with a Diploma in HIV management, who is working in the Amathole District Clinical Specialist Team (DCST). She worked at Mseleni hospital in rural northern KwaZulu Natal for 10 years, before moving to the Eastern Cape in 2008. She is passionate about providing integrated, quality health care to rural communities, mentoring and teaching health care workers. She has also been involved with analysing access rural communities have to surgical services, the skills needed for the “hub and spoke” district model to be effective, and how to address the gaps in clinical skills. In 2014 she was awarded the RuDASA Rural doctor of the year award, and in 2015 the SAMA Border Local hero award. In 2022 she was presented with a Certificate of Achievement by the District Manager for diligence in her work, and in 2023 received an award at the Provincial Batho Pele Awards for “Innovations: Rural health project.

## PACASA Keynote: Nomsa Ndaba

### Biosketch:

Nomsa Sheron Ndaba is a clinical associate from a small town called Bethal. She is working at Wits-Vida Research Unit in Johannesburg.

# Keynote Presentations

| | |
|---|---|
| **Title** | Access to healthcare for vulnerable communities |
| **Presenter** | Judiac Ranape |
| **Institution** | Mnceba clinic in Ntabankulu, EC |
| **Abstract** | The health status and outcomes of people who live in rural areas throughout the world, is generally worse than those living in urban areas. In South Africa, rural communities experience higher burdens of health conditions that are based on preventable social determinants such as unemployment, low educational status, race/ethnicity, health literacy and general apathy. This reality is more pronounced in the Eastern Cape, more specifically in Ntabankulu. Ntabankulu has the poorest human development index (HDI) score and the worst health indicators in South Africa. As a Global Atlantic Fellow at Tekano for Health Equity, I have had the task of implementing a Social Change Initiative (SCI) which required a team of health advocates to assess gaps in health services. I will detail, in my talk, the process we embarked on to solicit views, perceptions and more importantly rural health needs and service delivery gaps in 11 villages that make up the Ntabankulu municipality. In our intervention, I came to learn and to conclude that the district and local Departments of Health (DoH) run a top-down administration wherein health developmental objectives and service delivery goals are set solely by officials who are not in touch with the rural community's health needs.<br>Therefore, I want assert that in our findings, the two biggest social determinants of poor health outcomes in Ntabankulu are :1) rural community health illiteracy coupled with apathy and, 2) the Ntabankulu DoH's deliberate misapplication of the constitutional obligation to inform, consult, collaborate, involve rural communities in their health service. Barriers to health care access for rural communities is preventable when the legal and social principles of the constitution and Batho Pele are taught to rural residents. I will outline my proposed solutions to rural community engagements in shaping their own health outcomes. |
| **CPD Point** | Applied for ethics |
| **Biosketch** | I am Comprehensive District Health Nurse trainer and an abortion provider in the Southern/Western substructure of the Department of Health in Cape Town South Africa. I have BTECH Degree in Primary Health care and a Master degree in Nursing specialising in Nursing Education from the University of the Western Cape 2020. I am master trainer for Comprehensive Abortion Care with the Leading Safe Choice program of the Royal College of Obstetrics & Gynaecology (London). I am Comprehensive District Health trainer specializing in maternal & child health care. I am a Global Atlantic Fellow for Health Equity based at Tekano South Africa and my work in the fellowship is focused on access to healthcare for vulnerable rural communities, working with them by facilitating conversation, education around healthcare & amplifying their voices towards receiving accessible, acceptable, affordable, effective, reliable, and equitable health care services. |
| **Email** | Judiac.Ranape@atlanticfellows .org |

| | |
|---|---|
| **Title** | Is there hope for healthcare in the current economic climate? |
| **Presenter** | Jenny Nash |
| **Institution** | Amathole District Clinical Specialist Team (DCST) |
| **Abstract** | South Africa contributes approximately 8,6% of GDP towards healthcare. However, health outcomes are not in line with this investment. National treasury has indicated that, in order to pay for the unbudgeted salary increase paid to public servants, there is likely to be a health budget cut to provinces in this financial year of at least R25 billion. This is likely to seriously affect provinces, who are already facing high accruals from the previous financial year.<br>Given this rather gloomy background, is there hope for healthcare going forward? The plenary will discuss this situation, and some ideas of what can practically be done, by the clinician on the ground, right through to managers working at provincial level. There will be a reflection on how the ART program began in South Africa, and what factors contributed to the successful ART program. There will be debate about the role of advocacy in our current healthcare system. |
| **CPD Point** | |
| **Biosketch** | Dr Jenny Nash is a Specialist Family physician with a Diploma in HIV management, who is working in the Amathole District Clinical Specialist Team (DCST). She worked at Mseleni hospital in rural northern KwaZulu Natal for 10 years, before moving to the Eastern Cape in 2008. She is passionate about providing integrated, quality health care to rural communities, mentoring and teaching health care workers. She has also been involved with analysing access rural communities have to surgical services, the skills needed for the “hub and spoke” district model to be effective, and how to address the gaps in clinical skills. In 2014 she was awarded the RuDASA Rural doctor of the year award, and in 2015 the SAMA Border Local hero award. In 2022 she was presented with a Certificate of Achievement by the District Manager for diligence in her work, and in 2023 received an award at the Provincial Batho Pele Awards for “Innovations: Rural health projects”. |
| **Email** | stevejennash0@gmail.com |

| | |
|---|---|
| **Title** | Role of NMAH CP centre of excellence in the public health care: defence and lessons learnt. |
| **Presenter** | Gift Tshaka |
| **Institution** | |
| **Abstract** | The Eastern Cape Department of Health is amongst the provinces with the highest medico legal cases. As one of the strategies to mitigate, the national department of health gazetted hospital to have Cerebral Palsy centres of excellence of which Nelson Mandela Academic Hospital (NMAH) is one of them. NMAH hospital is a tertiary was gazetted as a Central hospital in 2012 to prove super specialist services among other services. It is located in the King Sabata Dalindyebo sub-district in the OR Tambo region which is deep rural in nature.<br>However, due to lack of spaces at NMAH main campus, two old and unused buildings were identified for renovations at the old sir Henry Elliot site outside of the main hospital site. That is where a comprehensive, effective and integrated CP service will be rendered to CP patients and medico-legal cases post renovations.This presentation tracks how the centre of excellence for cerebral palsy was conceived through a employee engagement , a SWOT analysis, a benchmarking exercise, development of management and communication systems. It highlights the problems, intervention recommendations for a centre of excellence and the progress made in developing the centre and the progress to date |
| **CPD Point** | Applied for ethics |
| **Biosketch** | He hails from a small town called Nqamakwe in Kotana administrative area. He matriculated at St John's college in Mthatha in 1993. He was active in sport and choral music. He did his junior degree in Bsc Occupational Therapy with the University of the Western Cape and graduated in 1996. In 2001 he furthered his studies with the same university doing Masters in Public Health which he obtained in 2004 at the same time with his Diploma in labour Law and the latter was obtained from Institute of Global Business Solution in EL. In 2009 he obtained a Post graduate diploma in district health management and leadership with the University of Fort Hare. In 2021 he enrolled with the National school of Government and obtained the following certificates; Nyukela Public Service SMS pre- entry programme, Project Khaedu: Field Assignment and in Methods and Perspectives.<br>He worked at Fort England Psychiatric hospital, Mthatha hospital complex as Manager Occupational Therapy, as CEO at Port Alfred Public Private Partnership then appointed as Clinical Support manager. In 2016 was offered a CEO post at Port Shepstone regional hospital but was later retained by ECDOH. |
| **Email** | gift.tshaka@gmail.com |

| | |
|---|---|
| **Title** | |
| **Presenter** | Nomsa Ndaba |
| **Institution** | Wits-Vida Research Unit |
| **Abstract** | |
| **CPD Point** | Standard |
| **Biosketch** | Nomsa Sheron Ndaba is Clinical Associate from a small town in Mpumalanga called Bethal. She is working at Wits-Vida Research Unit in Johannesburg. She graduated with a Bachelor's in Clinical Medical Practice from the University of Pretoria in 2015. She later did a postgraduate diploma in HIV Management at Stellenbosch University in 2018 and at just 28 years old, she holds an MPhil degree from Stellenbosch University and is well on her way for a PhD. As a Clinician, Nomsa has always been passionate about working in the rural areas to help people who can't afford Healthcare. That passion was soon followed by her move to the Northern Cape (Rural Kuruman) in 2019, after working at Evander District Hospital in Mpumalanga for 4 years. Working as a Unit Manager and Clinician in Kuruman was the fulfillment of her dream and yet it wasn't all, as Nomsa had big dreams of being in academics, that passion landed her in Johannesburg, at one of the leading Research Units in Africa ; Wits-Vida where she serves as a Clinical Associate and helps out with study coordinating. Nomsa is a people's person who loves public speaking.A famous line Nomsa is known for is "Dear Black Child, God can achieve your dreams." |
| **Email** | Sheronnomsa@gmail.com |

# Plenaries

| | |
|---|---|
| **Title** | Analysis of the conference and identification of rural health advocacy issues for the future |
| **Presenter** | Madeleine Muller |
| **Co-Presenters** | |
| **Institution** | Walter Sisulu University |
| **Abstract** | This session will highlight the key presentations that have identified either new clinical interventions that will improve health services, or systems that can be applied nationally rather than locally. Service gaps will be identified for future rural health advocacy by each of the Rural Health Conference partners. Delegates will be asked to commit to creating changes at the local level based on their learning from the conference presentations |
| **CPD Point** | Standard |
| **Biosketch** | Dr Madeleine Muller is the conference chair and a Family Physician and Senior lecturer at Walter Sisulu University department of Family Medicine & Rural Health, providing clinical services and teaching at Cecilia Makiwane hospital in Mdantsane, East London. She serves on the RuDASA exec committee, overseeing the Rural Mentoring portfolio, and has been the East London coordinator for the Southern African HIV Clinician Society since 2013.She completed her MBCHB (UP) in 1995, her MRCGP(Lon) in 2003 and in 2016 her DIPHIVMAN and the Advanced Health Management Program through FPD / Yale (cum laude). Since 2019 she has been the convenor for the CMSA Diploma in HIV Management and is extensively involved in the development of curriculum, training and continuing professional development for rural doctors and more recently, DIPHIVMAN candidates. She is on the executive board of SASHA (Southern Africa Sexual Health Association) and PATHSA (Professional Association for Transgender health SA) and is currently enrolled for her MPhil in HPE at Stellenbosch University. |
| **Email** | drmullerbz@gmail.com |

# Oral Presentations

| | |
|---|---|
| **Title** | A survey-based impact assessment of a workshop for novice rural anaesthesia providers: The Anaesthesia Launchpad story |
| **Presenter** | Rowan Duys |
| **Co-Presenters** | Simon le Roux, David Bishop |
| **Institution** | |
| **Abstract** | The need to improve surgical services in rural district hospitals is urgent because of preventable deaths. Lack of anaesthesia skill is a particular barrier. We need a scalable tool that enables rural clinicians to develop safe anaesthesia systems in home hospitals.<br>The Anaesthesia Launchpad was developed as the first step in this process aiming to close the skills gap, enable local problem solvers as change agents, and create a community of practice of rural generalists and urban specialists. The curriculum targeted the most important clinical situations and was deliberately empowering. We report our experience of developing the curriculum, delivering the first three two-day Anaesthesia Launchpad workshops and their impact on attendees and faculty.<br>Methods: We co-designed our workshop with local stakeholder input. Two attendees, a senior and junior staff member, were invited from selected DH's. Faculty were invited from tertiary institutions, secondary hospitals, and family medicine programmes. Three workshops (Bisho, Mthatha, and Gqeberha) were held over a 9 month period in 2022 and 2023. A digital survey tool is being developed to explore:<br>• Demographics of participants<br>• Prior exposure to anaesthesia and current practice<br>• Experience of the workshop including areas for improvement<br>• Immediate impact of the workshop<br>• Any changes in behaviour and clinical service<br>Results: We report the results of the survey describing the anaesthesia practice of attendees prior to the workshop and resultant changes. Further we report their experience of the workshop itself, what worked well, what participants would change, and what post-workshop support is required to sustain practice change.<br>Conclusions:The Anaesthesia Launchpad represents a first important step towards improving the quality of anaesthesia care in rural DH's. Through rigorous evaluation of the development, delivery and impact of these workshops, we will inform future iterations and plans to scale-up the programme to a wider audience. |
| **CPD Point** | Standard |
| **Biosketch** | Rowan Duys is a specialist anaesthetist at UCT's Department of Anaesthesia and Perioperative Medicine, and the Director of Implementation in the Division of Global Surgery. His mission is to unleash small teams of frontline healthcare change agents to improve the quality and quantity of surgical care they deliver. He tweets at @healthink and would like to be remembered as the husband behind his wonderful wife, the father of three girls, and someone who ran enthusiastically, but slowly, up mountains. |
| **Emai** | rowanduys@gmail.com |

| | |
|---|---|
| **Title** | Analysis of pertussis cases Buffalo City Metro Health District Facilities, Eastern Cape, October 2022 – March 2023 |
| **Presenter** | Ntombizonke Cecilia Mashicila-Sukwana |
| **Co-Presenters** | B. Maseti, K.B. Sisu |
| **Institution** | Buffalo City Metro Health District |

**Abstract**


Analysis of pertussis cases Buffalo City Metro Health District Facilities, Eastern Cape, October 2022 – March 2023

Introduction: Pertussis is a highly contagious disease caused by Bordetella pertussis. An increase in pertussis cases has been reported in South Africa (SA)among children <5 years of age, and particularly amongst infants <3 months of age. In South Africa, pertussis is a notifiable medical condition and it is vaccine preventable. We aimed to describe the demographic characteristics of pertussis cases in Buffalo City Metro (BCM) Health District, and to assess the notification period of the cases by healthcare facility.
Method: Descriptive analysis of pertussis cases in BCM Health District from October 2022–March 2023 was conducted. Data sources used was a dataset extracted from a notifiable medical conditions (NMCs) surveillance system, and review of medical records.

Results: Twenty-eight pertussis cases were reported in BCM Health District during the reporting period. Majority of cases were females (61%), and 71% were 0–10 months old. The regulations relating to the surveillance and the control of NMCs recommend immediate reporting followed by notification (within 24 hours) of category 1 conditions upon diagnosis. Notification period assessment showed poor notification as over 90% of cases were notified after 24 hours. Information on actions taken and contact tracing was limited.

Conclusion: Late reporting and notification of cases could lead to poor management of cases, and missed cases due to lack of contact tracing. To improve quality surveillance data, regular training on disease notification, and data management is recommended.


| | |
|---|---|
| **CPD Point** | Standard |
| **Biosketch** | Bachelor of Science in Health Promotion. Health Promotion Practitioner |


| | |
|---|---|
| **Email** | likuye4@gmail.com |

| | |
|---|---|
| **Title** | Assessing patients' experiences of care in four referral hospitals: A cross-sectional survey of outpatients in tow South African rural provinces |
| **Presenter** | Onke R. Mnyaka |
| **Institution** | Wits University |
| **Abstract** | Background: Patients' experience of care surveys are an important component of performance improvement and clinical effectiveness because they serve as a good proxy for patient's satisfaction and the quality of care. The purpose of this study was to assess PEC in four referral hospitals in two of South Africa's rural provinces.<br>Methods: A cross-sectional study was conducted in four public hospitals in Eastern Cape. Systematic random sampling was used to select 662 outpatients. Results: Females accounted for 71.6% (474/662) of participants; the median age was 47 years and 20.2% (133/657) required assistance with a disability. More than 78.5% (518/662) of the patients had received health services from the same facility within the immediate 12-months of the survey. Only 19.0% (31/659) of patients had been turned away from hospital previously; one hospital was reported to not have drinking water; the other was reported to not be clean (68.5%, 111/162); more than two-thirds of Mpumalanga province respondents (223/329, 67.8%) reported absence of drinking water (p-value<0.0001); At least 70% of respondents in each of the hospitals found the health professionals to be respectful towards patients (p-value<0.0001). In all hospitals, at least half of the respondents did not know the processes to be followed when lodging a complaint (p-value=0.002). Waiting times were not acceptable as reported by 72.4% (118/163) and 67.1% (112/167) of Themba and Rob Ferreira hospital respondents respectively (p-value<0.0001).<br>Conclusion: Whilst hospitals have made some positive efforts in trying to improve patients' experience of care, there are a few concerns such as non-availability of drinking water, lack of knowledge of complaints processes and acceptable waiting times. |
| **CPD Point** | Standard |
| **Biosketch** | Mr Mnyaka is a researcher based at the Health Systems Enablement and Innovation Unit (HSEI), University of the Witwatersrand. He holds a Master of Public Health; Bachelor of Commerce Honours (Economics) and Bachelor Commerce (Economics). He is currently enrolled for Master Commerce (Economics). He has gained research experience n in various research projects : Universal Coverage in Tanzania and South Africa (UNITAS) study a collaboration study between University of Cape Town, Walter Sisulu University, University of the Witwatersrand, and University of KwaZulu Natal; An Assessment of Private General Practitioners Contracting for Public Health Services Delivery in OR Tambo District, South Africa. He has a sound understanding of the South African public health system worked closely with rural hospitals and primary care. Mr Mnyaka was part of a team that recieved, a research Grant funding from Bristol Myers Squibb Foundation for a Cancer Health Economics and Evaluation research project in Africa. In his young research career, he has published research articles as the first author and co-author. And he is currently involved in various research projects within the HSEI unit.<br>Mr Mnyaka's area(s) of interest are Health policy, Health Economics, and the use of Discrete Choice Experiments to influence policy |
| **Email** | onkemnyaka@gmail.com |

| | |
|---|---|
| **Title** | Burden of Care of family caregivers of people diagnosed with serious mental disorders in Rural Health District in Kwa-Zulu Natal |
| **Presenter** | Jabulile Ndlovu |
| **Co-Presenters** | Prof Kebogile Mokwena |
| **Institution** | Manguzi Hospital (Disability & Rehabilitation Department) |
| **Abstract** | It is estimated that 6% of the world population has serious mental illness, with an estimated one in four families having a member with a psychiatric disorder (WHO, 2010), who are mostly cared for, by their relatives within their family setting . Care giving, especially at home level, is made worse by the fact that severe mental illness which includes disorders such as Schizophrenia, Bipolar Mood Disorders and Major Depressive Disorders is associated with significant impairment but the severity of the impairment and the associated psycho-social disabilities differ significantly with each disorder. The stress of care giving for family members with such disorders, especially due to scarce resources and poor support, has been labeled as care giver burden in literature and includes the individual caregiver's negative appraisal of circumstances, such as feelings of loss, guilt, shame and anger, as well as the observable effects of the care-giving process on the family; such as disrupted family routines, constraints on family's social, leisure activities and financial costs. Such burden expresses itself in disease–related factors, socio-economic factors, socio-demographic factors, psycho-social factors as well as cultural factors. To quantify the burden of care among family members who provide care for their relatives with chronic mental disorders, as well as to explore possible association between the caregiver burden and their contextual factors (including those of their MHCU relatives). Quantitative design using the care giver as well as mental health care user socio-demographic questionnaires, followed by the application of the Zarit Burden Interview Scale (ZBI scale), which evaluated the caregiver-patient relationship, the condition of the caregiver's health, psychological well being, finances and social life. A maximum of 357 participants were interviewed. The variables that were found to be contributing significantly to the burden of care as perceived by the caregiver relative were: Disease-related (Caregiver Self-reported Depression, MHCU Diagnosis, MHCU Recent Relapses), Socio-economic Related (Caregiver Family monthly income, MHCU Disability Grant status, MHCU Employment status) and Socio-demographic Related (MHCU Gender, MHCU Level of education).The continuity of care by mental health care user relatives in the midst of scarce resources brings about an increase in caregiver burden and therefore requires appropriate interventions and support at service delivery outlets so as to improve the quality of life at a homestead where a MHCU is taken care of.<br>Keywords: Home care giving, Care giver burden, Severe mental illness, Scarce resources, Disease–related factors, Clinical factors, Socio-demographic factors. |
| **CPD Point** | Applied for ethics |
| **Biosketch** | PhD-Public Health student : Sefako Makgatho Health Sciences University |
| **Email** | jabulilendlovu5@gmail.com |

| | |
|---|---|
| **Title** | Caregiver burden within mental health: The voice of informal carers from Bushbuckridge |
| **Presenter** | Fasloen Adams |
| **Co-Presenters** | Olindah Silaule |
| **Institution** | University of Stellenbosch, Division of Occupational Therapy |
| **Abstract** | Informal caregivers play an essential role in the care of persons with severe mental disorders (SMDs), especially in low- and middle-income countries with its limited access to mental health services. However, the voices of the informal caregivers are not always considered in the development and implementation of community mental health resources. Although previous studies have reported on the overall experience of informal caregivers, few studies report on the impact their role of caring have on the caregiving health or their coping strategies. This presentation will report on the finding of a study that investigated the health effects and coping strategies used by the informal caregivers of persons with SMDs within the Bushbuckridge municipality, Mpumalanga. This study used a qualitative, descriptive research approach and data was collected through semi-structured interviews with 12 purposively selected informal caregivers. Interviews were conducted in Xitsonga as it was the home language of the informal caregivers. Reflexive, inductive, thematic analysis was used to analyse transcribed data. The study found that informal caregivers lived in a constant state of vigilance and fear and experience feelings of hopelessness and helplessness. These feelings had a negative affect on their mental and physical health with caregivers reporting an increase in insomnia and forgetfulness. They also reported that the stress they experience is the reasons for health conditions like hypertension, body aches and weight loss. They used internal and external resources to cope with their roles, with many emphasizing the use of emotion-focused coping strategies. Coping strategies used include, prayer, support from health professionals and religious organisations and supports from other carers. The findings voice the struggles of the informal carers and insight on the impact of caring on their health and wellbeing. Information could be used for stakeholders to work together to find sustainable programmes to support the informal carers. |
| **CPD Point** | Standard |
| **Biosketch** | Dr Fasloen Adams currently a senior lecture in the Division of Occupational Therapy at Stellenbosch University. She has been in academia since 2001. Her clinical experience is predominantly in mental health both in South Africa as well as the USA. She obtained her PhD in 2016. Dr Adams's teaching focuses on occupational science, community rehabilitation and mental health applied to occupational therapy. Research interests include occupational justice, collective engagement, occupational science applied to the African context, disability studies and local relevance in terms of occupational therapy education. She has been involved in various international and local research collaborations including a SASUF (South Africa-Sweden University Forum) project that looked at community mobility of older adults.<br>She supervises various PhD projects with a focus on mental and community health and service delivery. |
| **Email** | fasloen@sun.ac.za |

| | |
|---|---|
| **Title** | Celebrating rural hospital involvement in school students development. looking back, seeing growth |
| **Presenter** | Victor Fredlund |
| **Co-Presenters** | Dr Jenny Nash |
| **Institution** | Mseleni |
| **Abstract** | Rural hospital doctors engaging with school students has brought hope and opportunity to a community suffering from both a lack of professionals seeing them and opportunities for the youth to develop.A number of stories identify hurdles overcome and profound achievements beyond normal clinical duties of a medical officer. |
| **CPD Point** | Standard |
| **Biosketch** | Dr Fredlund worked as rural generalist in Mseleni Hospital from 1981 to 2021. now working in Ngithume Nkosi project encouraging young professionals to use their skills in christian service and mission. |
| **Email** | victor.mseleni@outlook.com |

| | |
|---|---|
| **Title** | Celebrating the impact a hospital can have for health through non- medical interventions. |
| **Presenter** | Victor Fredlund |
| **Co-Presenters** | Mr Steve Nash |
| **Institution** | Mseleni |
| **Abstract** | This story celebrates how a rural hospital could provide a platform for the development of water and sanitation services in a very resource poor environment. |
| **CPD Point** | Standard |
| **Biosketch** | Dr Fredlund was a rural district generalist at Mseleni from 1981 to 2021. now working on Ngithume Nkosi project seeking to help young professionals to use their skills in Christian service and mission. |
| **Email** | victor.mseleni@outlook.com |

| | |
|---|---|
| **Title** | Celebrating the power of rural health service to influence health policy - seen in the ART rollout |
| **Presenter** | Victor Fredlund |
| **Institution** | Mseleni |
| **Abstract** | As advocates for rural communities, rural health establishments have often challenged the status quo of health delivery systems. in the roll out for ART Mseleni extended roles of clinics, counsellors and clinicians to deliver an efficient and effective start up which further informed the development of the province wide NIMART programme. |
| **CPD Point** | Standard |
| **Biosketch** | Dr Fredlund was a rural district generalist at Mseleni from 1981 to 2021. Now working on Ngithume Nkosi project seeking to help young professionals to use their skills in Christian service and mission. |
| **Email** | victor.mseleni@outlook.com |

| | |
|---|---|
| **Title** | Comparative study between ante-mortem clinical diagnosis and final autopsy diagnosis in an Academic Hospital in Ga-Rankuwa, South Africa. |
| **Presenter** | Moshawa Khaba |
| **Institution** | Sefako Makgatho Health Sciences University, Dr George Mukhari Tertiary Laboratory/ NHLS, Ga-Rankuwa |
| **Abstract** | There seems to be a global reduction in the numbers of clinical postmortems requested and performed worldwide, which suggests the decreasing need or decreasing relevance for postmortem examinations. Postmortem examination of patients who died from unknown natural causes serves to identify the cause of death and the mechanism of the disease process. The aim of this retrospective study was to explore the accuracy of similarities and differences between ante-mortem clinical diagnosis and autopsy diagnosis referred to our department between 2013 and 2018. The study involved assessment of all autopsy performed at our centre between 01 January 2013 and 31 December 2015. Clinicopathological data was retrieved using the NHLS's laboratory information system (TrackCare). Gross and microscopic features were reassessed to reach a definitive diagnosis. The discrepancies between ante- mortem and postmortem diagnosis were evaluated using the Goldman classification. A total of 276 postmortem results were retrieved during the study period and only 176 met the inclusion criteria. A total of 111 cases (60%) showed correlation between ante-mortem and autopsy diagnosis. However, 46 cases (25,9%) showed major discrepancies which could have been prevented if the correct diagnosis and interventions were implemented timeously. The most common missed diagnosis in adults was infectious causes while in the paediatric population was congenital anomalies, especially congenital heart diseases.<br>Conclusions: Thus even with marked improvements in diagnostic technology, postmortem examination is a necessary quality control tool that can be used to verify cause of death and thus improve clinical practice. |
| **CPD Point** | Standard |
| **Biosketch** | Dr Moshawa Calvin Khaba was born in Kokomeng Village, Taung in the North-West Province. He did his undergraduate degree in Cuba and graduated in 2008. He joined the registrar programme between 2012 and 2016 to train as an anatomical pathologist at the Inkosi Albert Luthuli Central Hospital through the National Health Laboratory Service and University of KwaZulu Natal. He obtained the fellowship in Anatomical Pathology (FC Path (SA) Anat) through the College of Medicine of South Africa (CMSA) and Masters of Medicine (MMed) in anatomical Pathology through the University of KwaZulul Natal in 2016 and 2017 respectively. His passion for rural health has influenced his interest in infectious diseases, autopsy pathology and placenta pathology, which will enable him to participate in the creation of primary health care policies. He is studying Postgraduate Diploma in Forensic Medicine and Postgraduate Diploma in HIV/AIDS Management, respectively. He currently employed as a principal pathologist and acting head of department at NHLS's Dr George Mukhari Tertiary Laboratory and lecturer at Sefako Makgatho Health Sciences University (SMU) where he teaches both undergraduate and postgraduate students in Anatomical Pathology. |
| **Email** | ckhaba@yahoo.co.uk |

| | |
|---|---|
| **Title** | Developing services for patients with severe non-communicable disease in rural district hospitals - the PEN-Plus experience |
| **Presenter** | Colin Pfaff |
| **Institution** | Centre Integration Science |
| **Abstract** | Non-communicable diseases (NCDs) are increasingly becoming the main cause of mortality in sub-Saharan Africa, yet development of clinical services for NCDs has often lagged behind those for other conditions. Patients with more serious or complicated NCDs frequently require services that are only available at larger hospitals in urban centres. PEN-Plus is a model that seeks to establish services for patients with severe NCDs at rural district hospitals in low income countries. Conditions addressed by PEN-Plus providers include relatively complex, less-common diseases such as type 1 diabetes, rheumatic and congenital heart disease and sickle cell disease for which treatment had not previously been available. These services are provided by mid-level health workers, including nurses and clinical officers who are trained and mentored to provide integrated chronic care. Services provided include point-of-care echocardiography, use of home glucometers, and point of care laboratory. This model was developed in Rwanda, where it has been scaled nationally to all district hospitals. Malawi and Liberia are also in the process of scaling up nationally, whilst eight other African countries have started PEN-Plus services at pilot district hospitals. To date, across 10 countries, there are 6111 patients receiving care for these conditions. Lessons learned include the importance of clinical mentoring, the challenge of retention of staff and drug supply chain, the process of developing monitoring and evaluation systems including electronic medical records, the provision of financial support for transport and social needs and the balance of providing care for patients with severe disease, when primary health care services are still lacking.<br>Conclusion<br>In many African counties PEN-Plus is the first model of care for severe NCDs at rural district hospitals. It is hoped that ongoing national scale up will help reverse the inequitable distribution of services that have historically been concentrated in urban centres. |
| **CPD Point** | Standard |
| **Biosketch** | Colin Pfaff is a family medicine and public health doctor and has worked in district level health services in South Africa, Nepal and Malawi. He is currently the Senior Southern Africa Regional Advisor for the PEN-Plus Partnership, and supports PEN-Plus sites at rural hospitals in Zambia, Zimbabwe, Mozambique and Tanzania. |
| **Email** | colinpfaff5@gmail.com |

| | |
|---|---|
| **Title** | Electrophysiology, a gateway to AI utilization in Rheumatology for rural health advancement. |
| **Presenter** | Sipho Ntshalintshali |
| **Institution** | Grey's Hospital, Stellenbosch University, University of KwaZulu Natal |
| **Abstract** | The involvement of internal medicine subspecialty services in rural health remains limited albeit evident worldwide advances in telecommunication services such as telemedicine and the usage medical cellphone applications (APPs) in the field of Medicine. This is mainly driven by the scarcity of trained personnel in these subspecialties. Rheumatology is one of the very scarce services both in the private and public sectors in South Africa.<br>Electrophysiology (EP) has been rarely utilized in most subdisciplines of internal medicine other than cardiology and neurology in the diagnosis and treatment of diseases. The understanding of cellular electric current generation and transmission in other tissues can aid the utilization of the same in other subdisciplines of medicine such as rheumatology. EP studies such as bedside ECG have led to advances in AI detection and prediction of catastrophic cardiac events, and has also been used to curb the shortage of specialized personnel in poorly resourced setting. We reviewed literature for evidence of EP utilization in rheumatology on PubMed using multiple keywords and no studies of this nature were found. We furthermore reviewed literature to understand the basics of human electrophysiology with an aim to later conduct pilot studies looking into the utilization of EP in rheumatology and its integration with AI algorithms and machine learning. A tool that could render rheumatology services remotely even in a rural setting.<br>The utilization of AI in Rheumatology and Medicine at large could address current challenges on equity and service delivery in the rural setting in South Africa and worldwide. |
| **CPD Point** | Standard |
| **Biosketch** | Dr SD Ntshalintshali hails from Newcastle, a small town in the northern parts of KwaZulu Natal where he completed his basic education. He studied Medicine in Cuba, and completed his MBChB at UKZN in 2008. He later trained in Internal Medicine at UKZN from 2012 to 2016. His passion for rural health led him to serve as a Clinical Manager and acting HOD of the Internal Medicine department at Ngwelezana Hospital, and later served as CEO and Medical Manager of Dannhauser and Turton CHCs where he became a recipient of the KZN Health MASEA award as a specialist physician in the rural setting in 2018. Upon recognising the scarcity and the need for clinical immunologists in the country when he conducted a study on hereditary angioedema in KZN, he spent 5 months at the Allergy and Clinical Immunology Unit under Professor J Peter at Groote Schuur Hospital where he was involved in clinical and laboratory research. In 2019 he subspecialized in Rheumatology at Tygerberg Hospital and Stellenbosch University and completed his studies in 2021. He also completed a 2 year EULAR (European Alliance of Associations for Rheumatology) course in Rheumatology, a worldwide recognised achievement. He has spent time in private practice due to unavailability of rheumatology posts within the public health sector upon his completion of rheumatology training, until recently that he was appointed as the Head of the Rheumatology Unit at Grey's Hospital in Pietermaritzburg, KwaZulu Natal. He has published 18 research articles on peer-reviewed journals. Currently he began his PhD in Rheumatology looking at Electrophysiology in Rheumatology, an innovative theme in the field. |
| **Ema** | sipho.duncan@gmail.com |

| | |
|---|---|
| **Title** | Equitable Access to Quality Health Care for Injured People. Fostering equitable partnerships through engaging and involving communities along the research continuum. |
| **Presenter** | Christina Laurenzi |
| **Co-Presenters** | Dr Ntombekhaya Tshabalala; Ms Tamlyn MacQuene; Ms Stacey Blows; Ms Sindiswa Mpepo; Ms Dambisa Manjuza; Dr Kathryn Chu |
| **Institution** | Institute for Life Course Health Research, Stellenbosch University |
| **Abstract** | While an increasing number of global research projects are integrating strategies to meaningfully engage communities in the process of conducting health research, community engagement and involvement (CEI) remains a largely tokenistic exercise. The Equi-Injury (EI) project aims to holistically understand barriers to equitable access to quality care across four countries—and CEI is necessary to successfully achieving this aim. To ascertain how best to embed research findings into policy and practice, the project engages with stakeholders in Ngqamakhwe (EC) and Bishop Lavis (WC) to develop a change strategy. Our team has adopted a diverse set of strategies to foster equitable collaboration, increase community member buy-in, and promote sustainable ways of interacting. We have co-created and refined our CEI approaches through a series of community workshops; meetings; conversations; social media platforms and surveys. Through Community Advisory Board (CAB) meetings held at project inception, we introduced the project to community members across rural and urban sites. Crucially, we relied on existing relationships and community structures to minimise complications and maintain trust over a short period of time to project implementation. Photovoice, podcasts, knowledge exchange and capacity building promote ownership and ensures acknowledgement of local assets and skills and joint stakeholder learning through the process of working together. Integrating CEI in various project platforms, meetings and board meetings ensures that communication is consistent and CEI is well-represented, not just an aspirational add-on. The project aims to uphold transparency in developing and retaining the social capital through which community engagement and involvement gets realised. By involving community members in understanding priorities to address, their involvement gives them agency and capacity to participate in potential policymaking. |
| **CPD Point** | Standard |
| **Biosketch** | Originally from the U.S., Dr Christina Laurenzi has lived and worked in South Africa since 2013, when she spent a year in the rural town of Zithulele, Eastern Cape, as a ReachOut International Fellow. Christina, a Senior Researcher at the Institute for Life Course Health Research (ILCHR), has experience conceptualising and managing research projects in complex settings, and has worked in areas including community engagement, adolescent HIV, maternal and child health, mental health, and social determinants of health. She is also interested in using research to optimise service delivery and improve multi-sectoral collaboration. She splits her time between the ILCHR at Stellenbosch University's Faculty of Medicine and Health Sciences, and the Centre for Social Science Research at University of Cape Town. Christina was named one of Stellenbosch's Postdoctoral Researchers of the Year in 2022, and also received an inaugural JIAS Impact Award for one of her first-authored publications from 2021. She holds degrees in Politics and Global Health and Health Policy (BA, Princeton University), African Studies (MSc, Oxford University), and Psychology (PhD, Stellenbosch University). |
| **Email** | christinalaurenzi@sun.ac.za |

| | |
|---|---|
| **Title** | Examining the knowledge, attitudes and practices of Charismatic churches in Emzinoni, Bethal, South Africa, in 2021 regarding HIV. |
| **Presenter** | Nomsa Ndaba |
| **Co-Presenters** | Nqobile Ngoma, Dr Clive Ferreira |
| **Institution** | |
| **Abstract** | Examining the knowledge, attitudes and practices of charismatic churches in Emzinoni, Bethal, There has been a deafening silence from charismatic churches in responding to the South African HIV epidemic. The study aimed to identify the response of charismatic churches by their knowledge, attitudes, and practices towards HIV/AIDS in 2021.A mixed-method cross-sectional study was conducted at three Charismatic Churches in Emzinoni Bethal in Mpumalanga, South Africa. Simple random sampling was used to select the churches and a structured online survey was conducted among youth members. Additionally, in-depth virtual interviews were conducted among church leaders to explore knowledge, attitudes and practices regarding HIV. Responses were computed into Microsoft excel and imported into STATA version 14 for analysis. Proportions, frequencies and measures of dispersions were used to report findings. The study comprised of 35 participants in total; 32 were from the youth groups (aged 18 years to 30 years) and 3 were the church leaders. Of the total participants 18 were female and 17 were male. 91% (29) of the youth are aware that HIV is a virus. 56% (18) of them know that using condoms is a way to prevent HIV and 96% (31) know that HIV is treated through lifelong antiretrovirals. 56% (18) of the youth participants feel that the church hasn't started responding to the HIV epidemic whilst 43% (14) believe that there has been some response from churches that talk openly about HIV. 100 % (32) of the youth group participants agreed that having HIV education in the church would be beneficial.<br>67% (2) of the church leaders are aware of HIV positive members in their church. The same 67% (2) believe in the importance of having an HIV policy and having HIV education and yet only 34% (1) have an HIV program in their church. The study established that the one-way charismatic churches could respond to the HIV epidemic, is through education. HIV education can help prevent the further spread of the disease. |
| **CPD Point** | Standard |
| **Biosketch** | Clinical Associate (BCMP), University of Pretoria.<br>Post graduate Diploma in HIV Management, Stellenbosch University<br>Masters in HIV Mananagement, Stellenbosch University |
| **Email** | Sheronnomsa@gmail.com |

| | |
|---|---|
| **Title** | Experiences and understanding of the health care team in the rural context around interdisciplinary practices and learning, an exploratory study |
| **Presenter** | Luke Profitt |
| **Co-Presenters** | K Von Pressentin, Z Geyer, D Swart, L Visser, N Beckett |
| **Institution** | UCT/Vredenburg hospital |
| **Abstract** | Vredenburg hospital is the district hospital for the Saldanha bay subdistrict of the West coast in the western cape. It is a teaching site for both medical students and Health and rehabilitation science students. There are up to 14 students on this rural platform at any given time. Integrated meetings prior to the disruption caused by the COVID-19 pandemic elicited good learning opportunities in interdisciplinary care. Recent informal student feedback has highlighted the interdisciplinary learning that students are achieving despite the barriers faced by the faculty in formally implementing interdisciplinary teaching. We have identified the need to examine this more formally to build on and improve interdisciplinary teaching. We will present the preliminary findings at the RuDASA conference.<br>Aim:<br>To determine the understanding, experiences and current practice of interdisciplinary teams in the Saldanha Bay sub-district. The secondary aim is to improve teaching regarding interdisciplinary care.<br><br>Objectives<br>1. To understand the perspectives on interdisciplinary teams from various groups of stake holders.<br>2. To use the perspectives to influence teaching on the Vredenburg hospital and Saldanha bay clinical teaching platform.<br><br>Method<br>This exploratory qualitative study using focus group interviews to answer questions. These will follow a semi structured interview approach with a thematic analysis of responses.<br><br>Impact<br>The results will assist with the planning and ability of the departments of family medicine and health and rehabilitation sciences to continue the mandate of interdisciplinary teaching and set an example of best practice. |
| **CPD Point** | Standard |
| **Biosketch** | Luke is a family physician working at Vredenburg hospital in Saldanha bay sub-district of the west coast in the Western Cape. He has interests in access and equitable care and improving health care in the system he is working in. He is currently employed by UCT as a senior lecturer in Family Medicine teaching final year students. |
| **Email** | lukeprofitt@gmail.com |

| | |
|---|---|
| **Title** | Experiences of Mobile Health Clinic nurses servicing rural communities of eThekwini municipality during covid 19 community response interventions. |
| **Presenter** | Silingene Ngcobo |
| **Co-Presenters** | professors in nursing |
| **Institution** | Mseleni |
| **Abstract** | Background: Worldwide covid 19 came unexpectedly and no healthcare system was prepared for it and rapid and on toe response decisions had to be made in order to identity, manage, and contain its spread. Nurses being the backbone of any healthcare system were not spared and they had to be in the forefront in implementation of any intervention measures towards covid 19. Nurses working in the mobile health clinics (MHCs) were thrown in the deep end and were summoned to be respondents to community health needs on the grassroot levels through community awareness mobilisation, mass screening and contact tracing.<br>Aim: To explore and describe the experiences of MHC nurses in covid 19 community response for rural communities.<br>Methods: Qualitative Explorative Descriptive design was employed using purpose sampling of thirteen professional MHC nurses. Data was collected using one-on-one, online, semi-structured interview guided by open-ended questions and a demographic form. All audio recorded interviews were transcribed. Transcripts were analysed using Atlas-TI following 7 steps for content thematic analysis and descriptive statistics were used for demographic profiling.<br>Results: Nurses involved in the study had been working in the MHCs for three to seven years and had between seven to 25 years' experience in nursing. Six themes merged from data which included: fear for nurses' lives, lack of protection, non-training, lack of essential working tools, feelings of guilt and abandonment of daily duties.<br>Conclusion: Being part of first line response to Covid 19 crisis with little preparedness left nurses psychologically, physically, emotionally, and occupationally vulnerable.<br>Recommendations: Caring for nurses who are carers on the ground post covid 19 pandemic is essential for motivating and strengthening continued commitment to nursing profession and promoting overall wellbeing. |
| **CPD Point** | Standard |
| **Biosketch** | Nurse academica |
| **Email** | ngcobos5@ukzn.ac.a |

| | |
|---|---|
| **Title** | Exploring the perceptions and experiences of the delays to accessing appendectomy in the Western Cape |
| **Presenter** | Johnelize Louw |
| **Co-Presenters** | Prof Peter Nyasulu, Prof. Kathryn Chu, Professor René English |
| **Institution** | Centre for Global Surgery Department of Global Health Faculty of Medicine and Health Sciences Stellenbosch University |
| **Abstract** | Background: A delay in accessing timely appendectomy can lead to complications. In South Africa, the perforation rate for appendicitis patients was 36%. Many persons who require appendectomy experience delays in seeking, reaching and receiving care, leading to increased morbidity or mortality. This study aimed to explore the perceptions and experiences of clinicians and patients, and obtain recommendations to improve access to appendectomy in the Western Cape, South Africa.Method: Participants were purposively and conveniently recruited. Interviews were translated and transcribed and an inductive approach was used for thematic analysis. Results: Seeking care was affected by a lack of health knowledge, the role of relatives and friends in the decision to seek health care, mistrust in the health care system, and cultural and personal factors. Barriers to Delay 2 were, accessibility of transport, emergency medicine services related barriers, and financial concerns. Overall, Delay 3 resulted from a lack of resources in the health system, and, and migration to the province. Recommendations by service users and providers to improve access included the need for health education of communities, and an increase in hospital resources. There is also a need for guidelines to be established to ensure timely access to appendectomy after entering the health system. Conclusion: Barriers to seeking, reaching and receiving appendectomy care are multifactorial. Delays can be minimised by improving community and patient health education, increasing the availability and accessibility of transportation to health facilities, and increasing in hospital resources. |
| **CPD Point** | Standard |
| **Biosketch** | Ms. Louw is a currently pursuing her doctorate in Health Systems and Public Health at the Stellenbosch University. |
| **Email** | 18205585@sun.ac.za |

| | |
|---|---|
| **Title** | Health system strengthening Post Covid-19 |
| **Presenter** | Samantha Maughan |
| **Co-Presenters** | Dr Atiya Mosam |
| **Institution** | Rural Health Advocacy Project |
| **Abstract** | Despite efforts and investment by the government, many people in rural areas still do not have access to quality healthcare. The Coronavirus Disease 2019 (COVID-19) pandemic caused disruptions in health services globally and further exposed the inequities in the health system, particularly in rural areas. This study examines the South African Health System response to COVID-19 and the lessons learned to: improve future pandemic preparedness and health system resilience, improve the provision of essential health services in stable periods, and highlight the relevance of these factors to rural areas. A literature review was conducted using both peer-reviewed and grey literature, and was reviewed by three public health researchers. Reviews by public health medicine specialists working in the relevant fields focused on the recommendations in each section and provided key informant insights. Data analysis was performed by a data analyst using existing datasets. The period of analysis is 1 March 2020 to 25 June 2022. The health system response in South Africa was outlined under COVID-19 diagnostics, therapeutics and vaccines sections. The literature review demonstrated that various challenges were encountered in the South African health system response to the COVID-19 pandemic. The pandemic and related lockdowns had a generally negative impact on the diagnostics for other essential health services. Adult HIV therapeutic services were resilient during lockdowns. However, seeking care for emergencies and potentially severe childhood illnesses were adversely affected, as was access to care for chronic conditions such as TB and non-communicable diseases. There was a decline in the number of fully immunised children in seven of the nine provinces. The largest declines were found in the Northern Cape, Eastern Cape and Mpumalanga.<br>Data analysis showed that the majority of COVID-19 tests were conducted during the waves. The private sector represented over half of the tests done. Limpopo, North West and Mpumalanga testing proportions were consistently lower than expected based on population size. The third wave accounted for almost a third of COVID-19 admissions. The public sector accounted for just over half of the admissions. In the Eastern Cape, Limpopo and Mpumalanga, a notable percentage of admissions were to district hospitals. Over half of individuals over 18 years were vaccinated during the third wave. Provincial vaccination proportions were in keeping with population size. Recommendations to strengthen the health system include, amongst others, putting contingencies in place now to create resilience in the health system, improving data systems, and strengthening essential health services. |
| **CPD Point** | Standard |
| **Biosketch** | After many years of clinical practice as a medical doctor, Dr Samantha Maughan developed a passion for strengthening the health care system in South Africa. As a result, she shifted her focus to the field of Public Health and obtained a master's degree in this field. Her areas of interest include effective governance, health workforce development and excellence in service delivery. Samantha works as a researcher for the Rural Health Advocacy Project. |
| **Email** | smaughan@rhap.org.za |

| | |
|---|---|
| **Title** | Impact of medical interventions for reducing cochlea toxicity of amino glycosides in adults on treatment for MDR tuberculosis at a rural hospital in the Eastern Cape |
| **Presenter** | Lineo Mawisa |
| **Co-Presenters** | Prof Katijah Khoza-Shangase, Liepollo Ntlhakana |
| **Institution** | Zithulele Hospital |
| **Abstract** | Treatment of MDR-TB warrants the use of potentially cochleotoxic medications for the preservation the lives of those affected. The resultant hearing loss negatively impacts one's ability to communicate and connect with the world around them. The World Health Organization (WHO) estimates that about 466 million people are living with disabling hearing loss. The WHO recommends regular monitoring for early signs of cochleotoxicity in patients diagnosed with MDR-TB. Early identification and monitoring of hearing loss in isolation is not useful if medical intervention strategies aimed at reducing cochleotoxicity do not form part of the protocol.<br>The aim of the current study was to investigate the impact of medical intervention strategies aimed at reducing the cochleotoxic effects of long-term use of aminoglycosides for the treatment of MDR-TB in a group of adult patients at a rural hospital in the Eastern Cape of South Africa.<br>A total of 86 participants (intervention group n=32 and control group n=54) which included both males and females comprised the research sample. A retrospective ex post facto research design was used, that involved a retrospective audiological and medical record review of all participants' files over a six-month period, including baseline. Descriptive and inferential statistics were used to analyse the data. A paired t-test statistical analysis method was utilized to draw conclusions on whether a relationship exists between audiological findings and the early medical intervention strategies applied.<br>The results revealed development of hearing loss in both groups, with progression at each subsequent assessment session. The development of hearing loss, however, was much slower in the intervention group as compared to the control group. Overall, the results revealed better hearing sensitivity in the intervention group as compared to the control group; thus, possibly suggesting early medical strategies implemented had a significant impact. |
| **CPD Point** | Standard |
| **Biosketch** | An Audiologist currently working for the Eastern Cape department of of Education. I got my Audiology qualification from UKZN, and completed my Masters in Audiology with Wits University. I am very passionate about early identification of hearing loss, especially within rural settings. I previously worked at Zithulele Hospital, a deeply rural hospital where I really got to harness my passion for rural health care and subsequently won the rural therapist of the year in 2016. |
| **Email** | dineomawisa@gmail.com |

| | |
|---|---|
| **Title** | Impact of socioeconomic factors on adherence in patients taking cancer treatment |
| **Presenter** | Vatiswa Henge-Daweti |
| **Institution** | Cecilia Makiwane Hospital , Department of health |
| **Abstract** | BACKGROUND<br>Socioeconomic factors seem to be contributing concerning patient adherence to cancer treatment.<br>AIM<br>To assess the impact of socioeconomic factors on adherence in patients taking cancer treatment<br>CASE SUMMARY<br>A 14-year-old female patient was diagnosed of osteosarcoma. This bone cancer affected her left proximal humerus, characterised as a growing mass on the left arm. This is a school going child from a remote area. At home she stayed with her grandmother, aunts and their children in one rondavel. Her mother had to work in town for an additional source of income to add on to the government pension fund received by the grandmother.<br>She was started on adjuvant treatment, to complete 6 cycles on an interval of 21 days. The aim was to shrink the tumor for a possible surgical intervention. Out of 6 cycles she could only honour 3 with noticeable gaps in between, far greater than the 21 days' interval as planned. She came back for treatment critically ill with sepsis on the affected area. Chemotherapy had to be halted, sespsis treated thereafter radiation therapy was initiated. The patient responded very well, chemotherapy was re-initiated with pain management as palliative care therapy. Lack of transport fee to access a nearby hospital was a major contributing factor to her defaulting chemotherapy. Conditions at home contributed to the sepsis and all lead to the progression of the disease. The patient demised before her second treatment cycle.<br>CONCLUSION<br>Socioeconomic factors had a major negative impact on the patient's adherence to treatment and disease progression.<br>RECOMMENDATIONS<br>Comprehensive history taking and a holistic approach in the management of cancer patients is critical. |
| **CPD Point** | Standard |
| **Biosketch** | Clinical Pharmacist, Responsible Pharmacist at Cecilia Makiwane Hospital, EC Pharmacovigilance Lead, Clinical Fellow (Rhodes University). |
| **Email** | vocoza@gmail.com |

| | |
|---|---|
| **Title** | Integrating clinical practice and population health- the advantages of teaching and learning in the rural context |
| **Presenter** | Steve Reid |
| **Institution** | University of Cape Town |
| **Abstract** | BACKGROUND: How can we balance the immediate demands of rural clinical practice with sick patients, against the need to work more “upstream” on the issues and systems at local and global levels that make them sick in the first place, or delay in getting the help they need? With the renewed interest in Universal Health Coverage (UHC) and the initiatives of several provincial Departments of Health to promote Community-Oriented Primary Care (COPC) as a way of addressing the social determinants of health, it is important to prepare our future health professionals more appropriately for more integrated practice.<br>Rural sites of teaching and learning afford excellent opportunities for students to understand, experience and learn about the “rural determinants of health” while they see individual patients and gain clinical experience.<br><br>METHODS<br>This presentation addresses teaching and learning approaches that make the links between the invisible mechanisms that produce all too tangible clinical problems such as trauma, anxiety and depression, malnutrition, tuberculosis, or drug and alcohol abuse, that are expressed in rural practice. The paper suggests how to think about them, where to start, how to teach and assess them, and what students will take away with them into future practice.<br><br>RESULTS<br>Helpful precedents for planning curricula can be found in specific courses teaching concepts such as ‘critical health literacy’, ‘structural competence’, ‘social medicine’, or using the SDH as a framework. Teaching and assessment using case studies, home visits, referrals and other approaches such as photovoice, will be discussed as a way of integrating clinical practice with population health.<br><br>CONCLUSION: Teaching the ‘rural determinants of health’ means intentionally bringing into the clinical learning process, the rural ‘conditions in which people live and die’, together with the structural, political, social and economic forces that shape them. |
| **CPD Point** | Standard |
| **Biosketch** | Family physician from KZN, currently Head of Department of Family, Community and Emergency Care at UCT |
| **Email** | steve.reid@uct.ac.za |

| | |
|---|---|
| **Title** | Investigating Factors affecting Employee productivity of Allied Health Professionals in the ECDoH and its Impact on service delivery: A case of NMAH and MRH |
| **Presenter** | Sigopotso Sikhosana |
| **Institution** | |
| **Abstract** | The main objective of this study was to investigate the factors affecting employee productivity among allied health professionals and its impact on service delivery. The target population for the study was allied health professionals in the Eastern Cape Department of Health (ECDOH), which dieticians, physiotherapists and physio assistants, speech language therapists, audiologists, social workers, radiographers, occupational therapists and OT technicians, dental technologists, orthotics and prosthetics, and psychologists.The following two hospitals were used for getting the sample. Mthatha Regional Hospital (MRH) and Nelson Mandela Academic Hospital (NMAH).<br><br>Employee productivity relates to the amount of task that can be completed by a worker in a specific time. There are numerous ways of measuring employee productivity, majority of the definitions on employee productivity focus on the output derived in relation to the resources sacrificed, for instance time and effort. The study utilised a quantitative approach. In this study, a questionnaire was used to collect numeric data from allied health professionals at Mthatha Regional hospital and Nelson Mandela Academic Hospital. The target for the study was 100 respondents, however only 91 filled the questionnaire whilst 9 failed to respond to the questionnaire. Nonetheless, the findings from the study do correspond with the arguments from empirical studies and theories on employee productivity and motivation. The following factors were found to be important for employee productivity within organisations, environmental factors, job factors, organisational factors, retention strategies and individual factors.<br><br>Organisations should ensure that employees are rewarded through fair compensation systems, Best performing employees should also be rewarded to encourage performance. non-monetary rewards to encourage performance among employees might lead to employee productivity. Organisation should ensure sufficient workload which ensures that employees can balance between their work and family life. Training and development for employees to ensure that employees can learn new skills and enhance their current knowledge. A relationship between employees should also be encouraged, and some form of orientation should be encouraged to ensure that new workers can fit in. Ergonomics related aspects should be improved to ensure that working environments are worker friendly to promote productivity, and worker safety. |
| **CPD Point** | Standard |
| **Biosketch** | BSc Dietetics 2007 University of Limpopo (Medunsa Campus)<br>Masters of Business Administration 2019 Regent Business School |
| **Email** | Sigopotsosikhosana@icloud.com |

| | |
|---|---|
| **Title** | Looking to the past to plan for the future - rural rehab |
| **Presenter** | Pam McLaren |
| **Co-Presenters** | |
| **Institution** | Centre Integration Science |
| **Abstract** | Translating rehab policies into clear rural rehab service packages with resources to support implementation requires accurate, evidence-based, appropriate data for service delivery at rural district and home level.<br>In November 2022 McCord Trust supported a funding proposal from Disability Action Research Team (DART) for the first phase of a four-phase Early Intervention Programme for children and youth in KZN based on disability resource material compiled and collected by Community Rehabilitation and Education for Empowerment (CREATE) over two decades (2000 - 2021).<br>The first phase entails cataloguing and digitising 2,000 hardcopies into an e-library. Cataloguing into seven main categories and 115 sub categories is almost complete. Digitisation will follow.<br>The remaining three phases include identification of items relating to risk factors for impairment and disability in children and youth in KZN in order to develop a disability prevention programme, simplification of this information to ensure accessibility for parents and caregivers with low literacy, including translation into Zulu and finally a pilot to disseminate the information among Non-profit Organisations and government departments, particularly working in Early Childhood Development, early education and youth sectors.<br>One may well say that hard copies are out of date and that in 2023 all information is on the internet. I disagree. The catalogued information is valuable, not readily available on the internet and represents a wealth of embedded history relating to the struggle for recognition of rights for children, women and persons with disabilities in South Africa, Africa and beyond.<br>The first phase brings together information on 1) Impairments/ conditions; 2) Approaches: Primary Health Care/ Community-based Rehabilitation / Inclusive Education; 3) Data/ situational analyses/ evidence-based research; 4) Policies/ legislation / conventions; 5) Services / Human resources for rehab; 6) NPOs; and 7) Age cohorts over two decades and identifies appropriate tools for early intervention for children and youth.<br>This information can inform future early intervention rehab service delivery in rural areas in KZN. |
| **CPD Point** | Standard |
| **Biosketch** | I worked in rural areas of Namibia (Oshakathi Hospital) and KwaZulu (Manguzi Hospital) during 1970's to 1990 and at KwaZamokuhle Special School during 1991 as an occupational therapist promoting Community-based Rehabilitation (CBR) and the 'demystification' of rehabilitation. I did a PhD in Community Health while at Manguzi hospital graduating in 1991. Since 1995 I have worked as a disability research consultant with Disability Action Research Team (DART). I was a founding member of RURACT (1986) and of RuReSA (2011). I was a member of the CREATE board from 2000 -2003 and from 2017 - 2019. |
| **Email** | dart@sai.co.za |

| | |
|---|---|
| **Title** | Medical practitioners' knowledge and awareness of multiple myeloma at public hospitals, Gauteng, South Africa |
| **Presenter** | Andiswa Pooe |
| **Co-Presenters** | Prof Sam Ntuli |
| **Institution** | 1 Military Hospital |
| **Abstract** | Background: Multiple myeloma (MM) is a plasma cell malignancy associated with morbidity and mortality worldwide, and most patients are referred for specialist care very late with complications. The low index of suspicion among medical practitioners is among the reasons for the delay in MM diagnosis and management. This study aimed to determine the level of awareness and knowledge of MM amongst medical practitioners working in public hospitals of Tshwane Municipality, Gauteng Province, South Africa.<br><br>Methods: A cross-sectional descriptive study on 74 doctors working in three district, one regional and one central hospital using a convenience sampling.<br><br>Results: Seventy-four medical practitioners participated in this study. Their median age was 37 years with an interquartile range of 43-30 years. The majority (85%) of the respondents were aware of MM, while 74% were knowledgeable regarding MM presentations and diagnostic investigations.<br><br>Conclusion: Our findings highlighted a high level of awareness and knowledge of MM among the study population, but almost all of the participants requested an educational information brochure on MM.<br><br>Contribution: Medical paractitioners have high level of awareness of multiple myeloma, however there is a discrepancy between this level of awareness and the delayed presentation of patients at the public hospitals. Since primary healthcare in South Africa is nurse driven, not all primary healthcare providers may be aware of this disease. Future awareness campaigns should target other primary healthcare providers, including nurses and private general practitioners. |
| **CPD Point** | Standard |
| **Biosketch** | Andiswa Pooe (Mtyobile) is a Haematological pathologist, born in the Eastern Cape. Her qualifications include BSc (University of Transkei/ WSU), MBChB (Cuba), Mmed/ FcPath Haem (SMU), PGDip health professions education (UCT).<br>She has worked as a medical officer at the East London Health Complex, Port Alfred and Butterworth hospitals.<br>She did her Registrarship at SMU and qualified in 2015 as a Haematological Pathologist.<br>She has worked in a private laboratory and is currently working at the Department of Defence, 1 Military Hospital in Pretoria while also managing a private laboratory. She is also in the expert committee for the Council for Medical Schemes (CMS). |
| **Email** | amtyobile@gmail.com |

| | |
|---|---|
| **Title** | Met and unmet needs: a short-term audit of orthopaedic practice and referrals from a rural district hospital, Eastern Cape, South Africa. |
| **Presenter** | John-D Lotz |
| **Co-Presenters** | Dr Juli Switala |
| **Institution** | Madwaleni Hospital |


**Abstract**

With around 30% of the world's global burden of disease being surgical, unmet surgical needs remain a pressing challenge that affects LMICs disproportionately. Disruptions in service delivery during the COVID-19 pandemic have served to further exacerbate this provision gap.

Locally, access to surgical services varies widely throughout the country - between levels of care and between surgical disciplines. In most cases, tertiary centres carry the bulk of the responsibility for service delivery, resulting in a bottleneck of provision due in large part to limitations on tertiary resources and access to care.

While suggested frameworks describe surgical services expected at district level facilities, very little data exist on their realisation throughout South Africa.

In recognition of this misty landscape of surgical service provision, Madwaleni hospital staff have partnered with UCT's Division of Global Surgery to better understand the met, and unmet, surgical needs of their surrounding community, with an initial focus on orthopaedics. Here we present interim data and findings from a short audit of local orthopaedic practice. Our hope is to inform the beginnings of targeted and effective interventions to meet the needs of our local community, and maybe to help inform the broader narrative in surgical service delivery from a rural 'grassroots' point of view.


| | |
|---|---|
| **CPD Point** | Standard |
| **Biosketch** | JD Lotz is a Family Physician based at Madwaleni - a deeply rural district hospital on the Wild Coast of South Africa. He arrived with his wife in 2014, and with a growing family of 2 daughters he specialised through Walter Sisulu University, focusing his Masters research on DR-TB in rural areas. He was honoured to share the award for Rural Doctor of the Year with his wife, Michaela, in 2021, and now serves as Secretary on the Executive Committee of RuDASA. Besides sharing life and work with an amazing community at Madwaleni, his passions include addressing major burdens on rural communities. TB is one such burden, which he hopes to influence in his work locally, and more broadly as a rural voice on the Childhood TB Working Group of the SA TB Think Tank. |
| **Email** | jdlotz@gmail.com |

| | |
|---|---|
| **Title** | Nurses' experiences in implementing Nurse Initiated Management of Anti-Retroviral Therapy (NIMART) in primary health care facilities in Dr Ruth Segomotsi Mompati District, North West Province |
| **Presenter** | Nthabiseng Sibisi |
| **Co-Presenters** | Professsor Richard Cooke, Dr Motlatso Mlambo |
| **Institution** | Department of Family Medicine and Primary Care |
| **Abstract** | South Africa has the largest Antiretroviral Therapy programme. Nurses have been the bedrock of HIV policy implementation since the start of the HIV epidemic. Researching nurses' perceptions and experiences on NIMART implementation can inform the development of quality improvement initiatives within the health system. This study aimed to explore the nurses' experiences in the implementation of NIMART from 2010-2017, in Dr Ruth Segomotsi Mompati District, a largely rural district in North West Province. This study employed an exploratory qualitative research design. Purposive sampling of sub-districts, facilities, and participants was applied. 16 in-depth interviews were conducted with nurses to explore (1) their experiences and perceptions of the NIMART programme, (2) factors facilitating and inhibiting NIMART implementation, and (3) nurses' recommendations for NIMART quality improvement. Inductive thematic analysis was employed to analyse data. Five key themes emerged from this study. These included: (1) perceptions about the NIMART programme as a task-shifting strategy and its benefits. (2) Contextual elements affecting access and adherence to NIMART such as rurality, socio-cultural factors, social norms, socio-political and governance factors. (3) facilitators of NIMART implementation, mainly health system-related; and (4) inhibitors, which also included patient adherence and nurse demotivation. (5) Recommendations for NIMART quality improvement related to HRH and patient support.<br><br>Conclusion<br>There is an opportunity of building on factors that improve nurses' experiences in NIMART implementation. NIMART programme improvement should consider the rural context allowing implementation at policy formulation, collaboration, and accountability in oversight. Regardless of the challenges they faced, the nurses can be commended for their resilience and ethos of service to humanity. |
| **CPD Point** | Standard |
| **Biosketch** | Nthabiseng is a professional nurse who is an expert in the field of HIV/AIDS and Reproductive Health Rights. She holds a Master of Public Health in Rural Health from the Waits School of Public Health. Chairperson of Rural Nursing SAl Researcherl Social Justice Activistl Stakeholder, Partnerships & Health Systems Strengthening expert. Passionate about adolescent and youth advocacy, she is currently Managing Director of the "It Starts with Me (I-SwIM)" programme in the Free State. She also manages an Adolescent & Youth programme in Tshwane Health District. |
| **Email** | nthabisengsibisi3@gmail.com |

| | |
|---|---|
| **Title** | Person-Centred Caring Experiences of Registered Nurses while Managing Foot Care for Patients with Type 2 Diabetes in a Rural District of Northern Kwazulu-Natal |
| **Presenter** | Anné Suzanne Joubert |
| **Co-Presenters** | Professor Jane Kerr |
| **Institution** | University of Zululand |
| **Abstract** | The five-year mortality rate after a diabetic foot amputation is higher than 40% globally. In KwaZulu-Natal, 2500 diabetic foot amputations are carried out per year. Only 7.8% of diabetic patients undergo foot examinations within KwaZulu-Natal public health, while 90% are not educated about foot care. Person-centredness and caring about patients can potentially improve foot care outcomes for patients with diabetes.<br>AIM & OBJECTIVES<br>• To describe registered nurses' experiences of person-centred caring in managing the foot care of patients with type 2 diabetes.<br>• To explore current practices of registered nurses regarding the foot care of patients with type 2 diabetes.<br>During the qualitative strand of the mixed-methods convergent design study,18 semi-structured interviews were conducted. In-Town and Out-of-Town primary health care clinics were selected from each sub-district for interviews with registered nurses. Qualitative content analysis was used to analyse these interviews. It was reported that patients with Type 2 Diabetes Mellitus were instantly dismissive of dietary advice. These patients almost solely rely on starch to prevent hunger and they struggle to secure a balanced diet. A scoping review was done which included global diabetic- and diabetic foot care guidelines to find evidence-based solutions. The WHO, among others, suggest that patients with Type 2 diabetes in rural areas should follow a low glycaemic diet.<br>OUTCOME: An in-service training program was developed to capacitate rural registered nurses. It guides them to care for the feet of patients with Type 2 Diabetes Mellitus in a caring and person-centred manner. Food classification by glycaemic index is also covered along with strategies to convert ordinary food to a low glycaemic status as part of achieving glycaemic control. |
| **CPD Point** | Standard |
| **Biosketch** | Dr. Anné S. Joubert (Doctor of Nursing (University of Zululand), Advanced Diploma in Nursing Education (UNISA), M.Cur – Critical Care Nursing (University of Pretoria), B.Cur – General Nursing, Midwifery, Psychiatry and Community Health) (University of Pretoria) is a lecturer at the Department of Nursing Science.) She has 4 years' experience as a critical care nurse and has been part of a team doing clinical research for pharmaceutical companies for 6 years. She has experience of clinical research in the following fields: Diabetes, Cardiovascular Diseases, Alzheimer's disease, Epilepsy and HIV. She has been a lecturer at the University of Zululand since 2015 teaching General Nursing and Pharmacology. She graduated in April 2007 having completed her Master's degree titled: Cardiac surgery patients' experiences of music therapy. Her Doctorate degreeis titled: PERSON-CENTRED CARING TOWARDS IMPROVEMENT OF DIABETIC FOOT CARE COMPLIANCE IN RURAL PRIMARY HEALTH CARE, KWAZULU-NATAL |
| **Email** | JoubertA@unizulu.ac.za |

| | |
|---|---|
| **Title** | Perspectives of recent rural clinical school graduates on rural practice and rural living |
| **Presenter** | Francois Coetzee |
| **Co-Presenters** | Ian Couper, Mia Duvenage, Selvan Naido |
| **Institution** | |
| **Abstract** | Stellenbosch University started a Rural Clinical School (RCS) in Worcester in 2011 with the intention to influence medical, physiotherapy, occupational therapy and human nutrition students to practice in rural settings. At present there is no definitive evidence that this longitudinal exposure at the RCS has succeeded in its goal of retaining graduates in rural practice. This study set out to document if the graduates of the RCS are choosing to work in rural areas or not, and to understand the reasons for their choices. This study consisted of a quantitative data collection phase which made use of an online survey using an online survey tool (REDCapÒ) followed by a qualitative phase during which interviews were conducted. Review of the literature regarding the tracking of health professional graduates and the online survey data informed the process of creating an interview guide for the semi-structured interviews conducted via Zoom. Surveys were sent to RCS graduates that qualified in 2011 -2018, these included occupational therapy students, human nutrition students and medical students that completed a yearlong training at the RCS. Interviews were transcribed and checked for accuracy, coding and data analysis were done by two independent investigators using AtlasTiÒ software version 23. 20 occupational therapy and 52 MBChB graduates completed the survey. At present 25% (5) of occupational therapy graduates and 46% (25) of MBChB graduates are working in rural areas. Some participants serve rural communities by means of outreach while living in urban areas. Preliminary analysis of the qualitative data has explored facilitators and barriers to pursuing careers in rural environments including factors related to personal motivations and families. Conclusion: The recruitment and retention of rural health care workers by means of an undergraduate training intervention was explored. Although undergraduate training in rural environments does motivate graduates to work in rural environments, several other factors related to opportunities, systems and personal circumstances determine their eventual journey. |
| **CPD Point** | Standard |
| **Biosketch** | Francois Coetzee is a family physician, and program coordinator of the Rural Clinical School based in Worcester, South Africa. He qualified as a medical doctor in 1998, as a Family Physician in 2010 and graduated with a master's in philosophy in health professions education at the end of 2022. He is employed as the coordinator of the Stellenbosch University Rural Clinical school and manages the training of final year medical students on the distributed platform. He has a passion for improving systems within health care and health professions education, making systems more person centered and more efficient. He views shared leadership as a key component of quality improvement and thinks that good leadership has to start by leading one-self towards wellness and success. He is also the module lead for the clinical governance module in the postgraduate diploma in rural health. For 12 years Francois practiced as a rural clinician and in 2013 he joined the Ukwanda Centre for Rural Health of Stellenbosch University. In 2017 Francois was appointed as coordinator of the longitudinal integrated clerkship and the rotation-based program at the Rural Clinical School.. |
| **Email** | franna@Sun.ac.za |

| | |
|---|---|
| **Title** | Reflective Report on District Level Perinatal Care Outreach in the Eastern Region of Eastern Cape (EREC) 2019-2022 |
| **Presenter** | Zolile Mlisana |
| **Co-Presenters** | |
| **Institution** | Independent practice |
| **Abstract** | The department of Paeds, MRH, commenced rigorous perinatal outreach support to all district facilities in the ECER between 01.2019 and 12.2021. It augmented a longstanding Helping Babies Breathe (HBB) project. It principally introduced the implementation of the concept of a lead clinician, available to 15 District Hospitals and 45 CHCs, and, to some extent, to the EMS leadership. None of the three districts had a paediatrician on their DCSTeams. The outreach support included identification of referral bottlenecks and facilitation of collaborations in continuity of care. The paper provides a reflective report which focuses on what can be termed 'silent drivers' which impact on perinatal outcomes. Further research is proposed, and recommendations are made for continuous interventions. This report follows the multi-step reflective method which was applied during the outreach:<br>• Step One: Baseline facts and hypothesis - Alert trigger, Hypothermia and encephalopathy<br>• Step Two: Informed intervention strategy design<br>• Step Three: Inquisitional, responsive interventions - Professional communications quality<br>• Step Four: Continuous impacts evaluation and strategy revision/improvisation<br>• Step Five: Retrospective Analysis<br>• Step Six: Recommendations for sustained intervention and research<br>Results: The outreach support was a concomitant assessment, intervention and reflective research process which identified and affirmed the drivers outlined on the PPIP tool. Furthermore, and in the specific interest of this report, sub-drivers were identified and described as 'soft' or 'silent'. They are soft because they are not easily identified or quantified. They are silent because they escape being addressed even when they are sometimes glaring. These sub-drivers are intrinsically psychosocial, reflective of leadership culture, both clinical and administrative, and affect continuity of care both in-facility, and along the referral pathway. They are summarised as subsets of communication and work ethic. Conclusion: Evaluation of perinatal drivers of outcomes is excellently facilitated through the PPIP tool, but escaped by some silent drivers which actually do get identified during M&M meetings but are neither recorded not addressed specifically. |
| **CPD Point** | Applied for Applied for ethics |
| **Biosketch** | General paediatrician since 1989 with balance of service between public and private, and rural and city in the period. Initiated paediatric departments/services in both private and public hospitals. Served at regional and district levels, trained DCST's and recently briefly served as DCST Paediatrician in the Eastern Region of the Eastern Cape. |
| **Email** | durbansouthpaeds@gmail.com |

| | |
|---|---|
| **Title** | Rural Early Childhood Development: Where early education, literacy and healthcare intersect |
| **Presenter** | Katy Miller |
| **Institution** | Layita Foundation |
| **Abstract** | Rural Early Childhood Development: Where early education, literacy and healthcare intersect.<br><br>Layita Foundation was founded in 2014 at Madwaleni Hospital out of a need to support the direct and indirect determinants of health in the hospital and the surrounding community. With an initial focus on supporting hospital services and reacting to urgent needs within the walls of the hospital, we were nevertheless aware of the large deficit with regards to early childhood education in our community.<br><br>Nowhere were these deficits more apparent than our rehabilitation department. Many children presenting with “learning difficulties” had issues exacerbated or created by challenges in early childhood. Often, these children presented to the hospital too late, making the task of the therapists seemingly impossible. An additional need identified was that due to the lack of early childhood education options in our community, many staff employed at the hospital would be forced to send their children away for school or alternatively look for employment elsewhere for the sake of education.<br><br>This presentation describes our experience as health care workers of starting an Early Childhood Development Centre (ECDC), growing into early childhood intervention programmes to support our local ECDCs and starting a hospital library. We will discuss what we have learnt about community participation and the importance of the slow nature of rural development. |
| **CPD Point** | Standard |
| **Biosketch** | Katy is an occupational therapist who arrived at Madwaleni Hospital in 2013. In 2014, she co-founded Layita Foundation while working as an OT in the hospital. In 2015 she shifted her attention from hospital based OT to her small children and managing Layita Foundation where she steered the organisation through its foundational years and co-established Masikhule ECDC in 2018. She was officially appointed as the first managing director of the organisation in 2021. |
| **Email** | katypmiller@gmail.com |

| | |
|---|---|
| **Title** | Special problems need special solutions. |
| **Presenter** | Victor Fredlund |
| **Co-Presenters** | Dr Mukubu Mwila |
| **Institution** | Mseleni |
| **Abstract** | Mseleni Joint Disease presented an unusual challenge to a small rural hospital. Appropriate management and research requires Taylor made responses. rural hospitals have proven to be capable of diversifying their responses according to local need and available resources. the story of the hospitals response to they disease is one such story. |
| **CPD Point** | Standard |
| **Biosketch** | Rural district generalist at Mseleni from 1981 to 2021. now working on Ngithume Nkosi project seeking to help young professionals to use their skills in Christian service and mission. |
| **Email** | victor.mseleni@outlook.com |

| | |
|---|---|
| **Title** | Stakeholder needs for embedding sustainable solutions in injury policymaking in South Africa |
| **Presenter** | Ntombekhaya Tshabalala |
| **Co-Presenters** | Dr Christina Laurenzi, Ms Tamlyn Mac Quene, Prof. Kathryn Chu |
| **Institution** | Stellenbosch University |
| **Abstract** | Background: Injury is an important cause of morbidity and mortality in South Africa. Involving key stakeholders in injury healthcare policymaking can increase policy relevance and uptake through building mutual understanding, credibility, and trust. The extent to which community members and health care workers (HCW), the two important stakeholder groups, are involved in injury policy making is unknown. The aims of this study were to assess the current involvement of these stakeholders in developing or prioritising solutions for access to quality injury care and to ascertain mechanisms of their involvement.<br><br>Methods: Four 2-day expert led workshops were held in the Eastern Cape (EC) and Western Cape (WC) provinces. Rural workshops were held with the community in Ngqamakhwe, (EC) and HCW in East London (EC). Urban workshops were held with the community in Bishop Lavis (WC) and HCW in Parow (WC). Mechanisms to injury policy involvement were discussed in small groups and top priorities ranked through voting by all participants per workshop.<br><br>Results: In total 49 persons participated in the four workshops in March and April 2023. There was a high level of interest in being involved in injury policy. The top mechanisms for rural and urban communities to become involved were community mobilisation and education, activism and engaging in community health boards. For HCWs, the top mechanisms of involvement were participating in community based health committees, interfacility communication, health education and working/action groups.<br><br>Conclusion: Injury care is an important health issue in South Africa and injury care policies are needed at local, provincial, and national levels. Mechanisms of community and HCW stakeholder involvement in injury policy are important to understand their potential involvement.<br><br>Key words: Injury policy, Equi Injury, Communities, Healthcare workers, mechanisms for involvement, South Africa. |
| **CPD Point** | Standard |
| **Biosketch** | Dr. Tshabalala is a Postdoctoral Research Fellow on the Equi-Injury project based in the Eastern Cape. She founded Imijelo yophuhliso Foundation after completing her PhD in Disability Studies at the University of Cape Town |
| **Email** | khayat@sun.ac.za / kaya.ts@gmail.com |

| | |
|---|---|
| **Title** | Strengthening inclusive healthcare screening through Support Groups formation for clients with chronic conditions (mentally ill clients included) at Manguzi Hospital PHC facilities |
| **Presenter** | Sibongile Vumase |
| **Co-Presenters** | Jabulile Ndlovu |
| **Institution** | Non-Governmental Organization |
| **Abstract** | Background<br>Visiting 12 residential clinics to start support groups for the chronically ill, including the mentally ill clients started on the last week of June 2022. Siletha Ithemba Disabled Peer Supporters NGO and Manguzi Therapy department saw the need to start support groups at clinics with none, and revive those that were no longer functional , post Covid-19 Pandemic. All residential clinics were therefore visited by March 2023.<br>The aim of the planned visits was for the group members to organize themselves through constitution formation, discussing among themselves as to what type of activities they will want to be busy with in their groups and how are they planning to get there. This achievement involved a lot of planning and communicating with clinic and hospital Management structures, the community health workers and the group members themselves.<br>The support group Coordinator, Mrs SP Vumase, from Siletha Ithemba, advised the members to go to Tribal Authority office to address iNkosi and iziNduna about the aim of the support group formation. Some iziNduna needed to be visited at their places by the group members themselves to secure land for their projects.<br>Support groups are at different levels of development. Some are already implementing their planned activities, while others are still organizing themselves to catch up with implementation stage.<br>Activities done and planned to be done by the various chronic support groups include : Indigenous chicken Farming, Groundnuts Harvesting, Goat farming, Baking ,Handcrafts, Tent for hire and vegetable gardens.<br>The benefits of belonging to a support groups: Support groups are motivated to be functional by the fact that once they are up and running, they are visited by the hospital team made up of a Social worker, Occupational therapist and a Psych Nurse (Professional) during one of the Medical Officer Clinic visits, to address their medical and psycho-social concerns. A questionnaire has been designed to collect such information from all members of the support groups.<br>Conclusion : There are currently 13 support groups established throughout the Manguzi Hospital Catchment area. Working together with various stake holders towards the same goal , makes everyone concerned to feel useful. |
| **CPD Point** | Applied for ethics |
| **Biosketch** | Ex-Occupational Therapy Technician, now Secretary for Siletha Ithemba Peer Supporters NGO |
| **Email** | vumasesibongile@gmail.com |

| | |
|---|---|
| **Title** | Sustainability in rural health: Balancing clinical and training demands in a rural district hospital |
| **Presenter** | Andrew Miller |
| **Institution** | Madwaleni District Hospital |
| **Abstract** | Recent years have seen district hospitals becoming increasingly involved in the training of undergraduate and post graduate students. Additionally, allocation of medical interns at district hospitals as part of the new 6-month family medicine rotation, as well as increased prioritisation for placement of community service health care workers at rural hospitals, has come with improved staffing but also an increased requirement for training and supervision.<br><br>There is a paucity of research evaluating training programmes for junior doctors. Programmatic changes can be made without evidence to justify this. This presentation will discuss recent research and surveys on junior doctors and their senior colleagues on the readiness of junior doctors to practice medicine independently in district hospital settings. It will include discussions on research published by the presenter on the readiness of medical interns to independently manage obstetric emergencies, the results of unpublished surveys on the confidence of doctors in rural hospitals to practice medicine independently and reflections from clinicians on their training experiences. It will explore the burden of training junior doctors and students in a rural setting and discuss strategies for maintaining clinical services while balancing growing expectations for offering decentralised training. |
| **CPD Point** | Standard |
| **Biosketch** | Andrew Miller is a Family Physician and Clinical Manager at Madwaleni District Hospital, where he has worked since 2013 |
| **Email** | mracmiller@gmail.com |

| | |
|---|---|
| **Title** | The assessment of movement skills and physical fitness of children in rural areas of South Africa |
| **Presenter** | Adri Burger |
| **Co-Presenters** | Professors of physiotherapy |
| **Institution** | Madwaleni Hospital |
| **Abstract** | Recently, there has been expression in literature of a need for more research in diverse and unique environments to determine the most accurate, valid and feasible motor competence tests to utilise with a perpetually developing paediatric population. This study aimed to objectively measure motor-skill related fitness in 5 - 7-year-old individuals, who were attending school in a physically demanding environment through analysis of a caregiver's report and results of two movement assessment tests. Secondly, the concurrent validity of these two tools, the latest version of the well-established Körperkoordinationstest für Kinder (KTK3+) and the Performance and Fitness Battery for Children (PERF-FIT) were used to determine the construct validity of the PERF-FIT, assuming a hypothesis of moderate to high correlation of the test results for the items intending to measure a comparable construct. Finally, therapists administering the KTK3+ and PERF-FIT reported their perspective of clinical utility of these motor performance tests in a rural setting. This observational and descriptive research adopted a cross-sectional study design and quantitative data was collected from questionnaires and the physical tests. Descriptive data was collected from therapists. A custom made "Caregiver's Perceived level of motor skill" questionnaire was created based on the activities of self-care, entertainment, and household chores. Results: There was a significant difference in expectation of performance of the different sexes, but analysis of the results of the physical tests did not confirm this. Overall the children in this study, who were perceived to have lower motor competence, outperformed the normative values in the items measuring balance, eye-hand coordination and strength. We found a statistically significant correlation in the expected range between the items of the KTK3+ and the PERF-FIT namely: walking backwards (KTK3+) and dynamic balance and "Pick up Cans" (PERF-FIT) [0.72], Jumping Sideways (KTK3+) and Sideways Jump (PERF-FIT) [0.67] and both the Bounce and Catch (PERF-FIT) and the Throw and Catch (PERF-FIT) and the modified Eye Hand Coordination test [0.64 – 0.80] Therefore, the construct of the PERF-FIT and the KTK3+ is comparable to test for components of motor competence. All 4 therapists favored the PERF-FIT, mostly due to the equipment needed for the KTK3+. Conclusion: The PERF-FIT is a valid test for the following components of motor performance: Agility, dynamic balance, eye-hand coordination. It is also a feasible test in a rural setting. |
| **CPD Point** | Standard |
| **Biosketch** | I am and have been a physiotherapist at Madwaleni District Hospital for the last 5 years. I have a special interest in movement development and evaluation and decided to conduct research in this very unique setting. I completed my masters by dissertation this year and would like to share my finding with other rural health care professionals. |
| **Email** | adriburger008@gmail.com |

| | |
|---|---|
| **Title** | The effects of social media on staffing of a rural hospital in the Eastern Cape |
| **Presenter** | Lalenja Kolbe |
| **Institution** | Isilimela hospital |
| **Abstract** | Being places at Isilimela hospital post community service year was daunting due to lack of communication. in the first year being placed here, I had many people asking about my lifestyle here and about my personal posts on instagram about working in rural Eastern Cape. We as a therapy team decided to start a facebook and instagram page, to share our experience. Since then our hospital has grown significantly with regards to likeminded health care workers and have gathered a bug following. Previous lack of human resources was due to students declining their placement for community service after being placed at Isilimela hospital for community service.<br><br>We have also had many more applicants every year, specifically for their community service year. According to these applicants, it was due to being able to follow our social media and be more informed before applying here. Due to rural hospitals also not always being what they were before, students are weary to apply to very rural hospitals.<br><br>The social media aims to inform people that one, there is a passionate team here wanting to make difference and work together and then two, creating a space for people to ask questions on logistics like accommodation, the community we serve and resources we have or do not have.<br><br>Furthermore, we have also been able to direct many NPO's wanting to partner with DOH. We have used it in the past to also raise money to buy a sewing machine for the therapy department and have baby clothes donated to mothers in maternity ward.<br><br>We have recently sent out a survey to see what the publics view was of our social media and we would like to present this to other hospitals wanting to start up their social media.<br><br>Tips on what has worked in the past and what hasn't, as well as navigating the red tape that is social media. |
| **CPD Point** | Standard |
| **Biosketch** | Occupational therapist placed at Isilimela hospital. completed community service at Zithulele hospital in 2020. |
| **Email** | isilimelatherapy@gmail.com |

| | |
|---|---|
| **Title** | The Higher Certificate in Disability Practice in strengthening the primary Health Care System: Perspectives of service users with disabilities on partnering with community rehabilitation workers |
| **Presenter** | Nafisa Mayat |
| **Co-Presenters** | Ms Shireen Damonse |
| **Institution** | Division of Disability Studies, Department of Health and Rehabilitation Services,University of Cape Town |
| **Abstract** | The Higher Certificate in Disability Practice contributes to the implementation of the policy on Re-Engineering Primary Health Care in South Africa, supporting the goal of the National Skills Development Strategy III (NSDS III) and the National Health Insurance.<br>The community rehabilitation worker complement the work of the therapists and work at community level as well as in intermediate facilities such as step-down facilities, mental health facilities, residential facilities and schools and assist in providing an ease in the transition of persons with disabilities being re-integrated into their communities.<br>This paper reports on a collaborative inquiry with the rehabilitation team servicing one subdistrict in Cape Metropole and one subdistrict in rural farming community. The research question was stated as: “How does a rehabilitation team contribute their knowledge of community-based, disability inclusive development to health system strengthening at the primary level?”<br>Participants in the metropole subdistrict included eight community rehabilitation workers (CRWs) who are alumni of the Higher Certificate in Disability Practice; eight persons with disabilities who received their services, and three occupational therapists and one speech therapists who support and supervisors the community rehabilitation workers. Participants in the rural subdistrict were community rehabilitation workers and one community development worker; two persons with disabilities and two rehabilitation therapists.<br>The findings explain the types and range of CBID services being rendered aligned to the 10 inter-related elements of the COPC framework and the role of the community rehabilitation within this framework.<br>The evidence indicates that the role of the community rehabilitation worker is critical within the primary health care team and in particular in creating ease of transition of a person with a disability from the rehabilitation facility to reintegrating back into their community and should be recognised and acknowledged as an important partner within the primary health care team. |
| **CPD Point** | Standard |
| **Biosketch** | I am qualified social worker with a MPhil and Phd in Disability Studies and many years of experience within the disability sector, in particular in higher education. I am currenty employed as a lecturer at the Division of Disability Studies at the University of Cape Town. |
| **Email** | nafisa.mayat@uct.ac.za |

| | |
|---|---|
| **Title** | The Maternawel PPH monitoring tray. A novel approach to effective PPH monitoring in a low resource setting. |
| **Presenter** | Craig Parker |
| **Institution** | Frere Hospital |
| **Abstract** | The recent eMotive trial results were made public and showed the large impact that accurate monitoring of postpartum bleeding had on maternal well being. The trial used custom disposable drapes to measure real-time blood losses but these are not well suited to low resource setting such as rural South Africa. Prof Justus Hofmeyr therefore developed a reuseable tray which can be used in place of the drapes for monitoring post partum bleeding. The tray has been licenced and commercialised through the Umoya Social Enterprise. This talk will review the astounding results of the eMotive trial and present a home grown solution that aims to make this the new Standard of care. |
| **CPD Point** | Standard |
| **Biosketch** | Engineer who became a Doctor who is now in Anaesthetics at Frere Hospital. Formed the social enterprise Umoya together with Volunteers to develop respiratory devices during Covid and now expanded to include additional low resource setting devices. He lives in EL with his wife and is involved in district level Anaesthetics training whenever possible. |
| **Email** | Craig@craigparker.co.za |

| | |
|---|---|
| **Title** | The perceived value of the 'MoreThan Process' on social cohesion: A case study from South Africa |
| **Presenter** | Innocentia Lediga |
| **Co-Presenters** | Andri Eloff, Louise Fouché, Louine Griessel |
| **Institution** | Ukwanda, University of Stellenbosch |
| **Abstract** | This study was a qualitative investigation of the perceived value of the "MoreThan Process" in the community of Touws River. This research explored the experiences of participants and how the MoreThan process contributed to their growth as individuals and as a group in the community. It also explored the process, the development and sustainability of creative projects and impact on social cohesion. Social cohesion has been a topic of interest for many researchers and scholars. The outcomes of this research can help policymakers understand the importance and effectiveness of ownership and responsibility (David et al., 2018). By doing so, community members will be empowered to take ownership and responsibility for creating a community beneficial for them. Participants (34 in total, 27 female, 7 male) were invited and randomly selected to join 4 groups. Each group went through the MoreThan process which included an intensive 4-day Group process, a hand-over day, and a creative part over a 3 month period. The experiences of the MoreThan facilitators and participants were recorded during focus group interviews. Participants who took part in the focus group interviews perceived their community to be poor, dependent and vulnerable. They experienced the MoreThan process, to be a therapeutic healing space, inviting them to emotional and inner healing, self-awareness, and personal growth. They also felt empowered to find creative ways of implementing community upliftment projects and programmes and in the process enable a disabling society. As the project is a collaboration between researchers and people working within the community, for non-degree purposes, the divide between academics and clinicians is bridged and hopes to inspire more projects in the future. The divide between health and social development is also closed at grassroots level, where the need is the greatest. |
| **CPD Point** | Applied for ethics |
| **Biosketch** | Manoko Innocentia Lediga is a social scientist, an educator, a facilitator, and an upcoming researcher. She is currently based at Ukwanda Centre for Rural Health where she assists with ongoing research activities such planning and writing protocols, submitting protocols for Applied for ethics and institutional approval, submitting manuscripts for approval, developing funding proposals, managing database spreadsheets among others. Her primary research interests are on sexual and reproductive health, maternal mental health, social determinants of ill health and young women. She hopes to pursue PhD in public health in the next year. She is a member of the South African Council for Educators (SACE) and the South African Sociological Association (SASA). She is also a member of various movements and NGOs aimed at improving the lives of young women. |
| **Email** | inno@sun.ac.za |

| | |
|---|---|
| **Title** | The power of the pill: An exploration to understand adherence practises of patients on their clinic visit date at a district hospital in the Eastern Cape |
| **Presenter** | Sipho Ngcongolo |
| **Co-Presenters** | |
| **Institution** | Butterworth Hospital |
| **Abstract** | Outpatients departments form a critical juncture between inpatient admissions and management at a primary level of care for non communicable diseases. As one of the four main pillars of the burden of disease in our country, adequate attempts should be made, first to properly describe the population, the phenomena that occur within this context and then use the data collected to justify interventions that have the potential to improve health outcomes and make the system more robust and efficient. This audit aims to do just that. A number of patients presented to our outpatient's department for their chronic medications and were found to be markedly uncontrolled. The data is scanty on why this is the case and furthermore on how strategies can be implemented at our level to responsibly and efficiently engage this population to improve its health outcomes. The aim of this study is to identify and describe the aforementioned population, identify reasons as to why they are uncontrolled at presentation and subsequently use the data to carry out interventions within and outside of the hospital setting. The audit also has the added benefit of providing much needed data on low-income communities, especially in the rural context as well as insight into the lived experiences of the people who we serve. |
| **CPD Point** | Standard |
| **Biosketch** | Currently a community service doctor working in the Amathole district |
| **Email** | Reedsipho7@gmail.com |

| | |
|---|---|
| **Title** | The role of community healthcare workers on the importance of the first 1000 days of life of a child, its effects on shield development and child mortality. |
| **Presenter** | Shadi Nyokong |
| **Institution** | Nelson Mandela Children's Fund |
| **Abstract** | Community participation through community-based interventions is identified as essential component in Primary Health Care (PHC). It is also an effective strategy towards achieving Sustainable Development Goals (SDG) 3. PHC uses different delivery models, one of which partners with community members to interpret and translate health services, assist communities to access relevant health services, provide health education, promote and advocate for healthy behaviors. These community members are called community healthcare workers (CHW). In some instances, CHWs are employed by local based NGOs and are linked to local clinics. While the aim is universal access to health care for the whole population, those living in hard-to-reach communities often face a variety of access barriers. In concert with barriers to access to health care for many rural residents, is the challenge of limited knowledge and evidence on the role of CHWs in child development and child mortality. The Nelson Mandela Children's Fund through its Child Survival, Development and Thriving programme has used CHWs model to prevent child mortality by visiting families to encourage mothers and pregnant women to attend antenatal and post-natal care, to be immunization-compliant, to practice good nutrition for both mom and the baby and to exclusively breastfeed for six months after childbirth. CHWs also establish community-based support through mentor moms who provide continuous support to mothers and pregnant women. They have facilitated community engagement activities and worked with local clinics and clinic committees as part of strengthening of community health systems. This session will unpack the role of CHWs on the first 1000 days of a child's life, their development and mortality. The importance of all the stakeholders and role players including the community's full participation in this delicate stage will be demonstrated, specifically how it facilitates life-saving community buy-in and timely interventions relating to this stage. |
| **CPD Point** | Standard |
| **Biosketch** | Shadi Nyokong is the Manager of the Nelson Mandela Children's Fund (NMCF)'s Child Survival, Development and Thriving Programme. A qualified social work, Shadi has worked in the non-governmental organization sector for 25 years. During this period, she has focused on programme design and development, concept development, programme management and coordination, monitoring and evaluation, resource mobilization and governance. Shadi has been with NMCF for past 20 years and has been responsible for executing the Fund's strategy in all provinces in South Africa. She has managed programmes such as family-based early childhood development within the organisation, a programme for children living and working on the streets, court support programme for children in legal system, care and support for children in vulnerable circumstances. Her programme's focus for past five years is reducing child mortality and supporting pregnant mothers and their babies in the first 1000 days of the life of a child through family outreach, community outreach and strengthening health systems. She was also a participant of GIBS social entrepreneurship programme, a concept about the using methods of mainstream business for social venture. |
| **Email** | Shadin@nmcf.co.za |

| | |
|---|---|
| **Title** | Tshemba Foundation-an agent for change for good clinical practice |
| **Presenter** | Rhian Twine |
| **Institution** | Tshemba Foundation |
| **Abstract** | Tshemba Foundation – an agent for change for good clinical practice: The Tshemba Foundation's medical volunteer programme recruits healthcare professionals from a range of disciplines with knowledge, skills, experience and a deep desire to give back to rural communities. Over 7 years, 274 volunteers have had a unique volunteering experience, many lessons have been learnt, and Tshemba is now firmly established, partnering with Mpumalanga Department of Health. Tshemba supports healthcare at the rural Tintswalo hospital, 7 of it's 14 feeder clinics, 10 nearby primary schools. It also supports an exceptional eye clinic with a focus on cataract operations as well as a new woman's health clinic.Through case studies, we will describe what local health care providers, Tshemba staff and volunteers have learnt. We will focus on how such lessons may apply to health care systems where there is no NGO as well as where there is. Case studies include:<br>• Improving things in OPD – transforming spaces, implanting a booking system<br>• Going from no pap smears to a pap smear service<br>• Reorganising utilisation of buildings renovated during COVID<br>• Improving staff morale – including some failures<br>• The outreach journey – amendments to the MOU, increasing use of local volunteers<br>Lessons that can be derived include:<br>• The Applied for ethics of sustainable development – deciding what to tackle<br>• Moving through scepticism-trust-partnership<br>• Taking the long slow road, that always has puddles<br>• Handling unrealistic expectations<br>• Who else if no volunteers?<br>• Reframing problems – thinking out of the box and keeping it simple<br>• The importance of working with hospital and unit management<br>• Everyone is part of the team, from the cleaner through to management<br>Tshemba Foundation would like to share their experiences in learning how to foster good practice in adverse conditions. During discussions, Tshemba hopes to also learn from others. |
| **CPD Point** | Standard |
| **Biosketch** | I have worked for 32 years in rural areas in South Africa, as an occupational therapist in rural hospitals, and in the field of public engagement in research. with the MRC/Wits Rural Public Health and Health Transitions Research Unit (Agincourt), focusing on developing strong links with the host community since a relationship of trust, respect and mutual fair benefit is essential to conducting longitudinal research in any one community. I obtained my PhD on community involvement in research in 2019. 2 years ago I made the move into the NGO world, where I now work as the coordinator of volunteers with the Tshemba Foundation. I have transformed the volunteer experience into one of solely patient treatment and some teaching, to one where in addition to treatment and teaching, volunteers assist the hospital in various quality improvement projects. |
| **Em** | rhian@tshembafoundation.org |

| | |
|---|---|
| **Title** | Two Worlds Apart |
| **Presenter** | Duncan Haynes |
| **Co-Presenters** | Dr Michelle Cocks, Dr Charlie Shackelton |
| **Institution** | Rhodes University |
| **Abstract** | The apparently opposite cosmological-orientations of African spiritual healing and allopathic medicine are today often described as being two separate worlds of understanding. Historically the former was labelled as superstition by a western lens and deemed developmentally inferior to the latter. Here: 'African beliefs would one day- through the influence of Christian conversion and Education- disappear in favour of enlightenment and rationality'. This orientational-paradigm results in the Cultures of Practice in South African medicine being predominantly aligned to the linear 'truths' of reductionist science at the expense of other ontologies.<br>By drawing on extensive research into Xhosa ancestral belief, as part of a masters study in Anthropology 2018-2021, this presentation aims at discussing the reasons for difficulties in communicating across these two worlds and even a 160 year veiling of the existence of the ancestral paradigm. This study indicates that far from disappearing this cosmological view remains stable, and thus that the holistic well-being of up to 87% of Xhosa speakers might be grounded in spiritual relationships with ancestors).<br>In the context of a strong contemporary drive in the west for holistic healing paradigms this study highlights Ancestral beliefs holistic dialogue of: individual-, communal-, psychological- and environmental- health as well as dialoguing of intergenerational traumas that are held in the 'Collective Unconscious' or 'Morphic Resonance' of a family or community.<br>This study explored the related veiling of the deep metaphors-of-being in Xhosa writing within school and church spaces as a necessary strategy to fit in with linear requirements western rationality . Understandably as part of this veiling, communication must of necessity only communicate surface issues rather than a depth of authenticity regarding who one is and what well-being (Impilo) really means to one.<br>In understanding the reasons for the difficulty of talking across this barrier between the worlds this presentation hopes to explore the potential of allopathic medicines as assistive stepping-stones in patients' life processes, rather than as complete 'cures' in themselves. |
| **CPD Point** | Standard |
| **Biosketch** | Anthropology Masters Student |
| **Email** | duncanhaynes.za@gmail.com |

| | |
|---|---|
| **Title** | Using the Integrated Longitudinal Community Clerkship to transform medical students to healthcare advocates in the rural communities |
| **Presenter** | Siyonela Mlonyeni |
| **Co-Presenters** | Prof Olanrewaju Oladimeji |
| **Institution** | Faculty of Health Sciences, Walter Sisulu University, Mthatha |
| **Abstract** | The Faculty of Health Science in the Walter Sisulu University (WSU) has the community-oriented education as its philosophy and boasts as one of the leaders in Community-Based Education (CBE) in the South Africa. The mission of the faculty is to excel in Problem-Based Learning (PBL), CBE, and social responsiveness through the integration of community service into its learning programs. As part of this commitment the Faculty of Health Sciences at WSU introduced a compulsory 20-week extensive Integrated Longitudinal Community Clerkship (ILCC) rotation block in June 2014, wherein the 5th medical students were placed in various district hospitals across the Eastern Cape Province.<br>The purpose of this study was to investigate the transformation in students' understanding of community needs and the ability to respond to those needs.<br>A cross-sectional, exploratory approach using a qualitative research method to explore the transformation in students' understanding of community needs and the ability to respond to those needs. The entire 5th year class was invited to participate. Data was collected using three techniques: Focus Group discussions augmented with field notes, observation technique and student journal entries.<br>A total of six focus groups were held. Using the transformation theory, evidence suggests that some students were able to undergo transformation during this rotation. Students documented their positive experiences, challenges and how they responded to the challenges. Some students were able to demonstrate the transformation in their understanding of community needs and how they responded to the needs of the rural communities.<br>Even though the clerkship program provided a valuable context for some students to develop and deepen their perceptions of "real life" community needs, some students had not completely transformed during this rotation. Various factors need to be considered when attempting to achieve full transformation in all students. |
| **CPD Point** | Standard |
| **Biosketch** | Siyonela Mlonyeni, B Med Sc (WSU), PG Dip: Chemical Pathology (WSU), MPH (WSU). Department of Health Professions Education, Walter Sisulu University, Mthatha, Eastern Cape, South Africa |
| **Email** | siyonela@gmail.com |

| | |
|---|---|
| **Title** | Vacuum deliveries - time to rekindle a dying practice? |
| **Presenter** | Andrew Wilkins |
| **Institution** | Madwaleni Hospital |
| **Abstract** | Maternal and perinatal health are global health priorities, yet in the past decade maternal and perinatal mortality rates have shown little improvement. This is especially true in rural and under-resourced areas. Due to medicolegal concerns, healthcare convenience and the perceived benefits of CDs over vaginal deliveries there has been a steady rise in caesarean deliveries in both public and private sector. These increased CD rates have shown little improvement in these rates. The use of CD especially in the second stage of labour and in rural settings has led to an increased risk of haemorrhage and infection; prolonged hospital stays; increased blood transfusions; and complications in future pregnancies. Vacuum assisted vaginal deliveries (VADs) have been proposed as safe alternatives to CDs in the second stage of labour yet despite this recommendation, there is limited data on their use in South Africa. In resource poor settings, access to VADs has the potential to improve maternal and neonatal outcomes and prevent unnecessary CDs. Available literature from LMICs is limited and was conducted in tertiary academic settings by obstetric specialists. Madwaleni Hospital is a district hospital in a deeply rural part of the Eastern Cape. A committed medical team and decentralized Family medicine program has provided clinical stability and maintained a culture of excellent obstetric practices. One of these practices includes the use of VADs. Community service officers, medical officers, clinical associates and Family physicians can all provide VADs to those who need. As part of my MMED for Family Medicine I am conducting a study comparing outcomes from VADs with SSCDs over a 5-year period at Madwaleni Hospital. The aim is to describe outcomes from VADs and compare those with SSCDs to gain a better understanding of the use of VADs in the hands of non-specialist medical doctors in a rural setting, spark further research on the topic, and encourage dissemination of knowledge, experience and training to other similar facilities. I have completed data collection and within the next few months will complete analysis, write up of results as well as publication. I hope to be able to present my findings at the Rural Health Conference this year. |
| **CPD Point** | Standard |
| **Biosketch** | Family physician (to be); Passionate about improving rural obstetrics; Husband to a hero therapist; Father to twin girls; Lover of the wild coast |
| **Email** | dr.agwilkins@gmail.com |

| | |
|---|---|
| **Title** | VILLAGE-BASED MOTHER MENTOR SUPPORT GROUPS (Supporting the motherchild dyad in its first thousand days of life) |
| **Presenter** | Sarah Wilkins |
| **Institution** | Madwaleni District Hospital |
| **Abstract** | In South Africa child health policymakers and practitioners have both the opportunity and obligation to turn focus not only on child survival, but on ensuring that all children also thrive and reach their full developmental potential' (Bamford, 2019). The environment that young children are nurtured in, need not only be free from harm but also provide the experiences which the brain and other systems need to grow and develop (Jameson & Richter, 2017). Establishing emotional attachment between parents and their infant during the first thousand days (FTD) of life is not only vital for survival in the short-term, but also determines the pathway for lifelong healthy, sustained development (Berry & Malek, 2017). Support systems for caregivers are therefore essential to provide practical assistance and emotional support, particularly during stressful periods. (Casale et al., 2015. Social support networks whether through the immediate and extended family or through community-based programmes play a valuable promotive and protective role in this.<br>The problem(s): The Qhawekazi mother-mentor breastfeeding project was introduced at Madwaleni Hospital in October 2020 to provide breastfeeding education and support for all women in both the antenatal and postnatal period at an institutional level to start overcoming poor breastfeeding rates. Over the last two years, we have come to realize two things:<br>1) Providing education & support at an institutional level is convenient and reaches more people, however it doesn't result in sustained breastfeeding practices without buy-in from a dyad's (mother-and-child's) family and community.<br>2) It is not possible to support breastfeeding practices alone without supporting other aspects of a child's early life i.e., pregnancy, family planning, nutrition, and development.<br>The solution: After conducting visits to a variety of breastfeeding mothers' homes, we freshly encountered the challenges that rural communities experience in accessing healthcare, but we were also made aware of the incredible opportunity we might have to support these heroic mothers to then support other mothers and their families living near them.<br>This presentation aims to share the story of the development of a village-based mother mentor project. Mothers received ongoing educational support and training on specific FTD content to then support other pregnant or breastfeeding mothers in their local villages through the formation of mother-mentor support groups. |
| **CPD Point** | Standard |
| **Biosketch** | I am Speech-Language Therapist with a special interest in early childhood intervention and completed a Masters in Early Childhood Intervention in 2021. My husband and I have lived and worked at Madwaleni since 2018. I quickly came to realize why supporting appropriate breastfeeding is so valuable and was involved in the development of the Qhawekazi Mother-Mentor Project in 2019. I now feel very passionate about taking first 1000 days support and education to the community to ensure ongoing support for pregnant and breastfeeding mothers, their children and their families. |
| **Email** | sa.vanre@gmail.com |

| | |
|---|---|
| **Title** | Were they prepared for rural community service? |
| **Presenter** | Stephanie Homer |
| **Institution** | University of the Witwatersrand and Rural Rehab SA |
| **Abstract** | Since 2018 RuReSA has been surveying community service therapists as they leave their com serv year. One component of this survey was to look at whether they were prepared for the work we thought com servs would commonly be involved in in rural areas, and areas of concern that we had: working in variety of multi-disciplinary teams, administration duties and management of workload and own learning, prescribing assistive devices, working with children with cerebral palsy, as well as skills for communicating with people from other languages and culture. Response options were: “well prepared”, “good theoretical knowledge and experience during training”, “enough theoretical knowledge and some practical experience” , some theoretical knowledge but no practice experience” , and “no theoretical knowledge and no practice experience”. The data will be disaggregated into professional groups, facility types, and urban-rural community service placements. Although we can celebrate that the community service therapists were generally positive about their preparation we can highlight some of the concerns they had that training institutions should consider in curriculum development. |
| **CPD Point** | Standard |
| **Biosketch** | Stephanie Homer currently works for RuDASA and the Occupational Therapy Department, University of the Witwatersrand; and she is a member of the RuReSA Executive committee. Prior to 2012 Stephanie had a number of posts including: RHC Office Co-ordinator, manager of a centre of adults with mental disabilities, disability grant panel member, and co-ordinator of the Wits-Tintswalo CRW Training Programme. She loves living and working rural. |
| **Email** | homer@dullstroom.net |

| | |
|---|---|
| **Title** | What are the barriers and challenges that Clinical Associates face in the practice of their profession? |
| **Presenter** | Siboniso Nene |
| **Institution** | Work |
| **Abstract** | Background: Human resources for health are a documented challenge, especially in the global south. In 2002, the South African government following a report by the Ministerial Task Team on Human Resources (Tick Report, 2001) decided to create a new cadre of mid-level healthcare workers. These workers were primarily going to be district based, especially in rural areas. The Clinical Associates (CAs), as known in South Africa were introduced into the South African Healthcare system in 2011. The introduction of CAs as mid-level healthcare workers was envisioned to help the country counteract medical professionals' shortages, especially in rural areas where there is rife shortage of doctors. However, the implementation of this reform has not been adequately studied to understand the experience of CAs in the South African context.<br>Methods: This study was qualitative and adopted phenomenology theoretical framework, explorative and inductive in nature. Data was collected through in-depth semi structured interviews done through telephone with 8 CAs based at level 1 healthcare facilities. Thematic analysis was employed to analyse data.<br>Findings: The study found multiple factors which act as a barrier in quality patient care. The most barrier voiced out being the limiting scope of practice and challenges with the government human resources system, which has not transformed and nor has it been amended to accommodate CAs. The barriers inhibit positive patient outcomes and client experience of care. The challenges affecting CAs have a direct impact on the emotional wellbeing of CAs. Emerged themes themes include;<br>a) Limiting scope of practice,<br>b) Inexistent Salary grading system,<br>c) Lack of career progression and<br>d) Lack of Employee benefits;<br>e) Acceptability of CAs as mid-level healthcare workers and<br>f) Perceived clinical role versus reality.<br>The CAs made a variety of recommendations to improve their experiences and integration in the health system.<br>Conclusion: The study identified various challenges faced by CAs in their daily practice, which may impact their experiences, patient experience, and the sustainability of the profession. These challenges and barriers voiced out by CAs can be used by policy makers with an aim of developing, shaping, and improving the CAs occupation. |
| **CPD Point** | Standard |
| **Biosketch** | Primary Healthcare Nurse specialist with 12 years experience within public and NGO sector. A seasoned healthcare manager currently serving at KwaZulu Natal Department of Health Head Office. A nurse specialist who has interest in human resources for health and how healthcare inequalities affect rural communities. Currently a post graduate student at the University of the Western Cape |
| **Email** | Sibonisonene@gmail.com |

# Panel Discussion

| | |
|---|---|
| **Title** | A call to embed disability inclusive workforce development in the ward-based district health system |
| **Presenter** | Theresa Lorenzo |
| **Institution** | University of Cape Town |
| **Abstract** | Re-engineering primary health care and the implementation of national health insurance scheme necessitates that ward based primary health care teams recognise that rehabilitation therapists and community rehabilitation workers as an essential part of human resource planning. The Community Oriented Primary Care framework was piloted in the Western Cape from 2017. Disability and rehabilitation did not feature in the framework. This paper reports on a collaborative inquiry with the rehabilitation team servicing one subdistrict in Cape Metropole and one subdistrict in rural farming community. The research question was stated as: "How does a rehabilitation team contribute their knowledge of community-based, disability inclusive development to health system strengthening at the primary level?" Participants in the metropole subdistrict included eight rehabilitation care workers (RCWs) who are alumni of the Higher Certificate in Disability Practice; eight persons with disability who received their services, and three occupational therapists and one speech therapists who support and supervisors the RCWs. Participants in the rural subdistrict were RCW and one community development worker; two persons with disabilities and two rehabilitation therapists.The findings describe the types and range of CBID services being rendered aligned to the 10 inter-related elements of the COPC framework. We also share the influence of CBID on strengthening PHC services. This evidence reveals that ward-based PHC teams need to clearly differentiated scope of practice of community health workers and home based careers from CRWs. The mental health needs of persons with disabilities and their families need to be integrated more holistically. In conclusion, policy makers and health systems researchers need to embed disability inclusion into all elements of the COPC to ensure continuity of care for persons with disability and their families, in order to effectively reduce burden of disease. |
| **CPD Point** | Applied for ethics |
| **Biosketch** | I am passionate about reciprocal capacity building of community based, disability inclusive workforces for more than 30 years. I gained practical experience in the Mhala district served by Tintswalo hospital when it was still Gazankulu homeland, and continued developing my capabilities with the SACLA Health Project in Cape Town after 1994. I have influenced curricular changes through spearheading disability studies in the training of health professionals and development practitioners at University of Cape Town and beyond. |
| **Email** | theresa.lorenzo@uct.ac.za |

| | |
|---|---|
| **Title** | Collaborative solutions with indigenous knowledge healers in rural Eastern Cape to improve awareness and treatment of surgical conditions. |
| **Presenter** | Kathryn Chu |
| **Co-Presenters** | Dr. Andrew Miller,Dr. Khaya Tshabalal, Mr. Bafana Tonga |
| **Institution** | Stellenbosch University |
| **Abstract** | Surgical care in rural South Africa is limited. Indigenous knowledge healers (IKHs) treat various health conditions in South Africa and are prevalent in rural Eastern Cape. Many surgical conditions are time sensitive and delay into the formal health sector has been reported through care seeking behavior with IKHs.<br><br>The aim of this panel is to discuss strategies to better understand treatment of surgical conditions in rural Eastern Cape by both IKHs and formal health care workers and how to develop collaborative solutions to improve care. The panel will be moderated by Prof Kathryn Chu, the Director for the Centre for Global Surgery and will include various stakeholder including Dr. Andrew Miller, clinical manager of Madwaleni district hospital, Dr. Khaya Tshabalala, director of a community-based organisation, Imijelo, who has also done research with IKHs, and Mr. Bafana Tonga, an established IKH who has been instrumental in establishing connections with other IKHs in the region to explore their treatment of surgical conditions. The current planned activities are a survey with IKHs, focus groups with community members and persons with surgical conditions who sought care with IKHs, and a multi-stakeholder workshop to discuss collaborative solutions to improve care. The desired output of the panel discussion is to receive peer feedback on these methodologies as well as to inform the audiences of the potential benefits and challenges of dual health systems in treating surgical conditions in rural South Africa. |
| **CPD Point** | Standard |
| **Biosketch** | Kathryn Chu is a general surgeon and the Director for the Centre for Global Surgery at Stellenbosch University. Her work focuses on improving surgical access to rural persons in South Africa and beyond. |
| **Email** | kchu@sun.ac.za |

# Posters

| | |
|---|---|
| **Title** | Adapting to stressful working parameters: innovative stories of rural health care workers |
| **Presenter** | Akhona Ncinitwa |
| **Co-Presenters** | Ms. Nomfuneko Sithole, Dr. Sikhombuzo A. Mabunda, Dr. Wezile Chita, Dr. Itumeleng Funani and Ms. Bongiwe Mkhabela |
| **Institution** | Wits Health Consortium |
| **Abstract** | Background: It is recognized that Sub-Saharan Africa rural and remote communities are the most socioeconomically deprived communities with the greatest health needs. Studies have shown uneven distribution of health professionals within countries. In South Africa, 46% of the population lives in rural areas where only 19% of the health professionals are based. This study aims to share innovative strategies that rural health workers adapt to cope with ever stressing working conditions in rural referral hospitals.<br>Methodology: This research draws insights from eight Focus Group Discussions (FGDs) with Heads of Departments and Operational Managers of four South African referral hospitals. These FGDs were held between June and September 2022 in two of South Africa's rural provinces (Eastern Cape and Mpumalanga). Data were audio-recorded and transcribed verbatim with peer and member checking of transcripts. Thematic inductive analysis was used to analyse the data.<br>Results: FGDs had 5 to 10 participants with a minimum of 5 years' experience in hospital management. Stressors identified ranged from those related to the work environment infrastructure (i.e., workforce and equipment), professional development, incentives and personal challenges. The discussions revealed how rural health care workers strive in their working environments.<br>Conclusion: Among the required skills necessary for rural health workers to perform their jobs, is innovation. These workers, day-in and day-out make plans and close gaps in their working stations to achieve the best results in patient care and outcomes. Health policymakers can gain a lot of insight from conversations with rural health workers. |
| **CPD Point** | Standard |
| **Biosketch** | Akhona Ncinitwa is a young and up coming Public Health researcher majoring in Epidemiology and Biostatistics. Currently working as a Data Manager in Health Systems Enablement and Innovation unit at the Wits Health Consortium. She has 10 years of experience in the research sector. Her interests are on HIV related cancers in the Eastern Cape province, which is part of her Master's Thesis work. |
| **Email** | Akhona.Ncinitwa@hsei.co.za |

| | |
|---|---|
| **Title** | An Education Initiative to Strengthen the Skills and Inter-Hospital Communication Amongst Doctors Working in District Hospitals of the Central Eastern Cape |
| **Presenter** | Chris Palfreeman |
| **Co-Presenters** | Prof Andy Parrish |
| **Institution** | Cecilia Makiwane Hospital Mdantsane East London Eastern Cape |
| **Abstract** | Discussion and referral of patients between specialties and hospitals is a common part of clinical practice. Throughout South Africa, district hospital doctors frequently discuss clinical cases with regional hospitals, to receive advice from specialists, arrange transfer of patients for imaging and escalation of care. District hospitals in rural areas are particularly reliant on this communication with regional centres, as large distances between hospitals can make transfer of patients challenging. It is therefore vital this communication is effective.<br>This qualitative study explores the experiences of doctors at both district and regional hospitals in the Buffalo City and Amathole Districts in the Eastern Cape regarding referral and discussion of cases with Internal Medicine, to identify areas of strength and improvement to inform educational initiatives and service development.<br>Doctors from six district and two regional hospitals participated in focus groups or semi-structured interviews, to capture views of both perspectives on the discussion. Twenty-two participants were included. Data was analysed using thematic analysis.<br>Six themes were identified: mode of communication, quality of communication, approach, relationships, roles and responsibilities and education. Key issues surrounding referrals were unreliable telephone or internet reception leading to cases discussed via alternative methods, misunderstanding of resources and skills available at each site, little formal handover and sub-optimal attitude or communication skills of individuals. Communication was improved when doctors had experience of working in both district and regional hospitals or could empathise with their colleagues, communicated using a clear structure, concise information and a clear purpose. Other positive influences were having experience of receiving referrals and having met each other previously.<br>The findings of this study are being used to inform local education initiatives, such as simulation of challenging referrals with doctors exchanging their usual roles and creating opportunities for doctors to meet and discuss their experiences, promoting empathy and understanding. |
| **CPD Point** | Standard |
| **Biosketch** | Dr Chris Palfreeman is a doctor from the United Kingdom currently training as an Anaesthetist. Chris is taking a break from his training and spending 6 months working in the Eastern Cape as part of the NHS Global Partnerships Fellow program. He will be working as part of the Buffalo City Municipality and Amothole District Medical Support Initiative (BAMSI) with his project specifically focused on improving communications and referrals between district and regional hospitals Improving |
| **Email** | chrispalfreeman93@gmail.com |

| | |
|---|---|
| **Title** | An education initiative to strengthen the skills and inter-hospital communication amongst doctors working in district hospitals of the central eastern cape. |
| **Presenter** | Chris Palfreeman |
| **Co-Presenters** | Prof. Andy Parrish |
| **Institution** | BAMSI |
| **Abstract** | The Buffalo City Municipality and Amathole Support Initiative (BAMSI) programme aims to equip clinicians working in resource-restricted settings in the central Eastern Cape with essential clinical knowledge and skills to effectively manage common medical conditions, while creating a forum for discussion between the regional and district hospitals.<br>The BAMSI group have been delivering regular, weekly online teaching to doctors in local district hospitals since 2021, following a topic guide developed by local education leads in Internal Medicine. To complement this online teaching, a series of Clinical Skills Days have been developed, to deliver in-person teaching to small groups of district hospital clinicians from the region.<br>Occurring monthly within the Internal Medicine department at Cecilia Makiwane Hospital (regional hospital in Mdantsane), each Skill Day hosts four doctors, either in Community Service or Medical Officer roles, from a range of district hospitals in the Amathole District and Buffalo City Municipality. The visiting doctors receive focussed small group teaching on clinical skills, such as bedside ultrasonography and ophthalmoscopy, aiming to improve their diagnostic thinking and independence. They also take part in communication skills sessions with regional hospital doctors, focusing on patient referrals and telephone escalation of care within simulated scenarios.<br>The BAMSI Skills Day has been designed not only to improve clinical skills, but also to promote a sense of connection and network between doctors working in the region. This has been reflected in the highly positive feedback from attendees, highlighting the usefulness and relevance of the practical sessions and the great value in meeting colleagues at the regional referral centres. We hope that through these in-person, inter-hospital teaching days, doctors in district hospitals can develop their clinical skills, build a strong professional network and be inspired to pursue further training, to ultimately improve patient care and streamline referral processes in rural areas. |
| **CPD Point** | Standard |
| **Biosketch** | Dr Chris Palfreeman is a doctor from the United Kingdom currently training as an Anaesthetist. Chris is taking a break from his training and spending 6 months working in the Eastern Cape as part of the NHS Global Partnerships Fellow program. He will be working as part of the Buffalo City Municipality and Amothole District Medical Support Initiative (BAMSI) with his project specifically focused on improving communications and referrals between district and regional hospitals Improving |
| **Email** | chrispalfreeman93@gmail.com |

| | |
|---|---|
| **Title** | Barriers to mitigating pressure ulcer risk among learners with paraplegia attending a South African special school – Learners' and caregivers' perspectives |
| **Presenter** | Undine Rauter |
| **Co-Presenters** | Dr Desmond Mathye |
| **Institution** | Gelukspan District Hospital |
| **Abstract** | OBJECTIVE: This presentation describes barriers to preventing pressure ulcers among learners with paraplegia in a South African special school context perceived by learners and their caregivers and their influence on pressure ulcer risk. BACKGROUND: Learners with paraplegia in the selected governmental special school experience barriers to implementing pressure ulcer prevention strategies that exacerbate pressure ulcer risk across care settings. METHODS: A qualitative, exploratory, descriptive study design was used. 28 semi-structured telephonic, audio-recorded interviews were held in with learners and their caregivers. A small focus group discussion also contributed to the data. All data were organized using Nvivo Pro 12. An inductive thematic analysis resulted in four risk categories. RESULTS: Learners and caregivers experienced interlinked barriers to preventing pressure ulcers such as societal perceptions and exclusion of persons with disability, unfavourable social determinants of health, lacking access to health care services, unavailability peer support, and personal factors. CONCLUSION: While many barriers to pressure ulcer prevention encountered by learners and their caregivers are beyond their control, some can be influenced at relatively low cost. To effectively prevent pressure ulcers among learners with paraplegia in a special school, barriers with the most potent influence on pressure ulcer risk must be targeted. These include improving access to health services and competencies across care settings. Implementing a holistic, participatory empowerment and capacity building program can become a game changer. |
| **CPD Point** | Standard |
| **Biosketch** | Undine has been involved in rural rehabilitation in South Africa since 1995 as a physiotherapist with growing expansion of her skills to a transdisciplinary interventionist. Employed in a governmental rural district hospital, she helped developing the rehabilitation services at Gelukspan, especially paediatric disability services through the Parents' Guidance Centre REAKGONA. She obtained a masters degree in Early Childhood Intervention with majoring in severe disability in 2007, and presently waits for examination results (maybe out by then) for her PhD). Her thesis was Developing a model for preventing pressure ulcers in learners with paraplegia attending a special school in the North West Province. |
| **Email** | mmatumelorauter@outlook.com |

| | |
|---|---|
| **Title** | Clinical presentation and outcomes of patients with acute rheumatic fever and rheumatic heart disease seen at tertiary hospital setting in Port Elizabeth South Africa |
| **Presenter** | Zongezile Masonwabe Makrexeni |
| **Institution** | NMAH |
| **Abstract** | Background:<br><br>The incidence of acute rheumatic fever (ARF) and rheumatic heart disease (RHD) has waned in Western countries, however that is not the situation in developing nations.<br><br>Methods:<br><br>Records were reviewed of patients from the Eastern Cape municipal districts who presented to the Paediatric Cardiology Unit with ARF and RHD from January 2008 to August 2015.<br><br>Results:<br><br>Total of 56 patients with ARF/RHD was reviewed. The majority of patients (n = 52) presented for the first time with RHD. Four patients presented with ARF and two had recurrent ARF. Six patients presented with a combination of RHD and congenital heart disease. Twenty-three patients were operated on for chronic rheumatic valve disease, with good outcomes.<br><br>Conclusion:<br><br>The true burden of ARF/RHD is unknown in the Eastern Cape. Prospective studies are needed to accurately determine the prevalence of RHD in this province.<br><br>Keywords: acute rheumatic fever, rheumatic heart disease, left ventricular dysfunction, rheumatic valve surgery, disease outcomes, prevention |
| **CPD Point** | Standard |
| **Biosketch** | Academic head of Paediatrics and Child Health at Walter Sisulu University |
| **Email** | mmmaso30@gmail.com |

| | |
|---|---|
| **Title** | Contextual Barriers and Facilitators to Implementing Clinical Governance in Selected Hospital in the Eastern Cape: A Qualitative Study |
| **Presenter** | Siphokazi Pahlana |
| **Co-Presenters** | Dr. Olanrewaju Oladimeji |
| **Institution** | Walter Sisulu University |
| **Abstract** | Many public hospitals in South Africa have been described as institutionally insufficient, dysfunctional and the management failures caused by lack of management capacity. Good clinical governance is needed to improve the quality of service delivery and to safeguard the high Standards of care.<br>Purpose:<br>The purpose of the study is to explore the barriers and facilitators to implementing clinical governance in the selected hospitals in the rural Eastern Cape.<br>Methodology:<br>A qualitative study. Sampling process; snowball approach. Key informant interviews, various group gender balance, racial balance in different facilities. Question items on barriers, facilitators, and clinical governance.<br>Conclusions: The identification of the barriers and facilitators to the implementation of clinical governance is needed to establish a successful clinical governance in the Eastern Cape. |
| **CPD Point** | Standard |
| **Biosketch** | MBChB (UNITRA), DA(SA), BSc (USA). Department of Health Professions Education, Walter Sisulu University, Mthatha, Eastern Cape, South Africa. |
| **Email** | spokipahlana@gmail.com |

| | |
|---|---|
| **Title** | Developing an online clinical audit toolbox for district hospitals to promote quality improvement practice and a tailored regional teaching programme in the Eastern Cape. |
| **Presenter** | Isobel Morton |
| **Co-Presenters** | Prof Andy Parrish |
| **Institution** | The Buffalo City Municipality and Amathole District Support Initiative (BAMSI) |
| **Abstract** | Clinical audit empowers clinicians to evaluate clinical practice, spark evidence-driven changes and assess their impact over time. Time constraints, lack of support and limited experience are commonly reported barriers to audit in rural settings.<br>The Buffalo City & Amathole Districts Medical Support Initiative (BAMSI) recently developed an online, user-friendly 'Clinical Audit Toolbox' for district hospital clinicians in the Eastern Cape. The Toolbox contains a growing series of simple pre-designed audits focussing on key aspects of clinical practice, currently ranging from prescriptions to post-admission reviews. The platform allows clinicians to remotely carry out audits on any online device, analyse results and compare them to regional averages, and facilitate effective results sharing and presentation. The audits are designed by BAMSI's senior Eastern Cape clinicians and UK-trained quality improvement fellows, with encouraged input from district hospitals. The Toolbox's aim is to inspire critical thinking and reflection amongst district hospital clinicians, while promoting clinician-driven quality improvement changes.<br>The programme's second aim is to provide BAMSI with real-time data to guide the weekly regional teaching programme for district hospitals. We aim to utilise pre and post-teaching audit data to quantify the programme's impact and improve teaching by focussing on lower performing areas and topics. For example, within our first pre-teaching cycle, we collected data on over 120 scripts from 8 hospitals and CHCs in 3 weeks, highlighting the tool's capacity for effective data capture. We have also received overwhelmingly positive feedback from its users, praising the Toolbox's "easy use and well-presented results" and 100% thinking the tool would make clinical audit easier for rural clinicians.<br>We now hope to build awareness for the Clinical Audit Toolbox within the region, grow its audit catalogue and establish regular audit cycles in relation to teaching to maximise the benefit for district hospital clinicians, their learning and practice. |
| **CPD Point** | Standard |
| **Biosketch** | Dr Isobel Morton is a Internal Medicine Doctor from the United Kingdom with a specialist interest in Palliative Care. Isobel is spending six months working in South Africa as part of the NHS England's 'Global Fellowship Partnership.' During this time, she is working with the The Buffalo City Municipality and Amathole District Support Initiative (BAMSI), on supporting doctors within the network with quality improvement and system strengthening. |
| **Email** | isobelmorton@doctors.net |

| | |
|---|---|
| **Title** | Factors contributing to delays to accessing appendectomy in low and middle income countries. A scooping review |
| **Presenter** | Johnelize Louw |
| **Co-Presenters** | Ms J Jassat, Mr C Fourie, Ms J Davies, Professor René English, |
| **Institution** | Centre for Global Surgery Department of Global Health Faculty of Medicine and Health Sciences Stellenbosch University |
| **Abstract** | Background: Appendicitis is one of the most common emergency surgical conditions worldwide. Delays in accessing appendectomy can lead to complications. Identification and synthesis of evidence on delays in low- and middle-income countries (LMICs) are lacking. The aim of this review was to identify and synthesize the available evidence on delays to accessing appendectomy in LMICs. Methods: This scoping review followed the Preferred Reporting Items for Systematic Reviews and Meta-analysis Extension for Scoping Review framework. The delays and their interconnectivity in LMICs were synthesised and interpreted using the Three Delays framework. We reviewed Africa Wide EBSCOhost, PubMed – Medline, Scopus, Web of Science, African Journal Online (AJOL) and Bioline databases. Results: Our search identified 21 893 studies, of which 88 were included in the final analysis. Most of the studies were quantitative. Nearly 50% of the studies included all three types of delays. The factors associated with the Delays were interconnected. Delays to seeking care were influenced by a lack of awareness of appendicitis symptoms, and the use of self and alternative medication which could be linked to the refusal of medical treatment due to fear. Financial concerns were a barrier observed throughout the care pathway. Delays to receiving care were attributed to a lack of hospital resources. Conclusion: According to our review, persons with appendectomy present late to health care facilities for several reasons. After reaching a health care facility, accessing appendectomy can further be delayed owing to a lack of resources that are required to provide the necessary care. As these delays are often accumulative, the outcome is often post-operative complications and sometimes even death. Overall, our review has highlighted the need for additional studies on delays to accessing appendectomy in additional LMICs, and for future studies to also consider the heterogeneity of the health system within the relevant countries. |
| **CPD Point** | Standard |
| **Biosketch** | Ms. Louw is a currently pursuing her doctorate in Health Systems and Public Health at the Stellenbosch University. Her PhD focuses on delays to accessing surgical care for appendicitis in the Western Cape. Appendicitis is a time sensitive disease that affects individuals across the lifespan and can result in excess morbidity and mortality if not treated promptly. |
| **Email** | 18205585@sun.ac.za |

| | |
|---|---|
| **Title** | Integrated community-focused Differentiated Service Delivery models of care and, faster and sustained control for people with Non- Communicable Diseases and HIV/TB in Eastern Cape |
| **Presenter** | Manivasan Thandrayen |
| **Co-Presenters** | George Mapiye |
| **Institution** | Doctors Without Borders South Africa Mission NPC |
| **Abstract** | The MSF Eshowe community outpost points created in 2017, operated by Community Health Workers(CHW) and overseen by professional nurses demonstrated to be a successful and sustainable model of care that was adopted by the Department of Health(DoH) in 2022. The services provided were health promotion, prevention and screening of disease with a Differentiated Service Delivery (DSD) model whereby stable patients registered on the Central Chronic Medicines Dispensing and Distribution (CCMDD) programme collected their chronic treatment. The Eastern Cape project was established noting the lessons learned from HIV/TB DSD models of care at Khayelitsha, Eshowe's achievements and the Non-Communicable Disease(NCD) need identified. The programme created aims to achieve the following:<br>• Improve access to care for patients living with chronic conditions by scaling up and enhancing the DoH's differentiated model of care of decanting stable patients for collection of medication at convenient and cost-effective points.<br>• Identify the needs of the community, healthcare worker and the DoH through engagement, surveys, data analysis, monitoring and evaluation and feedback loops to improve chronic disease management<br>• Improve the management and detection of chronic conditions through research, health promotion, prevention and education of the community and healthcare workers<br>• Document the lessons learned and advocate for policy changes where needed and roll out the programme to other districts and provinces. Using Geographic Information Systems (GIS) techniques sites are scientifically identified through population density and community engagement strategies. Analysed DoH data and created dashboards for monitoring and evaluation to aid management and direct the nurse mentorship programme. Assisting DoH with the creation of tools to monitor 90/60/50 targets for hypertension and diabetes. Started a work-study analysis and clinic analysis to study the disease burden. Although the project is in the infancy stage great strides have been made through stakeholder engagement and big data analysis thus assisting the project and the DoH in defining its strategic outlook. |
| **CPD Point** | Standard |
| **Biosketch** | Dr Thandrayen has been working with MSF since 2021 January MSF on the COVID-19, TB/HIV, the eThekwini flood intervention and recently setting up the Eastern Cape Non-Communicable Disease project. He was the CEO/GM of SAMA from 2018 to 2019. He completed his MBA in 2017 , his thesis was on the remuneration of general practitioners a nd its impact in private practice in KZN. Hewas employed in the public sector as medical manager and acting CEO of various institutes in KZN from 2006 to 2012.<br>His special interest is data analysis, staff norms and healthcare management systems. |
| **Email** | msfocb-eshowe-deputypmr@brussels.msf.org |

| | |
|---|---|
| **Title** | Knowledge, attitudes and perceptions towards HIV testing among isixhosa speaking men in the Zithulele catchment area of the rural Eastern Cape province, South Africa |
| **Presenter** | Philippa Sauls |
| **Co-Presenters** | Professor Olukayode Adeleke, Dr Hans Hendriks |
| **Institution** | Bhisho Hospital |


**Abstract**

South Africa carries the largest burden of HIV in the world, with over 7.9 million people infected and over 70 000 HIV-related deaths in 2019. Men are 25% more likely to die from AIDS, even though women are more likely to be infected. Statistics indicate that men in South Africa are not testing for HIV until it is too late. Aim: To explore the knowledge, attitudes, and perceptions towards HIV testing of isiXhosa-speaking men in the Zithulele catchment area of the rural Eastern Cape. Methods: A qualitative study using the phenomenological approach. It was conducted among a purposive sample of isiXhosa-speaking men from the Zithulele catchment area, in the OR Tambo district of the Eastern Cape Province. Ten semi-structured interviews and one focus group were conducted in isiXhosa. Interviews were audio-recorded, transcribed, and translated into English. The interviews were thematically analysed using an inductive approach. Results:Participants perceived HIV infection as a death sentence, a consequence of immoral behaviour and an indication of failure as man. Reluctance to test for HIV was attributed to the perception that testing hastens the onset of symptoms and death, whereas disclosure of an HIV-positive status was as difficult due to the fear of stigmatization. Barriers to accessing HIV testing services included masculine norms, the belief that sickness is equated with weakness, a perceived lack of confidentiality at health facilities and how clinics were not male-friendly spaces. Suggestions to improve HIV testing among men included improving targeted education, home-based testing services and utilizing traditional meetings to address men. Conclusions

The findings of this study may suggest that healthy men in the Zithulele catchment area of the rural Eastern Cape are not accessing HIV testing services. This reluctance can be attributed to include false beliefs around HIV, the fear of discrimination, disruption of masculine norms and reluctance to access care at female-dominated health facilities. Further research is needed to explore ways to reach, educate and encourage men


| | |
|---|---|
| **CPD Point** | Standard |
| **Biosketch** | Family Physician trained at Zithulele Hospital in the WSU decentralized Family Medicine Programme, now Acting Clinical Manager at Bhisho Hospital. |
| **Email** | philippa.scotcher@gmail.com |

| | |
|---|---|
| **Title** | Promoting Traditional and Indigenous Foods in South Africa: A Desktop Review |
| **Presenter** | Zizo Bobo |
| **Co-Presenters** | RA Beukes, Prof GO Sigge |
| **Institution** | Livingstone Hospital |
| **Abstract** | Introduction:<br>One of the most pressing issues confronting South Africa is ensuring adequate, nutritious, and affordable food produced in a sustainable manner. However, a significant proportion of the diverse foods available in our environment have been overlooked in favour of a few commercial staple foods, resulting in a limited food supply. Growing population rates, urbanization, and continuously rising food prices have caused eating patterns to change from more traditional to more westernized diets, all of which are contributing to the emergence of a nutrition crisis in SA. The consumption of Traditional and Indigenous Foods (TIF), which historically supported health and nutritional status, has substantially diminished. Current dietary patterns reflect a greater intake of a few domesticated plant staples. This study's goal is to evaluate the existing literature on TIF promotion in South Africa.<br>Methodology:<br>This review was conducted using a systematic search of current academic literature from the following databases: Science Direct, Jstor, EBcohost, Bio-med and PubMed, and Google scholar. The review included studies with both analytical and descriptive study designs.<br>Results:<br>The review included five studies that included TIF as part of the intervention strategy after the examination of full texts. All of the studies were based in rural communities. All the interventions had children, ages 1-12 years, as the primary benefactors. TIF promotion and consumption resulted in improved nutritional status, particularly vitamin A, zinc, and iron status. TIF promotion and inclusion in nutrition messages can significantly increase dietary quality and diversity. This is due to the numerous components that comprise effective community-based interventions.<br>Conclusion:<br>The five studies discussed in this review are widely regarded as successful in their own right. They have demonstrated that promoting, producing, and consuming TIF in conjunction with nutrition messages and health-based caring practices improves household food and nutrition security, especially in vulnerable groups. |
| **CPD Point** | Standard |
| **Biosketch** | Zizo Bobo is a Registered Dietitian from the Eastern Cape Department of Health. She received a bachelor's degree in dietetics from the University of the Western Cape and a master's degree in Food and Nutrition Security from Stellenbosch University. Zizo has been in the field of dietetics for 5 years. During this time she has gained experience in various aspects of nutrition. She has interests in food and nutrition security, optimal nutrition for infants and children, and public health nutrition. |
| **Email** | Zizo2626@gmail.com |

| | |
|---|---|
| **Title** | Prophylactic phenylephrine infusions as an effective management of spinal induced hypotension in a rural setting |
| **Presenter** | Lerato Pakade |
| **Institution** | Mthatha Regional Hospital |
| **Abstract** | Spinal hypotension is an inevitable consequence of giving spinal anaesthesia specifically in obstetrics for caesarean section. In South Africa, most of the anaesthesia-related mortality is associated with spinal anaesthesia. Prospective studies were done in order to compare the effectiveness of using phenylephrine as an infusion or as a bolus to treat spinal hypotension and it was found that fixed-rate low dose prophylactic phenylephrine infusions reduced the incidence of severe hypotension in resource-limited conditions (3,4). The central purpose of this intervention is to treat spinal hypotension and therefore abate all the other effects that characterize spinal hypotension, such as maternal symptoms, namely nausea, vomiting, dizziness, dyspnoea and shivering. The fetal adverse effects being depressed Apgar scores and umbilical acidosis which have been correlated with severity and duration of hypotension. In our resource-limited hospital, Mthatha Regional Hospital, we mix 1 ampoule containing 10mg of phenylephrine into 200ml of normal saline and draw 10ml of that solution which is 500mcg of phenylephrine into 1 litre of Ringer's lactate, this infusion is started after spinal anaesthesia, and is titrated to effect to maintain a blood pressure within 90% of the baseline. The infusion is stopped after delivery of the baby and administration of the oxytocin 2.5IU bolus. This infusion is given to patients who are coming for caesarean section and will be done under spinal anaesthesia. The patients excluded from getting the infusion are hypertensive cases, those done under general anaesthesia and patients with bradycardia. A study by das Neves et al found that continuous infusion of phenylephrine appeared superior at preventing hypotension, nausea and vomiting when compared to prophylactic dose of 50mcg phenylephrine . It is also shown that for the infusion to be effective it should not be delayed as soon as spinal anaesthesia is established (6). Also of great benefit is the clinical stability observed even after the infusion is stopped after delivery of the baby.<br><br>Prophylactic phenylephrine infusion as management for spinal anaesthesia induced hypotension has shown to be very effective. We have observed fewer events of nausea and vomiting as evidenced by decreased usage of antiemetics intraoperatively as well as fewer complaints of dizziness and loss of consciousness. We plan on demonstrating this finding in future research at our hospital. Prophylactic phenylephrine infusion is an effective management for spinal anaesthesia induced hypotension that can also be adopted in resource-limited hospitals to provide high |
| **CPD Point** | Standard |
| **Biosketch** | Grade 1 medical officer in Anaesthesia department MRH |
| **Email** | lrtmatabane1@gmail.com |

| | |
|---|---|
| **Title** | The experience of hearing loss in families with deaf school-going age adolescents within a rural context in South Africa |
| **Presenter** | Nomataru Gontse |
| **Co-Presenters** | Dr Lavanithum Joseph |
| **Institution** | Department of Education-Eastern Cape |


**Abstract**

Mothers in rural areas have little knowledge about the services available when their child has a hearing loss. Due to shortage of appropriately trained professionals for intervention services 90% of children with a hearing loss not being able to access services as they may be living in geographical disperse areas. A review of the literature reveals that there is a gap in policy development and implementation in relation to the management of deafness, particularly in low-resourced areas, faced with challenges such as access to audiological services and awareness about deafness. Most research has focused on the deaf child at school, and little attention has been given to the parents and families of deaf children and their experiences of deafness at home and in their rural communities. This paper is part of a PhD study. It links to objective one which is to determine the hearing families, their deaf children and the educational professionals' knowledge and perception about deafness about deafness. It is also linked to objective two which is to identify challenges faced by families in dealing with deafness.

This study looked at the descriptive survey completed by parents and learners based on their perceptions and experiences of deafness in their homes. One hundred hearing parents, 100 deaf learners and 12 educational professionals completed self-administered questionnaires. The main findings of this study indicate that parents and their deaf children lack the knowledge about the causes of deafness. Furthermore, this study has shown that although families and communities have accepted the deaf child however communication remains a big issue as hearing people are not able to communicate with the deaf.

Conclusion Parents, learners and educational professionals came up with suggestions that could be used to assist families to get a better understanding about deafness and be able to support their deaf children. Some of the suggestions included doing awareness campaigns about deafness in communities and offering sign language classes to everyone. These suggestions are going to be used in manuscript four which is tool development.


| | |
|---|---|
| **CPD Point** | Standard |
| **Biosketch** | Currently registered for a PhD in Audiology-UKZN |


| | |
|---|---|
| **Email** | noma.sopete@gmail.com |

# Workshops

| | |
|---|---|
| **Title** | An ode to rural healthcare in 55 |
| **Presenter** | Francois Coetzee |
| **Co-Presenters** | Cameron Reardon |
| **Institution** | Stellenbosch University |
| **Abstract** | Celebrating rural service begins with an appreciation of the “best of what is” - what the appreciative inquiry process calls “discovery”. Appreciative inquiry is a positive, strength-based approach to systems change. With its focus on what works appreciative inquiry readily inspires innovation. Appreciative inquiry has been used across a range of healthcare contexts to inspire innovation and drive positive change.<br>This exploratory workshop, which is grounded in the positive principle of appreciative inquiry seeks to generate meaningful insights that relate to rural healthcare by exploring participants best experiences of rural healthcare. During this exploratory workshop participants will reflect on their own experiences of best practice within rural healthcare settings. Participants will be introduced to and utilize the 55 Word story as a method for constructing a concise narrative that captures the essence of rural healthcare. By leveraging the inherent power of storytelling, the workshop aims to cultivate a deep sense of appreciation for the remarkable efforts and achievements within rural healthcare. Participants will collectively explore and analyze their own experiences, enabling the extraction of valuable insights for the advancement of rural healthcare and in so doing learn from and with another. Workshop objectives:<br>• Provide rural health champions a platform to creatively celebrate the success of rural healthcare.<br>• Provide a platform for sharing best practices that will stimulate thinking and problem solving amongst participants to effect positive changes in their own environments.<br>• In so doing inspire innovation and sustain excellence in rural healthcare<br>• Introduce participants to a strength-based change management model (Appreciative Inquiry) that is appropriate for rural settings. |
| **CPD Point** | Standard |
| **Biosketch** | Francois Coetzee is a family physician, and program coordinator of the Rural Clinical School based in Worcester, South Africa. He qualified as a medical doctor in 1998, as a Family Physician in 2010 and graduated with a master’s in philosophy in health professions education at the end of 2022. He is employed as the coordinator of the Stellenbosch University Rural Clinical school and manages the training of final year medical students on the distributed platform. He has a passion for improving systems within health care and health professions education, making systems more person centered and more efficient. He views shared leadership as a key component of quality improvement and thinks that good leadership has to start by leading one-self towards wellness and success. He is also the module lead for the clinical governance module in the postgraduate diploma in rural health. For 12 years Francois practiced as a rural clinician and in 2013 he joined the Ukwanda Centre for Rural Health of Stellenbosch University. In 2017 Francois was appointed as coordinator of the longitudinal integrated clerkship and the rotation-based program at the Rural Clinical School.. |
| **Email** | franna@sun.ac.za |

| | |
|---|---|
| **Title** | Anaesthesia skills update for district practioners |
| **Presenter** | Craig Parker |
| **Institution** | Frere Hospital |
| **Abstract** | The workshop would be designed to cover the following:<br>Intubation techniques including drug choices available in typical district settings. A number of intubating manikins (adult and paeds) would be used to allow hands on practice and teaching. We would also cover optimising patient positioning and hypoxia prevention.<br>Spinal techniques would be discussed and what to do with patchy/failed spinals<br>Obstetric anesthesia emergencies and management pearls<br>Demystifying the anaesthesia machine and basic trouble shooting. |
| **CPD Point** | Standard |
| **Biosketch** | Engineer who became a Doctor who is now in Anaesthetics at Frere Hospital. Formed the social enterprise Umoya together with Volunteers to develop respiratory devices during Covid and now expanded to include additional low resource setting devices. He lives in EL with his wife and is involved in district level Anaesthetics training whenever possible. |
| **Email** | Craig@craigparker.co.za |

| | |
|---|---|
| **Title** | Childhood TB in South Africa: A rural symposium on clinical experiences, and an opportunity for inputs on the new National Clinical Guidelines on Childhood TB |
| **Presenter** | John-D Lotz |
| **Co-Presenters** | Dr Juli Switala |
| **Institution** | Madwaleni Hospital |
| **Abstract** | Childhood TB remains a global, and local, challenge. Of approximately 1.15 million children 0-14 years who are estimated by the WHO to have developed TB globally in 2021, 62% remained undiagnosed and untreated. This reality is reflected in South Africa as well; among 0-4 year-olds, only 51% of children estimated to have active TB were notified in 2021, while among 5-14 year-olds only 34% were notified.<br><br>Diagnostic challenges remain a major factor in this notification gap, with a reliance on clinical (over microbiological) approaches. New National guidelines are currently in development by the Childhood TB Working Group and seek to address these, and other, known challenges in diagnosis and treatment based on new evidence and recommendations.<br><br>With almost half of children in South Africa currently living in rural areas, little data exist to elucidate how diagnostic and treatment dynamics play out geographically.<br>This symposium seeks to garner experiences and inputs from rural clinicians, to help inform the development of National Clinical Guidelines on Childhood TB which are contextually robust, and fit-for-purpose in rural healthcare settings. |
| **CPD Point** | Standard |
| **Biosketch** | JD Lotz is a Family Physician based at Madwaleni - a deeply rural district hospital on the Wild Coast of South Africa. He arrived with his wife in 2014, and with a growing family of 2 daughters he specialised through Walter Sisulu University, focusing his Masters research on DR-TB in rural areas. He was honoured to share the award for Rural Doctor of the Year with his wife, Michaela, in 2021, and now serves as Secretary on the Executive Committee of RuDASA. Besides sharing life and work with an amazing community at Madwaleni, his passions include addressing major burdens on rural communities. TB is one such burden, which he hopes to influence in his work locally, and more broadly as a rural voice on the Childhood TB Working Group of the SA TB Think Tank. |
| **Email** | jdlotz@gmail.com |

| | |
|---|---|
| **Title** | Co-designing a sustainable and scalable programme to improve the quality of surgical care in rural district hospitals |
| **Presenter** | Rowan Duys |
| **Institution** | UCT Department of Anaesthesia and Perioperative Medicine |
| **Abstract** | The need to improve surgical services in rural district hospitals is urgent because of preventable deaths. We need a scalable and sustainable programme that enables rural clinicians to develop safe surgical systems in their home hospitals. Programmes that address knowledge and skills gaps only are insufficient to effect sustained system changel. In Gqeberha in 2022, a collaborative of rural generalists and urban anaesthesia specialists produced a cause and effect analysis that identified urgent gaps in infrastructure and supply chain, relationships between DH's and referral hospitals, and opportunities for supervised clinical exposure. We propose a workshop bringing together rural stakeholders including DH leadership, rural clinicians of all cadres, and teaching hospital specialists, that will:<br>- Solidify the goals of the project,<br>- Define some key metrics of success and process<br>- Share a set of ideas for testing in rapid PDSA cycles<br>- Create a framework for sharing learning across the network to enable scale-up<br>Instructional design:<br>The workshop will use small-group discussions with feedback to the group to ensure engagement and that all voices are heard. Attendees will be equipped with flipcharts, sticky notes, and systems for aggregating ideas.<br><br>We propose forming a group from this workshop to write up the process followed and decisions made, and publish the key resolutions in a suitable Rural Health or Quality Improvement journal. |
| **CPD Point** | Standard |
| **Biosketch** | Rowan Duys is a specialist anaesthetist at UCT's Department of Anaesthesia and Perioperative Medicine, and the Director of Implementation in the Division of Global Surgery. His mission is to unleash small teams of frontline healthcare change agents to improve the quality and quantity of surgical care they deliver. He tweets at @healthink and would like to be remembered as the husband behind his wonderful wife, the father of three girls, and someone who ran enthusiastically, but slowly, up mountains. |
| **Email** | rowanduys@gmail.com |

| | |
|---|---|
| **Title** | Developing a quality autism service in an under-resourced rural hospital |
| **Presenter** | Alison Collinson |
| **Co-Presenters** | Keri Anne Collinson and Michaela Naude |
| **Institution** | Tintswalo Hospital - Rural district hospital |
| **Abstract** | This workshop is aimed at therapists and other health professionals who want to, or have already established an autism service. Autism is a complex and poorly understood condition. As the incidence of autism increases, more children are referred to health services. It requires an integrated multidisciplinary service, directed not only to the child, but also the caregivers and family. The interventions offered need to take into consideration the barriers caregivers face when seeking assistance for their child in a rural context. The workshop will be facilitated by three therapists. An experienced occupational therapist who set up the Tintswalo autism service; a lone community service OT who faced the challenge of treating children with autism in a small district hospital; and a current community service speech therapist.<br><br>The workshop will start with an overview of autism and recent developments in the field (15 minutes). Then the Tintswalo Autism Service will be presented and discussed (45 minutes). This service evolved in an organic manner over the past 8 years. An autism clinic was established in response to the growing need. Standardised interview forms, screening processes, treatment guidelines and Standard operational procedures were developed. These tools will be shared with participants for potential use in their own context. The second part of the workshop will focus on interventions used in the clinic (60 minutes). It will be interactive, where participants will have the opportunity to ask questions, share their experiences, challenges, and successes. These discussions aim to establish contextually responsive strategies for the development of a quality autism service. The facilitators are in the process of compiling a resource booklet. This workshop will inform and expand the content of the booklet which can be shared and become a practical guide for rural therapists. |
| **CPD Point** | Standard |
| **Biosketch** | Alison Collinson completed her OT degree at Wits University in 1986 and decided to go rural. Together with another OT colleague, she established the OT department at Tintswalo Hospital, in the former Gazankulu homeland. She has devoted more than half of her working career to Tintswalo Hospital and the surrounding communities. She was involved in the training of community rehabilitation workers for the CORRE programme. She has supervised and mentored countless OT students and community service therapists over many years. She spend 5 years working in England, gaining experience in the field of mental health and paediatrics. She also established her own private practice, but the pull of rural health saw her return to Tintswalo Hospital in 2011. She has mainly worked in paediatrics, with a special interest in cerebral palsy, autism, and inclusive education. She strives to develop responsive, needs-based services where strong partnerships are fostered with the caregivers of children with special needs. |
| **Email** | markcoll@mweb.co.za |

| | |
|---|---|
| **Title** | Number Power: turn stats into your secret weapon |
| **Presenter** | Kate Sherry |
| **Co-Presenters** | Maryke Bezuidenhout |
| **Institution** | Self-employed |
| **Abstract** | Data is a powerful tool for under-resourced services. It can help you direct what you have in the most impactful way, check whether what you're doing is working, and advocate for more of what you need (budget, transport, people and more). Unfortunately, most of us find stats one of the most frustrating and meaningless tasks in our daily work.<br><br>In this workshop, we hope to help clinicians, managers and activists think strategically about what data they collect, and how best to use them. By the end of the workshop, participants will:<br>Understand different types of service-related data and their usefulness<br>Be familiar with some basic data management tools<br>Be able to devise data-based strategies to address practical service challenges<br>Have a grasp of POPI and ethical considerations in data collection and use<br>Have insight into team processes and how to get others on board<br><br>The workshop will draw on our experiences developing and implementing a data management system for a multidisciplinary rural rehab service, but will have relevance for a wide range of service types. The format will alternate brief presentations with practical exercises and group discussion.<br><br>Ethical content in the workshop will cover the POPIA eight conditions for data processing, considering how these are applied in context. Beyond the usual issues of consent and confidentiality, we will also discuss our ethical responsibility to use data for the good of patients and communities. |
| **CPD Point** | Applied for Applied for ethics |
| **Biosketch** | Kate Sherry is an OT, rural health systems enthusiast and researcher, specialising in unlikely projects in far-flung places. In her current iteration, she is co-developer of a digital data management system for populations with complex healthcare needs and high barriers to access. |
| **Email** | kate.sherry@gmail.com |

| | |
|---|---|
| **Title** | Peer support how could various models of peer support for persons with paraplegia/ tetraplegia look like in present South Africa |
| **Presenter** | Undine (Mmatumelo) Rauter |
| **Co-Presenters** | Dr. Desmond Mathye |
| **Institution** | Sefako Makgatho Health Sciences University |
| **Abstract** | Background: Peer support for persons with SCI/ SCD has been documented as helpful for coping with the disability, preventing secondary health complications and inclusion in the community. Although there is evidence on the effectiveness of peer support, peer support services in South Africa are scarce and isolated. Learning from existing experiences is therefore limited.<br>Objectives: This workshop aims to share existing peer support experiences and various models practised and envisaged for the (South) African context and learn from one another. Barriers and facilitators for implementing paraplegic peer support will be identified. A map and description of existing peer support services as a resource document may be an outcome.<br>Methods/ Process: The workshop will start with a presentation of the Siletha Ithemba Community Based SCI peer support, a perspective of a person with SCI and a research feedback on the need for peer support in special schools. Then, participants are invited to share their experiences on existing formal and informal peer support for persons with SCI, and facilitators and barriers, to form pieces of a mosaic on peer support in Southern/ South Africa. In a last step upscaling of services is discussed.<br>Expected Outcomes: The outcomes of the workshop depend on participants' contributions, but could be tangible. For example, a resource document for users and health professionals resulting from the shared information, or a network of existing peer support services for persons with SCI/D could be initiated. |
| **CPD Point** | Standard |
| **Biosketch** | Undine has been involved in rural rehabilitation in South Africa since 1995 as a physiotherapist with growing expansion of her skills to a transdisciplinary interventionist. Employed in a governmental rural district hospital, she helped developing the rehabilitation services at Gelukspan, especially paediatric disability services through the Parents' Guidance Centre REAKGONA. She obtained a masters degree in Early Childhood Intervention with majoring in severe disability in 2007, and presently waits for examination results (maybe out by then) for her PhD). Her thesis was Developing a model for preventing pressure ulcers in learners with paraplegia attending a special school in the North West Province. |
| **Email** | mmatumelorauter@outlook.com |

| | |
|---|---|
| **Title** | Strategic plan beyond 2023: RuDASA Indaba |
| **Presenter** | Lungile Hobe-Nxumalo |
| **Institution** | RuDASA & Mseleni hospital |
| **Abstract** | RuDASA is an organisation that thrives for quality equitable health care for rural communities, with an aim of providing a platform for health workers with a similar mindset to network, share best practice, advocate and engage on issues that impact rural health.<br><br>The organisation met in Indaba 2022, to review the work done and commitments made for 2023, this was concluded by a clear need for the executive committee to meet and brainstorm the potential strategy and activities for period beyond 2023.<br><br>The executive committee took the task, had a strategic engagement in November 2022. The Indaba 2023 aims to unpack the strategy draft with RuDASA members and engage with the aim to draw up a clear plan for the period beyond 2023. |
| **CPD Point** | Standard |
| **Biosketch** | RuDASA chair, Manager:medical services Mseleni hospital in KZN, UMkhanyakude district, umhlabuyalingana subdistrict. Passionate about equity in rural health |
| **Email** | llhobe@gmail.com |

| | |
|---|---|
| **Title** | Sexual Health, Sexual Rights, Sexual Pleasure: The sexual health consultation through the pleasure lens. |
| **Presenter** | Madeleine Muller |
| **Institution** | Walter Sisulu University |
| **Abstract** | Sexual health makes up a major component of primary health care work, but usually the focus is on prevention of infection and family planning. Health care practitioners often do not feel comfortable to discuss sexual function and sexual pleasure when taking a sexual health history.<br>In February 2022 the World health Organisation and the Pleasure Project jointly published a systematic review on "What is the added value of incorporating pleasure in sexual health interventions", which showed that prioritising pleasure, rather than the fear of danger and disease, increases the likelihood of safer sex.<br>In this workshop Dr Madeleine Muller will present an updated version of the CDC guide to taking a sexual history, adding Pleasure to the traditional 5 P' within the context of a rural, primary health care setting and will address the use of language around sex and gender in our health care facilities. |
| **CPD Point** | Standard |
| **Biosketch** | Dr Madeleine Muller is a Family Physician and Senior lecturer at Walter Sisulu University department of Family Medicine & Rural Health, providing clinical services and teaching at Cecilia Makiwane hospital in Mdantsane, East London. She serves on the RuDASA exec committee, overseeing the Rural Mentoring portfolio, and has been the East London coordinator for the Southern African HIV Clinician Society since 2013.She completed her MBCHB (UP) in 1995, her MRCGP(Lon) in 2003 and in 2016 her DIPHIVMAN and the Advanced Health Management Program through FPD / Yale (cum laude). Since 2019 she has been the convenor for the CMSA Diploma in HIV Management and is extensively involved in the development of curriculum, training and continuing professional development for rural doctors and more recently, DIPHIVMAN candidates. She is on the executive board of SASHA (Southern Africa Sexual Health Association) and PATHSA (Professional Association for Transgender health SA) and is currently enrolled for her MPhil in HPE at Stellenbosch University. |
| **Email** | drmullerbz@gmail.com |

| | |
|---|---|
| **Title** | Working as a team with community service therapists in a rural rehab setting. |
| **Presenter** | Daleen (M.M) Du Plessis Venter |
| **Institution** | Kopanong Local Area, Free State Dept of Health |
| **Abstract** | In Kopanong Local Area I am the only permanent rehab staff member employed exclusively for PHC services. This means that my fellow team members are always community service staff. So the team challenge is working with young inexperienced therapists in a complex service delivery environment which also include 4th year Physio and previously OT student training platforms from UFS. We have to become effective as a team quite quickly and for me it is a repetitive process to maintain. I would like to share my working model developed in this setting which draw firstly from my Masters work which had a very strong focus on different team models including trans-disciplinary teamwork as well as my international team experiences. The model is based on: 1 Orientation this forms the foundation of being able to hit the ground running and personally the first time in my career when I was properly orientated in a new work setting was when I started work for SKMC under Cleveland Clinic. 2. Team structure and process which is based on a combination from personal experience, and the work of Briggs on creating collaborating teams. I teach and demonstrate how teamwork works and share info like the developmental stages of team development .This is embedded in team roles and communication norms which include a specific meeting minute model. I use the format of the minutes for us to keep track of all the complexities of the area including clinical oversight, community projects, general info sharing and mutual accountability. Each comm serve gets a turn to be team leader with specific responsibilities. We start the week with internal team meeting and we meet with students usually on Fridays. I wrap up the year with the comm serves by 1 providing a ref letter which summorizes the individual input in a specific manner 2. I have a comm serve team photo wall in my office and 3 exit interview (written) giving the comm serve opportunity to give input regarding issues like what worked what did not work level of supervision etc. |
| **CPD Point** | Standard |
| **Biosketch** | The presenter qualified as OT from University of Pretoria in 1996 and started her career at Rob Ferreira hospital, Mpumalanga DOH in 1997. In 2002 she left SA to work for Ministry of Health in the United Arab Emirates at the Abu Dhabi Rehab Centre as the first OT to establish a service and also the only South African. This later extented to working for Sheikh Khalifa Medical City in Abu Dhabi under Cleveland Clinic. She was headhunted to join the Rehab team at Oasis (now Kanad Hospital) in Al Ain again as the first OT. She completed her Masters degree in Early Childhood Intervention in 2009 from University of Pretoria just before the birth of her daughter in 2010. She presented on Teamwork at the 3rd Middle East Rehabilitation Conference in Abu Dhabi accredited by Cleveland Clinic in 2011 before returning to South Africa and joining Free State Dept of Health as a District OT in Xhariep in 2012 till date. She presented at the 5th Child Health Prioriry Conference held in Bloemfobtein in 2014. |
| **Email** | dplessismm@fshealth.gov.za |

| | |
|---|---|
| **Title** | Workshop on Interprofessional Education and Collaborative Practice: Strategies for Teamwork |
| **Presenter** | Elma de Vries |
| **Co-Presenters** | Zukhanyo Hlazo, Natasja Botha |
| **Institution** | Nelson Mandela University |
| **Abstract** | Introduction:<br>This will be a practical workshop to share ideas on Interprofessional Education and Collaborative Practice (IPECP) and teamwork. At Nelson Mandela University, we have established a new medical school, with a vision of producing Mandela doctors who will thrive in collaboration with a interdisciplinary healthcare team. Our curriculum includes specific outcomes related to IPECP to prepare our graduates for practice in this context. We are keen to learn from rural colleagues about their experiences of interprofessional teamwork.<br>Workshop format:<br>We will start with a brief presentation on IPECP and the related curriculum outcomes at Nelson Mandela University. This will be followed by group work to discuss specific scenarios, where teamwork may be difficult, to create the space for colleagues to share their experience and wisdom. Feedback on each scenario will be given to the big group following the group work, in the form of a role play. Thirdly, specific fun activities that can facilitate teamwork will be demonstrated, with practice in the groups, such as the smarties exercise, the spider web exercise, and the draw your vision exercise.<br>Outcomes of the workshop:<br>Participants will reflect on their own experience of teamwork.<br>Participants will practice strategies to enhance teamwork. |
| **CPD Point** | Standard |
| **Biosketch** | Elma de Vries is a family physician who is passionate about the right to access healthcare for marginalised populations, and is the MBChB Programme Coordinator at the School of Medicine at Nelson Mandela University. |
| **Email** | elma.devries@mandela.ac..za |

| | |
|---|---|
| **Title** | Worth a thousand words - exploring rural therapists support needs using photovoice |
| **Presenter** | Cameron Reardon |
| **Co-Presenters** | Ms Thandi Conradie, Ms Amanda Msindwana Thandi Conradie |
| **Institution** | Stellenbosch University |
| **Abstract** | Recent work has shown that a substantial proportion of the rehabilitation workforce in three rural provinces is made up of young, new graduates. The workforce composition may reflect low rates of retention within rural public service. Personal and professional development support is one of a multitude of factors that may influence retention of the workforce. This interactive workshop aims to delve into the support needs of rehabilitation professionals working in rural communities. This workshop will utilize complementary participatory processes, including Photovoice and nominal group technique to explore the support needs of rural therapists.<br><br>Prior to the workshop, community service therapists will be invited to submit a series of five images, each accompanied by explanatory text in response to the prompt “I was doing just fine until…”. These visual narratives will be showcased and displayed within the workshop space offering insights into the support needs of rural therapists.<br><br>Participants attending the workshop will participate in a gallery walk, exploring and reflecting upon the displayed images. This immersive experience will facilitate a deeper understanding of the therapists' perspectives, fostering empathy and promoting dialogue on the unique support needs encountered in rural rehabilitation practice.<br><br>Following the gallery walk, participants will be divided into small groups and guided through a nominal group technique process. This structured approach will enable in-depth discussions that unpack and prioritise the identified support needs of rural therapists and will allow those in attendance to reflect on their own support needs too.<br><br>Workshop objectives:<br>1. Give voice to the experience of community service therapists working in rural.<br>2. Promote dialogue on the unique support needs of therapists involved in the provision of rural rehabilitation.<br>3. Generate meaningful insights to inform the development of tailored support strategies that promote retention of the rural rehabilitation workforce. |
| **CPD Point** | Standard |
| **Biosketch** | Cameron is a lecturer in the Division of Physiotherapy at Stellenbosch University where (amongst other things) he is involved in the clinical training of undergraduate physiotherapy students across a range of clinical training sites including rural sites within the Cape Winelands. Through his work with Ukwanda Centre for Rural Health Cameron is involved in the postgraduate diploma in rural medicine as module convener for the module delivering healthcare in rural communities. Cameron is passionate about the health workforce and contributing to the development of a "fit-for-purpose" rural workforce through rural-proofing health professions education curricular. |
| **Email** | cameron@sun.ac.za |

# Thursday 14th September 2023 - Celebrating Rural Service

| | | | | |
|---|---|---|---|---|
| 08h00 - 09h00 | Registration | | | |
| 09h00 - 10h30 | **Welcome to Day One - Indaba (Plenary)** | | | |
| | Session Chair | | | |
| | Welcoming Remarks | | | |
| | PACASA Keynote Address | "The successful contribution of Clinical Associates to rural health service delivery" **Nomsa Ndaba** | | |
| | RuReSA Keynote Address | "Role of NMAH CP centre of excellence in the Public Health Care defense and lessons learnt." **Gift Tshaka** | | |
| 10h30 - 11h00 | Tea Break | | | |
| **Parallel Sessions** | | | | |
| 11h00 - 13h00 | **Igumbi lomlilo (Fireplace room)** | **Igumbi elincinci (Art room)** | **Igumbi eliphezulu (Upstairs room)** | **Indaba (Plenary)** |
| | **Chair:** | **Chair:** | **Chair:** | **Chair:** |
| 11h00 - 11h20 | OA: Sustainability in rural health: Balancing clinical and training demands in a rural district hospital **Andrew Miller** | | OA: Tshemba Foundation-an agent for change for good clinical practice **Rhian Twine** | OA: Celebrating the power of rural health service to influence health policy - seen in the ART rollout **Victor Fredlund** |
| 11h20 - 11h40 | OA: The Higher Certificate in Disability Practice in strengthening the primary Health Care System: Perspectives of service users with disabilities on partnering with community rehabilitation workers **Nafisa Mayat** | | OA: The perceived value of the 'MoreThan Process' on social cohesion: A case study from South Africa **Innocentia Lediga** | OA: Nurses' experiences in implementing Nurse Initiated Management of Anti-Retroviral Therapy (NIMART) in primary health care facilities in Dr Ruth Segomotsi Mompati District, North West Province **Nthabiseng Sibisi** |
| 11h40 - 12h00 | OA: Looking to the past to plan for the future - rural rehab **Pam McLaren** | | OA. Experiences of a Whole of Society Approach to Prevent Alcohol Use Amongst Youth **Herman Reuter** | OA. Person-Centred Caring Experiences of Registered Nurses while Managing Foot Care for Patients with Type 2 Diabetes in a Rural District of Northern Kwazulu-Natal **Anne Suzanne Joubert** |
| 12h00 - 12h20 | | **Workshop** Strategic plan beyond 2023 **Lungile Hobe-Nxumalo** 120 minutes | OA: Using the Integrated Longitudinal Community Clerkship to transform medical students to healthcare advocates in the rural communities **Siyonela Mlonyeni** | OA: The power of the pill: An exploration to understand adherence practises of patients on their clinic visit date at a district hospital in the Eastern Cape **Sipho Ngcongolo** |
| 12h20 - 12h30 | | | | OA: Developing services for patients with severe non-communicable disease in rural district hospitals - the PEN-Plus experience **Colin Pfaff** |
| 12h30 - 12h40 | | | PP: Khula - a homeopathic remedy for South Africa's crumbling rural primary healthcare system **Shamini Kara** | |
| 12h40 - 12h50 | **Workshop** Peer support how could various models of peer support for persons with paraplegia/tetraplegia look like in present South Africa **Undine Mmatumelo Rauter** 60 minutes | | PP: Referral Communication: A qualitative study exploring verbal communication in referrals to Internal Medicine between district and regional hospitals in Amathole District and Buffalo City Municipality **Chris Palfreeman** | OA: Celebrating the impact a hospital can have for health through non- medical interventions **Victor Fredlund** |
| 12h50 - 13h00 | | | PP: Factors contributing to delays to accessing appendectomy in low and middle income countries. A scooping review **Johnelize Louw** | |
| 13h00 - 14h00 | **Lunch Break - Lunch and Learn with MSF and partners - How to Establish Rural Pickup Points. 13h30 - 14h00 in the Fireplace Room** | | | |

# Thursday 14th September 2023

## Parallel Sessions

| 14h00 - 16h00 | Igumbi eliphezulu (Upstairs room) | Igumbi lomlilo (Fireplace room) | Igumbi elincinci (Art room) | Indaba (Plenary) |
|---|---|---|---|---|
| | **Chair:** | **Chair:** | **Chair:** | **Chair:** |
| 14h00 - 14h20 | OA: Met and unmet needs: a short-term audit of orthopaedic practice and referrals from a rural district hospital, Eastern Cape, South Africa<br>**John-D Lotz** | | OA: Two Worlds Apart<br>**Duncan Haynes** | OA: Comparative study between ante-mortem clinical diagnosis and final autopsy diagnosis in an Academic Hospital in Ga-Rankuwa, South Africa<br>**Moshawa Khaba** |
| 14h20 - 14h40 | OA: Infrastructure, Referral Pathways, Human Resources and Multidisciplinary Practice for Medical Rehabilitation Services in Kwazulu- Natal, South Africa: A Mixed-Methods Study<br>**Senzelwe Mazibuko** | | OA: Experiences of Mobile Health Clinic nurses servicing rural communities of eThekwini municipality during covid 19 community response interventions<br>**Silingene Ngcobo** | OA: The Maternawel PPH monitoring tray. A novel approach to effective PPH monitoring in a low resource setting<br>**Justus Hofmeyr**<br>**Craig Parker** |
| 14h40 - 15h00 | OA: Equitable Access to Quality Health Care for Injured People. Fostering equitable partnerships through engaging and involving communities along the research continuum.<br>**Christina Laurenzi** | | OA: Exploring the perceptions and experiences of the delays to accessing appendectomy in the Western Cape<br>**Johnelize Louw** | OA: Mothers' experiences in the first 3 days after caesarian section at a rural district hospital.<br>**Nicholas Fine** |
| 15h00 - 15h20 | | **Workshop**<br>Worth a thousand words - exploring rural therapists support needs using photovoice<br>**Cameron Rearden**<br>120 minutes | OA: Impact of socioeconomic factors on adherence in patients taking cancer treatment<br>**Vatiswa Henge-Daweti** | OA: Reflective Report on District Level Perinatal Care Outreach in the Eastern Region of Eastern Cape (EREC) 2019-2022<br>**Zolile Mlisana** |
| 15h20 - 15h40 | **PANEL**<br>Collaborative solutions with indigenous knowledge healers in rural Eastern Cape to improve awareness and treatment of surgical conditions<br>**Kathryn Chu**<br>60 minutes | | OA: Medical practitioners' knowledge and awareness of multiple myeloma at public hospitals, Gauteng, South Africa<br>**Andiswa Pooe** | OA: A survey-based impact assessment of a workshop for novice rural anaesthesia providers: The Anaesthesia Launchpad story<br>**Rowan Duys** |
| 15h40 - 15h50 | | | PP: Knowledge, attitudes and perceptions towards HIV testing among isixhosa speaking men in the Zithulele catchment area of the rural Eastern Cape province, South Africa<br>**Philippa Sauls** | OA: Vacuum deliveries - time to rekindle a dying practice?<br>**Andrew Wilkins** |
| 15h50 - 16h00 | | | PP: Contextual Barriers and Facilitators to Implementing Clinical Governance in Selected Hospital in the Eastern Cape: A Qualitative Study<br>**Siphokazi Phalana** | |
| 16h00-16h15 | Tea Break | | | |
| 16h15-17h30 | AGMs | | | |
| 18h00 - late | **Informal Braai sponsored by Discovery Health**<br>**Speaker: Dr Marian Jacobs introduced by Dr Madeleine Muller** | | | |

| Friday 15th September 2023 | | | | |
|---|---|---|---|---|
| 08h00 - 08h30 | Registration | | | |
| 08h30 - 10h00 | **Welcome to Day Two - Indaba (Plenary)** | | | |
| | Session Chair | | | |
| | MEC Welcome | MEC for Health **Ms Nomakhosazana Meth** | | |
| | RuDASA Keynote address | "Is there hope for healthcare in the current economic climate?" **Dr Jenny Nash** | | |
| | RuNurSA Keynote address | "Access to healthcare for vulnerable communities.<br>Under the theme Community engagement & the voice of the end user." **Judiac Ranape** | | |
| 10h00 - 10h30 | Tea Break | | | |
| **Parallel Sessions** | | | | |
| | **Igumbi eliphezulu (Upstairs room)** | **Igumbi lomlilo (Fireplace room)** | **Indaba (Plenary)** | **Igumbi elincinci (Art room)** |
| 10h30 - 13h00 | **Chair:** | **Chair:** | **Chair:** | **Chair:** |
| 10h30 - 10h50 | OA: Integrating clinical practice and population health- the advantages of teaching and learning in the rural context<br>**Steve Reid** | **PANEL**<br>A call to embed disability inclusive workforce development in the ward-based district health system<br>**Theresa Lorenzo**<br>30 minutes | OA: Village- based mother mentor support groups (Supporting motherchild dyad in its first thousand days of life)<br>**Sarah Wilkins** | PP: Prophylactic phenylephrine infusions as an effective management of spinal induced hypotension in a rural setting<br>**Lerato Pakade** |
| 10h50 - 11h10 | PP: Developing an online clinical audit toolbox for district hospitals to promote quality improvement practice and a tailored regional teaching programme in the Eastern Cape<br>**Isobel Morten** | | OA: The role of community healthcare workers on the importance of the first 1000 days of life of a child, its effects on shield development and child mortality<br>**Shadi Nyokong** | |
| 11h10 - 11h30 | **Workshop**<br>Interprofessional Education and Collaborative Practice: Strategies for Teamwork<br>**Elma de Vries**<br>120 minutes | **Workshop**<br>Number Power: turn stats into your secret weapon<br>**Kate Sherry**<br>120 minutes | OA: Rural Early Childhood Development: Where early education, literacy and healthcare intersect<br>**Katy Miller** | **Workshop**<br>Anaesthesia skills update for district practioners<br>**Craig Parker**<br>120 minutes |
| 11h30 - 11h50 | | | **Workshop**<br>Childhood TB in South Africa: A rural symposium on clinical experiences, and an opportunity for inputs on the new National Clinical Guidelines on Childhood TB<br>**John-D Lotz**<br>60 minutes | |
| 11h50 - 12h10 | | | | |
| 12h10 - 12h30 | | | | |
| 12h30 - 12h40 | | | | |
| 12h40 - 13h00 | | | | |

| Friday 15th September 2023 | | | | |
|---|---|---|---|---|
| 13h00 - 14h00 | **Lunch Break**<br>**Lunch and Learn with MSF and partners - How to Establish Rural Pickup Points.**<br>**13h30 - 14h00 in the Fireplace Room** | | | |
| **Parallel Sessions** | | | | |
| 14h00 - 16h00 | **Igumbi elincinci (Art room)** | **Igumbi eliphezulu (Upstairs room)** | **Indaba (Plenary)** | **Igumbi lomlilo (Fireplace room)** |
| | **Chair:** | **Chair:** | **Chair:** | **Chair:** |
| 14h00 - 14h20 | OA: Celebrating rural hospital involvement in school students development. looking back, seeing growth<br>**Victor Fredlund** | OA: Equitable Access to Quality Injury Care in Rural and Urban South Africa<br>**Faieeza Khalfe** | OA: The effects of social media on staffing of a rural hospital in the Eastern Cape<br>**Lalenja Kalbe** | **Workshop**<br>Working as a team with community service therapists in a rural rehab setting<br>**Daleen Du Plessis Venter**<br>60 minutes |
| 14h20 - 14h40 | OA: Perspectives of recent rural clinical school graduates on rural practice and rural living<br>**Francois Coetzee** | OA: Stakeholder needs for embedding sustainable solutions in injury policymaking in South Africa<br>**Ntombekhaya Tshabalala** | OA: Strengthening inclusive healthcare screening through Support Groups formation for clients with chronic conditions (mentally ill clients included) at Manguzi Hospital PHC facilities<br>**Sibongile Vumase** | |
| 14h40 - 15h00 | PP: An education initiative to strengthen the skills and inter-hospital communication amongst doctors working in district hospitals of the central Eastern Cape<br>**Chris Palfreeman** | OA: Assessing patients' experiences of care in four referral hospitals: A cross-sectional survey of outpatients in tow South African rural provinces<br>**Onke R Mnyaka** | OA: Burden of Care of family caregivers of people diagnosed with serious mental disorders in Rural Health District in Kwa-Zulu Natal<br>**Jabulile Ndlovu** | |
| 15h00 - 15h20 | **Workshop**<br>An ode to rural healthcare in 55<br>**Francois Coetzee**<br>60 minutes | OA: Impact of medical interventions for reducing cochlea toxicity of amino glycosides in adults on treatment for MDR tuberculosis at a rural hospital in the Eastern Cape<br>**Lineo Mawasa** | OA: Caregiver burden within mental health: The voice of informal carers from Bushbuckridge<br>**Fasloen Adams** | **Workshop**<br>Developing a quality autism service in an under-resourced rural hospital<br>**Alison Collinson**<br>60 minutes |
| 15h20 - 15h40 | | OA: Analysis of pertussis cases Buffalo City Metro Health District Facilities, Eastern Cape, October 2022 – March 2023<br>**Ntombizonke Cecilia Mashicila-Sukwana** | OA: Examining the knowledge, attitudes and practices of Charismatic churches in Emzinoni, Bethal, South Africa, in 2021 regarding HIV<br>**Nomsa Ndaba** | |
| 15h40 - 15h50 | | PP: The experience of hearing loss in families with deaf school-going age adolescents within a rural context in South Africa<br>**Nomataru Gontse** | PP: Clinical presentation and outcomes of patients with acute rheumatic fever and rheumatic heart disease seen at tertiary hospital setting in Port Elizabeth South Africa<br>**Zongezile Masonwabe Makrexeni** | |
| 15h50 - 16h00 | | PP: Barriers to mitigating pressure ulcer risk among learners with paraplegia attending a South African special school – Learners' and caregivers' perspectives<br>**Undine Rauter** | PP: Integrated community-focused Differentiated Service Delivery models of care and, faster and sustained control for people with Non-Communicable Diseases and HIV/TB in Eastern Cape<br>**Manivasan Thandrayen** | |
| 18h00 - late | **Gala Dinner and Awards**<br>**Guest speaker Dr Luvuyo Bayeni** | | | |

# Saturday 16th September 2023

| | | | | |
|---|---|---|---|---|
| 08h00 - 08h30 | Registration | | | |
| 08h30 - 10h00 | **Welcome to Day Three - Indaba (Plenary)** | | | |
| | Session Chair | | | |
| | NDOH Keynote address | **Dr Sibongiseni Maxwell Dhlomo** - Deputy Minister of Health | | |
| | Provincial Keynote address | **Dr Rolene Wagner** - HOD EC Health | | |
| 10h00 - 10h30 | Tea Break | | | |
| **Parallel Sessions** | | | | |
| 10h30 - 12h30 | **Indaba (Plenary)** | **Igumbi eliphezulu (Upstairs room)** | **Igumbi lomlilo (Fireplace room)** | **Igumbi elincinci (Art room)** |
| | **Chair:** | **Chair:** | **Chair:** | **Chair:** |
| 10h30 - 10h50 | OA: Experiences and understanding of the health care team in the rural context around interdisciplinary practices and learning, an exploratory study<br>**Luke Profitt** | **Workshop**<br>Co-designing a sustainable and scalable programme to improve the quality of surgical care in rural district hospitals<br>**Rowan Duys**<br>120 minutes | OA: The assessment of movement skills and physical fitness of children in rural areas of South Africa<br>**Adri Burger** | **Workshop**<br>Sexual Health, Sexual Rights, Sexual Pleasure: The sexual health consultation through the pleasure lens<br>**Madeleine Muller**<br>120 minutes |
| 10h50 - 11h10 | OA: What are the barriers and challenges that Clinical Associates face in the practice of their profession?<br>**Siboniso Nene** | | OA: Were they prepared for rural community service?<br>**Stephanie Homer** | |
| 11h10 - 11h30 | OA: Special problems need special solutions<br>**Victor Fredlund** | | **Workshop**<br>Building Strong Rural Teams for Resilient Healthy Communities - Do we want to be helped, heard or hugged?<br>**Lidia Pretorius**<br>60 minutes | |
| 11h30 - 11h50 | OA: Health System Strengthening Post-COVID-19<br>**Samantha Maughan** | | | |
| 11h50 - 12h10 | OA: Electrophysiology a gateway to AI utilization while in Rheumatology for rural health advancement.<br>**Sipho Ntshalintshali** | | | |
| 12h10 - 12h30 | PP: Adapting to stressful working parameters: innovative stories of rural health care workers<br>**Akhona Ncinitwa** | | | |
| 12h30 - 13h30 | Indaba (Plenary): **Prof Mfenyana Celebrating Rural Health** - a tribute to the rural health workforce<br>Best presentation awards and closing comments | | | |

# Sponsors


Discovery
suprahealthcare
an avacarehealth company
On
The African CRO
UMOYA
SINAPI
BIOKINETICSSA
LIFE THROUGH MOVEMENT
South African Society of Physiotherapy
SOUTH AFRICAN MEDICAL ASSOCIATION
PATHOLOGISTS
LANCET LABORATORIES
Key to Diagnostic Excellence
ZEBRA MEDICAL
SHONAQUIP SOCIAL ENTERPRISE
Enabling inclusion
DAYS FOR GIRLS
AFRICAN ANGELS
MEDICINES INFORMATION CENTRE
0800 212 506
Life Healthcare