24th Rural Health Conference
Shangri-la Hotel, Bela-Bela, Limpopo
2nd to 4th September 2021

RURAL HEALTH CONFERENCE

PACASA· RuDASA· RuNurSA ·RuReSA

Equity in Rural Health Care

Conference Proceedings

RuDASA

RuNurSA Rural Nursing South Africa

RuReSA Rural Rehab South Africa

PACASA

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About the Conference

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

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

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

The conference usually takes place 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

RHC2021: Equity in Rural Health Care

People in rural areas should get the same services as people based in urban areas: the same quality, the same resources, and the same ease of access to services. To achieve this we have to be innovative in securing health professionals passionate about working rural, demand redistribution of resources, recognise that “rural is different” and how we can support service delivery and the health workers in rural areas.

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.

Sponsorships

Welcome Note from the Organising Committee

Greetings colleagues, and welcome to the Rural Health Conference 2021.
The heart of the Rural Health Conference is in bringing together a diverse group of healthcare workers, activists, researchers, community members and others, who are united by their passion for rural health. You will have the opportunity to hear what's happening at local, provincial and national level from the advocacy organisations who fight for better rural budgets and policies, and to connect with people from different provinces, professions and perspectives on rural health. Whether you are an expert clinician or a student, an activist or an official, a researcher or the mother of a disabled child, your participation is welcomed.

The theme for this year's conference is "*Equity in Rural Health Care*". This is about ensuring that every person receives a similar or even the same kind of health care irrespective of their location. It is a known fact that the health care in the rural areas is not and could never be compared to that of the urban areas. This conference will be looking at ways to ensure that the resources that should be geared towards the upscaling of the health provision in the rural areas are recognised and mobilised for that purpose.

To start a process towards equity, the conference will look at the equity from different lenses of the different clinical domains, from nurses, through clinical associates and doctors, to rehabilitation teams. The aim is also to ensure that all aspects of the health provision are improved almost simultaneously so that the package presented to the patient is wholesome and complete.

To open the conference for us and to lay a foundation towards the understanding of the Limpopo province, the honourable MEC Dr Phophi Ramathuba will grace us with her presence. Her introduction will also give us an idea on how the department collaborates with the traditional healers in the provision of health care to the people of Limpopo.

Themba Maphophe
Chair
2021 Rural Health Conference Organising Committee

Committees

Organising Committee

Themba Selby Maphophe **Conference Chair**
Adam Asghar RuDASA
Thabisa Ngcakaza RuNurSA
Edwin Leballo PACASA
Vuthlarhi Shirindza UCT student rep
Fatouma Lo Wits student rep

Additional Assistance

Jennie McAdam RuReSA
Deshini Naidoo RuReSA
Mmaphuti Moeti RuDASA
Steve Reid RuDASA

Conference Office

Stephanie Homer (Office co-ordinator)
Abigail Dreyer RuDASA (Bank)
Erika Bostock RuReSA (Finance approval)

Scientific Committee

RUDASA

Adam Asghar
Victor Fredlund
Indira Govender

RuRESA

Kate Sherry
Maryke Bezuidenhout
Anthea Hansen
Saul Cobbing
Douglas Maleka
Michelle Flowers

RuNurSA

Guin Lourens

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
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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:

www.ruresa.com
www.facebook.com/ruresa
ruralrehabsa@gmail.com

RuNurSA

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

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

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

Our Vision

Strengthening rural nursing leadership.

Our Mission

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

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

Find out more and join us:
ruralnursingsa@gmail.com
www.facebook.com/ruralnursingsouthafricarunursa

The Key Note Speakers

25 Years of moving towards Rural Health equity

Keynote: Mark Heywood

Rural Health Equity

After 25 years, by all indicators, rural health equity is still a long way off. However, the Covid-19 pandemic is a game changer of the wrong sort: creating deeper inequalities, impacting negatively on social determinants of health and exacerbating healthcare service provision in rural areas. What needs to be done to put rural health equity back on track and to accelerate change, and by who? Is the vision of rural health advocates bold enough? Failure to act fast will leave rural health in a perpetual race against the effects of climate change and future pandemics. The lecture will try to address some of these questions and suggest a pathway towards equity and equality.

Biosketch:

Mark Heywood is a South African human rights and social justice activist. His activism in civil society spans the whole of the democratic period in South Africa. In 1994, Mark joined the AIDS Law Project (ALP) and headed ALP between 1997 and 2010. Later he co-founded SECTION27, a public interest law centre that seeks to influence, develop and use the law to protect, promote and advance human rights, which incorporated the ALP in 2010. He was also one of the founders of the Treatment Action Campaign (TAC) in 1998, the AIDS and Rights Alliance of Southern Africa (ARASA), Corruption Watch and Save South Africa. Mark stepped down as Executive Director of SECTION27 in May 2019. He is now dividing his time between a position as the founding co-editor of a new civil society/social justice segment of the South Africa's most widely read online news source, the Daily Maverick, Maverick Citizen, and research on activism and strategies to ensure the enforceability of socio-economic rights and the alignment of economic policy with state duties to realise these rights.

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Working with traditional healers and leaders for equity in healthcare

RuNurSA Keynote: Nthabiseng Sibisi

Sub-theme: Community and end users

Traditional healing is part of African indigenous practices, traditions, and customs in specific ethnic communities. People use traditional healing alone, or in conjunction with biomedical services for different illnesses (medical pluralism). About 80% of the poor and rural population use traditional healing. Therefore, biomedical practitioners need to take cognisance of its central role and how it translates into community engagement on rural population needs and the Department of Health if the end user's voice and their truth/roots is to be added in the greater discourse. Mistrust, tension, conflict, and lack of respect for traditional healing by biomedical practitioners has for a long time prevented collaboration between traditional healing and biomedical heath systems. While efforts being made to regulate the traditional healing practice are delayed, the end users continue with medical pluralism as directed by their beliefs, regardless of the lack of scientific evidence of safety and effectiveness of using both systems. Due to these concerns, the end users of both systems are unlikely to disclose consultations with the traditional healers to the biomedical practitioners for fear of being judged and scolded about drug interactions that could potentially "be fatal". Whilst we wait for the legitimisation of traditional healers into a formal council structure, Primary Health Care (PHC) practitioners are well positioned in rural communities to forge ahead, create, and strengthen links of bi-directional referrals with the traditional healing sphere. They need to go to the people, live with them, learn from them, and listen to what the end user is saying, and co- tailor interventions suitable to that context. Engaging in such a way will pave the way to the valuing the inevitable role of traditional healing in the health care delivery system in South Africa and beyond, and ultimately towards equity in healthcare.

Biosketch:

Nthabiseng is a nurse with 15 years of work experience in the public health sector, in both rural and urban contexts. Driven by passion for HIV/AIDS, Sexual Reproductive Health and Rights, she has worked in PEPFAR funded organisations as a Quality Improvement Advisor, NIMART Mentor, and Clinical Trainer. She currently manages the Adolescent Program at Wits RHI in the CDC funded Tshwane project. As part of her advocacy work to empower young people, she is also the Managing Director of the youth empowerment program It Starts with Me (I-SWIM) in Welkom, Free State. In addition, Nthabiseng is the North West province RuNurSA representative, working towards empowering rural nurses to advocate for equity in health. Academically, she is completing her MPH, specialising in Rural Health with the Wits School of Public Health. Proud of her rural, and culturally rich background, she hopes to use this platform to advocate for rural healthcare service providers (traditional, and biomedical), as well as health service users. It is her desire that the children she is raising will take the baton and be the change we want see around us.

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The plight of clinical officers and medical assistants in Malawi's healthcare system

PACASA Keynote: Solomon Chomba

Sub-theme: Policy & Practice

Clinical officers and Medical Assistants remain and will remain KEY players in health care system in Malawi and across the globe. Almost all (90%) of clinical work in Malawi are done by Clinical officers and Medical Assistants. It is high time that authorities and government consider recognizing these great men and women who have all along dedicated their time and passion in promoting quality health care while suffering in silence through unfair and unjustified remuneration and certification warranting the call for a clear academic and professional career pathway.A dedicated and passionate Clinical Associate with huge interest of seeing the Clinical Associate profession grow internationally and have big impact in changing the lives of people living in rural areas, he describes himself as an efficient, organized individual, hardworking, dependable with absolute discretion, and excellent attention to detail. I am also well-disciplined, focused and self-motivated with strong ability to conduct health related and all other research, strategic focus, mentoring skills, facilitation and mobilization skills, good interpersonal, field reporting and communication skills and able to work under pressure and minimum supervision. I also possess strong problem-solving skills, reporting skills and project planning, implementation, coordination, monitoring and evaluation skills. Furthermore, I am also a team player, logical thinker and able to learn, adapt and promote new ethical standards while maintaining high levels of integrity and professionalism.

presidentpaum@gmail.com

A journey to equity and rural health

RuDASA Keynote: Mayara Floss

Sub-theme: Building Teams

Populations that live in rural and remote areas are normally exposed to an environment full of disparity. There are less health care professionals, higher rates of chronic diseases, low breastfeeding rates and higher rates of infant mortality. Mayara Floss will share her journey through rural, the creation of Rural Seeds and the work to construct a more equitable world.

Biosketch:

Mayara is a Brazilian Family Doctor, writer, poet, film maker and activist and currently a PhD student at the University of São Paulo (USP). She created, and was an Ambassador of, Rural Seeds and is an executive member of the WONCA Working Party on Rural Practice and member of the WONCA Working Party on the Environment. Mayara also is a member of the planetary health group and the Advanced Studies Institute - IEA/USP, and creator and coordinator of the Planetary Health and Planetary Health for Primary Care MOOC. She was the junior author of the policy brief recommendations for Brazil of Lancet Countdown 2018 and 2019. She has spoken on women's health at the United Nations in 2018. Mayara is a champion for the health of rural and indigenous people across Brazil

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Towards qualitative comprehensive health service delivery: Moving those last in the queue to the front

RuReSA Keynote: Lidia Pretorius

Sub-theme: Health Systems

Equitable access to health care ultimately requires conscious, measurable political and administrative choices, decisions and action. As guaranteed in the Bill of Rights, equality of outcome demands that redress features prominently in the options, decisions, and actions we take as health professionals and administrators. The poor health outcomes for most persons with disabilities living in rural communities is an indictment on every leader, manager and professional working in the health system who has failed to use their agency to make a difference. The presentation will explore the social and professional hierarchies that inform current health services planning and budgeting. It will look at the impact these hierarchies have on the health status of disenfranchised health service clients, the efficacy of the investment made, and the morale of health professionals finding themselves on the periphery of health systems management. The presentation will draw on the lessons learnt from stories told and research conducted over the past 30 years of working with and for persons with disabilities and their families. These will be used to illustrate how we can improve health service delivery by moving those last in the queue to the front of more inclusive and responsive health ecosystems. The evidence will show that conscience and consciousness, combined with compassion and courage, are often required to connect the health system's dots that bring about equity and equality.

Biosketch

Lidia's career over the past 30 years has transcended working as a frontline rehabilitation therapist, a social justice activist, a full-time politician as Deputy Executive Mayor, a public policymaker, a rural development practitioner, and lately, disability empowerment consulting and life coaching. Career highlights have included supporting the establishment of the Disability Programme in The Presidency (2015), as well as participatory drafting of the Disability Rights Charter (1992), the White Paper on an Integrated National Disability Strategy (1996/7), the Promotion of Equality and Prevention of Unfair Discrimination Act (1998/99) and the White Paper on the Rights of Persons with Disabilities (2015/16). She was instrumental in drafting South Africa's Baseline Country Report on the Rights of Persons with Disabilities to the United Nations and has participated in several international conferences on the rights of persons with disabilities.

lidia.pretorius1@gmail.com

Plenaries and Panels

TITLE	Flexible contracting - a strategic approach to getting more health workers in rural areas?
AUTHORS	Russell van Rensberg Victor Fredlund Jayne Bezuidenhout Karen Campbell
INSTITUTION	Rural Health Advocacy Project
ABSTRACT	There is a constant shortage of health workers in rural areas and we need to think creatively about how we can ensure a comprehensive health service delivery in the future. Critical posts need to be identified. Flexible contracting could be an opportunity to develop pilot systems as well as short or medium term solutions. This discussion centres around: What are the critical posts that should be filled / What is flexible contracting? How can flexible contracting be used to bridge gaps in the team or service delivery? What are the advantages and disadvantages for health workers and managers? This panel discussion may be used by RHAP to develop seminars for health systems in transition
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Russell Rensburg is the director of the Rural Health Advocacy Project (RHAP) that advocates for equitable access to health care for rural communities . His work includes managing RHAP's rural proofing programme which advocates for the equitable allocation of resources for rural health care delivery. Before joining RHAP, he worked with the UNAIDS supported Technical Support Facility, managing technical assistance to 19 focus countries across Eastern and Southern Africa.
EMAIL ADDRESS	russell@rhap.org.za

TITLE	Overcoming Rural Inequities
AUTHORS	The Chairs for RuDASA, RuReSA, PACASA & RuNurSA and the conference delgates
INSTITUTION	Rural Health Conference
ABSTRACT	During the conference we look at existing inequities in service delivery and how it is possible to overcome some of these inequities through preparing students better for rural practice so that they are enthused to *Go Rural*, supporting our clinicians so that they *Stay Rural.* Building trans-disciplinary and inter-sectoral referral pathways and ensuring that the Standard Treatment Guidelines do not miss vulnerable groups. The Office of Health Compliance educates us an the process of certification for facilities under NHI. Best practice faciliites share their systems and innovations that can be copied to other provinces. Now is the time for us to draw these ideas together. To identify Plans of Action for the individual delegates; universities and NGOs, and RuDASA, RuReSA, RuNurSA and PACASA, so that together we can build a more equitable rural health service.
CPD POINTS	Ethics
PRESENTER'S BIOSKETCH	Our delegates are from the following professions: nursing, rehabilitation, health advocacy groups, pharmacists, clinical associates and doctors. They are passionate about better rural health care.
EMAIL ADDRESS	info@ruralhealthconference.org.za

TITLE	The double burden of malnutrition and its impact on the health of rural Populations: A call for a national food justice policy agenda
AUTHORS	Panel chair: Daddy Matthews, Deputy Director Nutrition Services Ms. TC Mudzedzi Ms. Makoma Bopape, University of Limpopo Mr. Nzama Mbalati, HEALA & RHAP
INSTITUTION	Limpopo Department of Health
ABSTRACT	The double burden of malnutrition (DBM) is when health conditions primarily related to undernutrition, such as stunting and malnutrition, occur alongside overweight, obesity or diet-related non-communicable diseases (NCDs), e.g., diabetes, hypertension and cardiovascular disease. The DBM can occur at the individual, household or community-level, and is driven by food and nutrition insecurity, where nutritious foods are unaffordable, inaccessible or too difficult to prepare in the context of daily life. In contrast, ultra-processed, packaged foods are cheap and widely available. These foods are often high in calories, sugar and salt and lacking in nutrients. The nutrition transition to ultra-processed foods is increasingly evident in rural South Africa. Rates of stunting are stagnant over the past two decades, while the burden of diet-related NCDs has grown steadily. This session will review the growing impact of diet-related NCDs on rural communities and the persistent challenge of undernutrition and food insecurity, focusing on Limpopo province – where fruits and vegetables are plentiful, yet the health impacts of poor nutrition are growing. Panellists will review the underlying factors driving poor nutrition and the role that both markets and government play in shaping access to food, and provide an overview of evidence-based and effective healthy food policies that can improve equitable access to nutritious food and contribute to improved population health. The session will also share information about a community-based food justice project, Xa Sisonke Siyaphila, focused on building community literacy on nutrition and mobilising communities to activate for policies and action to advance food justice for all.
CPD POINTS	Ethics webinar
PRESENTER'S BIOSKETCH	Daddy Matthews is Deputy Director, Nutrition Services, Limpopo Department of Health. Mr Matthews holds a BSc Hon in Dietetics, a PGD Health management, a PGD in Food and Nutrition Security, a PDG in Sports Nutrition and is studying for an MSc in Sports Nutrition.
EMAIL ADDRESS	nzama@heala.org

TITLE	The Past Year Through an Equity Lens
AUTHORS	Chair of each organisation Lungile Hobe Maryke Bezuidenhout Guin Lourens Zuki Tshabalala
INSTITUTION	RuDASA, RuReSA, RuNurSA and PACASA
ABSTRACT	The COVID-19 epidemic has provided a unique opportunity for South Africans to see Health Science and Health Systems in action. This past year has highlighted that systems that work in urban areas do not always work in rural areas. Local managers and clinicians have to be quick to adapt to ensure that the areas they serve are protected, maintain access to health services, and have innovative rural solutions . As doctors, nurses, clinical associates and therapists we reflect on the equities and inequities that were highlighted, the best practice that was seen, the solutions that were found, or those that still need to be developed.
CPD POINTS	Ethics
PRESENTER'S BIOSKETCH	Dr. Lungile Hobe: as a child she often accompanied her mother, a nurse, to the local hospital in rural Mseleni; these childhood visits inspired her to become a doctor. Supported by Umthombo Youth Development Foundation (UYDF, formerly Friends of Mosvold) she trained at University of KwaZuluNatal, graduated in 2006, and has returned to Mseleni to working the medical wards and High Care Unit. She completed her registrar training in family medicine in 2017 but her MMED which aims to highlight the barriers of breastfeeding in mothers of infants less than 6 months of age, is on hold during COVID-19. Lungile is currently acting Medical Manager at Mseleni and Chair of the Rural Doctors Association of Southern Africa (RuDASA). Maryke Bezuidenhout qualified as a physiotherapist in 2001. She has spent 19 years as a clinician, supervisor and manager at Manguzi Hospital in rural KZN. Her department has run a decentralized seating service since 2015 in collaboration with local Disability Organisations and NPOs. Maryke is as happy armed with her drill, repairing and adapting wheelchairs under a tree as she is advocating for improved access to disability and rehabilitation services in rural areas with random donors, politicians and budget holders. She is a founding member and current Chair of Rural Rehab SA (RuReSA) .

TITLE	Your Mental Health in Your hands
AUTHORS	Meba Khanda Prof Hoffie Conradie (Taking Care) Francois Coetzee (Team work) Cassey Chambers (NPower and Health Workers Care Network) Prof Bernhard Gaede (Taking Care)
INSTITUTION	RuDASA
ABSTRACT	The suffering caused by Covid-19 pandemic calls for a response to support the health care professionals who may have feelings of isolation, guilt, hopelessness, or helplessness but who may be reluctant to seek mental health care. To provide the best treatment for our patients we need to learn to care for ourselves. The panelists look at contextualising your mental health, common concerns health professionals have about their own mental health, what support is available and how to use these these for either short term coping or strengthening your own mental health for the long term by incorporating mental health practice into our daily working life.
CPD POINTS	Standard Webinar
PRESENTER'S BIOSKETCH	Meba Khanda is a doctor with a passion for mental health. He is the RuDASA mental health rep working with a small group of rural doctors working out common issues and ways to cope with stress and burnout. Francois Coetzee currently works at the Division of Family Medicine and Primary Care, Stellenbosch University. His most recent publication is 'Burnout among rural hospital doctors in the Western Cape: Comparison with previous South African studies'. He works with SUNSTRIPE looking managing teamwork. Hoffie Conradie is part of the Taking Care team that runs courses for healthcare professionals on recognising burnout and using mindfulness as a daily technique to cope. Cassey Chambers is from the South African Depression and Anxiety Group (SADAG) . SADAG saw a huge growth in people experiencing anxiety and depression due to the COVID-19 pandemic: and they have developed 2 programmes to help people cope better: NPower helping NGOs cope, and Health Workers Care Network helping health workers cope.
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Oral Presentations

TITLE	A system's thinking approach towards reviewing the Community Service Program for nurses
AUTHORS **INSTITUTION**	Lungile Gamede Rural Health Advocacy Project
ABSTRACT	The South African health system has experienced multiple shocks and disturbances over the years. The community service program as well as the nursing profession have not been spared from some of these shocks and disturbances. The most notable of these include the country's economic crisis and subsequent austerity measures that have been applied on public spending. The aging demographic within nursing constitutes a chronic shock to the health system. The current Covid-19 pandemic has also drawn attention to the role of the health system and its ability to respond to persistent shocks and disturbances. It has brought into focus the need for not only strong health systems but also resilient ones. This oral presentation aims to review how the community service program for nurses is administered using a systems thinking approach. By doing so, it seeks to understand the different elements that constitute a system, the relationships, and forces between these elements as well as the leverage points we can employ to re-envision the ways in community service can be administered for nurses. To date the community service program remains the only health workforce program instituted by the National Department of Health which seeks to address the maldistribution of health professionals in the country. Could this be an opportune time for a program that directly impacts the deployment of healthcare workers to rural facilities to be optimized in the face of acute and chronic health system shocks and disturbances?
CPD POINTS	Standard Webinar
PRESENTER'S BIOSKETCH	Lungile Gamede is a Project Officer at the Rural Health Advocacy Project (RHAP) in the Human Resources for Health Programme. She is a professional nurse by background and worked in a PHC clinic in the North West for her community service before joining RHAP in 2019. She is a current MSc Medicine (Rural Health) student at Wits and is passionate about the nurse's role in advancing rural health and maternal and child health.
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TITLE	An overview of the six weeks online Eastern Cape Rural On-boarding programme .for new clinicians piloted February to March 2021
AUTHORS INSTITUTION	Madeleine Muller Department Family Medicine & Rural Health, Walter Sisulu University
ABSTRACT	Rural Health care has a high turnover of its clinicians and every year new health care professionals join rural health care facilities, many of them community service officers. Providing health care in rural health requires a special skill set and clinicians often feel ill prepared after training in large regional and tertiary hospitals. There has been a patchy and irregular attempts at centralised in-service programs that are traditionally either poorly attended or disruptive to clinical services. COVID19 has opened up new avenues of training through virtual platforms. RuDASA piloted a full virtual in-service on-boarding program for new clinicians that joined the ECDOH in 2021. Launched in February it took place over 6 weeks. In collaboration with WSU Family medicine tutorials it consisted of one to two zoom tutorials twice a week, usually at 5pm or 6pm as well as weekly email resource packs on specific topics including HIV, TB, maternal health, child health, orthopaedics, anaesthetics, trauma, burn-out and support, patient centred care, the rural health professional team, isiXhosa language packs etc. All sessions were recorded and are available on a public YouTube channel. Sessions could be completed at participants own pace. The course was free and all facilitators volunteered their time for free. RHAP provided the access to their zoom licence for the training sessions. Outcomes: Sixty health care professionals signed up for the course including community service doctors and rehab staff, medical officers, existing mentors in the province. Although predominantly from the EC, other provinces and countries were also represented. Future implementation: The next step is to look at how to create a national Rural On-boarding program.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Dr Madeleine Muller is a Family Physician and Senior lecturer at Walter Sisulu University, at Cecilia Makiwane hospital in Mdantsane, East London (since 1 May 2021) and has the mentoring portfolio on the RuDASA exec. She qualified as medical doctor in 1995 and obtained her MRCGP in 2003 in the UK, where she worked as a GP until 2009. From 2009 until 2017 she was a clinical advisor at the NGO Beyond Zero and was awarded a certificate of special merit by RuDASA for her work in mentoring health care professionals in 2010. She helped implement the Advanced Clinical Care program for complicated HIV and created the decentralised Wits RHI ACC training program for doctors. She obtained her DipHIVMan in 2016 and has been the convenor for the Diploma of HIV management since 2020. In 2016 Dr Muller passed the Advanced Health Management Program through FPD / Yale cum laude and served for a year as the acting technical lead for the ACC program in Limpopo and Eastern Cape. She worked at Nkqubela TB hospital from 2017 until 2021 and has served as the Rural representative on the SAMA border branch since 2011.
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TITLE	Apps and equity: Building a rural rehab data management system
AUTHORS	Kate Sherry Maryke Bezuidenhout
INSTITUTION	RuReSA
ABSTRACT	Planning and budgeting for rural rehabilitation services are seriously hampered by lack of data, both on the need for the service, and on its impact. Without this information, setting staffing norms and advocating for resources is very difficult. At a service management level, lack of data makes it difficult to plan and run an equitable service. People living with disabilities in rural areas are by definition hard to reach. Without active outreach, the most vulnerable are systematically excluded, but keeping track of service users (or at least those who need the service) and organising the necessary outreach schedules can be extremely challenging. At Manguzi Hospital in northern KZN, these concerns came to the fore during the 2020 lockdown period, when the team began reviewing their community caseload. It became clear that many service users with moderate to severe disability had not been accessing services at all, and home visits to these households revealed considerable unmet needs. As part of a larger system-strengthening initiative, I was contracted to work with the team on the problem. The result was a web-based data management system, which we named TheraStats. This application combines electronic patient record-keeping with service scheduling, and also generates service statistics, and team members access it via a smartphone app. Although under ongoing development, the app is already having significant impacts on the service. At the same time, it is generating unique data on service need and utilisation, with significant implications for rural rehab resourcing and advocacy. This presentation will share our experiences in developing and implementing TheraStats, and discuss its potential for accelerating the cause of rural rehab in South Africa, especially under the projected National Health Insurance (NHI)
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Kate Sherry is an itinerant rural occupational therapist, researcher, activist and consultant. She has a special interest in health systems, and developing rehab services in remote areas, both in South Africa and abroad. Her most recent posting was to the island of Tristan da Cunha in the South Atlantic (where she also moonlighted as a research diver for the RSPB). She has an MSc in International PHC (UCL), and a PhD in Public Health (UCT).
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TITLE	Chronic care modle effectiveness in the management of type 2 diabetes in primary care setting
AUTHORS INSTITUTION	Yasir Mohammed Zaroug Elradi Dhaman co Sudan
ABSTRACT	Background: Type 2 diabetes mellitus (DM) is a growing worldwide epidemic with more than 422 million affected globally with high incidence and a prevalence rate of 10% in the Middle East and North Africa (MENA), particularly in Kuwait, where prevalence rate 15.8% and one third of Kuwaiti adults are affected [1]. There are many comprehensive studies confirming the large benefit to glycemic control and reduction of diabetic complication rates when the chronic care model is implemented effectively in diabetes care [2-7]. Methods: A literature review of PubMed and the grey literature (conference abstracts available online) was conducted to find high quality evidence around diabetes care and outcomes (randomized controlled trials and systematic reviews) for the MENA and Kuwait region, with a focus on the different models of care for DM in primary care settings. Of particular interest was to investigate how to establish new ways of providing effective care, in addition to addressing real and perceived barriers. These international models of care were then compared to our local model of care in Kuwait, to develop recommendations and potential solutions to improving diabetes care for our local context. Results: Studies showed that a model of care that consists of clinic visits with a nurse, doctor or pharmacist had a high rate of diabetes patients with uncontrolled diabetes and/or diabetes complications. Using the chronic care model (CCM) for diabetes resulted in improved diabetes outcomes for patients. The CCM for diabetes incorporates six evidence-based components that are implemented through a partnership the heath care system at micro and macro levels: self -management support, delivery system design, decision support, clinical information system, organization of health care, community support. The CCM has also shown to be cost-effective to provide high quality care for DM.
CPD POINTS	Standard Webinar
PRESENTER'S BIOSKETCH	I am family medicine diabetologist based on Sudan, Saudi Arabia and Kuwait
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TITLE	Education as health: Enabling inclusive policies to inform the lived experience of disability.
AUTHORS	Chioma Ohajunwa
INSTITUTION	Stellenbosch University
ABSTRACT	Studies conducted globally reveal a correlation between level of education a person has and their capacity to access economic and social resources required for wellbeing. There is a deep-rooted connection between access to education and health and wellbeing. Education influences people's opportunities in life, including psychosocial issues of self-worth and identity, thereby impacting on the quality of life. Despite this, persons with disabilities, are often excluded from education due to many challenges, especially within Indigenous rural African contexts. These challenges could be addressed through the development of inclusive education policies that are informed by relevant contextual knowledge that influences the health and wellbeing of indigenous communities. In this study, a critical analysis of the national inclusive education policies in South Africa, Ghana, and Uganda was done. This was conducted, using a qualitative, constructivist approach for data gathering which was done in two phases- desktop review and in-depth interviews. This presentation will focus on the initial outcomes of the desktop study related to the understanding of inclusion, and inclusion of local knowledge within the policy document. The inclusion of local, community knowledge has the potential to inform a more relevant and sustainable policy implementation and service delivery, influencing the quality of life of persons with disabilities and their families, especially within rural African communities.
CPD POINTS	Standard Webinar
PRESENTER'S BIOSKETCH	Dr Chioma Ohajunwa is a postdoctoral fellow at the Centre for Disability and Rehabilitation Studies at Stellenbosch University. Her research interests are in the areas of inclusive policies, health and spirituality, disability education and Indigenous Knowledge systems. Chioma currently coordinates Ph.D. Community of Practice and convenes the masters and post-graduate diploma course on disability policy analysis. Chioma is Chair, Advancing Disability Research in Africa (ADIRA) PhD Group, and a board member of African Network for Evidence-to-Action in Disability (AfriNEAD). Her most recent publications include chapter contributions to Clan and Tribal Perspectives on Social, Economic and Environmental Sustainability: Indigenous Stories from Around the Globe; and 12 lenses into Diversity in South Africa.
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TITLE	Escalating health care access through referrals
AUTHORS	Catherine Mather-Pike
INSTITUTION	Siyakwazi
ABSTRACT	For many children with disabilities in the rural setting, access to basic health care and rehabilitation support is often scarce and disrupted. Access to diagnosis, assistive devices, medical procedures and therapy-based services are just some of the ways that allow children with disabilities to participate to their full potential. In order to address these barriers Siyakwazi has developed a network of intervention through the use of a referral system, engaging medical practitioners in the private sector, and developing relationships with health care practitioners and therapists at local clinics. It is through this approach that Siyakwazi has supported almost 100 children access resources previously unknown to families. Furthermore, the model supports a process of empowering families with the knowledge about their child's condition which in turn builds advocacy and capacitates understanding of what interventions are necessary and accessible. Siyakwazi believes that replicating its referral process is a possibility for other organisations in a similar field and would like to share its methodology as well as some of the successes and challenges continued to be faced by families of children with disabilities.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Cathy Mather-Pike is the Founder and Director of Siyakwazi. She is a Special Needs teacher by profession with Honours in ECD and a Master of Education, specialising in development through participation. Her experience and expertise, gathered from the UK and rural development in KZN, is in particular linked to all children accessing holistic support and care through an inclusive community- based model.
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TITLE	Experiences of Community Health Workers and the Voices of Household Members Regarding Community Health Workers in KwaZulu-Natal, South Africa
AUTHORS	Euphemia Mbali Mhlongo Dr Euphemia Mbali Mhlongo
INSTITUTION	University of KwaZulu-Natal
ABSTRACT	Community health workers are an important cadre of health care personnel in underserved communities. This study reveals community health workers' experiences while also sharing the voices of household members as health care beneficiaries.This study aimed to explore the experiences of Community Health Workers and households in South Africa. The study used a qualitative approach with a purposively selected sample of participants in the primary health care settings. Individual interviews and focus group discussion were conducted using semi-structured interview guide during data collection. Interviews were transcribed verbatim and exported to Nvivo version 12 for further analysis using content analysis approach. The following major themes and subthemes emerged from the findings of this study, Services provided by CHWs during visits: Delivery and adherence to medication, and Taking sick family members to clinic or hospital; General challenges faced by CHWs: Challenges in the household, Impact of transport related issues on service provision, and Improvement of CHW services; Experience of support and supervision: Experience of intersectoral collaboration, Impact of support and supervision, Assistance from the department with referrals, Experience of support from ward councillors, and Impact on health and access to health care; Resources: Access to resources and Impact of no access to resources. Conclusion Findings from this study revealed insufficient resources, needs for ongoing training to CHWs, improved health coverage and intersectoral collaboration for referral practices among community health workers, communities and WBPHCOTs in the dedicated communities. Thus there is need to organise more in-service training for CHWs, raise awareness of the importance of CHWs among the community members.
CPD POINTS	Standard Webinar
PRESENTER'S BIOSKETCH	Mbali Mhlongo is a Senior Lecturer in the Nursing Discipline at the University of KwaZulu-Natal. She is teaching Community health and Primary health care nursing and also coordinating the Primary care programme. She is a fellow for an NIH funded programme developing research leadership in health researchers: Developing Research Innovation Localisation and Leadership (DRILL).
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TITLE	Facilitating learning of medical students on distributive learning platforms using the Vulamobile App
AUTHORS	Hoffie Conradie Dr William Mapham, SU
INSTITUTION	Stellenbosch Univeristy (SU)
ABSTRACT	Clinical training medical students at medical schools in South Africa are allocated to district hospitals and community health centres (CHCs). At these facilities, a student preceptor appointed by the relevant university as well as medical officers supervise students. Faculty members visit students during these rotations. During the Covid19 pandemic in 2020, visits by faculty members were severely curtailed due to travel restrictions. At Stellenbosch University 250 fifth year medical students could not be accommodated at Tygerberg Academic hospital, a designated Covid19 facility. We placed the students on a distributed platform in Western and Northern Cape provinces at sites previously used for PHC. The 12-week Integrated Distributed Engagement to Advance Learning (IDEAL) rotation used a range of sites (CHCs, district and regional hospitals). Online support from Faculty was provided to students. Forty-five Faculty from all disciplines including family physicians were each allocated 4-6 students. Students submitted five patients fortnightly on the Vulamobile app. Learning facilitators responded with questions to facilitate patient centred learning. Subsequently the Vulamobile app was used to support medical students from the Nelson Mandela Fidel Castro (NMFC) collaboration at the University of KwaZuluNatal (UKZN) allocated to a rural rotation for 7 weeks. 15-20 students were allocated to four district hospitals. Three academic supervisors were allocated five students each and responded to their Vulamobile patients submissions. Conclusions: The IDEAL rotation at SU successfully accommodated 250 students during a 12-week integrated rotation supported by Faculty members as learning facilitators using the VulaMobile app to facilitate patient centered learning. Subsequently the app was used successfully for a smaller number of students at UKZN.
CPD POINTS	Standard webinar
PRESENTER'S BIOSKETCH	Prof H H Conradie MBChB (SU, 1973), DCH (College of Medicine of SA, 1975), M Prax Med (Medunsa, 1985), FCFP (SA, 2009), Diploma in Practioner Coaching (2016, Centre for Coaching, Cape Town). I worked as general practitioner and family physician in both state health service and private practice for 20 years mostly in the Eastern Cape (EC), South Africa. From 2003, I joined Stellenbosch University (SU) as a family physician in Worcester hospital and as associate professor in the Division of family medicine and primary care at Stellenbosch University. Since 2016, I am facilitating learning in the distributed medical education learning programmes of SU) to build clinical and learning/teaching capacity in district hospitals in the WC, EC and KZN. I obtained the Diploma in Practitioner Coaching with the Integral Coaching Centre, South Africa (2016) and since then has been involved in individual and group coaching mainly for health workers.
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TITLE	Financial risk protection and disability: what are the implications for service delivery?
AUTHORS **INSTITUTION**	Maryke Bezuidenhout Manguzi Hospital
ABSTRACT	Disability and rehabilitation services remain under resourced, underdeveloped and fragmented across rural South Africa with marked inequities across geographical, racial and socioeconomic lines. Due to a number of challenges including human resources, many rehabilitation services remain centralized to district hospital or- at best- available on a monthly basis at residential clinics. This poses a significant financial barrier to access and retention in care by people with moderate or severe disabilities. Weak health systems and low levels of end user involvement in service implementation further drive program inequities and poor outcomes. This presentation explores the financial risk imposed on end users with spinal cord injuries or cerebral palsy within the Manguzi health catchment area and discusses the implications for models of care. In addition, key program uptake and output measures are explored across a standard care and a decentralized CBR model.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Maryke Bezuidenhout qualified as a physiotherapist in 2001, and has spent 19 years at the coalface in rural KZN as a clinician, supervisor and manager of a multidisciplinary rehabilitation team. She is a staunch activist and long serving member of RuReSA. She is currently completing a postgraduate diploma in health economics.
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TITLE	Founding the Final Year Health Science Students' Rural Mentorship Programme
AUTHORS	Fatouma Lo Vuthlarhi Shirindza
INSTITUTION	Wits Rural Health Club & Rural Support Network
ABSTRACT	From being a final year student - working under supervision with very little to no responsibility should things go wrong - there is a huge transition to being the professional-on-call, often patients first point of contact with the healthcare system. We will show the journey that final year health sciences students embark on during their period of internship and community service, post graduation from medical school; and the development of a Mentor-Mentee programme for final year students. By increasing awareness of this programme we should recruit more students and mentors, the goal being more students having the desire to work in rural. Dependent on their university, some graduates would have been exposed to rural health practice in their years of study, whilst others may have only been vaguely introduced to it. Regardless of the level of exposure, more health professionals are needed in rural health practice. This final year health sciences' students mentorship programme is to aid in the advocacy and raising awareness about rural healthcare. The aim of the programme is to provide final year health sciences' students with relevant resources and tools to prepare them for their internship and community service years, hopefully in rural. We believe it will bridge the gap between the students' knowledge and expectations with sound wisdom and experience of rural healthcare. This programme encourages participation from a diverse group of final year health sciences students across South African universities, including; occupational therapy, physiotherapy, medicine, speech therapy, and audiology students. There are currently 9 mentors and 30 mentees, the mentors of which have worked or are currently working in rural healthcare. There is a meeting once a month, on a Saturday, where a topic related to working in rural is shared by the mentors followed by a QnA session. The first meeting was held in July 2021. The mentorship programme still requires fine-tuning but we are happy with the progress made thus far. We aspire to increase the awareness of this programme so that we recruit more students and mentors, the end goal being more students having the desire to work in rural. We welcome you all to join either as mentors or mentees!
CPD POINTS	Standard webinar
PRESENTER'S BIOSKETCH	Fatouma Lo is a final year medical student at the University of the Witwatersrand. She is part of the Wits Rural Health Club and a student rep for the RuDASA Executive Committee. Vuthlarhi Shirindza has completed a BMedSci (Hons) in Medical Biochemistry, and is now a 4th year medical student and Deputy Chair of the Rural Health Network at UCT, and a student rep for the RuDASA Executive Committee. She has co-developed a pilot medication drone delivery programme. Both Fatouma and Vuthlarhi are active contributors to the RuDASA executive meetings and have been previous RHC speakers. Vuthlarhi won Best Student Presentation in RHC2019.
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TITLE	From zero to hero: the development of a peer support service in rural South Africa
AUTHORS	Michael Siebert
INSTITUTION	Siletha Ithemba
ABSTRACT	Multiple national health policies and supporting documents enshrine the need for a patient-centered service and for establishing a strong community-driven input in service delivery in South Africa. The Framework and Strategy for Disability and Rehabilitation lists peer supporters is an essential part of the core rehabilitation team. Despite this, no peer supporter training or mid-level rehab worker training has commenced since the Strategy's inception in 2015. Peer supporters in South Africa are limited to a few specialized hospitals/units in public and private sector, Western Cape's ACDP, or occur informally to meet needs at grass roots level. The lack of data, uniformity and lack of support (stipends, resources, formal cooperation with rehabilitation services) make it difficult to argue for upscale of this important service. Methods: Descriptive narrative applied to describe the initiation and development of peer support services in rural KwaZulu Natal. Results: The initiative was started by the public sector rehabilitation department in absence of any support from the Department of Health in 2015. It has been closely linked to the wheelchair repairer service (a joint initiative by the provincial department of health and Disabled People South Africa) and the local rehabilitation department. The service is now a formal non-profit organization (Siletha Ithemba) and has recently acquired its own All-terrain Vehicle with a handcontrol unit. The acquisition of the ATV has generated widespread interest and has pulled in donors from the disability sector, rehabilitation sector and civil society, both local and national. Whilst the first hurdles have been successfully tackled, new challenges are arising. However, with the widespread support from a variety of role players, we hope that the group will continue to develop and expand. Implications: As peer supporter organizations develop largely in response to a grass roots need and are entirely reliant on external funding, each new story could lend additional lessons and insights.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Graduated from WITS BSc(Hons) Physiotherapy in 2019, then completed my community service year at Manguzi Hospital in 2020. I am currently contracted to work with the NPO Siletha Ithemba which is an organization made of 7 Peer Supporters who service the wheelchair users in the Manguzi area.
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TITLE	Innovation in Action : Design-Thinking for low resourced contexts.
AUTHORS	Nabeela Laher
INSTITUTION	Rehab For All South Africa
ABSTRACT	Recently in South Africa, there has been a call towards developing sustainable and innovative models of intervention, eg through the NHI Bill. This presentation will describe an Action Learning Project undertaken through the Gordon Institute of Business Science. The presenter is a physiotherapist, who worked with children with disabilities residing in a non-profit organization in Gauteng, many of whom require specialized wheelchair services due to Cerebral Palsy. The organisation lacked the resources and expertise to support this service effectively, and an opportunity existed to design a new model of intervention that would contribute to the outcomes and sustainability of the service. A literature review was conducted to understand health systems and wheelchair service delivery in low-resourced contexts. Baseline data was collected at the organisation to establish need and qualitative research was undertaken using a purposive sampling method of experienced practitioners in the field. The results were used to design a model of service delivery unique to the challenges experienced within the ecosystem, and a six month action plan was drawn up to support implementation, facilitated by the physiotherapist. This model required very little financial resources to implement, and allowed the organisation to gain a clear direction of the steps needed for service development, including how to access new resources and use donor funding effectively. These steps would not ordinarily be understood, as the leadership team did not have a background in rehabilitation or health sciences. Following the project, the therapist was able to secure greater buy-in and lay a supportive foundation for establishing services within the organisation. Conclusion:When designing solutions for a low resourced context, it is important to work at the right level, to present a clear picture of the desired direction, to demonstrate value of the investment. Doing so may enable much potential to be unlocked
CPD POINTS	Standard - webinar
PRESENTER'S BIOSKETCH	Nabeela Laher is a registered physiotherapist, social entrepreneur and consultant in health and disability innovation.She has had a diverse career across the private, non profit and government sectors, working creatively within high resourced and low resourced contexts to design effective health services. Nabeela supports holistic and accountable services for people with disabilities, and is interested in the design and strategy of organizations themselves to support this aim. She is a graduate of the Social Entrepreneurship Programme at Gordon Institute of Business Science and the Launchpad programme at Impact Hub Johannesburg, and is the founder of a social advocacy platform, Rehab For All South Africa.
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TITLE	Investing in rural youth to become healthcare professionals for rural deployment
AUTHORS	Gavin MacGregor Andrew Ross
INSTITUTION	Umthombo Youth Development Foundation
ABSTRACT	The Umthombo Youth Development Foundation (UYDF) was established to identify and support rural youth who have the interest and potential to study and qualify as healthcare professionals. A condition of support was that on graduation they work in a rural setting for the same number of years they were supported for. Twenty years later, the UYDF has produced 488 rural origin graduates covering 16 health science disciplines , and has shown that: 1) sufficient rural youth can be recruited, 2) through appropriate mentoring support rural youth can succeed in qualifying as healthcare professionals - a 92% university pass rate has been achieved over the last 10 years, 3) that over 90% of graduates do take up employment in rural areas, with approximately 65% continuing to work in rural areas beyond their contractual obligations. The UYDF has partnered with 15 rural district KwaZulu-Natal hospitals in the selection, training, and support of students and employment of graduates. Current challenges include the fact that graduates of the scheme, who are willing to work in rural areas, cannot secure employment post-community service due to financial constraints experienced by the KwaZulu-Natal Department of Health. Despite these challenges the majority (±82%) of graduates are employed in the public healthcare system. The UYDF is an example what is possible in terms of investing in local youth to become the healthcare professionals needed at rural and underserved hospitals
CPD POINTS	Standard - Webinar
PRESENTER'S BIOSKETCH	Gavin MacGregor is the Director of the Umthombo Youth Development Foundation, and has been instrumental in growing and developing the scheme to support more students annually, and partner with more district hospitals in order to address staff shortages in 3 Districts of KwaZulu-Natal.
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TITLE	Is this rural obstetrics?
AUTHORS	Adam Asghar Thandaza Nkabinde Mergan Naidoo
INSTITUTION	University of KwaZulu-Natal
ABSTRACT	Background It is known that caesarean delivery (CD) is a potentially lifesaving obstetric intervention, but one which has many potential risks, as compared to vaginal delivery. What has not been done recently is to analyse a variety of outcomes in relation to mode of delivery, specifically at the rural primary healthcare level, where up to a third of South African mother-foetus pairs will have their deliveries managed. This study set out to address this gap in knowledge. Methods A cross-sectional retrospective observational analytical study utilising hospital records from 2018 to review obstetric practices and outcomes at a deep rural district-level hospital. Results Of a total of 634 Maternity Case Records reviewed, 193 (30.8%) were CDs. Only one was an assisted (vacuum) delivery. The majority (128 of 193 – 65%) of CDs were Lucas class II, and the median decision to delivery interval of these was 97 minutes. There was no difference (p=0.308) in this interval if these CDs took place during working hours or outside of working hours. CD was associated with an increased likelihood of bleeding (p<0.001), infection (p<0.001), and admission of the neonate to nursery (p<0.001). The observed rate of successful vaginal birth after one CD was 37.2%. Conclusions Targeted interventions for rural healthcare in South Africa have been few, and issues that particularly affect rural health facilities, such as a lack of human resources for health, drive avoidable and modifiable factors in maternal and child mortality. This study highlights a few focus areas for potential future interventions to make obstetric services in rural areas safer for both mother and baby.
CPD POINTS	Standard - Webinar
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TITLE	Knowledge, attitude and perception towards lower limb amputation among diabetic patients in rural Eastern Cape, South Africa
AUTHORS	Eyitayo O. Owolabi Kathryn Chu
INSTITUTION	Centre for Global Surgery, Stellenbosch University, Tygerberg, Cape Town, South Africa
ABSTRACT	Background: South Africa is experiencing an increasing prevalence of diabetes-related lower limb amputations (LLA). LLA is largely preventable through prompt identification and treatment of patients at risk and patient self-management practices. This study explored the knowledge, attitude, and perception of diabetes mellitus (DM) patients towards LLA and its prevention. Method: A qualitative study using semi-structured interviews involving 10 individuals living with DM. Participants were purposively recruited from a rural community in Eastern Cape, South Africa. Interviews were tape-recorded, transcribed verbatim and translated for analysis. Data analysis followed an inductive content analysis approach. Results: While participants were aware of LLA as a condition, there was a significant lack of understanding on the link between DM and its risk for LLA. There was an obvious gap in participants knowledge of various preventive measures for LLA. Prominent themes in the data were DM non-amputees fear of talking about LLA and perception of LLA as a death sentence. A common initial reaction to the news of undergoing LLA among amputees was fear and outright rejection. Worries are usually around perceived peri-operative pain of LLA, thoughts of a limb loss and resultant dependency and functional inability. LLA is however often finally accepted as a treatment of choice when patient's pain becomes unbearable. Positive family support also foster acceptance. There seems to be a positive experience with post-amputation rehabilitation as the amputees verbalised getting walking aids immediately with wheelchairs provided within six months of amputation. Conclusion: There is a poor level of knowledge of amputation and its prevention among DM patients in this setting. This highlights the need for awareness creation and adequate health education for diabetic patients on complications like LLA and prevention measures. Detailed explanation of the amputation procedure, rehabilitation process and provisions for walking aids, prosthesis and wheelchairs could further improve acceptance among those who require amputation.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Eyitayo Owolabi is a professional nurse/midwife and currently a postdoctoral fellow at Centre for Global Surgery, Department of Global Health, Stellenbosch University. She is a public health researcher and an advocate for health promotion and preventative healthcare.
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TITLE	Laboratory Results Delivery: Preliminary Lessons from a National Evaluation of the Cryptococcal Antigen Screening Programme
AUTHORS **INSTITUTION**	Daniel J DeSanto National Institute for Communicable Diseases
ABSTRACT	The Cryptococcal Antigen (CrAg) Screen and Treat National Evaluation (CAST-NET) study is a 2-part evaluation of a laboratory screening programme implemented in 2016. Remnant bloods from HIV-seropositive people with a CD4 count of <100 cells/µl are tested at National Health Laboratory Service (NHLS) CD4 labs for CrAg. CrAg-positive patients should be pre-emptively treated to halt progression to cryptococcal meningitis. The study aimed to understand and investigate potential gaps undermining the benefits of the screening programme - specifically are reflex CrAg laboratory results reaching healthcare providers? Methods:A cohort of CrAg-positive patients was formed using data from the National Institute for Communicable Diseases (NICD) Surveillance Data Warehouse (SDW), February 2017-January 2019. Data collectors visited facilities in 27 sub-districts, retrospectively located CrAg-positive patient records, redacted patient identifiers, and imaged records. Electronic images were later abstracted using a standard case report form by study doctors capturing key demographic and clinical information. We conducted healthcare worker interviews at selected facilities. Results:From October 2016 – March 2019, 612 295 patients presented to public health facilities with a CD4 count of <100 cells/µl nationally. Of those, 611 737 (99%) of patients were reflexively screened and 34 581 (5.7%) patients were CrAg-positive. We enrolled 3,853 patients into the CAST-NET study and found hard copy medical records for 2,960 (77%) of patients. Data collectors found that laboratory reports weren't consistently filed due to vast discrepancies in archiving room organizational management. Healthcare provider interviews illuminated electronic result delivery through NHLS TrakCare is available yet underutilized. Conclusions:Avenues for CrAg result delivery outside of traditional printed/couriered results are required. The Results for Action (RfA) portal provides aggregated reports of CrAg-positive & HIV viral load tests from facility up to provincial levels while TrakCare can only provide result look up on an episode or patient level. We encourage clinicians, especially in rural areas, to register for both RfA & TrakCare, thus linking directly with the NHLS to ensure result delivery.
CPD POINTS	Standard Webinar
PRESENTER'S BIOSKETCH	Daniel DeSanto, MScPH, is an epidemiologist consulting with the National Institute for Communicable Diseases (NICD) since 2018 on their national evaluation of the Cryptococcal antigen screening program. Prior to working with NICD he lived in rural Mtubatuba, KZN for a year volunteering with the Africa Health Research Institute (AHRI). He is interested in social determinants of health, program evaluation, and the broad intersection between society and health.
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TITLE	Opening learning to all – lessons from the experience of running online workshops for SUNSTRIPE
AUTHORS	Ian Couper Hoffie Conradie Marietjie de Villiers Francois Coetzee
INSTITUTION	Ukwanda Centre for Rural Health, Stellenbosch University
ABSTRACT	Since the COVID-19 pandemic began, the Stellenbosch University Network for Strengthening Rural Inter-Professional Education (SUNSTRIPE) has been delivering online workshops as part of the STRIPE-AFREhealth project. These included HIV modules, a Covid19 module, and modules on Wellbeing and on Teamwork. They have been delivered as interactive workshops with the support of facilitators from different health professional backgrounds, and a range of health professionals and students have participated in the sessions. The aim of providing these workshops online was to ensure access to such opportunities and information for all, regardless of who or where they are. As part of evaluating the project, we reviewed feedback received from participants and facilitators, and combined this with the reflections of the SUNSTRIPE project team in order to extract lessons that may be of broader value to colleagues across South Africa and beyond. Lessons Learned: The workshops were much appreciated and enjoyed. A key question pertains to the relationship between content and process, concerning the importance of each. Given that the participants were from multiple professions, it was important to understand how much detailed content is needed without being too profession-specific. A number of lessons were learned about the delivery of online workshops, including the training of small group facilitators, duration of workshops, adaptations for participants' context, and mapping of intended outcomes. Way Forward: It is clear that these resources, provided free using an online platform, were enriching for an interprofessional audience. The lessons learnt informed how we adapted subsequent presentations and developed additional modules. SUNSTRIPE developed guidelines for running interactive online workshops that can be used to further the training of trainers. At a time when there is an abundance of online offerings, which are mostly didactic, these lessons guide the use of approaches that enhance engaged and interprofessional learning.
CPD POINTS	Standard Webinar
PRESENTER'S BIOSKETCH	Ian Couper is Director, Ukwanda Centre for Rural Health and Professor of Rural Health, Department of Global Health, Stellenbosch University. He was a founding member of RuDASA, and worked in public health services in rural South Africa for 25 years.
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TITLE	Parent Champion Network: Equipping Parents as Change Agents for Inclusion
AUTHORS	Erna van der Westhuizen
INSTITUTION	Shonaquip Social Enterprise
ABSTRACT	The Shonaquip Social Enterprise (SSE) implements a broad-based approach, linking mobility device provision, capacity-building, and activism for sustainable change to benefit the participation and inclusion of people with disabilities.Informed by the social model and rights-based movement, SSE organises its programs in a framework called "Ecosystems for Inclusion". SSE founder, Shona McDonald, with first-hand experience of parenting a child with disability, has always prioritised connecting parents of children with disabilities for support and collective action. This has gained traction in research as evidenced in Van der Mark and Philpott's recent studies. Van der Mark's study in Khayelitsha describes many women becoming 'invisible' as they care for their disabled child alone and on the outskirts of society. She urges organizations to increase investment in peer support groups for parent well-being. The Disabled Children's Action Group reports that parents are seldom heard and need to go beyond information about rights and services if they are to make informed decisions about their children. Philpott's study (2019) also confirms that parent- professional partnerships thrive where there is openness to listening, collective learning, dialogue, and respectful guidance. Presentation:-Will focus on the SSE Parent Champion Program, developed to give power to parents of children with disabilities through connection to a network and equipping them for care and advocacy. A Parent Champion loves and cares for their child (ren) and extends this to other children with disabilities . Willing to tackle barriers that stand in the way of inclusion, each Parent Champion receives access to information, skills, tools in a network of support and agency. Conclusion:- The pandemic has worsened parents' isolation and seen a rapid increase in parents joining the network since its inception in June 2020. Parent-led platforms to share experience, learning and collective action, reduce isolation and empower parents to become change agents and equal partners in their children's future.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Erna van der Westhuizen has 16 years of experience in rural community capacity building and advocacy project and programme management. With an extensive background in building networks for social change, material development, community consultation, facilitation, organizational process design and implementation, stakeholder relationship management, impact conceptualization, design, and implementation and organizational leadership, she has in-depth understanding of community practice. Erna leads on the impact and research elements of the Shonaquip Social Enterprise, where she has been employed since 2016, and is currently working on a PhD at Vrije University in Amsterdam, with specific interest in how a parent movement can facilitate system change.
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TITLE	Perceived barriers and benefits of implementing HIV care at the community level in Tshwane district: A qualitative study
AUTHORS	Sanele Ngcobo Prof Theresa Rossouw
INSTITUTION	University of Pretoria
ABSTRACT	Little is known about the barriers and benefits of home-based HIV services offered by community health workers. These are especially important as the South African government embarks on scaling up community-based health services, which include HIV care. This study set out to understand potential benefits and barriers of these services in Tshwane district and develop recommendations for improvement. From June to August 2019, seven focus group discussions were conducted with 58 participants: four with 36 ward-based outreach team (WBOT) members and three with 22 people living with HIV (PLWHIV). Three aspects of care were explored: 1. Experience of performing, receiving or observing homebased HIV care; 2. Barriers to conducting home visits; and 3. The perceived value of WBOTs and home-based HIV care. Data analysis was conducted qualitatively by means of thematic analysis. ATLAS.ti 8 windows was used to arrange, resemble and manage qualitative data, and to facilitate text searching and coding. The quality and boundaries of themes were assessed, followed by analysis of the thickness and thinness of different themes. While home-based HIV care was seen as a support strategy which could motivate patients to take their medication, the unpredictability of patientsâ€™ responses to HIV test results, incorrect addresses (driven by the need for identity documents), fear of stigma through association with WBOTs, especially those in uniform, little or no preparation of patients for home-based care, and lack of confidentiality and trust were raised as potential barriers. To successfully implement effective home-based HIV care in South Africa, perceived barriers should be addressed and recommendations offered by people providing and receiving these services should be seriously considered. Pertinent recommendations include integrating WBOTs into clinics and existing support structures, improving training on confidentiality and HIV testing, and rethinking the recruitment, scope of work and safety of WBOTs. In addition, research should be conducted into the impact of the requirements for identity documents and community health worker uniforms.
CPD POINTS	Standard webinar
PRESENTER'S BIOSKETCH	Sanele Ngcobo is a Clinical Associate, currently working at the University of Pretoria as a Lecturer and a PhD Candidate in Family Medicine. Mr Sanele Ngcobo holds a Bachelor of Clinical Medical Practice, a PGD in Public Health and a Masters in Public Health. Sanele is also a Secretary General in PACASA.
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TITLE	Perceptions Of Healthcare Professionals Concerning Access To Quality Healthcare For Paraplegic Learners With Pressure Ulcers
AUTHORS **INSTITUTION**	Undine Rauter SMU Health Sciences University
ABSTRACT	Pressure ulcers (PU) are the most prevalent secondary complication of spinal cord dysfunction. They are a health hazard in special schools, leading to prolonged hospitalizations of affected learners. The neighboring district hospital is the primary referral-hospital for affected learners from a special school. This presentation aims to describe the perceptions of healthcare professionals pertaining to the access to quality healthcare for paraplegic learners who had PU. A qualitative, exploratory approach was used. Semi-structured telephonic interviews were conducted with 12 different health care professionals working in the district hospital or at the school. The interviews were conducted in English or Setswana according to participants' preference. Data were transcribed verbatim, translated and thematically analyzed by the primary researcher. Credibility was ensured by prior building of rapport, using participants' desired language and the researcher's knowledge of the context. Healthcare professionals expressed concern about the quality of care their institution offers to learners with PU. Positively, they mentioned their on-going efforts to provide the best possible care in a resource-limited setting. But foremost, they described the emotional, human and material resources related barriers to receiving quality care by affected paraplegic learners. These barriers were aggravated by lack of knowledge and negative attitudes of personnel towards them. Disability and chronic care related factors were also mentioned as reasons influencing access to equal treatment, compared to able-bodied patients. Severe PU are challenging for healthcare personnel and the affected. Emotional barriers contribute to in-equality in treating this condition in resource limited, rural contexts. Besides improvements in human and material resources, medical personnel need multidisciplinary opportunities to debrief, get encouragement and obtain appropriate knowledge and skills to provide continuous quality healthcare for the appropriate management of PU.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Undine Rauter is a longstanding rural physiotherapist who contributed to building rehabilitation-services for the rural Ngaka Modiri Molema District and beyond through the establishment and further development of the Parents' Guidance Centre REAKGONA (PGC) at Gelukspan District Hospital. IN 2007 she obtained a master degree in Early Childhood Intervention (Pretoria University). Within the PGC she has been involved with paraplegic children and youth for more than 2 decades. Pressure Ulcers (PU) were a major concern in the neighbouring special school pushing her into pursuing becoming doctoral student at the Sefako Makgatho Health Sciences University.
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TITLE	Perspectives on budget considerations for pharmaceutical expenditure in South Africa
AUTHORS	Lirosha Moodley
INSTITUTION	University of KwaZulu-Natal
ABSTRACT	South Africa (SA) has faced challenges of inequity in healthcare, a heavy burden of disease and an increased demand for medicines with limited funds. These challenges called for efficient budgeting for medicines to cater to the populations needs. This study aimed to report on pharmaceutical services perceptions on healthcare budgeting for SA and allocation for pharmaceutical expenditure for medicines provision on the Standard Treatment Guidelines and Essential Medicines List and non-essential medicines in the public sector. Methods: The budget process was documented through qualitative, semi-structured interviews with seven pharmaceutical services officials from the seven provinces involved in the budget process, (October 2019-March 2020). Interviews were transcribed verbatim, coded by the first author and verified by the other authors. Data was thematically analysed using content analysis. Results: This study documented the knowledge and participation of pharmaceutical services in the budget process. A collaborative, informed and more evidence-based approach is being adopted by all Provincial Departments of Health. From the interviews, pharmaceutical services of each province participated in advising, commenting, monitoring and taking accountability for their budget. The main considerations of budget determination included: population size and growth, historical expenditure, the extra heavy burden of disease and incidence rate, demand data and forecasting, with the Standard Treatment Guideline and Essential Medicines List being the principal guide for medicine provision. The local and provincial pharmacy and therapeutics committees played a vital role in monitoring the budget and expenditure; ensuring adherence to guidelines; controlling the extent to which non-essential items were used. Conclusions This was the first study in SA to report on the budget considerations and processes for pharmaceutical expenditure and its translation into pharmaceutical expenditure for medicine provision. The study provided insight into the factors and considerations used for budget determination and controls.
CPD POINTS	Standard Webinar
PRESENTER'S BIOSKETCH	
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TITLE	Preparing students for community service within the constraints of Lockdown
AUTHORS	Lebogang Maseko Olindah Silaule Stephanie Homer
INSTITUTION	Dept of Occuaptional Therapy, Universtiy of the Witwatersrand
ABSTRACT	The Occupational Therapy Department at Wits has a long history of rural fieldwork placements in Mpumalanga, Limpopo and North West provinces. Rural placements typically are very different from urban facilities and rural fieldwork had its own set of outcomes and requirements. The expectation of rural placements was for students to spend more time in the community than in the hospital; in order to learn about different communities, and practice CBR goals and principles. The COVID-19 disaster management regulations imposed restrictions on access to rural fieldwork sites, however Rural Fieldwork marks were still needed for students to be able to complete 4th-year requirements. This provided the impetus to create a more integrated approach to Wits fieldwork, away from the
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Lebogang Maseko is an Occupational Therapist and lecturer with a Master of Public Health in health systems and policy.. She has experience in working with clients of all ages who present with different physical and neurological conditions including spinal cord injury and traumatic brain injury. Work experience includes working in both the public and private sectors in South Africa as well as international experience within the National Health Service (NHS) in the United Kingdom. She is currently not only practicing as a part-time clinician, but also working as a full time lecturer in the occupational therapy department in the school of therapeutic sciences, faculty of health sciences at the University of the Witwatersrand where she coordinates the public health rural fieldwork component for the final year OT students. Her research interests include health systems and policy with a special interest in primary health care and disability. Lebo is an active member of RuReSA and was Vice-President of the Occupational Therapy Association of South Africa (OTASA).
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TITLE	Providing Education and Support to Rural, District Clinicians in Eastern Cape, South Africa: Adapting to Covid-19
AUTHORS	Dr. Alexandra Shields Prof. Andy Parrish Dr. David Stead Dr. Jenny Nash
INSTITUTION	BCM-Amathole District Medical Support Iniative (BAMSI), Cecilia Makiwane Hospital, East London
ABSTRACT	The Eastern Cape is the third most rural province in South Africa, where health inequities are greatest in rural areas. These cause significant social and economic costs at individual and population levels. In 2019, the province was reported as having the lowest compliance to national health core standards of care (46%).Since 2019, the Buffalo City and Amathole District Medical Support initiative (BAMSI) has aimed to improve quality of care through medical education and support of district clinicians, by consultants at the regional referral hospital. The district hospitals are up to 180km from the regional hospital, with a limited ambulance service. As a consequence of Covid-19, BAMSI had to pause its face-to-face education programme, and has adapted to develop electronic resources, appropriate for use in the local resource-constrained environment. The team developed CPD accredited, interactive consultant-led peer-reviewed weekly teaching sessions to district clinicians, via the video platform Zoom. The curriculum was curated through focus-group review of the current syllabus, and a survey of the district clinicians to identify key focus areas. Clinicians were also encouraged to send anonymised case examples via the Vula Mobile App.Each teaching sessions was critically evaluated, to identify improvements and apply regular quality improvement (PDSA) cycles, to ensure dynamic adjustment to the changeable environment. 103 clinicians from 20 hospitals have attended 14 one-hour weekly teaching sessions, with new clinicians attending each session. Clinicians have attended via their own, or shared devices. Teaching topics have been varied, including antimicrobial stewardship and ECGs, adapted as per clinician suggestion.Consultant-led education and support for clinicians working in rural South Africa can be adapted to challenging working environments. Support for district clinicians must be continued during disruptions (such as Covid-19), and interactive video teaching is feasible and effective. Future plans include development of a website to share education resources.
CPD POINTS	Standard Webinar
PRESENTER'S BIOSKETCH	The BAMSI team are made up of two consultants working at Cecilia Makiwane Hospital & Frere Hospitals - Prof Andy Parrish (Head of Medicine) and Dr. David Stead (ID Consultant), Dr. Jenny Nash (Specialist Family Physician, Amathole District), and Dr. Alexandra Shields (Improving Global Health Clinical Fellow, Health Education England, and General Practictioner Registrar based in Oxfordshire, England). The BAMSI team key aim is to strengthen the link between clinicians working in district hospitals and regional referral hospitals, through the improvement of education and support.
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TITLE	Rehabilitation and Disability Inclusion into Standard Treatment Guidelines at Primary Health Care and District Hospital Level
AUTHORS	Quinette Louw, Thandi Conradie, Maria Charumbira Karen Grimmer
INSTITUTION	Stellenbosch University
ABSTRACT	Rehabilitation and disability organisations have been invited to give input into the Primary Health Care (PHC) Standard Treatment Guidelines (STGs). These documents form the basis for discussions around resources and service delivery platforms. Where an item is proposed for consideration within the STGs it provides the visibility of a service which extends far beyond immediate client care. The STGs are reviewed once every three years. Experts co-opt specialists in the various fields for input where necessary. Hight level systematic review evidence and a detailed submission is required. Our objectives are to describe the approach to searching for good quality evidence for the relevant rehabilitation and disability STGs. A combination of methods was utilised for Cochrane evidence summaries. Scoping reviews were employed to find the best evidence supporting the effectiveness of rehabilitation treatments for health conditions treated at PHC. Evidence was extracted and summarised in a table. The summarised evidence was then collated into tables of rehabilitation interventions for which there is evidence for efficacy. Rural Rehab South Africa, Occupational Therapy Association South Africa and South African Speech-Language-Hearing Association were consulted to inform on the main conditions which are relevant to South African Primary Health Care. We found evidence for 55 conditions of the suggested conditions which fell under 15 of the chapters. Very few high-grade evidence reviews were found pertaining to rehabilitation conditions in primary care. The conditions with the highest evidence were summarised. Conclusion: whilst this is not evidence for all of the conditions that were suggested and definitely not all of the conditions seen by rehabilitation at primary health care level, this is a great step in the right direction. More high evidence research on rehabilitation needs to be conducted. The methodology we used is sufficient in finding evidence for future STGs for rehabilitation-related conditions.
CPD POINTS	Ethics
PRESENTER'S BIOSKETCH	Quinette Louw is a distinguished professor at Stellenbosch University. She has a SARChi chair and is head of the Department of Health and Rehabilitation Sciences. Maria has completed her Master's with Quinette in HIV and rehabilitation and is currently doing her PhD with Quinette in evidence-based treatment in rehabilitation. Thandi is currently completing her Master's with Quinette on the rehabilitation workforce in South Africa which is a sub-study of one of the major projects under the SARChi work which is assessing the capacity of rehabilitation in South Africa.
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TITLE	Rural doctors' lived experiences of clinical courage.
AUTHORS	Ian Couper Jill Konkin Lucie Walters Ruth Stewart
INSTITUTION	Ukwanda Centre for Rural Health, Stellenbosch University
ABSTRACT	BACKGROUND Rural doctors describe consistent pressure to provide extended care beyond the limits of their formal training in order to meet the needs of the patients and communities they serve. This study explored the lived experience of rural doctors when they practise outside their usual scope of practice to provide medical care for people who would otherwise not have access to essential clinical care. METHODS A phenomenological study was conducted, aimed at understanding the subjective, lived experiences of clinical courage. All doctors attending an international rural medicine conference and who practised medicine in rural/remote areas in a predominantly English speaking community were eligible to participate; 27 doctors were recruited. Semi-structured interviews were conducted. The transcripts were initially read and analysed by individual researchers before they were read aloud to the group to explore meanings more fully. Two researchers then reviewed the transcripts to develop the final results, which were then reviewed by the remaining researchers to reach consensus. RESULTS Participants provided in-depth descriptions of experiences we have termed clinical courage. This phenomenon included the following features: • Standing up to serve anybody and everybody in the community • Accepting uncertainty and persistently seeking to prepare • Deliberately understanding and marshalling resources in the context • Humbly seeking to know one's own limits • Clearing the cognitive hurdle when something needs to be done for your patient • Collegial support to stand up again. DISCUSSION & CONCLUSION This study elucidated six features of the phenomenon of clinical courage through the narratives of the lived experience of rural generalist doctors.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	
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TITLE	Screening for end-organ damage among diabetic patients in rural Eastern Cape, South Africa
AUTHORS	Eyitayo O. Owolabi Daniel T. Goon Anthony I. Ajayi Oladele V. Adeniyi Kathryn M. Chu
INSTITUTION	Centre for Global Surgery, Stellenbosch University, Tygerberg, Cape Town, South Africa
ABSTRACT	Screening for end-organ damage in individuals living with diabetes mellitus at the primary healthcare centres (PHCs) is critical for preventing disease progression, disability and premature death. Most end-organ damage is asymptomatic, hence the need to screen for early referral; particularly among rural dwellers who lack access to specialist care. The Eastern Cape (EC) Province has high poverty, high prevalence of diabetes mellitus and low rate of glycaemic control , predisposesing individuals to complications. One fourth of this population had asymptomatic chronic kidney disease. Data on screening for end-stage organ damage at the PHC level in EC, where the majority receive care, is poor. This study assesses the extent of screening for diabetes complications among 399 patients with diabetes attending six public PHCs in two rural districts of EC, using a descriptive, cross-sectional design . Demographic and clinical data were obtained through questionnaire interviews and review of medical records. We assessed the extent of screening for estimated glomerular filtration rate (eGFR), fasting lipogram, eye examination, foot examination and HbA1c, and analysed using simple frequencies (percentages) and Pearson Chi-square. Results: In the past year, HbA1c result was available for 78 (19.5%) of the participants, 65 (16.3%) had eGFR results while only 35 (8.8%) had lipid results documented. Fourteen percent (n=56) had eye examinations done, and only 9 (2.3%) of the patients had undergone foot examination. The proportion of patients who had HbA1C (23.7% vs. 11.7%), and eGFR (19.1% vs. 10.9%) tests was higher among those with uncontrolled diabetes than those with controlled diabetes. Conclusion: The coverage of complications screening was low across all indicators. Recommendations will be given.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Eyitayo O. Owolabi is a nurse/midwife and currently a post-doctoral student at Centre for Global Surgery, Faculty of Health Sciences, Stellenbosch University, Cape Town, South Africa. She is a public health researcher, passionate about health promotion and disease prevention.
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TITLE	Siyakwazi's Therapy Programme
AUTHORS	Catherine Mather-Pike
INSTITUTION	Siyakwazi
ABSTRACT	Siyakwazi's Therapy programme is a unique intervention that supports families of children with disabilities escalating the support for their child in a cost effective way. Therapy at the local clinic is limited to once a month for most children through Community Service Placement. Despite this access to trained therapists, we are acutely aware that approximately 12 sessions a year is insufficient to support a child's growth and development. Because of this, Siyakwazi has developed a strategy to capture this expert knowledge to ensure that the information given by therapists is utilised. The programme consists of documenting 5 activities/exercises that the Therapist recommends. This is done with the collaboration of both the therapist and the parent/guardian, photos are taken of the activity, then inserted into a document with an explanation of the activity and then translated into isiZulu. This document becomes a tool to ensure that the parent is able to access the specific information given at a session. These activities are then accessible to the child EVERY DAY and not once a month where details can easily be forgotten or even misunderstood. In addition to this, a child is seen by an OT Consultant once a term to update this programme and ensure it is still current and relevant for the growing child. Siyakwazi's Siyasizas visit the child weekly and encourage the parent to implement the programme. The Siyasiza's role is to answer any questions the parent may have and to help them gain confidence with all the activities, further enhancing the process of ensuring a child receives therapy input on a more regular basis. In this way, the programme is maximising on the input given by the therapist and ensuring this invaluable resource is utilised to its full capacity and the children benefit significantly as a result.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Cathy Mather-Pike is the Founder and Director of Siyakwazi. She is a Special Needs teacher by profession with Honours in ECD and a Master of Education, specialising in development through participation. Her experience and expertise, gathered from the UK and rural development in KZN, is in particular linked to all children accessing holistic support and care through an inclusive community- based model.
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TITLE	Stroke Care in SA: perspectives of persons with stroke and family members/ Understanding stroke care pathways in South Africa from persons with stroke point of view
AUTHORS	Thandi Conradie Gakeemah Inglis Jassiem Sjan-Mari Van Niekerk Quinette Louw
INSTITUTION	Stellenbosch University
ABSTRACT	Stroke is the second most common cause of morbidity in South Africa. Disability in South Africa is increasing and putting additional strain on South Africa's healthcare services. A person's well-being, function, and quality of life are determined by healthcare services quality. Most persons with stroke in South Africa have limited access to healthcare and rehabilitation services in the public sector. The implications of no or inadequate stroke care are unclear. It is therefore important to know where there have been positive and negative engagements with stroke care. This presentation will aim to share the experiences of persons with stroke engagement with the health system in South Africa and discuss what this means for healthcare practitioners. We conducted semi-structured interviews with 15 people with stroke living in urban and rural settings in the Eastern Cape and Western Cape, to explore their experiences within the first 24 months post-incident. Interviews were transcribed, coded, and thematically analyzed. Results: Some of the main issues in the care that persons with stroke experienced were related to transport, quality of care, continuity of care and holistic management. Despite these challenges, persons with stroke also reported positive experiences with stroke care services. Conclusion: Conducting interviews with persons with stroke and their caregivers have given us significant information on where the gaps are in stroke care and where there have been positive engagements. This information is vital in learning where and what changes need to be made to improve stroke care in South Africa.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Gakeemah Inglis-Jassiem is an experienced neuro clinician and has been working with persons with stroke for a number of years now. She previously lectured at Stellenbosch University on Neuro Rehabilitation. She completed her Master's in Physiotherapy based on stroke care and is currently doing her PhD in stroke care. She is an Adult Neuro Bobath Trainer for the Adult Bobath Training Courses. Thandi Conradie was trained by Gakeemah at undergrad level where she developed her passion for neuro. She has had experience with adult neuro at Madwaleni Hospital where she worked for 7 years. In that time, she facilitated setting up a stepdown ward for long-term care, where most of the persons seen have had a stroke. She has also completed her Adult Neuro Bobath course.
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TITLE	The development of a clinical training model for undergraduate physiotherapy education to promote longer and more immersive experiences in rural communities.
AUTHORS	Cameron Reardon Ms San Schmutz Professor Susan Hanekom
INSTITUTION	Ukwanda Centre for Rural Health and Division of Physiotherapy, Stellenbosch University
ABSTRACT	Educational strategies are a major component of the WHO's recommendations for health workforce development, attraction, recruitment and retention in rural and remote areas in an effort to redress the maldistribution of healthcare workers in a more equitable manner. More specifically, clinical training in rural communities at an undergraduate level is recommended. Stellenbosch University, through Ukwanda Centre for Rural Health, has a long history of training students in rural communities. Undergraduate physiotherapy students, historically, have trained in these contexts on short rotations with specific foci. A review of clinical physiotherapy education at these sites is timely. Methods: Utilizing a pragmatic approach we evaluated rural physiotherapy clinical training using the Stellenbosch University Collaborative Capacity Enhancement through Engagement with Districts (SUCCEED) framework. In response to our findings we reviewed the literature to identify alternative clinical training models in order to optimize rural clinical training. Following a consultative process, a longitudinal integrated rotation, based on a longitudinal integrated clerkship was developed. Results: We present the rationale for this alternative approach to clinical education and describe it in detail focusing on four aspects; simultaneous exposure across the health service platform, the integrated nature, longitudinality, and a multi-pronged approach to support. Conclusion: A longitudinal integrated approach to clinical physiotherapy education in rural contexts has intuitive appeal for both educationalists and health services staff. This approach has the potential to drive transformation of the future workforce by exposing students to and immersing them within rural health systems. The potential benefits extend to the current rural workforce too both in terms of capacity and continuity. The impact of rural clinical training on undergraduate physiotherapy students' preparedness for practice and career choice is an important avenue for further inquiry.
CPD POINTS	Standard Webinar
PRESENTER'S BIOSKETCH	Cameron Reardon is the distributed training platform coordinator for physiotherapy at Stellenbosch University where he manages undergraduate clinical training across a number of rural contexts within the Western Cape and Northern Cape. Having worked rurally for a number of years Cameron is particularly interested in the potential role academic institutions can play in creating a fit-for-practice rural workforce. He has a developing research interest in health professions education and human resources for health.
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TITLE	The Power of a Parent Facilitator in Rural KZN
AUTHORS	Tina De Freitas
INSTITUTION	Carer2carer Npo
ABSTRACT	Manguzi Hospital has offered a decentralized CP (cerebral palsy) service since 2006. CP children are triaged via OPD (out-patient department), clinics and occasionally, home visits. However, despite decentralized services, many have been lost to follow-up due to challenges with staff shortage/turnover, environmental and social factors, as well as data management. Covid-19 has further disrupted these services and urgent intervention was required. In response to these challenges, it was decided to increase and strengthen the role of parent facilitators. The presenter was a former community service Occupational Therapist at Manguzi Hospital and has now taken on the role of being an OT consultant, to provide support and improved governance to the Manguzi parent facilitator program. Methods: Reflective practice Results: The real work in managing an efficient parent facilitator program, begins after the parent facilitator training has been completed. Parent facilitators provide a good interface between the caregiver/family and the health care workers. Parent facilitators are able to pick up on issues that therapists may have difficulty in picking up. However, capacity building in the areas of channels of communication, case management and referral systems between the parent facilitators and the district hospital therapy department was necessary and is an on-going process. This capacity building is used to address a change in the needs of the CP program. To run an efficient parent facilitator program, a lot of background work and support is required. Impact/Relevance: This discussion will highlight the positive aspects that a CP parent-led service can offer. That being, legitimacy, acceptability, affordability, and service coverage. This presentation will dive into the background support and capacity building that is required to run an effective parent facilitator program in rural KZN.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	I graduated from Wits University in 2019. I completed my community service year at Manguzi Hospital, in rural KZN. I am currently an OT consultant for Carer2Carer NPO. The NPO provides parent facilitator services to mothers of children with disabilities (specifically, CP).
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TITLE	Translating theory into policy: A framework for CBR implementation in KwaZulu-Natal public sector (Proposal for PhD)
AUTHORS	Sithembiso Blose
INSTITUTION	University of KwaZulu-Natal
ABSTRACT	Background: People with Disabilities (PWDs) remain among the poorest and least empowered people globally. They experience limited access to basic services especially in Low and Middle-Income countries (LMIC). The level of infringement of their human rights remains alarming despite the availability of policies redressing this gap. The Community-Based Rehabilitation (CBR) Strategy and the United Nations Convention on the Rights of People with Disabilities (UNCRPD) provide strategies for poverty alleviation, social inclusion and equalization of opportunity, and has broadened its scope from a mere strategy for access to health and rehabilitation services to include education, livelihood, social and empowerment. CBR is implemented across the world with majority of LMIC signatories to the UNCRPD. South Africa is among the countries implementing CBR, however the extent and the nature of implementation is not known. KwaZulu-Natal has been one of the provinces implementing CBR through various non-governmental organizations, but there is no set framework or guide for the implementation; thereby resulting in duplication and unco-ordinated CBR strategies. This study aims to determine current trends of CBR practices in KwaZulu-Natal and develop a tool for integrated implementation of CBR in KZN. Method: A qualitative approach will be adopted. The Social Model of Disability will form a guide to this explorative study using an advocacy / participatory philosophical worldview. Unlike the post-positivist view that imposes structural law and theories, the advocacy /participatory view takes into consideration the marginalized individuals in society. Social justice issues fits this approach to qualitative research as it acknowledges and takes into account people's lived experiences. An interpretive phenomenology will be used for data collection through focus group and interviews with identified participants. Discussion: The information obtained from the participants of the study will be discussed in relation to the research question using a narrative to identify and explore emergent themes. The review will provide a baseline of evidence on the implementation of CBR and will highlight gaps regarding the implementation of CBR in the context of KwaZulu-Natal. A Delphi study will be undertaken to develop a framework for the implementation of CBR services in KwaZulu-Natal.
CPD POINTS	Standard webinar
PRESENTER'S BIOSKETCH	
EMAIL ADDRESS	BloseS1@ukzn.ac.za

Workshops

TITLE	Basic Emergency Skills Training - 12 years of training rural doctors in North West, what about the rest of South Africa?
AUTHORS	Dr Jurgens Staats Dr E v Niekerk Dr SD Murphy Mr Aldus Smit Dr HC Lion Cachet
INSTITUTION	BEST (Basic Emergency Skills Training) Course Committee
ABSTRACT	The Basic Emergency Medicine Skills (BEST) Course has been running for the past 12 years in the North West Province. As it was derived from the Australian REST (Rural Emergency Skills Training) Course, the approach and skills taught are extremely valuable in a rural setting. Community service medical officers (CSMO) and medical officers in rural areas may often feel overwhelmed and isolated when it comes to providing emergency care in low resource settings. Having a practical approach with the skills to back it up proves invaluable in patient care and the mental wellbeing of these healthcare professionals. With an expected increase in the number of rural CSMO in our near future, we need to think about investing in their skills as a way of ensuring adequate emergency care and hopefully retention. BEST has been run for 12 years on a minimal budget and is poised to be renamed as Rural Life Support (RuLS). The purpose of this workshop is to demonstrate the structure of this course and to explore the possibility of expanding to other provinces with interested role players.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Dr Jurgens Staats is a Family Physician working in the JB Marks Subdistrict of North West Province. Having served as student representative on the RuDASA committee 2009/2010 he remains Proudly Rural. Involved in training as BEST, BLS, ACLS and ITLS instructor, improving the skills of medical professionals is something he enjoys.
EMAIL ADDRESS	drjstaats@gmail.com

TITLE	Beating entropy: establishing systems and getting a grip on your wheelchair service in a rural setting
AUTHORS	Maryke Bezuidenhout Thandie Conradie
INSTITUTION	Manguzi Hospital
ABSTRACT	Despite The WHO comprehensive guidelines on wheelchair services in low resource settings, and the UN Convention on the Rights of People with Disabilities, there are marked provincial inequities in wheelchair issuing rates and little evidence of a working model of rural wheelchair service delivery. Few therapists have the necessary knowledge/skills to effectively seat children, or clients with progressive disorders, tone abnormalities or fixed postural deformities. Poor budgeting practices and procurement challenges exacerbate the problem. Tracing and following up clients within a deep rural setting have significant challenges. Coupled with minimal rehabilitation within the acute care setting, early discharges home and often insurmountable barriers in accessing further care, this can lead to poor program outcomes and community integration. Low levels of end user involvement in service design and implementation further drive low retention in care. We highlight policy issues and subsequent inequities-and explore the following themes: 1. Classification of different levels of user, measurement and general principles of addressing different postural needs (prac and theory) 2. Highlighting the different aspects of a comprehensive seating service and providing practical examples of how to structure and finance a service in a low resource setting 3. Only got a tuffee? How to make a plan with what you have. This workshop does NOT aim to produce competent advanced level wheelchair seating specialists but serves to give participants a broad overview of principles, pitfalls and structure- potentially developing a mentoring network and encouraging them to pursue further WHO-accredited training in the topic.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Maryke Bezuidenhout has spent 19 years as a physiotherapy clinician, supervisor and manager at Manguzi Hospital in rural KZN. She has completed her post graduate training in basic, intermediate and advanced wheelchair seating. Her department runs a decentralized seating service in collaboration with local DPOs and NPOs. Maryke is as happy armed with her drill, repairing and adapting wheelchairs under a tree as she is advocating for improved access to disability and rehabilitation services in rural areas with random donors, politicians and budget holders. Thandie Conradie is a physiotherapist who spearheaded Madwaleni Hospitals decentralized rehabilitation service in the Eastern Cape for close to a decade. Also advanced seating trained, she holds the accolade of having set up and sustained a rehabilitation step-down ward at minimal additional cost within a low resource setting, complete with a dedicated rehabilitation doctor. Skilled at making a plan with nothing but a piece of wire previously holding a goat and some masking tape, Thandie has shown that it is indeed possible to adapt the standard tuffee to many a clients needs.
EMAIL ADDRESS	marykebez@gmail.com

TITLE	Fostering Teamwork And Collaboration In Health Professional Teams
AUTHORS	Francis Coetzee Ian Couper Jacqui Couper Hoffie Conradie Thandi Conradie
INSTITUTION	Ukwanda Centre for Rural Health, Stellenbosch University
ABSTRACT	As rural health professionals educators, we all work in teams and we talk about the importance of teams. Teams are dynamic and living systems. Teams are constantly changing in response to demands, tensions, surprises, and successes. Teams are connected through individual roles and at the same time through collective and shared objectives. Teams do not automatically collaborate; this requires purposeful intention and active engagement. How do we support teams to develop and function better? The workshop will present an online module on teamwork and collaboration that was developed as part of the Stellenbosch University Network for Strengthening Rural Inter-professional Education (SUNSTRIPE) project. By the end of the workshop, the participants will be able to: 1.Understand diverse viewpoints and perspectives of team members as a way of seeing each other. 2.Understand the different roles and relationships in a team that allow for giving and receiving support. 3.Embrace the concept that our actions or inactions can make a difference in relating to others in a health care team. 4.Plan ways in which to support the development of teamwork and collaboration in their own contexts. Following an introduction to the concepts of the module overall, participants will engage in a number of separate small group activities, in person and/or virtually, to reflect on teamwork and engage in discussion around lessons arising from those. A wrap up will discuss possibilities for taking this forward.
CPD POINTS	Standard webinar
PRESENTER'S BIOSKETCH	Francois Coetzee is a family physician, and program coordinator of the Rural Clinical School based in Worcester, South Africa. For 12 years he practiced as a rural clinician in a 70-bed hospital 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. Clinical duties include doing outpatient clinics with a focus on chronic disease management including HIV. Current projects include: research tracking the RCS graduates and documenting their intentions to practice rurally or in urban settings. The re-designing of the final year of the new medical curriculum at Stellenbosch University, the development and coordination of a new longitudinal integrated clerkship in Upington and investigating the feasibility of online assessments by means of multimedia for students on the distributed platform.
EMAIL ADDRESS	franna@sun.ac.za

TITLE	Health Facility Regulations, Inspections, and Certification for National Health Insurance - what you need to know
AUTHORS	Ms Winnie Moleko Dr Ziyanda Mgugudo-Sello Ms Dikeledi Tsukudu Advocate Olebile Makompo
INSTITUTION	Office of Health Standards Compliance
ABSTRACT	Public and private medical practitioners are important as they are primary healthcare providers. The Office of Health Standards Compliance (OHSC) is preparing for the introduction of inspections of private general medical practices. The tools that OHSC inspectors will use conducting inspections is to determine whether the norms and standards are being met by medical practitioners. To reach out to all public and private medical practitioners, it is a consultative process used by OHSC to assist all involved to contribute, either they are from the rural or urban settings.The OHSC will engage with medical practitioners at the Rural Health Conference hosted by Rural Doctors Association of South Africa. The conference will be held from 2 - 4 September 2021 face-to-face and virtually. The OHSC will use the conference platform to enable medical practitioners understand the services offered by OHSC. The task of the OHSC is to safeguard the safety of users of health services and healthcare workers and to ensure quality services in medical practices. Some of the topics by OHSC to focus on: The norms and standards regulations for different categories of health establishments. Processes undertaken by OHSC to conduct inspections. Certification and enforcement process. The OHSC is a statutory body charged with promoting quality healthcare by ensuring health services meet prescribed standards. It does so through the inspection of health establishments to establish whether they meet prescribed norms and standards, certifying them as compliant or embarking on a process to ensure they become compliant, and the investigation of complaints about poor-quality of care experienced. The contracting of private and public healthcare providers by the planned National Health Insurance (NHI) Fund will depend, in part, on healthcare providers attaining certification by the OHSC.
CPD POINTS	Ethics - Webinar
PRESENTER'S BIOSKETCH	Ms Winnie Moleko – Executive Manager: Health Standards, Development, Analysis and Support. A highly experienced professional nurse with a Diploma in General Nursing and Midwifery (Chris Hani Baragwanath Hospital); holding degrees in Community Nursing Science, Nursing Education and Nursing Administration (MEDUNSA); Master's in Education (MeD) for Primary Health Care (University of Manchester –UK); Post Graduate Diploma in HIV/AIDS Management (University of Stellenbosch); Advanced Course in Health Management (Foundation for Professional Development (FPD) and YALE University) and MPHIL (HIV/AIDS) with University of Stellenbosch.

PRESENTER'S BIOSKETCH	Dr Ziyanda Mgugudo-Sello – Director: Compliance Inspectorate, a Public Health Medicine specialist with experience in Private Hospital and Netcare aeromedical emergency services, Emergency and Covid-19 Testing Centres , Assessor (Surveyor) and Quality Advisor for COHSASA (The Council for Health Services Accreditation of Southern Africa, Western Cape DOH's Health Impact Assessment and provided public health medicine expertise at Metro Health District Services, Epidemiology and Surveillance, Southern Western Substructure. Advocate Olebile Makompo – Acting Director: Certification and Enforcement Holds Bachelor of Laws (LLB) from North West University and admitted Advocate of the High Court of SA in 2014. Certificate of Monitoring and Evaluation: Indicators Development from Stellenbosch University. Currently studying towards Master of Business Administration with MANCOSA.
EMAIL ADDRESS	rmahlakanya@ohsc.org.za

TITLE	Re-imagining my approach to Primary Health Care for 2022
AUTHORS	Hermann Reuter
INSTITUTION	UCT and SAHARA - Smoking & Alcohol Harms Alleviation & Rehabilitation Association
ABSTRACT	South Africa is struggling with a quadrable epidemic MRC Briefing 2016 : HIV-TB, lifestyle illnesses, maternal & child mortality, injury and trauma driven by harmful alcohol use. The root causes could be addressed at community level through health promotion that brings about structural changes in the living environment. Yet our health system compels doctors to practice curative medicine. Is this the cause for 76% of primary care doctors reporting burnout and 81% of doctors working in a rural district of the Western Cape? This workshop is a think tank. Active collaboration in groups should help participants to think bigger/broader and start making changes in their practice. If I see twenty people with a chronic illness at a clinic during a morning in twelve-minute consultations, I have adjusted some peoples' medication - and feel exhausted. If I see the same twenty people in a club for two hours, I have discussed better understanding and adherence to the medication, addressed mental health challenges (stigma, depression, substance use), allowed patients to consider lifestyle changes and promoted people taking up an advocacy campaign for a healthier social environment – and I feel inspired. I have two hours left in my morning to consult people identified during the club individually, have time for tea, learn about nurses' challenges, and address system issue like medicine supply. In this session we will discuss approaches, based on clubs, to managing, a. First Thousand Days (maternal and childcare) b. HIV-TB c. mental health including substance use d. metabolic syndrome (diabetes, hypertension, obesity, and smoking). Guidance by allied health professionals will be prized. Outcomes: We will make personal pledges of what each one of us will change in our practice. PHC re-imagined that will be better for ourselves, our service users, and the community.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Doctor in public sector for seven years, mainly rural (Namibia and South Africa) Provincial coordinator of Treatment Action Campaign. Doctor with Doctors Without Borders - MSF for ten years (Khayelitsha, Lusikisiki, Swaziland) HIV-TB coordinator of John Hopkins University's HIV program for two years (Ethiopia)- mainly providing HIV & TB program development, clinical care, training and advocacy Presently and past six years: Community Based Education Coordinator of UCT in the Garden Route- training medical students on a rural platform
EMAIL ADDRESS	hermannreuter@gmail.com

TITLE	RuDASA Indaba 2021: Developing a mentoring programme
AUTHORS	Dr Lungile Hobe Dr Madeleine Muller Dr Mayara Floss
INSTITUTION	RuDASA
ABSTRACT	After the 2019 Indaba, RuDASA developed a Mentoring Strategic Plan. A brief synopsis of the plan and the activities that took place in 2020 and 2021 will be presented to provide the basis of a discussion on the need for mentoring in rural practice, levels of mentoring (student, young professionals, rural practitioners) and best practice models for each level. Existing models such as BAMSI in Eastern Cape and the Rural Student Health Clubs at UCT and Wits will be considered, as well as the growth of online learning opportunities as options to create support for the move from student to intern then community service officer to rural doctor. Our Keynote Speaker will provide ideas that have been developed in Brazil and through WONCA. This will form part of the cohesive business plan for a RuDASA mentoring programme first envisaged at Indaba 2019, but put on hold because of the COVID-19 pandemic, to submit to the Discovery Foundation.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Lungile Hobe is the Chair of RuDASA and acting medical manager at Mseleni Hospital, KZN. She has a special interest in mentorship based on the mentorship she received, during her training, from Umthombo Youth Development Foundation, and a veteran rural doctor mentor. Madeleine Muller is a Family Physician and Senior lecturer at Walter Sisulu University, stationed at Cecilia Makiwane hospital in Mdantsane, East London; and has the mentoring portfolio on the RuDASA Executive. She worked at Nkqubela TB hospital from 2017 until 2021 and has served as the Rural representative on the SAMA border branch since 2011. Doing the past 2 years she has championed the need for RuDASA to offer mentoring to young professionals. Mayara Floss (Brazil) is a family medicine registrar who has just completed her term as Wonca Young Ambassador. She recognised the need for dialogue between rural veterans and students and young professionals and developed Wonca's Rural Seeds programme.
EMAIL ADDRESS	chair@rudasa.org.za

TITLE	Skill building – taking your mentoring and teaching to the next level. Evidenced based teaching techniques to use at the bedside and in virtual and rural classrooms.
AUTHORS INSTITUTION	Madeleine Muller Department of Family medicine and Rural Health, WSU
ABSTRACT	Working in rural health settings is an extraordinary opportunity for learning and growing as a health care professional and this can be enhanced and supported by good mentoring, bedside teaching and since COVID19, virtual teaching support. Mentoring and teaching individuals or small groups in work-based settings takes a special skill set to maximise learning in busy and overstretched health care workers. This includes not only teaching clinical skills and knowledge but also how to shift attitudes, helping to create more patient centered doctors in our doctor centered working environments. In this workshop we will look at specific, evidenced based tools and skills that can be used when mentoring clinicians in a rural setting; whether community service officers, experienced medical officers and rehabilitation clinicians, pharmacists or nurses or even fellow specialists. We will cover a wide range of skills including creating work-based curriculums using Entrustable Professional Activity frameworks (EPAs), specific small learning teaching skills that can easily be added to your existing practices and a brief look at assessment methodology. Finally, we will look at some tips on creating learning environments using virtual classrooms for teaching and support. For those that have mentoring as the scope of practice and including any clinicians who ever find themselves giving advice to a colleague.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Dr Madeleine Muller is a Family Physician and Senior lecturer at Walter Sisulu University, stationed at Cecilia Makiwane hospital in Mdantsane, East London (since 1 May 2021). She is on the RuDASA exec co carrying the mentoring portfolio. She qualified as medical doctor from UP in 1995 and obtained her MRCGP in 2003 in the UK. She worked a GP in the UK until returning to South African in 2009. From 2009 until 2017 she worked as a clinical advisor at the NGO Beyond Zero and was awarded a certificate of special merit by RuDASA for her work in mentoring health care professionals in 2010. During this period she helped implement the Advanced Clinical Care program for complicated HIV and created the decentalised Wits RHI ACC training program for doctors. She obtained her DipHIVMan in 2016 and has been the convenor for the Diploma of HIV management since 2020. In 2016 Dr Muller passed the Advanced Health Management Program through FPD / Yale cum laude and served for a year as the acting technical lead for the ACC program in Limpopo and Eastern Cape. She worked at Nkqubela TB hospital from 2017 until 2021 and has served as the Rural representative on the SAMA border branch since 2011.
EMAIL ADDRESS	drmullerbz@gmail.com

TITLE	Spinal tuberculosis: A systematic review of case studies and development of an evidence-based clinical guidance tool for early detection
AUTHORS	Marisa Coetzee Quinette Louw Nassib Tawa Sjan-Mari van Niekerk Thandi Conradie
INSTITUTION	Stellenbosch University
ABSTRACT	Despite research being done on spinal tuberculosis, diagnosing this condition at an early stage remains problematic due to its insidious onset and the varying symptoms being associated. Most individuals present to the health care facility with either simple back pain at an early stage or neurological complications at a later stage, when spinal compression and vertebral collapse have occurred as a result of delayed diagnosis. The prevention of secondary complications is therefore dependent on early recognition and diagnosis. The objective of this review was to identify common clinical patterns in case presentations and develop an evidence-based clinical guidance tool to assist clinicians in the early identification of spinal tuberculosis. A comprehensive literature search was conducted for published spinal tuberculosis case studies, which yielded 28 cases after critical appraisal. Data from the studies were categorized in order to assist with a factor analysis and the development of an evidence framework for screening and diagnosing spinal tuberculosis. An evidence-based clinical guidance tool was then designed from the data obtained. Factors associated with spinal tuberculosis and frequently reported symptoms and physical signs with which the patient could present upon assessment were identified. Options for investigations at primary, secondary, and tertiary levels were also identified. Conclusion: Through the use of an evidence-based clinical guidance tool, the clinician could be guided in the early suspicion and management of individuals with spinal tuberculosis and prevention of secondary complications.
CPD POINTS	Standard Webinar
PRESENTER'S BIOSKETCH	Marisa Coetzee is a physiotherapist with clinical experience in rural health care as well as occupational health, ergonomics and functional capacity evaluation. She serves as an executive committee member of the World Physiotherapy subgroup called International Federation of Physical Therapists working in Occupational Health and Ergonomics. Her masters research described the contextual factors and relevance of guidelines on knee osteoarthritis self-management and education in rural setting of the Western Cape and she is currently a registered PhD student and senior research assistant at the University of Stellenbosch with a research interest in supported self-management of knee osteoarthritis and the preservation of function in adults during and after their economically active life years. In addition, she has a key interest in rural health and strives to empower patients with chronic conditions.
EMAIL ADDRESS	marcoetzee@sun.ac.za

TITLE	Supervising student consultations in district hospitals
AUTHORS	Hoffie Conradie
INSTITUTION	Stellenbosch University
ABSTRACT	Many medical schools in South Africa require students, both medical students and clinical associate students, to do part of their clinical training in rural district hospitals. Doctors in rural hospitals struggle to find time to balance a heavy clinical workload and attending to students. Participants will be asked to share their experience of supervising students at district hospital particularly supervising patient consultations. The workshop facilitator will share his experience of supervising medical students at district hospitals in the particular using the following resources and tools for formative assessment: •The use of the Adult Primary Care (APC) guide as resource for students while consulting the patient. •Observing students consulting with patients and using the Mini-CEX assessment •Practical demonstration in the use of the three stage assessment •The use of the SNAPPS format for presenting patients Participants will be given time to practice these tools in small group role-plays.
CPD POINTS	Standard webinar
PRESENTER'S BIOSKETCH	Prof H H Conradie MBChB (SU, 1973), DCH (College of Medicine of SA, 1975), M Prax Med (Medunsa, 1985), FCFP (SA, 2009), Diploma in Practioner Coaching (2016, Centre for Coaching, Cape Town) I worked as general practitioner and family physician in both state health service and private practice for 20 years mostly in the Eastern Cape (EC), South Africa. From 2003, I joined Stellenbosch University (SU) as a family physician in Worcester hospital and as associate professor in the Division of family medicine and primary care at Stellenbosch University. Since 2016, I am facilitating learning in the distributed medical education learning programmes of SU) to build clinical and learning/teaching capacity in district hospitals in the WC, EC and KZN. I obtained the Diploma in Practitioner Coaching with the Integral Coaching Centre, South Africa (2016) with accreditation from the International Coaching Federation (ICF) and since then has been involved in individual and group coaching mainly for health workers.
EMAIL ADDRESS	hoffie@sun.ac.za

TITLE	The Voice Project: Building the next generation of Health Advocates
AUTHORS	Karessa Govender Lungile Gamede
INSTITUTION	Rural Health Advocacy Project
ABSTRACT	The workshop provides an overview of ethical frameworks and local legislation that supports healthcare workers right to report health systems challenges.tEvery day, health workers working within the South African health system are confronted with incidents of patientsâ€™ rights violations. So much so, that these violations have become normalized and health workers become defeated or complacent about the state of healthcare. The ongoing Covid-19 pandemic together with stringent austerity measures will create more challenging environments for health workers and necessitate advocacy competent health workers. Using an interactive case-based approach, participants to this workshop learn how to advocate for health systems change using reporting mechanisms. Through this process, health workers and students are exposed to the legislation that supports their right to advocate, different advocacy strategies they can employ as well as the protection they are afforded when choosing to blow the whistle on workplace offences that compromise the health and safety of patients and themselves.
CPD POINTS	Ethics Webinar
PRESENTER'S BIOSKETCH	Karessa Govender works for the Rural Health Advocacy Project where she leads on the Human Resources for Health Program. She is an occupational therapist by profession and worked in the public sector for 7 years before making the transition to civil society. She is passionate about healthcare workers and their role in building humanising health systems. Lungile Gamede is a Project Officer at the Rural Health Advocacy Project (RHAP) in the Human Resources for Health Programme. She is a professional nurse by background and worked in a PHC clinic in the North West for her community service before joining RHAP in 2019. She is a current MSc Medicine (Rural Health) student at Wits and is passionate about the nurse's role in advancing rural health and maternal and child health.
EMAIL ADDRESS	karessa@rhap.org.za

TITLE	Why Rural?
AUTHORS	Mayara Floss
INSTITUTION	University of São Paulo Brazil
ABSTRACT	The Rural Family Medicine Café is a live interactive conversation. It started in 2015 and spread around the world. Please prepare your local beverage to sit with people around this virtual table and share a "coffee" in a global conversation where people from different backgrounds and career points have the same voice.
CPD POINTS	Standard
PRESENTER'S BIOSKETCH	Mayara Floss is a Brazilian Family Doctor, writer, poet, film maker and activist and currently a PhD student at the University of São Paulo (USP). She created, and was an Ambassador of, Rural Seeds and is an executive member of the WONCA Working Party on Rural Practice and member of the WONCA Working Party on the Environment. Mayara also is a member of the planetary health group and the Advanced Studies Institute - IEA/USP, and creator and coordinator of the Planetary Health and Planetary Health for Primary Care MOOC. She was the junior author of the policy brief recommendations for Brazil of Lancet Countdown 2018 and 2019. She has spoken on women's health at the United Nations in 2018. Mayara is a champion for the health of rural and indigenous people across Brazil. With Mayara will be speakers from the health students in South Africa, doctors training and working as Family Physicians, and other members of the multidisciplinary team.
EMAIL ADDRESS	mayarafloss@hotmail.com

Final Programme

<table>
<tr><th></th><th colspan="4">Thursday 2nd September 2021: Equity in Rural health</th></tr>
<tr><td>09h00 - 10h00</td><td colspan="4">Registration at venue</td></tr>
<tr><td>10h00 - 12h00</td><td colspan="4">Conference Opening</td></tr>
<tr><td rowspan="2">10h00 - 11h00</td><td colspan="4">Welcome by RHC Chair: Dr Themba Maphophe
Blessing for the conference</td></tr>
<tr><td colspan="4">Opening Speech: MEC for Health Limpopo</td></tr>
<tr><td>11h00 - 12h00</td><td colspan="4">Opening Plenary*: The Past Year Through an Equity Lens (Ethics)
The RHC Partners: RuDASA, RuNurSA, RuReSA and PACASA</td></tr>
<tr><td>12h00 - 13h00</td><td colspan="4">Lunch</td></tr>
<tr><td>13h00 - 14h00</td><td colspan="4">Key Note 1 Equity*: Health Systems: 25 years of moving towards Rural Health Equity (Ethics)
Mark Heywood</td></tr>
<tr><td>14h00 - 15h00</td><td colspan="4">Plenary: Flexible contracting - a strategic approach to getting more health workers in rural areas?
Russell van Rensburg & Panel</td></tr>
<tr><td>15h00 - 15h30</td><td colspan="4">Tea Break</td></tr>
<tr><td rowspan="2">15h30 - 17h30</td><td colspan="4">Parallel Sessions:</td></tr>
<tr><td>Venue A:
Building Teams (MDT)</td><td>Venue B:
Building Teams (students)</td><td>Venue C:
Community and End Users</td><td>Venue D:
Health Systems</td></tr>
<tr><td>15h30 - 15h50</td><td rowspan="4">Workshop: Fostering Teamwork and Collaboration in Health Professional Teams
Francois Coetzee
2 hours</td><td>The development of a clinical training model for undergraduate physiotherapy education to promote longer and more immersive experiences in rural communities
Cameron Reardon</td><td>Experiences of Community Health Workers and the Voices of Household Members Regarding Community Health Workers in KwaZulu-Natal, South Africa
Dr Euphemia Mbali Mhlongo</td><td>Innovation in Action: Design thinking for low resourced setting
Nabeela Laher</td></tr>
<tr><td>15h50 - 16h10</td><td>Facilitating learning of medical students on distributive learning platforms using the Vulamobile App
Hoffie Conradie</td><td>Escalating health care access through referrals
Cathy Mathe-Pike</td><td>Financial risk protection and disability: what are the implications for service delivery?
Maryke Bezuidenhout</td></tr>
<tr><td>16h10 - 16h30</td><td>An overview of the six weeks online Eastern Cape Rural Onboarding program for new clinicians piloted February to March 2021
Madeleine Muller</td><td>Perceived barriers and benefits of implementing HIV care at the community level in Tshwane district: A qualitative study
Sanele Ngcobo</td><td>Apps and equity: Building a rural rehab data management system
Kate Sherry</td></tr>
<tr><td>16h30 - 17h30</td><td>Workshop: Supervising student consultations in district hospitals
Hoffie Conradie
60 minutes</td><td></td><td>*Rehabilitation and Disability Inclusion into Standard Treatment Guidelines at Primary Health Care and District Hospital Level
Quinette Louw, Thandi Conradie, Maria Charumbira (Ethics)</td></tr>
<tr><td>17h30 - 19h00</td><td colspan="4">Student AGM Meeting by webinar in Venue A</td></tr>
<tr><td>18h00</td><td colspan="4">Informal Supper at venue</td></tr>
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<table>
<tr><th></th><th colspan="4">Friday 3rd September 2021: Equity in Rural health</th></tr>
<tr><td>7h30 - 8h00</td><td colspan="4">Conference & CPD registration at the venue</td></tr>
<tr><td>8h00</td><td colspan="4">Welcome to Day 2</td></tr>
<tr><td>8h00 - 9h00</td><td colspan="4">Key Note 2: Working with traditional healers and leaders for equity in healthcare
Nthabiseng Sibisi</td></tr>
<tr><td>9h00 - 10h00</td><td colspan="4">Key Note 3: The Plight Of Clinical Officers And Medical Assistants In Malawi's Healthcare System
Solomon David Chomba (Malawi)</td></tr>
<tr><td>10h00 - 10h30</td><td colspan="4">Tea Break</td></tr>
<tr><td rowspan="2">10h30 - 12h00</td><td colspan="4">Parallel Sessions</td></tr>
<tr><td>Venue A:
Building Teams
(Mentoring skills)</td><td>Venue B:
Community & end users</td><td>Venue C:
Policy & Practice NCD</td><td>Venue D:
Health Systems</td></tr>
<tr><td>10h30 -10h50</td><td rowspan="4">Workshop: Mentoring:
Skill building - taking your mentoring and teaching to the next level. Evidenced based teaching techniques to use at the bedside and in virtual and rural classrooms
Madeleine Muller
90 minutes</td><td>Education as health: Enabling inclusive policies to inform the lived experience of disability
Chioma Ohajunwa</td><td>Chronic care model effectiveness in the management of type 2 diabetes in primary care setting
Yasir Elradi , Kuwait</td><td rowspan="4">Workshop: Help us help you and your community - health advocacy in the times of COVID-19
Russell van Rensburg
90 minutes</td></tr>
<tr><td>10h50 - 11h10</td><td>Parent Champion Network: Equipping Parents as Change Agents for Inclusion
Erna van der Westhuizen</td><td>Screening for end-organ damage among diabetic patients in rural Eastern Cape, South Africa
Eyitayo Owolabi</td></tr>
<tr><td>11h10 -11h30</td><td>Stroke Care in SA: perspectives of persons with stroke and family members/ Understanding stroke care pathways in South Africa from persons with stroke point of view
Thandi Conradie</td><td>Knowledge, attitude and perception towards lower limb amputation among diabetic patients in rural Eastern Cape, South Africa
Eyitayo Owolabi</td></tr>
<tr><td>11h30 - 12h00</td><td>Walking into my dreams
Regina Tseisi</td><td>Improved enrolment and outcomes with medicine assisted out-patient treatment of tobacco-, alcohol-, and drug-use disorder in a rural town
Hermann Reuter</td></tr>
<tr><td>12h00 - 13h00</td><td colspan="4">Lunch Break</td></tr>
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<table>
<tr><th colspan="5">Friday 3rd September 2021: Equity in Rural health</th></tr>
<tr><td>12h00 - 13h00</td><td colspan="4">Lunch break & Exhibition</td></tr>
<tr><td>13h00 - 14h00</td><td colspan="4">Plenary*: The double burden of malnutrition and its impact on the health of rural populations: A call for a national food justice policy agenda (Ethics)
Daddy Matthews Deputy Director Nutrition Services & team</td></tr>
<tr><td>14h00 - 15h00</td><td colspan="4">Keynote 4*: A Journey to Equity and Rural Health (Ethics)

Dr Mayara Floss (Brazil)</td></tr>
<tr><td></td><td colspan="4">Tea break</td></tr>
<tr><td>15h30 - 17h00</td><td colspan="4">Parallel Sessions</td></tr>
<tr><td></td><td>Venue A:
Building Teams (Young Professionals)</td><td>Venue B:
Policy & Practice</td><td>Venue C:
Community & End Users</td><td>Venue D: Policy & Practice</td></tr>
<tr><td>15h30 - 15h50</td><td rowspan="3">RuDASA Indaba: Roll out of Mentoring
Lungi Hobe & RuDASA Team
2 hours</td><td>Translating theory into policy: A framework for CBR implementation in KwaZulu-Natal public sector
Sithembiso Blose</td><td rowspan="3">Workshop: The Voice Project: Building the next generation of Health Advocates
Karessa Govender & Lungile Gamede
2 hours
(Ethics)</td><td>Laboratory Results Delivery: Preliminary Lessons from a National Evaluation of the Cryptococcal Antigen Screening Programme
Daniel DeSanto</td></tr>
<tr><td>15h50 - 16h10</td><td>From zero to hero: the development of a peer support service in rural South Africa
Michael Siebert</td><td>Perspectives on budget considerations for pharmaceutical expenditure in South Africa
Lirosha Moodley</td></tr>
<tr><td>16h10 - 16h30</td><td>Perceptions Of Healthcare Professionals Concerning Access To Quality Healthcare For Paraplegic Learners With Pressure Ulcers
Undine Rauter</td><td></td></tr>
<tr><td>16h30 - 17h30</td><td></td><td>Workshop:Spinal tuberculosis: A systematic review of case studies and development of an evidence based clinical guidance tool for early detection
Marisa Coetzee
60 minutes</td><td></td><td></td></tr>
<tr><td>17h30 - 19h30</td><td>RuDASA AGM webinar</td><td>RuReSA AGM webinar</td><td>PACASA Meeting Webinar</td><td>RuNurSA Meeting Webinar</td></tr>
<tr><td>19h30 - 21h30</td><td colspan="4">Dinner & recognition of service to patients and profession Awards (webinar)</td></tr>
</table>

Saturday 4th September 2021: Equity in Rural health				
7h00 - 9h00	RHC meeting Executive Chairs & Organising Committee & RHC2021 (Working breakfast)			
8h30 - 9h00	Conference & CPD registration at venue			
9h00	**Welcome to Day 3**			
9h00 - 10h00	**Key Note 5***: Towards qualitative comprehensive health service delivery: Moving those last in the queue to the front (Ethics) **Lidia Pretorius**			
10h00- 10h40	**Parallel Sessions**			
	Venue A: Building Teams	**Venue B: Policy & Practice**	**Venue C: Community and End Users**	**Venue D: Systems**
10h00 -10h20	Founding the Final Year Health Science Students' Rural Mentorship Programme **Fatouma Lo & Vuthlarhi Shirindza**		Siyakwazi's Therapy Programme **Cathy Mathe-Pike**	A systems approach to Community Service **Lungile Gamede**
10h20 - 10h40	Providing Education and Support to Rural, District Clinicians in Eastern Cape, South Africa: Adapting to Covid-19 **Alexandra Shields**	Is this rural obstetrics? **Adam Asghar**	The Power of a Parent Facilitator in Rural KZN **Tina De Freitas**	Investing in rural youth to become healthcare professionals for rural **Gavin MacGregor**
10h40 -11h00	**Tea Break**			
11h00 - 12h30	**Parallel Sessions**			
	Venue A: Building Teams	**Venue B: Policy & Practice**	**Venue C: Health Systems**	**Venue D: Health Systems**
11h00 -11h20	Opening learning to all - lessons from the experience of running online workshops for SUNSTRIPE **Ian Couper**	Workshop: Re-imagining my approach to Primary Health Care for 2022 **Hermann Reuter** 90 minutes	Workshop: Beating entropy: establishing systems and getting a grip on your wheelchair service in a rural setting **Maryke Bezuidenhout & Thandi Conradie** 3 hours*	Workshop: Health Facility Regulations, Inspections, and Certification for National Health Insurance - what you need to know * **Ms Winnie Moleko & OHSC team** 3 hours* (Ethics)
111h20 -11h40	Rural doctors' lived experiences of clinical courage **Ian Couper**			
11h40 - 12h30/40	Panel: Looking after your mental health discussion panel **Meba Khanda** & team 60 minutes			
12h30 -13h30		Lunch Break		

Saturday 4th September 2021: Equity in Rural health				
12h30 -13h30	Lunch Break			
13h30 - 15h00	**Parallel Sessions**			
	Venue A: **Building Teams**	**Venue B:** **Policy & Practice**	**Venue C:** **Health Systems**	**Venue D:** **Health Systems**
13h30 - 14h30	International Rural Cafe: Why Rural? **Dr Floss & Team** 90 minutes	Workshop: Basic Emergency Skills Training - 12 years of training rural doctors in North West, what about the rest of South Africa? **Jurgens Staats** 60 minutes	Workshop: Beating entropy: establishing systems and getting a grip on your wheelchair service in a rural setting - continued **Maryke Bezuidenhout & Thandi Conradie** 3 hours*	Workshop: Health Facility Regulations, Inspections, and Certification for National Health Insurance - what you need to know * - continued **Ms Winnie Moleko & OHSC team** 3 hours* (Ethics)
14h30 - 15h00				
15h00 - 16h00	**Plenary: Overcoming Rural Health Inequities (Ethics)** **The RHC**: RuDASA, RuNurSA, RuReSA, PACASA & Delegates			
16h00 - 16h30	**Conference Awards for Best Presentations**			

Important notes to read before the conference

Ethics Points

We have 9 Ethics points allocated to the conference for some of the Keynote speakers, plenaries, orals and workshops. These are indicated on the programme of events.

Attending the conference venue at Shangri-La Hotel

- Impact of Covid 19: the hotel has a maximum number of conference delegates and day visitors. To make sure you can join the conference you must **register & pay before the evening of 30th August** so that we can ensure you can attend.
- If you are *not* staying overnight at Shangri-La you do **join us for supper**.
- If you have family they are welcome to join us for supper, but we need to know so that we can inform the hotel . Please complete the Dinner Booking form by the 1st September
- On Friday we will celebrate our health colleagues who have been recognised by RuDASA, RuReSA, RuNurSA and PACASA for their outstanding service to rural health. Please join us to make this a special occasion.
- The current Lockdown curfew is 10.00. Evening meals & events will finish by 9.30 to ensure you can get to your accommodation in time.
- There will be **no payment facilities** for conference registration at the venue. Please pay by the 30th August so that you are confirmed as a delegate and we do not go over the Covid limit for the hotel.
- We will communicate with speakers and delegates via MailChimp, please check it does not go to your Junk mail

Attending the virtual conference

- To make sure you can join the conference you must **register & pay before the evening of 30th August** so that we can send the conference links to you.
- Your entrance to the virtual conference will be the email address you included in your registration form
- Our intention is to stream all presentations.
- To prove that you attended while the conference was being streamed there will be question polls. CPD points will be allocated for those sessions that show you were connected AND completed the Poll for that session
- We will communicate with speakers and delegates via MailChimp, please check it does not go to your Junk mail