CHAIR'S REPORT 2014

Introduction (unofficial)

Who reads chair's reports? Especially when they are 5 pages long. But here's why you should: we all need to know that stuff is happening. We struggle, we get frustrated, nothing seems to change – but here are some things that will encourage you, give you hope, and hopefully inspire you to get more involved in RuReSA (and maybe leave us your fortune in your will). I've done my best to include everything relevant, but I may well have left things out – if so, apologies. Hope it's a good read!

Introduction (official)

It's been another action-packed adventure of a year for RuReSA, as our profile has grown, our direction as an organisation strengthened and opportunities continued to arise…

EXCO 2014:

Chair – Kate Sherry
Vice-chair – Maryke Bezuidenhout
Secretary – Thandi Conradie
Treasurer – Kate Sherry (in absence of any other volunteers!)
Other members: Pam McLaren, Erika Bostock

The Highlights Package:

- RHAP initiates an **alliance-strengthening project**, including RuDASA, RuReSA, PACASA
- RHAP offers us our first ever actual **funding** as part of the above
- We use the funding to contract **Stef Homer as our coordinator**, which changes our lives
- We finally manage to open a **bank account** with FNB, and start charging **member fees**
- The **National Rehab Strategy Task Team** (with Maryke on board) produces a disappointing draft strategy, and then grinds to a halt
- We start a partnership with **OTASA** to look at making sure OT is included in mental health planning
- We kick off the **Rural Mental Health Advocacy Campaign** (RMHC), with the alliance partners
- We co-host the **Rural Health Conference 2014** (Worcester, Western Cape, 21-24 September), with the alliance partners and the Ukwanda Rural Clinical School (University of Stellenbosch)

Organisational developments

The biggest development has been **an alliance-strengthening initiative by the Rural Health Advocacy Project (RHAP).** RHAP has secured a 3-year grant from Atlantic Philanthropies to build their capacity, and they have chosen to invest this in building up the whole rural health "cluster" (including RuReSA, RuDASA, PACASA) as a whole – both the individual organisations and the ways in which we work together. This has resulted in a stronger working relationship with the alliance (including a new joint project, the **Rural Mental Health Campaign**), assistance with our strategic planning from a contracted organisational development consultant, and a generous grant to invest in specific capacity-building activities. Most significant of the latter has been the contracting of Stef Homer (already a solid and very valuable contributor to exco) as our **part-time coordinator.**

As exco's workload continues to grow, we have begun looking at **adapting our organisational structure** to bring in more members on specific projects as well as in leadership. According to our constitution, the current office-bearers may be re-elected in their current positions for only one more year, and nobody seems to be queueing up to take over… We have begun discussions about how to ensure continuity and keep building on our existing position, and will most likely be presenting options to the members in the coming year for a decision on our future.

We continue to be grateful to our stalwart exco members and associated supporters for the countless hours of late-night work, km's flown/driven to meetings, personal funds dipped into, personal leave sacrificed for RuReSA activities and all their guts, endurance and bloody-minded optimism, in the cause of getting services to rural communities. We salute you!!

Priority areas for year

Our strategic planning weekend took place in February at Twin Streams Environmental Education Centre, Mtunzini, with funding from RHAP, and facilitation by Catherine Collingwood (Southern Hemisphere Associates).

We identified the following priorities for 2014-2016:

1. Rural Rehabilitation is **incorporated into health care policy** and service planning at national level
2. Support the **professional development of rural therapists**, in order to address recruitment, sustainability and quality of services
3. Develop an expanding, active, representative **membership**

You can read our full strategic plan online at www.ruresa.com.

SO HOW DID WE DO IN 2014?

Objective 1: Rural Rehabilitation is incorporated into health care policy and service planning at national level

We continued to feel our way in the NDOH policy and planning processes, with the highs and lows that this inevitably brings.

Maryke continued to represent rural on the **National Rehabilitation Strategy Task Team**, in the teeth of considerable obstacles. After several months of intensive discussion and working group activity, the first draft of the rehab strategy was a dismal disappointment. Short story, the Task Team seems to be in a bit of a stale mate, with lack of leadership and accountability from the NDOH official responsible. It's beginning to look like it might be up to civil society (i.e. us, and the professional organisations, public sector forums etc) to make it happen. Watch this space.

The Rural Health Alliance (i.e. RuDASA, RHAP, RuReSA, AHP, etc) has continued to build two key working groups/task teams of which we have been a part: the **Human Resources for Rural Health (HR4RH)** group, and the **Rural-proofing health policy** task team. Both groups have given us opportunities to meet with senior government officials and other bigwigs, get insight into what's going on, and share our concerns. We hope in the coming year, both will become even stronger platforms for advancing our cause (both specific to rehab and for rural health in general).

We continued to give **comments on specific policies and bills** as they did the rounds.

Even more exciting – the alliance has planned to launch a **Rural Mental Health Advocacy Campaign (RMHC)**, and RuReSA has already been playing a leading role in pulling this together. In August, we co-hosted an **Indaba on OT in Mental Health** with OTASA mental health interest group (POTS). Jabu Ndlovu (Manguzi), Claire Willows and Tammy Ayliffe (Mseleni) did rural proud with their presentations on PHC-based mental health programmes. We will continue working with OTASA/POTS on making sure OT is formalised as a key part of mental health service planning – which will also be dovetailed with the main RMHC

Finally, we continued to sing the rural rehab song at various events, presentations, lectures and meetings, including:

- **KZN Orientation/induction event 2014**: the need for improved service structure, resources, well trained staff and cars was highlighted at the induction event, to which new community service therapists, supervising senior therapists, forum members and the HOD of KZN Health were present. A few tips on how to gain access to the community, and how to work with community health workers and tribal structure in order to implement your services was explored. The presentation was incredibly well received.

- Forum Exco, Provincial Rehab coordinator, district rehab coordinators and heads of tertiary and secondary hospital rehab teams were present at an ad-hoc meeting called by the **KZN provincial rehab coordinator**. Sunette and Maryke (invited by the provincial rehab coordinator) presented 'the do's and don't of working in community- how to improve access and outreach services', which included theory, discussion and a hypothetical case study. This happened in December 2013.

- **Presentation at WHIRE North-west bursary alumni event**, to which alumni graduates, their parents, various heads of institutions, academics, the acting HOD of Health (NW) and the MEC of NW Province were present. Maryke was the guest speaker, and spoke on leadership and the need to design services with the end user as priority- to improve access and acceptability **(Key line: "Apathy is a sin").**

- **Presentation to rural-proofing policy working group** on rural-proofing rehab policy (and "rehab-proofing" health policy). Kate had 20 minutes of a captive audience with our usual rural partners, but also some key government officials,

including at least one DDG from NDOH (person below the person below the Minister), and someone from EC Treasury who now knows why she should allocate money to “OT” and “Physio” (hope that helps).

Objective 2: Support the professional development of rural therapists, in order to address recruitment, sustainability and quality of services

The demands of objective 1 have left objective 2 somewhat on the backburner. We have continued to offer both **personal mentorship and clinical consultation** on specific cases through our networks, but **uptake** has been pretty poor, and we are a little stumped. We hope to give it all another kick next year. Any ideas from rural therapists on what would help you, would be most welcome!!

On the plus side, **OTASA EC branch** invited me (Kate) to speak to their members about the **NHI and associated health policy changes.** Over 2 days, 4 meetings and [distance], we met with 95 therapists (including PT’s, SLT’s, the odd optometrist, and even a stray actuary), for some really good discussions. Turns out nobody knows what’s going on, or that we need to do something about it!! We hope to run follow-up events in the EC next year, in order to persuade/ lure/press-gang more therapists into active service with us. We are also kind of hoping other provinces will catch on and want this too!

Rural-relevant CPD is a big concern for us, and for this year, the focus has been on the **rural health conference.** We have some fantastic speakers and workshops lined up (hopefully you are already there, seeing as how you’re reading this report).

Other CPD events we helped with/organised:

- OTASA conference (April 2014) – **Workshop on “OT’s as change agents in the health system”**, based on RHAP’s guide for health-care workers

Finally, in the interests of recognising and showcasing rural rehab excellence and dedication, we have awarded our inaugural **“RuReSA Rural Rehab Healthcare Worker of the Year”** to the indomitable and indefatigable **Jabu Ndlovu** (Assistant Director OT, Manguzi). We are extremely proud to have a rural health legend of her calibre to hold up as an example of what rural rehab can do and be. Congratulations Jabu!

As a PS – we can’t not brag about the appearance of **Maryke Bezuidenhout** and **Shannon Morgan** in the 2014 M&G Top 200 Young South Africans, recently – we know you’re not in it for the glory, but it’s great when the (often hidden) awesomeness is recognised!!

Objective 3: Develop an expanding, active, representative membership

We have 182 members! The spread is KZN (33%), EC (19%), WC (13%), GP (13%) MP (12%), with the other provinces making up the remaining 10%.

Having finally managed to open a bank account with FNB (who can’t understand how anyone can live two hours from a bank and have to take a day off work to sign papers), we have begun charging **membership fees**. At present, these are a modest R175.00 per year for therapists, R85 for mid-level workers, and free for students. We have formalised and updated our “**membership package”** [http://www.ruresa.com/become-a-member.html], so now you know what you’re getting!

Some of the web pages and the Google Group discussions and information circulation will become restricted to “members only” in January 2015

Thandi has done great job of getting our **Facebook page** going, and we have 227 likes so far! The page has been especially useful for comm serves making contact with their placements – almost everyone who posted their placement in 2013 could be put in contact with someone at their hospital.

The **website** was started in 2013 and now has all of our background information. We are working hard to make it useful for you by adding links to organisations running regular CPD events, and building up links to national and international rehabilitation resources for research, policy and service development.

The **Google group** continues to circulate relevant bits of info, although this mostly comes from exco at the moment. We’d love members to use it to share relevant stuff themselves, ask questions, start discussions etc – please feel free! (your content will be screened by our moderator in line with our guidelines)

Some of our funding from RHAP has been earmarked for **capacity development** – in response to an urgent need for more members able and willing to help with our activities (e.g. student presentations, policy comment, guest lecturing and lots of other stuff). We have offered financial support for three selected members to attend the rural health conference in Worcester: **Harry Selala** (OT from Witbank Hospital with a passion for rural mental health), **Heidi Gevers** (4th-year student from UFS) and **Jabu Ndlovu** (AD OT, Manguzi Hospital). Funding is offered based on a proven commitment to rural rehab, and an undertaking from the recipient to take up an active role with RuReSA, (specifics still to be negotiated). We are very excited to have these three on board!

As our funding remains extremely limited, we were not able to offer support to everyone who requested it, and the selection experience has helped us develop a clear policy on how this will be done in future. Watch our website for our financial policies and application guidelines for next year.

The **Rural Health Conference 2014** will be our main opportunity to meet face to face as members. It’s always packed with good discussion and presentations, network strengthening and general inspiration, as well as lots of fun – we are really looking forward to seeing as many members as possible there.

Conclusion

Feeling better yet?

It’s been incredible to watch RuReSA continue growing, at a critical moment for both health and disability in our country. It continues to be a steep learning curve, and we are enormously grateful to the rural partners (especially RHAP) and other supporters for their ongoing encouragement, back-up and willingness to punt the rural rehab story.

Here’s to 2015! Please sign here…

Kate Sherry