Organisational Development of the Rural Health Advocacy Project's Individual Alliance Partners and Strengthening of the Alliance Assignment

RuReSA Three-year Strategic and Operational Plan

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Acronyms

CBR	Community Based Rehabilitation
DPO	Disabled People's Organisation
ECHCAC	Eastern Cape Health Crisis Action Campaign
HST	Health Systems Trust
NDoH	National Department of Health
NHI	National Health Insurance
PHC	Primary Health Care
PWD	People with Disabilities
RHAP	Rural Health Advocacy Project
RuDASA	Rural Doctors Association of Southern Africa
RuReSA	Rural Rehabilitation South Africa
SA	South Africa
TAC	Treatment Action Campaign
UN	United Nations

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1. Introduction

Rural Rehabilitation South Africa (RuReSA) is a membership-based organisation of rehabilitation health care professionals who are concerned with improving rehabilitation care in the rural areas of South Africa. RuReSA was established in 2011 at the annual conference of Rural Doctors Association of South Africa (RuDASA). It falls within the health activist tradition pioneered by RURACT in the 1980's, which also contributed to the formation of Disabled People South Africa (DPSA). RuReSA was officially launched in 2012. Currently, the organisation has approximately 140 members.

RuReSA serves on the Steering Committee of the Rural Health Advocacy Project (RHAP). In 2009 RuDASA, the Wits Rural Health Club (WRHC) and Section27 partnered to establish RHAP in order to strengthen advocacy for rural health care in general. Since its establishment, RHAP has broadened its partnerships by drawing in other partners with a similar focus on rural health. It realized the potential for greater impact in rural health through better coordination amongst partner organisations. While some of these rural health organisations are small, volunteer-driven and recently established, their credibility and potential to contribute to positive change for the health of rural people is significant.

In recognition of this potential, RHAP embarked on a process of organisational development and alliance strengthening. RuReSA is one of the partners involved. RHAP therefore commissioned Southern Hemisphere to conduct an OD Assessment of RuReSA which would culminate in a three year strategic and operational plan. For this purpose RHAP made available support for one day of facilitated time for an organisational workshop, plus time for interviews of the RuReSA executive and a review of a number of key organisational documents.

In order to prepare for the workshop the Southern Hemisphere consultant interviewed executive members of RuReSA, read the RuReSA Strategic Plan (dated 2013, as provided by RuReSA) and drafted a programme for the day's session.

From 21-22 February 2014, the members of the RuReSA Exco met for their annual strategic planning process. The consultant facilitated a full day OD Assessment Workshop on Day 1. On Day 2 the facilitation role was shared internally by the RuReSA committee. This report covers the outcomes of the OD Assessment Workshop but also includes, where appropriate, information from the interviews and initial document review process. Furthermore, it incorporates material generated by RuReSA on Day 2, as provided by the RuReSA Chair, as well as the Strategic Plan for 2013 – 2017 (with comments dated 18 February 2014).

2. The RuReSA Workshop

2.1. Workshop Objectives

The purpose of the workshop was to develop a three-year strategic and operational plan for RuRESA including the identification of short-, medium- and long-term objectives (as per RHAP's assignment ToR).

2.2. Workshop Preparation

To prepare for the workshop, the following was undertaken:

- Individual interviews with the Chair and Vice Chair of the executive committee of RuReSA; and
- Planning conversations for the workshop with RuReSA Chair.

During these conversations it was noted that potential outcomes for the workshop were:

- Review of RuReSA activities in 2013, reflecting on strengths and considering how these could be built upon in 2014;
- Review of the organisation's core identity and priorities, leading to a strategic plan for the next 3 years, including SMART goals
- A strategy for managing RuReSA's public relations (PR);
- A strategy for supporting rural therapists to deal with the challenges of service delivery in the public sector, including mentoring and resources;
- A strategy for building capacity, including engaging more members in organization activities such as critiquing policies;
- A strategy for building more effective relationships with other stakeholders, such as universities and with DPO's;

2.3. Workshop Process

The RuReSA Workshop took place from the 20-22 February 2014 in Mtunzini, KwaZulu Natal. The facilitator was present for the night of the 20 February and for the full day of the 21 February[1].

Day One (with external facilitation)

The following workshop aspects were covered:

- Team building;
- Sharing of significant moments in RuReSA's history;

[1] For a full attendance list, please refer to Annexure A.

- Review of achievements since last strategic plan - and factors which either promoted or inhibited progress;
- Revisiting of strategic goals set for the period 2013 – 2015;
- Identification of RuReSA's capacity building needs; and
- Identification of focus areas for 2014.

Furthermore, the justification, profile, role and tasks of a potential administrator were developed.

Day Two (with internal facilitation)

Day Two was comprised of further discussion and operationalising of specified goals and objectives.

3. Workshop Outcomes

The following areas were discussed and clarified during the workshop hosted with RuReSA representatives.

3.1. Contextual scan

The following factors relating to rural health care were noted in the course of the workshop:

Harsh conditions of rural health care persist

- Terribly difficult conditions are experienced by rural people with disabilities (PWD's)

Limited collective organisation of rural people living with disabilities

- Rural PWD's are not organized as a whole. However, there are some local and active organisations of people with disabilities (DPO's).

Rural rehabilitation is not prioritized in national health policy

- There is an ineffective Deputy Director for Disability, within the Directorate for Chronic Diseases at NDoH level (under which rehabilitation falls)
- The policy processes around NHI and PHC Re-engineering to date have not considered the needs of PWD's
- South Africa (SA) ratified the 2008 UN Convention on the Rights of People with Disabilities, and was rapped over the knuckles by the United Nations (UN) for its limited implementation. It is now under pressure to improve, which presents an opportunity for RuReSA
- There are diminished financial resources in the world available for public health care, and rural health care is not prioritised

Insufficient human resources

- There are insufficient numbers of rehabilitation therapists working in rural areas, and these tend to be new graduates.
- There are very few experienced therapists working in rural PHC;
- There are minimal opportunities for continuing professional development (CPD) activities appropriate for rural practice.

Rural rehabilitation is marginalized as a field/specialism amongst rehabilitation professionals

- Professional organisations are dominated by private practitioners working in urban areas, and many therapists are completely unaware of rural needs and conditions
- Territorialism within and between professions leads to competition between therapists, with negative effects on the multi-disciplinary team which is crucial in the rural context
- The issues taken up by professional organisations are dominated by the concerns of urban and predominantly private therapists, at the expense of the needs of rural communities, as well as low-income communities in peri-urban and urban settings

Support for rural rehabilitation is beginning to grow

- With the increasing emphasis on PHC in the health system, stakeholders (including universities and professional organisations) are beginning to shift their focus from urban and tertiary/specialist care to PHC-level needs, including those of rural communities.
- There is a newly established listserve, which is hosted by the Health Systems Trust (HST) to connect and disseminate information around NHI and Disability
- The rural health alliance is increasingly supportive of rehabilitation, including organisations such as Section27, RHAP and RuDASA

3.2. RuReSA Vision and Mission

In order to effective a positive change in the above context, RuReSA developed the following Vision and Mission.

Figure 1 RuReSA Vision and Mission

Vision	High quality, appropriate, accessible, comprehensive and equitable rehabilitation services are provided in all rural communities within a PHC framework. Services are responsive to local realities and are carefully designed from a systems/programme perspective; incorporating prevention, promotion, curative, rehabilitation and AD's.

Mission	To be an organisation whose members present the same articulate, well-researched PHC vision/standpoint in their capacities as members and representatives in professional organisations, forums, NDOH structures, universities and other relevant bodies, so as to influence the actions of the service delivery community to build towards this vision. To provide the support and capacitation required to recruit, retain and inspire rural therapists.

Definitions for key terms included in the Vision and Mission statements of RuReSA are listed below.

High quality:

- Best clinical practice is adapted for the rural service delivery context
- Practice is ethical, addressing the personal and professional challenges posed by low-resource settings
- Epidemiology and other available data are used to inform resource allocation and a programmatic approach to service design and delivery
- Therapists constantly develop their skills and seek the support they need

Comprehensive:

- Incorporate prevention, promotion, curative, rehabilitation and assistive devices
- Carefully designed from a systems/program perspective
- Holistic patient approach

Appropriate:

- Responsive to local realities (context, needs and acceptability)
- Do what works for the people, not for the system
- Apply underlying principles of PHC
- Should reflect a Systems/programmes approach to rehabilitation care and not a private practice/individual treatment model

Accessible:

- Comprehensive rehabilitation services are provided at the closest feasible point to where users live

- Consideration of physical access, information access, financial access, attitudes, etcetera

Equitable:

- Services are planned to address the needs of the most vulnerable and "hard to reach", i.e. active efforts to reach marginalized groups (e.g. mental health services, house-bound people with disabilities)
- Scarce resources are allocated fairly and on a rational basis

Rehabilitation services:

- Includes medical/technical rehabilitation (processes serving to reduce impairments and promote optimal functioning in context, through direct intervention on an individual or group basis), as well as the broader conceptualization of community-based rehabilitation, which concerns the removal of barriers to participation within the community, and the promotion of social inclusion and equal opportunities. The former is a necessary component the latter, which is a multi-disciplinary and multi-sectoral strategy that needs to be adopted by all stakeholders.
- Always considered to be a multi-disciplinary process
- Family-centered and with consideration of cultural and social context
- Given the origins, membership and limited resources of RuReSA, priority is given at this point to services provided in the health sector.

PHC Framework:

- Based on the ethic of universal coverage, as enshrined by the NDoH's plan for a National Health Insurance
- Principles outlined in the Alma Ata Declaration (1978), including equity, efficiency, effectiveness, accessibility, affordability, sustainability and self-determination, as well as comprehensiveness (five elements – curative, preventive, promotive, rehabilitative, palliative)
- Service structures outlined in the PHC Re-engineering plan (NDoH)

Rural Communities:

- Rural alliance is still working on a formal definition, which is controversial.
- We understand rural communities to be geographically remote from urban centres (where services and resources, including employment, are generally most available). In South Africa, people in these areas are often impoverished, characterized by social, economic and political marginalization, and "spatial poverty traps". However, rural areas can be very diverse, including productive agricultural areas as well as historically neglected former homelands.

- We recognize that the challenges experienced in rural health services are often shared by urban and peri-urban services provided at PHC level, although not always. This calls for thoughtful collaboration with therapists in such settings, with distinctions between universal service challenges and those specific to rural areas.

3.3. RuReSA's identity

RuReSA identifies itself with the following principles:

- Multi-disciplinary rehabilitation team, rather than profession-specific concerns (including OT, PT, SLT, audiology and MOPS), including mid-level rehabilitation workers
- Multi-disciplinary health team (including partnerships with doctors, nurses, clinical associates, and community health workers)
- Integration into the health system as a whole, rather than a silo approach
- Primary focus on the health sector, and the public service
- Partnerships with multiple stakeholders, including higher education, professional organisations, policy makers, etc

RuReSA's strategy

Top-down: Action at national, provincial and other policy level to create a supportive policy environment (norms & standards, budgets etcetera)

Bottom-up: Change attitudes among professional community through lectures, articles in newsletters and the media, promotion activities, etcetera. Support and capacitate rural therapists through developing and sharing best practice.

3.4. RuReSA's principles for action

In pursuit of its Vision and Mission, RuReSA is guided by the following principles

- Networking and non-duplication of existing bodies' functions. Instead, RuReSA encourages these bodies to have a rural/PHC slant
- RuReSA acts as a forum rep with RuReSA vision – don't have to wear the "RuReSA hat" or advertise widely
- Pro PHC re-engineering and universal access to care as promoted in the NHI
- Multi-disciplinary

3.5. RuReSA's target groups

RuReSA seeks to have a direct influence on therapists, health care policy makers, professional bodies, rehabilitation service providers, university health science faculties,

university health science rehabilitation students, community service therapists, and community health workers in rural health care practice.

3.6. RuReSA's achievements and strengths

The following achievements and strengths of RuReSA were noted. These will be drawn upon for the achievement of the organisation's objectives for 2014.

Establishment of technical advocacy relationship with health departments

- RuReSA is recognized by senior health department officials as a worthwhile partner in developing appropriate policies for rehabilitation at national level;
- RuReSA made input into policy submissions despite capacity limitations and gave timeous, sensible comments on at least 10 documents;
- RuReSA participated in rural alliance meetings with NDoH, including officials not currently involved with rehabilitation;
- RuReSA has managed to respond when issues and opportunities at NDoH arise so as not to miss them, despite the often disorganized processes of the NDoH
- RuReSA has been invited to sit on the National Rehabilitation Task Team Strategy - and a rural perspective has been incorporated into the Task Team

Working collaboratively with other advocacy organisations

- RuReSA participated in ECHCAC, exposing its members to advocacy strategies and work with grassroots organisations, as well as other stakeholders outside the health sector

Membership growth and support

- Membership numbers have increased and there has been an increased number of visits to the RuReSA website;
- RuReSA has provided support to rural community service therapists;
- RuReSA has created awareness of rural rehabilitation opportunities and of RuReSA amongst 4th year students;
- RuReSA has created a Facebook page, which is attracting attention

Strengthening relationships with rural health partners

- RuReSA was an active participant in the 2013 RuDASA Conference and has been invited to partner in organising the 2014 rural health conference with RuDASA;
- RuReSA has increasingly partnered with RuDASA and RHAP in NDoH meetings, advocacy activities and rural-proofing work. Relationships with Section27, TAC, AHP and others are also growing.

The following aspects were noted in the course of the workshop as the asset base which enabled the above strengths:

Positive Relationship with National Department of Health

- RuReSA has legitimacy with the National DoH

Clear set of requirements for effective rural rehabilitation

- RuReSA has a clear position on what is needed for effective rural rehabilitation in PHC

Presence on social media

- RuReSA has 188 Facebook 'friends'

Repository of rural rehabilitation experience and expertise

- Exhaustive access to existing research through Disability Action Research Team (DART)
- RuReSA has established a resource website for rehabilitation therapists

3.7. RuReSA's Challenges

3.7.1. Advocacy capacity is not optimal

There is a lack of general rural therapists' knowledge and confidence about advocacy. This means that responsibility for responding to health policy is currently over-concentrated and centralized in a few members of the RuReSA executive.

In the past year RuReSA has undertaken activities that were not part of the strategic plan. An example is the frequent, unscheduled input that RuReSA was asked to make into documents for the National Task Team. However, although this input was reactive it was strategic to do so since it built RuReSa's relationship with the DoH as well as other players on the Task Team. It provided an opportunity for RuReSA to build credibility with decision-makers.

3.7.2. Membership potential not fully realised

- Communication with members is characterized by irregular feedback from exco to members on activities, and a marked lack of member response to communication
- Provincial representation is concentrated in KZN and EC
- Members are not clear on what RuReSA does and offers
- RuReSA members are mostly community service therapists who are inexperienced. The pool of experienced rural therapists is extremely small.

3.7.3. Executive leadership is overstretched

The executive leadership is currently over-extended, threatening the effectiveness and sustainability of the organisation. Exco members are volunteers with large additional workloads. Advocacy and strategic activities have been prioritized at the expense of membership development.

3.7.4. Lack of dedicated administration capacity

This is undermining membership growth and weakening co-ordination and sustainability. Executive members sometimes lose track of the many tasks required of them. Membership outreach and support is not consistent. Fundraising is not yet underway, and we have not been able to put long-term sustainability plans in place because available resources are directed to immediate tasks, such as policy processes.

Communication with members is especially affected by these challenges.

3.7.5. Relationship with organisations of people with disabilities (PWD's) is not optimal

The ideal of self-determination by people with disabilities with regards to services and issues that affect them, has been extremely difficult to implement in RuReSA's activities thus far. This is largely due to the fragmented and highly politicized nature of the disability sector, as well as historical conflicts between service providers and PWD's. PWD's are poorly organized, and those from rural areas are seldom represented by existing organisations. A great deal of work will be required to build capacity among our service users to participate in advocacy activities, as well as to build constructive working relationships. Education is also required among PWD's about health policy processes and how (and why) to influence them. We don't currently have the capacity to do this.

3.7.6. Lack of data

No data is available nationally for the distribution of rehabilitation workers, disability prevalences and other relevant factors, in rural areas. This seriously limits advocacy potential.

3.7.7. Complex and differing needs

RuReSA has adopted a very broad remit, which includes the support needs of individual therapists as well as national-level strategic action. It can be challenging to accommodate these varying perspectives.

3.7.8. RuReSA is not yet financially sustainable

As yet, RuReSA has not charged a membership fee. All expenses have been paid for by committee members. Committee members take annual leave to implement RuReSA activities. The committee is aware that to charge, members need to be offered something.

RuReSA is in the process of opening a bank account, which has proved challenging.

3.8. RuReSA Objectives (2014-2016)

On the basis of the aforementioned, RuReSA has developed the following objectives:

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

Activity:

- Continue to explore and document best practice for rural rehab, including both clinical and programmatic strategies
- Use above evidence to develop policy recommendations based on practical experience in rural areas
- Join and/or address relevant task teams constituted by professional and other organisations (including OTASA, SASP, SAHSLA, public sector rehab fora)
- Build relationships with other organisations advocating for rural health, (including RHAP, RuDASA, TAC, Government, Sec27), and participate in their activities as invited
- Build relationships with rural PWD's to strengthen user input into policy activities

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

Activity:

- Implement a mentorship programme, including both personal and clinical support
- Partner with other stakeholders to foster continuing professional development activities appropriate to rural practice
- Build rural rehabilitation community through online and face-to-face
- Build resource base for rural practice and advocacy (website)
- Work with universities to increase rural relevance of undergraduate training

Objective 3: Develop an expanding, active, representative membership

Activity:

- Formalise and disseminate membership benefits
- Develop a members communication strategy (including Facebook, web, email group, etc)
- Build members' capacity and motivation to engage in advocacy activities, policy comment etc
- Coordinate student and community service recruitment activity cycle (including liaison with universities, student rural health clubs, presentations to promote rural placement, linking new CSO's with hospital staff, etc)

4. Opportunities/potential to increase RuReSA's impact and credibility

4.1. Strengthen existing positive DoH relationships

Key NDoH officials have actively sought RuReSA's participation in policy processes, indicating our growing credibility with government.

Maryke Bezuidenhout (RuReSA vice-chair) was invited to sit on the Rehabilitation Strategy task team, and was able to give rural input into policy development. This also increased rural (and RuReSA) profile among rehabilitation "experts" and gave opportunities to build further relationships with key stakeholders.

4.2. Strengthen role and relationships with rural health alliance

The rural health alliance (including RHAP and RuDASA) have been supportive of RuReSA's growth, and have increasingly included rehabilitation and disability concerns in their work. Through them, RuReSA have had opportunities to take part in meetings with high-level NDoH officials, and to network widely with health stakeholders.

The proposed Rural Mental Health Campaign offers an opportunity to work more closely with the alliance to promote the needs of PWD's.

3. Strengthen grassroots relationships

RuReSA has experience in working alongside TAC in the ECHCAC and this relationship could be strengthened in order for RuReSA to include the voices of grassroots PWD living in rural areas (as TAC works at grassroots level).

4. Strengthen partnerships with professional and disability sector organisations

RuReSA has signed an MoU with OTASA (Occupational Therapy Association of South Africa), which commits both to work together to support rural therapists, for example through rural-friendly CPD events and incorporating rural concerns into OTASA strategic activities.

Similar relationships are being negotiated with SASP and SAHSLA.

RuReSA members also sit on the various fora for rehabilitation in the public sector, at both provincial and national level.

5. Document best practice evidence for advocacy purposes

Programme data from existing rural rehabilitation services can be used to inform policy debates, advocate for best practice, and inform development of other services by rural therapists (e.g. Manguzi/Mseleni High Risk Baby programme)

6. Organisational capacity funding offered by RHAP

RHAP has offered RuReSA funding to develop our capacity as a partner in the rural health alliance. Exco has identified the need for a coordinator to consolidate organizational processes and ensure routine activities are carried out reliably. This will also free up Exco members to spend scarce volunteer time on more specialist tasks.

7. Leadership sustainability

All members of the committee are rural rehabilitation professionals. Some have many years of experience while others are relatively new to rural health care practice. The current chair is nearing the end of her term in office.

The RuReSA committee has identified a need for stricter portfolios and a narrower focus, partly to reduce the current stress on overstretched executive committee members and also to improve handover procedures. To this end, Stephanie Homer has developed portfolio guidelines for the consideration of the Executive Committee.

The development of defined portfolios should take into consideration the need at this young stage in RuReSA's life for as much leadership continuity as possible, by factoring this into any created portfolio's and any handover processes. For example, RuReSA may consider either a policy and/or a portfolio that allows for further contribution of past chairs, as with RuDASA.

4.8. Readiness for growth

Within the space of two short years RuReSA has established a respected profile with the national DoH, provided mentoring to newly qualified rehabilitation professionals working in rural health, developed a website of resources for rehabilitation practitioners, and presented research on the issues of rural rehabilitation at collegial health science conferences - to name but a few achievements. This has been achieved through the extraordinary pioneering energy and dedication of the committee - and without the aid of an office base, external financing, extra administrative or employed operational hands.

All of these achievements have positioned RuReSA as an organisation with policy influence and it is now experiencing increased demand for its input from above and below as well as from collegial organisations.

2. Conclusion

RuReSA has accomplished much in a short period. With its intention to connect more strongly with other rural health advocacy organisations, from within a strong identity as rural

rehabilitation practitioners, the possibility for improving rural rehabilitation health care is that much closer.

Annexure A: RuReSA Workshop attendance list

Kate Sherry

Maryke Bezuidenhout

Pam Heyns/MacLaren

Thandi Conradie

Apologies:

Stef Homer

Erika Bostock