

**UNIVERSITY OF THE WESTERN CAPE  
DEPARTMENT OF PHYSIOTHERAPY**

**The evaluation of processes of care at selected rehabilitation  
centres in the Western Cape**

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## KEYWORDS

**Disability**

**Process of care**

**Rehabilitation centres**

**Client**



## **ABSTRACT**

Following the introduction of the Health Act of 1995, the Primary Healthcare Package for South Africa, a set of norms and standards was developed in 2000, to ensure good quality of care and to act as a guide to provide good service at this level of care. Related to this, and bringing health services to the people, was the aspect of rehabilitation. It was highlighted that rehabilitation services should be restructured and strengthened in order to improve access to these services for those who did not have them before. This led to the development of the National Rehabilitation Policy in 2000, which focused on improving accessibility to all rehabilitation services, in order to facilitate the realisation of every citizen's constitutional right to have access to healthcare services, but this policy was not implemented. During 2002, the Department of Health produced a strategic plan for the reshaping of public health services in the Western Cape. This initiative, Healthcare 2010, the Future for Health in the Western Cape 2020, mapped the way forward to improve substantially the quality of care provided by the health service. This plan was based on the primary healthcare approach and aimed to shift patients to more appropriate levels of care. It became evident that in order to move forward with the 2020 vision, there needed to be a greater understanding of the current situation.

This study focused primarily on the aspect of rehabilitation, with a specific focus on systematic review and three dimensions of the process of care, namely patient information; service provider information; and realised access. These dimensions assisted in evaluating the rehabilitation service in order to understand what was happening in the delivery of rehabilitation services, focusing on the experiences of patients with physical disabilities, as well as service providers and caregivers, and realised access that included satisfaction of all participants in the rehabilitation centres. Hence the aim of this study was to evaluate the process of care at three selected rehabilitation centres in the Western Cape Province within the contextual framework of the National Rehabilitation Policy (NRP) and the United Nations Convention Rehabilitation Policy for People with Disabilities (UNCRPD). To assist in achieving this aim, objectives were developed as follows: to determine the reported barriers and facilitators to rehabilitation services through a systematic review; to determine the profile of patients with disabilities accessing rehabilitation services at three rehabilitation centres in the Western Cape Province; to determine the profile of

service providers providing rehabilitation service to patients with disabilities attending rehabilitation centres in the Western Cape Province; to explore clients' perceptions of and satisfaction with the rehabilitation services; to explore caregivers' perceptions of and satisfaction with the rehabilitation services; to explore the experiences of service providers with the rehabilitation services; and to map the links between the experiences and perceptions of the key stakeholders.

This was an evaluation study, which was primarily descriptive, with the focus on process evaluation. Process evaluation provides an indication of what happened, and why. The study was conducted at three rehabilitation centres in the Western Cape Province. Voluntary participation of patients, service providers and caregivers was gained by signing a consent form. Both qualitative and quantitative methods of data collection were used in this study. Questionnaires were used for quantitative data collection and SPSS version 17 and 21 was used to analyse the data. Focus group discussions and in-depth interviews, which were based on interview guides and tape recorded, were used to gather information on experiences and perceptions of all the participants. Quantitative data capturing was checked for errors by using excel spread sheets, where data was entered twice in two different spread sheets and checked for differences, as responses were coded by using numbers. Qualitative data was checked for errors by following the trustworthiness process where data was transcribed verbatim, and where necessary translated by two different translators to ensure accuracy. The researcher consulted with the supervisors during data analysis to enhance quality in the coding process and identification of themes and relevant quotations.

Results showed that barriers to rehabilitation outnumbered facilitators of the rehabilitation process. There was a gap identified in the profile of the patients with regards to their rehabilitation needs. Records of the patients had missing information posing a challenge to data collection and possibly presenting a distorted picture of service provision. However, records showed that not all rehabilitation professionals were not consulted during the rehabilitation process of care. Ninety-five percent (95%) of the clients consulted with physiotherapists, whereas only 4% consulted social workers. Rehabilitation service providers did not reflect a rehabilitation team. There was a shortage of rehabilitation service providers, in that some centres had

full time staff while other centres only had sessional rehabilitation professionals. Service providers were negligent with some of the processes to be followed when consulting clients, such as getting consent to treat the patient and educating patients regarding their ailments, which then affected satisfaction of the patients. However, there were also positive aspects like treating patients with respect and allowing patients to ask questions during consultation. Caregivers on the other hand were satisfied with the rehabilitation process, as they found the centre easily accessible for their family members and were involved in the rehabilitation of the patients.

In conclusion, the rehabilitation process was satisfying to the participants of this study. The main challenge that patients and caregivers experienced was financial constraints. Staffing remains a problem in rehabilitation centres in the Western Cape Province, as there were not enough staff for rehabilitation service delivery at these selected rehabilitation centres. Other staff members were not utilised during the rehabilitation process. These findings raise issues for the Western Cape Department of Health to consider regarding rehabilitation, as people with disabilities are not receiving optimal care. The study makes recommendations to the Department of Health in the Western Cape Province regarding the improvement of the rehabilitation process of care.

## DECLARATION

I declare that “The evaluation of processes of care at selected rehabilitation centres in the Western Cape” is my own work that has not been submitted for any degree or examination at any other University and that all the sources used or quoted have been indicated or acknowledged by means of complete references.

Nondwe Bongokazi Mlenzana

.....

Signature



.....

Date

## ACKNOWLEDGEMENTS

In all the things that I went through in life God was and is always by my side. Thank you Lord for carrying me through this PhD process: it was not easy but it was worthwhile.

Sincere thank you to the SANPAD project for allowing me to be part of the project and provide funding for my studies. And to Gubela Mji, project co-leader, for identifying me as one of the PhD students, thank you so much for your thought and calling me to participate in the project.

Thanks to the University of the Western Cape for providing me with funding to complete this journey.

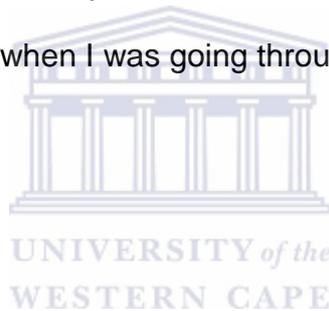
My supervisor, Professor José Frantz, what a supervisor, colleague and a friend. Thank you for sacrificing your family time for me, allowing me to invade your resting time. You have taken me through this journey because you managed to balance my life and helped me to focus on my studies. In times of happiness with the process we laughed, when I was down you lifted me up. Without your support I am not sure whether I would have been completed this PhD journey. This is the beginning of the journey so be sure to be around for the next phase of my journey. My other supervisor, Professor Arne Eide, your support was valuable as we communicated with emails. Thank you for your support and input to shape my PhD.

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## **DEDICATION**

I dedicate this PhD thesis to my God that carried me throughout this journey; His righteous hand was always there for me. I confirmed this by reading Isaiah 41 verse 10.



## **PUBLICATIONS AND OTHER OUTPUT**

### **Articles Submitted**

Barriers and facilitators of rehabilitation services for people with physical disabilities: Systematic review. **Submitted to the African Journal of Disability: Under review.**

Profile of patients with disabilities accessing rehabilitation services in the Western Cape Province. **Submitted to the SA Health Gesondheid Journal: Under review.**

Patient satisfaction with rehabilitation services at selected rehabilitation centres in the Western Cape, South Africa. **Submitted to the SAJP: Under review.**

Perceptions and satisfaction of caregivers regarding rehabilitation services from selected rehabilitation centres in the Western Cape. **Submitted to the African Journal of Primary Healthcare and Family Medicine**



### **Presentations**

Barriers and facilitators of rehabilitation services for people with physical disabilities: Systematic review. Platform presentation, AFRINEAD, 29-30 November 2011, Zimbabwe

The need for rehabilitation professionals in PHC rehabilitation settings, Platform presentation, Faculty of Health Sciences Research day, 11 October 2012



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## LIST OF ABBREVIATIONS

ANC	African National Congress
CASP	Critical Appraisal skills programme
CBR	Community-based rehabilitation
CHCs	Community Health Centres (CHCs)
CVA	Cerebrovascular accident
DOH	Department of Health
FGD's	Focus group discussions
GoO	Government of Osria
HIV/AIDS	Human Immune-Deficiency Virus
ICF	International Classification of Functioning, Disability and Health
INDS	Integrated National Disability Strategy
NDoH	National Department of Health
NRP	National Rehabilitation Policy
PHC	Primary healthcare
PHCCs	Primary healthcare centres
PIO	Population, Issue, Outcome
PWDs	Persons with disabilities
RDP	Reconstruction and Development Programme
SANPAD	South African Netherlands Research Programme on Alternatives in Development
SPSS	Special Package of Social Statistics
UN	United Nations
UNCRPD	United Nations Convention Rehabilitation policy for People with Disabilities
WCDoH	Western Cape Department of Health
WCRC	Western Cape Rehabilitation Centre
WHO	World Health Organization

# CHAPTER ONE: INTRODUCTION

## 1.1 ORIENTATION OF THE RESEARCH

The aim of this study was to evaluate the process of care at three selected rehabilitation centres in the Western Cape Province, within the contextual framework of the National Rehabilitation Policy (NRP) and the United Nations Convention Rehabilitation policy for People with Disabilities (UNCRPD). These policies focused on achieving the needs and rights of people with disabilities. NRP was developed in the year 2000 with the hope of it being implemented so as to meet the rehabilitation aspect of Primary Healthcare. In 2006 UNCRPD was launched globally with the purpose of strengthening the human rights base for individuals with disabilities, and all the countries that were interested in the implementation of this policy agreed that the needs of people with disabilities would be met. Over the last 20 years, rehabilitation services in South Africa have undergone major changes within the healthcare system, partly because of a change in the political climate and partly because of changes within healthcare models. Politically, when the African National Congress (ANC)-led democratic government came to power in 1994, it developed many policies aimed at introducing change in the lives of the South African population, especially in the underserved peri-urban and rural environments. The plan of the government was to develop a national health system offering affordable healthcare, where the focus would be on primary healthcare to prevent disease and promote health, as well as to cure illnesses. It used the yardstick of broader basic government policy, namely the Reconstruction and Development Programme (RDP), to measure whether its policies would respond to and have an impact on the development of the South African people (African National Congress, 1994; Louw &

Edwards, 1997). This meant that if the newly designed policies were not geared towards people's development, there would be little sustainable growth. In 1996, the Provincial Administration of the Western Cape Department of Health, in line with the South African national initiatives, developed a district health plan to improve access to community health centres and clinics.

The healthcare system within South Africa is managed at national and provincial level. Within the National Department of Health (NDoH), key stakeholders made a conscious decision to improve health services within the Western Cape. This started with the development of health plans to improve health services in 1997 (Government of South Africa, 1997). Following the introduction of the Health Act of 1995, the Primary Healthcare Package for South Africa – a set of norms and standards that act as a guide to provide service at the primary level of care and ensure the good quality of care expected at this level - was developed in 2000 (DoH, 2000). Related to the latter and together with bringing health services to the people the aspect of rehabilitation was one of the key aspects of Primary Healthcare. It was highlighted that rehabilitation services should be restructured and strengthened in order to improve access to these services for those who had not had them before. This led to the development of the National Rehabilitation Policy (NRP) in 2000, which focused on improving accessibility to all rehabilitation services, in order to facilitate the realisation of every citizen's constitutional right to have access to healthcare services. This National Rehabilitation Policy aimed to serve as a vehicle to bring about equalisation of opportunities and to enhance human rights for persons with disabilities with regard to rehabilitation services (DoH, 2000). Linked to the introduction of policies focusing on accessibility was the introduction of the Policy on Quality in Healthcare in South Africa (DOH, 2007). It was introduced to assist the

public healthcare system in refocusing on improving the quality of care provided at public health facilities and in communities. These efforts were supported by provincial efforts from the Western Cape Department of Health.

In the Western Cape, the Department of Health was committed to providing equal access to quality healthcare for all the people in the province. During 2002, the Western Cape Department of Health produced a strategic plan, Healthcare 2010, for the reshaping of public health services in the Western Cape. This initiative mapped the way forward to improve substantially the quality of care provided at healthcare centres. This plan was based on the primary healthcare approach and aimed to shift patients to more appropriate levels of care (Western Cape Department of Health, 2003). During the implementation of these strategies, changes within the Western Cape Department of Health were made, which included an increase in the number of health professionals at district level, the development of acute and mental hospitals and rehabilitation centres, and the improvement of human resources.

Based on lessons learnt regarding gaps in delivery of healthcare services by the Western Cape Department of Health in the Healthcare 2010 document, the Future for Health in the Western Cape 2020 document was produced, with the aim of improving patient experience and quality of life, as well as further operational efficiencies; the main focus being the improvement of health outcomes and information systems. This 2020 Health Plan aims to focus on the following points to improve the health service: 1) client centred quality of care; 2) a move towards an outcomes-based approach; 3) the PHC philosophy; 4) strengthening the district health services model; 5) equity; 6) an affordable health service; and 7) building strategic partnerships. In the light of these developments, the researcher identified

the need to further explore certain aspects of the 2020 health plan which included the client-centred quality of care and the PHC philosophy with specific reference to the care of people with disabilities at rehabilitation centres. According to the Western Cape Department of Health, it has been reported that primary healthcare centres (PHCs) were being utilised more since 2001, which was an indication that accessibility to the PHCs has improved. Thus as the core vision of this 2020 document is a focus on patient experiences, based on service delivery at health centres, it is thus important to explore the current reality of service delivery.

## **1.2 CURRENT SITUATION WITHIN REHABILITATION AND HEALTH**

With regard to healthcare models in South Africa, such as social, biopsychosocial and traditional medical models, the medical model was challenged by the introduction of the primary healthcare approach after 1994. In the past, healthcare was organized and delivered based on the traditional medical model (Louw & Edwards, 1997; Davies, 1997; Fry & Hasler, 1986; Fry, 1980). The medical model may be summarized as “a mechanistic view of the body, in which illness is simply a fault in the machine that should be fixed” (Waddell & Aylard, 2010:8). About a decade ago, in South Africa, the focus was still geared towards tertiary institutions and as a result primary healthcare services lacked resources (Woods & Power, 1993). Additional criticism expressed towards the medical model was that it tended to ignore the psychosocial and cultural well-being of patients. The Primary Healthcare (PHC) approach was premised on community development and community participation in the planning, provision, control and monitoring of services. In terms of the PHC philosophy, provinces have to devolve responsibility for health to district level, a very complex task that requires high levels of management competence to co-ordinate.

Within the arena of disability and rehabilitation, the biopsychosocial model is proposed as an alternative to the traditional medical model (Caplan, McCarty & Sisti, 2004). According to Waddell and Aylard (2010:22), “the biopsychosocial model recognizes that biological, psychological *and* social factors, and the interactions between them, can influence the course and outcome of any illness. Human beings *are* biopsychosocial – an integrated whole of body and mind in a social being – so a comprehensive model of human illness must be biopsychosocial”. This model is in line with the health plan of the current South African government. The major trajectory of the ANC Health Plan, published in 1994, was towards a healthcare delivery system based on the primary healthcare model. This Plan was informed and guided by the Alma Ata Declaration of 1978 and the ‘*Health for All by 2000*’ slogan, which was seen as the most appropriate way to reverse half a century of neglect and uneven distribution of healthcare resources (*The Star*, 1995; South African Health Review Committee, 1995; Reddy, 1996; Department of Health, 1996; Louw & Edwards, 1997). Thus in redesigning healthcare in South Africa towards implementation of primary healthcare, emphasis on rehabilitation has been established. According to the primary healthcare approach, rehabilitation at primary level care should have the following in place:

- There should be a designated room or area for rehabilitation and therapy
- Rehabilitation services should be delivered in the wards and outpatients departments and at community level
- Hospital services should be accessible to people with disabilities, and beds, bathrooms and toilets should be accessible to wheelchair users

Rehabilitation services in primary healthcare (PHC) settings are important for the treatment of patients with various conditions, including patients with physical

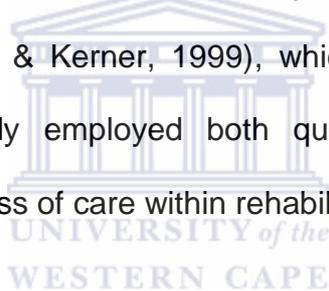
disabilities. However, a number of studies have pointed to the underutilisation of rehabilitation services for persons with disabilities by PHC physicians, and an unmet need for rehabilitation services reported by persons with disabilities (Cott *et al.*, 2005; Hirini *et al.*, 1999). PHC rehabilitation professionals offer non-pharmacological interventions that have a promotive and therapeutic role in the management of patients with physical disabilities. However, explicit service delivery models are lacking to operationalise a PHC and rehabilitation approach to physical disability care where rehabilitation professionals are working with the clients, as well as collaborating and communicating with other members of the PHC team. Such models are needed to ensure that persons with physical disabilities receive appropriate rehabilitation interventions early in the rehabilitation process. Using this approach, their needs and preferences should be considered in the continuum of care.



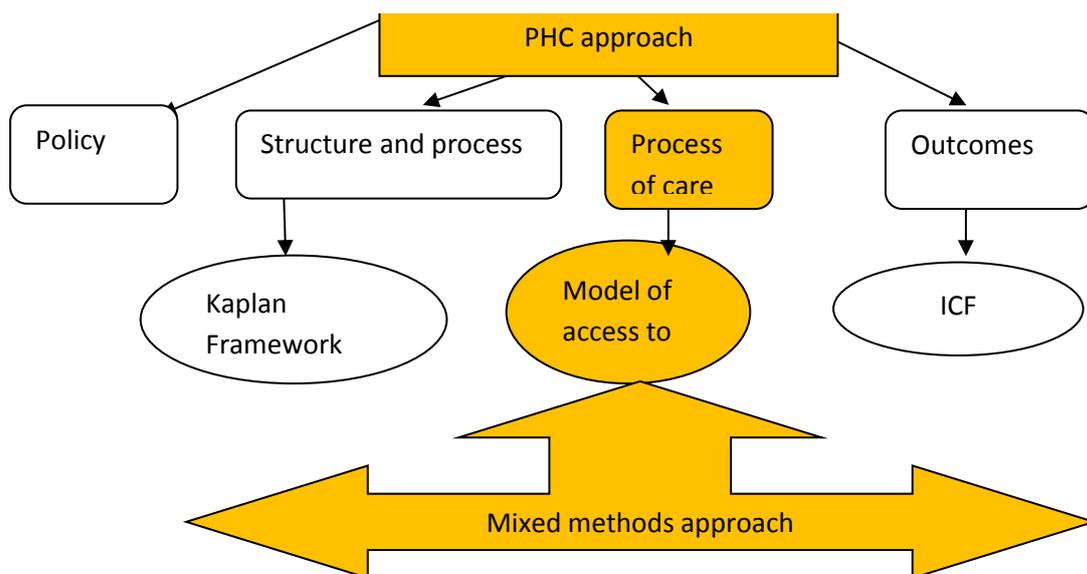
### **1.3 PURPOSE OF THIS STUDY**

In line with the above mentioned policies and strategies, it has become evident that in order to move forward with the 2020 vision, there needs to be a greater understanding of what is currently happening in the rehabilitation centres in the Western Cape. This study focused primarily on the aspect of rehabilitation within the context of PHC, with a specific focus on the following dimensions of the process of care, namely systematic review, patient information; caregiver information; service provider information and realised access. These dimensions assisted in evaluating the rehabilitation service delivery to understand what was happening in the process. The focus was on the experiences of patients with physical disabilities, as well as service providers and caregivers and realised access to the rehabilitation centres, focusing on the satisfaction of all stakeholders.

This study was part of a bigger study that focused on the alignment of rehabilitation services with relevant policies in the Western Cape and the impact on clients accessing these services. The PHC framework was used for the evaluation of rehabilitation services in the bigger study (see Figure 1.1). This evaluation framework has four domains, consisting of the evaluation of organizational structures and processes; the evaluation of process of care; and evaluation of outcomes. Within the bigger project a specific framework, as indicated in Figure 1, guided each domain. As illustrated in the figure below, this study focused on the third domain, namely to evaluate the process of care at selected rehabilitation centres. This was done by using the Model of Access of Care (Mandelblatt, Yabroff & Kerner, 1999), which uses different tools to evaluate services. This study employed both qualitative and quantitative methods to evaluate the process of care within rehabilitation services.



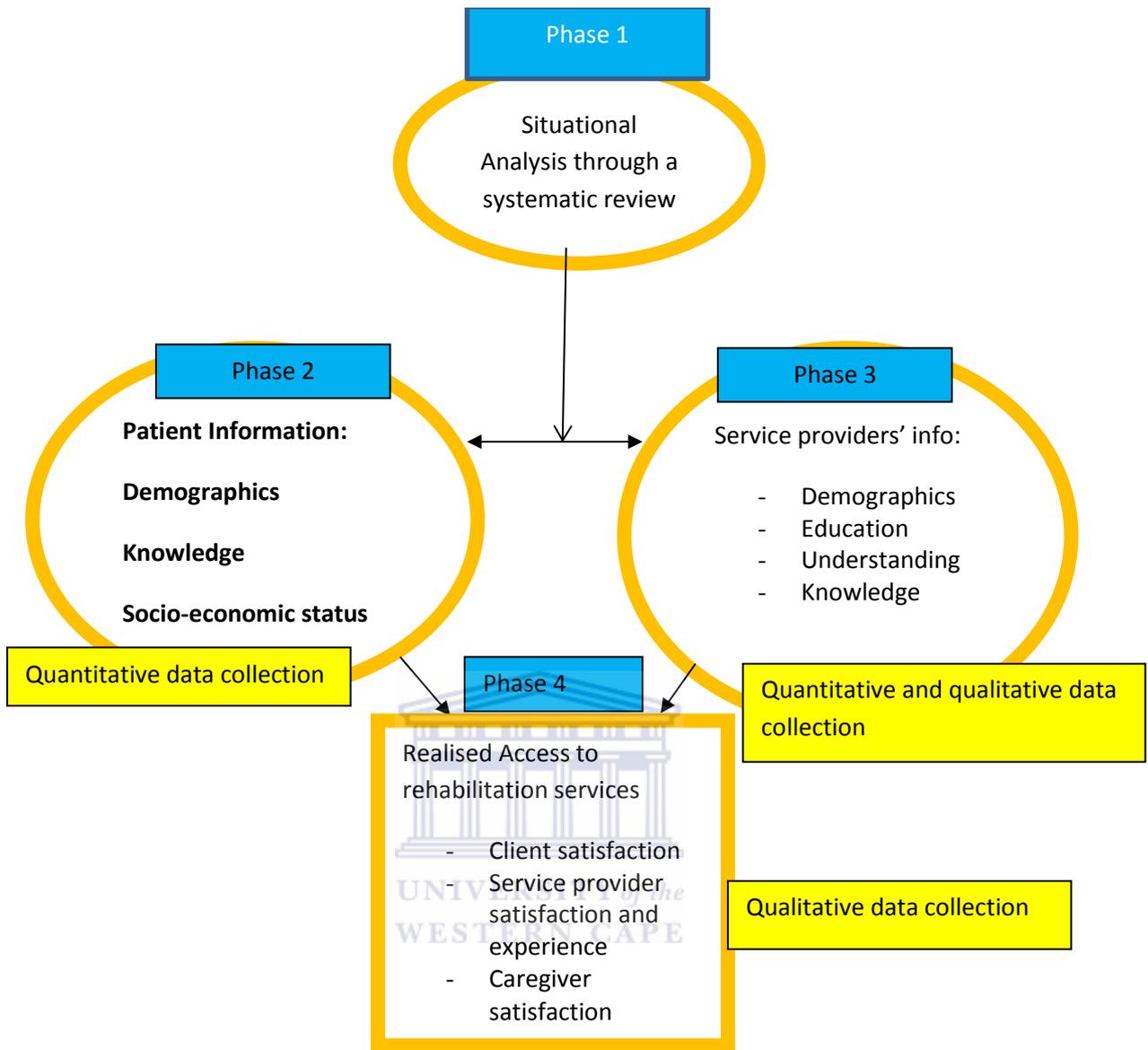
**Figure 1.1: Visual diagram of the bigger project**



This model was found suitable as it allowed the researcher to assess the process through the eyes of various stakeholders. When looking at the process of care, it is important to realize that it is a sequence of dynamic interactions amongst various stakeholders. The patient as an individual interacts with healthcare providers who, in turn, are operating in a variety of changing structures and with constrained resources. The one aspect of this model that the research was going to study in particular was the aspect of “realised access” as it provided in-depth information about satisfaction of all participants in this study. This assisted the researcher in identifying whether access has occurred and whether the key stakeholders were satisfied with the outcomes.

The study was thus conducted in four phases (Figure 1.2). Prior to implementation of the model which had three phases, it was felt that the current situation regarding barriers and facilitators of rehabilitation services should be assessed by means of a systematic review in order to have a better understanding of the situation and this was identified as phase 1. The intention of phase 2 was to highlight the profile of patients accessing the rehabilitation services, the treatment received and the services provided. The intention of phase 3 was to highlight the profile of service providers at the centers and explore their understanding and experience with rehabilitation services. Phase 4 then aimed to highlight the satisfaction of the service providers, patients and caregivers with the rehabilitation services.

**Figure 1.2: Phases and flow of the current study**



**1.4 PROBLEM STATEMENT**

The National Rehabilitation Policy (DoH, 2000) was developed to ensure the accessibility and affordability of rehabilitation services to persons with disabilities. This Policy aims to address the structure, process of care and outcomes of rehabilitation. The Western Cape Department of Health also developed strategies to improve healthcare services within the Province. The 2020 Health vision document was developed and it is primarily focusing on patients’ experiences, based on service delivery at health centres. Within the policies highlighted earlier, the needs of

people with disabilities were, however, not covered fully in these documents. A high workload, lack of time and lack of facilities and human resources, particularly at primary healthcare level, are the usual barriers to the implementation of policies in the health sector.

In South Africa, however, it is evident that rehabilitation professionals are based mostly at the tertiary level of care (in-patient), whilst the need is more at the primary level of care (out-patients). However, the shifts to improve delivery of rehabilitation services may not be achieved, as service providers for the provision of rehabilitation are limited in South Africa. People with disabilities are referred mainly to the primary level of care. Healthcare professionals at the primary level of care are overburdened and frustrated by a heavy patient load (Mlenzana & Mji, 2010). Rehabilitation professionals at this level of care book patients for longer periods so that they see a more manageable number of patients per day. Patients often have to wait for two to three weeks to be seen by rehabilitation professionals at the primary level of care. This is a concern for the process of care, as the patients hope to be seen by rehabilitation professionals immediately after consultation with the doctor or primary healthcare professional nurse.

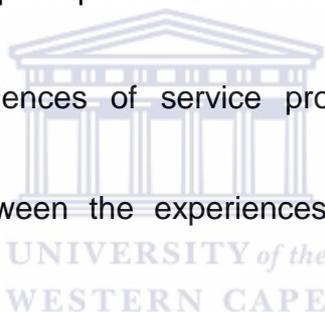
## **1.5 AIM OF STUDY**

The aim of this study was to evaluate the process of care at three selected rehabilitation centres in the Western Cape Province within the contextual framework of the National Rehabilitation Policy (NRP) and the United Nations Convention Rehabilitation policy for People with Disabilities (UNCRPD).

## 1.6 OBJECTIVES

The objectives of the study were as follows:

- (a) To determine the reported barriers and facilitators to rehabilitation services through a systematic review
- (b) To determine the profile of patients with disabilities accessing rehabilitation services at three rehabilitation centres in the Western Cape Province
- (c) To determine the profile of service providers providing rehabilitation service to patients with disabilities attending rehabilitation centres in the Western Cape Province
- (d) To explore clients' perceptions of and satisfaction with the rehabilitation services
- (e) To explore caregivers' perceptions of and satisfaction with the rehabilitation services
- (f) To explore the experiences of service providers with the rehabilitation services
- (g) To map the links between the experiences and perceptions of the key stakeholders



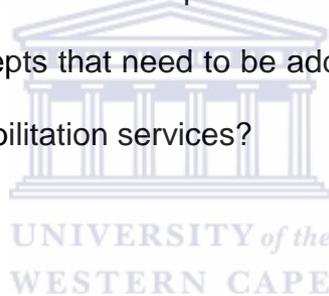
## 1.7 RESEARCH QUESTIONS

This research project aimed to answer the question: What are the current practices of process of care within rehabilitation services and what are the perceptions of the key stakeholders regarding this process at the selected rehabilitation service centres in the Western Cape Province?

In order to answer the main research question, the following questions were derived in relation to the objectives:

1. What are the identified barriers and facilitators to rehabilitation services according to people with physical disabilities?

2. What is the profile of patients with disabilities accessing rehabilitation services at three rehabilitation centres in the Western Cape Province and which services are accessed and how often?
3. What is the profile of service providers providing rehabilitation service to patients with disabilities attending rehabilitation centres in the Western Cape Province?
4. What are the clients' perceptions of and satisfaction with the rehabilitation services?
5. What are the caregivers' perceptions of and satisfaction with the rehabilitation services?
6. What are the experiences of service providers with the rehabilitation services?
7. What are the key concepts that need to be addressed in order to improve the process of care of rehabilitation services?



## **1.8 SIGNIFICANCE OF STUDY**

In understanding the process of care, one is able to understand better the needed health outcomes. This in turn assists in the enhancement of patient care by minimising gaps in service delivery, hence it plays an important role for continuous quality improvement. According to Rubin, Pronovost and Diette (2001), it is important that we have a purpose, clearly identify the clinical area to be evaluated, choose the components to be evaluated, and ultimately identify the people who could best contribute to providing the information. In this study rehabilitation service delivery has been identified as a challenge both nationally and in the Western Cape Province. Thus the researcher deemed it important to determine the process of care within rehabilitation services in order to address this challenge.

The outcomes of this study will assist service providers to rearrange the way service is currently provided for people with disabilities. Together with development of different policies such as NRP, Healthcare 2010 and Future for Health in the Western Cape 2020, this study may assist with identification of gaps that arose with the implementation of these policies based on the feedback of the participants of this study. This feedback could in turn assist National and Provincial Department of Health with reorganization of what needs to be done to improve health systems, with the focus on persons with disabilities based on different articles of the UNCRPD that they ratified in 2006. This study could also assist the rehabilitation professionals with identification of barriers and facilitators that are experienced in other countries and compare them with what the participants at these selected rehabilitation centres experienced with rehabilitation services. With this kind of research clear processes may be highlighted and the gaps in the process of care identified.

## 1.9 DEFINITION OF TERMS

**Client:** “The individual, family or significant other who receives rehabilitation services” (McKell, 2000:vii).

**Disability:** This is an umbrella term for impairment, activity limitation and participation restriction, created through the interaction between a disease or an injury and contextual factors, including both environmental and personal factors (WHO, 2001).

**Process of care:** This entails the process that enlightens the route through which clients access treatment, the waiting list to access treatment, the procedure followed during treatment, the link between treatment and assessment, the period of waiting and receiving treatment, discharge plans, and whether services are within the community treatment network (McDowell, 2003).

**Rehabilitation services:** Services provided by health professionals that may include audiologists, occupational therapists, physiotherapists, speech language pathologists, nurses and doctors (McKell, 2000).

**Realized access:** It is concrete access to a health service where barriers are known to be in the health system (Mandelblatt et al., 1999).

## 1.10 OUTLINE OF CHAPTERS

The thesis is structured in such a way that each chapter addresses one of the objectives. In Chapter One the problem that the study aims to address is outlined. Chapter Two describes the overarching research methods that were used to guide this study. Chapter Three to Seven focus on phase one to four of the study and finally Chapter Eight aims to draw inferences from the findings. Below each chapter will be briefly summarized.

### Chapter One

This chapter introduced the policies that focused on achieving the needs and rights of people with disabilities. These policies aim to improve access to health and rehabilitation services. Even though such policies are in place, there are challenges around a shortage of staff and the growth of chronic diseases and health challenges. Essential health at primary level is emphasised in respect of primary healthcare, and

the World Health Organization developed plans, aimed at achieving the goal of improved healthcare. There are challenges in developing countries regarding the Primary Healthcare model, where effectiveness and safety of care is still a challenge. Health needs are still not being met in South Africa, due to budgetary constraints. Accessibility to rehabilitation services, especially for people in rural areas, continues to be problematic. People with disabilities have identified barriers such as social, psychological and structural barriers that affects the accessibility of rehabilitation centres. South Africa has ratified UNCRPD to meet the needs of people with disabilities and is working on improving health services by identifying and improving services for people with disabilities. This chapter also highlighted the problem statement, the aim of the study, and the objectives and significance of the study.

## **Chapter Two**

This chapter focuses on the research methodology. The Primary Healthcare Framework was used as the framework for the evaluation of the process of care at the selected rehabilitation centres. This evaluation framework has four domains, consisting of the evaluation of organizational structures and processes, evaluation of processes of care and evaluation of outcomes. This study focused on the third domain, which is to evaluate the process of care. This was evaluated using the Model of Access to Care, which has different tools to evaluate services. The study used both qualitative and quantitative methods to evaluate processes of care at rehabilitation service. Chapter two focused on four phases: Phase 1 – Systematic review where barriers and facilitators were identified; Phase 2: Patient information, entailing demographics, knowledge and socio-economic status; Phase 3 – Service providers' information, entailing demographics, education, knowledge and perceived barriers to rehabilitation services; lastly, Phase 4 – Realised access, entailing client

satisfaction, service provider satisfaction, and caregiver satisfaction. These phases correspond to specific aims of the study.

### **Chapter Three**

This Chapter focused on a review undertaken to assist an understanding of processes of care with regards to the barriers and facilitators experienced by persons with physical disabilities regarding during the rehabilitation process. It is evident from the review that there are mixed perceptions of rehabilitation services. This highlights to rehabilitation practitioners the gaps that need to be addressed to make this service a comprehensive one. Lack of knowledge of patients' views on the service could contribute to poor service delivery. It is therefore important for rehabilitation providers to assess the satisfaction of people with disabilities regarding rehabilitation services as well as goal attainment. The barriers identified in this review could be addressed to strengthen rehabilitation programs within the Western Cape Province.

### **Chapter Four**

Understanding the profile of the client base accessing health services plays a major role in the development and implementation of health related policies. This aspect of the study was a descriptive, quantitative study design, using retrospective data. The study was conducted at three rehabilitation centres in the Western Cape Province. The population consisted of patients with physical disabilities. A total of 370 records of patients who presented with physical disabilities at the centres during 2009 were included. Data was initially recorded on a self-designed data capture sheet and then entered into SPSS for analysis. Descriptive statistics were used to analyse the data. The most common health conditions were of a neuromusculoskeletal origin (31%);

strokes (26%); and fractures (21%). Physiotherapists were the most common rehabilitation professionals seen. It appeared as if rehabilitation professionals at the primary level of care in this study were underutilised. Associated with their physical disabilities, the patients experienced psychological, physical, mental and emotional stresses, which require input from a range of healthcare professionals.

## **Chapter Five**

This chapter explored the profile and experiences of service providers with rehabilitation services in the Western Cape. Healthcare professionals play a crucial role in service provision hence it is important to make sure that their knowledge, skills and attitudes are sound for good quality service. This chapter highlighted the profile of the service providers, based on demographics and relations with their patients. Challenges that service providers experienced at the rehabilitation centres were also highlighted focusing on service delivery at these centres. Various aspects of challenges were discussed and there may be a need to reorganize rehabilitation services to improve accessibility to all levels of rehabilitation services.

## **Chapter Six**

Rehabilitation services are important to patients with physical disabilities. To enhance the effectiveness of the services provided, the views of the patient are essential. In this chapter, patients' satisfaction with rehabilitation services was highlighted. Focus group discussions were used to explore patients' level of satisfaction and their perceptions with regards to rehabilitation service. The study highlighted the dissatisfaction experienced by clients with service providers regarding treatment sessions, waiting times and issuing of assistive devices. However the overall impression was that the patients were generally satisfied with the outcomes of treatment, which highlighted positive aspects of rehabilitation. It is

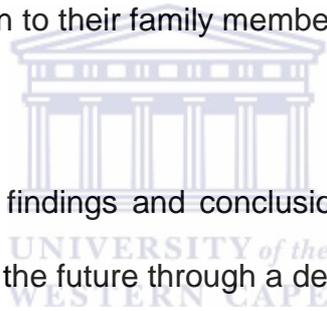
therefore important to make sure that clients' views of service delivery are taken into account in the improvement of services.

### **Chapter Seven**

An important aspect of rehabilitation involves including more role-players than the patients and the health professionals. Key role-players in the rehabilitation process are the caregivers (Mudzi, 2010). This chapter explored the perceptions and satisfaction of the caregivers with the rehabilitation services. The involvement of the caregiver with the rehabilitation process within the treatment realm is evident, but support with reintegration back into society is lacking. Caregivers were generally satisfied with the services given to their family members.

### **Chapter Eight**

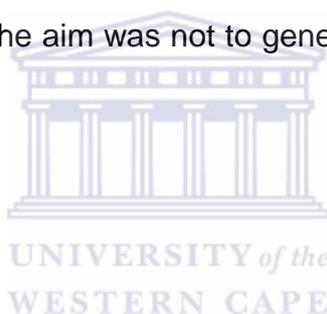
This chapter summarised the findings and conclusions of this study and aimed to highlight recommendations for the future through a devised model.



## CHAPTER TWO: METHODOLOGY

### 2.1 INTRODUCTION

According to Gephart (1999), research paradigms can be classified into three distinct categories namely the positivist, interpretive and critical postmodernist approach. The interpretive paradigm is underpinned by the view that an attempt is made to make meaning of the information by drawing inferences or by judging the match between the information received from the various sources (Aikenhead, 1997). This paradigm is focused on understanding the phenomena under investigation from subjective experiences of individuals. During this study the researcher largely employed an interpretivist approach as views of various participants are collected and interpreted in order to provide meaning. The aim was not to generate new theory but to evaluate what was actually happening.



### 2.2 STUDY DESIGN

The study thus employed a mixed methods approach using both qualitative and quantitative research strategies within the interpretivist paradigm. Table 2.1 displays these characteristics.

**Table 2.1: Characteristics of interpretivism (Cantrell, 2001)**

Feature	Description
Purpose of the research	Understand and interpret various stakeholders perceptions of rehabilitation services
Ontology (nature of ontology)	The reality of the phenomena and investigates people's knowledge, views and experiences
Epistemology (Relationship between the researcher and the participants)	The researcher is not outside but engages in the research process and discerns the meanings that are expressed
Methodology	Process of data collection through interviews, surveys and focus group discussions. Linked to figure 1.2 the phases included a situational analysis with a systematic review, patient information using document analysis and focus groups discussions, service provider information using a survey, and interviews.

### **2.3 STUDY SETTING**

The study was conducted at three rehabilitation centres in the Western Cape Province. The rehabilitation of physically disabled persons in the Western Cape takes place at various levels of healthcare and at a variety of institutions. These institutions represent different levels of intervention and serve populations that reside in different catchment areas. The institutions in the Western Cape chosen for this study included representation from Community Health Centres (CHCs) across the Western Cape; Gugulethu Community Health Centre, Bishop Lavis Rehabilitation Centre and the Elangeni (named TC Newman after completion of data collection) Rehabilitation Centre (Paarl). These rehabilitation centres were visited so that

statistics of 2009 could be perused to look for all patients who presented with different types of physical disabilities, and also to figure out the common physical disabilities with which the patients presented. The centres were purposefully selected based on the different set-ups. The first one, Centre A, primarily serves an urban population that is mostly unemployed. At this centre, patients access the Rehabilitation Unit through referral from other institutions or self-referral. In addition, patients screened by a doctor at the centre could also be referred to the rehabilitation unit of the centre. At this centre, the rehabilitation unit was run by a physiotherapist, an orthopaedics sister, a sessional occupational therapist and a nutrition advisor.

The second centre, Centre B, renders rehabilitation services to both urban and rural communities. The patients at this centre were being referred from primary health clinics in the catchment areas and through outreach programs. Doctors from the secondary hospitals in the area also referred patients to the centre. Based at this unit were a physiotherapist, an occupational therapist, a speech therapist, as well as physiotherapy and occupational therapy assistants.

The final centre namely, Centre C, was a semi-independent rehabilitation centre linked to a community health centre and an academic university. Referral to this centre occurred primarily via the community health centre and walk in from private doctors and other referring hospitals. The centre provided physiotherapy and occupational therapy services, while students from a local university provided speech therapy on a part-time basis.

## 2.4 STUDY POPULATION AND SAMPLING

The targeted population for this study consisted of various stakeholders. During phase two (figure 1.2) the targeted population was clients that presented with physical disabilities, attending one of the three rehabilitation centres and who had been discharged from the relevant rehabilitation centre in 2009. The clients who were chosen were diagnosed with a physical disability and were seen by one or more rehabilitation workers. The folder numbers from the relevant rehabilitation unit were randomly selected so as to obtain a representative number of folders of patients that presented with physical disabilities for the year 2009. The Yamani formula,

$$n = \frac{N}{1 + N(e^2)}$$
 (Israel, 1992), where the letter n stands for the study sample, N for study population and e for constant error = 0.05, was used to obtain the study samples.

A total of 370 records of the clients who presented with physical disabilities were selected for data collection, using a data collection sheet. Of these, 106 records of clients were selected from Centre A, 150 records of clients were selected from Centre B, and 114 records of clients were selected from Centre C, after applying the formula to the three CHCs.

Phase three focussed on the service provider information and was obtained by means of a questionnaire with close ended questions that focused on the profile and relationship with clients and satisfaction with services provided. All service providers at the selected rehabilitation centres were also invited to participate in in-depth interviews. Interviews were conducted with 43 rehabilitation professionals from all rehabilitation centres. In addition, purposive sampling was done to ensure that

service providers from each centre were represented and also facility managers were included. In depth interviews were conducted so as to gain the information that was needed based on the research question of this study. Qualitative research approaches involving detailed interviews produce findings that are unobtainable through statistical procedures (Golafshani, 2003). This author further posits that qualitative approaches deal with natural or real world situations. Problems pertinent to the world of rehabilitation are holistically approached in qualitative studies (Hammell & Carpenter, 2000). These authors further stated that in qualitative studies, participants are confident enough to express their beliefs, value systems and meaning. The number of rehabilitation team members varied at each institution, as presented in Table 2.2.

**Table 2.2: Number of rehabilitation professionals at the 3 rehabilitation centres**

	Speech therapist	Doctors	Clinical nurse practitioners	Orthopaedic sisters	Occupational therapists & OTA	Physiotherapists and PTA	Health promoter and volunteers
Centre A	0	9	5	1	1	1	1
Centre B	1	15	19		2	2	
Centre C		5	5	1	1	1	12
TOTAL	1	29	29	2	4	4	13

PTA: Physiotherapy Assistant

OTA: Occupational Therapy Assistant

CHC: Community Health Sciences

For phase four, participants included the patients, caregivers and service providers. The target population for patients was those who presented with physical disabilities at the selected rehabilitation centres in the Western Cape, South Africa. A total of 43 patients were purposively selected and telephonically contacted to participate in this study. Only 29 participants indicated their willingness to participate in the focus group discussions. With regards to the caregivers, 26 viable participants were

conveniently selected from the list of patients who participated in the focus group discussions and were telephoned to make appointments. However, of these participants, only 13 were available for interviews. The sample thus consisted of caregivers of 13 individuals conveniently selected.

## **2.5 DATA COLLECTION METHODS AND PROCEDURES**

Data collection methods will be presented according to the various phases of the study and will be expanded on in the relevant chapters.

### **2.5.1 Phase 1: Systematic Review (Chapter 3)**

A review protocol (Appendix 1) was developed in response to a specific research question. For the systematic review, the PIO (population, intervention and outcome) was identified and thus the population (P) focused on people with physical disabilities, the intervention (I) focused on rehabilitation services, and the outcome (O) was barriers and facilitators. Data bases such as CINAHL with full text, ERIC, Academic search premier, MEDLINE, Health resource-consumer edition, Health source: Nursing/Academic edition, PsychARTICLES, SocIndex with full text and Ebscohost were searched for this review. Studies that were used included both quantitative (surveys) and qualitative studies (focus groups, in-depth interviews or structured interviews with open-ended questions) with people with physical disabilities. Grey literature was searched through websites and referrals from experts in the area. However, documents obtained did not specifically address the research question of this systematic review. However, from the literature found, information relevant to the systematic review was included in the introduction and discussion section. Two reviewers independently analysed articles that were screened, using the PIO method as a screening tool where eligibility of the articles were identified.

Reviewers compared opinions and reached consensus on the final articles that were included in the review. The main focus was articles that had participants who presented with physical disabilities, attended rehabilitation centre, and had provided information about barriers and facilitators of rehabilitation services.

### **2.5.2 Phase 2: Profile of patients (Chapter 4)**

A descriptive, quantitative study design was chosen, using retrospective data collection methods. A descriptive research design gives direction to healthcare service delivery in health education and the evaluation of community health services (Mahasneh, 2001). It provides baseline data upon which other studies can be built. It is also accurate and precise (Babbie & Mouton, 2006), and was therefore considered suitable for addressing the objectives of this study. Data from the files were captured on a data capturing sheet (Appendix K) that described the participants who visited the centres regarding demographic information, type of disability, duration of attending the rehabilitation centre, number of health professionals that consulted the patient, total number of sessions per health professional, and the referrals done for the patients. Piloting the data capturing sheet was done at a rehabilitation centre that functioned on a similar basis as the selected ones, and information that was found missing from the data sheet was added before the study was conducted. This process assisted the researcher in screening all the records and not leaving out any information needed from the records.

### **2.5.3 Phase 3: Service providers' information and satisfaction (Chapter 5)**

This was a descriptive study design that utilised both the quantitative and qualitative approach to collect the data. The quantitative method captured the profile and relationship with clients and satisfaction with services provided in a numerical format,

which were subsequently analysed using statistical methods. A test-retest was conducted to ensure the reliability of the data-gathering instrument. The data collected for testing the tool were collected at the two intervals and were compared for similarities, using appropriate statistical tests. Once the self-developed questionnaire was drafted, it was given to the study co-group (SANPAD) and the Deputy Director of WRCR, who are specialists in the field of rehabilitation. This was done to ensure the content validity of the instrument. The changes that were recommended by the experts were effected and the final version of the instrument was used. The content validity tests were done to check whether the instrument covered the full domain of the content intended to be captured (Rungtusanatham, 1998). According to this author, this type of validity distinguishes itself from others by using experts in the field being investigated. The two processes of reliability and content validity were conducted before the final version of the data gathering instrument was adopted. The questionnaire was completed at a time convenient to the service providers.

Appointments for in-depth interviews were set up at a convenient time and venue for the service providers. The interview guide (Appendix N) contained a section asking about the level of satisfaction of the service providers regarding rehabilitation services. Interviews were tape recorded and generally lasted for an hour. The tape recordings were played back to the service providers so that if there were errors in the responses, they could be corrected immediately. Transcripts were done from the tapes and analysed using the categories that emerged from the interviews, and these categories were then grouped to form different themes. Numerical and textual data were analysed quantitatively and qualitatively respectively.

#### **2.5.4 Phase 4: Realized access (Chapter 6, 7)**

In this phase of the study, in-depth interviews were conducted among the service providers and caregivers. Focus group discussions (FGD) were conducted among patients who had received rehabilitation services in the year 2009. The in-depth interviews with the service providers were conducted after they had completed a questionnaire provided to them three days prior to the interviews. This process ensured adequacy/accuracy of the information contained in the questionnaire and allowed for further exploration of information that was mentioned in the questionnaire. According to Hammell and Carpenter (2000), the researcher in qualitative studies acts as an integral part in the research process, by shaping the collection and interpretation of the data. Using this process, the researcher describes human behavior through the participants' perspectives.

A focus group discussion (FGD) was held with the identified participants. Clients were informed of the presence of the research assistant and what his/her role would be in the research process. All FGDs (3) were conducted in the language of the clients. Data analysis involved the analysis of transcripts and then grouping together commonalities. Two trained, multilingual translators translated the Afrikaans and isiXhosa transcriptions into English. The translators were instructed by the researcher to keep the original words throughout the process of translation, to ensure validity. One translator translated the transcriptions into English, while the other one back translated them into the original language to ensure that the content had not been lost through translation. Where there were errors, both translators met and discussed the mismatch and corrected it accordingly.

The researcher made an appointment with the rehabilitation centres to gain access to the records of the clients. Once permission was granted, the researcher contacted the clients who were selected for the survey and explained the reason for the call. The researcher asked the clients if they had caregivers who looked after them in the year 2009, and the clients then provided contact information of the caregivers. The researcher contacted the caregivers and explained the purpose of the study. Appointments were made for in-depth interviews at a convenient time and place for the caregivers. The caregivers gave consent for the researcher to conduct the interview and also gave consent to be audio-taped during the interview. Each interview lasted approximately 45 minutes and the tape recording was then played back to the participant to make sure that the information that was recorded was correct.



## **2.6 DATA ANALYSIS**

### **2.6.1 Quantitative data analysis**

Information of both clients and service providers was collected using a data capturing sheet for client information and a questionnaire for service providers. This information was captured on both excel spread sheets and SPSS programme. Data was analysed using SPSS 17.0 and version 21.0. The purpose of using excel spread sheets was for data cleaning. Descriptive and inferential statistics were used to identify relationships between variables, for example, age or race and a particular experience.

### **2.6.2 Qualitative data analysis**

Analysis of interviews identifies the meaning in the information gathered in relation to the purpose of the study (Rubin & Rubin, 2004). There were three groups that were

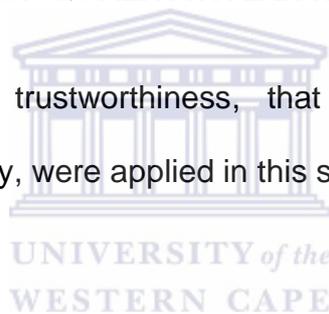
interviewed through focus group discussions and in-depth interviews. Data were analysed manually. The content of the transcribed notes was read and the audio tapes were listened to several times to familiarise the researcher with the content and to understand the data (Marshall & Rossman, 1999). The process involved identifying codes, looking for commonalities, categorising, and identifying themes that emerged from the recorded data. The opinion of the independent qualitative researcher was used to confirm the themes and categories that were identified during analysis. When there were disagreements both researchers sat to discuss those and agreed on correcting the disagreements.

## **2.7 TRUSTWORTHINESS OF QUALITATIVE DATA**

Four qualitative criteria for trustworthiness, that is, credibility, transferability, dependability and confirmability, were applied in this study (Lincoln & Guba, 1985).

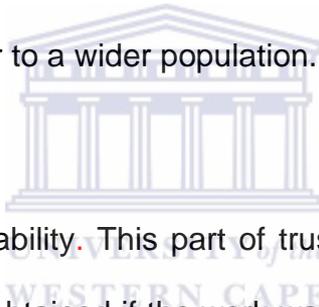
### **2.7.1 Credibility**

Member checking was done to ensure the credibility of the information received from the FGDs and in-depth interviews. This was done by summarising the information from the transcription notes and playing the audiotapes back to the participants at the end of the interviews and FGDs. This was to ensure the clarity of the information provided by the participants. In addition to this, the transcribed data were presented to five of the clients who participated in the study – all caregivers – and electronic copies were sent to the relevant service providers to ensure the credibility of the information Smith (2004). The qualitative data were believable from the perspectives of the participants who took part in the research. According to Shenton (2004), credibility ensures how congruent the research findings are with reality.



### **2.7.2 Transferability**

Transferability refers to the degree to which qualitative results can be generalised or transferred to other populations or settings (Marshall & Rossman, 1999). The participants in the current study were purposively selected with different characteristics. In-depth interviews and FGDs were chosen to strengthen the qualitative part of this study. The FGDs obtained information from clients regarding their experiences of rehabilitation service delivery at the rehabilitation centres. The in-depth interviews provided information on the experiences of the service providers and caregivers regarding rehabilitation services. Qualitative findings are usually specific to a small number of individuals in a particular setting (Shenton, 2004). Based on this fact, the findings and conclusions of this study cannot be applicable to any other population, setting or to a wider population.



### **2.7.3 Dependability**

Dependability is similar to reliability. This part of trustworthiness provides evidence that similar findings would be obtained if the work was to be repeated. However, this would only be possible if the same participants and methods were to be used in similar contexts (Shenton, 2004). A code-recode procedure of analysing the data was used to reduce this problem and thus to ensure dependability. The researcher scrutinised the recorded interviews and transcripts using this procedure. This process was followed by an interpretation of the results of the study and providing detailed recommendations. The same study would produce similar results, if repeated by another researcher using similar procedures (Shenton, 2004).

### **2.7.4 Confirmability**

The field notes, recorded interviews and the analysis were submitted to the study supervisor to ensure confirmability (Lincoln & Guba, 1985). Peer reviews were

conducted by the study supervisor at all stages of the analysis. This was achieved by providing an audit trail consisting of raw data, reconstruction and synthesis products to the study supervisor. In addition, the process notes, personal notes and preliminary developmental information were also provided to the supervisor. The data collection and analysis processes were described in detail so that the research trail could be followed easily. The findings and conclusions were therefore justifiable in relation to the research material (De Vos, 2002).

## **2.8 METHODOLOGICAL TRIANGULATION**

This phase consists of data sources triangulation to illustrate a picture of what is happening. According to Thurmond (2001), data source triangulation can be used to reveal atypical data and to identify similar patterns, thus increasing the credibility of the data. In addition, different types of data may give different kinds of insight on the research questions, and the combination yields a stronger knowledge base for drawing conclusions. In this study the data were obtained from patients, service providers as well as the caregivers of the patients thus allowing the researcher to obtain opinions and views from different sources about the same topic. It also assists in providing a clearer understanding of the problem being investigated. This assimilation of this information will be presented in Chapter 8.

## **2.9 SCHEMATIC PRESENTATION SUMMARY OF STUDY**

The study aimed to report the research outcomes by presenting the process followed in respect of each objective of the study. Table 2.3 below presents a schematic presentation of how the different objectives were addressed.

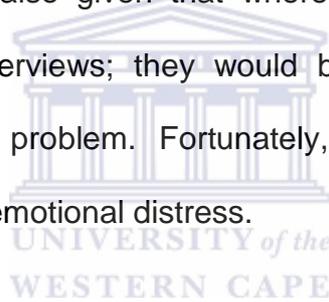
**Table 2.3: Design and methods to be used to answer objectives**

<b>Objective</b>	<b>Participant</b>	<b>Design</b>	<b>Method</b>
Reported barriers and facilitators	Literature review	Quantitative and qualitative studies	Article/Systematic Review
Profile of patients	Documents of persons with disabilities	Quantitative	Data gathering sheet
Profile of service providers	Rehabilitation service providers	Quantitative	Questionnaire
Clients' perceptions and satisfaction	Clients with physical disabilities	Quantitative and qualitative	Questionnaire and FGD
Caregivers' perceptions and satisfaction	Caregivers of clients	Qualitative and quantitative	FGD
Experiences of service providers	Rehabilitation service providers	Qualitative	In-depth interviews
Mapping outcomes of the objectives	Clients, Service providers and caregivers		

## 2.10 ETHICS

Permission was obtained from the Research Grant and Study Leave Committee of the University of the Western Cape (Project number: 10/1/3, Appendix C), the Department of Health (Appendix D), facility managers and participants. The participants were informed that their participation would be entirely voluntary and that they could withdraw at any time from the process without stating any reason. Clients were also assured that withdrawal would not influence their treatment in any way, while service providers were assured this would not influence their employment in any way. Anonymity and confidentiality was maintained by not mentioning any

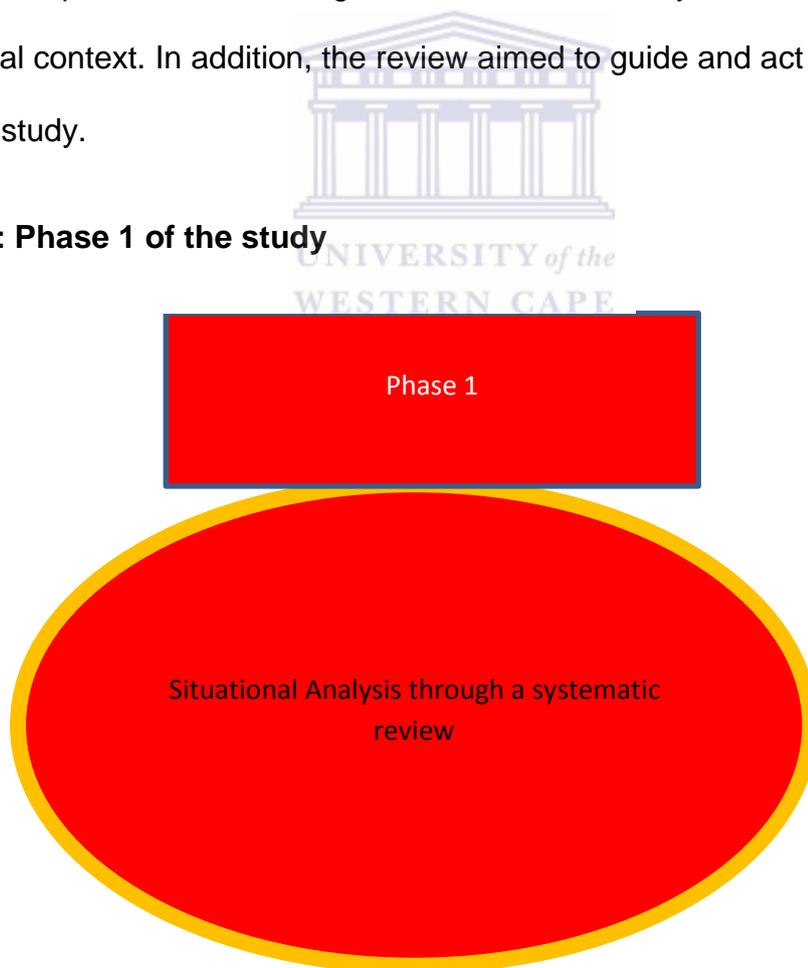
participants or centres' names during the interview. The participants were also assured that the information would be kept locked in a cupboard after the interviews. The purpose of the study was explained to the participants; consent forms (Appendices E, F and G) were given to them for the interviews, so that they could sign them, indicating their willingness to participate in the study, and an information sheet (Appendices H, I and J) regarding the study was provided for clarity on questions that the participants had. Consent to being audiotaped was also gained from the participants during the in-depth interviews. The undertaking was given that the results of the study would be made available to all stakeholders at the three rehabilitation centres and to the District and Provincial Health Offices of the Western Cape. The undertaking was also given that where participants showed signs of emotional distress during interviews; they would be referred to a counselor to address the causes of the problem. Fortunately, there were no incidents of participants showing signs of emotional distress.



## INTRODUCTION TO CHAPTER THREE

Chapter three focuses on phase one of the study and presents the results of a systematic review that aimed to explore the barriers and facilitators to rehabilitation services as highlighted in literature (Figure 3.1). This chapter answers the question: What are the identified documented barriers and facilitators to rehabilitation services according to people with physical disabilities? A systematic review was relevant for this study so that the researcher could have an idea of national and international perceptions of barriers and facilitators of rehabilitation services for people with physical disabilities. Understanding the views and experiences of other countries will help us best position the findings of the current study in both a national and international context. In addition, the review aimed to guide and act as a basis for the rest of the study.

**Figure 3.1: Phase 1 of the study**



## **CHAPTER THREE: SYSTEMATIC REVIEW**

### **BARRIERS TO AND FACILITATORS OF REHABILITATION SERVICES FOR PEOPLE WITH PHYSICAL DISABILITIES: A SYSTEMATIC REVIEW**

#### **3.1 INTRODUCTION**

According to the recently launched World Report on Disability (WHO, 2011), 15% of the population globally presents with disabilities, with physical disability being most prevalent. The numbers of disabled people are increasing globally, due to factors such as population growth, ageing, the emergence of chronic diseases, and medical advances that preserve and prolong life (WHO, 2005). Studies done from 1991-1997 by different authors have confirmed that persons with disabilities are identified as a group that have challenges with access to healthcare services (Weissman, Stern, Fielding & Epstein, 1991; Davis & O'Brien, 1996; Gold, Nelson, Brown, Ciemnecki, Aizer, & Docteur, 1997). These challenges create overwhelming demands for health and rehabilitation services, which are very far from being met, particularly in low-income countries (WHO, 2005). Disability is conceptualised as a complex process involving bodily functions, health, environment, activity limitations and restrictions in social participation (WHO, 2001). This description is based on the International Classification of Health, Disability and Function (ICF) (WHO, 2001). Optimal healthcare for persons with physical disabilities is essential if their quality of life is to improve. Understanding the needs of the physically disabled population may be a complex process, as it involves understanding the person, the society in which he or she lives, and how these interact. In order to assist in improving the health outcomes of people with disabilities, it is essential to understand the barriers and facilitators of this population relating to medical services that include rehabilitation.

Different categories of people are in need of rehabilitation services. When looking at the selected rehabilitation centres in the Western Cape Province for this study, the common conditions seen were as follows: arthritis, spinal cord injuries, head injuries, neuromuscular disorders, strokes, fractures, and amputations. Investing in health and rehabilitation services would not only help ensure equality of opportunities and quality of life for persons with disabilities, but also promote social participation and a valuable contribution to society. Disability worldwide has been a challenge in many countries, and people with disabilities have stood up and raised concern at not being accommodated within all government sectors. In 2006 the UN Convention on the Rights of People with Disabilities (UNCRPD) (United Nations, 2006) was developed, and a majority of countries ratified the document that was set up by persons with disabilities. This document has further underlined the rights of individuals with disabilities to play an active role in society, and that accessing rehabilitation services plays a key role in achieving this. An important step in promoting active participation among individuals with disabilities will be to identify barriers and facilitators that promote or hinder access to rehabilitation services.

If the needs of individuals with disabilities are to be met, we need to understand the barriers and facilitators to utilising services. More than a decade ago, Keith (1998) highlighted that there was a need to understand patients' views on service delivery and explore whether rehabilitation services acknowledge patients' views, and to make relevant adjustments. This was supported by Haynes, Devereaux and Guyatt (2002), who highlighted the role of patients' preferences in disease management, and the importance of their views being heard. In a more recent study, van Til, Drossaert, Punter, & Ijzerman (2010) continue to highlight the need to understand the barriers that patients experience in the field of rehabilitation and how these can

be overcome. Their recommendation is that clients be involved in decision making on their rehabilitation so that they can be part of the process. The authors further recommend that studies to be conducted to explore the barriers to rehabilitation and how they may be overcome.

Literature has indicated that a client-centred and holistic philosophy takes into account the goals and expectations of clients, and should be put into the context of the individuals' broader life circumstances (Cott, 2004). When applying these concepts to a Primary Healthcare (PHC) approach, Cott (2004) suggests the following important components for client-centred rehabilitation: "the individualisation of programs to the needs of the client for a smooth transition between rehabilitation programs and the community; sharing of information and education that is appropriate, timely and according to clients' wishes; family and peer involvement in the rehabilitation process; coordination and continuity within and across sectors; and outcomes that are meaningful to the client" (Cott, 2004:1411-1422). This is also in line with the PHC approach to health in South Africa, which highlights that, "specific rehabilitative services should include a basic assessment of people with disabilities, followed by an appropriate treatment programme, in consultation with the disabled person and his family" (Department of Health, 2000:43).

Rehabilitation services in PHC settings are important for the rehabilitation of patients with physical disabilities. Over the last decade, new rehabilitation evidence for specific interventions has been conceptualised, but not practised (Wade & De Jong, 2000). Studies that were chosen for this systematic review focused on clients who had disabilities and received rehabilitation services at community level. PHC rehabilitation professionals offer non-pharmacological interventions that have both a

preventive and therapeutic role in the management of patients with physical disabilities. However, there is a need to identify explicit service delivery models that operationalize a PHC and rehabilitation approach to patients with physical disabilities. Understanding the views of persons with disabilities will assist in identifying the gaps in the rehabilitation services being offered to them. According to the searches conducted by the current authors, no previously published systematic reviews on this specific topic could be found. Hence this study aims to review literature on barriers and facilitators regarding rehabilitation services for people with physical disabilities.

## **3.2 METHODOLOGY**

A systematic approach to the review was adopted and is reported in a narrative form. The protocol for developing a systematic review was developed before the study was conducted as a guideline. This systematic review is one of the objectives of a bigger project (Project number: 10/1/3).

### **3.2.1 Criteria for review**

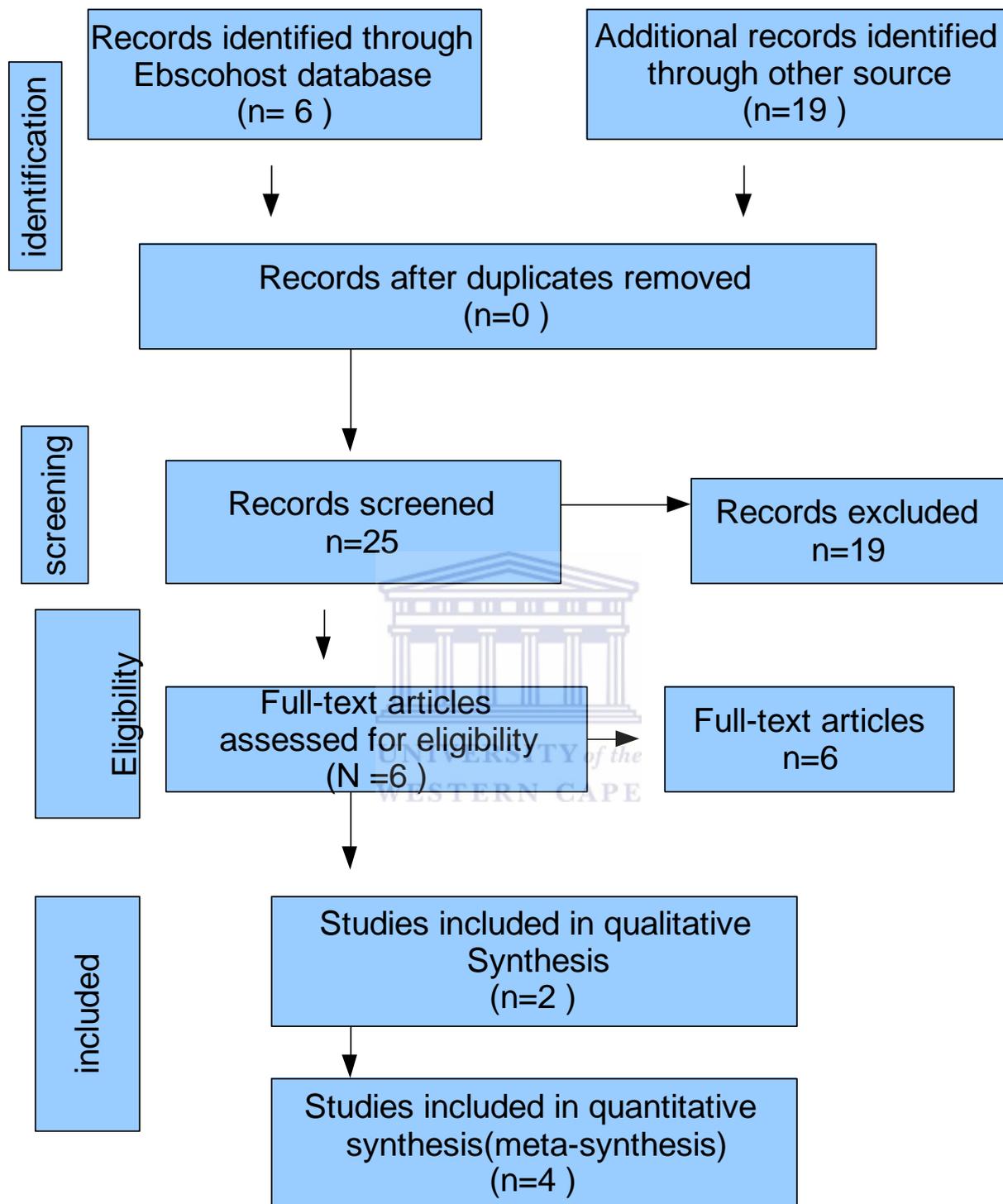
Criteria to select articles for inclusion were available and full text articles on line, both qualitative and quantitative studies, published in English were selected for the period January 1990 – May 2010. The studies focused on people from different backgrounds and with physical disabilities who attended rehabilitation services and were exposed to rehabilitation services, either institution based or community based. All levels of evidence were considered for the review (Sackett, Straus, Richardson, Rosenberg & Haynes, 2000). Documents for the last two decades were reviewed. The PIO (population, issue, outcome) method was used to select articles relevant for the study. This method assisted in identifying the participants to be used in the

studies, and the barriers to and facilitators of rehabilitation services, as well as the outcomes of these studies. If the articles did not meet these criteria, they were excluded from the study.

### **3.2.2 Search strategy**

The search strategy was implemented as follows. Databases, such as CINAHL with full text, ERIC, Academic search premier, MEDLINE, Health resource-consumer edition, Health source: Nursing/Academic edition, PsychARTICLES, SocIndex with full text and Ebscohost, were searched for this review. The terms used to search for literature included 'rehabilitation service', 'facilitators and barriers', 'physically disabled', 'rehabilitation service providers' and 'user satisfaction'. Search terms such as 'positives and negatives', 'persons with disabilities', 'physical therapists', 'occupational therapists', 'doctors', 'nurses', 'social workers', 'client satisfaction' with similar meanings from other studies to these were used as alternatives to search terms such as 'barriers' and 'facilitators'. A reference list of included studies was also perused to identify articles that did not emerge in the initial data base search. In addition grey literature was searched through websites and referrals from experts in the area, although documents obtained did not specifically address the research question of this systematic review. Studies were excluded if they did not specifically focus on rehabilitation services. Altogether six articles were found on the identified databases, while 19 articles were found, based on their titles, identified from the reference lists of these articles (Figure 3.2).

Figure 3.2: Search strategy followed for articles used in this study (Moher et al., 2009)



....  
**3.2.3 Data extraction**

Two reviewers examined the articles and selected the studies that met the inclusion criteria. They separately reviewed the articles using the PIO method and discussed the most suitable studies for inclusion in the review. The reviewers used a critical

review form for the quantitative studies, while a critical appraisal skills programme (CASP) form was used to make sense of evidence, with ten questions, for the qualitative studies (CASP, 2004). Table 3.1 below presents the questions asked.

**Table 3.1: CASP review questions**

No	Questions
1	Was there a clear statement of the aims of the research?
2	Is the qualitative methodology appropriate?
3	Was the research design appropriate to address the aims of the research?
4	Was the recruitment strategy appropriate to the aims of the research?
5	Were the data collected in a way that addressed the research issue?
6	Has the relationship between researcher and participants been adequately considered?
7	Have ethical issues been taken into consideration?
8	Was the data analysis sufficiently rigorous?
9	Is there a clear statement of findings?
10	How valuable is the research?

Both reviewers had copies of the articles that were suitable for the study and used the CASP to trace articles that answered the review questions. Six articles out of eligible 19 articles met the criteria of this review.

### **3.2.4 Conceptual framework**

Global health initiatives tend to influence rehabilitation and health assessment. The wide adoption of the World Health Organization's (2001) International Classification of Functioning, Disability, and Health (ICF), a model that promotes an understanding of the complexity of health and well-being practices, is an indication of this. The ICF provides a framework for viewing behaviours from three broad and different perspectives, namely physiologic, physical-environmental, and psychosocial functions. When evaluating the current articles, the authors took ICF into consideration (WHO, 2001). The two main components of the ICF include the individual via Functioning and Disability; and Contextual Factors. The main aspects important for this review were activities and participation from an individual perspective. According to the ICF, the contextual factors include environmental factors, which include the physical, social and attitudinal environments in which people live and conduct their lives. In addition, personal factors include an individual's life and living, and comprise features of the individual (gender, race, age, health conditions, fitness, lifestyle, coping styles, social background, education, profession, etc.). In terms of implications for the review, the ICF provided a useful framework and vocabulary for identifying barriers and facilitators.

### **3.2.5 Data analysis**

Two reviewers independently analysed 25 articles that were screened, using the PIO method as a screening tool, to identify the eligibility of the articles. From the 25 articles, the reviewers identified six articles that met the criteria for the review.

Reviewers compared opinions and reached consensus on the final articles to be included in the review. The main focus was on articles in which the participants presented with physical disabilities, attended rehabilitation centres, and had to comment about the barriers and facilitators in the rehabilitation services.

### **3.3 RESULTS**

Of the 25 article titles identified according to key words through the literature review, only six articles were found to meet the inclusion criteria. The omitted articles (19) were excluded mostly because they did not address the aim of this review or did not include the identified population based on the CASP form (Appendix B) used to select the articles for this review. The findings focused on the barriers and facilitators identified by people with physical disabilities regarding rehabilitation services. Of the six studies, five were from developed countries (Australia, Norway, Canada, USA and England) and one from a developing country (China). As some areas in China are still underdeveloped it is categorized as a developing country (Yifan, 2010). These studies will be reported individually, based on the aim of the study, population and outcome of the study. Table 3.2 below focuses primarily on the individual's personal factors, according to the ICF.

**Table 3.2: Articles that were reviewed and met the criteria of the study**

No	Author	Gender	Race	Country	Type of study	Occupation	Level of Education	Study Population
1	Mangset <i>et al.</i> (2008)	Females – 7 Males – 5	<b>Not mentioned</b>	Norway	Qualitative	Pensioners	<b>Not mentioned</b>	Stroke patients
2	Zongjie, Hong, Zhongxin & Hui (2007)	Females – 175 Males – 285	Han and Other nations	China	Quantitative	Officials and leaders – 51 Professional technical personnel – 41 Clerk – 24 Shop workers – 51 Factory workers – 159 Military – 12 Others – 144 Retired – 226	College and above – 51 Middle school – 337 Primary school – 49 Illiteracy – 23	Strokes, Spinal cord injuries, cerebral palsy, head injuries
3	Vincent, Deaudelin, Robichaud <i>et al.</i> (2007)	Females – 7 Males – 10	<b>Not mentioned</b>	Canada	Qualitative	<b>Not mentioned</b>	Elementary – 9 Secondary – 6 Post-secondary – 2	Stroke
4	Kroll <i>et al.</i> (2006)	Females – 16 Males – 20	White, Black, Asian and Hispanic	USA	Qualitative	<b>Not mentioned</b>	Primary – College – 14	Spinal cord injuries, strokes, multiple sclerosis
5	Crisp (2000)	Females – 21 Males – 14	<b>Not mentioned</b>	Australia	Qualitative	Employed – 7 Unemployed – 24	Students – 3	Physical disability
6	Williams & Bowie (1993)	<b>Not specified</b> <b>181</b> <b>participants</b>	<b>Not mentioned</b>	U.K.	Qualitative	<b>Not mentioned</b>	<b>Not mentioned</b>	Severely physically disabled

Within both barriers and facilitators to rehabilitation services, the physical, social and attitudinal environments in which people live and conduct their lives are addressed. Mangset *et al.* (2008) used semi-structured interviews to explore patient's satisfaction as a quality indicator in the rehabilitation of elderly stroke patients. The population were clients who had a stroke and were between the ages of 60-87 years. In this study, participants vocalised **facilitators** relating to the rehabilitation process. These included being treated in a humane manner by the health professionals, being acknowledged as individuals, having autonomy respected, having confidence and trust in health professionals and, lastly, exchange of information.

Williams and Bowie (1993) used interviews to report on the quality of monitoring and managing the needs of residents with severe physical disabilities who were in regular contact with health professionals. The population were clients with severe physical disabilities between the ages of 16-64 years. Based on the research findings, the **barriers** identified regarding rehabilitation included that their needs were not being met by health professionals regarding activities of daily living, communication, lack of resources in the areas of psychology, speech therapy and neuropsychology, lack of education given to the disabled, and lack of community awareness regarding disability.

Zongjie *et al.* (2007) used a series of comprehensive questionnaires, aimed at exploring the requirements regarding rehabilitation services of residents with disabilities. The population were clients with disabilities who were between the ages of 30 to 70 years. The **facilitators** identified in this study by the participants included the provision of information, doctors having good skills, easy access to doctors, good

understanding of rehabilitation services, confidence in the value of rehabilitation services, and ease of access to rehabilitation services.

Vincent *et al.* (2007) used focus group discussions and explored the met and unmet rehabilitation needs of older adults who had suffered a stroke and who lived in the community. The population were clients who had suffered a stroke and were over the age of 65 years. These clients identified **barriers** to rehabilitation as being that rehabilitation was not being personalised to the needs of the individual patient and there was not enough support for patients.

Kroll *et al.* (2006) used focus group discussions to explore the barriers and strategies affecting the utilisation of primary preventive services for people with physical disabilities. The population were clients aged 18 years and older with physically disabling conditions. Clients identified structural-environmental and process **barriers** as poor facilities, equipment, procedural accessibility issues, poor transportation, poor appointment scheduling, inadequate patient-provider communication, unprofessional manner, inadequate disability-specific knowledge, lack of personal motivation, cognitive issues, inadequate information and self-education, and not having a personal doctor/usual source of care.

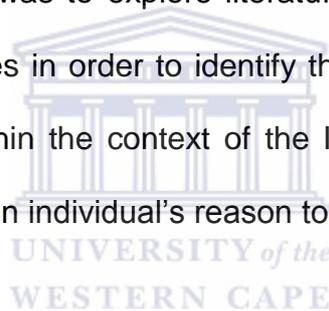
Finally, Crisp (2000) used interviews to examine the perceptions of persons with disabilities concerning their interaction with health and rehabilitation professionals. The population were clients with disabilities in the age group 24 to 56 years. The **barriers** to rehabilitation included that health and rehabilitation professionals were ineffective, family members who were part of rehabilitation process were devaluing the clients, association of rehabilitation with unwanted dependency and social

discomfort, and dissatisfaction with the help received. The **facilitators** identified included meaningful assistance from health and rehabilitation professionals, having therapeutic relationships with the health and rehabilitation professionals, and being assertive and independent in the rehabilitation process.

The services utilised by the participants included rehabilitation medical services, psychological services and social services. Rehabilitation education was received as part of the rehabilitation process.

### **3.4 DISCUSSION**

The aim of the current study was to explore literature on rehabilitation services for people with physical disabilities in order to identify the barriers to and facilitators of accessing such services. Within the context of the ICF, it is important to consider various factors that influence an individual's reason to access health services.



#### **3.4.1 Policies**

The World Health Organization adopted a primary healthcare approach for effective health service delivery (WHO, 1978). The primary healthcare approach includes five types of care, namely promotive, preventive, curative, rehabilitative and palliative. Within this approach, healthcare must be accessible, affordable, appropriate and accountable. From the studies included in the review, five were from developed countries, which adopted a healthcare system similar to the PHC approach. Table 3.3 below highlights the various healthcare systems in these countries including South Africa.

**Table 3.3: Healthcare systems identified**

Country	Aim of healthcare system
South Africa (ANC, 1994)	Healthcare in South Africa varies from the most basic primary healthcare, offered free by the state, to highly specialised health services available in the both the public and private sectors. Therefore, parallel private and public health systems exist. The public system serves the vast majority of the population, but is underfunded and under-resourced.
Norway (Johnsen, 2006)	The organizational structure of the Norwegian healthcare system is built on the principle of equal access to services. The emphasis in its health system is on primary healthcare model, in terms of which residents should have the same opportunities to access health services, regardless of social or economic status and geographic location.
China (Xinming, 2005)	The health policy in China focuses on addressing the health challenges of the 21st century and ensuring access to care. Priorities include preventive, promotive and curative care.
Canada, (Irvine <i>et al.</i> , 2005)	According to Irvine <i>et al.</i> , (2005), there is a need to accommodate the changing pattern of care from an institutional to a community-based model. This will allow accessibility of the health centres to all citizens of the country.
UK (Boyle, 2011)	Health services in England are largely free. The National Health System provides preventive medicine, primary care and hospital services to all.

### 3.4.2 Individual factors

It is evident from the studies that patients with varying conditions access rehabilitation services even though they may have had positive and negative experiences regarding the service. The expectations of the service from the participants were the same; they both complimented and criticised the rehabilitation service received. Although four out of the six studies reported on the education level of the participants, the conclusion cannot be drawn that there was a link to the

knowledge of the participants regarding rehabilitation service. Literature indicates, however, that receiving health information from health professionals and physicians is an important measure in increasing knowledge among users of the service (Tian *et al.*, 2011). In addition, Paasche-Orlow *et al.* (2005), highlight that health literacy is associated with education, ethnicity and age. They further highlight that there is a need to simplify health information provided to patients as part of health services.

Although the ICF was officially launched in 2001, it is evident from the articles in this review that personal and contextual factors were considered and highlighted in various ways. In the review, Williams and Bowie (1993), Zongjie *et al.* (2007) and Vincent *et al.* (2007) focussed on personal factors. In the study by Williams and Bowie (1993), the focus was on the disorder of the patient and highlighted the need for specific health professionals to focus on the disability. In contrast, Zongjie *et al.* (2007) focused on personal factors that included finances, years of disability and understanding of the required rehabilitation services related to the disability.

### **3.4.3 Environmental factors**

This review systematically identified the barriers to and facilitators of rehabilitation services for people with physical disabilities, as described in the literature. A key outcome of the review was that clients with physical disabilities identified health professionals' attitude towards them as both a facilitator and a barrier. Environmental factors include aspects such as physical, social and attitudinal aspects. Respect and human treatment were highlighted as facilitators, but people with disabilities were concerned that some health professionals focused on their disabilities and not their health.

A client-centred approach is favoured in the literature, highlighting respect, autonomy and acknowledgement (Mangset *et al.*, 2008). In line with this approach would be the need for client education, which was also identified as a challenge for the patients. This is supported by other researchers (Harris, Hayter & Allender, 2008), who suggested that communication and lack of information were barriers related to healthcare professionals when managing patients with chronic illnesses. In the review, communication also had positive and negative outcomes at the rehabilitation centres. Some felt that healthcare professionals exchanged information during consultation, while others felt that communication was lacking, especially regarding issuing of assistive devices and education about the health conditions with which people with disabilities presented (Williams & Bowie, 1993; Vincent, Deaudelin, Robichaud *et al.*, 2007).

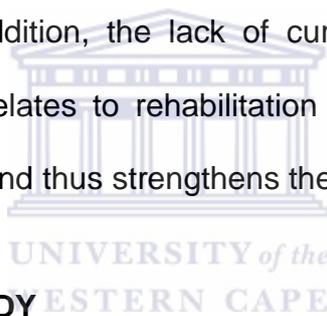


In addition, participants were concerned about the lack of resources in the areas of psychology, speech therapy and neuropsychology in rehabilitation services. This was seen to limit the holistic approach to the management of a person with a disability who was in need of one of these services. Although certain types of services were found to be limited, the participants in this review felt that rehabilitation services were easily accessible to them and they valued the existence of rehabilitation centres in their areas/community (Zongjie *et al.*, 2007).

### **3.5 CONCLUSION AND IMPLICATIONS FOR PRACTICE**

The systematic review presented above highlighted that there were few studies evaluating the barriers and facilitators to rehabilitation services according to people with physical disabilities. However, from the articles identified, it is evident that there

were mixed sentiments about rehabilitation services. This highlights to rehabilitation practitioners the gaps that need to be addressed to make this service a comprehensive one. Lack of knowledge about patients' views on the service could contribute to poor service delivery. It is therefore important for rehabilitation providers to assess the satisfaction of people with disabilities regarding rehabilitation services as well as goal attainment. Through participation and inclusion in the process of rehabilitation, the needs and concerns of persons with disabilities are clarified to the health professionals. It is also evident from the review that contextual factors play a major role in understanding the impact of disability and the need for rehabilitation services. The barriers mentioned in this review could be addressed to strengthen rehabilitation programs. In addition, the lack of current studies focussing on the South African context as it relates to rehabilitation services clearly highlights the need for further investigation and thus strengthens the need for this study.



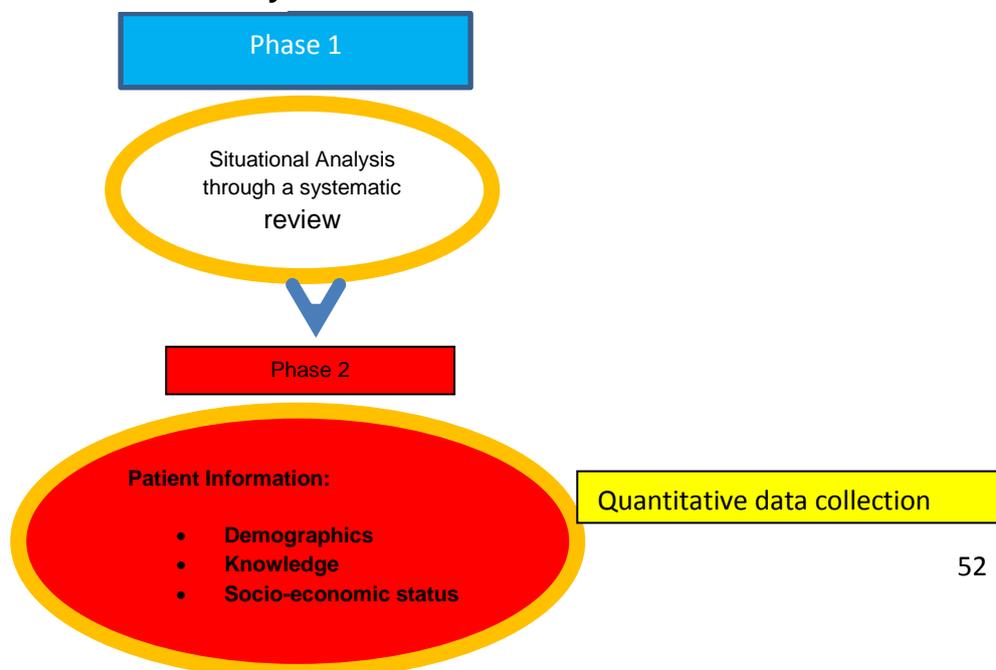
### **3.6 LIMITATIONS OF STUDY**

This review had several limitations. Because only English language articles were included, it is possible that this review was a not complete representation of the available evidence. In addition, the databases accessed were limited to those available at a single institution and could therefore present a publication bias. As both qualitative and quantitative articles were included, it was difficult to compare the results of the studies.

## INTRODUCING CHAPTER FOUR

In order to understand how to address these impediments, it is important to understand the profile of patients accessing the service and the amount of service received (Figure 4.1). In the previous chapter the personal factors of the ICF was used when considering barriers and facilitator to rehabilitation services. Understanding personal factors is important according to the ICF because it provides a comprehensive picture of the clients. This indicates that it is important to understand the profile of patients attending / accessing rehabilitation services in the South African context in order to understand and employ the best mode and type of service delivery. In addition if we want to move towards patient-centred care taking, consideration of the clients' personal situation is important. Currently the profile of patients accessing rehabilitation services and the component of rehabilitation service accessed is not well documented. The aim of this chapter was to determine the profile of patients accessing rehabilitation services, including the types of services and how often they were accessed. This chapter thus aims to answer the question: What is the profile of patients with disabilities accessing rehabilitation services and which service is accessed and how often?

**Figure 4.1: Phase 2 of the study**



## **CHAPTER FOUR: PROFILE OF THE PATIENTS**

### **PROFILE OF AND SERVICES TO PATIENTS WITH DISABILITIES ACCESSING REHABILITATION SERVICES IN WESTERN CAPE PROVINCE**

#### **4.1 BACKGROUND AND LITERATURE**

The profile of the client base accessing health services plays a major role in contributing to the development and implementation of health related policies. One of the goals of the South African government after the 1994 elections was to meet the basic health needs of all South Africans. The Department of Health's Policy on Quality in Healthcare (Department of Health, 2007) states that public services need to respond to customers' needs, wants and expectations. The health of patients in South Africa depends largely on the primary health level of care, as it is the first-line entry for healthcare services. Primary healthcare is an approach to care that emphasises health promotion and illness prevention includes diagnosis and treatment, as well as provides links to care at secondary and tertiary levels. Providing rehabilitation services in the context of PHC involves a multi-disciplinary approach in the management of people with disabilities. In order for specialised rehabilitation services to meet the needs of the client base and to form an effective link with primary healthcare, it is vital that these services provide the range of different professional services required.

South African health policies afford high priority to the development of PHC services located close to the people, with the emphasis on preventive and promotive services. PHC entails providing 'essential healthcare', which is universally accessible to individuals and families in the community and accessible from where people live and

work (WHO, 1978: Declaration of Alma-Ata). PHC was intended to be the foundation of the national healthcare system, with a sustainable long-term relationship between interdisciplinary healthcare teams and clients (Bonnie, Brent, Ken & Philip, 2007). Aligned with these policies, a major thrust of successive state plans has been to provide improved medical care to the rural sector (Martinez *et al.*, 1995; Peters *et al.*, 2002; Government of Orissa, 2004). There are, however, concerns regarding the utilisation of services by patients. Primary Healthcare Centres (PHCCs) are sometimes staffed with a single doctor and a few clinical nurse practitioners. These centres were developed to receive referrals from four to eight clinics within the catchment area. The district and regional hospitals provide significant numbers of in-patient beds and specialist facilities. The rationale is to deliver basic, low-cost medical care, effectively and efficiently, at the local level, with the option for upward referral for more complex conditions (World Bank, 1997; Peters *et al.*, 2002). Within this PHC approach, there are four key strategies, namely prevention, curative, promotive and rehabilitative services. Rehabilitation services therefore form an integral part of the operational level of primary healthcare.

According to Zere and McIntyre (2003), the positive aspects of post-apartheid health policies include accessibility, reporting of illness in early stages, and the recruitment of doctors from other countries. However, substantial inequities remain in self-reported illnesses, injuries, disabilities, and the use of services, which still favour the rich in South Africa. Redressing these inequities will take considerable effort to change policy. Ramklass (2009) highlights that the introduction of PHC created an opportunity for the transformation of health services at the primary level of care. The introduction of PHC came as an alternative approach to going straight to a hospital, aimed at equity in health for all South Africans. Equity was previously compromised

by the fragmented and divided services available, which meant that many South Africans did not receive help at healthcare centres (Ramklass, 2009).

South Africa's most recent attempt to address rehabilitation services is encapsulated in the National Rehabilitation Policy (Department of Health, 2007), which was designed to improve services for all people, including those with disabilities (Department of Health, 2000). With the focus on the needs of individuals, families and populations, there is a shift from the medical model, in terms of which people with disabilities were disempowered, to a social model, which "implies that the reconstruction and development of our society involves a recognition of and intention to address the developmental needs of disabled people within a framework of inclusive development" (South Africa, 2007:22).



A shift in the delivery of healthcare from hospitals to the community, and an acute shortage of health professionals, have placing increased demands on the South African health system. In order to meet these demand, and to strengthen the South African PHC system, with a specific emphasis on rehabilitation services, it is important that policy makers, together with service providers and patients, look at ways to enhance the delivery of interdisciplinary and collaborative PHC services. Eldar (2000) argues that PHC teams need to integrate rehabilitation into their day-to-day work, offer rehabilitation services in the PHC environment, and coordinate disability services at community level. Establishing rehabilitation services in PHC settings could result in several positive outcomes, including increased levels of satisfaction with services among patients and decreased waiting times for access to services; greater continuity of care for people with disabilities (Eldar, 2000); and

improved client-related outcomes, such as quality of life, participation in activities, and health status (Tyrell & Burn, 1996; Stanley *et al.*, 2001).

Rehabilitation services, including physiotherapy and occupational therapy, are based on a philosophy that interdisciplinary teamwork and a holistic, client-centered approach are keys in successful outcomes in disabling conditions (McPherson *et al.*, 2002). Literature has indicated that nurses' contribution within rehabilitation should aim to maximise patients' choices, to enhance independent living in their home environment (Long *et al.*, 2002). The authors further state that at a practice level, the nurses' role must be valued and recognised, both by the nurses themselves and other team members. The challenge of how to organise and deliver PHC services is not clearly understood and remains a key issue facing South African health policy makers. The real test of the health system in South Africa is whether it delivers quality care equitably to all, and specifically to disadvantaged groups, such as those with disabilities. In addition, with the move to a patient centred approach it is important to understand the profile of patients. According to Hoffman (2010), in order to ensure progress, many proposed policies imply that we need a better understanding of where efficiency gaps exist and how to deploy existing resources more effectively to improve quality. In addressing the gaps, understanding the client profile and needs is a key indicator of success in any form of service delivery, and is therefore a key component of such a test. Obtaining this information can be made possible through an audit process. According to M'Kmbuzi, Amosun and Stewart (2004:1111), 'audits have been conducted in various clinical disciplines but to a lesser extent in rehabilitation care.' This study thus aimed to contribute to the gap in knowledge on the capacity of rehabilitation services in South Africa to provide services that match the profile of patients with physical disabilities. The study was

carried out in 2010 among patients attending three rehabilitation centres in the Western Cape.

## **4.2 METHODOLOGY**

### **4.2.1 Research design**

A descriptive, quantitative study design, using retrospective data was used in this study. A descriptive research design involves observing and describing the behaviour of a subject, without influencing it in any way (Kerlinger, 1986). It gives direction to healthcare service delivery in health education and the evaluation of community health services (Mahasneh, 2001). The researcher chose to carry out a descriptive study because studies of this kind are accurate and precise (Babbie & Mouton, 2006). They provide baseline data on which other studies can be built. The outcome of this study design allows the researcher to make inferences about the population from which the sample was drawn (Currier, 1979). Quantitative research methods are used to gather facts that can be captured in numerical format and analysed through statistical methods. Responses are easily aggregated for analysis, because they are systematic and easily presented in a short space of time (Hicks, 1995).

### **4.2.2 Research setting**

Three rehabilitation centres were purposefully selected to be part of this study in the Western Cape Province. They were chosen from different districts within the Western Cape so as to represent different types of services offered at the rehabilitation centres. These centres have different types of rehabilitation professionals, with some health professionals available in one centre and others not

available at other centres. Table 4.1 below illustrates the availability of the rehabilitation health professionals at the various centres.

**Table 4.1: Available rehabilitation health professionals at selected rehabilitation centres**

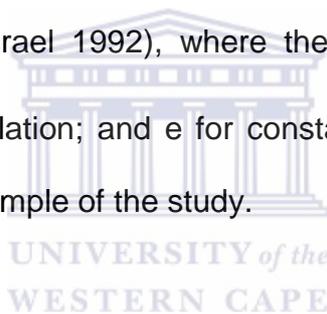
Rehabilitation health professional	Centre A	Centre B	Centre C
Physiotherapist and students	Available	Available	Available
Occupational therapist	Available	Available	Available
Orthopaedic nurse	Available	No service	Available
Doctor and students	Available	Available	Available
Social worker	Available	Available	No service
Clinical nurse practitioner	Available	Available	Available
Health promoter	Available	Available	No service
Volunteer	No service	Available	No service
Home-based carer	Available	Available	Available
Speech therapy students	No service	No service	Available
Speech therapist	No service	Available	No service
Dietician	No service	Available	Available
Psychologist	No service	Available	No service
Radiographer	Available	Available	Available
Pharmacist	Available	Available	Available

#### **4.2.3 Population and sampling**

A list of patients was identified from the physiotherapy statistics book, in which the researcher traced those patients who had physical disabilities. All the patients who went through physiotherapy had hospital folders. The records of the patients comprised mainly physiotherapy and doctors' notes. The researcher wrote down all the identified folder numbers and then screened the folders to determine if the

patients were suitable for the study. A total of 370 records of patients who presented with physical disabilities were selected (106 from Centre A; 150 from Centre B; and 114 from Centre C).

As this was a retrospective study, all the 2009 records were screened for the following common conditions: amputations, head injuries, cerebro-vascular accidents (strokes), musculoskeletal injuries, fractures, osteoarthritis, and spinal cord injuries. The records were then stratified by condition. Patients who were still receiving rehabilitation services, and those who did not comply with the service, were excluded from the survey. The researcher used a data capturing sheet to collect data. The Yamani formula  $n = \frac{N}{1 + N(e^2)}$  (Israel 1992), where the letter n stands for the study sample; N for the study population; and e for constant error = 0.05, was used for each condition to obtain the sample of the study.



#### **4.2.4 Data collection methods and analysis**

Piloting of the data capturing sheet was done at a rehabilitation centre that functioned similarly to the selected ones, and information that was found missing from the data sheet was added before the study commenced. This process assisted the researcher in screening all the records and not leaving out information needed from the records. The data were entered and cleaned by two data capturers in SPSS version 17 and Microsoft Excel. A double entry system was used for quality assurance. Descriptive statistics data analysis was performed in order to convert independent variables into frequencies and percentages. Descriptive data analysis was presented in figures and tables.

## **4.3 RESULTS**

### **4.3.1. Profile of patients**

Of the 370 records of participants in the sample, 43% were male and 57% were female, with a mean age of 51.2 years (SD=14.4). The patients' ages ranged from 18 to 93 years. The characteristics of the participants are presented in Table 8 below. The most common health conditions were neuromusculoskeletal problems, stroke and fractures. The three rehabilitation centers differed in the number of patients who presented with the different types of health conditions. Rehabilitation Centre A presented mostly with neuromusculoskeletal conditions, with a minority being spinal cord injuries. Rehabilitation Centre C presented mostly with stroke patients, with the least common condition being spinal cord injuries. Finally, patients at Rehabilitation Centre B presented mostly with neuromusculoskeletal injuries, with the least common condition being head injuries. Overall, patients in this study presented mainly with neuromusculoskeletal injuries (n=117), while the least common conditions were head injuries (n=5) and spinal cord injuries (n=5). Rehabilitation professionals who were mostly seen by patients were physiotherapists (n=365) and doctors (91), while the rehabilitation professional least seen was a social worker (n=4). No patients were seen by the psychologist, dietician or prosthetist at this level of care. Table 4.2 below reflects the characteristics of the participants.

### **4.3.2 Overall sessions of management per disability with different rehabilitation professionals**

Patients' sessions with different rehabilitation workers differed from 0 – 23 sessions. Table 4.3 below reflects the sessions that patients had with different rehabilitation professionals. It is noticeable in Table 4.3 that the large majority of patients (n=365)

underwent physiotherapy, with an average of one visit, while the majority of patients did not receive services from any of the other rehabilitation professionals, such as social workers, nurses and speech therapists. Looking at this table, most patients did not receive a holistic rehabilitation service, as they had not consulted most of the rehabilitation professionals.



**Table 4.2: Characteristics of the participants**

<b>Variable</b>	<b>N</b>	<b>%</b>
<b>Gender</b>		
Male	159	43%
Female	211	57%
<b>Types of conditions</b>		
1 Head injuries	5	1%
2 Spinal cord injuries	5	1%
3 Amputation	17	5%
4 Osteoarthritis	54	15%
5 Fractures	80	21%
6 Stroke	95	26%
7 Neuromusculoskeletal conditions	114	31%
<b>Number of participants who visited rehabilitation professionals</b>		
Physiotherapists	365	99%
Doctors	91	25%
Pharmacists	72	19%
Occupational therapists	48	13%
Speech therapists	12	3%
Radiographers	10	3%
Nurses	5	1%
Social workers	4	1%

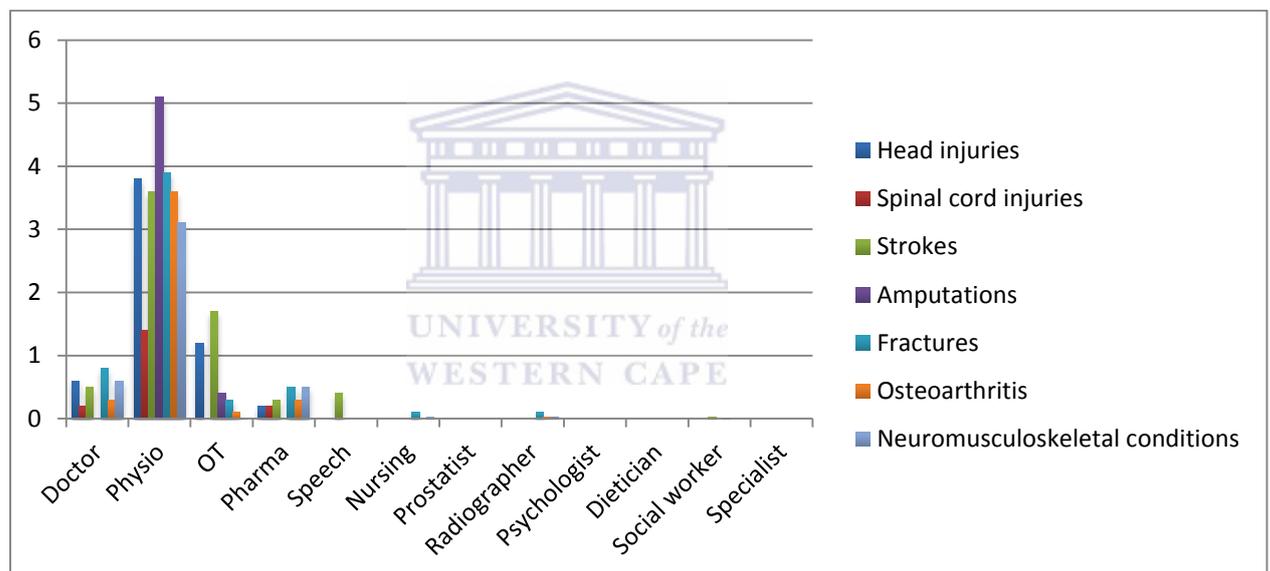
**Table 4.3: Sessions that patients had with different rehabilitation professionals**

<b>Rehabilitation professional sessions</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>16-23</b>	<b>Total</b>	<b>Ave</b>
Social worker	366	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0.01
Nurse	365	3	0	1	0	0	1	0	0	0	0	0	0	0	0	0	5	0.01
Speech therapist	358	4	2	2	3	0	0	0	1	0	0	0	0	0	0	0	12	0.03
Occupational therapist	312	10	6	11	3	2	7	1	3	1	1	0	2	0	1	0	48	0.13
Pharmacist	297	36	19	9	5	4	0	0	0	0	0	0	0	0	0	0	73	0.19
Doctor	278	52	16	9	3	5	1	4	2	0	0	0	0	0	0	0	92	0.25
Physiotherapist	5	117	71	43	27	25	34	9	12	8	4	2	2	4	0	3	365	0.98

### 4.3.3 Mean number of sessions with rehabilitation professionals per type of disability

Some rehabilitation professionals had no opportunity to consult with patients with physical disabilities at the rehabilitation centres, as patients were not exposed to a variety of rehabilitation professionals during their visit(s) to the primary healthcare centre. Figure 4.2 below describes the type of disability and mean number of sessions with all the rehabilitation professionals present at the centre.

**Figure 4.2: Mean contact sessions with health professionals**



The mean number of sessions with different rehabilitation professionals varies across the disability types. This variation could, however, largely be explained by variation in the dominating profession, i.e. physiotherapists. This shows a gap in rehabilitation service delivery. If radiographers were seen by few patients, one wonders how physical disability was confirmed for the patients who presented with physical disabilities. Nurses are seen as first-line professionals. Based on this figure, very few patients consulted nurses with regard to physical disability. Physiotherapists and

doctors saw most of the patients, and the question remains: why were patients not exposed to all rehabilitation professionals?

#### **4.4 DISCUSSION**

One of the objectives in this chapter was to explore the need for rehabilitation professionals in PHC rehabilitation settings. By highlighting the profile of patients visiting these rehabilitation centres and linking the health professionals accessed during these visits, the gap in rehabilitation service delivery will be highlighted and consultation of patients by rehabilitation professionals will also be highlighted.

##### **4.4.1 Profile of the patients**

Information gathered from the patient records allowed the researcher to gather information about gender, type of disability and type of rehabilitation professionals consulted, as well as number of sessions with them. However, because patients with various disabilities can represent a significant societal burden, it is important to understand the profile of patients in order to ensure that limited healthcare resources are allocated appropriately. According to Willems *et al.* (2012), many patients may benefit from intensive rehabilitation, however given the strain on the health system, it is not cost-effective to offer in-patient rehabilitative care to all patients, and thus understanding their profile and services needed could help determine adequate guidelines for referral to out-patient treatment vs in-patient rehabilitation. The results of this study may be used to estimate the number of rehabilitation sessions patients with different physical disabilities may require at an out-patient level.

Although there seemed to be information lacking from the folders it was evident that patients were not consulting all relevant rehabilitation workers. What was highlighted

in this study was the under-utilization of some of the rehabilitation professionals, although the conditions of the patients indicated the need for rehabilitation teams. Expectations of service delivery at the primary level of care were to ensure that all the needs of people who presented with disabilities were met. Patients that visited these rehabilitation centres were not given the opportunity to be referred/seen by relevant rehabilitation professionals for the types of disabilities with which they presented. Eldar (2000) emphasizes that when patients present at the PHC centre with a disability they should be consulted by the full rehabilitation team, however this was not the situation in this study. Specifically, literature highlights the role of nurses (Long *et al.* 2000) in the primary healthcare setting, and thus emphasizes the need for them to motivate and advise patients about options that they have when visiting the health centres. In this study, nurses were only consulted by 5% of the patients. This means that in most cases no motivation or consultation options were given to the patients to improve their health status. Tucker *et al.* (2009) also highlights the role of nurses with regards to patient health records as an important one. These authors emphasize that each patient record should contain the following information so as to be clear about what information is available to describe the patient: admission, referral and discharge document; patient profile; adult vital signs assessment; care plans; and multi-professional continuation notes and variance records. This means that if some of this information is not included in patient records there is a problem with the system used for record keeping, as identified at the rehabilitation centres in this study. In the review of patient files in the current study it was evident that there was not good record keeping.

#### **4.4.2 Availability of human resources**

Effective rehabilitation depends on inputs from a variety of skilled multi-professional team members. The selected rehabilitation centres had most of the rehabilitation professionals but lacked a number of allied rehabilitation professionals. The results indicate that some professionals are not available at the rehabilitation centres and others are underutilized for rehabilitation services. According to the National Rehabilitation Policy document, there must be an appropriate allocation of resources (financial and equipment) so that all individuals, including health professionals, can access the resources allocated to them. This document also emphasizes that all people should experience equality, especially those with disabilities, so that they can easily access all services available to them (Department of Health, 2000). There is also a need for resources within the rehabilitation centres to be available, and the roles of all health professionals should be properly understood by the full medical team. This study has shown that although clients with physical disabilities did have access to some of the rehabilitation services, they did not access all the rehabilitation health professionals that could be accessed by those with the conditions highlighted. This indicates a gap in service delivery at a primary level of care that aims to meet the needs of the majority of the population. Rehabilitation team members at the selected rehabilitation centres need to be reviewed so that patients visiting these centres will receive holistic rehabilitation care. The primary level of care service is meant to be accountable for the health needs of patients at large, have relationships with patients and engage family members and the community at large with health issues (Burnett et al., 2007).

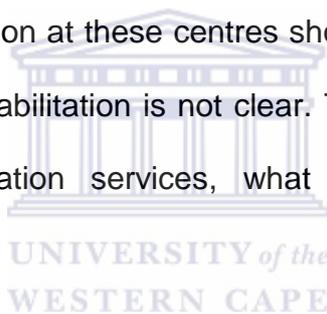
The fact that some rehabilitation professionals were not available at some of the centres on a full-time basis, such as speech therapists, occupational therapists,

dieticians and psychologists, had an impact on why other health professionals, such as physiotherapists and doctors, were the most consulted rehabilitation professionals. It is also noted that nurses, radiographers and social workers each saw fewer than 2% of the total number of patients. If these rehabilitation professionals are underutilised at primary healthcare centres, then the need for such rehabilitation services at this level of care will be ignored, affecting the creation of rehabilitation posts. The South African government experiences challenges around budgetary constraints, while shifting services from tertiary institutions to the PHC level, as well as the migration of health professionals, and poor staff motivation (Theunis, Van Rensburg & Claasens, 2006). Community health centres in South Africa are seen as first-line centres for all patients who are in need of health services. The Western Cape Department of Health (WCDoH, 2003) has proposed that rehabilitation programs should at least have a physiotherapist, an occupational therapist, a nurse, speech therapist and therapy assistants to provide continuity of care. This study has revealed large gaps in access to various types of rehabilitation professionals, with the consequence that most patients visited only one or two rehabilitation professionals. The domination of physiotherapy, with medical doctors as the second most common professional category, may indicate that the level of rehabilitation in the participating centres was relatively narrow. This may imply that many rehabilitation patients miss out on a particular service from which they could have benefitted.

#### **4.4.3 Referral**

Linked to the diagnosis of physical disabilities, associated complications affect patients' psychological, physical, mental and emotional health (Collingwood, 2012). This implies that there is a need for patients to be referred to a range of appropriate rehabilitation professionals during the rehabilitation process. However, if this practice

is to be sustained, availability of healthcare professionals at all levels of care is vital. Currently, the most commonly seen health professional is the physiotherapist, and it raises the question of whether physiotherapists at other levels of care are adequately referring patients to the necessary health professionals at the primary level of care. Long *et al.* (2002) have indicated that nurses' contribution within rehabilitation should allow patients to make choices of treatment, to enhance independent living within their future environment. These authors further state that, at a practice level, nurses' role must be valued and recognized, first by the nurses themselves and also by other team members (Long *et al.*, 2002). The nurses in this study were underutilised in respect of rehabilitation services, as less than 2% of patients with physical disabilities consulted them. The situation at these centres shows that nurses' role at the primary level of care related to rehabilitation is not clear. The question arises that if they are underutilised for rehabilitation services, what role they are playing at these rehabilitation centres.



#### **4.4.4 Sessions of treatment**

In this study, physiotherapists recorded high mean session scores, compared to other rehabilitation professionals, with all patients being seen by at least a physiotherapist. Very few patients were also seen by nurses, who are the first-line practitioners that patients should consult when entering a community rehabilitation centre. Long *et al.* (2002) have identified the role of nurses as significant in rehabilitation processes, as they play a supportive role to patients who are undergoing therapy. As first-line practitioners in the rehabilitation process, nurses should direct patients to relevant rehabilitation professionals to ensure that they receive input from all the relevant rehabilitation team members. De Wit *et al.* (2007) have noted that physiotherapists and occupational therapists spend less time than expected with patients, and some

activities that are supposed to be included in the treatment sessions are not included. These rehabilitation professionals use a tool to tick what was covered in the treatment session, therefore, in their tick list some activities were not done due to time constraints. Van Langeveld *et al.* (2011) recorded similar outcomes to this study in respect of the mean number of sessions, with patients treatment sessions varying between different rehabilitation professionals. Van Langeveld *et al.* (2011) also contends that the focus on treatment is not sufficiently widespread to cover what is needed to be covered in the treatment sessions. This makes the rehabilitation process difficult, as the progress of the patients is not comprehensive as expected.

#### **4.5 CONCLUSION**

The profile of patients that was presented in this study did not present socio-economic status of the patients, employment history and in-depth history of the type of disability. The lack of this information was due to the lack of information present in files and this ultimately would influence recommendations that could be made relevant to patient profiles and access to rehabilitation services. Rehabilitation professionals at the primary level of care in this study appeared to be underutilised, and there seemed to be a gap in the rehabilitation centres with regard to human resources to ensure that patients receive the full input from rehabilitation team members. Patients with physical disabilities go through psychological, physical, mental and emotional stresses, which require input from a range of healthcare professionals. If some of the rehabilitation professionals are not consulted, the question arises as to whether the rehabilitation process is adequate for these patients. Stroke patients (n=95), which ere the majority of patients seen in this study, need to be managed by a multi-disciplinary rehabilitation team to ensure their

successful rehabilitation. Without a full rehabilitation team at the primary level of care, patients will miss out on a holistic rehabilitation process. It is thus evident that although rehabilitation service is essential, it is currently not extensively utilised at PHC level and fails to reach many people in need due to a lack of resources. By checking patients' folders, the researcher was able to identify who consulted the clients during the rehabilitation process, noting that some of the rehabilitation professionals were not available, while others were underutilised. Patient records did not have all the information of the patients who attended these rehabilitation centres. This lack of information in patient records caused limitations in gathering information that could provide more information about patients who attend rehabilitation services. Thus this study highlighted that in order to realise a primary care oriented vision there is a need for more health professionals.

#### **4.6 IMPLICATIONS FOR PRACTICE**

The profile of the patients that was presented in this study was not an accurate profile, as a result of information in patients' folders. This highlights the need to emphasise the importance of record keeping. Literature has indicated that the lack of basic health data renders difficulties in formulating and applying a rational for the allocation of limited resources that are available for patient care and disease prevention (Bali *et al.* 2011). All the information that was gathered is presented in Tables 8 and 9, and this demonstrates a gap in record keeping. Also it was noticed that patients that go through a rehabilitation process are not getting the opportunity for a holistic rehabilitation service, whereby all rehabilitation professionals get consulted by those patients presenting with physical disabilities. More patient load and strain is put on physiotherapists and doctors, which is not a true reflection of

rehabilitation team members, meaning that some of the rehabilitation team members are overloaded with patients and others are underutilised.

#### **4.7 LIMITATIONS**

The limitations of this part of the study included:

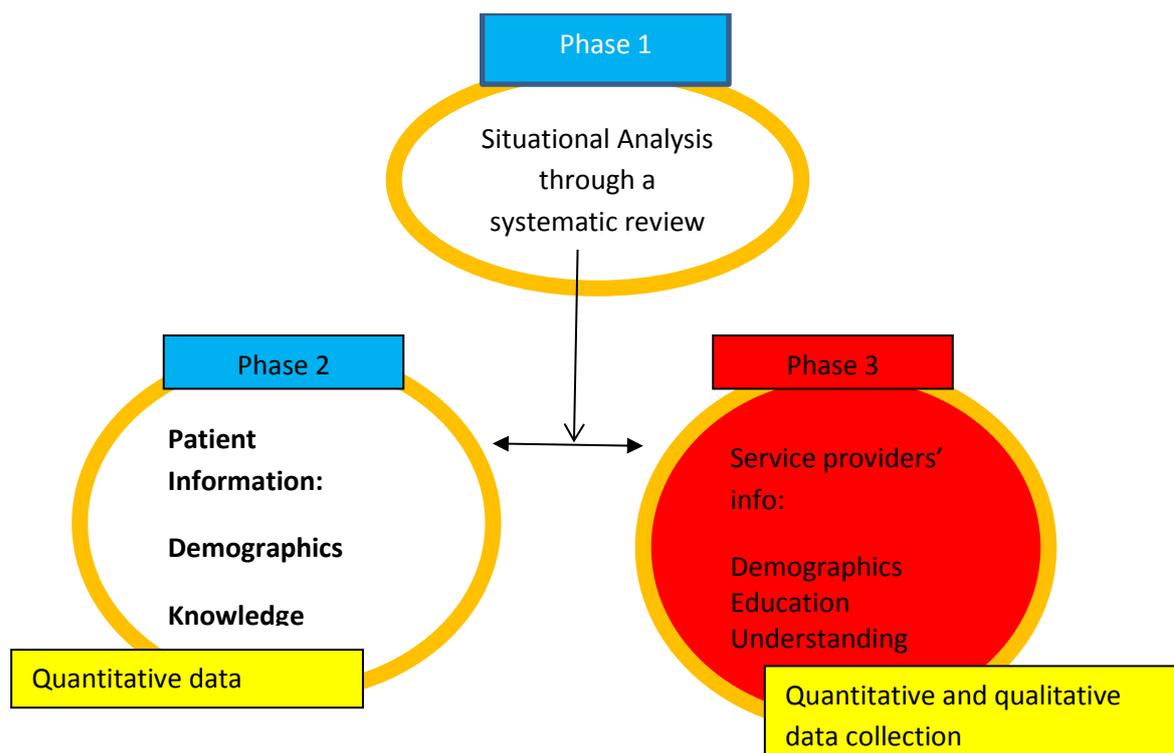
1. The quality of the records and information documented, in which information on socio-demographics and co-morbidity diseases were found lacking.
2. In-patient folder notes varied and lacked detail depending on the health professional consulted.
3. Accessing in-depth patient information from folders of different rehabilitation professionals.



## INTRODUCTION TO CHAPTER FIVE

The previous chapter focussed on identifying the patients accessing rehabilitation services and the types of services accessed. Although a challenge was experienced with poor record keeping, there was evidence of underutilisation of rehabilitation services. Thus Chapter Five focuses on determining the profile of the service providers and their knowledge and understanding and experience of implementing the national rehabilitation policy (Figure 5.1). Service providers are expected to be knowledgeable people in the field of practice, and circumstances under which they work will indicate how they are delivering the service. Service providers in this study were key role-players of service provision as patients and caregivers would always have to say something about them regarding service delivery. This chapter will highlight the type of service providers that are forming part of rehabilitation team and how they express their experiences of working in the field of rehabilitation.

**Figure 5.1: Phase 3 of the study**



## **CHAPTER FIVE: PROFILE OF SERVICE PROVIDERS**

### **PROFILE OF SERVICE PROVIDERS AND THEIR SATISFACTION WITH THE PROVISION OF REHABILITATION SERVICES IN THE WESTERN CAPE**

#### **5.1 INTRODUCTION**

According to Henderson and Tulloch (2008) and Pakenham-Walsh and Bukachi (2009) healthcare professionals play a crucial role in service provision. Hence it is important to make sure that their knowledge, skills and attitudes are sound in order to ensure good quality service. Factors which may influence the provision of services include patients' bad behaviour, challenges with administration duties such as: lack of clear policies, bureaucracy and complicated government rules, unclear demarcation of duties and responsibilities, and undone responsibilities (Cockcroft *et al.*, 2011). On the other hand Gilson, Palmer and Schneider (2005) reported that healthcare providers who do not deliver good service are doing so because they feel undervalued and are mistreated by their employers. According to Henderson and Tulloch (2008), the knowledge, attitude and beliefs of health service providers are important confounders for quality service delivery.

In their interaction with clients, the role of healthcare providers is important. When patients visit healthcare centres there is an expectation that they will be provided with information to make informed decisions about their health. According to Chen and Yang (2009:139), rehabilitation service providers are "direct service providers as well as supportive and consultative service that provides management of neuromuscular and musculoskeletal disorders that alter functional status". The authors further state that rehabilitation services can be provided by therapists alone or only doctors or ideally by a comprehensive rehabilitation team. The process of rehabilitation thus

involves the sharing of the expertise and knowledge of the various team members with their patients and their families.

According to Eldar (1999), in understanding the quality of care in the rehabilitation process, inferences can be made about quality of care using three areas, namely structure, process and outcome of care. The role of structure is important and includes aspects such as physical resources and human resources (their education, training, experience and staffing ratio). When one refers to structure what comes to mind is the building. Space to do your duties is vital so that one is able to move around to accommodate both service providers and patients. This may lead service provider to cover all that is necessary during assessment. This will lead to positive outcomes for both patients and service providers.

Qualified service providers are vital to the success of health systems and are often neglected. According to Henderson and Tulloch (2008), various factors may contribute to the shortage of skilled service providers and these include “a lack of effective planning, limited health budgets, migration of health workers, inadequate numbers of students entering and/or completing professional training, limited employment opportunities, low salaries, poor working conditions, weak support and supervision, and limited opportunities for professional development”. These authors emphasise the importance of making sure that during service delivery all important resources must be in place, and these will motivate service providers to do their duties freely. Minimal resources demotivates the people working in the environment hence satisfaction will be compromised.

According to Gupta *et al.* (2011), there remains a need to enhance accessibility to health services and one of the main aspects that needs attention is the constraints related to human resources. Within the health plan and national rehabilitation policy,

the issue of health professionals for rehabilitation is not adequately addressed (DoH, 2000). The 2010 healthcare plan has highlighted the need to ensure a qualified workforce in order to improve access to quality healthcare. With regards to the 2020 healthcare plan focussing on a patient centred approach to healthcare, healthcare professionals who are experienced would be able to drive this approach. However, gaining insight into the understanding of how healthcare providers perceive quality of care is important.

In the previous chapter, the researcher identified that people with disabilities are in need of health and rehabilitation services. In addition, it is evident that rehabilitation services for people with disabilities still experience challenges. A study by Cockcroft *et al.* (2011) clearly highlighted how the negative experiences of service providers can influence service delivery if not addressed. The rehabilitation process requires rehabilitation professionals to be available to ensure good service delivery and effective outcomes. Rehabilitation professionals primarily comprise of the following rehabilitation professionals: physiotherapists, occupational therapists, doctors, nurses, social workers, psychologists, pharmacists, radiographers and counsellors.

In South Africa, the development of the National Rehabilitation Policy (NRP) in 1997 was based on underdeveloped services in areas where rehabilitation existed, and where there were no rehabilitation services especially in the rural areas. Development of this policy involved different stakeholders, including people with disabilities (PWDs) (Department of Health, 2000). The policy was developed based on a situation analysis which indicated that rehabilitation services were inaccessible to PWDs, as most of the services were institution based and also the services were not satisfying to the users of the service. Dissatisfaction with the services was due to the shortage of rehabilitation professionals willing to work in disadvantaged areas. During the

period 1996 to 1998 there was a marked increase in the number of rehabilitation professional posts to encourage those who were still training to get posts in those disadvantaged areas. The policy aimed to ensure that rehabilitation services would be accessible, acceptable and affordable for people with disabilities at all levels of care. Hence the aim of this section of the study was to determine the profile of service providers providing rehabilitation services to people with disabilities, and to explore their experiences of rehabilitation services. This will assist to know who is allocated to run rehabilitation services in the Western Cape and identify the gaps if any in the rehabilitation service.

## **5.2 METHODOLOGY**

### **5.2.1 Research Design**

A descriptive quantitative and qualitative framework was applied. Information regarding the demographic profile of service providers was obtained from the rehabilitation professionals at the selected rehabilitation centres, whilst the qualitative data focussed on their perceptions of service delivery.

### **5.2.2 Population and sampling**

The study population included all rehabilitation service providers (N=82) working at the selected rehabilitation centres, and 43 purposefully selected rehabilitation professionals participated in the study for quantitative data. De Vos *et al.* (2005) emphasise that volunteer sampling refers to a method of sampling in which the participants volunteer to participate in a research study. Silverman (2000) as cited in De Vos *et al.* (2005:330) add that the significant advantage of using volunteer sampling is that the respondents will provide accurate and relevant information for the

study. The qualitative phase applied purposive sampling and targeted representation of the population. Altogether, 16 participants were targeted for in-depth interviews.

### **5.2.3 Data collection methods**

Data was collected via two methods. The demographic data and satisfaction with service provision was collected using a questionnaire (see Appendix L). The questionnaire was taken to an expert in the field of rehabilitation at Western Cape Rehabilitation Centre for content validity, and it was distributed to all members of the SANPAD project to test for face validity. Discussions regarding how the tool should look went on for two weeks among the group members and in the third week all the members rechecked it again for clarity. All service providers who were willing to participate in the study read the information sheet and signed a consent form. They filled in the questionnaire, which took them approximately 10 minutes to complete. Data was kept in a locked cupboard where only the researcher was able to access it. In addition, service providers who consented following completion of the demographic questionnaire were purposefully selected to be interviewed by the researcher. There were 16 rehabilitation professionals who agreed to participate in in-depth interviews. Data was collected by means of semi-structured interviews (see Appendix N). The interviews lasted an average of 45-60 minutes. During the interview, the researcher reflected on the comments made by the participants and highlighted the main concepts in order to ensure that the information obtained was correct.

#### **5.2.4 Data analysis**

All the quantitative data were captured on an Excel sheet and then imported into SPSS version 21. Two data capturers were asked to capture data on the Excel sheet in order to ensure that the data was clean. Descriptive analysis of the quantitative data was done using frequencies and percentages.

The information from the interviews was transcribed verbatim and pre-determined themes were identified from the interviews, and sub-themes to support the themes were identified. The researcher identified an independent person who was an expert in qualitative research to analyse the data for sub-themes in order to correlate the information identified by the researcher. The researcher and the independent researcher came together to check if the themes identified were similar. The interviews were analyzed using Braun and Clarke's (2006) six-phase guide to conduct a thematic analysis. Thematic analysis is seen as a basic method for qualitative analysis and encompasses everything from identifying, analyzing and reporting patterns within data. Phase one involves familiarizing oneself with the data, phase two requires the generating of initial codes. The next step is the search for themes in the transcripts. The researcher then also reviewed these themes under consideration and then defined and named the themes. Lastly, the report is produced based on the first five steps of analysis.

### **5.3 RESULTS AND DISCUSSION**

#### **5.3.1 Socio-demographic information of service providers**

Of the 82 service providers targeted at the centres, 43 service providers volunteered to participate in the study, yielding a response rate of 52%. Table 5.1 illustrates the socio-demographic information of the service providers. The majority of the participants was female (84%) with a mean age of 36 years (SD=12.50 years). Their

ages ranged from 23 years to 64 years. Amongst the service providers their years of working experience ranged from less than 1 year to 44 years with a mean of 12.6 (SD=12.6). Years of experience in rehabilitation amounted to a mean number of eight years (SD=10.0). Most of the participants were doctors (n=19) followed by the nursing category (n=13). Other disciplines such as physiotherapists, occupational therapists, social works etc. accounted for 12 of the participants.

The majority of participants (52%, n=22) were young, lacked experience (1-5 years) in rehabilitation and were at the lower scale of payment (n=14), as they were new in the field of work and were still learning the process of rehabilitation. Considering the age and years of experience of the service providers with rehabilitation service, it poses the question of whether service providers were clear on how rehabilitation is implemented at these centres. Cockcroft *et al.* (2011) strongly believe that if there are complications within government rules and unclear demarcations of duties, service delivery will be affected. In addition, if the service providers lack experience with rehabilitation provision, the impact on the patients will mean that the outcomes of rehabilitation for patients presenting with disabilities will be poor.

**Table 5.1: Socio-demographic information of service providers**

Variable	N	%
<b>Gender</b>		
Male	7	16%
Female	36	84%
<b>Age</b>		
20-30 years	22	52%
31-40 years	6	12%
41-50 years	8	19%
>50 years	7	17%
<b>Profession</b>		
Doctor	19	44%
Nurse	5	12%
Physiotherapist	3	8%
Occupational therapist	4	9%
Speech therapist	1	2%
Social worker	1	2%
Dietician	1	2%
Orthopaedics sister	1	2%
Clinical nurse practitioner	7	17%
Health promoter	1	2%
<b>Salary level</b>		
Level 6	5	12%
Level 7	9	21%
Level 8	9	21%
Level 9	14	33%
Level 10	4	9%
Level 11	2	4%
<b>Years at current institution</b>		
1-5	32	74%
6-10	5	12%
11-15	1	2%
16-20	1	2%
21-25	3	8%
> 25	1	2%
<b>Years in rehabilitation</b>		
1-5	27	64%
6-10	4	9%
11-15	5	12%
16-20	1	2%
21-25	2	4%
>25	4	9%

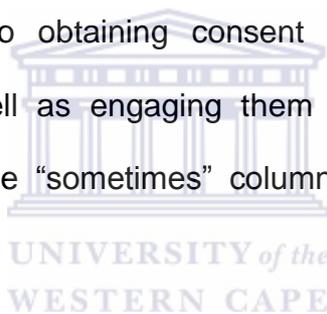
### 5.3.2 Service delivery and provider satisfaction

Service delivery is measured by satisfaction with the service received. To guide this process, the primary goal of the National Rehabilitation Policy was “to improve accessibility to all rehabilitation services in order to facilitate the realization of every citizen’s constitutional right to have access to health services” (DoH, 2000:2). This goal is in line with the UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities, where families, persons with disabilities and communities must be involved in the rehabilitation process. The service providers in this study were thus asked about their understanding of the NRP and UNCRPD, as well as to measure their service delivery by answering questions that focused on their relationship with patients and their satisfaction with service delivery. With regards to the policies, the participants had no knowledge about the policies and their implementation strategies. However the researcher continued to explore current practices amongst the service providers as well as their understanding of the process of rehabilitation services.

Table 5.2 below highlights how service providers rated their service delivery to their patients. The results highlight an area that needs further investigation if we are to move towards a patient-centred approach to healthcare. According to Coulter (2002: 648), “patient-centred care is the concept of 'informing and involving patients, responding quickly and effectively to patients' needs and wishes, and ensuring that patients are treated in a dignified and supportive manner”.

Key aspects that emerged were obtaining informed consent from patients and also respect for patients. According to Wakefield (2011), one aspect that is central to patient-centred healthcare is informed decision making. As informed decision-making is the two-way communication process between a patient and one or more health

practitioners, it highlights that “a patient has the right to decide what is appropriate for them, taking into account their personal circumstances, beliefs and priorities. This includes the right to accept or to decline the offer of certain healthcare and to change that decision. In order for a patient to exercise this right to decide, they require the information that is relevant to them”(Wakefield , 2011:1). Henderson and Tulloch (2008) emphasize that service providers who are knowledgeable, skilled and have good attitude will be complimented for good service delivery. The current study found that 12% of the service providers did not ask permission from their patients and 32% sometimes asked permission. The findings in Table 5.2 highlight that there is a need to educate and create awareness amongst health professionals about patient-centred healthcare and its link to obtaining consent from patients prior to treatment, respecting patients as well as engaging them in the treatment process. It thus becomes essential that the “sometimes” column in Table 5.2 decreases and the “always” column increases.



Respect is another aspect of good relations with patients: in this study 72% of service providers treated patients with respect and there were 23% who did not show respect to patients. Ndlhovu (1995) found that patients have certain expectations of quality of caring, such as good provider attitudes, privacy and confidentiality during and after consultation, and availability of supplies to compensate for their illnesses. When these are not happening during their visit to healthcare centres they are disappointed and feel they were not cared for properly. Cockcroft *et al.* (2011) stated that if service providers show negativity to patients, service delivery will be poorly rated by patients.

**Table 5.2: Relationship and satisfaction of service providers with service provision**

		Never	Sometimes	Always	No response
1	I obtain informed consent from the service users before commencing treatment	12%	32%	49%	7%
2	I treat the service user as a person instead of just another “case”	3%	23%	67%	7%
3	Service users can choose how much they want to participate in their care	0%	35%	58%	7%
4	I always treat the service users with respect	0%	21%	72%	7%
5	I encourage my service users during sessions to talk about their problems	0%	35%	58%	7%
6	I explain things in a language that service users can understand or use an interpreter when they don't	2%	33%	58%	7%
7	I explain different treatment choices to the service users	0%	32%	61%	7%
8	Service users feel free to ask questions	0%	23%	70%	7%
9	I answer all of the service users questions	0%	28%	65%	7%
10	I treat all service users the same	5%	21%	67%	7%
11	I am sensitive to the needs of the service users	0%	19%	74%	7%
12	I give service users information to use at home in different ways (i.e. books, kits, video, pamphlets)	9%	61%	23%	7%
13	I provide opportunities for the family/friends of the service users to participate in their care	2%	47%	44%	7%
14	I trust that the service users are being truthful when they tell me about their problems	0%	51%	42%	7%
15	I make the service users feel at ease during sessions	0%	21%	72%	7%
16	I encourage service users to talk about their problem(s)	0%	30%	63%	7%
17	I give service users enough time to talk so that they do not feel rushed	2%	51%	40%	7%
18	I make service users feel like a partner in their care by allowing them to contribute to their treatment	0%	42%	51%	7%
19	I help service users to understand and gain insight into their problem(s)	0%	32%	61%	7%
20	I help service users learn how to manage on their own after discharge	0%	37%	56%	7%

In addition, the table tends to highlight the challenges raised by Dunn (2003:327), who indicated that “there is too little time to treat patients as the most important part of the system. The emphasis is on throughput, not input, and this has the effect of putting quality of interaction second to quantity”. Dunn (2003) further highlighted that if patient centred healthcare is to work, there is a need for more healthcare workers on the ground, so that more time can be dedicated to patients, and this is 2020 policy endeavour. Education of patients during consultation is very important for the rehabilitation process. Due to limited resources for continuous education, as observed in the rehabilitation centres, service providers struggled to fulfil this role of providing educational material for patients to take home, as 61% highlighted that sometimes they gave patients pamphlets to inform them about their conditions and 9% never gave patients information. Donovan (1991) found that educating patients effectively about their disease and its treatments is extremely difficult. Another fact that the author highlighted was the dissatisfaction of doctors regarding providing information during consultation time, as they think that the consultation room is not effective for education. On the other hand when patients consult doctors they want more information about cause of disability, diagnosis, reasons for further investigations and prognosis of their disabilities (Donovan, 1991). Henderson and Tulloch (2008) warned that weak support for patients from service providers would affect the outcome of the service. Thus the tension between limited time and providing the patient with information needs to be addressed.

### 5.3.3 Understanding and experience of service providers with rehabilitation services

The understanding and experience of service providers with rehabilitation services was emphasised under four main themes: accessibility, rehabilitation process, resources and satisfaction with service delivery. These four themes explain the manner in which the service providers interact within the rehabilitation process and how they experience the process of service delivery. The main themes and categories are highlighted in Table 5.3 below.

**Table 5.3: Themes and categories identified**

Themes	Categories
Accessibility	Transport Communication Human resources Catchment area Environment Equipment
Rehabilitation process	Patient consent and goal setting Family involvement Information provision Structure of rehabilitation sessions
Resources	Budget Skills of service providers Physical environment
Satisfactions with service delivery	Staff availability Monitoring and evaluation Workload Equipment Referral system Budget

### **5.3.3.1 Accessibility**

#### ***Environmental***

Participants addressed various aspects of accessibility. They first mentioned the accessibility of the institutions with regards to the building itself and access to the services provided. This was considered satisfactory and providers mentioned the signage at the centres which indicate where patients should go. Although it is available and in a language that is understandable to all the clients, some providers highlighted that the signs were too high for patients in wheelchairs and this caused strain among the patients when they struggled to find directions to different areas to which they have to go:

*“There is signage... signs are quite high and not all my patients can read”* (PT Centre A and C)

*“We have complaints box and there are no complaints in there instead we get thank you notes”* (Volunteer Centre B and PT Centre A)

A resolution to provide universal coverage that was defined as access for all to appropriate promotive, preventive, curative and rehabilitative services at an affordable cost was endorsed by World Health Organization member states (WHO, 2005). Rehabilitation is one of the services that were explored in this study. Participants looked at coverage of the service by focusing on accessibility as it informs the patients of where to go within the centre during their visit. When one is focusing on access there are dimensions that need to be taken into consideration such as availability, geographic accessibility, affordability and acceptability when visiting a centre (Eldar, 2004; O'Donnell, 2007). Barriers to accessing health services can be from the consumer side and/or the provider side (Ensor & Cooper, 2004; O'Donnell, 2007). Hoenig *et al.* (1999) strongly feel that outcomes of rehabilitation can be

influenced by organizational structure, hence it is important to make sure that patients are accommodated well when they visit the healthcare centres.

### ***Human resources***

Another aspect of accessibility highlighted is the human resource aspect and the link to the catchment areas of the centres. Even though there was satisfaction with this service within the centres, service providers were dissatisfied with the shortage of rehabilitation professionals. This was a challenge especially when there was a patient back log for physiotherapists, while other rehabilitation professionals saw fewer patients. This back log could also be associated with catchment areas that are covered by these centres. They get patients who are from other catchment areas coming for rehabilitation services:

*“We have a back log of patients that stretches up to a month later, so if I am seeing patients now, he [a new patient] will only get an appointment in 2-3 weeks’ time”* (PT Centre B)

*“...if they have chronic conditions might be put on a waiting list and might be asked to attend the group sessions...”*. (PT Centre C)

Human resources need to be organized prior to service delivery. Gupta *et al.* (2011) felt strongly that if human resources are not well organized there will be flaws in the delivery of service. Accessibility to health services is one of the strengths of any service if it is well thought of. Currently in South Africa there is still a strain on delivery of service with regards to rehabilitation services. The rehabilitation policy was drawn up with the hope of improving provision of rehabilitation services (DoH, 2000). However, service providers are currently putting patients on a waiting list in order to minimize their daily load. An additional strategy is to refer patients to groups rather,

than seeing them individually thus resulting in patients who may deserve one-to-one service being denied access to this service.

### ***Transport***

Transport to the centre is another accessibility aspect that was found to be a challenge. There was dissatisfaction with transport services, as patients were not arriving for their appointments or would come late due to transport challenges. The general feeling of the service providers was dissatisfaction with this type of service offered to clients with physical disabilities:

*“We do not supply transport for patients. Dial- a -ride (government transport) is available but patients have to wait very long to get the service”. (PT Centre A)*

*“The only thing that is available is the Dial-a-ride... patients need to register with the organization before they can get use of it.” (FM Centre C)*

Hoenig *et al.* (1999) found that outcomes of patients who are admitted to hospital are poor compared to those who are receiving treatment by visiting the centre as those coming from home get more assistance from the caregivers. Transport in this study was seen as a barrier for those patients who are in need of the service. Dial-a-ride comes late to pick up the patients and some will miss out on using the transport as they have to be registered to access the transport.

### ***Communication***

Service providers indicated that communication on the whole was adequate but there were some challenges. There was a feeling that the large range of catchment areas influenced the patients who attended the centres and that the languages spoken was also a problem. In addition, the lack of translators tended to be a frustration:

*“Most clients come from areas outside our catchment area”.* (Sen OT Centre B)

*“Sometimes language is not understandable ... language needs to be worked on”.* (Volunteer Centre C)

Language is a challenge when communicating. Participants expressed difficulty in transferring information to the patients during and after treatment as most speak French and isiXhosa. They end up involving family or staff members to get the message across to the patients. Brez *et al.* (2009) identified clear communication of detail as a facilitator when dealing with patients. It appears that service providers found ways of communicating with patients, which were better than being totally unable to communicate with their patients.

### ***Accessible equipment***

Service providers highlighted that although basic equipment for providing rehabilitation services was available, there were challenges with the equipment. A basic example given was the height of plinths for patients with disabilities, as the beds were not adjustable it was difficult to provide an effective service. In addition, treatment provided was also influenced by the amount of available equipment. The equipment available impacted on the number of patients able to be seen and the time frame in which they could be seen:

*“I would like parallel bars as these are safer to walk weak patients than an assistive device”.* (PT Centre A)

*“We have high beds we also need more plinths because our plinths are getting quite old”.* (PT Centre C)

Accessibility of equipment is a challenge for people with physical disabilities. Brez *et al.* (2009) noted that if patients have accessible equipment to monitor their illness there are good outcomes in the progress of the illness. Participants noted that if equipment is not accessible it hinders the progress of the condition of patients. They mentioned that if equipment is accessible patients find it easier to transfer themselves during treatment sessions.

### **5.3.3.2 Rehabilitation process**

#### **Patient consent**

When dealing with patients healthcare professionals are expected to ask permission from the patients to ask, assess and treat them. It is one of the important factors in building a relationship with patients so that they can be open and free to share the cause of the visit to the health centre. When participants were asked if they asked for consent of the patients to ask, assess and treat them they said the following:

*“Basically at the beginning of my sessions, I ask for patients that they become involved, because most of the people are illiterate, we normally ask consent, and explain/inform that it will work, if they come back after every session.”* (PT Centre B)

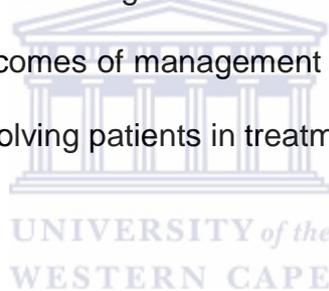
#### **Goal setting**

Setting goals after assessing your patient is vital if you want to provide essential health and effective treatment. The majority of healthcare professionals just provide the treatment without discussing with the patient what will be the plan to manage the patient’s condition. One will notice that when you are consulted by different healthcare professionals during rehabilitation process, some will spend only a short

time with a patient, while others will have more time with the patients, which helps the patient understand and be involved in the management of his /her condition. Few rehabilitation professionals expressed the following regarding goal setting for treatment:

*"For my treatment to be successful it is essential that my patients get involved and participate in their rehabilitation. I also ask the patients what his or her expectation is from the treatment and let them know what I expect from them. Once this is done, we plan the treatment together".* (PT Centre A)

Fuller *et al.* (2011a) found that if the management of the patient is goal directed it produces positive outcomes. The goal was to identify evidence that if people are working collaboratively outcomes of management of patients tend to be positive. This study proved that when involving patients in treatment patients take ownership of their illnesses.



### ***Family involvement***

Family support came out strongly from one of the centres, where patients that they saw were mainly children, and others had more severe patients who presented with physical disabilities. In addition, healthcare professionals were forced to involve families when they had challenges with language during consultation:

*"I do use a lot of the family support. I will do a lot of phone calls, for some children, I have done some creche visits..."* (OT Centre B)

*"I encourage families and caregivers to come in with my patients as it is important that they see what the patient is doing at their treatment sessions".*  
(PT Centre A)

Family is one of the stakeholders within the rehabilitation process. It is seen as a support system for patients who are presenting with disabilities. Fuller *et al.* (2011a) consider the concept of collaboration with other stakeholders to produce best clinical outcomes.

### ***Information provision***

Service providers highlighted that they realise the importance of providing patients with information, however there is not always time to do this within the available sessions. At the moment the focus of rehabilitation is geared towards curative rather than health promotive rehabilitation, and thus when information is provided it is primarily focused on curative rehabilitation rather than health promotive rehabilitation. Some rehabilitation professionals, when they have the time to do so, will also inform patients about services that are available to assist with welfare and education. They stated the following about sharing information with patients:

*“If appropriate I inform them about which department to contact for disability grant applications, old age pensions, legal matters and labour issues, as well as issues to do with education”.* (PT Centre A)

Time to spend with the patients to share information was identified as a barrier in this study. Scheer *et al.* (2003) also found out that if you as a service provider do not have knowledge about the condition it will be difficult to share information with patients regarding their disabilities. This is a problem when it comes to holistic care of patients with disabilities, as they get disappointed with the service during consultation.

### ***Structure of rehabilitation sessions***

Rehabilitation sessions are an important aspect of the rehabilitation services provided. However there is a range of events that have been highlighted that could

negatively influence the rehabilitation sessions, and these include the long waiting periods for appointments, lack of adequate referral guidelines, length of treatment sessions and content of care. In addition, all of these aspects play a role in caregiver training, which is an essential but much neglected aspect of rehabilitation:

*“The waiting period of the referral system is long so yeah it does affect the rehab service delivery”.* (PT Centre C)

*“Sisters are quite on top of things with the developmental disadvantages. They can say for instance they must be able to speak/say one word at 18 months, if not, they are referred to me”.* (PT Centre C)

Scheer *et al.* (2003) strongly recommend that medical students and allied health students must be exposed to proper processes of healthcare delivery for people with disabilities, owing to consequences that people with disabilities experience if their needs are unmet when visiting healthcare centres. In this study the processes that are followed are disadvantaging the patients from getting proper service with immediate effect. This is mainly due to shortages of staff and increased workload for one healthcare professional.

### **5.3.3.3 Resources**

#### ***Budget***

Budgets were highlighted as a major challenge. Although money was available for further training of health professionals, there was no funding available to train volunteers and home based carers, who were felt to be essential to address the aspect of limited treatment session times and shifting the focus from curative

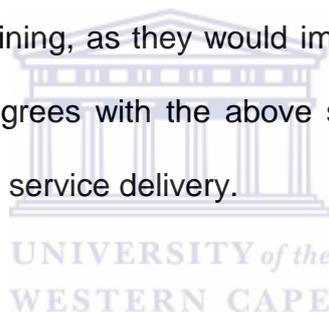
rehabilitation to health promotive rehabilitation. This training of home based carers was voluntary service from rehabilitation professionals as the gap from treatment sessions was identified. Rehabilitation professionals from one of the centres were grateful to attend a course that was offered by the department to up skill themselves with knowledge:

*“I feel like we really need training, we really need to get courses funded for”.*

(PT Centre C)

*“Basic seating course was fantastic, and I am really thankful for that, even that was enough for me” (OT Centre B)*

Budget constraints can limit quality of service delivery. Participants felt strongly that they should be sent for training, as they would improve their level of knowledge and skills. Brez *et al.* (2009) agrees with the above statement as they say that lack of funding policies impacts on service delivery.



### **Equipment**

Patients with physical disabilities experience challenges with space and equipment when visiting healthcare centres. Equipment that was suitable for patients at the centres was limited, and if not limited it was old stock that needed to be changed. Equipment that service providers focused on was consultation room equipment. They expressed themselves in this way:

*“I am still waiting for parallel bars and a wax bath. I must get round to ordering new hot packs which will be supplied”.* (PT Centre A)

*“we do have high beds, the other thing is sorry this goes back to equipment, we also need more plinths because our plinths are getting quite old but we have requested for some but I think it will take long”.* (PT Centre C)

Inadequate equipment creates problems with service delivery. In this study equipment was inappropriate to treat patients. Patients in a study by Scheer *et al.* (2009) felt that offices, examination and diagnostic equipment hindered service provision to them. Examination tables, x-ray and mammography machines and scales were physically challenging for patients with physical disabilities to use, and they found the strain of using these stressful.

### ***Skills of service providers***

Rehabilitation professionals have skills that they obtained at universities and institutions during the process of training to get their degrees. When they join the institutions to work or provide a service, they apply what they learnt and develop themselves from there. Policies that are developed to run a service are in place and these rehabilitation professionals are not aware of what is available as a guideline to treat their patients. They expressed the following regarding guidelines to manage patients:

*“We try to write out guidelines down, like to write down the management of our patients”.* (SOT Centre B)

*“I feel I am equipped to deal with any and all disabilities I encounter at the centre”.* (PT Centre A)

Skills of service providers need to be revived yearly. Even though some of the participants felt confident about their skills, they felt that they needed more skills to improve their treatment techniques for some conditions. Scheer *et al.* (2003) strongly feel that service providers should be well trained to manage disabilities. They recommend that they should have knowledge about the comprehensive healthcare needs of those presenting with disabilities.

### ***Physical environment***

Although there has been a shift from tertiary to primary healthcare and service provision should happen at primary healthcare level, all resources were not shifted to primary level of care. This was emphasised with the lack of space available to provide services linked to rehabilitation. In addition, service providers emphasised that they could possibly cope with the lack of space but the conditions of the available space needs to be addressed. In most cases service providers were referring to broken windows and broken equipment. Also lack of knowledge regarding mission and vision of the centre makes it a challenge for both patients and service providers what the centres believe in. The service providers had to say the following about this matter:

*“I would like more space to accommodate larger groups and parallel bars”*. PT  
Centre A

*“The rooms are fine but we need more space...everyone fights for space”*. PT  
Centre C

Even though the service providers were somehow comfortable with space they were concerned when more people come and join the team for a while. They were somehow feeling that the place is overcrowded and inappropriate for team building as they were fighting for space. This is in line with the study that was conducted by Fuller *et al.* (2011b) as they noticed that when services are collaborated some health professionals are satisfied with space and others are dissatisfied. The ones who were dissatisfied could not do their duties due to lack of space and others were satisfied as they were transparent to the patients. Physical environment need to be user friendly to all stakeholders so as to ensure good service.

### **5.3.4 Satisfaction with service delivery**

#### ***Staff availability***

Service providers in the study felt that they were stretched to the limit in terms of numbers of staff. If there were staff absent it further stretched the limited human resources available, and this definitely impacted on service delivery. Lack of posts for rehabilitation professionals was a definite challenge that was not in line with the primary healthcare approach:

*“I would also like another physiotherapist to be appointed at Centre G who would then cover the community work as there are so many physiotherapy referrals at the centre that I do not have time to go out into the community”.*

(PT Centre A and Centre C)

Satisfaction is considered a health outcome, a quality of care indicator, as well as a predictor of patient behaviour. It is perceived as a social construct between the consumers of healthcare, healthcare providers, and a component as well as an outcome of effective care (Mahoney *et al.*, 2004). Service providers in this study were dissatisfied with shortages of staff, and they felt strongly that there was a need for additional staff members to minimize their workload. This impacted on service delivery as service providers were overwhelmed with their workload.

#### ***Monitoring and evaluation***

When providing a service, there must be systems in place to measure progress in what you are doing. Some service providers were dependant on patients' feedback and others on evaluation processes that were available within the centre. This is how the service providers are evaluated on what they are doing at the centres:

*“My performance is assessed by my supervisor every quarter. She checks whether I have reached my targets for the quarter and also does a quality assurance audit”. (PT Centre A and C)*

*“I think we also use the outcome measures off course not for all patients, we’ve got a couple in use especially for back, neck patients, we usually use it when they start till the end”. (PT Centre C)*

Monitoring and Implementation are factors that influence service delivery (WHO, 2002; UN, 2007) as they help to identify gaps within the service. In this study service providers claimed that monitoring and evaluation of their service was being conducted, in order to check that whether they were meeting their targets for the year.

### **Workload**

Workload was a challenge in all the centres included in this study. Service providers felt that they did not have equal load of patients, as there were long waiting lists and backlog of patients at some of the centres. The suggestion was to get additional staff members to manage the workload at the centres:

*“CHC E has a back log of patients that stretches up a month later, so if I am seeing a patient now, he will only get an appointment in 2-3 weeks’ time”. (PT Centre B)*

*“Inadequate staff, which might even be the problem why I might leave here that’s how big it is. We really need community service PT because the workload is too much”. (PT Centre C)*

The above statements demonstrate staff dissatisfaction with their workload. This was a general problem encountered at all the rehabilitation centres in this study. Some of the service providers wanted to leave the job due to dissatisfaction over their workload.

## 5.4 CONCLUSION

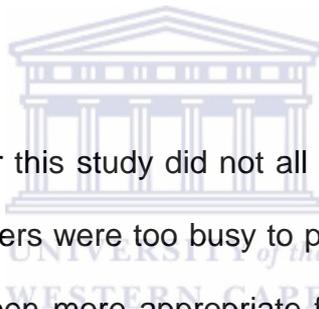
Although most of the service providers show care to their patients during their visit to the rehabilitation centres, there are still areas that need attention. In the current study the majority of service providers were not familiar with the concept of rehabilitation and were inexperienced in managing patients with physical disabilities. Based on the findings of this study, factors that emerged included lack of experience in the field of rehabilitation, lack of time to educate patients, lack of rehabilitation service providers, inadequate equipment and minimal space. All of these factors indicate that there may be a need to reorganize rehabilitation services to improve rehabilitation service delivery. Service providers were dissatisfied with accessibility of the rehabilitation centre. Also patient overload at the rehabilitation centres made the service to be inaccessible to the patients as they expected to be consulted on the day that they visited the centre. The expectation for rehabilitation service delivery is to have a designated room for rehabilitation and therapy of patients; rehabilitation should be available at all levels of care; and healthcare centres should be accessible to all people who have disabilities and use assistive devices. Service providers are dissatisfied with service delivery as they are overwhelmed with the patient load, as a result of the shortage of staff and lack of equipment for patients. Service provided at these selected rehabilitation centres seemed smooth to outsiders but the service providers struggled to run the service with shortcomings that they expressed in this study. This information that was gathered from service providers showed a gap in rehabilitation services, and hence services at the primary level of care need to be looked at to minimise dissatisfaction with service delivery.

## **5.5 IMPLICATIONS FOR PRACTICE**

The availability of information regarding disability will minimize the problem of not having time to give patients information about their concerns. The majority of patients presenting with physical disabilities require an assistive device to compensate for their disability, and when they get to the centre they must apply and wait some time for delivery. Hence the Department of Health needs to change their strategy in delivery of assistive devices and allocate budget within centres to buy equipment that they need. This will improve process of care during the rehabilitation process.

## **5.6 LIMITATIONS**

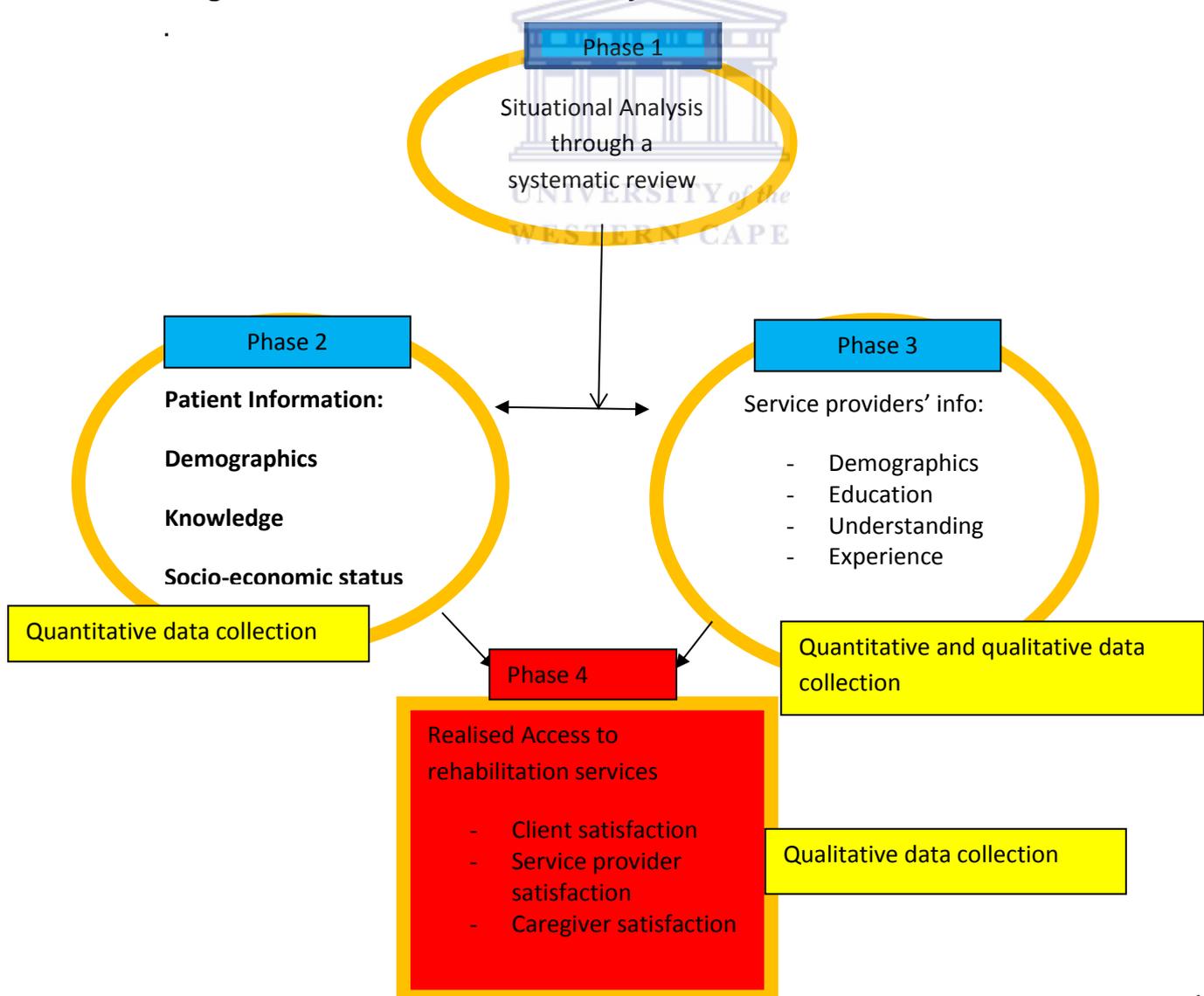
The targeted population for this study did not all participate in the study, as some of them were off duty and others were too busy to participate in the study. Focus group discussions would have been more appropriate for service providers, as they could have been targeted during their lunch break for questioning. During the in-depth interviews some of the service providers were rushing to go back to work as they felt that the interview took long and that influenced the way that the researcher conducted the interview.



## INTRODUCTION TO CHAPTERS SIX AND SEVEN

Chapter Six marks the beginning of phase four of the study which explores the perceptions and realised access to rehabilitation services of the key stakeholders with the services they have received. A patient-centred approach to healthcare highlights the need to explore the views of patients and their caregivers, as they access the services and would thus be well-positioned to express opinions regarding their experience with the service. By the end of this phase (Chapter Seven), there should be a clear idea of how stakeholders accessing the rehabilitation services experience them.

**Figure 6.1: Phase four of the study**



# CHAPTER SIX: PATIENT SATISFACTION

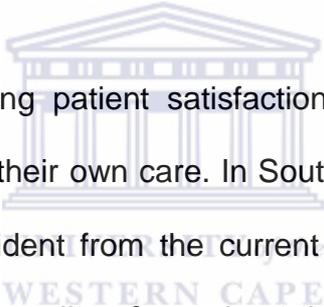
## PATIENT SATISFACTION WITH REHABILITATION SERVICES AT SELECTED REHABILITATION CENTRES IN WESTERN CAPE, SOUTH AFRICA

### 6.1 INTRODUCTION

Understanding patient satisfaction with healthcare services has become increasingly important, as they are seen as key role players in ensuring quality healthcare delivery. More than a decade ago, Keith (1998) highlighted a need to understand patients' views on service delivery and explore whether health professionals acknowledge patients' views in order to make the relevant adjustments. This was supported by Haynes, Devereaux and Guyatt (2002), who highlighted the role of patient preferences in disease management and the importance of their views being heard. Keith (1998) identified satisfaction as having two major components, namely affective and cognitive components. The affective component can be described as a reflection of the feelings of the patient, while the cognitive component is concerned with what the patient considers as important and how the service is being evaluated by the patient. Recently, Argentoro *et al.* (2008) again identified patient satisfaction as a good indicator of the effectiveness of a healthcare service.

Rehabilitation services are internationally recognised as one of the key components of health care, especially for the person with disabilities (WHO, 1995). In South Africa, a Primary Healthcare (PHC) approach was incorporated into health services in 1994. The PHC approach includes "...essential healthcare; based on practical, scientifically sound, and socially acceptable method and technology; universally accessible to all in

the community through their full participation; at an affordable cost; and geared toward self-reliance and self-determination” (WHO, 1978:1). With the shift in healthcare approach in South Africa from a health system based on apartheid and characterised by geographical and racial disparity, there is a need to determine how effective the current delivery of primary healthcare is and, in the case of this study, to highlight rehabilitation care in a primary healthcare setting. In improving service delivery at primary healthcare clinics, there is a need to prioritise consumers and their level of satisfaction with the services provided. Patients’ perception of satisfaction is an aspect of healthcare quality that is being increasingly recognised as important (Dansky & Miles, 1997).



Another element in ensuring patient satisfaction with service delivery is to allow patients to have a voice in their own care. In South Africa, the importance of this has been recognised, as is evident from the current 2020 Health Plan. “Improving the patient experience and the quality of care is at the heart of the vision for 2020” is a statement from the Western Cape Department of Health (WCDoH, 2011:45). However, Holliday *et al.* (2006) contend that health professionals do not engage patients in goal setting as part of the rehabilitation process. This lack of inclusion could affect the rehabilitation of patients, if there are different goals between the rehabilitation professionals and the patients. Holliday *et al.* (2006) therefore recommend that patients need to engage with the rehabilitation professionals regarding the management of their condition, and there needs to be a good relationship in order to achieve quality rehabilitation outcomes. However, this can only become possible if patients have access to rehabilitation professionals. In a study conducted in China, Zongjie *et al.* (2007) discovered that people with disabilities

found it difficult to access the limited number of rehabilitation centres in the country. Difficulties experienced when accessing rehabilitation facilities lead to patient dissatisfaction with the services delivered by these institutions. In addition, patients felt that their needs were not being met.

In South Africa rehabilitation services are considered as part of the primary healthcare approach, but these services are underutilised by clients with physical disabilities. The Western Cape Department of Health (2003) recommended that rehabilitation staff at primary healthcare centres should comprise physiotherapists, occupational therapists and speech therapists. Rehabilitation includes a multidisciplinary team, which means that all rehabilitation professionals need to engage with each other and patients to determine the best rehabilitation process. Studies concerning satisfaction with rehabilitation services in Africa highlight certain degrees of dissatisfaction with the service, for various reasons (Mlenzana & Mwansa, 2012; Kahonde, Mlenzana & Rhoda, 2010). Implementing the National Rehabilitation Policy effectively is dependent on the satisfaction of the clients who access the service. The aim of this study was therefore to explore the satisfaction of people with physical disabilities with the rehabilitation services provided at the selected rehabilitation centres in the Western Cape.

## **6.2 METHODS**

### **6.2.1 Research setting**

In the Western Cape Province, rehabilitation services are offered at primary, secondary and tertiary levels. This study focused only on the rehabilitation services offered at the primary healthcare level. Three centres were purposively selected

based on their location and their contextual differences. These centres had a rehabilitation department and attended to the referral of patients presenting mainly with physical disabilities. Limited types of rehabilitation healthcare providers were employed at these community health centres.

### **6.2.2 Research design**

This study employed a qualitative research approach, using focus group discussions.

### **6.2.3 Population and sampling**

The target population for this study involved all patients who presented with physical disabilities at selected rehabilitation centres in the Western Cape, South Africa. A person with a physical disability was based on the conditions that were commonly seen at the rehabilitation centres. A total of 43 patients were telephonically contacted to participate in this study, and 29 participants came for FGDs from the three centres: 11 from Centre A; 6 from Centre B; and 12 from Centre C. They were purposively selected according to their diagnosis and experience of rehabilitation service to participate in the study.

### **6.2.4 Procedure**

Ethical clearance to conduct the study was obtained from the Ethics Committee of the University of the Western Cape (project registration number: 10/1/3) and the Western Cape Department of Health. Access to the patient information was obtained from the facility managers of the selected centres. Three hundred and seventy folders were selected for the quantitative component of the big study, and 43 folders were purposefully selected, based on the diagnosis and experience of receiving rehabilitation services at the selected centres. These selected folders contained contact details of the clients. All the chosen participants were contacted and given an

explanation as to why they were being contacted, and then given an opportunity to ask any questions related to the study before agreeing to participate. The expected number of participants for the focus group at each centre was 12 participants. Due to unforeseen circumstances, only one centre had twelve participants for the focus group. The venue to meet the participants was negotiated, based on centrality of location and convenience. Participants who had transport problems were asked to hire transport to be at the venue, and the researcher paid the cost of transport. The participants were all given an information sheet about the study, and clarity on the study was verbally provided to the participants. Written, informed consent was obtained from all participants. Anonymity was used for all participants, as they were given numbers for identification purposes when the researcher needed to follow up with questions. The right to withdraw from the study was stated as an option and it was explained to the participants that they would not be disadvantaged regarding rehabilitation services if they did so. The focus group discussions were conducted in a non-threatening environment and the participants were given the option of communicating in a language in which they were comfortable. One FGD was conducted in Afrikaans, another one in isiXhosa, and the last one in English. All focus group discussions were tape-recorded, after consent was obtained from the participants. During the focus group discussions, the perceptions of patients regarding rehabilitation services were explored (Appendix M). All the tapes were kept in a locked safe and were taken out during the analysis of the results. An independent person was asked to transcribe the information from the tapes verbatim. Translations were done by two experts in all the languages used in this study to ensure that the translated information had not lost the meaning during the translation process. Communication between the translators ensured clarity about concepts.

### **6.2.5 Data analysis**

Data analysis was done according to Creswell (2003), who states that the process of qualitative data analysis involves making sense of text data continually, and therefore several generic steps must be followed to warrant valid data. In this study, the FGD tape-recorded interviews were transcribed verbatim to produce a transcript. The data were managed manually, and different highlighters were used during the coding process. Several readings of the material that helped in code-recording were done so as to create familiarisation. Thematic content analysis in the form of themes and categories was used for data analysis (Graneheim & Lundman , 2004). The data were subsequently cut and pasted from transcripts according to the predetermined and emerging themes and described in narrative form for the process of interpretation and analysis. Each theme was coded into categories of related information and corresponding verbatim quotations were put under different categories to support each theme. Two individuals with expertise in the field of disability and rehabilitation conducted a peer review of the transcripts to verify the identified themes and categories.

## **6.3 RESULTS**

Among the 29 participants, the mean age was 53 years, with a range from 19 to 78 years. Seventeen of the participants were female, and 12 were male. The diagnosis of the participants included nine cerebrovascular accidents, nine neuromuscular disorders, six orthopaedic conditions, like a fracture, three degenerative disorders, like osteoarthritis, and two lower limb amputations. Table 6.1 below presents a summary of the demographic data of the participants.

Based on the analysis of the data, six main themes emerged, including initial reaction to the disability; patient's response to referral for rehabilitation; access to rehabilitation services; therapists' interaction during rehabilitation, treatment sessions and equipment. Within each theme, several categories and subcategories emerged, as presented in Table 6.2.

**Table 6.1: Demographic details of participants**

Participant	Age	Gender	Disability	CHC
P1	63	Female	Left hemiplegia	Centre B
P2	59	Female	Fracture	Centre B
P3	71	Female	Left hemiplegia	Centre B
P4	19	Male	Right hemiplegia	Centre B
P5	70	Male	Neuromuscular	Centre B
P6	70	Male	Amputation	Centre B
P7	54	Female	Neuromuscular	Centre A
P8	38	Male	Fracture	Centre A
P9	70	Female	Right hemiplegia	Centre A
P10	78	Male	Fracture	Centre A
P11	48	Female	Neuromuscular	Centre A
P12	63	Female	Neuromuscular	Centre A
P13	72	Male	Right hemiplegia	Centre A
P14	50	Female	Left hemiplegia	Centre A
P15	51	Female	Neuromuscular	Centre A
P16	69	Female	Osteoarthritis	Centre A
P17	48	Male	Neuromuscular	Centre A
P18	51	Female	Neuromuscular	Centre C
P19	22	Male	Neuromuscular	Centre C
P20	46	Female	Fracture	Centre C
P21	64	Male	Left Hemiplegia	Centre C
P22	53	Female	Right hemiplegia	Centre C
P23	45	Female	Left hemiplegia	Centre C
P24	48	Male	Neuromuscular	Centre C
P25	23	Female	Fracture	Centre C
P26	36	Male	Amputation	Centre C
P27	78	Female	Osteoarthritis	Centre C
P28	46	Male	Osteoarthritis	Centre C
P29	32	Female	Fracture	Centre C

**Table 6.2: Themes and categories developed from qualitative data analysis**

Themes	Categories	Subcategories	Participants' experiences	Quotes
<b>Initial reaction to becoming physically disabled</b>	Positive responses	Acceptance, grateful	Participants were grateful when they compared their status to that of others.	<i>"At first when the doctor told me that I had a stroke, I was surprised, but the way I live my life at home I told myself that as long as I am alive, I will take care of my children, because there are other people who are worse than me who are in wheelchairs..."</i>
	Negative responses	Shock, fear, anger	Participants experienced feelings of initial shock, which gradually translated into anger, and also experienced fear of the unknown.	<i>"It really got to me. I was very negative, tearful, because I couldn't accept it. Very short tempered...everything worked on my nerves... because I couldn't do it myself...It made me very angry and frustrated, because I couldn't do things on my own anymore, like going to the toilet..."</i>
<b>Patients' response to referral to rehabilitation professional</b>	Emotional	Happy, relaxed, excited or a more concerned manner (worried, hurt, fear of the unknown).	Patients initially experienced fear of the unknown, but when they understood the role of the rehabilitation, they expressed feelings of being more relaxed.	<i>"When I was told to go there, I was hurt, because I didn't know where they were sending me and I was not sure."  "At first, I was very scared, but after I received treatment, I became comfortable and relaxed."</i>

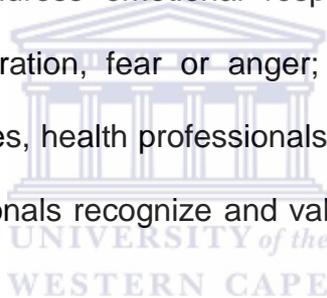
Themes	Categories	Subcategories	Participants' experiences	Quotes
<b>Access to rehabilitation services</b>	Environmental	Location of rehabilitation units, overcrowded hallways	Although they have access to the services, the location of the rehabilitation unit (e.g. Physiotherapy Department) in the CHC is not easily accessible.	<i>"It is not easy (at the hospital), the passage is crowded and when you ask to pass, people just ignore you and there is only one door to get to the facility and that's the door that is used by everyone, hence it's always crowded. There is no door that goes directly to the physiotherapy room."</i>
	Transport	Transport to the centres	Patients experienced using public transport to get to the rehabilitation centre as a challenge, as public transport may not be equipped to transport them.	<i>"If you are in a wheelchair, most drivers don't stop for you, because they think you will waste their time since they have to help you get into the taxi and pack your wheelchair, that's just inconveniencing them, because they want to make money."</i>
<b>Therapists' interaction during rehabilitation process</b>	Attitude	Friendly, welcoming, developed trust	Patients experienced the therapists as friendly and they developed trust in them. They also felt that therapists were concerned about them during the sessions and asked how they felt.	<i>"...trusted, lovable people and they communicated with me throughout the rehabilitation process. They are always aware of when you have pain and they were positive with me."</i>

Themes	Categories	Subcategories	Participants' experiences	Quotes
	Shared decision-making	No consultation about rehabilitation, Autocratic decision making	Although the therapists explained to the patients what they were doing, patients felt they were not consulted on what they wanted.	<i>"No I was not given a chance to decide; they just told me to get onto the bed. I was not asked anything about wanting or not."</i>
<b>Treatment sessions</b>	Time Content of sessions Appointments	Increase in the consultation time  Lack of variation  Time between follow-up sessions was too long	The time spent was too short as they did not get time to grasp what needed to be done.  Patients experienced treatments sessions as being routine with limited variations.  Patients felt that the time between the follow-up sessions was too long.	<i>"...we do the same thing all the time during the sessions."  "I just want slightly longer sessions so we can get used to it".  "...but they gave me a long period....if I received my exercises today for instance, then I have to come back after a month again."</i>
<b>Equipment</b>	Issuing	Suitability  Time	At times the patient felt that the equipment issued by the therapist was not suitable.  Patients felt that the time taken for issuing walking aids and equipment was acceptable.	<i>"I was given a wheelchair to help go to the toilet, but I could not use it at home."  "When they see that you need something, they give it to you with a reasonable time period."</i>

## 6.4 DISCUSSION

Understanding the patients' views on rehabilitation services is essential. In a study conducted in the Western Cape among ten participants accessing rehabilitation services in community health centres, the following main themes emerged: access to the service; client participation and involvement in rehabilitation; provision of information; interaction of service providers with the clients; and family/caregiver involvement in rehabilitation (Kahonde *et al.*, 2010). It is evident that becoming disabled is a challenge for anyone. The onset of a serious health problem or becoming disabled has an impact on the individual's everyday life requiring considerable adjustments. Apart from managing the pain, discomfort and inconvenience that may be caused directly by the condition, changes may be imposed by new needs for financial and practical support, as well as the psychological impact. For most people with disabilities, this is a considerable challenge, and the initial period following the disability is therefore vitally important. This highlights the importance of the rehabilitation process, and addressing the needs of disabled for the same life opportunities and the same choices in everyday life that their non-disabled brothers and sisters, neighbours and friends take for granted. In most instances, the majority of disabled people experience the onset of their health problem or impairment in adulthood. In the current study, the average age of the participants was 53 years. The main themes that emerged from this study were patients' reaction to the news of disability, their response to referral for rehabilitation, access to rehabilitation services, interaction with health professionals and, finally, treatment sessions and equipment.

In the current study, participants' responses to the news of becoming disabled varied from denial, shock, anger and tears to acceptance. This is important for health professionals to understand, as for most people the onset of disability heralds an era of intensive self-evaluation, the beginning of a process that never actually reaches conclusion. Good communication from the relevant health professionals is therefore vital in order to assist in reducing patients' anxiety and uncertainty (Leonard, Graham and Bonacum, 2004). There is evidence that good communication improves compliance (Williams *et al.*, 2000) and that improving, doctor-patient communication may be the most effective way of reducing patients' negative reaction to the news of being disabled. As reflected in the current study, it is important that health professionals identify and address emotional responses. Patients may express shock, denial, sadness, frustration, fear or anger; and each of these emotions deserves attention, yet, at times, health professionals often fail to address them. It is important that health professionals recognize and validate their patients' feelings as best they can.



#### **6.4.1 Patients' response to referral for rehabilitation**

When dealing with persons with disabilities, healthcare professionals tend to think it is easier to think for them regarding what needs to be done for them to be assisted. However literature has highlighted the need for shared decision making, which involves that patients and health professionals contribute as partners to treatment decisions (Long *et al.*, 2006). The patients in this study expressed different emotions regarding referral to rehabilitation services. They were not sure whether or not it was a good thing to go for rehabilitation. Some of them were dissatisfied with the referral, as they feared the unknown. After receiving treatment, they were satisfied with the

service received. This aspect was picked up by Argentero *et al.* (2008) who found that the satisfaction of patients was low, due to lack of involvement and inadequacy of information given by healthcare professionals.

#### **6.4.2 Access to rehabilitation services**

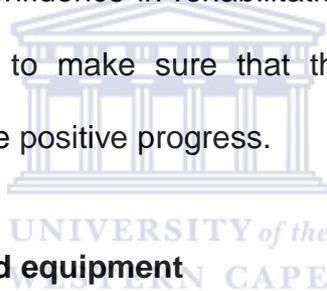
Various challenges were raised regarding accessing the rehabilitation services at the centres. These factors included internal and external environmental challenges, as well as personal challenges. Environmental challenges include the location of the rehabilitation sections in the hospital, as well as the overcrowding of hospitals, which hampered the movement of the disabled with walking aids and wheelchairs. Other factors regarding access highlighted included transport to the centres and movement with walking aids to get to the primary healthcare centre. Patients experienced unhappiness with the taxi drivers, which is in line with the statement by Kahonde *et al.* (2010) that taxi drivers refuse to wait for patients with physical disabilities, as they take longer to get in and out of the taxi.

#### **6.4.3 Therapists' interaction during rehabilitation**

The participants in this study were asked to share their views on the rehabilitation professionals during the rehabilitation process. Most of the patients stated that therapists had a positive attitude, with reference to the therapists taking them into consideration during the treatment process. However, involvement in decision-making processes was limited, as patients were given treatment without an opportunity to discuss what effect it would have on their disabilities. This shows that patients were satisfied with the rehabilitation professionals, as they communicated with them and greeted them in a friendly manner as they came into the therapy

room. The attitude of health professionals clearly has an impact on patients, whether positive or negative. Argentero *et al.* (2008) agree that if healthcare staff is in a bad emotional state it will affect the patients' satisfaction level with the service. This highlights that healthcare professionals should try and always have a positive attitude towards their patients, as this will improve the satisfaction level of the clients and uplift the standard of service (Satchidanand *et al.*, 2012).

Holliday *et al.* (2006) noticed that health professionals generally did not engage patients in goal setting as part of the rehabilitation process. In their study patients were not informed of what was going to be done to them. This causes dissatisfaction among patients and loss of confidence in rehabilitation professionals. Rehabilitation professionals therefore need to make sure that they involve the clients in the rehabilitation process to ensure positive progress.

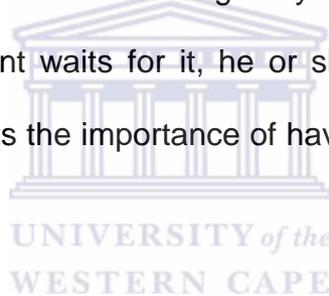


#### **6.4.4 Treatment sessions and equipment**

Participants were asked about their perceptions of treatment sessions, and they expressed dissatisfaction, as they expected to use or undergo different techniques to manage their disabilities, and because time spent with them was not sufficient. Baltussen *et al.* (2002) report that if patients are not happy with health personnel practices, it ultimately affects the satisfaction of the clients. These results were similar to the findings of Van Langeveld *et al.* (2011), who report that clients were not happy with the time spent with them during the session; as time was spent on irrelevant things. This caused dissatisfaction among the patients. It is important to spend enough time with the patients and have positive outcomes in a session. This

highlighted the need for greater patient involvement in rehabilitation decision-making processes.

Some participants reported receiving assistive devices promptly, while others had to wait long to receive them. Assistive devices are part of rehabilitation service delivery. If one has an impairment that needs an assistive device, it should be available as part of the rehabilitation process. This means that rehabilitation centres should have assistive devices in stock to prevent long waiting times for patients. The rehabilitation centres used in this study took a minimum of two weeks to issue assistive devices to patients. The procedure that they must follow requires rehabilitation professionals to complete a form requesting and motivating why the patient must receive the assistive device. As the patient waits for it, he or she may be fully dependent on family members. This highlights the importance of having assistive devices on site to improve service delivery.



Waiting times in the healthcare centres are problematic. They are the first-line service to provide healthcare to the community. This causes these centres to be overcrowded with clients who are seeking to improve their health. Rehabilitation centres are also sometimes affected by overcrowding and end up making appointments for the patients. The patients in this study did not like the fact that they had to wait a month to get help after making an appointment. If the patients missed their appointments, the date would be shifted further, which extended the waiting period to receive treatment as prescribed by a referring person. Even the patients who came on time felt the pressure of being rushed through treatment by the rehabilitation professionals. This is dissatisfying to the patients, and rehabilitation

professionals need to come up with strategies that will facilitate the patients into accepting the procedures of the appointment system or alternatively find a method that adapts to the needs of the patients.

Long *et al.* (2002) clarify the role of nurses during rehabilitation. These authors state that nurses as first-line practitioners should address the following when interacting with the patient: assessment, coordination and communication, technical and physical care, therapy integration and carry-on, emotional support and involving the family. Nurses address the mood of the patients after diagnosis and ensure that patients participate in the rehabilitation process. Having dealt with those issues, nurses refer the patients to all relevant team members so as to get input in the rehabilitation process. The patients in this study had less contact with nurses than physiotherapists and doctors, and the role that the nurses should play in the rehabilitation process was clearly not being practised at the rehabilitation centres. The patients in this study were devastated about their condition and had to deal with their disabilities on their own. None of the patients mentioned that they went for counselling to deal with the disability or that they spoke to rehabilitation professionals to deal with their disability.

## **6.5 CONCLUSION**

The participants in this study were dissatisfied with the service providers regarding treatment sessions, waiting times and the issuing of assistive devices. During the rehabilitation process patients felt that time spent with them during consultation was not enough as they felt that they needed more time to ask about other issues that they needed clarity on. Patient outcomes in respect of functioning were however

satisfying to the patients, as they felt better after treatment sessions, while the friendliness of the service providers made them feel better regarding the challenges with which they presented. Accessibility in finding the rehabilitation rooms was not good, as patients struggled to find the place and had to ask around in order to find the rehabilitation rooms. Also transport that they used to visit the rehabilitation centres was a challenge for the patients as the drivers did not stop for them when they tried to get the taxis. Patients assumed that the drivers would complain about the delay in getting them in and out of the taxi.

## **6.6 IMPLICATIONS FOR SERVICE DELIVERY**

Clients' views on service delivery are important for the improvement of services. If clients are dissatisfied about services, it will affect the entire centre, from staff to the environment. They will lose clients and clients will damage the reputation of the centre by sharing their bad experiences. When clients visit centres for rehabilitation purposes they are given appointments where they have to come back in two to three weeks' time. Even though they were satisfied with the relationships that they had with staff members, they were dissatisfied with the treatment routine. This dissatisfaction with treatment routines could serve as a warning to service providers that when they treat their patients they must use different modalities to manage different conditions.

## **6.7 LIMITATIONS OF THE STUDY**

The clients who participated in this study were drawn from physiotherapy records which are not a true reflection of rehabilitation service provision. The following were limitations of this study:

1. Views of the clients might be restricted to experiences with physiotherapy only and not the other rehabilitation team members.
2. Clients were not asked what changes they would like to see implemented in the rehabilitation process.
3. Clients were not asked if they were aware of what the rehabilitation process entailed



# **CHAPTER SEVEN: PERCEPTIONS AND SATISFACTION OF CAREGIVERS**

## **PERCEPTIONS AND SATISFACTION OF CAREGIVERS REGARDING REHABILITATION SERVICES FROM SELECTED REHABILITATION CENTRES IN THE WESTERN CAPE**

### **7.1 INTRODUCTION**

Rehabilitation services within healthcare provision often face challenges, as they have to compete with resources for communicable diseases. With the movement of resources for rehabilitation in South Africa towards primary healthcare, it is essential that the views of the key role players are understood, if effective rehabilitation of patients is to occur. The Integrated National Disability Strategy (INDS) in South Africa defines rehabilitation as “ways of helping people with disabilities to become fully participating members of society, with access to all the benefits and opportunities of that society” (South Africa: INDS, 2007: 22).

A key aspect of rehabilitation involves including more than the patient and the health professionals in the rehabilitation process: caregivers are key role players in this process (Mudzi, 2010). An increase in the number of people with disabilities (Lehohla, 2005) emphasises the need for a better understanding of the rehabilitation services provided at primary care level. Feedback from patients and other key stakeholders, such as caregivers, is required if deficiencies are to be identified and addressed. In addition, it is important that the impact of the caregiving process is understood in order to facilitate this process. The burden experienced by caregivers

is usually considered to be both task orientated as well emotionally challenging. The actual tasks performed by caregivers are dependent on the physical dependency of the patient, while the emotional challenge is influenced by the mental and emotional health of the patient. It is essential that the needs of the caregivers be understood and supported, because coping with these reactions is paramount for a healthier caregiver and, ultimately, also for a healthier patient (Edwards, 2008).

In addition to understanding the needs of the key role players in rehabilitation, it is valuable to understand their satisfaction with the services provided. While customer satisfaction in the marketing industry is linked more to sales and profit generation (Woodside *et al.*, 1989), in healthcare it ensures the provision of quality outcomes, which is the goal of every health facility (Steiber & Kowinski, 1995). Healthcare providers are therefore challenged to deliver the specific expected outcomes to satisfy the patient/customer by providing superior service. As a construct, customer satisfaction has been described as a consumer attitude; it is a post-purchase phenomenon reflecting how much the customer likes or dislikes the service after experiencing it. Because of the multidimensional nature of satisfaction, researchers have over time, continued to develop models to explain the factors that influence satisfaction (Conway & Willocks, 1997; Fiebelkorn, 1985; Woodside, *et al.* 1989). Based on literature, it is envisaged that within the health setting, patients enter a service setting with needs, wants and expectations. The extent to which the provider fulfils these, defines the degree to which the patient will be satisfied. Research has been limited regarding the needs of the caregiver and the barriers and facilitators of the caring process. According to Kruzich, Jivanjee, Robinson and Friesen (2003), the involvement of caregivers in rehabilitation processes requires attention. Allied health

professionals have an important role to play in supporting the caregivers of patients with physical disabilities. However, research suggests that support for caregivers is often not forthcoming. This study therefore aimed to explore the perceptions and satisfaction of caregivers regarding the rehabilitation services at selected rehabilitation centres in the Western Cape.

## **7.2 METHODOLOGY**

### **7.2.1 Research design**

The study used a qualitative study design, using in-depth interviews to explore the perceptions and satisfaction of caregivers regarding rehabilitation services at selected rehabilitation centres in the Western Cape.

### **7.2.2 Population and sampling**

The target population and inclusion criteria for this study involved all caregivers who accompanied people with disabilities to the selected rehabilitation centres. The sample consisted of the caregivers of 13 individuals, conveniently selected from the list of persons with physical disabilities who had received rehabilitation services at the identified rehabilitation centres. The persons receiving rehabilitation at the centres included those with conditions such as strokes, amputations, head injuries, spinal cord injuries, osteoarthritis and neuromuscular disorders leading to disability.

### **7.2.3 Instrumentation**

An interview guide, which consisted of open-ended, non-directive questions, was used to explore the caregivers' perceptions of and satisfaction with the rehabilitation services their family member were receiving. An initial open-ended question was

used to explore the caregivers' perceptions of the rehabilitation service. Probes were then used to obtain in-depth descriptions of their perceptions of and satisfaction with the services. To ensure trustworthiness (Lincoln & Guba, 1985) in this study, the interview guide was developed after the researcher conducted a systematic review, which focused on barriers and facilitators to rehabilitation services (Mlenzana *et al.*, 2012). The interview guide was developed and reviewed by individuals considered experts in the areas of disability and rehabilitation.

#### **7.2.4 Procedure**

Twenty-six viable participants were telephoned. Following an explanation of the purpose of the study, they were asked to participate in the study. However, of these participants, only 13 were available for interviews. An appointment to conduct the interviews was made with those who agreed to participate in the study. Informed written consent was obtained from all participants before each interview was conducted. Anonymity and the right to withdraw from the study were assured. In addition, permission to audio-record the interview was obtained from the participants. Interviews were conducted during June 2011, and were carried out in the caregivers' homes or at the rehabilitation centres at a time suitable for them. The audio-recordings were transcribed verbatim. The participants were given an option of the language in which the interviews would be conducted. Eight of the interviews were conducted in Afrikaans.

#### **7.2.5 Data analysis**

The transcripts of the interviews were compared to the voice recordings, to verify accuracy. The Afrikaans transcripts were translated into English after the recordings were verified. The transcriptions were translated from English and back to the

interview language to ensure validity. Data were analysed using a coding process to sort the information according to categories within the predetermined themes. Data analysis was done using the following predetermined themes: financial difficulties; patient-therapist relationship; facility management; and caregiver service delivery. Within the predetermined themes, categories were identified by the first author and consensus was reached through discussions with the second author. All categories were supported with quotes from the interviews.

## 7.3 RESULTS AND DISCUSSION

### 7.3.1 Characteristics of participants

The sample consisted of 13 participants, with mean ages of 47 years for caregivers and 59 years for patients. The majority of the caregivers were female (Table 7.1).

**Table 7.1: Patient and Caregiver demographics**

Caregiver			Patient		
Age	Gender	Relation to patient	Age	Gender	Condition
70	F	Wife	77	M	Amputation
58	M	Husband	58	F	Amputation
56	M	Husband	54	F	Amputation
34	F	Nephew	68	M	Cerebrovascular accident
27	F	Aunt	12	F	Neuromuscular disability
45	F	Daughter	67	F	Cerebrovascular accident
29	M	Friend	28	M	Neuromuscular disability
56	M	Brother-in-law	65	F	Neuromuscular disability
27	F	Daughter	59	F	Cerebrovascular accident
63	M	Husband	58	F	Cerebrovascular accident
46	F	Neighbour	68	F	Neuromuscular disability
34	F	Neighbour	64	M	Cerebrovascular accident
60	F	Daughter	84	F	Ortho

### 7.3.2 Finances

The majority of caregivers who were interviewed indicated that they experienced financial difficulties. The most common financial challenge was the cost associated with transportation. Six of the caregivers stated that they frequently experienced difficulty with transportation when travelling to and from centres:

*“... Every now and then I had to borrow money... for the taxi.”* (Caregiver 9)

*“... there isn't always money for the taxi.”* (Caregiver 12)

*“... to go there and back, we pay R100.”* (Caregiver 3)

A similar situation was highlighted in South Africa more than ten years ago by Whitelaw *et al.* (1994), who reported that rehabilitation at a tertiary hospital in Cape Town was a challenge due to poor attendance caused by transport problems. More recently, De la Cornillere (2007) reported that at one of the CHCs in Cape Town, transport was the major problem interfering with the attendance of rehabilitation sessions. This remained the case even more recently as reported by Kahonde *et al.* (2010).

### 7.3.3 Caregiver-therapist relationship

Categories identified within this theme included caregiver integration in the rehabilitation process, exchange of information by the therapist and, finally, the trust relationship between caregiver and therapist. The majority of caregivers stated that they had received education and had been included in the rehabilitation process. They furthermore indicated that they had a pleasant interaction with the therapist. This indicates a positive caregiver-therapist relationship:

*“... I sat in on the session ...”* (Caregiver 2)

*“... they give me exercises, they write it down and draw it ...”* (Caregiver 12)

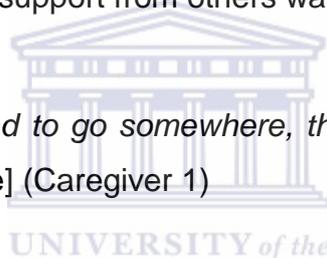
*“they were not ... people that you had to be afraid of.”* (Caregiver 1)

Contrary to previous studies (Kahonde *et al.* 2010), the participants in this study reported good interaction with their therapists, and indicated that they received the necessary information. A review conducted by Mlenzana *et al.* (2012) highlighted the importance of a positive caregiver-therapist relationship.

#### **7.3.4 Caregivers’ physical and emotional health**

During the interview process, it became evident that the quality of the care provided by caregivers is influenced by support for their own physical and emotional health. The caregivers highlighted that they were not always physically capable of actively assisting the patients and that support from others was welcomed:

*“I had a friend... if I had to go somewhere, then there was someone ...”* [to give physical assistance] (Caregiver 1)



In addition, it was evident that caregivers often neglected their own emotional needs. Caring for another person also seems to have an impact on the caregivers’ stress levels:

*“It is a full-time job. I became very sick afterwards... I did not take notice of myself...”* (Caregiver 1)

*“... sometimes it was very stressful...”* (Caregiver 9)

The findings reported by the carers regarding their own physical and emotional health is similar to other studies (McClaughlin *et al.*, 2010, Shewchuck *et al.*, 2004) which highlighted that living with and caring for people with disabilities, whether physical or mental, affects various aspects of caregivers’ lives. Although the perceptions of the caregivers regarding rehabilitation services were primarily

positive, it is evident that there is a need for consideration to be given to incorporate carers in the process of rehabilitation, with a focus on ways to decrease the burden of caring. Shewcuck *et al.* (2004) highlight the need for rehabilitation interventions that focus on helping caregivers develop skills and strategies to address patient-centred emotional issues.

### **7.3.5 Facility management**

Caregivers highlighted that access to rehabilitation services was not a problem, even when using assistive devices:

“... very easy [to access centre with wheelchair] ...” (Caregiver 1).

However, processes within the centres were a challenge, including accessing files prior to therapy and obtaining appointments:

“... *the department where she has to go [for therapy] is there at the back. Her files are here in front. The distance is far.*” (Caregiver 3)

“... *it's the administration that makes this a disaster.*” (Caregiver 2)

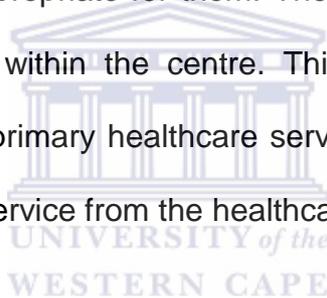
At least eight of the caregivers felt that the frequency of appointments was insufficient. Caregivers highlighted the long waiting periods between follow-up sessions as follows:

“... *for an appointment... one month or even two months ...*” (Caregiver 5).

“*They are full, now I just have to be patient ...*” (Caregiver 13).

The PHC approach refers to accessibility. However, the question is how accessibility is defined: is it only about the geographical location of the service and having access to the service? What about the challenges highlighted by the caregivers with regards

to administration services that make rehabilitation a challenge? Veltman *et al.* (2001) in their study highlighted that people with physical disabilities were dissatisfied with the way their doctors treated them when they consulted them. The participants felt that the doctors were insensitive towards them and valued them less than respecting them. This emerged particularly strongly when the participants identified barriers regarding access to the service. They mentioned that when given appointments to visit the health centre, it was difficult to keep them, as transportation was a challenge for them. The participants in this study complained of a long waiting time for the next appointment. Also within the healthcare centre the rooms of the doctors were mostly inaccessible for people with physical disabilities and the available equipment was inappropriate for them. The participants in this study were dissatisfied with accessibility within the centre. This dissatisfaction generally led people with disability to view primary healthcare services as inappropriate for them, as they did not receive good service from the healthcare centres.



#### **7.4 CONCLUSION**

Caregivers who took care of people with disabilities were mainly unemployed as they took care of their family members or neighbours. Difficulties that they experienced with rehabilitation were transport, health delivery and access to services. Participants found it very challenging when it came to follow-up appointments for the people they cared for as they were booked months later. Having someone with a disability sometimes is challenging to caregivers, as there are situations where they need to be seen by doctors for health reasons but there is no money to pay for transport. Complications to health will develop and add to the burden of the patient and the caregiver.

## **7.5 IMPLICATIONS FOR PRACTICE**

Based on the current study, the rehabilitation services seem to be meeting the basic rehabilitation needs of the patients. However, the needs of other role-players, like caregivers, need attention. Currently, there is no intervention within the rehabilitation context that addresses the needs of caregivers. The involvement of caregivers in the rehabilitation process within the treatment realm is evident but support with reintegration back into society is lacking.

## **7.6 LIMITATIONS**

Caregivers who participated in this study were mainly family members. They saw their main role as carers who were instructed on what needed to be done. There were no activities of debriefing about caring for people with disabilities. Some of them mentioned their own health was deteriorating but the focus of the service providers was on the patients.

## CHAPTER 8: SUMMARY AND RECOMMENDATIONS

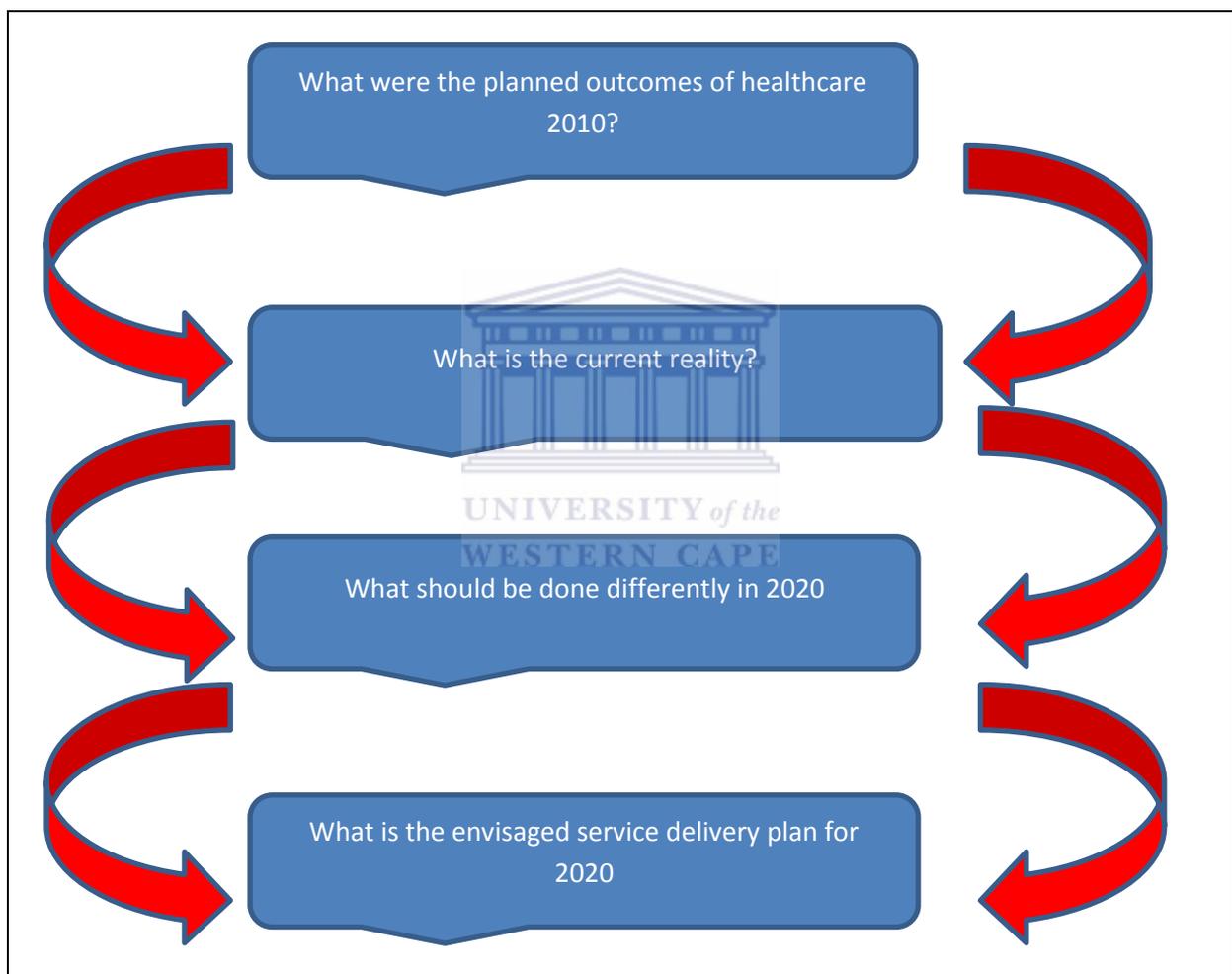
### 8.1 SUMMARY

In understanding the process of care, one is able to better understand the needed health outcomes. This assists in the enhancement of patient care by minimising gaps in service delivery, and thus plays an important part in continuous quality improvement. In this study rehabilitation service delivery has been identified as a challenge both nationally and in the Western Cape Province. Thus the researcher deemed it important to determine the process of care within rehabilitation services, in order to address this challenge by involving all the key stakeholders such as persons with disabilities, service providers of the rehabilitation services and caregivers of patients with disabilities. The outcomes of this study are important and will be presented below. According to Guion, Diehl and McDonald (2011:1), data triangulation involves “using different sources of information in order to increase the validity of a study”. In the current study various sources were used to explore the process of care within rehabilitation services and these included a systematic review of literature, patient perceptions, as well as caregiver and service provider perceptions.

According to the Department of Health in the Western Cape, in moving from Healthcare 2010 to Healthcare 2020, there needs to be an approach that promotes continuity from the Comprehensive Service Plan adopted in the 2010 to the new 2020 plan. The Western Cape Department of Health based the new plan on trying to address key issues, and encouraged all stakeholders in the health sector to contribute to shaping the public health sector. The working document drafted by the Department of Health (WCDoH, 2011) primarily highlighted that improving the patient

experience and the quality of care is at the heart of the vision for 2020. In preparing for this new endeavour an understanding of the current status quo was essential and this study assists in focussing on the aspect of rehabilitation services. Figure 8.1 below highlights the key approach adopted by the Western Cape Department of Health in facilitating the transition from 2010 to 2020.

**Figure 8.1: Western Cape DOH Transition Approach (Adopted from DOH, 2011)**



Thus when looking at the approach of the Department of Health, we aim to report on the current reality of rehabilitation services in the Western Cape and through the utilisation of feedback from various stakeholders will be able to present a holistic picture of rehabilitation services. Figure 8.2 below summaries the key findings of each phase of the study and highlights the areas that need to be addressed as we

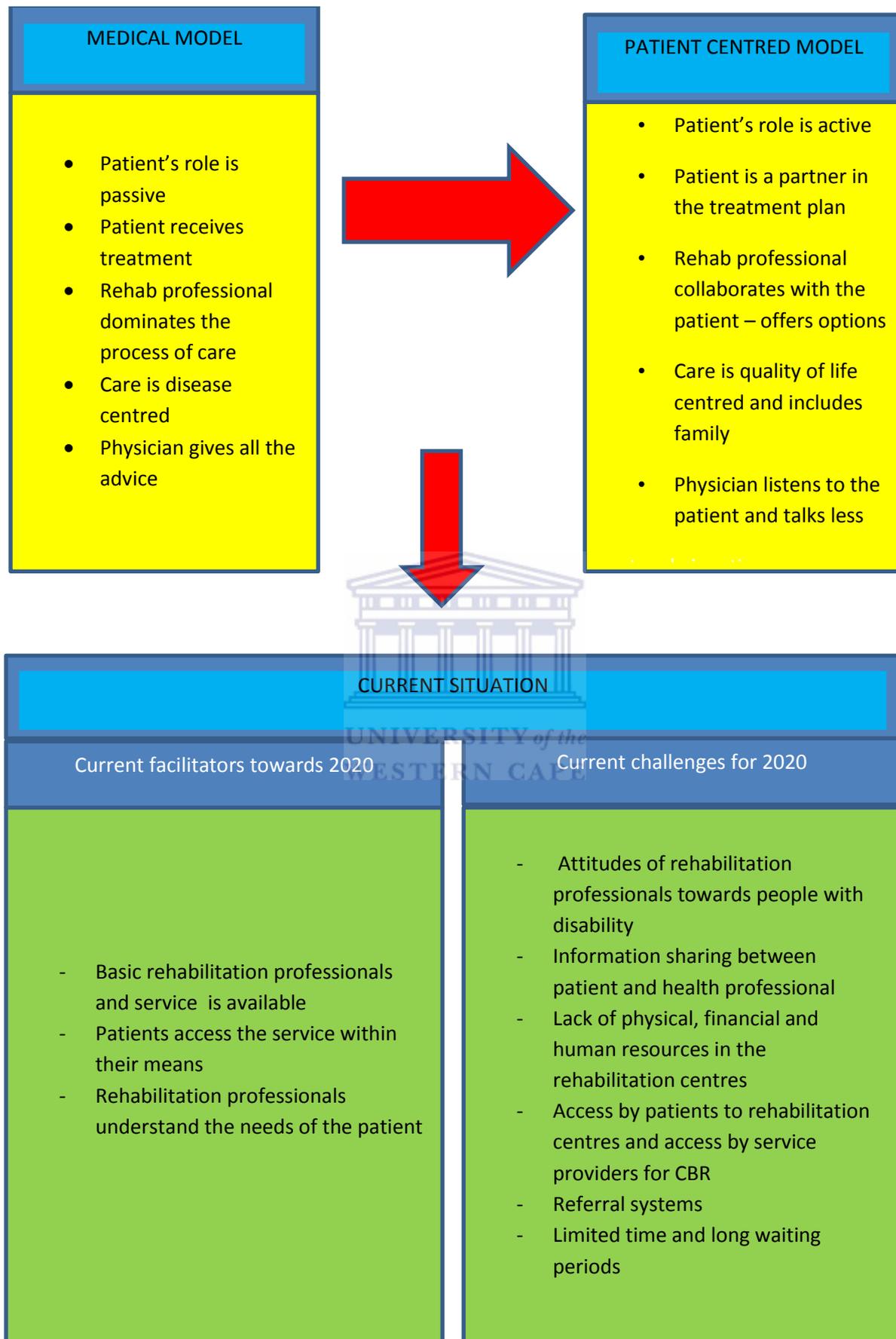
move from a medical model to the 2020 patient centred healthcare plan. The study assisted in identifying areas that need to be addressed if we are to succeed with the 2020 healthcare plan in South Africa.

The Department of Health believes that the CSP in 2010 laid a strong foundation and infrastructure for health services in the Western Cape. A major focus going towards 2020 will be to superimpose a new strategy on the existing base to:

- Improve the patient experience
- Improve quality of care
- Strive for further operational efficiencies

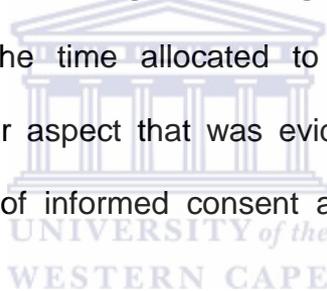
It is clear that the views from three independent sources and key stakeholders involved in rehabilitation services confirm that the direction in which healthcare in the Western Cape is being driven through the 2020 vision is correct. Various aspects will however require specific attention and this study clearly assists in identifying the needs of rehabilitation services in the Western Cape. In moving in the above direction the current study highlights that there are areas under the key focus areas that need improvement.

**Figure 8.2: Current situation in moving from a medical model to a patient centred model**



### **8.1.1 Improve the patient experience**

It is clear that within rehabilitation services there is a clear link between the service provider, the patient and the caregiver of the patient. This link is important if we aim to meet the Department of Health 2020 vision of a patient centred approach to healthcare. Despite the fact that quality patient centred care is the primary focus for healthcare services, the evidence provided by this study indicates that the health system faces some challenges with regards to achieving this aim for rehabilitation services. In addition, for a patient-centred approach there needs to be improved client-clinician relationships with involvement of all stakeholders in the management of the patient's condition. One of the largest challenges identified as a lack within the rehabilitation services was the time allocated to health education during the rehabilitation process. Another aspect that was evident from the service provider questionnaires was the lack of informed consent and decision-making regarding treatment options.



### **8.1.2 Improve the process of care**

Lack of resources influenced the process of care according to the views of services providers and patients. Service providers emphasised the need for more resources in order to provide holistic management of patients. A concerted effort needs to be made to address the human resources shortages currently experienced in the area of rehabilitation services at primary healthcare level. In addition, patients also highlighted that treatment sessions have become routine rather than specific to the needs of the patient. These tensions are linked to the fact that lack of resources

places a strain on time, and thus leads to limited interaction between the patient and the service provider.

### **8.1.3 Strive for operational efficiencies**

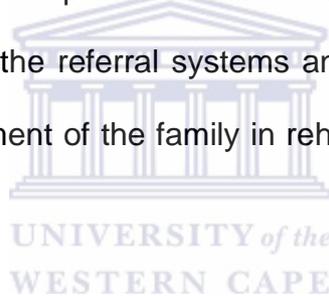
Within rehabilitation service provision the process of care is compromised by long waiting times within the centre, inadequate referral systems amongst rehabilitation professionals and within hospitals, lack of respect between patients and service providers, long waiting times for next appointments, and minimal time allocated to health education. Important components of client-centred rehabilitation should include individualization of programs to the needs of the client for a smooth transition between rehabilitation programs and the community; sharing of information and education that is appropriate, timely, and according to the clients' wishes; family and peer involvement in the rehabilitation process (e.g. emotional support); coordination and continuity within and across sectors (e.g. access to rehabilitation through more than one door, follow-up as a continuum of access); and outcomes that are meaningful to the client.

Patient records did not have all the information of the patients that attended these rehabilitation centres. This lack of information from patient records caused limitations in gathering information about patients who attend rehabilitation services.

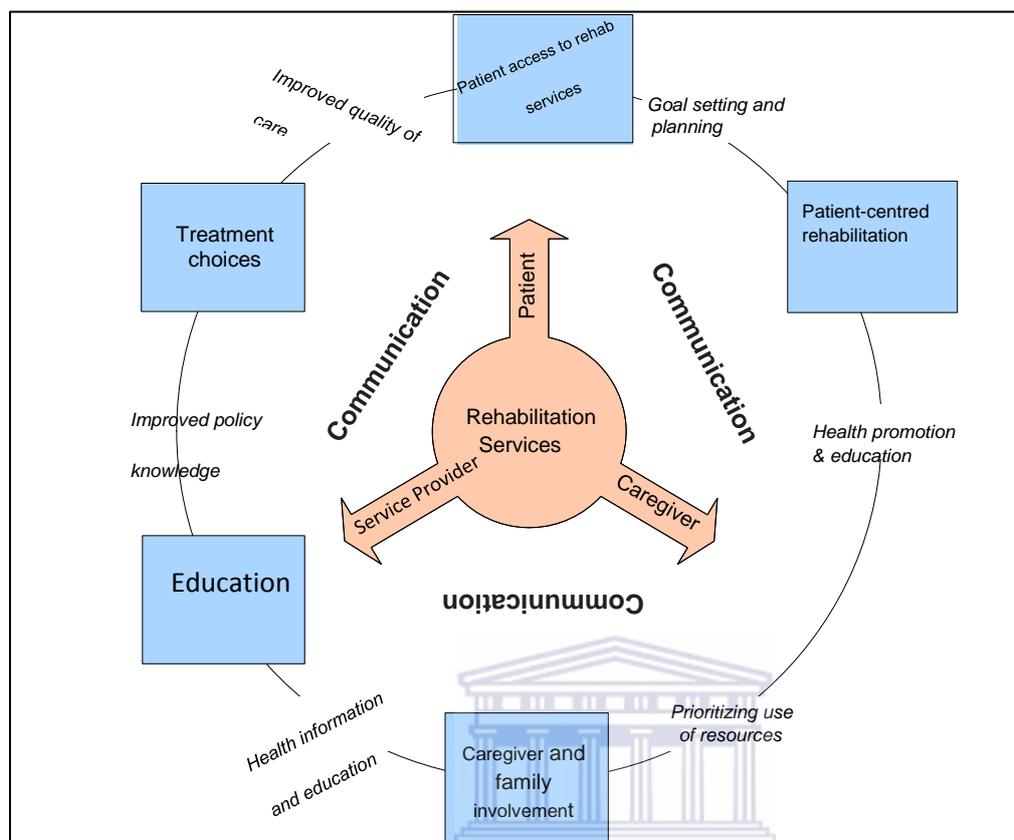
### **8.1.4 Possible model for rehabilitation**

Based on the views of the various stakeholders and the concerns identified in moving towards 2020, a proposed model for rehabilitation services in the Western Cape is identified (Figure 8.3). This model includes access to rehabilitation services, patient centred rehabilitation, caregiver and family involvement, stakeholder

education and rehabilitation interventions. Access to rehabilitation has been highlighted as a necessity in this study. The results also stressed the importance of obtaining clients' perspectives on healthcare needs, in order to identify deficits in care and to examine more specifically why and what specific problems rehabilitation clients experience. In addition, process elements of care are important, and besides individual interventions, health promotion and education should also be included. Client education is an important component of effective rehabilitation services and may contribute to both physical and psychosocial well-being of the patient. The aim of client and caregiver education is to enable people with disabilities to develop the skills and strategies that are required to manage and live with their condition. In addition, education of the services providers will assist in facilitating the rehabilitation process, if they are aware of the referral systems and also of services available in the catchment areas. Involvement of the family in rehabilitation will also improve the quality of care of the clients.



**Figure 8.3: Model for recommended rehabilitation services**



## 8.2 RECOMMENDATIONS

### 8.2.1 Short term goals

Based on the findings of the study the following recommendations are made:

- Education of the all service providers on the national and provincial health policies.
- Workshops are needed to provide service providers with information regarding the basic needs of the patient and the caregiver.
- The basic model identified in this study needs to be converted into a research pilot project that aims to address all the aspects of the model.

- A similar project needs to be implemented nationally in order to influence policy nationally.

### **8.2.2 Long term goals**

From this project, the following long term recommendations are made:

- Implementation of a longitudinal research study to monitor the effects of knowledge based workshops for service providers.
- Evaluation of the impact of including health education in the rehabilitation process on the satisfaction of clients and caregivers.
- Advocacy for policy change regarding more prominent featuring of rehabilitation in the Healthcare 2020 plan.



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# APPENDICES

**APPENDIX A: SYSTEMATIC REVIEW PROTOCOL**

**SYSTEMATIC REVIEW**

**Barriers and facilitators of rehabilitation  
services for persons with physical disabilities**



**Nondwe Bongokazi Mlenzana**

# 28-30 June 2010

## Review Topic:

Barriers and facilitators of rehabilitation services for persons with physical disabilities

## Background

People with disabilities face many challenges when they go through the process of disability. When one is diagnosed with a disability there are changes that they have to adjust to due to a disability. Physical disability is one of the commonest disabilities that falls under the umbrella of disability. In order to understand the challenges faced by the disabled, one needs to have a common definition for disability. According to WHO (2001), *"Disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives."*

When one presents with an abnormality they need to be accommodated by getting assistive devices to compensate the movement so that an individual finds it easy to be active again. This depends on availability of rehabilitation professionals that assists with the rehabilitation process. Rehabilitation means a goal orientated and time-limited process aimed at enabling an impaired person to reach an optimum mental, physical and/or social functional level, thus providing her or him with the tools to change his/her own life. It can involve measures intended to compensate for a loss of function or a functional limitation and other measures intended to facilitate social adjustment or readjustment.

Crisp (2000) did a study in Australia on perceptions of individuals with disabilities concerning health and rehabilitation professionals. When categorising the respondents he categorised them based on their sense of well-being: battlers (low sense of well-being), strugglers, contenders and optimisers (high sense of well-

being). From these categories battlers and strugglers felt stigmatised when they were given assistive devices and others felt that they were unsuccessful when requesting assistive devices. This category was not satisfied with the services that were provided to them by health and rehabilitation professionals. Contenders and optimisers see disability as a manageable condition. They were satisfied with what they received as they no longer consulted rehabilitation professionals, they were continuing with their own rehabilitation process and very independent.

Harris, Hayter and Allender (2008) explored barriers and facilitators for the management of chronic illnesses. They found out that communication, a lack of adequate and timely service provision, difficult referral process, time pressures and lack of information were barriers to healthcare professionals making an offer to patients with chronic illnesses. It has been proven that good management of chronic illnesses improves patient care and cuts down on health costs for rehabilitation. When looking at rehabilitation programs they focus on working in a team of rehabilitation professionals, and they either use multidisciplinary or interdisciplinary team members so as to optimise physical and social well-being of patients.

Wade and de Jong (2000) strongly believe in a well-organized, coordinated, multidisciplinary rehabilitation service based on a problem orientated approach rehabilitation programme. Currently there is new rehabilitation evidence for specific interventions that is conceptualised but not practical. It is clear that rehabilitation need to move to evidence based when rehabilitating clients with disabilities. While (2005) says that the rehabilitation process comprises of assessment, goal setting, intervention and evaluation of the programme, which is in line with the definition of rehabilitation. In China rehabilitation services are limited, which makes delivery of services to people with disabilities difficult, which leads to complications of disability. People with disabilities in China find it difficult to access rehabilitation services due to severity of disability, financial constraints, poor quality of rehabilitation programs and poor awareness of rehabilitation services (Zongjie *et.al.*, 2007)

Chappell and Johannsmeier (2009) conducted a study within a community where rehabilitation was offered by community rehabilitation facilitators. These facilitators were in existence because people with disabilities faced challenges in getting rehabilitation from rehabilitation professionals. In this study community rehabilitation

professionals played a significant role in advising and counselling people with disabilities during consultation visits. This service was identified as a gap in rehabilitation services for people with disabilities. In this study people with disabilities improved self-esteem, self-confidence and acceptance of their own disabilities as rehabilitation facilitators played a vital role in their disabilities and for family members. Some clients commented that community rehabilitation facilitators changed their lives in many ways: some can work on their own, some changed their attitudes towards their children with disabilities, and some changed their way of thinking because of the input of community rehabilitation facilitators. Even though this programme of rehabilitation facilitators is in place there are gaps that were identified by people with disabilities such as poor identification of the needs of people with disabilities, basic needs that were unmet by rehabilitation services, the social situation of the family of the person with disability, and inadequate community interventions to reintegrate people with disabilities back into the community. The impact of introducing community rehabilitation facilitators was evident in the communities that were targeted, as community rehabilitation facilitators showed improvement in community development, poverty reduction, social inclusion and equalisation of opportunities.

This literature highlights the facilitators and barriers of rehabilitation services for people with disabilities. This review will assist with the facilitators of rehabilitation services so as to improve what is currently happening in rehabilitation centres. Also this review will raise the awareness of rehabilitation professionals towards the facilitators of rehabilitation services, as barriers are mostly presented in the studies done previously. Some of the studies highlight what rehabilitation professionals and people with disabilities say about rehabilitation process.

### **Aim of the review**

To identify the barriers and facilitators of rehabilitation services for clients presenting with physical disabilities.

### **Question**

What are the common barriers and facilitators of rehabilitation services for clients presenting with physical disabilities?

## **Inclusion criteria**

The inclusion criteria for this review will be:

- Available full text articles on line published in English for the period 1990 - 2010
- Studies using a qualitative design
- Studies focusing on people with physical disabilities attending rehabilitation services
- Participants had to be exposed to rehabilitation services: institution based or community based

## **Search strategy**

The search strategy will be implemented as follows. Data bases such as CINAHL with full text, ERIC, Academic search premier, MEDLINE, Health resource-consumer edition, Health source: Nursing/Academic edition, PsychARTICLES, SocIndex with full text and Ebscohost will be searched for this review. The terms that will be used to search for literature will include rehabilitation service, facilitators and barriers, physically disabled, rehabilitation service providers and user satisfaction. Search terms such as positives and negatives, persons with disabilities, physical therapists, occupational therapists, doctors, nurses, social workers, client satisfaction with similar meanings from other studies to these will be used as alternatives to search terms such as barriers and facilitators. The search will be restricted to full text English publications, human studies and articles published between 1st January 1990 to 31 December 2010. Studies will be excluded if they do not specifically focus on rehabilitation services.

## **Data extraction**

Studies that will be used will be qualitative studies that use focus groups, in-depth interviews or structured interviews with open-ended questions to people with physical disabilities. The intervention will be the rehabilitation services provided to

people with physical disabilities. These studies will assist to identify common barriers and facilitators of rehabilitation services for people with disabilities. Two reviewers will examine the articles and select the studies that meet the inclusion criteria. They will separately review the articles using PIO method and discuss the most suitable studies that meet the criteria for inclusion in the review. The reviewers will use a critical review form for the quantitative studies and a critical appraisal skills programme (CASP) form to make sense of evidence with 10 questions for the qualitative studies (CASP, 2004). Table 1 below illustrates the questions asked.

Table 1: CASP review questions

No	Questions
1	Was there a clear statement of the aims of the research?
2	Is the qualitative methodology appropriate?
3	Was the research design appropriate to address the aims of the research?
4	Was the recruitment strategy appropriate to the aims of the research?
5	Were the data collected in a way that addressed the research issue?
6	Has the relationship between researcher and participants been adequately considered?
7	Have ethical issues been taken into consideration?
8	Was the data analysis sufficiently rigorous?
9	Is there a clear statement of findings?
10	How valuable is the research?

Both reviewers will have copies of the articles that will be suitable for the study and use the CASP to get articles that will answer the review question.

## Data analysis

Two reviewers will independently analyse articles that will be screened using PIO method as a screening tool where eligibility of the articles will be identified. Out of the articles that the reviewers will identify as eligible articles that meet the criteria for the review those articles will be used. Reviewers will compare opinions and reach consensus on the final articles to be included in the review. The main focus will be articles that have participants who presented with physical disabilities, attended rehabilitation centres, and have to comment about barriers and facilitators of rehabilitation services.

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## APPENDIX B: CRITICAL APPRAISAL SKILLS PROGRAMME

# CRITICAL APPRAISAL SKILLS PROGRAMME

## Making sense of evidence

10 Questions to help you make sense of

Qualitative Research



This assessment tool has been developed for those unfamiliar with qualitative research and their theoretical perspectives. This tool presents a number of questions that deal very broadly with some of the principles or assumptions that characterise qualitative research. It is *not a definitive guide* and extensive further reading is recommended.

*General comments*

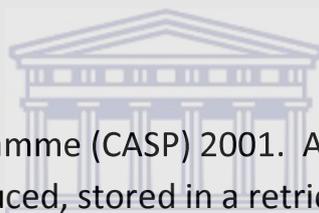
The first two questions are screening questions and can

be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions.

The subsequent questions ask you to read the main question in bold first and then use the sub-questions underneath to give more detailed feedback.

Record your answers to each question in the spaces provided.

The 10 questions have been developed by the national CASP collaboration for qualitative methodologies



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## Screening Questions

1	Was there a clear statement of the aims of the research?	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>

<p><i>HINTS: What was the research trying to find out?</i></p> <p><i>Why is it important?</i></p> <p><i>What is its relevance?</i></p>					
<p>2 Is a qualitative methodology appropriate?</p> <p><i>HINT: Does the research seek to interpret or illuminate the actions and/or subjective experiences of research participants?</i></p>	<table> <tr> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No				
<input type="checkbox"/>	<input type="checkbox"/>				



**Detailed Questions:**

<p><i>Appropriate research design</i></p> <p>UNIVERSITY of the WESTERN CAPE</p>	
<p>3 Was the research design appropriate to address the aims of the research?</p>	<p><i>Write comments here</i></p>
<p>Has the researcher justified the research design ? (eg have they discussed how they decided which methods to use)</p>	
<p><i>Sampling</i></p>	
<p>4 Was the recruitment strategy appropriate to the aims of the research?</p>	<p><i>Write comments here</i></p>

Has the researcher explained how the participants were selected?

Have they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study?

Are there any discussions around recruitment? (eg why some people chose not to take part)

### *Data collection*

5 Were the data collected in a way that addressed the research issue?

*Write comments here*



Was the setting for data collection justified?

Is it clear how data were collected?

*eg: focus group, semi-structured interview etc*

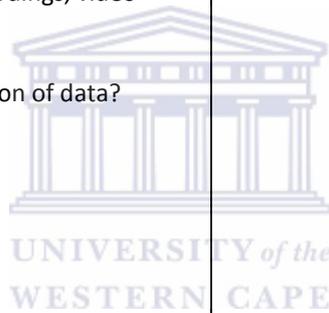
Has the researcher justified the methods chosen?

Has the researcher made the methods explicit (eg for interview method, is there an indication of how interviews were conducted, or if they used a topic guide?)

e) If methods were modified during the study, has the researcher explained how and why?

f) Is the form of data clear (eg tape recordings, video material, notes etc)

g) Has the researcher discussed saturation of data?



*Reflexivity (research partnership relations/recognition of researcher bias)*

6 Has the relationship between researcher and participants been adequately considered?

*Write comments here*

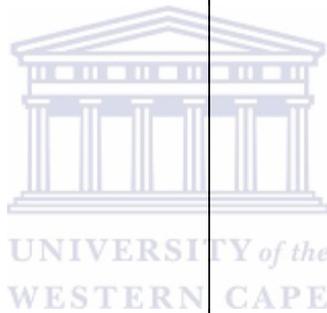
Is it clear:

If the researcher critically examined their own role, potential bias and influence during:

formulation of research questions

data collection including: sample recruitment, choice of location

How the researcher responded to events during the study and whether they considered the implications of any changes in the research design?



*Ethical Issues*

7 Have ethical issues been taken into consideration?

*Write comments here*

Are there sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained?

Has the researcher discussed issues raised by the study (eg issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study?)

Has approval been sought from the ethics committee?

### *Data Analysis*

8 Was the data analysis sufficiently rigorous?

*Write comments here*

Is there an in-depth description of the analysis process?

If thematic analysis is used, is it clear how the categories/themes were derived from the data?

Does the researcher explain how the data presented was selected from the original sample to demonstrate the analysis process?

Is there sufficient data presented to support the findings.

To what extent is contradictory data taken into account?

Did the researcher critically examine their own role, potential bias and influence during analysis and selection of data for presentation?

### *Findings*

9 Is there a clear statement of findings?

*Write comments here*

<p>Are they explicit?</p> <p>Is there adequate discussion of the evidence both for and against the researchers' arguments?</p> <p>Has the researcher discussed the credibility of their findings?</p> <p>Are the findings discussed in relation to the original research questions</p>	
--	--

<p><i>Value of the research</i></p> <p>10 How valuable is the research? <i>Write comments here</i></p>	
<p>Does the researcher discuss the contribution the study makes to existing knowledge or understanding?</p> <p>Eg - do they consider the findings, in relation to current practice or policy, or relevant research based literature?</p> <p>- do they identify new areas where research is necessary? Have the researchers discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used</p>	

# APPENDIX C: RESEARCH PROJECT AND PROJECT NUMBER

## RESEARCH PROJECT AND PROJECT NUMBER

**OFFICE OF THE DEAN  
DEPARTMENT OF RESEARCH  
DEVELOPMENT**

Private Bag X17, Bellville 7535  
South Africa  
Postcode: 7535  
Telephone: 27 21 959-2346/2945  
Fax: +27 21 959 2170  
Website: www.uwc.ac.za

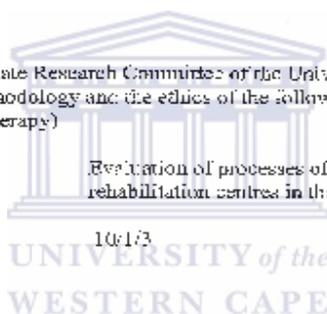
25 March 2010

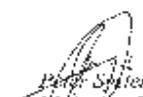
To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and the ethics of the following research project by Mrs. N Mlezana (Physiotherapy)

Research Project: Evaluation of processes of care at selected rehabilitation centres in the Western Cape

Registration no: 1061/3



  
Prof. S. J. van der Merwe  
Manager, Research Development Office  
University of the Western Cape



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WESTERN CAPE

A place of quality, a place to grow, from hope to action through knowledge

# APPENDIX D: ETHICS APPROVAL FROM DEPARTMENT OF HEALTH

## ETHICS APPROVAL FROM DEPARTMENT OF HEALTH



Verwysing  
Reference 19/18/RP 33(b)/2010

Isalathiso

Navrae  
Enquiries  
Imibuzo Dr A Dearham

Telefoon  
Telephone 021 483 4193

P O Box 19063

Tygerberg  
7505

Departement van Gesondheid  
Department of Health  
iSebe lezeMpilo

FAX: - 021 931 9835, 021 9591217

Dear Prof M deVilliers  
Ms G Mji  
Ms S Statham  
Ms S Gcaza  
Ms A Rhoda  
PhD student Nondwe Mlenzana

**RE: The evaluation of process of care at selected rehabilitation centres in the Western Cape Province**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following people to assist you with access to:

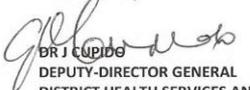
Bishop Lavis Rehabilitation Centre	Ms. R. Carelse	Tel: (021) – 9345060
Elangeni Rehabilitation Centre	Ms Marvinina Johnson	Tel: (023) 348 8111
Guguletu	Ms Mabusela	Tel: (021) 637 1280

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator ([healthres@pgwc.gov.za](mailto:healthres@pgwc.gov.za)).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

  
DR J CUPIDO  
DEPUTY-DIRECTOR GENERAL  
DISTRICT HEALTH SERVICES AND PROGRAMMES  
DATE: 23/02/2010

Page 1 of 2

Dorpstraat 4  
Posbus 2060  
KAAPSTAD  
8000

4 Dorp Street  
PO Box 2060  
CAPE TOWN  
8000

## APPENDIX E: CONSENT FORM FOR SERVICE PROVIDERS

# CONSENT FORM FOR SERVICE PROVIDERS



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2807, Fax: 27 21-959 1217

E-mail: [nmlenzana@uwc.ac.za](mailto:nmlenzana@uwc.ac.za)

### CONSENT FORM FOR SERVICE PROVIDERS

Title of Research Project: The evaluation of processes of care at selected rehabilitation centres in the Western Cape.

The study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

I agree to be audiotaped during my participation in this study.

I do not agree to be audiotaped during my participation in this study.

Participant's signature.....Witness.....

Witnesses' signature.....

Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Mrs. Nondwe Mlenzana

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021) 959 2807

Fax: (021) 959 1217

Email: [nmlenzana@uwc.ac.za](mailto:nmlenzana@uwc.ac.za)

# APPENDIX F: CONSENT FORM FOR PATIENTS

## CONSENT FORM FOR PATIENTS



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E-mail: [nmlenzana@uwc.ac.za](mailto:nmlenzana@uwc.ac.za)

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The study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

\_\_\_ I agree to be audiotaped during my participation in this study.

\_\_\_ I do not agree to be audiotaped during my participation in this study.

Participant's signature.....Witness.....

Witnesses' signature.....

Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Mrs Nondwe Mlenzana

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021) 959 2807

Fax: (021) 959 1217

Email: [nmlenzana@uwc.ac.za](mailto:nmlenzana@uwc.ac.za)

## APPENDIX G: CONSENT FORMS FOR CAREGIVERS

# CONSENT FORMS FOR CAREGIVERS



UNIVERSITY OF THE WESTERN CAPE

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E-mail: [nmlenzana@uwc.ac.za](mailto:nmlenzana@uwc.ac.za)

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I agree to be audiotaped during my participation in this study.

I do not agree to be audiotaped during my participation in this study.

Participant's signature.....Witness.....

Witnesses' signature.....

Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Mrs Nondwe Mlenzana

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021) 959 2807

Fax: (021) 959 1217

Email: [nmlenzana@uwc.ac.za](mailto:nmlenzana@uwc.ac.za)

## APPENDIX H: INFORMATION SHEET FOR PATIENTS

# INFORMATION SHEET FOR PATIENTS



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E-mail: [nmlenzana@uwc.ac.za](mailto:nmlenzana@uwc.ac.za)

### INFORMATION SHEET FOR PATIENTS

**Project Title:** The evaluation of processes of care at selected Rehabilitation Centres in the Western Cape



#### **What is this study about?**

This is a research project being conducted by Nondwe Bongokazi Mlenzana at the University of the Western Cape. We are inviting you to participate in this research project because you are accessing rehabilitation services at the rehabilitation centre in the Western Cape. The purpose of this research project is to evaluate the implementation of the national rehabilitation policy as it relates to the process of care according to the service providers and clients with disability at rehabilitation centres in the Western Cape Province. This information will inform Department of Health regarding rehabilitation services in the Western Cape.

#### **What will I be asked to do if I agree to participate?**

You will be asked to complete the questionnaire or answer questions asked by the researcher that will be in a questionnaire. You will be asked to participate in a focus group discussion that will approximately take 45 minutes of your time to answer. All the questions will be relating to accessibility of rehabilitation services in the Western Cape.

#### **Would my participation in this study be kept confidential?**

We will do our best to keep your personal information confidential. To help protect your confidentiality and anonymity, no names will be required when completing a questionnaire and the

information that you have given us will be kept in a locked cupboard and will be used for this study only. If you answered the questions from a questionnaire your questionnaire will be coded using numbers as identification and the data will only be used by the researcher.

If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

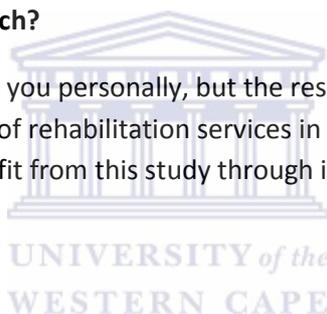
In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning neglect to you.

### **What are the risks of this research?**

There are no known risks associated with participating in this research project.

### **What are the benefits of this research?**

This research is not designed to help you personally, but the results may help the investigator learn more about barriers and facilitators of rehabilitation services in the Western Cape. We hope that, in the future, other people might benefit from this study through improved understanding of rehabilitation.



### **Do I have to be in this research and may I stop participating at any time?**

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

### **Is any assistance available if I am negatively affected by participating in this study?**

If you are negatively affected by this study you will be referred to a counsellor to address your problems.

### **What if I have questions?**

This research is being conducted by *Nondwe Bongokazi Mlenzana* at the University of the Western Cape. If you have any questions about the research study itself, please contact Nondwe Bongokazi Mlenzana at:

University of the Western Cape

Department of Physiotherapy

Private Bag x 17

Bellville

Phone: 021-9592807

Cell: 0832261916

e-mail: [nmlenzana@uwc.ac.za](mailto:nmlenzana@uwc.ac.za)

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department: Professor Julie Phillips

Dean of the Faculty of Community and Health Sciences: Professor Ratie Mpofu

University of the Western Cape

Private Bag X17

Bellville 7535



This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.



## APPENDIX I: INFORMATION SHEET FOR SERVICE PROVIDERS

# INFORMATION SHEET FOR SERVICE PROVIDERS



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**Project Title:** The evaluation of processes of care at selected Rehabilitation Centres in the Western Cape

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#### **What will I be asked to do if I agree to participate?**

You will be asked to complete the questionnaire or answer questions asked by the researcher in a focus group discussion. You will be asked to complete a questionnaire that will approximately take 30 minutes of your time AND be involved in an in depth interview that will approximately take 45 minutes of your time to participate. All the questions will be relating to accessibility of rehabilitation services in the Western Cape.

#### **Would my participation in this study be kept confidential?**

We will do our best to keep your personal information confidential. To help protect your confidentiality and anonymity, no names will be required when completing a questionnaire and the information that you have given us will be kept in a locked cupboard and will be used for this study only. If you answered the questions from a questionnaire your questionnaire will be coded using numbers as identification and the data will only be used by the researcher.

If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

### **Audio taping**

This research project involves making *audiotapes* of you during an indepth interview. We are using these to make sure that all the information is recorded as it is challenging to write all the information during a discussion session. There will be a scribe also who will take notes during the interview as the researcher will be facilitating the discussion. Participants will be asked to keep information to themselves after interviews. The researcher will lock the tapes in a cupboard that will only be accessed by her during data transcribing. After transcribing tapes will be kept and be destroyed after the final document of the thesis is submitted.

### **What are the risks of this research?**

There are no known risks associated with participating in this research project.

### **What are the benefits of this research?**

This research is not designed to help you personally, but the results may help the investigator learn more about barriers and facilitators of rehabilitation services in the Western Cape. We hope that, in the future, other people might benefit from this study through improved understanding of rehabilitation.

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## APPENDIX J: INFORMATION SHEET FOR CAREGIVERS

# INFORMATION SHEET FOR CAREGIVERS



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### **INFORMATION SHEET FOR CAREGIVERS**

**Project Title: The evaluation of processes of care at selected Rehabilitation Centres in the Western Cape**

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#### **Would my participation in this study be kept confidential?**

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Department of Physiotherapy

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Bellville

Phone: 021-9592807

Cell: 0832261916

e-mail: [nmlenzana@uwc.ac.za](mailto:nmlenzana@uwc.ac.za)

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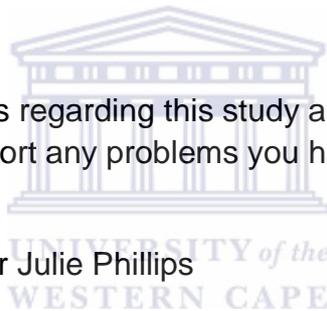
Dean of the Faculty of Community and Health Sciences: Professor Ratie Mpofu

University of the Western Cape

Private Bag X17

Bellville 7535

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.



## APPENDIX K: DATA CAPTURING SHEET FOR FOLDERS

# DATA CAPTURING SHEET FOR FOLDERS



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E-mail: nmlenzana@uwc.ac.za

### DATA CAPTURING SHEET

#### A. DEMOGRAPHIC DATA

1. Age:

2. Gender:

1. Male
2. Female

#### B. MEDICAL DATA

3. Type of disability
- Head injury
  - Spinal cord injury
  - Strokes
  - Amputation
  - Fracture/Dislocation
  - Osteoarthritis
  - Neuromusculoskeletal

4. Date of admission

5. Date of discharge

6. Classification of spinal cord injury:

7. Extent of injury:

- None
- Complete
- Incomplete

8. Presence of stroke:

- Yes
- No



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9. Side of body impaired:

- 0. None
- i. Left
- ii. Right
- iii. Both
- iv. Missing

10. Type of amputation:

**Upper limb**

- 0. None
- i. Amputations of digits
- ii. Metacarpal amputation
- iii. Wrist disarticulation
- iv. Forearm amputation (transradial)
- v. Elbow disarticulation
- vi. Above-elbow amputation (transhumeral)
- vii. Shoulder disarticulation (forequarter amputation)

**Lower limb**

- 0. None
- i. Amputation of digits
- ii. Partial foot amputation
- iii. Ankle disarticulation
- iv. Below- knee amputation (transtibial)
- v. Knee bearing amputation (knee disarticulation)
- vi. Above- knee amputation (transfemoral)
- vii. Hip disarticulation
- viii. Hemipelvectomy (hindquarter amputation)

**Waist**

- 0. None
- i. Hemipelvectomy (amputation at the waist)

11. Presence of head injury:

- i. Yes
- ii. No

12. Fractures and dislocations

- 0. None
- i. Upper limbs
- ii. Lower limbs
- iii. Trunk

13. Osteoarthritis

- 0. None
- i. Upper limbs
- ii. Lower limbs
- iii. Trunk

14. Neuromusculoskeletal

- 0. None
- i. Cervical
- ii. Thoracic
- iii. Lumbar
- iv. Sacral
- v. Referred

15. Team members involved in patient management:

- |                                  |        |       |
|----------------------------------|--------|-------|
| i. Counsellor                    | 1. Yes | 2. No |
| ii. Psychologist                 | 1. Yes | 2. No |
| iii. Physiotherapist             | 1. Yes | 2.No  |
| iv. Occupational therapist       | 1. Yes | 2. No |
| v. Speech and language therapist | 1. Yes | 2. No |
| vi. Dietician                    | 1. Yes | 2. No |
| vii. Social worker               | 1. Yes | 2. No |
| viii. Medical doctor             | 1. Yes | 2. No |
| ix. Specialist: Specify.....     | 1. Yes | 2. No |
| x. Nurse                         | 1. Yes | 2. No |
| xi. Prostatist & orthotist       | 1. Yes | 2. No |
| xii. Radiographer                | 1. Yes | 2. No |
| xiii. Pharmacist                 | 1. Yes | 2.No  |

**C. FREQUENCY OF RECEIVING SERVICES AT THE CENTRE**

1. Number of counselling sessions:
2. Number of sessions with psychologist:
3. Number of physiotherapy sessions:
4. Number of occupational therapy sessions:
5. Number of speech and language therapy sessions:
6. Number of sessions with dietician:
7. Number of sessions with social worker:
8. Number of doctor sessions:
9. Number of specialist visits:

10. Number of nursing care sessions:

11. Number of prostatis & orthotist sessions:

12. Number of pharmacy visits:

13. Number of sessions with radiographer:

14. Where was the patient referred to after being discharged from hospital:

- i. Patient's home
- ii. Closest CHC
- iii. Secondary or tertiary hospital
- iv. Rehabilitation unit
- v. Other



## APPENDIX L: QUESTIONNAIRE FOR SERVICE PROVIDERS

### Questionnaire for Service Providers

Section A: Demographic information			
A.1		Elangeni	
		Bishop Lavis	
		Gugulethu	
A.2	Age	Years	
A.3	Gender	Male	
		Female	
A.4	Profession	Doctor	
		Nurse	
		Physiotherapist	
		Occupational therapist	
		Speech therapist	
		Prosthetist	
		Social worker	
		Home based carer	
		Dietician	
		Orthopaedic sister	
		Psychologist	
		Clinical nurse practitioner	
		Peer supporter	
		Health Promoter	
Occupational therapy assistant			
Physiotherapy assistant			
Other			
A.5	Salary level	Level 6	
		Level 7	
		Level 8	
		Level 9	
		Level 10	
		Level 11	
		Level 12	
A.6	How long have you been working at this institution?	Years	
A.7	How long have you been working in the field of rehabilitation?	Years	
A.8	Total number of years of working experience?	Years	

## Section B: Relationship with clients and satisfaction with services provided

Comment	always	sometimes	never
<b>B1.1</b> I obtain informed consent from the service users before commencing treatment			
<b>B1.2</b> I treat the service user as a person instead of just another “case”			
<b>B1.3</b> Service users can choose how much they want to participate in their care			
<b>B1.4</b> I always treat the service users with respect			
<b>B1.5</b> I encourage my service users during sessions to talk about their problems			
<b>B1.6</b> I explain things in a language that service users can understand or use an interpreter when they don't			
<b>B1.7</b> I explain different treatment choices to the service users			
<b>B1.8</b> Service users feel free to ask questions			
<b>B1.9</b> I answer all of the service users' questions			
<b>B1.10</b> I treat all service users the same			
<b>B1.11</b> I am sensitive to the needs of the service users			
<b>B1.12</b> I give service users information to use at home in different ways (i.e. books, kits, video, pamphlets)			
<b>B1.13</b> I provide opportunities for the family/friends of the service users to participate in their care			
<b>B1.14</b> I trust that the service users are being truthful when they tell me about their problems			
<b>B1.15</b> I make the service users feel at ease during sessions			
<b>B1.16</b> I encourage service users to talk about their problem(s)			
<b>B1.17</b> I give service users enough time to talk so that they do not feel rushed			
<b>B1.18</b> I make service users feel like a partner in their care by allowing them to contribute to their treatment			
<b>B1.19</b> I help service users to understand and gain insight into their problem(s)			
<b>B1.20</b> I help service users learn how to manage on their own after discharge			

## APPENDIX M: INTERVIEW GUIDE FOR PATIENTS

### INTERVIEW GUIDE FOR PATIENTS



UNIVERSITY OF THE WESTERN CAPE  
Private Bag X 17, Bellville 7535, South Africa

*Tel: +27 21-959 2807, Fax: 27 21-959 1217*

E-mail: [nmlenzana@uwc.ac.za](mailto:nmlenzana@uwc.ac.za)

1. When you were referred to rehabilitation professionals, what was your reaction?
2. When you were diagnosed as someone who has a disability, what was your reaction?
3. How has your disability affected your life?
4. Can you explain what was done to you when you were at the rehabilitation consulting rooms? Probes: reception, interaction, assessment, treatment sessions, involvement of the family, privacy.
5. Please discuss problems you have encountered getting access to the rehabilitation service. Probes: transport, entrance, movement in the centre, attitude from service providers, environment.
6. Can you explain the processes that are followed when you apply for an assistive device eg. Wheelchairs, walking stick, walking frame?

# APPENDIX N: INTERVIEW GUIDE FOR SERVICE PROVIDERS

## INTERVIEW GUIDE FOR SERVICE PROVIDERS



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2807, Fax: 27 21-959 1217

E-mail: [nmlenzana@uwc.ac.za](mailto:nmlenzana@uwc.ac.za)

Please tell me about the accessibility of services here at this facility in terms of rehabilitation services.

Probes:

- Service providers
- Equipment
- Transport for patients
- Within the facility (therapy rooms/ space, toilets, lamps availability)



Tell me about your relationship with your patients, do you interact with your patients?

Probes:

- Respect and love patients
- Communication (language used)

Are your patients allowed to get involved and actively participate in their rehabilitation?

Probes:

- Setting goals with patients
- Explaining the procedures to patients

- Take part in their treatment sessions.

Do patients come with their families for therapy? Are their families allowed to get involved in the patient's rehabilitation sessions?

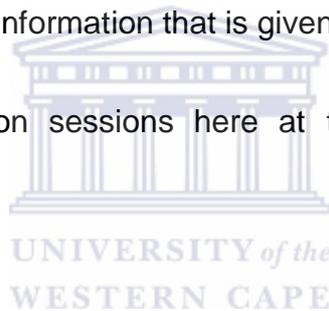
Regarding the provision of information, do you think your patients are adequately informed of any information they seek or need to know from you?

Probes:

- Their disability
- Treatment

Tell me more about any other information that is given to patients?

Tell me how the rehabilitation sessions here at this Rehabilitation Centre are structure or organized?



Probes:

- Appointment schedules
- The referral system

Do you think the rehabilitation services your offer here are adequate for all the patients that access the facility?

Tell me about the general budget allocated to this facility services and programs.

Probes:

- For equipment
- For training skills

Do you think you are well equipped and skilled enough to treat any type of disability?

What are your needs in order to provide the best services for the persons with disabilities in your catchment area?

Are you satisfied with the services you provide and do you think the patients are satisfied?

Do you think there are some topics that we did not cover that needed to be covered as relates to rehabilitation services?



## APPENDIX O: INTERVIEW GUIDE FOR CAREGIVERS

# INTERVIEW GUIDE FOR CAREGIVERS

### Introduction:

- Thank you for being willing to participate in our study.
- Purpose: In this session we will be discussing your perception and satisfaction of the rehabilitation services you received at the selected centre.
- Anonymity and confidentiality
- Recording of proceedings (tape recording)

1. Are you satisfied with the rehabilitation service your client has received at...?  
Please elaborate. How have the following factors influenced your experience?
  - Is the facility easy to access, e.g. appropriate transport to the facility or easy access with a wheelchair?
  - Does your transport cost you a lot of money?
  - Is the centre neat and clean?
  - Do you have to wait a long time for an appointment?
  - Did you receive assistive devices, e.g. crutches and wheelchairs readily?
  - Do you have to pay for any services or goods you receive at...?
2. What is your relationship with the rehabilitative team/therapists?
  - Do you feel comfortable approaching them with questions/worries/fears? Do you feel intimidated by them, or were they friendly, sympathetic and helpful?
  - Do they explain things to you without you asking?
  - Do you receive a HEP, and understand why you do the exercises?
  - Do they involve you in the treatment of your client?
3. What makes your day to day life as a caregiver challenging, with regards to caring for your client?
  - Financial difficulties?
  - Emotional difficulties? (feeling unappreciated, unvalued, no alone time)
  - Difficulty lifting/bathing/transferring etc?
  - Lack of physical help?
4. What makes your day to day life as a caregiver less challenging, with regards to caring for your client?
  - Emotional support?
  - Financial support?
  - Information/education provided by community health workers?

Thank you for participating in the study.