

**REHABILITATION SERVICES OF PERSONS WITH DISABILITIES:
EXPERIENCES OF PATIENTS AND SERVICE PROVIDERS IN A
REHABILITATION CENTRE IN THE WESTERN CAPE PROVINCE**

ANNE KUMURENZI

**Mini-thesis submitted in fulfilment of the requirements for the degree of Masters of
Science in Physiotherapy, Faculty of Community and Health Sciences, Department of
Physiotherapy, University of the Western Cape.**

**UNIVERSITY of the
WESTERN CAPE**

Supervisor: Prof. Anthea Rhoda

Co-supervisor: Mrs. Mlenzana Nondwe

June 2011

DECLARATION

I hereby declare that this study entitled **“Rehabilitation services of persons with disabilities: Experiences of patients and service providers in a rehabilitation centre in the Western Cape Province”** is my work and I have not submitted it for any degree or examination to any other university. All the sources that I have used or quoted have been indicated and acknowledged by means of complete reference.

Anne Kumurenzi

SignatureDatedJune 2011

Witnesses



Supervisor: Prof Anthea Rhoda

SignatureDated.... June 2011

Co-supervisor: Mrs. Mlenzana Nondwe

Signature.....Dated.... June 2011

DEDICATION

I dedicate this mini-thesis to my lovely and supportive mother, Mrs. Joyce Murenzi, who has devoted all her efforts, emotional and financial support, in seeing me succeed. I would not have achieved success without your help. To my brothers: Adolf, Erwin and Otto, my sisters: Elinah and Doris, for your love and support, I dedicate this mini-thesis. I love you all, may the Almighty God bless the works of your hands.



ACKNOWLEDGEMENT

I am grateful to the Almighty God for opening the opportunity for me to pursue my studies, his protection, grace and support granted to me.

I thank the Government of Rwanda for granting me a scholarship to further my studies. Kigali Health Institute for giving me study leave from work to pursue my studies, I am grateful.

I would like to express my appreciations to my supervisor Prof. Anthea Rhoda for her support and guidance in writing and completing this mini-thesis and her commitment for transporting me to the research setting. My co-supervisor Mrs. Mlenzana for her guidance in writing this mini-thesis and committing yourself to transport me to the research setting, I am grateful.

All the participants who accepted to take part in this study, I am grateful.

My appreciations to the research assistants who devoted their time to help me.

To my mum, Mrs. Joyce Murenzi, who provided considerable support and love, I will always be grateful to you.

My appreciations also go to my brothers: Adolf, Erwin and Otto, my sisters: Elinah and Doris, thank you for your support and care.

I am grateful to the SANDAP group for their contributions to this study. I would like to thank my classmates for their support. Charity, Lela, Manqoba, Robert, Simon and Wallace I am grateful for all your support and prayers. Thank you to the family of Restoration Life Ministries (RLM) for your spiritual support, guidance, and care during my stay in South Africa.

Thank you to the staff of the department of physiotherapy at UWC, who supported me in one way or the other. My appreciation to Conran and Nicole for their support in the completion of this study.

I extend my thanks to my writing coaches: Peter & Anthony. Those whom I have not mentioned by name who contributed to my success and stay in South Africa, may the Almighty God bless you.



ABBREVIATIONS

BLRC: Bishop Lavis Rehabilitation Centre

BLCHC: Bishop Lavis Community Health Centre

CBR: Community Based Rehabilitation

CHC: Community Health Centres

CSP: Comprehensive Service Plan

DOH: Department of Health

FGD: Focus Group Discussion

IBR: Institution Based Rehabilitation

ICF: International Classification of Functioning Disability and Health

ICIDH: International Classification of Impairments, Disability and Handicaps

INDS: Integrated National Disability Strategy

NRP: National Rehabilitation Policy

OTs Occupational Therapists

PHC: Primary Health Care

PTs: Physiotherapists

PWDs: Persons with Disabilities

SSA: Statistics of South Africa



UK: United Kingdom

UN: United Nations

UNCRPD: United Nations Convention on the Rights of Persons with Disabilities

USA: United States of America

WHO: World Health Organisation



KEY WORDS

Disability

Experiences

Rehabilitation

Rehabilitation services

Patient

Service providers

Community Health Centre

Primary Health Care

Rehabilitation facility

Qualitative research

Western Cape Province

Bishop Lavis



APPENDICES

Appendix A: Permission letter from Provincial Department of Health

Appendix B: Ethical approval letter from the University of the Western Cape

Appendix C: Permission letter from Bishop Lavis Rehabilitation Centre

Appendix D: English interview guide for patients

Appendix E: Afrikaans interview guide for patients

Appendix F: English interview guide for service providers

Appendix G: Afrikaans interview guide for service providers

Appendix H: English consent form

Appendix I: Afrikaans consent form

Appendix J: English information sheet for patients

Appendix K: Afrikaans information sheet for patients

Appendix L: English information sheet for service providers

Appendix M: Afrikaans information sheet for service providers



LIST OF TABLES

Table 4.1 Demographic characteristics from the focus group discussion

Table 4.2 The pre-determined themes and emerging theme from the focus group discussion

Table 4.3 Demographic characteristics from the in-depth interviews

Table 4.4 The pre-determined themes and emerging themes from the in-depth interviews



TABLE OF CONTENTS

DECLARATION	ii
DEDICATION	iii
ACKNOWLEDGEMENT	iv
ABBREVIATIONS	vi
KEY WORDS	viii
APPENDICES	ix
LIST OF TABLES	x
Table 4.1 Demographic characteristics from the focus group discussion	x
Table 4.2 The pre-determined themes and emerging theme from the focus group discussion	x
Table 4.3 Demographic characteristics from the in-depth interviews	x
Table 4.4 The pre-determined themes and emerging themes from the in-depth interviews	x
TABLE OF CONTENTS	xi
ABSTRACT	1
CHAPTER ONE	3
INTRODUCTION	3
1.0 INTRODUCTION	3
1.1 BACKGROUND OF THE STUDY	3
1.2 STATEMENT OF THE PROBLEM	8
1.3 RESEARCH QUESTION	9
1.4 AIM OF THE STUDY	9
1.5 OBJECTIVES OF THE STUDY	9
1.6 DEFINITIONS OF TERMS	10
1.7 OVERVIEW OF CHAPTERS	11
1.8 SUMMARY	12
CHAPTER TWO	13

LITERATURE REVIEW	13
2.0 INTRODUCTION.....	13
2.1 DISABILITY DEFINITION AND PREVALENCE	13
2.2 IMPACT OF DISABILITY ON PERSONS WITH DISABILITIES	14
2.3 AN OVERVIEW OF REHABILITATION.....	16
2.4 EXPERIENCES OF PERSONS WITH DISABILITIES.....	18
2.4.1 Accessibility of services.....	19
2.4.2 Interaction with service providers.....	22
2.4.3 Patient participation and involvement in rehabilitation	24
2.4.4 Provision of information	26
2.4.5 Structure of rehabilitation sessions	28
2.5 SERVICE PROVIDERS' EXPERIENCES	29
2.5.1 Service providers knowledge.....	29
2.5.1.1 Skills training.....	31
2.5.2 Interaction with patients.....	33
2.5.3 Patient involvement in rehabilitation	35
2.5.4 Provision of information to patients.....	36
2.5.5 Accessibility of resources	38
2.6 SUMMARY.....	40
CHAPTER THREE	42
METHODOLOGY	42
3.0 INTRODUCTION.....	42
3.1 RESEARCH SETTING.....	42
3.2 RESEARCH DESIGN	43
3.3 STUDY POPULATION AND SAMPLING	44
3.3.1 Study Population.....	44
3.3.2 Sample for patients.....	44

3.3.3 Sample for the service providers.....	45
3.4 METHODS OF DATA COLLECTION	45
3.4.1 Interview guide for Focus group discussion	45
3.4.2 Interview guide for In-depth interviews.....	46
3.5 PROCEDURE FOR DATA COLLECTION.....	47
3.5.1 Focus group discussion for patients	47
3.5.2 In-depth interviews for service providers	49
3.6 TRUSTWORTHINESS OF QUALITATIVE DATA	50
3.6.1 Credibility	50
3.6.2 Transferability.....	51
3.6.3 Dependability	51
3.6.4 Confirmability.....	51
3.7 DATA ANALYSIS	52
3.7.1 Focus group discussion of patients	52
3.7.2 In-depth interviews for service providers	53
3.8 ETHICAL CONSIDERATIONS	53
3.9 SUMMARY.....	55
CHAPTER FOUR.....	56
RESULTS	56
4.0 INTRODUCTION.....	56
SECTION A: RESULTS FOR PATIENTS.....	56
4.1 Demographic characteristics for the patients.....	56
4.2 PATIENTS' PERCEPTIONS REGARDING THE SERVICE PROVIDERS' KNOWLEDGE	59
4.2.1 Knowledge regarding patients' condition	59
4.2.2 Knowledge regarding patients' treatment	60
4.3 ACCESSIBILITY.....	60
4.3.1 Accessibility to transport	60

4.3.2 Accessibility within the facility	61
4.4 INTERACTION OF SERVICE PROVIDERS WITH PATIENTS	62
4.4.1 Respect for patients	62
4.4.2 Communication	63
4.5 PATIENT PARTICIPATION AND INVOLVEMENT DURING THERAPY SESSIONS	63
4.5.1 Setting goals	64
4.5.2 Involvement of families in patients' rehabilitation	64
4.6 PROVISION OF INFORMATION	65
4.6.1 Information related to disability	65
4.6.2 Information related to treatment	65
4.7 STRUCTURE/ORGANIZATION OF REHABILITATION SESSIONS	66
4.7.1 Frequency of therapy	66
4.7.2 Group and individual sessions	67
4.7.3 Appointment schedules	67
4.8 SATISFACTION WITH THE REHABILITATION SERVICES	68
4.8.1 Satisfied with treatment outcomes	69
4.8.2 Satisfied with Service providers	69
SECTION B: RESULTS FOR SERVICE PROVIDERS	70
4.2 Demographic characteristics for the service providers	70
4.3 PERCEPTION OF SERVICE PROVIDERS REGARDING THEIR KNOWLEDGE	72
4.3.1 Knowledge about patients' condition	72
4.3.2 Knowledge about treatment selection	72
4.3.3 Skills training among service providers	73
4.4 ACCESSIBILITY	74
4.4.1 Accessibility to transport	74
4.4.2 Accessibility within the facility	75
4.4.3 Accessibility of service providers	75

4.4.4 Availability of equipment	76
4.5 INTERACTION OF SERVICE PROVIDERS WITH PATIENTS	77
4.5.1 Relate to patients	78
4.6 PATIENT PARTICIPATION AND INVOLVEMENT IN THE REHABILITATION.....	79
4.6.1 Setting goals.....	79
4.6.2 Explaining activities prior therapy	80
4.6.3 Involvement of families in patients rehabilitation	80
4.7 PROVISION OF INFORMATION	81
4.7.1 Information related to disability.....	81
4.7.2 Information related to treatment	82
4.8 STRUCTURE/ORGANIZATION OF REHABILITATION SESSIONS	82
4.8.1 Frequency of therapy	82
4.8.2 Appointment schedules	83
4.8.3 Referral system	83
4.9 SATISFIED WITH SERVICES PROVIDED.....	85
4.9.1 Patients' satisfaction	85
4.9.2 Service providers' satisfaction	85
4.10 BUDGET ALLOCATION	86
4.10.1 General budget for rehabilitation	86
4.10.2 Budget for skills training.....	86
4.11 SUMMARY	86
CHAPTER FIVE	88
DISCUSSION	88
5.0 INTRODUCTION.....	88
5.1 PERCEPTIONS OF PARTICIPANTS REGARDING SERVICE PROVIDERS' KNOWLEDGE	88
5.1.1 Knowledge of service provider regarding disability and treatment	89
5.1.2 Skills training among service providers.....	90

5.2 ACCESSIBILITY.....	91
5.2.1 Accessibility of transport	92
5.2.2 Accessibility within the facility	93
5.2.3 Accessibility of resources	94
5.3 INTERACTION OF SERVICE PROVIDERS WITH PATIENTS.....	95
5.4 PATIENT PARTICIPATION AND INVOLVEMENT IN REHABILITATION.....	96
5.4.1 Involvement of families/caregivers in patients’ rehabilitation.....	97
5.5 PROVISION OF INFORMATION	98
5.6 STRUCTURE/ORGANIZATION OF REHABILITATION SESSIONS	99
5.6.1 Frequency of therapy	99
5.6.2 Appointment schedules	100
5.6.3 Referral system	101
5.7 BUDGET ALLOCATION	101
5.8 SUMMARY.....	102
CHAPTER SIX.....	104
SUMMARY, CONCLUSION, LIMITATIONS, SIGNIFICANCE OF THE STUDY AND RECOMMENDATIONS.....	104
6.0 INTRODUCTION.....	104
6.1 SUMMARY OF THE STUDY.....	104
6.2 CONCLUSION.....	105
6.3 LIMITATIONS OF THE STUDY.....	107
6.4 SIGNIFICANCE OF THE STUDY	109
6.5 RECOMMENDATIONS.....	109
REFERENCES	111



ABSTRACT

Rehabilitation is important for persons living with disabilities as it contributes to their sense of autonomy, self-worth, social participation and improving their quality of life. Improving the quality of rehabilitation services requires the incorporation of patients' perceptions with those of service providers regarding these services. Different studies have revealed that persons with disabilities have experienced inaccessibility of rehabilitation services with regards to inaccessibility and unavailability of transport, inadequate provision of information related to their disability. Lack of staff and skills training are the main experienced challenges encountered by the service providers in the rehabilitation service provision.

Hence, the current study aims at exploring the persons with physical disabilities and service providers' experiences regarding the rehabilitation services provided at Bishop Lavis Rehabilitation Centre. A qualitative study design was used for data collection. Eleven participants among patients were conveniently selected for the focus group discussion and three key informants among the service providers participated in the in-depth interviews. The focus group discussion and the interviews were tape-recorded and transcribed verbatim and the data was thematically analysed using pre-determined themes.

Permission to conduct the study was sought and granted from the Senate Research Grant and Study Leave Committee at the University of the Western Cape, the Western Cape department of Health as well as the facility manager of Bishop Lavis Rehabilitation Centre. Written informed consent was obtained from the participants prior to the focus group discussion and interviews.

The results indicated that patients experienced problems of accessing transport to and from the rehabilitation facility. The taxis and buses were either inaccessible or unavailable for

persons with physical disabilities. Poor referral systems, shortage of staff, lack of skills training were among the main challenges that arose in the interviews with the service providers. Due to the workload that service providers encountered, they sometimes lacked time to interact and communicate with patients. Participants in both groups reported positive responses regarding patient participation and involvement in the rehabilitation sessions and interaction between patients and service providers. Though some patients expressed the view that the dissemination of information related to group sessions was inadequate, most of the participants in both the focus group discussion and the in-depth interviews stated that patients were adequately informed on their conditions and treatment. The study concludes by highlighting the need to improve rehabilitation services in terms of increasing the capacity of service providers, equipment, training of service providers and providing transport services for persons with disabilities. There is a need for those planning the rehabilitation services and policy makers to recognise the challenges encountered by those receiving rehabilitation services as well as those providing these services as discussed in this study. Hence, this will help in developing appropriate, accessible and cost effective rehabilitation services that meet the needs of persons with disabilities.

CHAPTER ONE

INTRODUCTION

1.0 INTRODUCTION

This chapter provides information on disability and its impact worldwide. It further describes rehabilitation and its impact on persons with disabilities (PWDs) worldwide, with focus on Cape Town, South Africa. The statement of the problem, research question, aims and objectives are explained. Thereafter, the chapter ends with a description of the definitions of terms used and a summary of the other chapters in the mini-thesis.

1.1 BACKGROUND OF THE STUDY

Large numbers of people worldwide live with disabilities. This has negatively impacted on them, physically, psychologically, mentally, economically and socially (Mont, 2007; Anderson, Mhurchu, Brown & Crater, 2002). Worldwide, disability rates are estimated to be 10% of the population (United Nations, 2007). As at 2008, the rate recorded in the United States of America (USA) was higher than estimated because 20% of the population were living with a disability (Hwang, Johnston, Tulsy, Wood, Dyson-Hudson & Komaroff, 2008). In Africa, disability makes up to 16% (50 million) according to the United Nations Population Information Network in 2006. According to the 2001 census, 5.9% of the population in South Africa has a moderate to severe disability (Statistics South Africa, 2005). According to the statistics of South Africa (2005), 4.7% of the total provincial population in the Western Cape Province has a disability.

Among the main common disabilities reported in the 2001 census in South Africa are: hearing, sight, communication, physical, intellectual and emotional disabilities. Nationally sight is the most common disability with 32% which is followed by physical disability 30% (SSA, 2005). Disability has affected a large number of people's lives. Its impact is vast, negatively affecting PWDs, their families, communities and health services (Mont, 2007). Rehabilitation helps PWDs by contributing to their sense of autonomy, self-worth and social participation (Eva & Wee, 2010). The disability and rehabilitation World Health Organization (WHO) action plan 2006-2011 document, supports rehabilitation as a concept that aims at enabling PWDs, that allowing them to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels. Though, rehabilitation is reported to improve on the quality of life of PWDs, it has been estimated that among the 16% people living with disabilities in Africa, only 2% have access to rehabilitation services (UN, 2007), 3% in developing countries (Helander, 1999).

Patients' perspectives regarding rehabilitation can be incorporated with those of service providers in planning and delivering effective and efficient services (Morrison, George & Mosqueda, 2008; Wottrich, Stenstrom, Engardt, Tham & Koch, 2004). According to Wottrich et al (2004), comparing the perceptions of service providers with those of patients proved to be crucial in improving the physiotherapy services.

Seeking to know patients' perceptions regarding the rehabilitation programmes and services in responding to their needs is important (Cott, Teare, McGilton & Lineker, 2006). Different studies in the USA, United Kingdom (UK), Canada and Sweden have reported different health/rehabilitation dimensions that patients reveal when asked about their experiences regarding health and rehabilitation services (Morrison et al., 2008; Kroll, Jones, Kehn & Neri, 2006; Wottrich et al., 2004; Parry, 2004; Darrah, Magil-Evans & Adkins, 2002). Most

common dimensions arising in patients' experiences in different studies include: accessibility of services, patient interaction and communication with service providers, provision of information and patient participation and involvement in rehabilitation. The aforementioned studies have reported that PWDs still encounter challenges while accessing health/rehabilitation services due to unavailability of transport and shortage of service providers. The shortage of service providers has influenced the patients' interaction with service providers, patient participation in rehabilitation and provision of information (Morrison et al., 2008) (Further discussed in the Literature review).

In addition to the patients' experiences, the service providers' experiences have been explored regarding their level of knowledge and skills training, accessibility of resources, their interaction with patients and allowing patients to participate in rehabilitation (Armstrong & Ager, 2006; Burry, 2005; Wottrich et al., 2004; Eccleston & Eccleston, 2004; McNeal, Carrothers & Premo, 2002). As mentioned before, the shortage of resources has also influenced the way service providers perceive the services they provide. The shortage of service providers in rehabilitation services has influenced the lack of time among service providers to engage in skills training courses and investing less time to interact and provide patients with adequate information (Wottrich et al., 2004; McNeal et al., 2002). At present studies highlighted are those that were conducted in developed countries like USA, United Kingdom. There has been limited information regarding patients' and service providers' experiences regarding rehabilitation services in South Africa and other less developed countries where rehabilitation resources are limited.

In South Africa, quite a few studies have reported on the patients' experiences: persons with physical disabilities experiences regarding rehabilitation services in the province of the Western Cape (Matsika, 2010). In addition, De la Cornillere (2007) reported on stroke

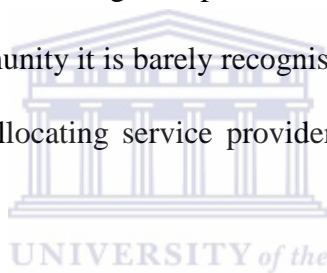
patients' experiences regarding stroke groups, Wazakili, Mpofu and Devlieger (2006) reported on the experiences and perceptions of sexuality and HIV/AIDS among young disabled people. Maart, Eide, Jelsma, Loeb and Toni (2007) reported on the environmental barriers experienced by disabled people. All have reported that patients still encounter problems in accessing rehabilitation services in terms of transport, a shortage of resources and a lack of information provision regarding programmes and services of PWDs. Although there were studies conducted in some CHCs in the Western Cape, the information is only based on patients' experiences, information regarding patients' experiences combined with that of the service providers is lacking.

There has not been any study conducted that sought to know the patients and service providers' experiences regarding rehabilitation services at BLRC. The current study seeks to explore the experiences of persons with physical disabilities with those of service providers regarding: service providers' knowledge, accessibility of services, patient interaction with service providers, patient participation and involvement in rehabilitation, provision of information and structure of rehabilitation sessions.

The Primary Health Care (PHC) services are offered at Community Health Centres (CHCs) which are non-profitable organisations that provide PHC services and health promotion programs for individuals with disabilities, their families and communities (Gabow, Eisert & Wright, 2003). In 1994, the African National Congress encouraged provinces to advocate and start CHCs, as they are a foundation of the national health services. The PHC services offered at CHCs include preventive, promotive, curative and rehabilitation aspects as indicated in the Comprehensive Service Plan of the Western Cape (Department of Health Western Cape, 2002). The main rehabilitation services offered at CHCs in South Africa are physiotherapy

and occupational therapy. In addition, there are speech, respiratory recreational, cognitive/psychological and social service therapy at the CHCs.

PWDs attending CHCs in the Western Cape still encounter difficulties in accessing rehabilitation facilities and services due to inaccessible rehabilitation services (Matsika, 2010; De la Cornillere, 2007; Department of Health, 2000). These difficulties include inaccessible and unavailable transport. In addition to these, the National Rehabilitation Policy (NRP) booklet of South Africa highlighted limited resources like staff involved in rehabilitation services and equipments. Bishop Lavis Rehabilitation Centre (BLRC) which is an independent CHC, is sponsored by the a University in the Western Cape. It provides rehabilitation services to PWDs. Although, it provides rehabilitation services to a large population in Bishop Lavis community it is barely recognised by the Department of Health in the Western Cape Province in allocating service providers, equipments and funding skills training.



Considering the myriad of challenges encountered in rehabilitation services at BLRC, the current study first, sought to know the persons with physical disabilities' experiences regarding the rehabilitation services they had received. Second, the study sought to know the experiences of the service providers compared with those of the persons with physical disabilities. Correlating the persons with physical disabilities' experiences with those of service providers regarding rehabilitation services at BRLC can be a way of planning and delivering appropriate and effective services in future. A change in the disability and rehabilitation services is recommended by policy makers to improve on the provision of these services (Kendall, Buys & Lerner, 2000). Providing services that are currently practised in health systems can be one of the ways of improving health care services which might lead to

providing services that are appropriate to PWDs (Stetler, McQueen, Demakis & Mittman 2008).

1.2 STATEMENT OF THE PROBLEM

Access to timely and appropriate rehabilitation services is vital to the health and well-being of PWDs. Rehabilitation services in South Africa encounters many challenges in delivering effective and efficient services to PWDs (DOH, 2000). The inaccessibility of rehabilitation service may pose a risk to the PWDs: In order for rehabilitation services to be more accessible and effective, the patients' needs and recommendations regarding these services need to be addressed and incorporated with those of the service providers.

However, there is yet to be a concerted and successful intervention for the above mentioned problems, mainly due to the limited information on the subject matter. In the Western Cape, various studies have reported on the patients' experiences regarding the rehabilitation services (Matsika, 2010; De la Cornillere, 2007). Though, Matsika (2010) conducted her study in some CHCs in the Western Cape, BLRC was excluded and the fact that rehabilitation provided at BLRC is different to other CHCs motivated the current research. BLRC provides fulltime physiotherapy and occupational therapy and also students that offer speech therapy. Other CHCs have fulltime physiotherapists with part time or seasonal occupational therapists and no speech therapy. It is therefore important to determine whether the patients' experiences of rehabilitation at BLRC differ from other CHCs.

De la Cornillere (2010) conducted a study regarding the experiences of therapy groups at BLRC among stroke patients only. BLRC, which provides rehabilitation services, encounters problems in providing effective rehabilitation services, due to limited resources in terms of rehabilitation personnel, funds and equipment (De la Cornillere, 2007). There is therefore a

dearth of documented information on the experiences of persons with physical disabilities and service providers regarding rehabilitation services at BLRC. The lack of information on their experiences regarding rehabilitation services may be a barrier in developing and improving these services at BLRC.

1.3 RESEARCH QUESTION

What are the experiences of persons with physical disabilities and service providers regarding rehabilitation services provided at the Bishop Lavis Rehabilitation Centre?

1.4 AIM OF THE STUDY

To explore the persons with physical disabilities and service providers' experiences regarding the rehabilitation services provided at the Bishop Lavis Rehabilitation Centre.

1.5 OBJECTIVES OF THE STUDY

1.5.1 To explore the persons with physical disabilities experiences regarding:

1.5.1.1 service providers' knowledge

1.5.1.2 interaction with service providers

1.5.1.3 information obtained from the service providers

1.5.1.4 accessibility of rehabilitation services

1.5.1.5 patient participation and involvement in the rehabilitation

1.5.1.6 structure of rehabilitation sessions

1.5.2 To explore the rehabilitation service providers' experiences regarding:

1.5.2.1 knowledge and skills training

1.5.2.2 interaction with patients

1.5.2.3 information provided to patients

1.5.2.4 accessibility of rehabilitation services

1.5.2.5 patient participation and involvement in the rehabilitation

1.5.2.6 structure of rehabilitation sessions

1.6 DEFINITIONS OF TERMS

Disability: In the current study disability is described according to the International Classification of Impairments, Disability and Handicaps (ICIDH), the International Classification of Functioning, Disability and Health (ICF) which describes disability as an umbrella term for impairments (affecting the body), activity limitations (affecting an individual's actions or behaviour) and participation restriction affecting a person's experience in life (WHO, 2001).

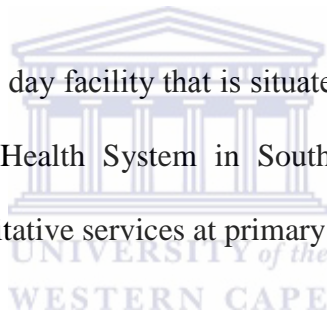
Physical disability: In the current study physical disability is described as a person who has a physical impairment which prevents him/her from participating fully in their community due to physical obstacles (UN, 2007).

Rehabilitation: Rehabilitation is a concept that aims at enabling and empowering PWDs. It allows PWDs to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels while improving their quality of life (WHO, 2006).

Experiences: Is defined as the immediate thoughts and feelings emerging in the midst of performance that can comprise any feeling of pressure, anxiety, comfort, challenge or boredom (Kielhofner, 2002).

Primary Health Care (PHC): Is an integral part of both the country's health system and the social and economic development of the community according to the Alma-Ata Declaration. This is the level where the health care services are brought closer to where people live and work by the national health system. The declaration of Alma-Ata adopted by the PHC in order to find ways of providing comprehensive, universal, equitable and affordable healthcare services to all countries (WHO, 1978). The PHC services are based on the full participation of patients, their families and the community.

Community Health Centre: Is a day facility that is situated within the patient's community. CHCs are part of the District Health System in South Africa that provide promotive, preventative, curative and rehabilitative services at primary care level.



1.7 OVERVIEW OF CHAPTERS

The first chapter gives the current background on disability and rehabilitation of the study. The statement of the problem, research questions, aim and objectives are also presented in this chapter. The second chapter presents the literature review related to the global, regional and national situation of disability and rehabilitation. It further describes the experiences of patients and rehabilitation service providers working with patients.

The third chapter describes the methods used to conduct the study, namely the research setting, the research design, study population and sampling and methods of data collection. The pilot study and the procedures used to collect and analyse the data, is also explained. The chapter finally presents the ethical considerations pertaining to the study.

The fourth chapter presents the results of the study under the pre-determined themes that were developed as shown in the objectives plus the themes that emerged. The fifth chapter analyses and discusses the results under different themes that correspond with the study objectives. The sixth chapter summarises the key findings, limitations of the study, significance and delineates recommendations from the study for future research.

1.8 SUMMARY

This chapter summarizes the background of the current study, the context of disability and its prevalence worldwide. The impact of disability among PWDs is also highlighted by introducing the importance of rehabilitation. The chapter also indicates the lack of patients' and service providers' experiences regarding health/rehabilitation services as a barrier to improving these services. The different dimensions of rehabilitation services according to patients' and service providers' experiences as discussed by previous studies are highlighted in this chapter. Finally the rehabilitation service provision situation prevailing in South Africa is provided which is followed by the problem statement, aim, objectives, definition of terms used in the current study and wraps up with an outline of the chapters for the current study and summary of chapter one. Chapter two will discuss the literature review of the current study, providing more detailed information highlighted in the previous chapter.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

This chapter presents the existing knowledge that is relevant to the current study. It is divided into four sections. The first section presents information on the context of disability and its prevalence. The second section provides an overview of rehabilitation and its services. The third section discusses the different literature on the patients' experiences regarding rehabilitation services, and finally the fourth section focuses on the rehabilitation service providers' experiences as it relates to the rehabilitation service provision.

2.1 DISABILITY DEFINITION AND PREVALENCE

According to the ICF, disability is regarded as an umbrella term for impairments (affecting the body), activity limitations (affecting an individual's actions or behaviour) and participation restriction affecting a person's experience of life (WHO, 2001). The ICF further defines disability as negative aspects of the interaction between an individual, (with a health condition) and that individual's contextual factors (personal and environmental factors) (WHO, 2006). These definitions are based on the fact that a disability can vary from one society to the other within different societies. The PWD's roles in the community can be hindered by his/her interactions with his/her health and the environmental factors they live in. There are various types of disabilities. These include sensory (blind, dumb and deaf), physical (congenital deformities, paralysis and amputation) and intellectual (mental retardation and illness) (WHO, 2006). Hearing, sight, communication, physical, intellectual and emotional disabilities are the common types that were reported in the 2001 census in

South Africa. Traumatic brain injury, spinal cord injury, amputations, stroke, diseases such as diabetes, hypertension, rheumatoid arthritis, poliomyelitis and congenital conditions were the most identified causes of physical disabilities in South Africa (Office of the Deputy President, 1997, Mont, 2004). In addition to these were injuries due to road traffic, domestic or work accidents, war injuries, poverty and violence. Disability comprises of all diseases, disorders, injuries, or other health conditions that prevent the person's ability to function (Hwang et al., 2008).

Therefore it is essential for rehabilitation service providers to understand how a particular society is affected and perceives disability which may help in planning and implementing rehabilitation services that are relevant to the targeted group of people (Matsika, 2010).

2.2 IMPACT OF DISABILITY ON PERSONS WITH DISABILITIES

Disability rates are on the increase and becoming a concern. The various types of disabilities limiting one's activities include; physical, mental, or psychological (Mont, 2007). The rates of disability vary dramatically, with 10% of the world's population living with a disability (UN, 2007). Mont (2007) also reported that persons living with a disability worldwide were reported to be between 10% and 12%. According to Mont (2007), the rates in developed countries i.e. USA and Canada were high compared to those in developing countries i.e. Kenya and Bangladeshi. The rates in the USA and Canada were 20% and 18.5% respectively, compared to 0.7% in Kenya and 0.8% in Bangladeshi. The variation is caused by different factors which include "differing definitions of disability, different methodologies of data collection and variation in the quality of the study design" (Mont, 2007, page 1). However, the low rates of disability in developing countries might have been because of the limited resources for conducting household surveys (Mont, 2007).

The UN Population Information Network (2006) estimates that 16% (50 million) of the African population live with a disability. In South Africa, according to the 2001 census, it was estimated that the disability rate was between 5.9% and 12% of the population with 52% women and 47% men (SSA, 2005). This census revealed how disability affected South Africans in all populations groups namely; 82% were African, 8% were Whites, 7% were coloured and 1.8% were Indian/Asian. Disability rates in South Africa were also reported according to different types of disability, the highest disability being sight (32%) followed by physical disability (30%), and then hearing (20%), emotional (16%), intellectual(12%) and communication disability (7%). The department of health of the Western Cape Province by 2002 estimated that 4.7% of the Western Cape Province was disabled (DOH, 2002). The highest type of disability in this province being visual disability (28.0%), followed by the physical disabilities (24%), 20.8%, whose nature of disability was not specific and then hearing (13.0%), mental (9.6%) and multiple disability (4.5%).

Though studies have reported that developed countries had higher rates of disabilities compared to developing countries, the majority of persons living with disabilities are residing in developing countries (Helander, 1999). According to Mont (2004) and Saetermoe, Gomez, Bamaca and Gallardo (2004), the high prevalence rates in developing country is a result of poverty, poor or nonexistent health care and lack of rehabilitation. Persons living with disabilities can easily be trapped in a life of poverty due to barriers they encounter while seeking employment, taking part in education, social activities and other aspects of their lives (Mont, 2004). These barriers impact on the PWDs lives in engaging in the activities of daily living and also challenges their participation in the society. In South Africa, disability might be a consequence of failure in medical services due to inadequate PHC in the communities (Office of the Deputy President, 1997). PWDs are highly impacted by their disabilities in

cases where health and rehabilitation services are inadequate or not available. Health and rehabilitation service providers and other organs involved in health sectors need to treat PWDs individually. PWDs experience different and personal challenges and each has his/her own needs. Due to the fact that disability creates costs on both the economy and on the society, there is a need for effective rehabilitation programmes and services (Burry, 2005).

2.3 AN OVERVIEW OF REHABILITATION

Rehabilitation is referred to as a goal-orienting and time-limiting process that allows a PWD to reach his/her functional level (Evans, Zinkin, Harpham & Chaudury, 2001). According to the UN Standard Rules on the Equalization of Opportunities for Persons with Disability, rehabilitation aims at enabling PWDs. It allows them to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional. Rehabilitation process also provides the PWD with the tools that facilitate him/her in the daily life. South Africa as well as other developing countries need well restructured and strengthened rehabilitation services in order to provide services that are accessible and efficient to PWDs (DOH, 2000). These services are either provided in form of Institution-Based or Community-Based services. Institution-Based Rehabilitation (IBR) are service provided at the level of special schools, training centres and hospitals, while Community-Based Rehabilitation (CBR) are provided within the PWDs communities. CBR is implemented through the combined efforts of PWDs, their families and the society they live in. South Africa therefore adopted this approach of service provision. CBR principle involves providing PWDs with the opportunity to plan, implement and monitor the programmes that affect them and ensures that PWDs are accessing all services they need at the right time.

In South Africa, CBR has been adopted. However, its implementation of shifting rehabilitation service provision from the tertiary/secondary level to PHC facilities is rarely recognised (DOH, 2000). There are also inadequate funds and limited resources in terms of staff and equipment at PHC levels, restricting the provision of effective and appropriate services in South Africa. The PHC facilities that provide CBR services were established as an approach of providing health to all. The international conference on PHC held in 1978, established the principle and movement for *Health For All by the Year 2000*, identifying PHC as an approach of achieving *Health for All*. PHC rehabilitation services in developing countries still need more growth in terms of human and material resources as provided to health promotion and disease prevention programs (Burry 2005). Though the PHC approach forms integration between the country's health care system with the social and economic development of the community, this integration is rarely implemented (Burry 2005). Since PHC services still encounter limited resource allocation compared to other secondary and tertiary services, this has negatively affected the patients accessing its services (DOH, 2000). The fact that PHC services are geographically located close to patients' homes, South Africa adopted its approach, in order to respond to the deluge of PWDs whose rehabilitation needs and access to health and rehabilitation services are not met at tertiary levels (DOH, 2000). However, the NRP of South Africa reported that the shortage of rehabilitation service providers in rehabilitation has negatively affected the provision of rehabilitation services. In South Africa the shortage of rehabilitation service providers is reported and the few that graduate at universities often lack the skills to work in and within rural areas. They are also disadvantaged by the lack of resources in these areas (DOH, 2000).

Rehabilitation of PWDs in the Western Cape takes place at various levels of health care and institutions and these include: primary level - secondary level - tertiary level - , specialist and

academic rehabilitation services. Primary level rehabilitation services are offered at the CHCs level and these services include preventive, promotion, curative and rehabilitation aspects. Nevertheless, rehabilitation services and programmes have historically been seen as low priority (Leavitt, 1995; Bhatia & Joseph, 2001; World Confederation Physical Therapy, 2003). The rehabilitation services and programmes are accorded minimal attention compared to those of prevention and health promotion. It lacks the capacity in terms of equipments and service providers to deliver effective services (DOH, 2000).

CHCs are non-profitable organisations that provide PHC with health promotion programs for individuals with disabilities, their families and communities (Gabow et al., 2003). Among the main rehabilitation services offered at CHCs are physiotherapy and occupational therapy. In addition, there are speech therapy, respiratory recreational, cognitive/psychological and social service therapy. When necessary, patients at the primary level can be referred to secondary or tertiary level. Patients seeking rehabilitation services at these CHCs still encounter challenges which include, but are not limited to inaccessibility of these services. In order to advocate for the PHC and CHCs services, addressing the perceived needs and recommendations of PWDs is important and this can be achieved by exploring their experiences regarding these services. The next section discusses different rehabilitation dimensions as perceived by PWDs.

2.4 EXPERIENCES OF PERSONS WITH DISABILITIES

PWDs require different negotiations in resolving individual and social tensions that arise in their daily life (Crisp, 2002). These different tensions are generated from different ways that include individual, social and biomedical perceptions of the patient's impairment, disability or handicap. Patients' perceptions regarding the services provided to them are crucial. If the patient's perceived perceptions are incorporated into planning and delivering rehabilitation

services, it might be used to improve on the effectiveness of services rendered to them (Crisp, 2000). Therefore, rehabilitation service providers need to be attuned on how the PWDs perceive the services rendered to them (Crisp, 2000). In this way, the rehabilitation service providers help the PWDs to manage the different obstacles encountered in their daily lives. Patients' experiences are discussed which include accessibility of services, interaction with service providers, patient participation in rehabilitation, provision of information and structure of rehabilitations sessions.

2.4.1 Accessibility of services

Accessibility to rehabilitation is a key component, which successively meets the needs of PWDs when catering for a potentially large number of PWDs in a community (Jones, 2002). Accessibility can be perceived negatively or positively by PWDs or the professional working at the facility (Rimmer, Riley, Wang, Rauworth & Jurkowski, 2004). The approved standard UN convention on the equalization of opportunities for PWDs recognizes accessibility as a way that allows PWDs to utilize any services available on an equal base with others who have no disabilities (UN, 2007). These approved rules ensure that PWDs are able to access physical environment, transport, information, equipment and communication on an equal basis with others without disabilities.

The NRP of South Africa has a goal of improving the accessibility of rehabilitation services ensuring that PWDs have rights to accessible, affordable and acceptable services like those without disabilities. The fewer the barriers to rehabilitation are, the more effective rehabilitation processes are to take place (DOH, 2000). The number of PWDs is increasing highly mostly in developing countries, however, those receiving accessible and appropriate rehabilitation services are few (Beatty et al., 2003; Burry, 2005). Different studies have investigated challenges encountered by PWDs that relate to inaccessibility and unavailability

of health/rehabilitation services. These include physical (transport, building), information, communication and health/rehabilitation services (Morrison et al., 2008; Burry, 2005; Tod, Lacey & McNeil, 2002).

Identified problems/challenges of inaccessibility among patients in the UK and USA included limited or lack of rehabilitation services and unavailability of transport (Morrison et al., 2008; Tod et al., 2002). In a study conducted by Tod et al (2002) in South Yorkshire Coalfield locality in the UK, women and the elderly reported that they felt abandoned, isolated and vulnerable due to delayed and limited rehabilitation services. Delayed services due to long waiting lists affected women since they had to return home and fulfil their other daily responsibilities at home. Due to their age and co-morbidity, the elderly encountered problems of travelling, transportation and walking long distances to rehabilitation services (Tod et al., 2002). As a result, patients decided not to attend rehabilitation sessions due to these challenges that disrupted their daily routine.

Morrison et al (2008) investigated the perceptions of patients and service providers regarding the primary care for adults with physical disabilities reported that physical inaccessibility was the main concern that patients encountered. The physical access barriers included transportation to and from PHC facility, inaccessible therapy rooms and inadequate services. Morrison et al (2008)'s study adopted the focus group discussions (FGDs) to compare the patients' perceptions with those of the professionals regarding the primary care services. Patients reported that the primary care facilities had awful ramps, lacked disability parking, had high tables for examinations and high level check-in counters that were not accessible for wheelchair users (Morrison et al., 2008). However, the study findings of Morrison et al (2008) should be taken with care since the study excluded non-English speakers; hence their perceived experiences were not included in the study findings. Inaccessibility to rehabilitation

buildings/areas such as unavailability of ramps in facility areas or rooms was also a concern reported by patients in a qualitative exploratory study in the USA (Kroll et al., 2006).

Kroll et al (2006) grouped the barriers that patients encountered while accessing primary preventive services into two categories, namely: structural-environmental and process barriers. The structural-environmental barriers included the inaccessibility of facilities (inadequate disability parking, lack of ramps, narrow doorways and cramped waiting and examination rooms) and examination equipments (lack of height-adjustable exam tables and weight chairs that could accommodate wheel chairs). The process barriers included in Kroll et al (2006) study findings are: lack of disability awareness and knowledge, respect and skills among service providers during office visits.

Some studies conducted in the Western Cape, reported findings that indicated that transport unavailability was also a concern reported among patients with physical disabilities (Mastika, 2010; De la Corniellere, 2007). In a study conducted by Matsika (2010) in some CHCs in the Western Cape which adopted the mixed methods design, reported that patients encountered problems of getting taxis or using public transport. This hindered their attendance to rehabilitation sessions. Similar findings regarding the inaccessibility of transport are reported by De la Corniellere (2007), who reported that stroke patients' attendance to rehabilitation at a CHC in the Western Cape was hindered by inaccessibility of transport to this CHC. The study findings conducted by De la Corniellere (2007) cannot be generalized to the rest of the other types of disabilities attending rehabilitation at this CHC because the study was confined only to stroke patients. The fact that De la Corniellere's study only provided information of participants who had recently joined the stroke groups, the patients might have not been able to provide the negative experiences that only emerge after years.

Different studies have reported the concerns/problems of patients due to inaccessibility of health/rehabilitation services in terms of human and material resources (Tod et al., 2002; Morrison et al., 2008). In developing countries the aforementioned problems are a result of inadequate funds allocated to rehabilitation services (Hall & Taylor, 2003; Burry, 2005). This makes the health and rehabilitation service providers and policy makers aware about the challenges encountered by PWDs. In order to achieve the health/rehabilitation targets, there is a need of addressing first the barriers that lead to inaccessible rehabilitation services among PWDs.

In summary, there is an overlap of the accessibility of services and other aspects of rehabilitation. Thus, meaning that the inaccessibility of services can negatively influence the other aspects. The unavailability and inaccessibility of transport influences patients' attendance to rehabilitation sessions. The inaccessibility or unavailability of service providers negatively influences their interaction with patients which can also limit the patient's participation in rehabilitation and provision of information.

2.4.2 Interaction with service providers

The patients' expressions towards the interaction with their service providers are crucial in rehabilitation because it can negatively or positively influence the patient's attitude towards his/her service provider. Based on the findings of the study conducted in Australia by Crisp (2000) who reported that patients were affected by the lack of a relationship with their service providers and this created ineffectual attitudes towards their service providers. Studies have reported the lack of interaction between patients and their service providers (Kroll & Neri, 2003; Hills & Kitchen, 2007). In a study conducted by Hills and Kitchen (2007) in the UK which investigated patients' satisfaction with physiotherapy, reported that patients

experienced attitudes that were not friendly and caring. This was due to the fact that PTs did not invest time to relate with and talk to their patients.

Contrary, Darrah et al (2002) study findings revealed that patients and their families reported that the service providers were caring and supportive across all service areas. The process of caring and listening to the patients and their families by service providers was reported by patients to be more important than other acts performed to them (Darrah et al., 2002). It is during the interaction of patients and their service providers that the specific needs are altered by patients. Patients feel that their problems are not only physical, so physicians and other service providers need to communicate with their patients in order to listen and be able to address the other challenges that patients encounter (Kroll & Neri, 2003). Studies have reported that the interaction and communication among service providers and their patients has continuously been inadequate (Parry, 2004; Kroll & Neri, 2003; Darrah et al., 2002). These authors reported that service providers rarely knew what patients encountered since they seldom communicated with their patients. When talking to patients, service providers used complex terminologies that were not understood by patients (Darrah et al., 2002).

Communication in rehabilitation is an important aspect in which both patients and service providers interact, share challenges and difficulties (Parry, 2004). However, its inadequacy remains a complaint raised by patients. In a report based on semi-structured interviews with 15 staff and 20 patients, conducted in South Yorkshire Coalfield locality, communication barriers fell into two categories (Tod et al., 2002). The first barrier was failure on communication systems, and the other was on poor standards of information provision. However, according to the staffs' perceptions, these barriers were a result of the shortage of staff. Service providers invested less time to communicate and provide patients with adequate information (Tod et al., 2002). Non-English speakers and those patients using sign languages

encountered difficulties to communicate with service providers since there was an unavailability of interpreters. The findings of the study by Tod et al (2002) however included only a small ethnic group in South Yorkshire Coalfield locality in UK and should be considered with care.

As a practicing PT, the researcher has observed that the insufficiency of personnel involved with rehabilitation service provision has led to lack of communication and interaction between the patients and their service providers. This may be due to the fact that service providers dedicate their time to treating patients than creating opportunities to interact and communicate with patients. Contrary to this, a study conducted by Matsika (2010) reported in South Africa in some CHCs in the Cape Town Metro Health District reported that patients mentioned that their service providers respected, communicated well with them and emotionally supported them.

In summary, studies have revealed that patients can be positively affected with the way their service providers relate to them. Though, service providers might be overwhelmed with work, they need to invest enough time to listen, talk and relate to their patients as this positively influences the patients' attitudes towards their service providers and therapy.

2.4.3 Patient participation and involvement in rehabilitation

The involvement of patients in what is being done for them is crucial since it's important for service providers to incorporate their ideals with those of patients while designing the patient's treatment procedures. Though, active participation of patients during rehabilitation process is recognised as a process that results in quick functional outcomes and service providers rarely put it into practice (Cott et al., 2006). Patients and service providers can however provide different opinions regarding patients' participation in rehabilitation process

(Wottrich et al., 2004). This is why conducting a comparative study of both patients and service providers' experience regarding rehabilitation services is important. In a qualitative descriptive comparative approach study conducted by Wottrich et al (2004) investigated the perceptions of patients and PTs regarding the characteristics of physiotherapy sessions. This study indicated that the PTs claimed to have involved the patients in their physiotherapy sessions. However, patients did not confirm this during their interviews.

Constraints in patient participation and involvement in rehabilitation process is reported (Cott, 2004). In this study conducted by Cott (2004) in Canada, patients reported the need to collaborate with their service providers in defining their needs, goals and outcomes. Though patients were allowed to participate in the goal setting of their treatment, their goals were not incorporated in their treatment procedures. Service providers followed their own goals in designing the treatment since the patients' goals and those of service providers did not match (Cott, 2004). Cott (2004) and Wressle, Eeg-olofsson, Marcusson and Henriksson (2002) reported the different ways that were identified to be beneficial in patients' lives when actively involved in their health/rehabilitation sessions. These ways include: patients who are able to solve problems that concern them, the feeling that they are controlled over their health is decreased and patients feel they have increased power in the health settings.

Studies have reported that patients feel frustrated, neglected and ignored when they are denied to participate and make decisions in their rehabilitation sessions (Martensson & Dahlin-Ivanoff, 2006; Darrah et al., 2002). Active participation of patients coupled with special education provided by trained rehabilitation service providers was reported to improve the outcomes of stroke patients like improving their quality of life (Anderson et al., 2000). When patients know that their views are incorporated in their rehabilitation process then they feel free to express their needs, challenges encountered and expectations (Wottrich

et al., 2004). Patients also value their families being involved in their rehabilitation since it enlightens the family on their patients' condition and might reduce the burden of care (Wottrich et al., 2004).

The involvement and training of family members in the health/rehabilitation of their patients assist the family to achieve treatment effects beyond the medical/rehabilitation settings and successful long-term outcomes (Yen & Wong, 2007). In this way, patients and their families are able to obtain any kind of information they need from their service providers. Family involvement in the patients' rehabilitation guides the families on how to assist their patients physically and emotionally (Cott, 2004). The families of persons with physical disabilities were involved in providing ideas relating to their patients treatment (Cott, 2004). It is through the participation of patients and their families that service providers equip the patients and their families with information that help them through.

In summary, the incorporation of patients in their rehabilitation sessions is important since patients feel they have the opportunity to the planning of their therapy and other decisions taken. It's also important to incorporate the patients and service providers perceptions since the treatment procedures can be effective based on perceptions of both groups.

2.4.4 Provision of information

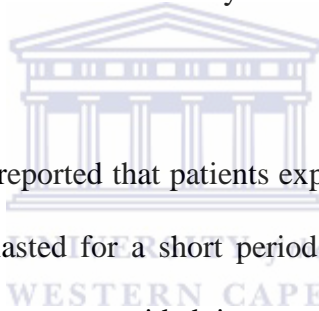
Despite that the provision of information is the greatest need reported by different studies (McNeal et al., 2002; Darrah et al., 2002), it is the least fulfilled need in rehabilitation. According to a study conducted by Darrah et al (2002) in Canada, the results of the study indicated that patients and their families encountered difficulties while giving and receiving information during and after rehabilitation. These difficulties included less provision of information related to patient disability and patients having to repeat the histories regarding

their disabilities. Different service providers involved in the patients' rehabilitation always ask patients to repeat the history of their disabilities which was bothersome to the patients. Service providers also used difficult terminologies when they provided information to patients and it was misinterpreted or not understood by patients (Darrah et al., 2002). Leith, Phillips and Sample (2004) conducted four focus groups that explored the patients and their families' perceived needs regarding traumatic brain injury (TBI) rehabilitation services. Patients and their families reported that they lacked information and education about their disability and other supportive service available to them. Patients stated that sometimes the service providers gave them information that seemed not to be practical or helpful (Leith et al., 2004). This was due to the fact that their medical professionals and service providers lacked information related to TBI and its services.

Although the findings in Matsika (2010) study reported that patients with physical disabilities received the information regarding the nature of their disabilities, they expressed the need of being informed about disability support services available to them. According to Barton (1999) study findings which reported on persons with mental problems indicated that the lack of information regarding patients' supportive groups led to risks of relapse among these patients. Rehabilitation service providers need to optimize their efforts in responding to the PWDs' needs and problems whether rehabilitation related or other challenges PWDs encounter daily (Zimmerman & Warschausky, 1998). This can be achieved if patients interact with their service providers and are provided sufficient information that informs them of their conditions and treatment. Hence, the need to know how patients perceive the sessions provided to them is crucial.

2.4.5 Structure of rehabilitation sessions

How rehabilitation sessions are organised or structured can be negatively or positively perceived by patients. Group sessions in some rehabilitation CHCs in South Africa like BLRC were introduced to address the shortage of service providers. According to a study conducted by De la Corniellere (2007) in the Western Cape, group sessions were introduced to address the problem of shortage of service providers in providing rehabilitation services to PWDs at BLRC. Though, the group sessions shorten the time service providers spend with their patients. The needs of patients are not effectively addressed as they would with individual sessions (De la Corniellere, 2007; Tod et al., 2002). These authors reported that patients preferred individual sessions because they felt they participated more than in the group sessions.



In contrast Matsika (2010) study reported that patients expressed the need for group sessions because the individual sessions lasted for a short period. According to De La Corniellere (2007), patients benefit from therapy provided in groups in many ways. These include provision of information, hope is instilled among the discouraged patients, humanity and interpersonal learning. Similarly, in a study conducted by Tod et al (2002), some patients reported that group sessions were beneficial since it involved educating patients. In a similar study, other patients reported that group sessions were inappropriate and unappealing as they were socially stressful and lacked privacy. Group sessions are advantageous to patients since they spend time with fellow patients. This happens rarely with service providers in individual sessions.

Different studies have reported patients' complaints regarding spending less time with service providers during therapy sessions (Wottrich et al., 2004; Tod et al., 2002; Lopopolo, 2001).

Service providers lack time to spend with patients due to the workload. This is usually as a result of shortage of staff and also creates negative attitudes among patients towards their service providers.

In summarising patients' experiences, according to studies conducted in some developed countries as well as South Africa, patients remain challenged while accessing health and rehabilitation services. These include inaccessible and unavailability of transport, lack of patient participation in rehabilitation, inadequate interaction between patients and their service providers and lack of provision of information. Though there were negative reported results regarding patients' experiences, some studies revealed that patients were adequately informed of their disability, interacted and communicated with their service providers and were also involved in rehabilitation.

2.5 SERVICE PROVIDERS' EXPERIENCES

Rehabilitation service providers are involved in providing services that assist PWDs, achieve a safe, timely and durable return to their normal activities (Kenny, 1998). The rehabilitation professionals include, but are not restricted to physiotherapists, occupational therapists (OTs), speech therapists, counsellors, support staff, orthotists/prosthetists and technicians. As some of the objectives of this study, this section will focus on the experiences of health and rehabilitation service providers regarding their level of knowledge, skills training, interaction with patients, provision of information, patient involvement in rehabilitation and accessibility of resources.

2.5.1 Service providers knowledge

According to Kaplan (1999), individual skills, abilities and competencies are ways of generating confidence and a sense of control among people in working organisation. Among

the normative requirements of health professionals, they are to assess, treat (Veltman, Stewart, Tardif & Branigan, 2001), educate and advise the patients (Tod et al., 2002). The health professionals' abilities of assessing and responding positively to patients' concerns about their illness and treatment has been reported to yield positive/successful outcomes among patients (Parle, Maguire & Heaven, 1997; Al-Abdulwahab & Al-Gain, 2003).

In Australia as well as in developing countries, the personnel involved in the rehabilitation lack co-operation, and this results in providing the patients with different and contradicting information regarding their conditions and care (Kenny, 1998). Patients' trust and confidence towards the rehabilitation professionals' competency/knowledge is reported (Wottrich et al., 2004). Patients were more approaching and cooperative to service providers who were more knowledgeable to their conditions (Wottrich et al., 2004). In a study conducted by Wottrich et al (2004) which adopted a qualitative, descriptive, comparative approach that explored the patients and their therapists' perceptive regarding physiotherapy sessions. Though the patients trusted their physiotherapists' competencies and knowledge, the physiotherapists felt they lacked knowledge on their patients' treatment. The physiotherapists felt they lacked the theoretical knowledge and existing evidence regarding treatment and training after a stroke incidence (Wottrich et al., 2004). In a study conducted by Tod et al (2002) reported that the patients' confidence towards their service providers was hindered/limited by the lack of knowledge/skills among rehabilitation professionals.

In Leith et al (2004) study findings reported that patients as well as their medical professionals and service providers lacked the knowledge/education related to TBI and patients' needs. This created significant gaps and lags in services due to the fact that service providers who were not able to choose eligible services and treatment for TBI patients. McNeal et al (2002) study findings reported that the inadequate provision of information to

patients was due to the fact that the physicians at the PHC facilities in California were not adequately/appropriately knowledgeable on physical disabilities. McNeal et al (2002), attributed the inadequacy of information among patients to limited skills training among service providers. Leith et al (2004), corroborated with the previous statement, stating that patients with TBI received inadequate and inaccurate knowledge about TBI due to the fact that their service providers were inadequately educated/knowledgeable on TBI. Hence, this raises the need of developing skills for health and rehabilitation professionals to improve their expertise to treat, educate and train patients. In order to develop skills and competencies of service providers, Kaplan (1999) recommended the need for training and acquisition of new skills.

2.5.1.1 Skills training

Skills' training is a very important aspect in rehabilitation that assists the personnel involved in health and rehabilitation services. It can assist the rehabilitation personnel to be able to draw out the effectiveness of the rehabilitation services since the level of knowledge/education influences the patients' attitudes towards their service providers. However, the lack of the recognition of rehabilitation providers like physiotherapists in developing countries affects their skills development (Burry, 2005). Similarly, in Afghanistan the physiotherapy professional is rarely prioritised by the Ministry of Health. Doctors' negative perception of PTs has resulted in creating a barrier to develop this profession (Armstrong & Ager, 2006). The fact that service providers in health and rehabilitation services lack skills in this domain might influence patients where service providers tend to develop a hierarchical relationship towards their patients. Service providers tend to develop negative attitudes towards patients who need to know more about their conditions. Service providers want patients to accept whatever is offered to them (Stubbs, 1999). According to

Stubbs (1999) and Al-Abdulwahab and Al-Gain (2003) study findings, the aforementioned challenge is attributed to lack of knowledge among service providers which can lead to lack of quality services.

Service providers lack the knowledge and skills to educate patients, and this has raised the need for training among health professionals in order to make a sustained impact at their workplaces (Stubbs, 1999). Health/rehabilitation professional practice is improved through continuous training (Parry, 2004) which is reported to be one of the unaddressed problems. Armstrong and Ager (2006) and Burry (2005) study findings revealed that PTs as well as other rehabilitation professionals in developing countries are not skilled enough due to little attention that is accorded to rehabilitation. Most service providers in rehabilitation service provision are focused on the workload of providing services to PWDs (Burry, 2005; Leith et al., 2004). This has hindered them from obtaining opportunities that allow them to pursue their knowledge/education. Salbach et al (2009), documented similar indications among PTs in the USA. Although, the PTs recognised the need to be engaged in continuous training, their management and organisation staff did not support them in providing them with vacation coverage, educational leave and pay for the courses and conferences (Salbach et al., 2009). Similarly, these are the challenges that the current researcher has been observing as a practising PT in a developing country.

In a study conducted by Burry (2005), the findings indicated that PTs needed training in areas regarding the provision of rehabilitation services at PHC level but due to the workload were denied the opportunity. Afghanistan like other developing countries encounters challenges of developing skills of their health and rehabilitation professionals due to wars and other disasters. In a study conducted by Armstrong and Ager (2006) in Afghanistan revealed that PTs were deprived of their opportunities to continue studies and training in order to update

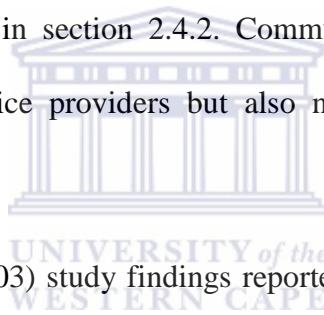
themselves with new concepts of disability and rehabilitation due to the war. The war in Afghanistan has isolated the PTs from completing their professional trainings and the curriculum of the country does not match other developed countries. This has hindered any development in training the PTs and other rehabilitation professionals in this country.

Doctors as well as other health professionals lack the trainings that allow them to acquire knowledge and skills in identifying and responding to patients' needs (Leith et al., 2004; McNeal et al., 2002; Parle et al., 1997). Therefore, this raises the need for training the personnel involved in rehabilitation to improve their knowledge and skills (Morrison et al., 2008). In a study conducted by Morrison et al (2008) in the USA, health professionals and support staff experienced the lack of knowledge while treating different kinds of disabilities. Although these professionals and support staff felt they lacked knowledge on different conditions and other disability related issues, they were less interested in learning or being trained (Morrison et al., 2008). The study findings of Morrison et al (2008) should be considered with care due to the fact that the study combined health professional supervisors and support staff in a single focus group which might have restrained the freedom of expressions among the support staff. Training among service providers is a necessity that improves on their skills and they are able to recognise the need to involve patients in rehabilitation and interact with them.

2.5.2 Interaction with patients

Developing a trusting relationship through interacting with patients proved successful treatment outcomes in Australia (Kenny, 1998). Service providers might however feel disrupted from their activities when they have to spare time to talk to their patients (Parry, 2004). This hinders their interaction with patients. Studies have revealed that, most of the time service providers and physicians are restrained from interacting with their patients due

to the workload (Hills & Kitchen, 2007; Kroll & Neri, 2003). Therefore, service providers focus on treatment of patients due to the large numbers they see. However, due to other problems PWDs encounter, service providers need not to only focus on the physical problems but also listen to the other challenges patients encounter like emotional and social. Patients with physical disabilities provided positive responses regarding their clinicians' support (Cott, 2004). These patients were positively influenced by the clinicians' emotional support, their sense of care and concerns regarding the patients' needs. It's through interacting with patients that service providers are able to listen to the patients' needs and find ways of addressing them. Therefore, service providers do not only need to focus on the physical conditions of patients but also communicate to them and listen to other challenging issues patients encounter as discussed in section 2.4.2. Communication is not a necessity only between patients and their service providers but also needed between service providers themselves.



According to Kroll and Neri (2003) study findings reported that the lack of communication among service providers resulted into lack of care co-ordination for patients. Hence, there is a need of communication among service providers themselves so that patients' conditions and needs are discussed as a team before measures are taken. Communication among professionals involved in health/rehabilitation is important since providing care to PWDs does not only require knowledge on different disabilities (Cott, 2004). It also requires skilled professionals who are able to communicate on preventing, treating, and identifying other health concerns that might or might not be associated to the primary condition. Professionals involved in the health and rehabilitation of PWDs need to be informed on how to effectively communicate with PWDs in order to help them as they might have developed psychological problems as a result of living with a disability (Parle et al., 1997).

In summary, not only do service providers need to communicate with patients, but there is a need to share information on conditions/concerns of patients among service providers themselves as a team. This can assist in sharing expertise. The lack of communication and interaction among service providers themselves and their patients might result inadequate dissemination of information regarding patient's condition (Kroll and Neri, 2003).

2.5.3 Patient involvement in rehabilitation

There is a significant improvement when patients are involved in the decisions regarding their rehabilitation sessions. In a study conducted by Wottrich et al (2004) that reported findings obtained from semi-structured interviews and observations regarding the perceptive of patients and PTs towards the physiotherapy sessions. PTs reported that they empowered their patients with information regarding their conditions through actively involving them in the physiotherapy sessions. However, the study findings of Wottrich et al (2004) reported that the PTs' desire to involve patients in their sessions was not prominent.

Client-centeredness emerged as a concept that service providers base on in delivering health and rehabilitation services in which the role or the involvement of patients in decision making is recognised (Cardol, De Jong & Ward, 2002). It encompasses the needs of the patient and the views of service providers regarding the patient's condition and treatment. For the effectiveness of client/patient-centeredness, the service providers reflect on the patients' needs, goals and expectations by entering in his/her world (Mead & Bower, 2000).

Nevertheless, in a study conducted by Parry (2004) in the UK reported that service providers urged that incorporating the patients' views and setting goals during rehabilitation was demanding and time-consuming and preferred to follow what they thought was best for the patients. Patients might be asked to provide goals regarding their treatment but are not

incorporated with those of the service providers. Due to the fact that sometimes these goals might not correspond, service providers tend to follow their own. Patients should then accept what is offered (Cott, 2004). In a study conducted by Cott (2004) which reported on the patients' perceptions regarding client-centeredness revealed that patients needed their service providers to reflect on their needs rather than only focus on what the service providers thought patients wanted.

Service providers' perceptions to allow patients to participate in their rehabilitation sessions were based on the service providers' perceptions on disability (Cott, 2004). Service providers who perceived a PWD as someone who could recover and be able to live independently and could fully participate in the community, allowed their patients to participate fully in decision making regarding their treatment. However, some service providers based their ideas during the treatment sessions with PWDs as being perceived as dependent and helpless.

According to Candol et al (2002) study findings, patients reported that they were allowed to make decisions regarding their health and rehabilitation. Service providers provided this through educating and informing patients of the right decisions. Patients might have different needs to be informed of at different times and preferences. However, service providers should ensure that patients are informed of the appropriate information at the right time, to prevent any complications that might arise during the rehabilitation process due to inappropriate information (Candol et al., 2002)

2.5.4 Provision of information to patients

The provision of appropriate and timely information to patients by service providers is crucial (Cott, 2004). This requires service providers who are well equipped with the appropriate knowledge regarding disabilities, disability related issues and health/rehabilitation services

available to patients and other health promoting programmes. Parry (2004) reported that the provision of information not only improves the patients' knowledge on different disability related issues but also improves the professional practice, guidance and education among service providers. However, service providers lack the recognition of the importance of providing patients with relevant information due to limited skills training (Morrison et al., 2008; Leith et al., 2004; McNeal et al., 2002). Service providers are hindered to provide the necessary information to patients because they lack the knowledge on the exact or appropriate information to give to patients (Leith et al., 2004; McNeal et al., 2002). For example service providers might be hindered to provide a patient with the information on his/her condition if they themselves are not aware of that condition.

In Cott (2004) study findings, patients reported that they were able to cope with their chronic conditions because they were well equipped with the information regarding their disability and other services available to them by their service providers. In addition to the aforementioned information provided to patients, service providers need to ensure that the families of the patients and their communities are also informed. This helps them to support the patients to adapt and integrate into the society. In a study conducted by Yen and Wong (2007), families with PWDs were informed and were involved in the training on issues regarding the patient's condition and care. This aided families in helping their patients achieve effective treatment effects after discharge from medical care and have successful long-term outcomes.

The next section discusses the accessibility of resources as they are among the major aspects that can influence other rehabilitation aspects. For example as discussed in the above sections, the shortage of service providers might influence their interaction with their patients. Service providers tend to focus on the workload and do not invest time to interact

with their patients. This might also influence the provision of information to patients and their participation in their rehabilitation since service providers do not recognise the need to relate to their patients.

2.5.5 Accessibility of resources

The main resources that are to be discussed in this section include: human (health and rehabilitation professionals), material (equipments or assistive devices) and financial resources. Poor management of finances and lack of natural resources like service providers and equipment is reported to result in poor service delivery of rehabilitation (Baxi, 2004). The shortage of rehabilitation service providers consequently influences other aspects of rehabilitation, like interaction between patients and their service providers which also influences the patient participation rehabilitation and provision of information. Due to the inadequacy of rehabilitation service providers, they tend to focus only on treating patients and do not invest time to interact or listen to patients (Hills & Kitchen, 2007; Kroll & Neri, 2003). As a result of the aforementioned challenge, service providers do not provide the enabling environment for patients to participate in the decisions taken regarding their conditions and treatment (Burry, 2005; Cott, 2004). In a study conducted in California in the USA, Morrison et al (2008) reported that patients and their primary care professionals perceived lack of equipment and staff as challenges encountered by professionals. These challenges hindered the professionals from completing physical examinations, making follow-ups and providing timely services and referrals for patients. Due to lack of the aforementioned resources, one of the professionals expressed the concerns as quoted: *“I feel that I am not giving my best”*

Studies have reported that the lack of interaction between patients and their service providers might be a consequence of shortage of health/rehabilitation service providers (Kroll & Neri,

2003; Hills & Kitchen, 2007). In the UK, a study conducted by Hills and Kitchen (2007) that investigated patients' satisfaction with physiotherapy revealed that PTs interacted less with their patients due to the insufficiency of PTs. Service providers feel overwhelmed by the existing workload and deny patients time to interact and relate with them. The shortage of the personnel involved in treating patients also raised negative perceptions among the patients and their families in Canada due to poor quality of services provided (Camden, Swaine, Tetreault, & Brodeur, 2010). According to these authors, patients expressed their views about the inadequacies of rehabilitation service delivery.

Service providers also encounter problems of long waiting lists due to a deluge number of PWDs needing services which do not correspond to the service providers' capacity (Neri & Kroll, 2002; Tod et al., 2002). This creates delayed services and prevents PWDs to access services when needed. It also delays referrals leading to negative consequences for the health and well-being of PWDs. The shortage of human and material resources is due to different factors including the fact that rehabilitation services and programmes remain less prioritized, accorded minimal attention, compared to prevention and health promotion programmes (Leavitt, 1995; Bhatia & Joseph, 2001; WCPT, 2003). It is because of this reason that the inadequacy of rehabilitation service providers and equipment remain unaddressed.

In South Africa, the NRP recognizes the need to facilitate appropriate resources allocation addressing the shortage of rehabilitation service providers in certain provinces. Service providers involved in rehabilitative services and service users in South Africa encounter problems with the rehabilitation service delivery due to inadequate funds allocated to these services (DOH, 2000). Despite the enormous stake health and rehabilitation services have on PWDs in the USA, there are ill-equipped service providers who are responding to less patients' needs due to inadequate funds allocated to these services (Dejong et al., 2002). The

development of the service providers' skills and equipments enables them to effectively treat, educate and inform the patients (Eccleston & Eccleston, 2004).

In summary as discussed in the service providers' experiences, the shortage of resources like service providers and equipment can influence the level of participation of patients in their rehabilitation. Due to the fact that service providers tend to focus on treating patients, they rarely invest time to relate and allow patients to play a role in their own rehabilitation. This also influences the provision of information. Service providers recognise the importance of involving patients in their rehabilitation sessions and relating to them but rarely find time to practice it.

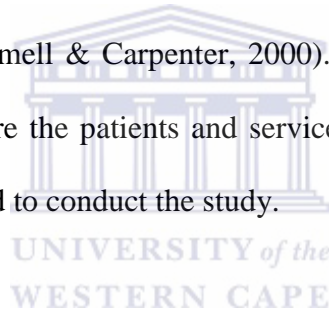
2.6 SUMMARY

This chapter reviewed different studies conducted in the USA, Europe and South Africa which reported that patients are still struggling when accessing health and rehabilitation services. Main issues that patients still encounter include: inaccessible and unavailability of transport in rural areas in developed countries as well as in South Africa. Both positive and negative issues regarding the interaction of patients with service providers have been reported. Regarding the patient involvement in rehabilitation sessions, one study revealed that patients and their service providers tend to provide different perceptive. Service providers had positive responses regarding patients' involvement, while patients provided negative responses. Another study reported that some service providers did not recognise the need of involving patients in their rehabilitation sessions as they felt it was time consuming.

Though some studies revealed negative experiences regarding the provision of information, there are some that reported positive findings. Service providers provided information to patients regarding their disabilities and services available to them. The experiences of

patients and service providers overlap as one aspect influences the other. Provision of information and patient participation in rehabilitation sessions was influenced by the level of interaction of patients and their service providers. This was also influenced by the availability of service providers. The provision of information to patients was also influenced by the skills and the level of knowledge/education of service providers.

Most of the studies that investigated the experiences mainly adopted qualitative research methods which have been found to be more appropriate for exploring participants' experiences (Hammell & Carpenter, 2000) as opposed to quantitative methods. Most problems pertinent to the world of rehabilitation are holistically approached in qualitative studies because participants are confident enough to express the depth of their beliefs, value systems and the meanings (Hammell & Carpenter, 2000). Hence the current study adopted the qualitative methods to explore the patients and service providers experiences. The next chapter presents the methods used to conduct the study.



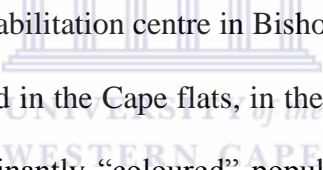
CHAPTER THREE

METHODOLOGY

3.0 INTRODUCTION

The chapter presents the methods used to conduct the study. It begins with the research setting in which the study was conducted, the research design, the study population, sampling methods, data collection instruments and procedure for data collection. The chapter concludes with the data analysis followed by ethical considerations pertaining to the study provided.

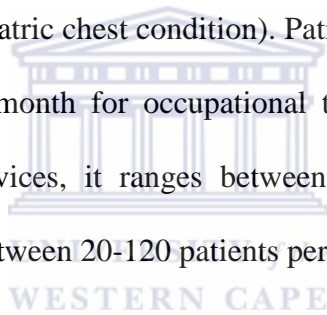
3.1 RESEARCH SETTING



This study was conducted at a rehabilitation centre in Bishop Lavis which is located in a peri-urban geographical setting situated in the Cape flats, in the Western Cape, South Africa. The Bishop Lavis area has a predominantly “coloured” population who is Afrikaans-speaking. Bishop Lavis Rehabilitation Centre (BLRC) is among the 39 CHCs that provide rehabilitation services to PWDs in the Western Cape and forms part of the Bishop Lavis Community Health Centre (BLCHC). The BLCHC provides comprehensive health care services to its catchment population. These services include preventive, promotive, curative and rehabilitation services. In this community, the rehabilitation services are provided at BLRC and these include full time physiotherapy and occupational therapy as well as part time speech and language therapy services to patients with physical and psychosocial impairments and disabilities.

The BLRC functions as an ambulatory, out-patient unit which provides rehabilitation services to patients eight hours a day, five days a week. It’s a project that was initiated by the

University of Stellenbosch (US), in November 1993, and has a multidisciplinary rehabilitation team that in addition to the Provincial Government is also administered by Stellenbosch University (De la Cornillere, 2007). BLRC is a project that was developed with two aims of providing comprehensive therapy services to the Bishop Lavis community and providing students of US opportunities to gain experiences in PHC. BLRC service providers basically treat all conditions and these include: orthopaedic (e.g. vertebral and peripheral joint and muscle conditions, hand injuries, fractures and sport and work related injuries); neurological and surgical (e.g. stroke, head injury, amputation, spinal cord injuries, burns); gynaecology and obstetrics, paediatrics conditions (e.g. cerebral palsy, spinal cord injury bifida, developmental delay and learning disorders) and respiratory (e.g. chronic obstructive airway disease, pneumonia, paediatric chest condition). Patients treated on an individual basis can range between 59-154 per month for occupational therapy services (BLRC patients' records). For physiotherapy services, it ranges between 65-325 and for speech therapy provided by students, it ranges between 20-120 patients per month.



3.2 RESEARCH DESIGN

A qualitative, comparative approach was adopted for this study that involved focus group discussion for persons with physical disabilities and in-depth interviews for service providers. Qualitative research approaches involve detailed information which produces findings that are unobtainable by statistical procedures (Golafshani, 2003). Most challenges pertinent to the world of rehabilitation are holistically approached in qualitative studies (Hammell & Carpenter, 2000). These authors further stated that with qualitative studies, participants are confident enough to express their beliefs, value systems and the meanings. According to Hammell and Carpenter, (2000), the researcher in qualitative studies acts as an integral part in the research process in shaping the collection and interpretation of the data. Using this

process, the researcher rationalises the human behaviour through the participants' perspectives in order to investigate the experiences of the participants negatively and positively perceived throughout the process of rehabilitation. Hence, the patients' experiences were incorporated with those of service providers providing rehabilitation services.

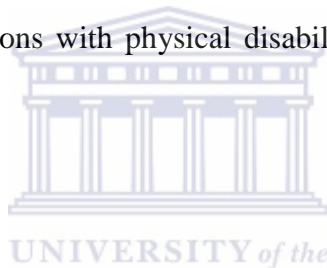
3.3 STUDY POPULATION AND SAMPLING

3.3.1 Study Population

The study population consisted of the full time service providers of BLRC providing rehabilitation services to patients. All patients with physical disabilities who received rehabilitation services at the BLRC in 2009 also formed part of the population. The total population consisted of 157 persons with physical disabilities from all patients' records as mentioned in section 3.3.2.

3.3.2 Sample for patients

A sample size of 21 persons with physical disabilities was contacted to participate in the study. The selection characteristics for the study were a patient with a physical disability and his/her age. It proceeded as follows. Files of patients, aged 18 years and above, who received rehabilitation in 2009, were divided into strata, according to the seven most common physical conditions received at BLRC. These conditions were: spinal cord injuries, head injuries, strokes, amputees, fractures/dislocations, osteoarthritis and neuromuscular conditions. From this population, three patients per condition were conveniently selected to take part in the study. Three patients from each stratum were selected and totalled 21. They were contacted to participate in the study. However, only 11 agreed to participate in the study.



3.3.3 Sample for the service providers

Key informants were identified from service providers. Among the five service providers working at BLRC, three key informants provided the information about the experiences of the service providers. Key informants are individuals who are expected to have particular knowledge or are experts on knowledge on a certain type of people and their values (Cowles, Kiecker & Little, 2002). The key informants' professional titles are not mentioned due to the fact that BLRC has few service providers and it would be easy for the information provided by the participants to be tracked back to them. The other two service providers were not available to participate in the study.

3.4 METHODS OF DATA COLLECTION

The study adopted two methods of qualitative data collection namely; FGD for the patients and in-depth interviews for service providers.

3.4.1 Interview guide for Focus group discussion

According to Martensson and Dahlin-Ivanoff (2006), FGDs are more often used to provide people's experiences regarding health services. These authors further stated that participants are more critical of their comments during FGDs compared to other forms of interviews. The researcher was able to compare similar experiences that were raised during the discussions since every participant was given a floor to express their experiences (Krueger and Casey, 2000). The researcher is able not only to listen to the content of the discussion but also the emotion, contradictions and tensions that arose from the discussions (Krueger and Casey, 2000). The interview guide (Appendix D) of the FGD was developed based on the objectives of the study and literature on patients' experiences with rehabilitation services (Morrison et al., 2008; Wottrich et al., 2004). In addition some questions used in the study by Matsika

(2010) on patients' experiences were included in the current study. The interview guide with the probes for the discussions was developed to assist the participants to open-up, think deeply and stay focused on the main concepts (Krueger and Casey, 2000). The interview guide of the FGD with its probes assisted the current researcher to guide the discussion and help participants stay focussed and open-up to share their experiences of rehabilitation services.

3.4.2 Interview guide for In-depth interviews

According to Skinner (2007), in-depth interviews are forms of discussion with open ended questions between the interviewer and the interviewee. The interviewer directs the discussion to get the required information and this allows the respondents to talk and express themselves on their own terms and perspective (Skinner, 2007). The researcher adopted this type of data collection in order to explore the depth of the service providers' experiences regarding the provision of rehabilitation services at BLRC allowing them to express their views regarding rehabilitation services offered at BLRC.

Participants were asked open ended questions from the interview guide (Appendix F), the researcher was able to develop probes that aimed at providing the in-depth information on the experiences regarding rehabilitation services. A question like this was asked: "please tell me about the accessibility of rehabilitation services at this facility". If the participant provided little information, the researcher would develop probes on the issue needed to be discussed. The in-depth interviews provided a complete picture of the experiences of service providers regarding rehabilitation services of BLRC. The researcher adopted the type of data collection to distinguish the service providers' opinions regarding rehabilitation services at BLRC. The in-depth interview guide (Appendix F) was developed based on the objectives of the study

and literature regarding rehabilitation services that related to rehabilitation service providers' experiences (Morrison et al., 2008; Wottrich et al., 2004). Two interviews were conducted in English and one in Afrikaans as discussed in the next section of the procedure for data collection.

3.5 PROCEDURE FOR DATA COLLECTION

After obtaining and being granted permission to conduct the study as described in the section of the ethical considerations (3.8), the data for the study was collected.

3.5.1 Focus group discussion for patients

An appointment was made with the rehabilitation staff at BRLC and the researcher held a meeting with them to explain the purpose and procedures of the study. The therapists at BLRC were requested to arrange patients' files of 2009 that the researcher needed to access, to select the participants who participated in the FGD. A multilingual research assistant was trained by the researcher on how to select the patients. The files of patients aged 18 years and above who received rehabilitation during 2009 were divided into strata according to the seven most common physical conditions received at BLRC. The first three patients were conveniently selected from each strata. All together 21 patients were selected and contacted telephonically (contact numbers were obtained from the patients' files at the facility) to participate in the study. The purpose of the study was explained to them and only 11 agreed to participate. The patients who agreed to participate in the FGD were invited to the facility. The date for the FGD was set, based on a mutual agreed time and place by participants.

The study was explained to the 11 participants and a copy of the information sheet (Appendix J) was given to them for more information. They also signed an informed consent (Appendix

H) form prior the FGD. Since there were participants who were not fluent in English, only fluent in Afrikaans, the information sheet (Appendix K) and the consent form (Appendix I) were translated from English to Afrikaans. In addition, the FGD participants provided a verbal permission as a reminder of their ethical responsibilities of the information provided during the discussions. The place where the FGD took place was assessed before the FGD commenced. The staff members at BLRC were informed about the FGD to avoid any interruptions and distractions. The discussions were audiotape-recorded by the researcher after permission to do so was sought and granted prior the FGD. The interviewing and field notes were taken by the research assistant.

Information saturation for each question was reached when issues were repeated by other participants. The FGD was conducted within an hour. The FGD was conducted in a quiet room. The questions asked during the FGD were related to the participants' experiences towards the rehabilitation services at BRLC. These included service provider's knowledge, accessibility of services, interaction with service providers, their relationship with service providers, patients' participation in rehabilitation and the structure of rehabilitation sessions. The research assistant started with an open ended question, for example "please tells me about your relationship with the service providers" and if the participant provided little information, she would probe for more on the issue discussed following the interview guide. All the 11 participants selected were involved in one FGD.

The FGD guide (Appendix E) was translated from English to Afrikaans since some participants were more fluent in Afrikaans. The FGD were conducted by the researcher and the research assistant in a language preferred by the participants. The participants were free to express themselves in either Afrikaans or English since the researcher was fluent in English and the research assistant was fluent in both languages. The participants were verbally

assured of consultation from a clinical psychologist, if emotions arose from the FGD. After the FGD for the patients was conducted, the researcher conducted in-depth interviews for service providers.

3.5.2 In-depth interviews for service providers

The researcher visited the facility once more with the purpose of inviting service providers to participate in the study. The dates for the interviews were set at a mutual agreed time and place by the participants and the researcher. There was a participant who felt she would express her experiences well in Afrikaans, so another multilingual research assistant was trained by the researcher on the purpose of the study, the interview guide of the study and how to conduct the interview.

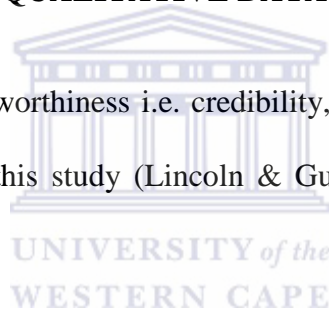
Prior to the interviews, the study was explained to the participants and a copy of the information sheet (Appendix L) was given to them with more information about the study and they signed an informed consent form (Appendix H) prior the interviews. Due to the fact that one of the in-depth interviews was in Afrikaans, the information sheet (Appendix M) and the consent form (Appendix I) were translated from English to Afrikaans prior the interview. The interviews ranged between forty minutes and one hour. The in-depth interviews conducted in English were audiotape-recorded after permission to do so was sought and granted. Field notes were taken by the researcher. The interview in Afrikaans was audiotape-recorded by the researcher. The field notes and the interviewing was done by the research assistant. The interviews for the service providers were conducted in quiet rooms. Other staff members were informed about the interview, to avoid any distractions during the interview.

The interview guide (Appendix F) for all participants was used to obtain the required information from the in-depth interviews. The interview guide (Appendix G) was translated

from English to Afrikaans due to one of the interviews that was conducted in Afrikaans. The information gathered from participants related to their experiences regarding rehabilitation services at BLRC which included their relationship with patients, accessibility of services, skills training, provision of information to patients and structure of rehabilitation sessions. In order for the participants to be able to determine and narrate their experiences, the researcher would start with an open ended question to set the tone for the interview. Questions like, “please tell me about your relationship with the patients” were asked. If the participant did not provide enough information, the researcher would develop probes on the issue needed to be discussed.

3.6 TRUSTWORTHINESS OF QUALITATIVE DATA

Four qualitative criteria for trustworthiness i.e. credibility, transferability, dependability and conformability were applied in this study (Lincoln & Guba, 1985) for quality of the data (Shenton, 2004).



3.6.1 Credibility

According to Shenton (2004,), credibility ensures how congruent the findings are with reality. The transcribed quotations of the data from the in-depth interviews and FGD were presented under the pre-determined themes to ensure the credibility of the data (Graneheim & Lundman, 2004). Member checking for this study was done to ensure credibility of the information obtained from the FGD and in-depth interviews. This was done by summarising the information from the field notes to the participants at the end of the interviews and FGD. This was to ensure the clarity of the information provided by the participants.

3.6.2 Transferability

Transferability refers to the degree to which qualitative results can be generalised or transferred to other population or setting (Marshall & Rossman, 1995). In the current study, transferability was measured by conveniently selecting 11 participants with different characteristics that included: age, type of condition and type of service received. Three key informants selected represented the service providers working at BLRC. The study setting, the selection of participants, data collection and data analysis process followed were clearly described to ensure the transferability of the qualitative data (Graneheim & Lundman, 2004).

3.6.3 Dependability

A code-recode procedure of analysing the data was used to ensure the dependability of this study. The researcher scrutinized the field notes, recorded interviews and discussions, and transcripts using this procedure. This process was followed by interpreting the results of the study and providing recommendations in details. The same study would produce similar results, when repeated by another researcher, using similar procedures (Shenton, 2004).

3.6.4 Conformability

A peer review was conducted by the study supervisor at all stages of the analysis. The recorded interviews and discussions and its analyses were given to the study supervisor to ensure conformability. This was achieved by providing an audit trail consisting of raw data, analysis notes, and reconstruction and synthesis products to the study supervisor (Lincoln & Guba, 1985). The process of data collection and analysis was described in detail so that the research trail could easily be followed. Findings and conclusions were therefore justifiable in relation to the research material (De Vos, 2002).

3.7 DATA ANALYSIS

3.7.1 Focus group discussion of patients

The process of data analysis for the FGD involved making sense of audio tape recordings and the field notes and then transcribing the interviews (Creswell, 2002). The analysis of the FGD began with verbatim transcriptions of all the information provided. The audio tapes for the patients information was transcribed by an independent person who was fluent in both English and Afrikaans. The transcript was professionally translated from Afrikaans to English. The English transcript was translated back into Afrikaans to verify accuracy of the information.

The researcher started by reading the transcript and familiarising herself with the data. Throughout this process of reading the transcript, the researcher would mark ideals for coding. This helped her in getting ready for the formal coding as advocated by Braun and Clarke (2006). According to Miles and Huberman (1994), the coding involved assigning unique labels to text passages which contained references to specific categories of information.

The data was coded into pre-determined themes from the objectives of the study which included the patients' experiences on service providers' knowledge, accessibility of services, interaction with service providers, patient participation and involvement in rehabilitation, information provision and structure of rehabilitation sessions at BLRC. The emerging theme from the patients' FGD was: satisfaction of services.

The information from the transcript was coded into different categories under each theme. For example; under the theme of patients' interaction with service providers were: respect for patients and communication.

3.7.2 In-depth interviews for service providers

The analysis of in-depth interview began with verbatim transcriptions of all the information provided. The transcripts were then compared to the voice recordings to verify accuracy. One of the interviews that was in Afrikaans was transcribed by an independent person who was fluent in this language. The Afrikaans transcript was professionally transcribed into English while the English was transcribed back into Afrikaans to verify the accuracy of the information.

Then the researcher followed the same procedure of data analysis as discussed with the patients, because the themes in the service providers' information were also pre-determined. The data was coded into pre-determined themes from the objectives of the study which included the patients' experiences on; service providers' knowledge and skills training, accessibility of services, interaction with patients, patient participation and involvement in rehabilitation, provision of information to patients and structure of rehabilitation sessions at BLRC. The emerging themes from the interviews were: satisfaction of services and budget allocation.

3.8 ETHICAL CONSIDERATIONS

Permission to conduct the study was sought and granted from Senate Research Grant and Study Leave Committee at the University of the Western Cape (Appendix B). As well as; the

Western Cape Department of Health (Appendix A) and the facility manager of BLRC (Appendix C).

The participants in the FGD were requested to sign information sheets (Appendix J) which informed them about the study. Written informed consent (Appendix H) were also obtained from each participant prior to the FGD and ensured them of their right to withdraw from the study at any time. The participants who took part in the FGD and were not able to read English, were given information sheets (Appendix K) and consent forms (Appendix I) which were translated from English to Afrikaans. In addition, the FGD participants provided a verbal permission for confidentiality purposes, ensuring that the information provided during the FGD will not be taken away after the discussion. This made them conscious of the ethical responsibilities in advance. To preserve the anonymity of the participants' information, the researcher gave names to participants P1-P11 throughout the study preserving the participants' names.

The service providers also signed information sheets (Appendix L) to inform and explain to them the study. Informed written consent forms (Appendix H) were also obtained from the service providers to ensure confidentiality and anonymity throughout the study and their right to withdraw from the study at any time. The information sheet (Appendix M) and consent form (Appendix I) for the service providers were translated into Afrikaans since one of the in-depth interviews was conducted in Afrikaans. Furthermore, the professional titles of the service providers are not indicated to ensure the confidentiality of the information provided since there were only three participants. BLRC has few service providers so the information can be easily tracked to them. The participants were given names SP (A)-SP (C) to avoid the use of the actual names to preserve the anonymity of the information provided.

The participants were verbally assured of consultation from a clinical psychologist, if emotions arose from the interviews and discussions. The researcher introduced herself as a student pursuing a master's degree in physiotherapy at the UWC, and that the study was part of the requirements needed to complete the degree. The aim of the study was explained to the participants prior to the FGD and the interviews. Permission to use an audiotape recorder was obtained from the participants. All tapes and transcripts were stored safely in the researcher's locked cupboard. They could not be accessed by unauthorised persons and will be discarded when the research is completed. The results of this study will be made available to participants, BLRC and the Ministry of Health of the Western Cape Province.

3.9 SUMMARY

An outline of the methodology of the current study is provided. The research setting for this study is described. The means of data collection and procedures followed in collecting the data is also provided. The descriptions of data analysis processes and the ethical issues followed for the current study are provided. The next chapter, chapter four presents the findings of the study.

CHAPTER FOUR

RESULTS

4.0 INTRODUCTION

The current chapter presents results of the analysis of qualitative data collected for this study that investigated the experiences of patients and service providers regarding rehabilitation services at BLRC. The results are presented in two sections, section A: presents the patients' results while section B: presents the service providers' results.

SECTION A: RESULTS FOR PATIENTS

The results were obtained by means of FGD. The demographic data among patients comprised of age, gender and patients' conditions. The extra language and phrases used by participants during the FGD are preserved in such a way that the study presents the uniqueness of their language expressions. The transcribed quotations of the data obtained from the FGD are cited in the cryptogram P1-P11 to ensure the anonymity and confidentiality of the information obtained.

4.1 Demographic characteristics for the patients

The demographic characteristics of the participants are presented in Table 4.1. A total number of 11 patients with the most common physical disabilities treated at the BLRC participated. 55% females and 45% males were selected and invited to attend the FGD that was conducted at BLRC. The mean of age of the participants was 54.82%.

Table 4.1 Demographic characteristics from the focus group discussion

Name	Age	Gender	Patient's condition
P1	66	Female	osteoarthritis
P2	47	Male	Rotator cuff repair
P3	54	Female	Rheumatoid arthritis
P4	55	Female	Frozen shoulder
P5	52	Female	Stroke
P6	77	Male	osteoarthritis
P7	44	Male	Stroke
P8	52	Male	Frozen shoulder
P9	70	Female	osteoarthritis
P10	26	Male	Amputation
P11	60	Female	osteoarthritis

The predetermined themes with sub-themes that were set for the FGD for the patients as well as the emerged theme that arose are presented in Table 4.2.

Table 4.2 The pre-determined themes and emerging theme from the focus group discussion

Predetermined themes	Sub-themes
Service providers' knowledge	Knowledge regarding patients' conditions. Knowledge regarding patients' treatment.
Accessibility	Accessibility to transport. Accessibility within the facility.
Interaction with service providers	Respect for patients. Communication.
Patient participation and involvement in the rehabilitation process	Setting goals. Involvement of families in patients' rehabilitation
Provision of information	Information related to disability Information related to treatment
Structure/organisation of rehabilitation sessions	Frequency of therapy Group and individual sessions Appointments schedules
Emerging theme	Sub-themes
Satisfaction with the rehabilitation services	Satisfied with treatment outcomes Satisfied with Service providers

4.2 PATIENTS' PERCEPTIONS REGARDING THE SERVICE PROVIDERS' KNOWLEDGE

Under this theme, the participants were asked to comment on their experiences regarding the service providers' knowledge. The participants' responses were related to: service providers' knowledge regarding the patients' condition and treatment.

4.2.1 Knowledge regarding patients' condition

Most of the participants were positively influenced by competencies of the service providers. They always knew what was wrong with them, while a few of the participants provided negative responses regarding the service providers' knowledge on disability:

Most participants felt that the service providers were well educated and always knew what was wrong with the patients and how to handle them as expressed in the following quotes:

"The people treating us here are well educated, they are very good". P2

"I have not been here for a while but I experienced they knew what was wrong with me". P6

Two male participants who had osteoarthritis expressed their concerns regarding the way service providers sometimes misdiagnosed the patients' conditions or followed the doctor's diagnosis:

"I came to be treated for my back. When I started doing the exercises I felt it was not my back, but my hip. Then I had to go back for x-rays". P9

"The same thing happened to me, they treated me for rheumatoid arthritis but it was not, it was osteoarthritis". P6

4.2.2 Knowledge regarding patients' treatment

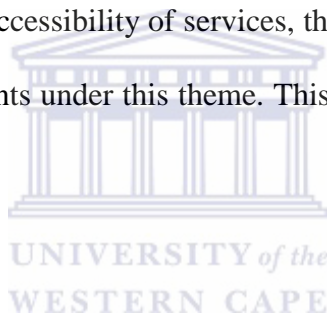
Participants were happy with the service providers' choice of treatment provided as quoted below:

"... for the ten weeks that I was here, everything they did for me was helpful. Every exercise changed something in my body every day" **P1**

"I always looked forward to come here for therapy and exercises. What they did always worked" **P5**

4.3 ACCESSIBILITY

When asked to comment on the accessibility of services, the need for transport was the major issue that was raised by participants under this theme. This was followed by the accessibility within the facility.



4.3.1 Accessibility to transport

Participants expressed the challenges of transport that related to its inaccessibility and unavailability for patients:

"It is very difficult to get into the bus or the taxi. There is no one to help" **P5**

"The bus takes long to come. When it comes, we are already late for our appointments" **P7**

Some other participants decided to walk to the facility due to unavailability of transport:

"I get pain in my legs, I cannot walk long. Sometimes I cannot make it here the next day. If we had transport, we would be here on time" **P6**

"Sometimes my feet get swollen when I walk, so I miss the appointment because of my feet"

P1

Participants in the FGD expressed that accessible transport would be especially beneficial during the winter season when it rained as revealed in the following quotes:

“...we don't want to get wet during winter... if there was a car from the rehabilitation centre it would be a lot more comfortable and easier...then we would always make it to the appointment” P4

“During winter I do wait outside for transport to the rehabilitation centre for a long time. If there was transport it would be easier and we won't get wet”. P8

Participants wished the facility provided them with transport and they would not care if they had to pay for it:

“...if we had transport we would be here on time” P6

“...but if there was a car from the rehabilitation centre it would be a lot more comfortable” P4



4.3.2 Accessibility within the facility

Though some participants did not encounter problems getting to the facility, some participants expressed their concerns as quoted below regarding the difficulties they experienced once at the facility:

“...with this sore leg I cannot walk long distances from the gate to the door” P5

“I find the gate is far from the door. When I walk from the gate it's so tiresome and painful” P3

Some participants felt the benches in the waiting rooms were too low for them and expressed themselves in the following quotes:

“There are times I have pain I can’t even sit on those chairs they have in the waiting room. Because they are low” P5

“Those benches in the waiting room are too low for patients to sit on” P9

When asked about the accessibility of the toilets and other rooms of the facility, one of the participants said that they did not encounter any problems. The rest of the group agreed by nodding their heads:

“I do not have any problems when am using the toilets and the rest of the centre here” P3

4.4 INTERACTION OF SERVICE PROVIDERS WITH PATIENTS

The participants’ responses regarding their interaction by service providers were positive. They stated that the service providers respected and cared for them.

4.4.1 Respect for patients

It was evident that participants were positively influenced with the service providers’ respect and care towards them as expressed during the FGD:

“...they are loving people and show respect towards the patients” P8

“They are always aware when you have pain and they react positively and loving throughout the treatment” P2

One male participant (stroke patient) narrated how good the patients felt when their service providers came to check on them when they were treated by students. This showed them that the service providers wanted to make sure that the students were using the right techniques:

“Every time the students are working with us, she (service provider) is there to check if they are doing everything right. She (therapist) also asks us how the students work, she wanted to

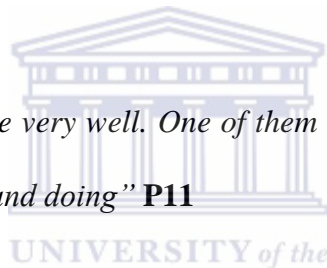
know if the students were doing a good job. It satisfies us and makes us feel that we are cared for, loved and are in good hands". P7. This was agreed upon by most of the group members who nodded their heads in agreement to what was said.

4.4.2 Communication

Participants were happy with the fact that service providers communicated with them during the therapy sessions. Some participants stated they understood what their service providers communicated to them. Others said that language was sometimes a barrier to communicate with service providers.

"She (service provider) made me feel that I could ask any question and she would listen and answer" P9

"The service providers treated me very well. One of them always talked to me and made me understand what she was saying and doing" P11



When asked if the service providers used the language that patients understood, participants provided both positive and negative responses:

"They spoke to me in Afrikaans, my home language so I did not have any problems" P2

"... they had difficulties in speaking my language. I knew it was not personal so I was fine with it" P1

4.5 PATIENT PARTICIPATION AND INVOLVEMENT DURING THERAPY SESSIONS

Participants provided positive responses regarding their participation and involvement in rehabilitation. They stated that, they were given opportunity to set goals and their families were involved in their rehabilitation.

4.5.1 Setting goals

Participants in the FGD felt that they were all allowed to take part and be involved in their rehabilitation, they had a say in providing ideals of what they wanted to achieve and gave feedback after sessions:

“I had to sit with my therapist and tell her I want to be able to use my hand and build another room on to my house” P7

“They let me choose how much I wanted to do during my treatment. I felt good because I could do something to help them (service providers) get me well” P4

Participants were also allowed to provide feedback related to therapy:

“You had to say how you felt about your treatment” P6

“The next time we came she (service provider) would ask us how the exercises we did with her helped us” P7

4.5.2 Involvement of families in patients’ rehabilitation

Families and caregivers of patients were given opportunities to observe and assist the patients during the sessions with service providers. As quoted below:

“My daughter saw what they did to me. She helped carry my leg and also do with exercises” P5

“My son sometimes came with for my rehabilitation; they (service providers) allowed him to observe what was being done on me because he would help me next time” P7

4.6 PROVISION OF INFORMATION

When asked to comment on the kind of information they obtained from their service providers, participants gave positive responses. They stated that service providers gave them information related to their disability and treatment.

4.6.1 Information related to disability

During the FGD, the participants reported that they received information regarding the nature of their disability.

“The service provider talked to me about my problem, explained to me, using the x-ray, exactly what was the problem I had and where it was in the body” P1

“...before I started my treatment here, which is very good compared to other places (other facilities), the therapist explained to me what was wrong with me. I received a form which explained my problem” P10

4.6.2 Information related to treatment

Participants reported that before the sessions commenced the service providers explained the treatment procedures and their effectiveness clearly. Prior to any session, patients signed consent forms. One female participant expressed herself in the following quote that was agreed on by other participants:

“They would explain to you what they were going to do and you had to sign a form to show that you have agreed” P4

Participants stated that after therapy they were given information in pamphlets or handouts indicating the exercises they were to do at home:

“They would give you a form about your problems with notes of exercises that you can try at home” P10

“No one came here with me. I took the form with exercises home and my sister helped me” P3

Most participants were satisfied and encouraged with the group sessions. However, one female and one male participants felt that they needed more dissemination of information regarding group exercise sessions provided at the facility:

“They can inform more patients about the exercise sessions. It took me too long to know these sessions...” P8

“They need to make sure that each patient that comes here knows about these exercises because it has helped us very much” P7

4.7 STRUCTURE/ORGANIZATION OF REHABILITATION SESSIONS

Regarding how structured the therapy sessions are at BLRC, participants expressed issues related to increase of frequency of therapy, group sessions and appointment schedules.

4.7.1 Frequency of therapy

The participants in the FGD commented about treatment sessions received. Some participants felt the sessions were adequate, while the others felt the service providers could increase the period of time and days they spent with patients:

“I just want slightly longer sessions with them (service providers)” P4

“...and we need them (service providers) to add more days to see us because I have also heard other patients complaining about it” P7

4.7.2 Group and individual sessions

BLRC sessions are provided on an individual basis and in groups. Regarding the sessions, participants provided both positive and negative responses. Some participants preferred individual sessions compared to group sessions:

“I just enjoyed the exercises that I did with... (therapist) because that is when I felt that I was working. In group sessions some patients work harder than you and you feel bad” P7

“I told them that I preferred not to do the exercises in the group. I don’t see any big change as when I work with the service provider alone” P11

However, some other participants felt good, motivated and encouraged by other patients in the group sessions:

“Every week there was an improvement with the exercises that I did here. The chats we had with friends (other patients) during exercises encouraged us to come back for more (exercises)” P3

“Working in groups helps, they (other patients) encourage you too, if one person goes a bit further than you then you feel as though you also want to achieve that. It is very encouraging and it motivates you because someone else does it better than you. If they can do it then you can also do it” P6

4.7.3 Appointment schedules

When asked to comment on how long patients took to make appointments and wait to start treatment, participants provided both positive and negative responses:

“I was sent here and they told me they would call me. When they called I came and started treatment... I don't think it took long” P5

However, one of the participants revealed that it took long to be booked in for therapy as quoted below:

“I remember I waited for a long period to start treatment...” P3

The participants shared their experiences regarding the cancellation and re-booking of appointments and they provided mixed responses:

“They tell you that you must phone and inform them you are not coming” P1

“They tell you if you cannot come you must phone because then they can help someone else. You can then come in another time” P3

However, with regards to other rehabilitation services that were provided on a part time basis at the facility, one male participant expressed the challenges encountered by patients when in need of these services as quoted below:

“We always had problems making appointments with the ... (type of service provider) who comes here once after many weeks” P7

4.8 SATISFACTION WITH THE REHABILITATION SERVICES

When participants were asked if they were satisfied with the services offered to them, they all provided positive responses that related to satisfaction of treatment and service providers.

4.8.1 Satisfied with treatment outcomes

During the FGD, the participants reported that the rehabilitation they underwent was beneficial, since their physical impairments were addressed as reflected in the following quotes:

“I am definitely happy I because I am able to use the parts of my body that were not working” P5

“I argued with them (service providers) at first and asked them what the ... (type of therapy) had to do with my pain. Now I am satisfied with what they did” P11

A female participant who was referred for physiotherapy came with the private doctor’s perception that she was never going to get better. However, she was assured by the service providers of her recovery as narrated below:

“I was told that my pain will stay away for a year, but it will come back...now they have done exercises by lifting my legs. It was painful but I was satisfied with what they did and my pain is gone” P3

4.8.2 Satisfied with Service providers

Participants expressed their feelings regarding how appreciative they were to their service providers and wished the service providers joined the discussion group so that they would express their excitements:

“The difference between this rehabilitation centre and another rehabilitation centre is that here we got more help, support from service providers and the progress was quick” P4

“Let them know that we appreciate what they did for us and we still love them...”P7

SECTION B: RESULTS FOR SERVICE PROVIDERS

The results were obtained by means of in-depth interviews. The demographic data among service providers comprised of age, gender and years of experiences in the professions. The extra language and phrases used by participants during the in-depth interviews are preserved in such a way that the study presents the uniqueness of their language expressions. The transcribed quotations of the data obtained from the in-depth interviews are cited as SP (A)- SP (C) which stands for: service provider A- service provider C to ensure the anonymity and confidentiality of the information obtained.

4.2 Demographic characteristics for the service providers

The demographic characteristics of the participants are presented in Table 4.3. The information was obtained from three participants as they were the only full time rehabilitation service providers working at BLRC. The mean age for the participants was 41%.

Table 4.3 Demographic characteristics from the in-depth interviews

Name	Age	Gender	Experiences in practice
SP(A)	36	Female	15 years
SP(B)	47	Female	7 months
SP(C)	40	Female	9 years

The predetermined themes with their sub-themes that were set for the interviews for the service providers and the emerged themes that rose are presented in Table 4.4.

Table 4.4 The pre-determined themes and the emerging themes from the in-depth interviews

Predetermined themes	Sub-themes
Service providers' knowledge	Knowledge about patients' conditions Knowledge about treatment selection Skills training among service providers
Accessibility	Accessibility to transport Accessibility within the facility Accessibility of service providers Availability of equipment
Interaction with patients	Relate to patients
Patient's participation and involvement in the rehabilitation process	Setting goals Explaining activities prior to therapy Involvement of families in patients rehabilitation
Provision of information	Information related to disability Information related to treatment
Structure/organisation of rehabilitation sessions	Frequency of therapy Appointments schedules Referral system
Emerging themes	Sub-themes
Satisfied with services provided	Patients' satisfaction Service providers satisfaction
Budget allocation	General budget for rehabilitation Budget for training

4.3 PERCEPTION OF SERVICE PROVIDERS REGARDING THEIR KNOWLEDGE

Participants expressed what they perceived to be a lack of knowledge and training skills in some specific types of disabilities that sometimes hindered them to treat certain conditions.

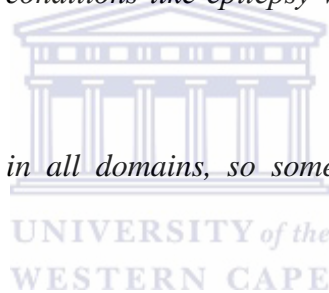
4.3.1 Knowledge about patients' condition

As reflected in the following quotes participants expressed the challenges they encountered regarding knowledge about patients' conditions:

"I lack some knowledge on certain conditions, like paediatrics, that we normally see here at this centre" **SP (A)**

"...I lack knowledge on different conditions like epilepsy which we see at this centre..." **SP (C)**

"We do not have the expertise in all domains, so sometimes we may refer the patients because of this" **SP (B)**



4.3.2 Knowledge about treatment selection

Participants provided mixed responses regarding the treatment they selected for patients, if they knew the condition it would be treated but if the rehabilitation facility lacked more expertise on the condition then the patients would be referred:

"Most of the conditions that we get here, we are capable of treating them. There are other conditions though that we refer to other facilities because we lack expertise" **SP (A)**

"I think the treatment that I choose for each patient is always effective because I see the outcomes" **SP (C)**

Two participants shared how they managed the conditions they were less knowledgeable about:

“I’ve got two ways of dealing with such a problem. Firstly I seek consultation with my colleagues here or lecturers at the university. I ask them for advice or I would refer the patient” SP (A)

“We try and gather all the expertise about the treatment techniques we have on different types of disabilities. Not every service provider is skilled enough to manage each disability” SP (B)

4.3.3 Skills training among service providers

All the participants expressed the need for training, mostly regarding certain types of disabilities as quoted below:

“I feel like we need more training, because there are conditions that we do not easily attend to, like paediatrics” SP (A)

“We all need to be trained enough. Everyone in their profession needs to be trained to develop his/her skills but this is rarely done here” SP (B)

Though there were some opportunities to attend different courses that would improve their skills, one of the participants stated that the shortage of staff sometimes hindered them to attend these courses since there was no one to fill the gap in their absence:

“The problem remains that we have no one to replace us to attend training” SP (A)

One of the participants stated that the management of the facility should sponsor their training, since the ones they attended were sponsored by themselves. These fears were expressed in the following quotation below:

“Part of the courses that I undergo is funded by myself. Sometimes it is too expensive for me.

We wish that the management of the centre would see the need of being trained” SP (A)

4.4 ACCESSIBILITY

Accessibility issues mentioned by participants in the in-depth interviews were: accessibility to transport among patients, accessibility within the facility, accessibility of service providers and equipment.

4.4.1 Accessibility to transport

When the participants were asked to comment on the access of transport among patients, they revealed the challenges and concerns of patients related to transport and the challenges service providers encounter while conducting home visits as narrated in the following quotes:

“...patients are complaining about the transport issue but we don’t have anything to do with it” SP (A)

“...patients using the Dial-a-ride, encounter problems because it’s not always available. Dial-a-ride gets the patients late to their appointments and leads to patients missing their appointments. It affects the whole system as all the appointments move to a later slot. This affects patients already waiting at the centre” SP (C)

Regarding the transport that service providers might need during their home visits and other community engagement, one of the participant provided a negative response:

“We usually use our own cars, which is sometimes a burden for us we have to pay for our own fuel” SP (B)

4.4.2 Accessibility within the facility

Regarding the accessibility within the facility, the participants observed that the patients did not encounter any challenges. The facility has a ramp for wheelchair users as quoted below:

“I don’t think patients struggle while accessing the centre because the gate is not far from the building. There is a ramp that wheelchair-users can use when coming in and out of the building. There is also a toilet handle for wheelchair-users while using the toilet” SP (A)

“...I’ve never seen a patient struggle. Those who are brought by cars sometimes have complaints when they are left outside the gate and have to walk to the facility. Though, I don’t think it’s a problem” SP (B)

4.4.3 Accessibility of service providers

Regarding the accessibility of services, the facility is facing problems of inadequate resources in terms of staff that constitute a rehabilitation team, the available staff are few in number. Referrals to other health care providers were a problem. They expressed their concerns in the following quotations:

“As I told you, there are many unfavourable conditions here. We short of staff. We get students but they are here to be trained, not to work or help us” SP (A)

“I would not say the service providers are enough but at least when students are here they help a bit” SP (C)

“At the moment the access of these rehab service providers is limited. There is only one rehab service provider and 10 clinicians seeing patients at the day clinic. Patients wait long to be helped. There are only a few therapists and many patients are being referred to us” SP (B)

The facility lacks other staff that constitutes a rehabilitation team:

“The facility lacks other components, for instance if we need to refer patients to psychologists, we have the services at the clinic but it’s only once a week. We get blocked at the social worker because there is a waiting list for home visits. We have speech and language therapy (SLT) as part of our rehab, like physio and OT, but it is run by (...) University students. There is no full time therapist available” SP (A)

“...patients who need the social worker or psychologist sometime encounter problems, because the psychologist comes to us once a week” SP (B)

The fact that patients do not have access to these services hinders the service providers in continuing with the rehabilitation of the patient.

“We can’t go on treating a patient who has a social problem. You don’t progress with rehab cause because the social worker needs to manage the problem first” SP (A)

“...when patients need services that are not available here, we make an appointment for the patient to come back when that service is available. This affects the patient to continue with therapy” SP (B)

4.4.4 Availability of equipment

The participants shared their ideals regarding the availability of equipment. The equipment is enough but the facility lacks assistive devices specifically for the OT. Replacements for the broken plinths for therapy is needed as illustrated in the following quotes:

“...we also need more plinths because our plinths are getting quite old. We have requested for some but I think it will take long” SP (B)

“...yes, definitely I will say that all equipment are accessible to the patients. Though it is not enough. We would like some more beds and assistive devices” SP (C)

Sometimes the assistive devices are provided, though not adequate. Two of the participants illustrated the problems they encounter in the following quotes:

“Assistive devices for the OT have started to come, but it’s still a problem. There is always never enough money in the budget” SP (B)

“I think it’s the assistive devices that are still inadequate. When the OT is training a patient on how to bath and the bath board isn’t available then it creates a problem” SP (A)

With regards to the space, participants expressed their concerns about the insufficiency of therapy space in the following quotations:

“The rooms are fine, but we need more space. If we have a total of 6-7 students here for clinical training during the year then the space is not enough” SP (A)

“...it is just too little space, our groups (therapy groups) get bigger and especially amputation and spinal cord groups are quite big. Sometimes we need to use the gym when the group is big but then the students are using it” SP (C)

“...we have not complained about the rooms for therapy. When students are here it seems to be not enough” SP (B)

4.5 INTERACTION OF SERVICE PROVIDERS WITH PATIENTS

The participants responded when asked to comment on their interaction with patients. They tried to relate and communicate with patients despite the inadequacy of the number of staff.

While communicating with patients, service providers sometimes encountered challenges due to language barriers.

4.5.1 Relate to patients

Participants provided mixed responses regarding how they interrelated to patients as quoted below:

“I usually make sure that I am not only treating the patients throughout the session. I make time to relate to my patients so that I may avoid them seeing me as someone superior” SP (A)

“Patients feel at ease with me. Sometimes when I feel down during the session they will ask me what is wrong. They know that I am always happy and ready to work with them. I make sure that I am in a good mood when I work with my patients everyday” SP (C)

“we make time for the patients, despite the workload. We try to see a patient as an individual and try to assist the patient the best we can. We talk to them regarding their disabilities” SP (B)

Sometimes the workload hindered service providers from relating with patients:

“Some days when I have many patients and seeing that I am the only service provider in this profession, I concentrate on treating patients and communicating less” SP (A)

Regarding the language service providers communicated with the patients. They encountered some challenges with patients who did not understand English or Afrikaans as narrated below:

“At the moment, we are seeing more foreigners than before. There are a lot of French speaking people in our catchment area now. Our main languages are English and Afrikaans.

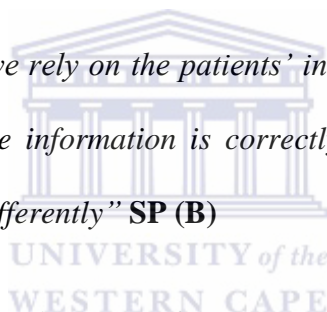
Other languages like French or Xhosa is a challenge because we don't have any people speaking those language here at the rehab” SP (B)

“Those that understand English I don't have any problems. My Afrikaans is not good so I sometimes ask my colleagues to help” SP (A)

“Some people (patients) might be from the up-country and do not understand English. When you try speaking English they just look at you, not understanding you. Their languages are difficult for us” SP (C)

The following quotes were expressed with regards to the availability of interpreters at the facility:

“We don't have interpreters so we rely on the patients' interpreters. That causes a problem because you can never tell if the information is correctly translated as it should be. The interpreter might understand it differently” SP (B)



4.6 PATIENT PARTICIPATION AND INVOLVEMENT IN THE REHABILITATION

Participants provided positive responses regarding the patient participation and involvement in their rehabilitation. Participants stated that, patients are given opportunity to set goals according to what they want to achieve. Activities are explained to patients prior to therapy and the patients' families are involved in their rehabilitation.

4.6.1 Setting goals

Participants in the in-depth interviews stated that patients are allowed to provide goals they would like to achieve after therapy as quoted below:

“The first thing I do is that I ask my patients what they want to achieve before we start the treatment. Both the patient and I work to achieve what he/she wants” SP (A)

“I encourage patients to keep on exercising to keep them engaged in their rehabilitation, so that they can be able to do what they used to do before they became the disabled and most of the time I usually ask them what they would like to do that they are not doing now” SP (C)

4.6.2 Explaining activities prior therapy

All the participants during the interviews stated that before they commence therapy, they usually explain to their patients the activities that need to be done and the importance. Therefore, they are allowed to comment on those procedures as quoted in their own statements:

“I inform the patients of the treatment procedures that they will be involved in and I allow them to engage...” SP (A)



“They often ask me what is the use of the exercises I give them. I make sure that I explain to the patient what exercises he/she is going to do and the importance of those exercise in the patient’s condition” SP (B)

4.6.3 Involvement of families in patients rehabilitation

The participants provided positive responses regarding the families of patients being involved in the rehabilitation of their family members with disabilities. Their responses are narrated in the following quotations:

“Patients who come here with their families are allowed to check and observe on what the patient is doing” SP (C)

“We do allow the family members or caregivers to come and observe what is being done during the sessions since there are exercises we ask them to help with at home” SP (A)

4.7 PROVISION OF INFORMATION

When participants were asked to comment if patients were provided the necessary information that helps them, they revealed positive responses related to information regarding disability and treatment provided to patients.

4.7.1 Information related to disability

Participants in the in-depth interviews emphasized that their patients were well informed about their conditions. More information was provided in the forms and booklets that they took home as illustrated in the following quotes:

“Patients get pamphlets. We have booklets of all the conditions that we treat. If it’s a stroke patient, he/she will be provided with information regarding his/her condition and the exercises that he/she needs to do at home” SP (B)

“There are different posters up in the rehab centre where they can get more information. They ask for any other information they need. We usually help them. We also have health promotion talks. We invite different health promoters to come and teach our patients about different health risks like HIV/AIDS” SP (A)

Though the patients are well informed regarding their nature of disabilities and health promotion, the facility lacked signage emergencies as expressed by the participants in the following quotes:

“The signage emergencies are lacking and the ones available are not placed at the right heights for patients to clearly see them” SP (B)

4.7.2 Information related to treatment

Participants also reported that patients were given verbal and written information regarding the exercises to do.

“Patients are given information regarding their therapy prior to any procedures of their treatment” SP (B)

“We provide patients with forms that contain exercises to do at home” SP (C)

“Prior to any treatment, I make sure my patients are well informed of their treatment” SP (A)

4.8 STRUCTURE/ORGANIZATION OF REHABILITATION SESSIONS

Regarding how structured the therapy sessions are at BLRC, participants expressed issues related to increase in frequency of therapy, appointment schedules and referral systems.

4.8.1 Frequency of therapy

One of the participants expressed their concerns with regards to the rehabilitation sessions offered at the facility as illustrated in the following quote:

“The sessions that I set out are sometimes not enough. At this time of year (November) I would prefer to see them more often for a long period. Unfortunately I only get to see them every second or third day of the week” SP (A)

However, during the group sessions, patients were able to exercise for a long period. Participants reported how group sessions were useful to patients and how these sessions reduced the workload service providers had. The following statements relate to participants as quoted below:

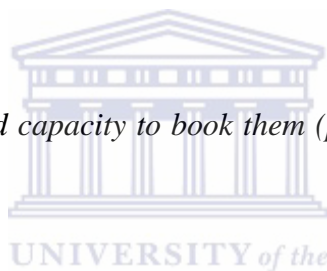
“I think the group sessions here help patients, not only in rehabilitation but also encourage them to continue with therapy. There are other patients actively involved and they encourage each other” SP (B)

“Group sessions are beneficial to patients and to us. As service providers it relieves the workload we have” SP (A)

4.8.2 Appointment schedules

When participants were asked to comment on how long it took them to book patients in for therapy, the shortage of service providers was the major problem that hindered them to book more patients in at the right time. These are expressed by the participants in the following quotations:

“I sometimes need more time and capacity to book them (patients) in because we are under staffed” SP (A)



“...but during November and December...there are waiting lists for patients. There no students at the centre to help, but we try our best to accommodate all the patients even though it's not easy” SP (C)

“At the moment we have a challenge because the students are not here. Patients can wait for up to 2/3 weeks. Which might be too long for them” SP (B)

4.8.3 Referral system

Participants expressed their concerns regarding the referral systems as grouped into categories: lack of other rehabilitation components and referral to tertiary or specialised facilities.

4.8.3.1 Lack of rehabilitation components

The participants expressed the challenges they encountered when the patients need to start with a rehabilitation service that is not offered or is rarely offered at the facility:

“Like I told you, at this facility we lack some rehabilitation services. If I am treating a patient and in the process she happens to need a psychologist, I have to stop the treatment and wait till the psychologist comes to check on the patient. That happens after a week when she comes to check/book in her patients” SP (A)

“We are having problems with referrals to other rehabilitation services, i.e. social services, since we do not have any here at the facility” SP (B)

4.8.3.2 Referral to tertiary or specialised facilities

When asked about the referral system between BLRC and other facilities, the participants expressed their concerns on how the delays in the referral system negatively affect both the patients and the service providers’ services, as quoted below:

“The waiting period of the referral system is long, so it does affect the rehab services. It affects referrals, particularly to tertiary and specialised facilities, when they (patients) are not responding to our rehab services and need to see specialists” SP (A)

“I guess we can’t go any further if the patient needs referral. The only thing you can do is to check on the patient to see if he/she is fine. You can’t do anything else because he needs to be taken to the facilities that have specialists” SP (C)

4.9 SATISFIED WITH SERVICES PROVIDED

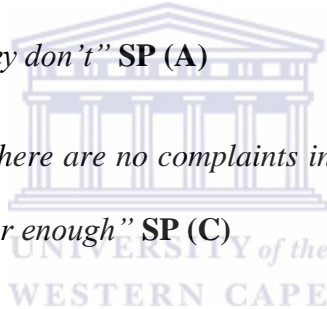
When asked to comment on the patients' satisfaction, the participants expressed that the patients were satisfied. They stated that the facility needed some improvement in order to deliver more effective services to a big number of patients in the community.

4.9.1 Patients' satisfaction

The participants were asked if their patients were satisfied with the services rendered to them, they expressed their sentiments in the following quotations:

"I think they are. We do a patient satisfaction survey twice a year. We get them to fill out forms. We looked at the last part of the year's survey and it seemed very good. Sometimes we do want them to complain, but they don't" **SP (A)**

"We have a complaints box but there are no complaints in. Instead, we get thank you notes. People cannot stop thanking us for enough" **SP (C)**



4.9.2 Service providers' satisfaction

One of the participants felt that though their patients were satisfied, the facility needed to do some adjustments to allow for a bigger capacity patients to be treated. As expressed in the following quotes:

"Yes patients are satisfied, but we are overworked. We need more staff to ease the workload and be able to provide enough services to a large area" **SP (A)**

The other quote was related to skills training:

"We would be more satisfied if we had more expertise providing services here at the facility which we can obtain from training" **SP (B)**

4.10 BUDGET ALLOCATION

The participants provided their apprehensions regarding the budget allocated to the facility and put emphasis on the general budget for rehabilitation and that for training skills.

4.10.1 General budget for rehabilitation

Throughout the interviews, the participant continued emphasising that the shortage of staff, equipment and lack of skills training was due to insufficient budget allocated for rehabilitation service at BLRC as quoted below:

“The rehab budget which is supposed to do things...like ordering assistive devices, hiring more staff. Currently the money is used for other things” SP (A)

“...by January and February we ran out of money. Money was spent on spectacles this year. We need a better budget to service all the patients” SP (B)

4.10.2 Budget for skills training

Participants also emphasised on the budget for training as quoted below:

“...we hear the budget is available but we have never used it because we fund our own training courses. It is expensive to attend” SP (A)

4.11 SUMMARY

Participants in the current study expressed the positive and negative perceived experiences regarding rehabilitation services at BLRC. The main challenges or negative issues expressed by patients included: transport challenges among patients, less intensity of treatment sessions. The participants in the FGD provided positive responses regarding: provision of information, interaction with service providers and patient and their family involvement in rehabilitation

sessions. Patients received adequate information regarding their disability and treatment, service providers respected and communicated to them. Sometimes challenges of language barriers existed. Though, a few expressed that the dissemination of the information related to groups was inadequate. Participants in the FGD revealed that they were involved in setting goals regarding their treatment and that their families were involved in rehabilitation. Service providers' challenges were related to: lack of staff, need for skills training and equipment. The lack of staff sometimes hindered service providers to deliver effective services and invest time to relate to their patients due to the workload. The referral system with other tertiary and specialised facilities seemed to negatively influence with the rehabilitation service delivery of BLRC. The following chapter presents the discussion of the results of the current study in relation to the objectives of the study and findings of other similar studies.



CHAPTER FIVE

DISCUSSION

5.0 INTRODUCTION

The chapter presents the discussions of the results in relation to the research objectives and the previous published literature related to the area. This study explored the experiences of 11 patients who received rehabilitation services at BLRC in 2009 and three key informants that represented service providers who provide rehabilitation services to patients at BLRC. Participants shared their experiences in the FGD and in in-depth interviews regarding rehabilitation services at BLRC. The discussion will be based on the participants' findings on the pre-determined thematic domains such as service providers' knowledge, accessibility of services, interaction of patients and their service providers, patients' involvement and participation in rehabilitation, provision of information and structure/organisation of rehabilitation sessions. The other themes that also emerged from the excerpts such as satisfaction of rehabilitation services and budget allocation are also discussed.

5.1 PERCEPTIONS OF PARTICIPANTS REGARDING SERVICE PROVIDERS' KNOWLEDGE

Though most patients trusted the competencies and knowledge of their service providers, service providers reported that they lacked knowledge and training on some disabilities. Health professionals' abilities of assessing and responding positively to patients' concerns about their illness and treatment was reported to yield positive outcomes among patients (Al-Abdulwahab & Al-Gain, 2003). According to Kaplan (1999), individual skills, abilities and

competencies are ways of generating confidence and a sense of control among people working in an organisation.

5.1.1 Knowledge of service provider regarding disability and treatment

Concerning this sub-thematic domain, most patients provided positive responses while the minority gave negative responses. The findings of the study revealed that the patients expressed that the service providers always knew what they were doing and the conditions they dealt with. Some of the patients even emphasised that the service providers checked on them while they were being treated by students, ensuring that the students were doing the right techniques. Some patients provided negative responses that they experienced regarding service providers' knowledge on their conditions. In a study conducted by Wottrich et al (2004), reported that service providers' knowledge is one of the components that allow patients to feel free to express their needs and worries knowing the service providers will respond to their needs. This can be a hindering factor in rendering appropriate services to patients if service providers might lack the knowledge on patients' disabilities as reported in the current study.

Though most patients trusted the service providers' knowledge, the service providers felt they were not knowledgeable enough to deal with all types of disabilities. These findings are consistent with those in a qualitative study conducted in Sweden by Wottrich et al (2004) which reported that patients trusted their physiotherapists' competencies but the physiotherapists felt they lacked scientific knowledge on certain areas of stroke. Though patients expressed their appreciations of their PTs' awareness of their problems, the PTs expressed their concerns they perceived as poor theoretical knowledge and lack of existing evidence on effective treatment of stroke patients. Lack of knowledge and treatment selection can be one of the contributing factors that patients might develop negative attitudes towards

their service providers which might affect the patients' outcomes. Hence, training is one of the ways of developing service providers' skills (Morrison et al., 2008).

5.1.2 Skills training among service providers

Lack of skills training might have been the problem of lack of knowledge among service providers in the current study. Though, some patients in the current study reported that their service providers were adequately skilled to deal with their conditions. Others revealed that their service providers misdiagnosed their conditions which might have influenced the treatment. The patients reported that sometimes service providers treated patients referring to the doctor's diagnosis which would turn out to be the wrong diagnosis. Similarly, the study findings of McNeal et al (2002) reported that California primary care physicians lacked the training in disability awareness where they encountered difficulties in examining and setting treatment for patients with physical disabilities.

In the current study the service providers felt they were not skilled enough to deal with some disabilities like paediatrics. This was attributed to lack of training as expressed by the service providers. These findings are consistent with those of Darrah et al (2002) study conducted in Canada, which reported that service providers lacked knowledge on patients' disabilities which was due to inadequate training. The current study's findings therefore advocates for the need of training among the service providers that participated in this study. This is also consistent in a study conducted by Morrison et al (2008) who also supported the need of training among rehabilitation service providers. These authors further reported that through the service providers' training, the need for substantial improvements among patients can be addressed.

The few training courses that the service providers attended were sponsored by themselves which was a burden to them. Though the service providers needed training, the opportunity to

be released from work was difficult, since there were an inadequate number of service providers at the centre. Most service providers in rehabilitation services are focused on providing services to PWDs and this has hindered them from obtaining opportunities that allow them to pursue their knowledge/education (Salbach et al 2009; Burry, 2005). According to the study findings of Salbach et al (2009) and Burry (2005), PTs reported that they lacked time to engage in continuous training due to the workload. Though the PTs were aware of the advantages of these trainings which were: to develop their skills in reviewing research findings and applying them to practice, they lacked time to attend them (Salbach et al., 2009). McNeal et al (2002) study findings also indicated that primary health care physicians' efforts and time was dedicated to patients care and treatment. They were less privileged to attend trainings/courses that would increase their disability awareness.

In the current study, service providers sought guidance from their peers and fellow service providers when they encountered conditions they were less knowledgeable about. Similarly, Salbach et al (2009) study findings reported that PTs relied on their peers for information regarding the research on clinical management that was related to walking rehabilitation after stroke. Lack of training is one of the contributing factors that leads to lack of knowledge and confidence among service providers that might affect the quality of services rendered to patients. Hence, it's the role of health/rehabilitation sectors and management to ensure that their professionals and staff are adequately empowered and trained to provide high quality and effective services to patients.

5.2 ACCESSIBILITY

In both, the FGD and in-depth interviews, there were main issues that arose under the pre-determined theme. Accessibility were categorised into three sub-themes, i.e. accessibility to

transport and accessibility within the facility. In addition to these, the service providers provided more information related to: availability of equipment and service providers.

5.2.1 Accessibility of transport

Most of the issues that were raised during the interviews among service providers were related to patients. The only transport issue that was raised among service providers was related to fuel expenses they encountered when they had to conduct home visits due to lack of transportation homes of patients. Unavailability and inaccessibility of transport were the main problem that arose during the FGD with patients under the accessibility theme. Patients in the current study expressed their concerns that were related to delayed and inaccessible transport to the rehabilitation facility. Patients encountered difficulties in using a bus or taxi and those who were able to get a bus or taxi were challenged by getting on it. The study findings indicated that it was evident that PWDs are discriminated against by some public transport users and workers. Due to the fact that some patients waited long for transport and others walked. During winter when it was raining, patients feared going out and this hindered them to attend therapy sessions. These findings are consistent with those of Matsika (2010) and De la Corniellere (2007) which reported that patients in the Western Cape, in South Africa, encountered problems of inaccessible and inefficient transportation services to attend rehabilitation appointments.

Some participants who had to walk to the facility experienced problems since there were no means of transport to the facility. They experienced joint pains and swelling the next day which sometimes restricted them from attending their next appointments. These findings are consistent with those of Velema and Cornielje (2003) from their study conducted in the Netherlands which revealed that patients with physical disabilities were negatively affected by walking to rehabilitation facilities. These patients developed pain and dizziness that

hindered their attendance to other rehabilitation sessions (Velema & Cornielje, 2003). The service provider in the current study also confirmed that patients attending BLRC services are challenged with transport issues and that the capacity of the facility was not adequate enough to provide transport as requested by patients. Service providers also reported that, the type of transportation “Dial-a-ride” availed to patients, was sometimes delayed. Patients’ appointments would then be cancelled. The findings of the current study are consistent with those of Morrison et al (2008) which reported that the main physical inaccessible concern that the patients experienced was transportation to and from the PHC services. This was affirmed by their service providers. The study findings of the current study revealed the unavailability and inaccessibility of transport. Walking hindered the patients’ attendance to rehabilitation appointments. This might be a contributing factor that would negatively affect patients’ recovery and effective outcomes (Velema & Cornielje, 2003).

5.2.2 Accessibility within the facility

Most of the patients provided positive responses while few provided negative responses regarding the accessibility at the entrance and within the facility. Some patients in the current study reported that they did not encounter any problems regarding the physical accessibility of the facility i.e. entrance and accessing therapy rooms and toilets. This was also affirmed by their service providers. However one of the patients and confirmed by one of the service providers, patients complained about the chairs they sat on in the facility’s waiting room that they were very low and caused more pain. Other rooms like the therapy rooms and toilets were accessible according to patients’ experiences. The service providers were able to reveal that the facility was wheelchair friendly with ramps with easy access to the like the therapy rooms and the toilets. Contrary, Kroll et al (2006) and Morrison et al (2008) study findings indicated that patients encountered inaccessible physical areas in some health/rehabilitation

facilities in the USA. Some of these inaccessible areas included the absence of ramps in the facility areas or rooms, inaccessible parking spaces and examination rooms.

A few patients shared the problems they encountered while walking from the entrance of the facility. They experienced dizziness and painful joints. However, during the in-depth interviews, the service provider stated that the distance between the gate and the facility building was too short to pain or dizziness. During the discussions the researcher realized that the patients who experienced the dizziness and pain had been walking from their homes. The dizziness and pain was the consequence of the long distance they walked from their homes and not because of the distance between the gate and the facility building.

5.2.3 Accessibility of resources

In the current study, the service providers frequently raised the need to employ more staff and purchase equipment, such as assistive devices and beds. Since this also affected them in rendering effective rehabilitation services too there are many persons with disabilities in the community hence they book enough patients for the day. Similarly, in a study conducted by Burry (2005), reported that most developing countries encountered the challenge of increasing numbers in PWDs however those receiving accessible and appropriate rehabilitation services are few. In Burry's (2005) study findings reported that there was a huge gap between the number of rehabilitation professionals and services required for PWDs in developing countries.

The in-depth interview results of the current study were consistent with the findings of a qualitative study that was conducted by Morrison et al (2008) in California in the USA. Morrison et al (2008) study findings reported that patients' needs like, their treatment and support from service providers were unmet due to lack of resources that included rehabilitation professionals. Stroke patients in China were negatively affected to a certain

extent in the provision of rehabilitation due to the inadequacy of rehabilitation resources in terms of the service providers and equipment (Woo, Chan, Sum & Chui, 2008). Lack of resources like service providers and equipment can be a hindering factor that might affect the patients' satisfaction of their therapy outcomes due to ineffective services.

5.3 INTERACTION OF SERVICE PROVIDERS WITH PATIENTS

Participants' responses in the current study regarding the interaction of service providers and patients were that, the patients were respected and loved, because the service providers were able to provide time to relate and communicate with their patients. The patients in the current study experienced their relationship with their service providers positively. Patients mentioned that their service providers encouraged, respected and talked to them during consultation. The findings of the current study are consistent to those of Darrah et al (2002) which reported on the perceptions of adults and adolescents and their families regarding the service delivery. Darrah et al (2002) study findings reported that patients were respected, cared for and supported across all service areas. Contrary, Hills and Kitchen (2007) study conducted in the UK which investigated on patients' satisfaction with physiotherapy reported ineffectual attitudes of service providers. Patients experienced attitudes that were not friendly and caring from their PTs because the PTs did not invest time to relate and talk to them.

The expressions of the patients in the current study are confirmed by their service providers' responses when asked about their relationship with patients. However, service providers reported that, they sometimes lacked time to relate to their patients due to the shortage of service providers. They only focused on the workload. Nevertheless, they tried their best to create time to listen to their patients' needs and thoughts regarding their conditions and treatment. The current results are contrary to Parry (2004) findings where service providers

did not value the importance of relating with patients. They felt disrupted from their activities when they had to spare time to talk and interact with their patients.

Patients as well as service providers in the current study provided positive responses regarding communication between them. Patients expressed positive response regarding how service providers talked and encouraged them throughout the sessions. The patients' expressions were further affirmed by service providers during the interviews. The workload would sometimes be a hindering factor for service providers to communicate with their patients. However, the findings of the current study are contrary with Darrah et al (2002) results which reported that patients and their families experienced difficulties in communicating with their service providers. Darrah et al (2002) study findings reported that patients felt ignored during service provider's conversations and decision making. When the service providers talked to patients, they used complex terminologies that were not understood by patients (Darrah et al., 2002). Patients can be positively or negatively impacted by the way service providers relate to them and this can either hinder or motivate their co-operation during therapy. Therefore, health/rehabilitation providers need to positively influence patients during and after the sessions by relating, caring and listening to them.

5.4 PATIENT PARTICIPATION AND INVOLVEMENT IN REHABILITATION

Concerning this thematic domain, the participants in both the FGD and interviews had positive opinions regarding the patient participation and involvement in rehabilitation. The patients in the FGD reported that their service providers gave them opportunities to give their goals. Service providers also explained the procedures of the treatment. This was confirmed by the service providers in their interviews. Contrary, Wottrich et al (2004) study findings reported that physiotherapists claimed that patients were actively involved in the

physiotherapy sessions while the patients denied their involvement. The participation and involvement of patients in their rehabilitation sessions assist service providers to work at targeting the patient's expectations. Patients are also able to increase their compliance during therapy (Cott, 2002). Contrary, Cott (2002) study findings reported that patients were allowed to participate in the goal setting of their treatment. However, service providers followed their own goals in designing the treatment since their goals did not match those of the patients.

5.4.1 Involvement of families/caregivers in patients' rehabilitation

The involvement and training of family members in the rehabilitation of their family members with disabilities assist them to achieve treatment effects beyond the medical settings and successful long-term outcomes (Yen & Wong, 2007). Concerning this sub-theme, the few participants who attended rehabilitation sessions with their families gave positive responses regarding their families' involvement in rehabilitation. Family members/caregivers were allowed to observe and were taught the different techniques/exercises to help their family members with disabilities at home. Those patients who did not come with their families/caregivers were given a list of exercises to do at home and some gave positive responses regarding the help of their families with home exercises. Similarly, Darrah et al (2002) study findings reported that families were positively influenced by the education and support offered by service providers that assisted them to take care of the patients. However, the findings of Leith et al (2004) are contrary to the aforementioned results. This study that adopted focus group discussions reported that families were not involved in the patients' rehabilitation. This hindered them from helping the patients at home where service providers were not available.

5.5 PROVISION OF INFORMATION

The provision of information is among the greatest component that assists PWDs with information related to their disabilities and services available for them. In the current study, most patients reported positive responses and less reported negative responses regarding the provision of information. Most patients reported that they received most of the information they needed from the service providers. The information provided was well explained. However, some patients reported that there was a need of adequate dissemination of information regarding group exercise sessions. When the patients were asked whether they received information regarding their disability and treatment procedures, they provided positive responses. It was evident that each patient involved in the FGD obtained information regarding their disability and treatment procedures.

In the in-depth interview, the service providers confirmed what the patients had reported regarding the provision of information. Service providers reported that patients were informed of their conditions and the kind of treatment they were to undergo. Patients reported that the service providers gave them forms which informed patients about their conditions and exercises to do at home. These findings are however contrary to the results of other studies (Darrah et al., 2002; Leith et al 2004) which reported that patients were misinformed and lacked the knowledge regarding their disabilities. In Darrah et al (2002) study, patients experienced problems in giving and receiving the information from their service providers. Patients with TBI in South Carolina in the USA reported that, they as well as their medical professionals and service providers lacked the knowledge/information on TBI and its services (Leith et al., 2004). This resulted to delays of service provision, negativity of service providers, decrease in choices of services available and ineligibility for certain important services. If patients lack information regarding their disability, it might lead to lack of

cooperation during therapy sessions and this might lead to certain complications to the patients' outcomes (Parry, 2004).

5.6 STRUCTURE/ORGANIZATION OF REHABILITATION SESSIONS

The main sub-themes that emerged when the participants were asked to comment on how rehabilitation sessions were structured, participants provided their experiences on: frequency of therapy, appointment schedules and in addition to the in-depth interviews was the referral system.

5.6.1 Frequency of therapy

Though some participants in the FGD expressed positive responses regarding the time spent in therapy, some wished for longer sessions during consultation. The patients expressions of increasing the time service providers spend with patients were also confirmed by service providers. However, the inadequacy of the number of service providers would be a barrier in its achievement. These findings are similar with those of Lopopolo (2001) and Wottrich et al., (2004) which reported that patients were concerned with the little time they spent in therapy.

The findings of this study reported that, though the group sessions had its advantages, some patients preferred individual sessions. Though, some patients were encouraged by their mates during the group sessions, some felt they were more actively involved in their therapy during individual sessions. From the perspective of the service providers, the development of group session exercises was one of the ways that eased their workload. Contrary to the findings of the current study, Matsika (2010) reported that persons with physical disabilities in her study preferred group sessions because the individual sessions lasted for a short period. BLRC structured group sessions after the individual sessions were not adequately responding to the

deluge of PWDs that were not corresponding to the facility's capacity in terms of staff and equipment. De la Cornielle (2007) study which explored the experiences of group sessions among patients with stroke reported that, the group sessions did not respond to the patients needs compared to the individual intervention.

5.6.2 Appointment schedules

Despite the lack of sufficient service providers at BLRC, most patients in the current study provided positive responses regarding the scheduling of appointments. Though service providers in the current study stated that they were well organised to schedule and keep the patients' appointments, sometimes they would be hindered by the problem of being understaffed. The findings of the current study are contrary to Morrison et al (2008) results in which both patients and service providers complained on the longer awaiting periods for therapy. Patients were negatively affected by the time they had to wait for the first time slots of therapy. In a study conducted by Tod et al (2002) in South Yorkshire Coalfield locality in the UK, patients also encountered problems of waiting for long to be booked in for therapy. This affected both the patients' health and their satisfaction of the rehabilitation services.

The fact that BLRC offered only physiotherapy and occupational therapy services on a full time basis interrupt the therapy of those patients who wanted to be seen by other services which were offered on a part time basis. For example, if the patient had to be seen by a service that is provided on an individual basis, the current therapy he/she was undergoing could be stopped until he/she is seen by that particular service provider. This influenced the patient negatively to continue with his/her treatment.

5.6.3 Referral system

The referral procedures according to the service providers' responses in the current study were categorised into lack of other rehabilitation components and referrals to tertiary or specialised facilities. Delays in obtaining referrals are a major concern reported in literature that remains unaddressed (Morrison et al., 2008). Service providers in the current study stated that the existing referral system delays negatively affected both the patients' rehabilitation and the service providers' services. Service providers experienced problems that were related to lack of other rehabilitation components like psychologists, social services and this sometimes delayed the therapy for patients. Whereby, if the patient had a psychological problem that needed to be dealt with first, he/she had to stop the therapy to see a psychologist who was working part time at BLRC.

The other challenge expressed by service providers was related to referrals to tertiary or specialised facilities. They stated how the delays in the referral system with these facilities negatively affected both the patient outcomes and the service providers' services. When a patient was referred he/she had to wait till these tertiary or specialised facilities book the patient in.

5.7 BUDGET ALLOCATION

The service providers involved in rehabilitation services and service users in South Africa encounter problems with the rehabilitation service delivery due to inadequate funds allocated to these services (DOH, 2000). This has led to inefficient distribution of the limited resources and inadequate response to rehabilitation services with the needs of PWDs. The NRP of South Africa proposes that the budget allocated to rehabilitation services covers: assistive devices, training of disability and rehabilitation personnel, staffing rehabilitation services. As

reported in the in-depth interviews by service providers in the current study, the inadequacy of equipment like assistive devices, the lack of space and service providers, is a result of the inadequate budget allocated to the rehabilitation services at BLRC. These findings are confirmed by the results in the study by Hall and Taylor (2003) which reported that the limited funds allocation, negatively impacted on the quality of rehabilitation service delivery.

The aforementioned problems do not only affect a developing country like South Africa, but also Canada as a developed country which encountered delays in rehabilitation service delivery due to the limited number of rehabilitation personnel compared to the number of patients needing services (Camden et al., 2010). Camden et al (2010) reported that the limited number of rehabilitation personnel was due to the inadequate budget that was allocated to rehabilitation services. In some cases, the national budget allocated to healthcare services is utilized more by tertiary services (often located in urban areas) than PHC services which are mostly located in rural areas (Hall & Taylor, 2003). This might hinder the quality of services provided in rural areas, ultimately affecting PWDs' rehabilitation process and affecting the level of patients' satisfaction and recovery.

5.8 SUMMARY

The existing rehabilitation services at BLRC are fragmented. Its service delivery presents barriers of access to services such as transport, staff and training skills, inadequate equipment like assistive devices and beds. Despite, the aforementioned challenges, BLRC service providers try their best to offer effective services by communicating with patients, providing patients with adequate information and involving them in their rehabilitation.

The findings of this study found that the challenges encountered by patients and service providers are due to a lack of human and material resources allocated to rehabilitation. These

results are also confirmed in different studies (Camden et al., 2010; Hills & Kitchen, 2007). Whereby, Hills and Kitchen (2007) reported that patients were dissatisfied with the health care services due to service providers who offered inadequate assistance to patients because they lacked the capacities. Camden et al (2007) also reported that patients encountered delays in rehabilitation service delivery due to the limited number of rehabilitation personnel. Not only do rehabilitation services in South Africa encounter the challenge of a shortage of service providers but the service providers also lack skills, mostly when working with rural communities (DOH, 2000).

The next chapter, chapter six, presents the summary, conclusions, limitations, significance of the study and recommendations of the study.



CHAPTER SIX

SUMMARY, CONCLUSION, LIMITATIONS, SIGNIFICANCE OF THE STUDY AND RECOMMENDATIONS

6.0 INTRODUCTION

The final chapter concludes the study by providing a summary of the current study, the conclusion highlights the major issues of the study and the limitations of the study are provided. Finally the significance of the study are outlined and the recommendations emerging from the study are proposed.

6.1 SUMMARY OF THE STUDY

The purpose of the study was to explore the patients' experiences and those of the service providers' regarding the rehabilitation services at BLRC since information in this area is lacking. Using the qualitative means of data collection, the study explored the patients and service providers' experiences regarding specific aspects of rehabilitation services as indicated in the objectives of the study. Eleven participants with physical disabilities who received rehabilitation services at BLRC in 2009 were selected for the FGD and three key informants among the service providers were selected for the in-depth interviews.

The FGD and interview transcripts were thematically analyzed. The data was coded into pre-determined themes that included: service providers' knowledge, accessibility of services, interaction of patients and service providers, patient participation and involvement in rehabilitation, provision of information and the structure of rehabilitation sessions.

The findings of this study revealed that persons with physical disabilities accessing rehabilitation services at BLRC experienced different challenges that included: inaccessible transport, inadequate services which were influenced by a lack of resources. Service providers indicated that the shortage of service providers and lack of skills training were some of the challenges that they encountered. Though, the facility had such challenges of inadequate service providers, they invested time to interact with patients, provided patients with information related to their disability and treatment procedures. Patients were also involved in their own rehabilitation.

6.2 CONCLUSION

The study findings provide insights into the views, ideas and needs of the patients and their service providers regarding the rehabilitation services offered at BLRC. Considering that there has been information related to persons with physical disabilities' experiences in other CHCs except BLRC in the Western Cape Province (Matsika, 2010) and stroke patients' experiences only in BLRC (De La Cornillere, 2007). The current study provides experiences of persons with other physical disabilities with stroke inclusive and those of the service providers offering rehabilitation services at BLRC.

Despite the study indicating positive responses regarding rehabilitation services reported by participants, service providers reported that the rehabilitation services at BLRC needed an extensive improvement in the services provided. These include; addressing the problem of inadequate service providers, skills training and equipment like beds and assistive devices. Rehabilitation services and policies need a paradigm shift in addressing the needs that arose in this study.

The study highlights the problem of a lack of transport for patients that was raised in both the FGD and interviews. This problem was mostly raised by the patients since they were the ones directly affected. As evident in this study, service providers needed to improve their knowledge and skills on certain disability related issues. The inadequacy in the number of service providers is a burden that has hindered opportunities for service providers to attend further courses and trainings. The few chances that service providers have to attend different courses are self-sponsored. They need the management of BLRC to sponsor any courses and workshops available for them. Due to a shortage of service providers at BLRC, the rehabilitation sessions are not provided at a frequency that is satisfactory to both patients and service providers. Addressing the inadequacy of service providers could be one of the ways of increasing the effectiveness of services delivered at BLRC.

Though service providers were challenged with the shortage of service providers, they provided patients with the information related to their disabilities and treatment. Service providers also invested time to interact with patients. However, service providers lacked time to relate with patients due to the workload that did not correspond to the service providers' capacity. Service providers explained to the patients the procedures of the treatment prior to therapy and gave patients opportunities to participate in their own rehabilitation. Patients who came to the facility with their families, provided positive responses regarding their families involvement in their rehabilitation sessions. This was also affirmed by their service providers. Though, group sessions were beneficial to patients, some preferred individual sessions because they felt more actively involved than in group sessions. The service providers and some patients raised their concerns regarding the delays of referral systems with tertiary or specialised facilities. Some patients also expressed the need for follow-up after rehabilitation.

The findings of the study indicate that the inadequate service is likely a product of delayed services, inadequate rehabilitation sessions and inadequate skills training among service providers. The results can be used to guide the development of rehabilitation services offered at BLRC by addressing the problems that include: the inadequacy of service providers and their skills training, and transport issues among patients. Therefore this study concludes that the aforementioned issues need to be addressed by the health care systems, policy makers and the management of BLRC. Addressing issues like transport will increase the patients' attendance to rehabilitation sessions. If the problem of the shortage of service providers is addressed, the rehabilitation sessions with patients will increase and service providers will more easily attend courses and workshops available for them.

6.3 LIMITATIONS OF THE STUDY

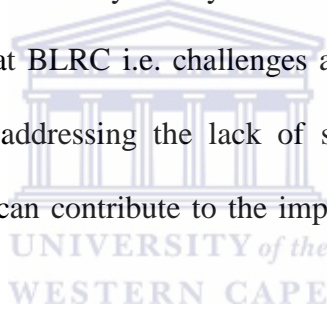
1. The study adopted the FGD to gather the data related to the patients experiences regarding the rehabilitation services. The discussions could not thus be conducted in the patients' homes but at the facility which was the only place they all agreed to meet. However, this environment curtailed the freedom to speak freely, it might have hindered the patients from expressing the negative perceptions they had, fearing to be heard by their service providers. The freedom to express an opinion might have been curtailed among patients themselves, fearing to express the negative issues that would have been reported to the service providers and this limited the depth of information. In-depth interviews to exploring patients' experiences must be done where they feel free to express themselves without fear of being heard by the other parties.
2. The targeted selection of the participants among patients excluded some of the disabilities like those with speaking and hearing disabilities, possibly because the

researcher did not consider these disabilities to have experienced problems during the course of their rehabilitation sessions. For this reason that the current study information is limited to be generalised.

3. Due to the fact that the study findings were based on qualitative means of data collection, the findings cannot be representative among all persons with physical disabilities attending BLCHC and a clear distinction was not made between people attending BLRC with impairments verses those with disabilities.
4. The fact that the study was conducted in two different languages i.e. English and Afrikaans might have affected some original expressions. The translations or the interviews and discussion processes might have been negatively affected, despite the researcher hiring professional translators.
5. The service providers might not have provided all the negatively perceived issues, due to the fact that BLRC consists of a few service providers. They might have developed the feeling that the data might be easily tracked back to them, despite the researcher assuring them of their anonymity in the report of the study and in any publication papers.
6. The fact that the participants had received rehabilitation services at BLRC in 2009 might have limited the depth of the information provided. Recall bias could affect the results due to the fact that some of the patients might have forgotten some of the issues that were being discussed that they might have experienced which could have been important for the study.

6.4 SIGNIFICANCE OF THE STUDY

The results of this study are important not only to the service providers and the management of the facility but also the future researchers and policy makers. The current study informs the management of the facility how patients and service providers perceive the rehabilitation services provided at BLRC. It is anticipated that the results of this study could be used to inform the rehabilitation management of the facility as to whether their expectations about the services were achieved. The results of this study could assist service providers to adapt their services if needed. The results of this study could be of significance to the professionals and staff when planning, developing and implementing rehabilitation services and programmes for PWDs. The current study finally informs the Department of Health about rehabilitation services delivered at BLRC i.e. challenges and needs for patients and service providers. The interventions in addressing the lack of service providers, equipment and transport issues among patients, can contribute to the improvement of rehabilitation service delivery at BLRC.

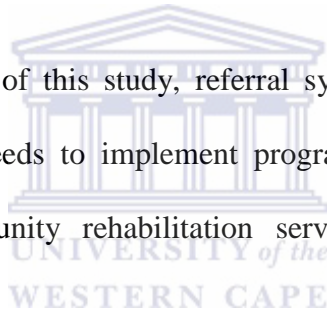


6.5 RECOMMENDATIONS

The following recommendations are made based on the findings of the study:

1. The findings of the study indicate that the government sectors in South Africa need to develop public transport systems that are accessible and affordable to PWDs to assist them in attending rehabilitation sessions and also in their daily lives. In addition the public transport such as taxis, trains, buses should be adjusted making them accessible to PWDs and ensuring that the public is educated and are aware of disability. This will allow them to be able to advocate for and help the PWDs integrate in the community.

2. There is a need for health policy makers to improve means of ensuring that rehabilitation facilities and service providers are adequately equipped with equipment and the staff needed to provide services that will effectively and efficiently satisfy the needs of patients. Patient's sessions and interaction with service providers would increase since the workload of service providers would be reduced.
3. The health policy makers should develop programmes that allow service providers to access training courses that will develop their skills. The facility management can ensure that the rehabilitation professionals and staff are provided opportunities to attend these training courses that increase their awareness and competency on a variety of disability and rehabilitation issues.
4. According to the results of this study, referral systems were also a problem. The Department of Health needs to implement programmes that facilitate the referral systems between community rehabilitation services and those of tertiary and specialised institutions.



REFERENCES

- Al-Abdulwahab, S. S., & Al-Gain, S. I. (2003). Attitudes of Saudi Arabian health care professionals towards people with physical disabilities. *Asia Pacific Disability Rehabilitation Journal*, 14(1), 63-70.
- Anderson, C., Mhurchu, C. N., Brown, P. M., & Crater, K. (2000). Stroke rehabilitation services to accelerate hospital discharge and provide home-based care. *Pharmacoeconomics*, 20(8), 537-552.
- Armstrong, J., & Ager, A. (2005). Physiotherapy in Afghanistan: an analysis of current challenges. *Disability & Rehabilitation*, 28(5), 315-322.
- Barton, R. (1999). Psychosocial rehabilitation services in community support systems: A review for outcomes and policy recommendations. *Psychiatric Services*, 50(4), 525-534.
- Baxi, M. V. (2004). Rehabilitation in developing countries. *Canadian Medical Association Journal*, 170(6), 930-931.
- Beatty, P. W., Hagglund, K. J., Neri, M. T., Dhont, K. R., Clark, M. J., & Hilton, S. A. (2003). Access to health care services among people with chronic or disabling conditions: patterns and predictors. *Arch Phys Med Rehab*, 84, 1417-1425.
- Bhatia, S., & Joseph, B. (2001). Rehabilitation of cerebral palsy in a developing country: the need for comprehensive assessment. *Paediatric Rehabilitation*, 4(2), 83-86.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.

Burry, T. (2005). Developmental articles primary health care and community based rehabilitation: Implications for physical therapy. *Asia Pacific Disability Rehabilitation Journal*, 16(2), 29-61.

Camden, C., Swaine, B., Tetreault, S., & Brodeur, M. M. (2010). Reorganizing rehabilitation services to improve accessibility: do we sacrifice quality. *BMC Health Services Research*, 10(227), 1-37.

Cardol, M., De Jong, B. A., & Ward, C. D. (2002). On autonomy and participation in rehabilitation. *Disability and Rehabilitation*, 24, 970-974.

Cott, A. C. (2004). Client-centred rehabilitation: Client perspectives. *Disability and Rehabilitation*, 26(24), 1411-1422.

Cott, A. C., Teare, G., McGilton, K. S., & Lineker, S. (2006) Reliability and construct validity of the client-centred questionnaire. *Disability and Rehabilitation*, 28(22), 1387-1597.

Cowles, D. L., Kiecker, P., & Little, M. W. (2002). Using key informants as a foundation for e-retailing theory development. *Journal of Business Research*, 55(8), 629-636.

Creswell, W. J. (2002). Research design, Qualitative, Quantitative and mixed approaches. University of Nebraska, Lincoln. Second Edition.

Crisp, R. (2000). A qualitative study of the perceptions of individuals with disabilities concerning health and rehabilitation professionals. *Disability & Society*, 15(2), 355-367.

Crisp, R. (2002). A counselling framework for understanding individual experiences of socially constructed disability, *Disability Studies Quarterly*, 22(3), 20-32.

Darrah, J., Magil-Evans, J., & Adkins, R. (2002). How well are we doing? Families of adolescents or young adults with cerebral palsy share their perceptions of service delivery. *Disability and Rehabilitation*, 24(10), 542-549.

De la Cornillere, W. L. (2007). Participants' experiences of the Bishop Lavis Rehabilitation Centre stroke group. Unpublished Master's Thesis. Centre for Rehabilitation Studies. University of Stellenbosch. South Africa.

Dejong, G., Palsbo, S. E., Beatty, P. W., Jones, G. C., Kroll, T., & Neri, M. T. (2002). The organization and financing of health services for persons with disabilities. *The Milbank Quarterly*, 80(2), 261-301.

De Vos, A. S. (2002). Research at grass roots for the social sciences and Human Service professionals. (2nd ed). Pretoria. Van Schaik.

Eccleston, Z., & Eccleston, C. (2004). Interdisciplinary management of adolescent chronic pain: developing the role of physiotherapy. *Physiotherapy*, 90, 77-81.

Eva, G., & Wee, B. (2010). Rehabilitation in end-of-life management. *Supportive and Palliative Care*, 4(3), 158-162.

Evans, P. J., Zinkin, P., Harpham, T., & Chaudury, G. (2001). Evaluation of medical rehabilitation in community based rehabilitation. *Social Science & Medicine*, 53, 333-348.

Gabow, P., Eisert, S., & Wright, R. (2003). Denver health: A model of integration of a public hospital and community health centres. *Annals for Internal Medicine*, 138(2), 143-149.

Golafshani, N. (2003). Understanding Reliability and Validity in Qualitative Research. *The Qualitative Report*, 8(4), 597-607.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24(2), 105-112.

Hall, J. J., & Taylor, R. (2003). Health for all beyond 2000: the demise of the Alma-Ata Declaration and primary health care in developing countries. *Medical Journal of Australia*, 178, 17-20.

Hammell, K., & Carpenter, C. (2000). Using qualitative research. A practical introduction for occupational and physical therapist. Churchill, Livingstone.

Hills, R., & Kitchen, S. (2007). Toward a theory of patient satisfaction with physiotherapy: Exploring the concept of satisfaction. *Physiotherapy Theory and Practice*, 23(5), 243-254.

Helander, E. (1999). Prejudice and Dignity-An Introduction to Community Based Rehabilitation. New York: United Nations Division of Public Affairs.

Hwang, K., Johnston, M., Tulskey, D., Wood, K., Dyson-Hudson, T., & Komaroff. (2008). Access and coordination of health care services for people with disabilities. *Journal of Disability Policy Studies*, 20, 28-34.

Jones, R. (2002). Pulmonary rehabilitation. *British Medical Journal*, 57(5), 468-470.

Kaplan, A. (1999). The Development of Capacity. UN Non-Government Liaison Service (NGLS). Palais des Nations. CH-1211 Geneva 10. Switzerland.

Kendall, E., Buys, N., & Larner, J. (2000). Community-based service delivery in rehabilitation: The promise and the paradox. *Disability and Rehabilitation*, 22(10), 435-445.

Kenny, D. T. (1998). The role of rehabilitation provider in occupational rehabilitation: providing for whom: Part 2 perceptions of stakeholders. *Australian Journal of Rehabilitation Counselling*, 4(2), 111-122.

Kiehofner, G. (2002). Model of human occupation. Theory and application (3rd ed.).

Kroll, T., & Neri, M. T. (2003). Experiences with care co-ordination among people with cerebral palsy, multiple sclerosis and spinal cord injury. *Disability and Rehabilitation*, 25(29), 1106-1114.

Kroll, T., Jones, G. C., Kehn, M., & Neri, M. T. (2006). Barriers and strategies affecting the utilisation of primary preventive services for people with physical disabilities: A qualitative inquiry. *Health and Social Care in the Community*, 14, 284-293.

Krueger, R. A., & Casey, M. A. (2000). Focus group: A practical guide for applied research (3rd edition). Thousand Oaks, California: Sage.

Leavitt, R. (1995). The development of rehabilitation services and suggestions for public policy in developing nations. *Paediatric Physical Therapy*, 7, 112-118.

Leith, H. L., Phillips, L., & Sample, P. L. (2004). Exploring the service needs and experiences of persons with Traumatic Head Injury (TBI) and their families: the South Carolina experiences. *Brain Injury*, 18(12), 1191-1208.

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage Publications, Inc.

Lopopolo, R. B. (2001). Development of professional role behaviours survey (PROBES). *Physical Therapy*, 7, 1317-1327.

Maart, S., Eide, A. H., Jelsma J., Loeb, M. E., & Toni, M. Ka. (2007). Environmental barriers experienced by urban and rural disabled people in South Africa. *Disability and Society*, 22(4), 357-369.

Marshal, C., & Rossman, G. B. (1995). *Designing qualitative researcher*. Newbury Park: Sage publications.

Martensson, L., & Dahllin-Ivanoff, S. (2006). Experiences of a primary health care rehabilitation programme. A focus group study of persons with chronic pain. *Disability and Rehabilitation*, 28(16), 985-995.

Matsika, C. K. (2010). Persons with physical disabilities' experiences of rehabilitation services at Community Health Centres in Cape Town Metro Health District. Unpublished Master's Thesis. Physiotherapy Department. The University of the Western Cape.

McNeal, M. A. L., Carrothers, L., & Premo, B. (2002). Providing primary health care for persons with disabilities: A survey of California physicians. Centre for Disability Issues and the Health Professionals. 1-16.

Mead, N., & Bower, P. (2000). Patient-centeredness: a conceptual framework and review of the empirical literature. *Social Science and Medicine*, 51, 1087-1110.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis*. 2nd edition. Thousand Oaks, CA: Sage publications.

Mont, D. (2007). Measuring disability prevalence. Social Protection. The World Bank. No.0706.

Morrison, E. H., George, V., & Mosqueda, L. (2008). Primary care for adults with physical disabilities: perceptions from consumers and provider focus groups. *Family Medicine*, 40(9), 645-651.

Neri, M. T., & Kroll, T. (2002). Understanding the consequences of access barriers to health care: experiences of adults with disabilities. *Disability and Rehabilitation*, 25(2), 85-96.

Office of the Deputy President. (1997). White Paper on an Integrated National Disability Strategy, Government of South Africa, Pretoria.

Parle, M., Maguire, P., & Heaven, C. (1997). The development of a training model to improve health professionals' skills, self efficacy and outcome expectancies when communicating with cancer patients. *Social Science & Medicine*, 44(2), 231-240.

Parry, H. R. (2004). Communication during goal-setting in physiotherapy treatment sessions. *Clinical Rehabilitation*, 18, 668-682.

Rimmer, J. H., Riley, B., Wang, E., Rauworth, A., & Jurkowski, J. (2004). Physical activity participation among person with disabilities. Barriers and facilitators. *American Journal of Preventive Medicine*, 26(5), 419-425.

Saetermoe, C. L., Gomez, J., Bamaca, M., & Gallardo, C. (2004). A qualitative inquiry of caregivers of adolescents with severe disabilities in Guatemala city. *Disability and Rehabilitation*, 26(10), 1032-1047.

Salbach, N. M., Veinot, P., Rappolt, S., Bayley, M., Burnett, D., Judd, M., & Jaglal, S. B. (2009). Physical therapists' experiences updating the clinical management of walking rehabilitation after stroke: A qualitative study. *Physical Therapy Journal*, 89(6), 556-568.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Journal for Education for Information*, 22, 63-75.

Skinner, D. (2007). Qualitative methodology: an introduction. In Joubert, G & Ehrlich (Eds.). *Epidemiology: a research manual for South Africa*. Cape Town, South Africa: Oxford University Press (pp. 318-327).

Statistics South Africa. (2005). Prevalence of disability in South Africa. Census 2001. Report no. 03-02-44 (2001). Pretoria: Statistics South Africa.

Stetler, C. B., McQueen, L., Demakis, J., & Mittman, B. S. (2008). An organisational framework and strategic implementation for system-level change to enhance research-based practice: *QUERI series Implementation Science*, 3(30).

Stubbs, S. (1999). Engaging with difference: soul searching for a methodology in disability and development. *Disability and Development*. London: Disability Press.

The Department of Health, Western Cape (2002). Comprehensive Service Plan (CSP) for Implementation of Health Care 2010. Western Cape Province.

The Department of Health. (2000). Rehabilitation For All. National Rehabilitation Policy. Pretoria: South African Government Printers.

Tod, A. M., Lacey, A. E., & McNeill, F. (2002). "I'm still waiting.....": barriers to accessing cardiac rehabilitation services. *Journal of Advanced Nursing*, 40(4), 421-431.

United Nations (2007). From Exclusion to Equity. Realizing the rights of persons with disabilities. Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol.

United Nations Population Information Network. (2006). Database of International Statistical Activities. Retrieved on 21 September, 2010 from

http://unece.unog.ch/disa/archive/disa.element_details.asp.

Velema, J. P., & Cornielje, H. (2003). Reflect before you act: providing structure to the evaluation of rehabilitation programmes. *Disability and Rehabilitation*, 25(22), 1252-1264.

Veltman, A., Stewart, D. E., Tardif, G. S., & Branigan, M. (2001). Perceptions of primary healthcare services among persons with physical disabilities: Part 2 Quality Issues. *Medscape General Medicine*, 6(3), 2-19.

Wazakili, M., Mpofu, R., & Devlieger, P. (2006). Experiences and Perceptions of Sexuality and HIV/AIDS among Young People with Disabilities in South African Township: A Case Study. *Sexuality and Disability*, 24, 77-80.

Woo, J., Chan, S. Y., Sum, C. M. W., Wong, E., & Chui, M. P. Y. (2008). In patient stroke rehabilitation efficiency: Influence of organisation of service delivery and staff numbers. *BMC Health Services Research*, 8(86), 1-7.

World Confederation for Physical Therapy. (2003). Primary health care and community based rehabilitation. An overview of WCPT's work and plan of action. 15th General meeting papers, Agenda Item 10.5. London: World Confederation for Physical Therapy.

World Health Organization (1978). Report of the international conference on primary health care, Alma-Ata. USSR, 6-12. Geneva.

World Health Organization (2001). International Classification of Functioning, Disability and Health. World Health Organization. Switzerland: Geneva. Retrieved on 23 June, 2010 from <http://www3.who.int/icf/icftemplate.cfm>.

World Health Organisation (2006). Disability and rehabilitation WHO Action plan 2006-2011. Retrieved on August 18, 2010 from

http://www.who.int/disabilities/publications/dar_action_plan_2006to2011.pdf

Wottrich, A. W., Stenstrom, C. H., Engardt, M., Tham, K., & Koch, L. V. (2004). Characteristics of physiotherapy sessions from the patient's and therapist's perspective. *Disability & Rehabilitation*, 26(20), 1198-1205.

Wressle, E., Eeg-Olofsson, A. M., Marcusson, J., & Henriksson, C. (2002). Improved client participation in the rehabilitation process using client-centeredness goal formulation structure. *Journal of Rehabilitation Medicine*, 34, 5-11.

Yen, H. L., & Wong, J. T. Y. (2007). Rehabilitation for traumatic head injury in children and adolescents. *Annals Academy of Medicine Singapore*, 36, 62-66.

Zimmerman, M. A., & Warschausky, S. (1998). Empowerment theory for rehabilitation research: Conceptual and methodological issue. *Rehabilitation Psychology*, 43, 3-16.



APPENDIX A

12/10/2010 15:04 0214839895

FINANCE

PAGE 02/02



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

Isalathiso

Navrae
Enquiries Dr A Dearham
Imibuzo

Telefoon
Telephone 021 483 4193

P O Box 19063

Tygerberg
7505

Departement van Gesondheid
Department of Health
iSebe lezeMpilo

FAX: - 021 931 9835

Dear Prof M deVilliers
Ms G Mji
Ms S Statham
Ms S Gcaza
Ms A Rhoda
Masters student Anne Kumurenzi

RE: The description of the organisational framework of rehabilitation service delivery in an out-patient rehabilitation centre in the Western Cape.

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:

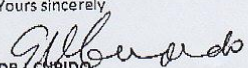
Bishop Lavis Rehabilitation Centre Ms. R. Carelse Tel: (021) - 9345060

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@pawc.gov.za).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely


DR. L. CUPIDO
DEPUTY-DIRECTOR GENERAL
DISTRICT HEALTH SERVICES AND PROGRAMMES

DATE: 9/1/2010

CC DR L BITALO DIRECTOR: NORTHERN/TYGERBERG SUBSTRUCTURES

Page 1 of 2

Dorpstraat 4
Postbus 2060
KAAPSTAD
8000

4 Dorp Street
PO Box 2060
CAPE TOWN
8000

APPENDIX B

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

Private Bag X17, Bellville 7535
South Africa
Telegraph: UNIBELL
Telephone: +27 21 959-2948/2949
Fax: +27 21 959-3170
Website: www.uwc.ac.za

24 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:
Ms A Kumerenzi (Physiotherapy)

Research Project: The description of the organizational framework of rehabilitation service delivery in an out-patient rehabilitation centre in the Western Cape

Registration no: 10/1/22


UNIVERSITY of the
WESTERN CAPE


Peter Syster
Manager: Research Development Office
University of the Western Cape



UNIVERSITY of the
WESTERN CAPE

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

APPENDIX C



DEPARTMENT of HEALTH

Provincial Government of the Western Cape

METRO DISTRICT HEALTH SERVICES

Bishop Lavis CDC
tel: +27 21 934 6050; +27 21 934 6051
fax: +27 21 934 4143; +27 21 934 6127
Lavis drive, Bishop Lavis, Cape Town, 7490

REFERENCE: BISHOP LAVIS CDC

ENQUIRIES: Ms R. Carelse

Date : 21/04/2011

Responding to your request to do Research at Rehabilitation Department Bishop Lavis CHC

This is to confirm Ms. A Kumerenzi has permission to conduct research at Bishop Lavis CHC.

Research topic: Rehabilitation services of persons with disabilities: Experiences of patients and service providers in a rehabilitation centre in the Western Cape Province.


R. Carelse
Facility manager
Bishop Lavis CDC



UNIVERSITY of the
WESTERN CAPE

T

APPENDIX D

Interview guide for patients

Please tell me any problems you might have encountered getting access to the rehabilitation services at Bishop Lavis Rehabilitation Centre?

Probes

- Transport
- Within the facility (therapy rooms/ space, toilets)

Tell me about your relationship with the service providers here at Bishop Lavis Rehabilitation Centre? Do the service providers offer time to interact with you as patients?

Probes

- Respect and love patients
- Communication (language used)



Were you allowed to get involved in your rehabilitation?

Probes

- Setting goals with patients
- Explaining the procedures to patients
- Take part in your treatment sessions.

Who came with their families for therapy? Were your families involved in your rehabilitation sessions?

Did the service providers allow and provide time for you to ask questions about issues you needed to know?

Probes:

- Disability
- Treatment

Tell me more about any information you were given?

Do you think they answered your questions adequately?

Do you think your service providers always knew what your problems were and knew what treatment to give you?

Tell me about the rehabilitation sessions provided to you?

Probes:

- Appointment schedules



What else can you tell me about your rehabilitation at Bishop Lavis Rehabilitation Centre?

Probes

- What do you think should be improved

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

APPENDIX E

Onderhoudgids vir pasiente


Vertel my van enige probleme wat u al teekom het om toegang te kry tot die rehabilitasie dienste by die Bishop Lavis Rehabilitasie Sentrum.

Kyk na:

- Vervoer
- Binne die fasiliteit (terapie kamers/spasie, toilette,)

Vertel my van die verhouding wat U het met die diensverskaffers hier by Bishop Lavis Rehabilitasie Sentrum, bied die diensverskaffers tyd vir interaksie met U as pasiente?

Kyk na:

- 
- Respek en liefde teenoor pasiente
 - Kommunikasie (taalgebruik)

Was U toegelaat om betrokke te wees by U rehabilitasie?

Kyk na:

- Doele wat gestel word vir U as pasiente
- Verduideliking van prosedure aan U as pasiente
- Deelname aan jul behandeling sessies

Wie het met hul families gekom vir behandeling? Was jul families betrokke by jul rehabilitasie sessies?

Het die diensverskaffers tyd voorsien en toegelaat dat u vrae kon vra oor dinge wat U wou weet?

Kyk na:

- Gebrek
- Behandeling

Vertel my meer oor die inligting wat aan U verskaf was. Dink U hul het U vrae toepaslik beantwoord?

Dink U, u diensverskaffers het te alle tye geweet wat die problem was en het hul geweet hoe om dit te behandel?

Vertel my van die rehabilitasie sessies wat verskaf was aan U.

Kyk na:

- Afspraak skedules



Wat anders kan U my vertel van u rehabilitasie hier by Bishop Lavis Rehabilitasie Sentrum?

Kyk na:

- Wat dink U moet verbeter word?

Dink U daar is enige aspekte wat ons nie gedek het nie, aangaande die rehabilitasie dienste?

APPENDIX F

Interview guide for Service Provider

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

Probes:

- Service providers
- Equipments
- 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 Bishop Lavis Rehabilitation Centre are structure or organised?



Probes:

- Appointment schedules
- The referral system

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

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

Probes:

- For equipments
- 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 you needed to be covered as relates to rehabilitation services?



APPENDIX G

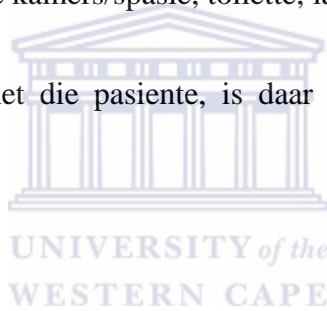
Onderhoudgids vir Diensverskaffer

Vertel my van die toeganklikheid van dienste hier by die fasiliteit in terme van rehabilitasie dienste.

Kyk na:

- Diensverskaffers
- Toerusting
- Vervoer vir pasiente
- Binne die fasiliteit (terapie kamers/spasie, toilette, lampe beskikbaarheid)

Vertel my van U verhouding met die pasiente, is daar enige interaksie tussen U en die pasiente?



Kyk na:

- Respek en liefde teenoor pasiente
- Kommunikasie (taalgebruik)

Word U pasiente toegelaat om betrokke en aktief deel te neem aan hul rehabilitasie?

Kyk na:

- Doele wat gestel word vir die pasiente
- Verduideliking van prosedure aan die pasiente
- Deelname aan hul behandeling sessies.

Kom pasiente met familieledede na die behandeling sessies? Word die familieledede toegelaat om betrokke te wees by die pasient se behandeling sessies?

Aangaande die verskaffing van informasie, dink U die pasiente word toepaslik ingelig oor enige informasie wat hul nodig sou hê?

Kyk na:

- Hul gebrek
- Behandeling

Vertel my meer van die informasie wat deurgegee word aan die pasiente.

Vertel my hoe die rehabilitasie sessies hier by Bishop Lavis Rehabilitasie Sentrum georganiseer en gestruktureer is.



Kyk na:

- Afspraak skedules
- Die verwysings sisteem

Dink U die rehabilitasie dienste wat aangebied word is toepaslik vir al die pasiente wat toegang het tot die fasiliteit?

Vertel my van die algemene begroting geallokeer aan hierdie fasiliteitsprogramme en dienste.

Kyk na:

- Vir toerusting
- Vir opleidingsvaardighede

Dink U, u is goed genoeg toegerus en opgelei om enige tipe gebrekke te kan behandel?

Wat het U nodig om die beste moontlike dienste te lewer aan mense met gebrekke in U area?

Is U tevrede met die dienste wat gelever word en dink U die pasiente is tevrede?

Dink U daar is enige aspekte wat ons nie gedek het nie, ten opsigte van die rehabilitasie dienste?



APPENDIX H



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

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

E-mail:

CONSENT FORM

Title of Research Project: Rehabilitation services of persons with disabilities: Experiences of persons with physical disabilities and service providers in a rehabilitation centre in the Western Cape.



The study has been described to me in 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.

Participant's name..... **Witness' name**.....

Participant's signature..... **Witness' 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: Prof. Anthea Rhoda

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021)959-2543

Fax: (021)959-1217

Email: arhoda@uwc.ca.za



APPENDIX I



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

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

E-mail:

TOESTEMMINGSVORM

Titel van Navorsingsprojek: Rehabilitasie dienste vir persone met gestremdhede: Ervaringe van persone met getremdhede en diensverskaffers in 'n rehabilitasie sentrum in die Wes-Kaap.



Die studie was aan my beskryf in 'n taal wat ek verstaan en ek gee hiermee vrywilliglik toestemming tot deelname aan die studie. My vrae van die studie was beantwoord tot my bevrediging. Ek verstaan dat my identiteit nie bekend gemaak sal word nie en dat ek kan onttrek aan die studie op enige tydstip sonder om enige rede te verskaf en dat my onttrekking geen negatiewe impak op my sal het nie.

Naam van deelnemer: _____

Getuie: _____

Handtekening van deelnemer: _____

Datum: _____

Indien u enige vrae aangaande hierdie studie het of enige probleme wat u ervaar het wil
aanmeld kan u die studie koördineerder kontak:

Studie Koördineerder: Prof. Anthea Rhoda

Universiteit van Wes-Kaapland

Privaat sak X17, Belville 7535

Telefoon: (021)959-2543

Fax: (021)959-1217

Email: arhoda@uwc.ca.za



APPENDIX J



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

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

E-mail:

INFORMATION SHEET FOR PATIENTS

PROJECT TITLE: Rehabilitation services of persons with disabilities: Experiences of persons with physical disabilities and service providers in a rehabilitation centre in the Western Cape.

What is this study about?

This is a research project being conducted by Kumurenzi Anne at the University of the Western Cape. We are inviting you to participate in this research project because you are one of the persons with disability that attended out-patient programmes at the Bishop Lavis Rehabilitation Centre.

The **Aim** of this research is to explore the persons with physical disabilities and service providers' experiences regarding the rehabilitation services at Bishop Lavis Rehabilitation Centre.

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

You will be asked to participate in a focus group discussion that will take place at a time and place that is convenient for you. The other people who will be participating in the focus group discussion will be the researcher and the research assistant.

Would my participation in this study be kept confidential?

We intend to do our best to keep the information given confidential. All tapes and transcripts will be stored safely in the researcher's locked cupboard and will be discarded when the research is completed. There will not be any exposure of your name in writing a report or article on this research project.

What are the risks of this research?

There are no known risks associated with this research project.

What are the benefits of this research?

This research project is intending not to help you personally but the results of this study may help to explore the experiences of patients and their service providers regarding the rehabilitation services at Bishop Lavis Rehabilitation Centre. And through these experiences, we anticipate that other people like patients, service providers etc may benefit from this study if, the recommendations of this study are implemented in improving the capacity of Bishop Lavis Rehabilitation Centre in rendering rehabilitation services. Hence, providing services that are accessible, equitable and effective.

Do I have to be in this research or may I stop participating at any time?

Your participation in this research project is entirely voluntary, you can choose not to participate at all. You can withdraw at anytime. You will not be penalized or lose any benefits for which you qualify after you have decided not to participate in this study or if you stop participating at any time.

Is any assistance available if I am negatively affected by this research?

Should the questioning during the discussion affect you in anyway, you would be referred to an appropriate health care professional available at Bishop Lavis Community Health Centre.

What if I have questions?

This research is being conducted by Kumurenzi Anne, Department of physiotherapy at the University of the Western Cape. If any question arises during and after the discussions of this research project, feel free to contact:

Kumurenzi Anne

University of the Western Cape

Department of physiotherapy

Private bag X79

Bellville 7535



Tel: +277182825523

Email address: 2971184@uwc.ac.za.

As a research participant, should you have a question or any other problem that you experienced related to this research project, please feel free to contact:

The head of physiotherapy department:

Professor Julie Phillips

The dean of the Faculty of Community and Health Sciences

Professor Rati Mpfu

University of the Western Cape

Private bag X79

Bellville 7535



APPENDIX K



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

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

E-mail:

INFORMASIE BLAD VIR PASIENTE

Titel van Navorsingsprojek: Rehabilitasie dienste vir persone met gestremdhede: Ervaringe van persone met getremdhede en diensverskaffers in 'n rehabilitasie sentrum in die Wes-Kaap

Waaroor gaan die studie?

Dit is 'n navorsingsprojek wat uitgevoer word deur Anne Kumurenzi 'n student verbonde aan die Universiteit van Wes-Kaapland. Ons nooi u om deel te neem aan hierdie navorsingsprojek omdat u rehabilitasie dienste ontvang het by die Bishop-Lavis Gesondheids dag sentrum.

Doel van die studie?

Om te ondersoek die persepsies van persone met gestremdhede en diensverskaffers rakende rehabilitasie diensverskaffing by Bishop-Lavis sentrum.

Wat sal van my verwag word om te doen as ek instem om deel te wees:

U sal gevra word om 'n sessie met die navorser en die assistent by die sentrum by te woon waar die navorser 'n fokus-groep bespreking sal hou om u ervaring rakende rehabilitasie te ondersoek.

Sal u deelname aan die studie vertroulik wees?

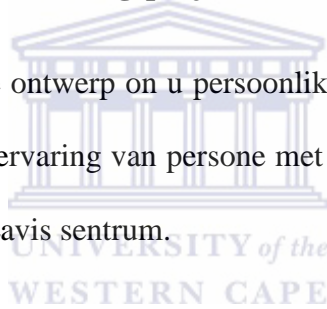
Ons sal ons bes doen om te verseker dat u persoonlike inligting vertroulik bly. Alle informasie wat ingesamel word, gaan in 'n geslote argiefkas gestoor word om u privaatheid verder te beskerm. Die diensverskaffer of enige ongemagtigde party sal nie instaat wees om toegang tot die inligting te verkry nie. U identiteit sal tot die maksimum mate beskerm word wanneer daar artikels of verslae geskryf word.

Wat is die risiko's van hierdie navorsingsprojek?

Daar is geen bekende risiko's wat verband hou met hierdie navorsingsprojek.

Wat is die voordele van hierdie navorsingsprojek?

Hierdie navorsingsprojek was nie ontwerp om u persoonlik te help nie, maar die resultate sal die navorser inlig aangaande die ervaring van persone met gestremdhede en diensverskaffers rakende rehabilitasie by Bishop-Lavis sentrum.



Moet ek deel wees van hierdie navorsingsprojek en mag ek enige tyd onttrek?

U deelname in hierdie navorsingsprojek is vrywillig. U mag kies om nie deel te wees van die projek nie. Deelnemers mag ter enigetyd gedurende die projek onttrek met geen negatiewe effekte op u nie.

Is enige hulp beskikbaar vir my as ek op 'n negatiewe manier geaffekteer word?

Daar is geen direkte risiko's geassosieer met deelname aan die navorsingsprojek nie. U sal wel na 'n gekwalifiseerde gesondheidswerker gestuur word as u emosioneel of oorweldig voel oor vrae wat beantwoord moet word of take wat nie uitgevoer kan word nie.

Wat as ek vrae het?

Die navorsing word onderneem deur Anne Kumurenzi wat verbonde is aan die Universiteit van Wes-Kaapland. Indien u enige vrae oor die studie self het, kan u Anne Kumurenzi kontak by: of selfoon: 071 8285523

e-pos: 2971184@uwc.ac.za

Indien u enige vrae het in verband met die studie en u regte as deelnemer, of as u enige probleme wil rapporteer, kontak asseblief :

die Hoof van die Fisioterapie:

Prof. Julie Phillips

(e-pos: jphillips@uwc.ac.za)

Die Hoof van die Gemeenskap en Gesondheid Wetenskap Fakulteit :

Prof. Ratie Mpofu (e-mail: mpofu@uwc.ac.za)

Universiteit van Wes-Kaapland



Privaat Sak X17

Bellville 7535

APPENDIX L



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

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

E-mail:

INFORMATION SHEET FOR SERVICE PROVIDERS

PROJECT TITLE: Rehabilitation services of persons with disabilities: Experiences of patients and service providers in a rehabilitation centre in the Western Cape.

What is this study about?

This is a research project being conducted by Anne Kumurenzi at the University of the Western Cape. We are inviting you to participate in this research project because you are one of the staff providing rehabilitation services to patients at Bishop Lavis Rehabilitation Centre in the Western Cape.

The **Aim** of this research is to explore the persons with physical disabilities and service providers' experiences regarding the rehabilitation services at Bishop Lavis Rehabilitation Centre.

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

You will be asked to participate in an in-depth interview that will take place at Bishop Lavis Rehabilitation Centre, where you are working currently in your convenient time.

Would my participation in this study be kept confidential?

We intend to do our best to keep the information given confidential. In order to protect your confidentiality. All tapes and transcripts will be stored safely in the researcher's locked cupboard and will be discarded when the research is completed. There will not be any exposure of your name in writing a report or article on this research project.

What are the risks of this research?

There are no known risks associated with this research project.

What are the benefits of this research?

This research project is intending not to help you personally but the results of this study may help to explore the experiences of patients and their service providers regarding the rehabilitation services at Bishop Lavis Rehabilitation Centre. And through these experiences, we anticipate that other people like patients, service providers etc may benefit from this study if, the recommendations of this study are implemented in improving the capacity of Bishop Lavis Rehabilitation Centre in rendering rehabilitation services. Hence, providing services that are accessible, equitable and effective.

Do I have to be in this research or may I stop participating at any time?

Your participation in this research project is entirely voluntary, you can choose not to participate at all. You can withdraw at anytime. You will not be penalized or lose any benefits of which you are qualified after you have decided not to participate in this study or if you stop participating at any time.

Is any assistance available if I am negatively affected by this research?

Should the questioning during the in-depth interviews affect you in anyway, you would be referred to an appropriate health care professional available at Bishop Lavis Community Health Centre.

What if I have questions?

This research is being conducted by Anne Kumurenzi, Department of physiotherapy at the University of the Western Cape. If any question arises during and after the in-depth interview of this research project, feel free to contact:

Anne Kumurenzi

University of the Western Cape

Department of physiotherapy

Private bag X79

Bellville 7535

Tel: +277182825523

Email address: 2971184@uwc.ac.za



As a research participant, should you have a question or any other problem that you experienced related to this research project, please feel free to contact:

The head of physiotherapy department:

Professor Julie Phillips

The dean of the Faculty of Community and Health Sciences

Professor Rati Mpfu

University of the Western Cape

Private bag X79

Bellville 7535



APPENDIX M



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

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

E-mail:

INFORMASIE BLAD VIR DIENSVERSKAFFERS

Titel van Navorsingsprojek: Rehabilitasie dienste vir persone met gestremdhede: Ervaringe van persone met getremdhede en diensverskaffers in 'n rehabilitasie sentrum in die Wes-Kaap

Waaroor gaan die studie?

Dit is 'n navorsingsprojek wat uitgevoer word deur Anne Kumurenzi'n student verbonde aan die Universiteit van Wes-Kaapland. Ons nooi u om deel te neem aan hierdie navorsingsprojek omdat u deel vorm van die rehabilitasie personeel by Bishop-Lavis Gesondheids dag sentrum.

Doel van die studie?

Om te ondersoek die persepsies van persone met gestremdhede en diesverskaffers rakende rehabilitasie diensverskaffing by Bishop-Lavis sentrum.

Wat sal van my verwag word om te doen as ek instem om deel te wees:

U sal gevra word om 'n sessie met die navorser en die assistent by die sentrum by te woon waar die navorser 'n fokus-groep bespreking sal hou om u ervaring rakende rehabilitasie verskaffing te ondersoek.

Sal u deelname aan die studie vertroulik wees?

Ons sal ons bes doen om te verseker dat u persoonlike inligting vertroulik bly. Alle informasie wat ingesamel word, gaan in 'n geslote argiefkas gestoor word om u privaatheid verder te beskerm. Die diensverskaffer of enige ongemagtigde party sal nie instaat wees om toegang tot die inligting te verkry nie. U identiteit sal tot die maksimum mate beskerm word wanneer daar artikels of verslae geskryf word.

Wat is die risiko's van hierdie navorsingsprojek?

Daar is geen bekende risiko's wat verband hou met hierdie navorsingsprojek.

Wat is die voordele van hierdie navorsingsprojek?

Hierdie navorsingsprojek was nie ontwerp om u persoonlik te help nie, maar die resultate sal die navorser inlig aangaande die ervaring van persone met gestremdhede en diensverskaffers rakende rehabilitasie by Bishop-Lavis sentrum. Sodoende kan die stappe geneem word om veranderinge te maak, as nodig.

Moet ek deel wees van hierdie navorsingsprojek en mag ek enige tyd onttrek?

U deelname in hierdie navorsingsprojek is vrywillig. U mag kies om nie deel te wees van die projek nie. Deelnemers mag ter enigetyd gedurende die projek onttrek met geen negatiewe effekte op u nie.

Is enige hulp beskikbaar vir my as ek op 'n negatiewe manier ge affekteer word?

Daar is geen direkte risiko's geassosieer met deelname aan die navorsingsprojek nie. U sal wel na 'n gekwalifiseerde gesondheidswerker gestuur word as u emosioneel of oorweldig voel oor vrae wat beantwoord moet word of take wat nie uitgevoer kan word nie.

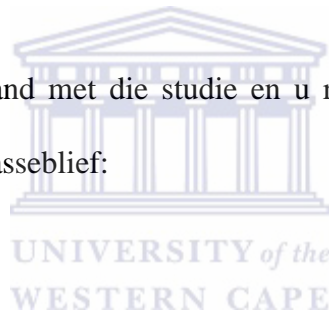
Wat as ek vrae het?

Die navorsing word onderneem deur Anne Kumurenzi wat verbonde is aan die Universiteit van Wes-Kaapland. Indien u enige vrae oor die studie self het, kan u Anne Kumurenzi kontak by: of selfoon: 071 8285523

e-pos: 2971184@uwc.ac.za

Indien u enige vrae het in verband met die studie en u regte as deelnemer, of as u enige probleme wil rapporteer, kontak asseblief:

die Hoof van die Fisioterapie:



Prof. Julie Phillips (e-pos: jphillips@uwc.ac.za)

Die Hoof van die Gemeenskap en Gesondheid Wetenskap Fakulteit :

Prof. Ratie Mpofu (e-mail: mpofu@uwc.ac.za)

Universiteit van Wes-Kaapland

Privaat Sak X17

Belville 7535