The implementation of the rehabilitation service package in the Metropole Health District, Western Cape Province, South Africa

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Abstract

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This health services research investigates the availability and nature of the rehabilitation service at primary health care (PHC) level rendered by rehabilitation staff in the Metropole district health services. The aim of the study was to gain insight into how far we are with implementing the PHC package so as to assist with programme planning. The availability and nature of the seven elements (facility based provision, home based rehabilitation, self help groups, provision of rehabilitation training, networking, co-ordination and disability committee involvement) of the service package were determined through the use of 21 semi-structured telephonic interviews. The use of population to staffing ratios and the availability of therapy services at the 44 CHCs were determined. Focus groups were held with key rehabilitation staff to explore the dynamics of delivering a service at sub district level.

It was established that access to rehabilitation services at PHC level remains a problem. A small proportion (35%) of the CHCs have a therapy service available, while an even smaller proportion (14%) have a combined occupational therapy and physiotherapy service. Only 27% of the CHCs have a daily service. The limited access is directly related to the poor availability of rehabilitation staff as seen in the population to therapist ratio of 1: 139 189, in contrast to the long-term policy ratio of 1: 30 000. Examination of the elements indicates that physiotherapists were predominantly involved in facility based disability prevention services for mainly adults with neuromuscular conditions. In comparison, occupational therapists were more involved in rendering home-based

rehabilitation serving patients who had strokes and functional problems, whilst occupational therapy assistants were involved in support groups for clients with chronic mental health conditions. The findings may suggest that the two therapy services complement each other, however, the lack of a co-ordinated service in any of the sub districts suggest scope for improvement.

Interestingly, the elements on networking and involvement in disability forums - that lean towards the social model and community based rehabilitation (CBR) practices, indicate that there may be constraints and difficulties with implementing both facility-based services and community development activities. However, it may also reflect the changing practices from the medical to the social model. A number of systemic health system issues were identified as impacting negatively on the development of the service – including poor co-ordination, limited resources, and unclear supervision systems and accountability.

The study highlights the challenges to implement the service package in the Metropole. Key recommendations include the need for leadership and advocacy in the programme, with a strong emphasis on strengthening the contribution of rehabilitation in mental health, home based rehabilitation and the disability prevention services at facility level. The study also highly recommends establishing a formal working relationship with the district management team to support integration. Furthermore, a system for supervision and mentoring is required to support the development of practices that reflect the government's philosophy of the social model and CBR approaches to service delivery. More importantly the study identifies the urgent need for more human resources to implement the rehabilitation package in the Metropole and recommends an exploration on the best mix of human resources to render the service package.

November 2004

Declaration

I declare that "The implementation of the rehabilitation service package in the Metropole Health District, Western Cape province, South Africa" is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Sadia Misbach   Date: 19 November 2004

Acknowledgements

Abbreviations

CASE   Community Agency For Social Enquiry

CBR   Community Based Rehabilitation

CHC   Community Health Centre

DOH   Department Of Health

DHS   District Health System

INDS   Integrated National Disability Strategy

ILO   International Labour Organisation

NGO   Non Governmental Organisation

OT   Occupational Therapist/Occupational Therapy

OTA   Occupational Therapy Assistant

PHC   Primary Health Care

PT   Physiotherapist/Physiotherapy

UN   United Nations

UNESCO   United Nations Educational, Scientific and Cultural Organisation

WHO   World Health Organisation

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Chapter 1: **Introduction**

A significant proportion (5%) of the South African population is estimated to have a disability[1] according to the Census 2001 (Statistics South Africa, 2003). It is not known what percentage of the population have impairments[2] but it is generally accepted that at any one point in time 1.5% of the entire population require rehabilitation[3] services. It is further speculated that only 2 to 3 % of those who need rehabilitation in developing countries receive any meaningful service (United Nations Development Programme, 1993). In a worldwide review conducted on access to rehabilitation services in the health sector, South Africa is reported to provide services to 21 to 40% of the disabled population, higher than most developing countries (World Health Organisation, WHO, 2002).

South Africa's policy framework for disability and rehabilitation, the Integrated National Disability Strategy (INDS, 1997) describes appropriate rehabilitation as a process that assists people with disabilities to become fully participating members of society. The policy acknowledges the value of rehabilitation in contributing towards people leading economically independent and active roles in society.

In an effort to increase coverage to the majority of the population, community based rehabilitation (CBR)[4] was developed and promoted as a low cost strategy (International Labour Organisation, United Nations Educational, Scientific and Cultural Organisation; WHO, 1994). This approach leans towards the social model as it focuses on facilitating

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[1] "Disability denotes the collective economic, political and cultural and social disadvantage encountered by people who have a physical, sensory, intellectual or psychological deviation or loss, and which results in restricted participation in life-situations". (Coleridge, 1993).

[2] "Impairment is any loss or abnormality plus the effect on function". (Disabled People International, 1990)

[3] "Rehabilitation is a process aimed at enabling persons with disabilities to reach and maintain their optimal physical sensory, intellectual and psychiatric and/or social functional levels, thus providing them with the tools to change their lives towards a higher level of independence. Rehabilitation may include measures to provide and/or restore functions, or compensate for the loss of absence of a function or a functional limitation. The rehabilitation process does not involve initial medical care. It includes a wide range of measures and activities from more basic and general rehabilitation to goal-orientated activities, for instance vocational rehabilitation". (United Nations Department for Policy Co-ordination and Sustainable Development, 1994).

[4] "Community Based Rehabilitation is a strategy within community development for the rehabilitation, equalisation of opportunities and social integration of all people with disabilities. It is implemented through the combined efforts of disabled people themselves, their families and communities, and the appropriate health, education, vocational and social services". (ILO/WHO/UNESCO, 1994).

the empowerment of mainly disabled people and is dependent on community initiatives and collective action. Its main objectives are to ensure that persons with disabilities are able to maximize their abilities, have access to regular services and opportunities and achieve social integration within their communities and societies. Thus, rehabilitation forms part of a broader concept of equalization of opportunities and community integration.

In a recent review conducted on CBR, there appears to be wide support amongst the occupational therapy (OT) and physiotherapy (PT) professional groups for CBR. Therapists view their roles in CBR, as supporting community initiatives by transferring skills to community workers through training, to deliver services (World Confederation of Physical Therapy, 2003; World Federation of Occupational Therapy, 2003). There is however, recognition that current therapy practice requires a stronger orientation to CBR and primary health care (PHC).

The rehabilitation needs identified by recipients of the service in a few studies conducted in South Africa indicate the following: skills necessary to manage disability, access to income generation activities and resources such as day care centers and support groups (Meyer and Moagi, 2000; Lorenzo, 2001).

1.1 Policy direction for rehabilitation services in South Africa

Five key factors have been found important to consider in planning rehabilitation services - these include - the governments' philosophy, access to general health services and the availability of existing rehabilitation services and local resources including the rehabilitation and disability prevention services still required (Kay, 1994; Twible and Henley, 2000; Thomas and Thomas, 2003).

Historically, in South Africa rehabilitation provision within public health services was predominantly at institutions, focused on individual therapy rendered within a medical model approach (INDS, 1997). This approach had a number of limitations in that the

health and welfare government departments were mainly responsible for services that were focused on correcting impairments and disabilities and providing charity. There was no responsibility on other government departments to address disability within their sphere, thus little attention was paid to the environment to facilitate social integration (INDS, 1997).

As a measure to reduce barriers in society that prevent equal participation of persons with disabilities, the United Nations (UN) developed an instrument for states to implement. The UN Standard Rules on the equalization of opportunities have 22 rules, of which access to health care and rehabilitation form part of the four rules that are viewed as preconditions that enable people with disabilities to enjoy equal opportunities (UN Department for Policy Co-ordination and Sustainable Development, 1994).

Since 1994, the South African disability and rehabilitation policies have largely been based on the UN Standard Rules that promote social model practices. This policy directive requires that government departments remove barriers within their sphere of control, thereby progressively realizing the rights of all citizens as stated in the constitution. Within the health department, commitment towards addressing the rehabilitation needs of the population led to a strong emphasis on strengthening PHC rehabilitation services and CBR as a co-ordinated entity with the support of secondary and tertiary level services (Department of Health, (DOH) 2000; Barnes, 2001).

The South African PHC service package has specifically prioritized eight focus areas to be fully implemented across the service platform (PHC facilities, home, community and non health institutions) in the district by 2005. Child health services receive first priority, followed by services for communicable diseases such as sexually transmitted infections, acquired immune deficiency syndrome and tuberculosis. This is followed by services for reproductive health, mental health, chronic diseases, trauma and injuries and lastly, disabilities. It is expected that these priority areas will tackle the leading causes of mortality and morbidity in the country if addressed in a comprehensive manner. It must be recognized that rehabilitation cuts across all the abovementioned health programmes

and is not confined to disability issues only.   The policy has the benefits of being used as a planning and budgeting tool for managers, whilst its use for health workers is to assist with identifying the scope of services to be rendered (DOH, 2001a).

The PHC service package for rehabilitation describes the scope to be rendered at clinic, community health center (CHC), home and community level. At clinic level the emphasis is on the early detection of people at risk of developing a disability as well as those already with a disability. The PHC nurse is seen as a vital health worker that screens and refers clients, whilst the visiting therapists assesses and provides treatment. This implies that therapists are to provide sessions at the clinics. The Western Cape's developmental screening service is an example of an early detection programme at clinic level that targets children between 0 to 18 months. The main purpose is to start early intervention so as to reduce the effects of impairment and disability (Provincial Administration of the Western Cape, 1999).

Services at the CHC level are more extensive than at clinic level as it includes the early detection and initial assessment of all cases referred by either the clinic, hospital or the community. In addition, rehabilitation needs are to be screened at all the service points within the facility. Whilst services are to be available on a daily basis, taking in all cases referred, therapists are to assess and prescribe treatment interventions, while therapy assistants implement the interventions. The support provided from the CHC to the surrounding community is on an outreach basis (DOH, 2001a).

The policy indicates that CBR is to be initiated from the facility. A strong emphasis is placed on intersectoral collaboration as services are to be organized in partnership with people with disabilities, government departments and other sectors.   The main purpose is to ensure that persons with disabilities are represented in the health sector and secondly to develop the capacity of community groups and non-governmental organizations (NGOs) to provide basic rehabilitation programmes. The CBR elements in the package have a lesser clinical focus as it relies on community action and involvement. Therapists are to support and develop opportunities for caregivers of children or disabled people to be

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involved in community services. This includes day care facilities; support and self help groups and home visiting services (DOH, 2001b).

1.2 Implementation challenges

Despite the existence of a number of national policy frameworks for rehabilitation, implementation in the Western Cape remains a challenge; hindered by a number of factors. These barriers include the concentration of services at the three tertiary academic hospitals in the Metropole, the existence of few rehabilitation teams, limited staff and services at PHC level and severe budgetary constraints leading to the loss of critical posts. In addition the lack of intersectoral planning and co-ordination was also emphasized. Although rehabilitation services have existed for a number of years at PHC level in the Metropole, its status as a programme has only been recent. Whilst public health programmes in the Metropole work towards implementing the PHC service package, the current service status and the barriers that staff face are important factors to consider in future planning exercises – an activity which is urgently required so as to give direction to the rehabilitation programme. This study forms part of the planning process by examining what is currently provided within the broader context of the Metropole district health system[5].

The literature review in the next chapter briefly discusses disablement and some of the broader societal implications. This is followed by a brief review of the policy trends and a more detailed review of the PHC service package as they relate to this study. The literature review then considers a number of implementation challenges by focusing on common factors found in a few local disability and rehabilitation studies in South Africa as well as on international views on PHC and CBR approaches to service delivery. The next chapter discusses the methodology used in this study. This is followed by an

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[5]The Metropole District Health System is geographically divided into 11 sub districts. Two authorities manage the PHC services. The City of Cape Town, manages 133 clinics, while the Provincial Administration of the Western Cape manages 44 CHCs. The services referred to are at the 44 CHCs.

analysis and discussion of the results in three broad sections.   Finally, the last chapter includes the discussion, conclusion and recommendations.

Chapter 2:   **Literature Review**

2.1 Background

Despite the recent finalisation of the WHO's International Classification of Functioning, Disability and Health (2001), inconsistency remains with defining and determining disability, making comparisons between national prevalence studies from one country to another and within countries difficult. (Barbotte; Guillemin; Chau and the Lorhandicap Group, 2001) conducted a review on prevalence rate studies and found estimates varying between 0.1 to 92 % of the population, due to the use of different indicators and definitions. The general disability estimate used by the WHO (2003 a) ranges between 7% and 10% of the population - significant enough to be concerned about rehabilitation service provision.   Despite a number of policy frameworks that show government's commitment to address disability within a human rights and development approach in South Africa, there have been a number of challenges to implement rehabilitation services in the health sector in the Western Cape (Integrated Provincial Disability Strategy, 2002).

2.2 The extent of disability and impairment

Besides the difficulty with determining disablement, developing disability indicators to monitor the progress with implementation of policies remains problematic (McLaren; Solarsh; Saloojee; 2003).

Although different tools and definitions were used in two national disability surveys recently conducted in South Africa, slight variations in prevalence rates were found. The study by Community Agency for Social Enquiry (CASE), (1999) used a functional screening tool and estimated that 5.9% of the population has a moderate to severe disability nationally, with the Western Cape estimated at 3.8% of the population. While the Census 2001 used broad screening questions and found an estimated prevalence rate

of 5%, with the Western Cape estimated at 4.1% of the population (Statistics South Africa, 2003).

The main types of disabilities found in the CASE and Census surveys were related to visual disability (1.3%, 1.7%), and physical disability (1.2%, 2.0%) followed by hearing related disabilities (0.7%, 1.0%) respectively (CASE, 1999; Statistics South Africa, 2003). These figures need to be used cautiously as they include the permanently disabled population, thus exclude impairment rates that are also required for planning rehabilitation services particularly within the health sector.   Although no national impairment studies were conducted, of interest is the high impairment rate (12.9%) found in a local study in Mitchells Plain, a sub district in the Metropole region of the Western Cape province (Katzenellenbogen; Joubert; Rendall; Coetzee, 1995).

Poverty levels and the distribution of age groups are important factors to consider when planning rehabilitation services. The CASE (1999) survey indicates a high distribution of disability in the poverty-stricken magisterial district of Mitchells Plain (28.5%) in the Metropole region.   Furthermore, a significant percentage of the young working population between the ages of 25 to 29 years (8.0%) and 30 to 34 years (8.2%) respectively are disabled in the Western Cape.

Causes of impairment and disability in South Africa reflect global trends of the prevalence where non-infectious and infectious diseases (26%), are the highest. However, a high percentage of causes are unknown (21%), while birth related injuries are significant (19%), followed by injuries and trauma (15%) and violence and crime that accounted for 5% of the disability prevalence rate (CASE, 1999).

Of great importance is the impact of disability on the broader population. Despouy (1993) estimated that disability affects at least 25% of the population adversely, while Erb and Harris (1999) explain further that the impact of disability contributes towards the poverty and disability cycle in society. They attribute three factors to this cycle of which all can be directly or indirectly related to rehabilitation service provision. These include

the direct treatment cost including travel and access that often falls onto the family of a person with a disability, the indirect cost to carers and the lost opportunity for future income.

An example of the impact of disability is highlighted in a survey conducted by Teerink (1999) in Uganda with 49 people with severe physical disabilities, where the findings show that even though most of the participants had access to a rehabilitation service, only few were able to obtain essential assistive devices due to a lack of finance. This in turn led to a high unemployment rate amongst the group. A similar study by Hildebrandt (1999) in the United States identified that vulnerable people such as those with disabilities, experienced barriers in accessing health care and self-care services mainly because of low income and unemployment. While Kent et al (2000) found that where people with disabilities in the United Kingdom had informal family support networks, access to services, employment and transport, this assisted in reducing the isolation that persons with disabilities may experience.

The findings of a few studies on rehabilitation service provision show that the needs of people with disabilities are mainly addressed in health settings by therapists. The services rendered include provision of therapy services to promote independence in activities of daily living, training of caregivers to stimulate and manage children with disabilities, provision of training in the use of assistive devices, emotional and social support (Sharma and Deepak, 2001; Shipham and Meyer, 2002).

2.3 Policy trends: towards a human rights approach

An international shift towards a human rights approach to disability has taken place in society since 1981, the UN International Year of Disabled Persons. Price et al (2001) state that since then a number of initiatives followed, that included, The World Programme of Action concerning Disabled Persons, (1982), the Decade of Disabled Persons (1983), and the UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (1994).

Of specific interest is that South Africa has adopted the UN Standard Rules (1994), a human rights framework that assists with policymaking, legislation and action in all spheres of society. South Africa's White Paper on an INDS (1997) has been developed to address disability issues and impairment in a comprehensive manner through all government sectors. The UN Standard Rule (1994) on rehabilitation places the responsibility for states to guide services in health, education and labour, so that persons with disabilities can reach and sustain their optimum level of independence and functioning in society.

It is well documented in South African policies that there are multiple barriers that limit accessibility. Barriers have been identified in the environment and institutional practices and in society's attitudes as preventing persons with disabilities from participating fully in society. In an effort to realize the rights of persons with disabilities, South Africa has adopted the social model and CBR strategy to promote a human rights and development oriented approach to service provision. This led to a strong emphasis in the National Rehabilitation Policy to improve rehabilitation services at PHC level (DOH, 2000).

2.4 Models of disability

Another key policy directive is the embodiment of the social model of practice. Miles, (1999) reflects on the traditional medical model and asserts that it is rooted in medical and technical approaches that focus on individual differences rather than inclusion in society. While Coleridge (2000) agrees and relates this specifically to rehabilitation practices stating that the medical model focuses on assisting individuals by fixing the impairment or disability, often ignoring the environment.

A key recommendation for rehabilitation service providers within the health sector is the orientation towards understanding the implications of the social model (INDS, 1997). This is necessary if one considers that the social model of disability, in essence, calls for changes to be made in society rather than for persons with disabilities to fit into society

(Department for International Development, 2000). Ashton (1999) reasons that the social model of disability addresses discrimination on all three levels - institutional, environmental and attitudinal and thus a developmental approach is necessary as proposed in the UN Standard Rules. It is important to compare the social model and medical model as Lang (1998) describes the former as focusing on discrimination, choice and social action, while the latter, focuses on prejudice, control and individual treatment.

Given that there are differences between the models, there appears to be agreement that neither model provides a complete approach, thus integration of the two models is required to meet the needs of people, their carers and the communities (Cole, 1999; WHO, 2003b). This implies that the individual, environment and society are the focus for action.

Schneider (1998) conducted an evaluation on six rehabilitation services located in South Africa and their adherence to the social model of disability by using criteria to measure the power relations between the service provider and user. These criteria specifically measured the reasons for providing the service, the role of rehabilitation and the locus of service provision and the locus of power. It was generally found that even though some of the rehabilitation services provided aspects of service delivery associated with the social model and community based approaches such as; home therapy, support groups, networking, training and activities related to intersectoral collaboration - the power relationships reflected the medical model approach. The involvement of disabled people in the planning and monitoring activities was limited.

2.5 Community based rehabilitation

Miles (1999) estimates that 80% of a populations' rehabilitation needs can be met at community level, while 20% require a specialist rehabilitation service. In an effort to increase coverage in developing countries at low cost, the WHO initiated the CBR strategy (1994) shifting some of the responsibilities of providing home based interventions to the disabled person's families (Thomas and Thomas, 1998). The CBR

philosophy extends beyond provision of services to community action and development where various sectors are required to work in a co-ordinated collaborative manner with disabled people to facilitate their integration into society (ILO, WHO, UNESCO, 1994).

However, in a review by the WHO (2002) on the implementation of CBR in 119 countries it was found that rehabilitation provision in the health sector paid less attention to development aspects related to their social integration and equalization of opportunities for persons with disabilities. The WHO (2003b) recommends that CBR programmes in the future build onto existing development activities in communities. This has implications for therapists' practices in health settings as it means involvement in development activities such as networking, collaboration and training, even though these activities are not necessarily the responsibility of the health sector alone.

McLaren and Philpott (1999) are more specific in stating the purpose of CBR in PHC namely, to ensure access to appropriate services, improve environmental access to CHCs, provision of information to public services and to ensure positive attitudes toward disabled people. Much has been written on CBR programmes and its application.   Hess (2003) classifies CBR service delivery models in three: consumer driven, professional outreach and home-based therapy. Whichever service delivery models are adopted, both Coleridge (1993), and Werner (1998) caution against CBR becoming institutionalised community-based programmes, designed as service delivery systems rather than developmental processes.   CBR programmes have been found to be of benefit in the lives of individuals as seen in a number of field studies conducted between 1982 and 1997 in developing countries such as Botswana, India, Guyana, Vietnam, Egypt and Zimbabwe. Success rates were found to range between 40% and 91% in various rehabilitation programme activities. These include improvement of individuals in self-care activities, mobility, communication, integration into schools, work and family and community participation. The common factor that contributed to the success rates in the CBR programmes included the good relationship with government departments, where support, training and technical assistance was provided (Helander, 2000).

A recent South African review on the future direction of CBR raised concerns about the lack of a common understanding, aim and value of CBR in the country. It was proposed that consensus be sought for CBR in the South African context (McLaren, Philpott, Rule, 2004). Helander (2000) acknowledges the difficulty in developing a system that covers all needs, but also proposes that management systems in government start to address the sustainability of CBR by focusing on the following: formulation of clear policies, quantification of need for rehabilitation services, development of strategies and approaches, national planning, evaluation, financing and budgeting systems.

2.6 The rehabilitation service package

The WHO (2004) categorises the organization of rehabilitation provision in the health sector into three areas: specialized rehabilitation services, PHC services and CBR programmes. In many countries the specialized rehabilitation services are better developed, whilst the weakest development has been found at PHC level. This is evident in the Metropole, where PHC services were found to be the most under resourced and under developed (Integrated Provincial Disability Strategy, 2002).

Although CBR is multisectoral, the WHO views the link with the health sector at PHC level as important as the skills of specialized rehabilitation professionals (occupational therapists, physiotherapists, etc) is required to strengthen community based service (WHO, 2003a). This is also supported by the findings mentioned previously in the study conducted by Helander (2000) where the health sector support to CBR programmes was identified as a key factor for success and sustainability.

South Africa has two key policies that guide PHC and CBR service provision (National Rehabilitation Policy DOH, 2000; The National PHC Service Package DOH, 2001a, 2001b). The National Rehabilitation Policy (2000) lists the following key guidelines:
- Services are to be accessible, affordable, and equitable to all,
- Provision of all the components of the rehabilitation process,
- A balance between institution and community based services,

- Participation of disabled people in planning and,
- Optimal use of resources through co-ordination of services with different sectors, health care levels and intersectoral collaboration.

The core functions of the health sector in rehabilitation are mainly disability prevention, medical diagnosis and therapeutic services, assistive device provision and provision of psychosocial rehabilitation. The PHC package describes services to be rendered at both PHC facility and community level. The package for community-based services is to be initiated from the facility by therapy staff with a focus on developing the capacity of various community groups and NGOs to provide basic rehabilitation programmes. It is proposed that each sub district is required to have a community rehabilitation centre that includes a day care centre and workshop as a minimum. Therapists are required to liaise, collaborate and network with various sectors to ensure the referral of clients to appropriate services as well as to assist with the design of programmes.

The aim at CHC level is to provide a therapeutic service with the following elements:

- Daily therapy service providing assessment and therapy services for all age categories, mainly treating people with physical disabilities such as strokes, cerebral palsy and impairments that may arise from backache and sports injuries. The therapist is responsible for guiding the Medical Officer in disability grant and care dependency assessments and the referral of cases that require daily rehabilitation to the district hospital. Furthermore, access to OT services as part of the specialist mental health services is to be provided at least once a month. (DOH, 2001a, 2001b).

Elements of community level services include:
- Home visiting through outreach from the CHC
- Training caregivers or family members
- Facilitating self help support groups
- Networking with other sectors and government departments

-   Co-ordination of rehabilitation at sub district level and

-   Involvement in disability forums (DOH, 2001a, 2001b).

2.7 Implementation challenges

Coverage and access to rehabilitation services remain the most important challenge as noted earlier in the literature review. Specifically, in the Metropole, there is recognition that rehabilitation services are poorly developed as services are failing to meet the needs of most. Furthermore, even though the primary level rehabilitation services are responsible for most of the community-based programmes, serious problems exist due mainly to insufficient number of staff, resulting in inadequate coverage and poor referral and follow-up systems (Integrated Provincial Disability Strategy, 2002).

The poor availability of human resources was found to limit access to rehabilitation services in a number of situational analyses conducted in various districts in Kwazulu Natal (McLaren, et al, 2001, 2002).   However none of the studies quantified the gap in service provision.   The availability and distribution of human resources for rehabilitation generally within developing countries is poor (1: 550 000) in comparison to developed countries where the population to physical therapist is 1:1400 (Twible and Henley, 2000).

The South African National Rehabilitation policy (2000) proposes a staffing norm of 30 000 population to one PHC team in the long term and 1: 15 000 in the short term. The staffing in South Africa is grossly inadequate as reflected in the 1998 persal records for OT where the ratio of occupational therapist (OT) to population was 0.09 to 10 000 for the Metropole, less than the national ratio of 0.14 to 10 000 of the population (Makan, 1998).

2.7.1   Roles and scope of practice

There have been a number of debates in the last few years on the role and scope of work of rehabilitation therapists (OT, physiotherapists (PT), speech and hearing therapists (ST)

and audiologists) particularly in PHC settings. The scope of work for PT services is the treatment and prevention of human movement disorders with the aim of restoring function or minimizing dysfunction and pain in all age groups, using various hands on techniques such as mobilization, manipulation, massage or acupressure (South African Society of PT, 2004). The OT scope focuses mainly on enhancing the functional abilities of individuals in their various life roles and use techniques such as adaptations and modifications to the environment and activity analysis (Health Professions Council of South Africa, 2004). Speech therapy services predominantly work in the area of feeding, hearing testing, fitting and techniques for improving communication.

The role of therapy assistants is that of working under the guidance and supervision of a therapist to carry out treatment. The Professional Board for OT and Medical Orthotics and Prosthetics has recently developed the scope of practice for occupational therapy assistants (OTA) that guide training, practice and supervision (Health Professions Council of South Africa, 2004).

The therapy professions mentioned above have in the past been synonymous with individual based therapy services provided at institutions. In the last few years there has been a call to physiotherapists and occupational therapists to shift their focus to disability prevention, PHC rehabilitation and community based services (World Confederation of Physiotherapy, 2003: World Federation of Occupational Therapy, 2003).

Oliver (1999) asserts that the role of therapists needs to change to meet the needs of a greater number of people, and to take on a more developmental role. He suggests therapists focus on changing the environment for the benefit of many. This approach points towards practices that adhere to the social model of disability and CBR. The PHC service package supports this, particularly in its description of the varying roles of therapists across the service platform. Cornielje (2002) suggests that therapists make an impact in the area of public health by expanding their consultancy and advocacy roles.

However, the challenge remains on how therapists balance the role between therapy provision at PHC facilities and more development activities such as training, empowerment, networking and collaboration, given the limited resources. The national service package outlines the role of therapists in mainly programme design, needs assessment, training, and supervision of therapy assistants. It also describes the functions of therapy assistants at facility level as being directly involved in the provision of services. Whilst the package describes the health sectors' role in support groups, income generation and CBR co-ordination, it is not the sole responsibility of the therapist or the health department (DOH, 2001b).

Thornburn (2000) and Thomas et al (2003) propose three levels of personnel required for CBR. This includes CBR workers to deliver services, mid level workers to organise and supervise CBR workers, while professionals such as OT and PT are involved in programme management activities, providing technical and clinical support. The role of rehabilitation professionals as proposed above, differs from the South African national service package, as therapists are expected to be more directly involved in service provision by supporting and initiating community activities as well as in programme design and training activities (DOH, 2001b). There is no clarity in the package on the role of CBR workers.

McLaren and Philpott, (1999) suggest that limited resources require that therapists play the role of enablers and resource persons. O'Toole and McConkey (1998) are more direct in stating the role of therapists as trainers and supervisors of family supporters who in turn provide basic rehabilitation activities. An example of this is the Hark project, run by an NGO in the Western Cape that initially provided direct services for hearing impaired as well as disabled children. As the service developed, their activities were adapted to reach a greater number of children through training and capacity building of professionals at schools, crèches, day care centres and caregivers at community level in collaboration with other NGOs. This was found to improve the detection rate and basic management of children with hearing impairments (Michelson, 2003).

2.7.2   Co-ordination of rehabilitation services

The CBR strategy requires collaboration between different departments and sectors for its success. Although collaboration is highlighted in the rehabilitation component of the PHC package (DOH, 2001a), a number of local studies indicate that co-ordination within rehabilitation at any level within the health sector is problematic.

McLaren et al (1997, 1999) summarise the functions of co-ordination of therapy services in health as; the management of referrals between local, home based care and community level services, co-ordination with other sectors, as well as support and training of rehabilitation personnel.

In a rapid appraisal of mental health rehabilitation services in Kwazulu Natal, poor co-ordination was found to be a barrier in service provision. Key state service providers and NGO informants recommended improved co-ordination to strengthen the links between government services and NGOs at provincial level (McLaren et al, 1998).

At a more local level, the importance of co-ordination to plan rehabilitation and disability services has been highlighted in a number of situational analyses conducted in the districts of Jozini and Durban Metropolitan of Kwazulu-Natal province (McLaren et al, 2001, 2002). The studies recommend the establishment of local intersectoral disability forums to promote networking and co-ordination activities to enable role players to consult and work together to prevent duplication and fragmentation.

In an evaluation on the developmental screening programme at PHC facilities in the Western Cape, the referral between the child health service at local authority clinics and the rehabilitation service was described as "patchy" (Michelson, 2003).

2.7.3 Considerations on integrating rehabilitation into PHC

The WHO recommends horizontal integration of health programmes into the district health system (DHS). However, Migochi-Harrison (1998) cautions that a decline on programme emphasis at district level can be expected as a result of competing demands for curative care. The author further argues for three prerequisite conditions to be met for successful implementation of PHC programmes. These include: enabling policies and legislation, personnel and well functioning districts. Although the PHC service package stipulates the core management functions for the implementation of the service package as: (leadership, planning, finance, supervision, transportation, communication, information management and collaboration with other sectors) a number of barriers have been found specifically in the Metropole.

An investigation into the Metropole DHS indicated a number of organisational problems related to the structure being underdeveloped to support the change towards decentralization (Kane-Berman, 2000). Effective management structures are necessary to support the development of rehabilitation services as noted in a study in the Durban Metropole, where the lack of a formal working relationship with the district management team contributed to the absence of rehabilitation in the planning cycle (McLaren et al, 2001). Bamford and McCoy (1999) acknowledge that many districts lack the capacity, skill or mechanisms to integrate programmes into a comprehensive plan. The authors recommend that programmes support the clinic and district management structures to aid integration, by working via the facilities, to provide technical support. In addition, they suggest that integrated planning is introduced whereby e.g. maternal and child health, school health and health promotion programme managers work together to implement a co-ordinated plan.

Although rehabilitation services have been provided for a number of years it is only recently that a programme manager has been appointed in the Metropole to develop the programme. Given the challenges identified with rendering the rehabilitation programme at local level, it is important that this study is conducted to show the current status and

contribution by rehabilitation services and to highlight the barriers that therapists face. This is necessary to aid planning, budgeting and implementation in the future.

2.8 Implications for this study

The literature review raises a number of challenges and issues with disability and rehabilitation services at PHC level. Two key issues have emerged and have implications for this study. Firstly, the poor availability of rehabilitation services at PHC level even though policies are focused on strengthening this level. Secondly, the challenge of transforming service delivery practices, whilst at the same time integrating the rehabilitation service into the DHS. Of importance in this study are the seven elements of the service package as they provide a useful way to explore the range and nature of the current service provided within the context of the policy. Furthermore, the study will also unpack the complexity of integrating the programme into the Metropole DHS, by determining key barriers and the necessary support required.

Chapter 3:   **Research design and methodology**

3.1 Introduction

This chapter describes the aim of the study and the outline of the study design chosen. A brief description of the research setting and study population is given. This is followed with a more detailed discussion on the data collection tools, process and analysis. Finally the limitation of the study is described.

3.2 Aim and objectives

The study aims to determine the extent to which selected elements of the rehabilitation components of the PHC service package are currently being implemented within the Metropole district of the Western Cape Province. In doing so, the study aims to identify obstacles within the district management as perceived by rehabilitation therapists that hinder the implementation of the rehabilitation programme, so as to make recommendations for future planning. The study focused on the following specific objectives:

1. To determine the distribution of rehabilitation services provided by (OTs and PTs) at PHC level in the Metropole DHS.
2. To describe the nature of the seven selected elements of the national PHC service package as provided by rehabilitation staff (OT and PT) in the Metropole district.
3. To determine the availability of the seven selected elements of the PHC rehabilitation service package as provided by rehabilitation staff in the Metropole district.
4. To describe the obstacles that rehabilitation staff perceive as hindering the implementation of the rehabilitation programme, with particular emphasis on district management functions within the Metropole DHS.
1. To make recommendations for future planning and research that can be utilized by the Metropole DHS.

3.3 Study design

Crombie and Davies (1996) state that the purpose of health services research is to improve health care delivery by determining inadequacies in the provision and distribution of services and/or organizational systems for delivery. Given that the study objectives concentrate on all three aspects in varying detail, a health systems research design was found most suitable. The flexibility of the health services design allowed the researcher to use both quantitative and qualitative methods. The quantitative methods suited the aim of capturing the distribution of PT and OT services, while the qualitative methods allowed the researcher to explore and document the nature of the services provided as reported by therapists as well their diverse experiences and perceptions of working within the DHS. Seven elements were selected from the PHC package to be used to describe the rehabilitation services:

1. Provision of facility based services
2. Home visiting through outreach from the CHC
3. Training caregivers or family members
4. Facilitating self help support groups and
5. Networking with other sectors and government departments
6. Co-ordination of rehabilitation at sub district level, and
7. Involvement in disability forums (DOH, 2001a, 2001b).

3.4 Research setting

The research was conducted in the Metropole health district of the Western Cape province. The Metropole district is an urban area that has 11 geographically defined sub districts. Each sub district has a number of CHCs located in its area. OTs and PTs are employed at a CHC, but often provide services at a number of CHCs within the sub district.

3.5 Study population

The study population consisted of all rehabilitation staff employed at the 44 community health centers (four OTs, 11 PTs and six OTAs) in the Metropole DHS. The list of rehabilitation therapists employed was obtained from the PT co-ordinator at the Metropole DHS and crosschecked with the CHCs as OTs and PTs work at more than one CHC.

3.6 Sample

The total (21) study population was interviewed by telephone to document service provision as reported by rehabilitation staff in the Metropole DHS.

A smaller population was drawn consisting of a total of nine key informants who participated in a focus group discussion. Patton's (1990) purposeful sampling method was used to identify information rich cases by drawing a smaller population consisting of a total of nine key informants, that provide both a variation in the group itself and in their experiences so as to document common patterns found within the diverse group. The nine key informants participated in two separate discussions. The first group consisted of four therapists, selected on the basis of their work experience and representation from the two therapy professions under investigation. Two therapists had worked for many years at PHC level in the Metropole, while the other two participants had lesser experience being transferred a few years ago from tertiary hospital settings to the DHS. The second group of six OTAs was selected on the basis that they were all therapy assistants. In addition, the five therapy assistants were devolved less than a year ago from the regional mental health programme into the DHS and the remaining therapy assistant was transferred from a tertiary institution two years ago.

3.7 Data Collection tools: questionnaire and focus group discussions

Two data collection tools were used, a telephonic semi-structured questionnaire and a focus group discussion. The researcher conducted 21 telephonic semi-structured interviews and two focus group discussions during April and August 2002.

3.7.1 Telephonic semi-structured questionnaire

The objectives of the study served as the basis for developing the questionnaire, together with the national PHC service package for rehabilitation. As therapists provide services at both CHC and community level, elements were selected on this basis. A semi-structured telephonic questionnaire was developed in consultation with the PT co-ordinator and consisted of a combination of open and closed-ended questions for the seven elements (Appendix 1) selected from the rehabilitation service package. In addition the questionnaire allowed for information on the distribution of therapists and availability of services per CHC in the Metropole to be collected. Using Robson's (1993) guide for semi-structured interviews and introductory comments were used to explain the purpose and process of the interview to all participants. The seven elements or topics for discussion were listed and the key questions and prompts for each element were designed. Two interviews were conducted to pilot the questionnaire and adjustments incorporated into the final questionnaire.

3.7.2 Focus group discussion

A similar process was used, whereby the PHC core management functions served as a guide to develop the focus group questions (Appendix 2) to explore the rehabilitation staff's experiences and perceptions on working within the DHS (Kitzinger, 1995).

3.8 Data collection process

3.8.1   Telephonic-semi structured interviews

Robson (1993) indicates that telephonic interviews have the same value and benefits as face-to-face interviews in that a high response rate is expected and the process allows for probing and clarification. However, the author cautions that difficulties can be experienced in developing a rapport with respondents. This obstacle was overcome in that the researcher already had an established relationship with all 21 rehabilitation therapists, having previously worked with them. The telephonic interviews were conducted while therapists were at the CHC and when they indicated their availability. The nature of the semi-structured interviews allowed the researcher to be flexible in wording and sequencing questions and to add new questions and prompts where needed (Rice and Ezzy, 1999).

During the interview process the data were captured directly onto a pre coded Excel spreadsheet. The Excel spreadsheet was coded based on the interview schedule. This allowed for easy capturing of the data in the sequence and format that the interview followed. Once the interview was completed, reflections on the interview process were recorded. These notes were later added as a separate section to each individual interview and used later in the analysis.

3.8.2   Focus group discussions

Kitzinger (1995) states that the group process assists members to explore and clarify their views and experiences and is especially appropriate when the researchers' aim is to explore issues of importance to the group. Two focus group discussions were held. The first focus group discussion was held with four key informants, tape-recorded and later transcribed. The second focus group was held in a workshop format and information recorded onto newsprint. The information from the workshop was summarized at the

end of the session by involving the participants to identify key points discussed during the interview process.

3.9 Reliability

The process of capturing quantitative data directly onto the Excel spreadsheet minimized the researchers' risk of losing information or introducing a recall bias. The Microsoft Excel statistical package was used to calculate the ratio of therapist to population and to quantify the availability of the different elements according to the three different professional groups.

3.10   Validity

The use of triangulation and member checking are ways to improve the validity and rigour of qualitative research, as suggested by Mays and Pope (2000). Three methods were used during various stages of collecting the qualitative data.

Firstly, different sources (therapists and therapy assistants) and different methods (interviews and focus group discussions) were used to crosscheck information and ensure comprehensiveness (Mays and Pope, 2000).   Secondly, the use of member checking was used specifically in the workshop to ensure that the researcher's notes corresponded with the participants' information.

Lastly, the transcripts from the focus group discussions were given to another person to review. Themes were generated and compared to the researchers', so as to prevent the researchers' bias from shaping the study.

3.11 Data analysis

Quantitative data obtained from the telephonic semi-structured interviews were analysed by creating three separate excel spreadsheets. Firstly, the population to therapist ratio was calculated per sub district using projections for 2002 based on the Census 2001 population data. Secondly, the availability of services in each sub district per professional category was plotted against a list of CHCs. Thirdly, data were analysed by counting the entire Yes and No answers for each of the seven elements examined. The information was further analysed according to the three different professional groups (PT, OT, OTA) and transferred onto two-way tables.

Qualitative data from the open-ended telephonic interview questions were analysed through content analysis, whereby common and divergent patterns were recorded (Gifford, 1996). The data were compared to the standards in the policy documents.

The transcripts of the focus groups and workshops were reviewed initially by using thematic analysis to generate broad themes so as to make sense of the data (Gilford, 1996). The data were then revisited to identify emerging patterns. The researcher used content analysis to search for quotations that reflected the main themes. The transcripts were given to a colleague to review. The categories generated by the researcher were compared and discussed with a colleague and agreement reached on the final themes.

3.12 Ethics

Permission to conduct the research was received following a written request to the medical superintendent of the Metropole DHS. Verbal consent was obtained from the medical superintendent to conduct the study. Prior to commencing with the telephonic interview, the research participants were provided with an explanation on the purpose and process of the research and given an opportunity to decide to participate. Verbal informed consent was requested from each participant before commencing with the interview and

focus group discussions and recording. Anonymity and confidentiality were assured to all participants.

3.13   Limitations of the study

The study focused on the different elements of service provision as reported by therapists and did not include observations of the elements or review of the records and statistics. Another limitation is that the facility and district management staff were not interviewed to corroborate the experiences and perceptions of the rehabilitation staff.   The study did not focus on discussing the solutions to the perceived obstacles expressed by the rehabilitation staff as this forms part of the ongoing development of the programme and would be addressed in forums. A number of NGOs and community-based organizations provide disability related services in the Metropole and were not included in this study. Furthermore, the study did not comment on the match between the needs of people with disabilities and the service provision as this was beyond the scope of the study as needs based information is not readily available.

The research design and methodology described in this chapter assisted with the process of examining and selecting the different elements of the rehabilitation service package. The study design made provision for each staff category to report on the provision of the different elements of the service within the context of the Metropole district.   The following chapter discusses the results of the study.

Chapter 4:   **Results**

4.1 Introduction

The results are discussed in three broad sections. The first section provides a profile of the distribution of human resources and the availability of rehabilitation services at PHC level in the Metropole, while the second section reports on the most important findings of the study as it relates to the programme elements examined. The final section describes the issues related to working within the district health system as experienced by rehabilitation staff.

4.2   Accessibility

4.2.1   Distribution of human resources

A total of 21 rehabilitation staff provides a service at PHC level in the Metropole region. The total staff is comprised of 11 physiotherapists, four occupational therapists and six OTAs. Overall the total population to therapist distribution in the Metropole is 1:139 189, which is below the national norm of 1: 30 000.

More specifically, the findings show that the ratio of physiotherapist to total population is 1: 265 724, whilst occupational therapist to population is even less at 1: 730 741 Furthermore the geographical spread of therapists indicates further inequities in that two sub districts (Blaauwberg and Central) have no rehabilitation staff (See Table 1).

Table 1 The distribution of rehabilitation staff across sub-districts in the Metropole

Sub district N=11	Estimated Population per sub district 2002[6]	Total Physiotherapist: Population	Total Occupational therapists: Population	Occupational therapy assistants: population	Total rehabilitation staff: population
Central	234 325	0	0	0	0
Athlone	201 658	2	0	1	3
Mitchells Plain	284 115	1	0	1	2
Nyanga	292 371	1	0	0	1
Tygerberg East	267 146	1	0	0	1
Tygerberg West	346 853	1	1	1	3
Khayelitsha	334 108	2	1	1	4
South Peninsula	350 965	1	1	1	3
Oostenberg	307 767	1	0	1	2
Helderberg	156 538	1	1	0	2
Blaauwberg	147 120	0	0	0	0
METROPOLE	2 922 965	11	4	6	21

4.2.2   Coverage at CHCs

Only 39% (17) of the CHCs provide a rehabilitation service that is either OT or PT, while 14% of the facilities have a combined OT and PT service.   The sub districts of Blaauwberg and Central have no service, although they account for 16% of the total facilities.   In addition, the distribution of OT services shows that less than a 5th (18%) of the facilities or four sub districts have access to OT services (See Table 2).

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[6] Adjusted population figures based on Census 2001 was used to project the population by municipal districts based on a population growth factors of (male 1.014612737 and female 1.016405110). Equity Gauge, University of the Western Cape, (2004).

Table 2 The distribution of therapy services at Metropole CHCs

	Central	Athlone	Mitchells Plain	Nyanga	Tygerberg East	Tygerberg West	Khayelitsha	South Peninsula	Oostenberg	Helderberg	Blaauwberg	Metropole
No of facilities	5 (11%)	3 (7%)	1 (2%)	4 (9%)	6 (14%)	7 (15%)	3 (7%)	6 (14%)	3 (7%)	4 (9%)	2 (5%)	44 (100%)
Facilities with a therapy services	-	3 (7%)	1 (2%)	1 (2%)	1 (2%)	2 (5%)	3 (7%)	3 (7%)	1 (2%)	2 (5%)	-	17 (39%)
Facilities with PT service	-	3 (7%)	1 (2%)	1 (2%)	-	2 (5%)	3 (7%)	1 (2%)	1 (2%)	2 (5%)	-	14 (32%)
Facilities with OT service	-	-	-	-	1 (2%)	1 (2%)	2 (5%)	3 (7%)	-	1 (2%)	-	8 (18%)
Facilities with both OT and PT service	-	-	-	-	1 (2%)	1 (2%)	2 (5%)	1 (2%)	-	1 (2%)	-	6 (14%)

Table 3 The distribution of the availability of a daily rehabilitation service at Metropole CHCs

	Central	Athlone	Mitchells Plain	Nyanga	Tygerberg East	Tygerberg West	Khayelitsha	South Peninsula	Oostenberg	Helderberg	Blaauwberg	Metropole
No of facilities	5 (11%)	3 (7)	1 (2%)	4 (9%)	6 (14)	7 (15%)	3 (7%)	6 (14%)	3 (7%)	4 (9%)	2 (5%)	44 (100%)
Daily service	-	2 (5%)	1 (2%)	1 (2%)	1 (2%)	2 (5%)	2 (5%)	1 (2%)	1 (2%)	1 (2%)	-	12 (27%)

Table 3 indicates that approximately less than a third (27%) of the total facilities have a daily therapy service available.

4.3 The nature of the seven selected elements

In the above section the distribution and availability of the different therapy services was examined. This section describes the findings in terms of the seven elements of the programme (facility based services, home based rehabilitation, self help groups, training, co-ordination, networking, disability forum involvement). Firstly, the nature of each element is described, then the emerging service delivery patterns as described by the

rehabilitation staff is outlined, and lastly, the availability of each element as provided by the rehabilitation staff categories is noted.

4.3.1   Facility based services

The findings of the facility-based service (CHC) are reported in two categories that describe the most common and least common of the four descriptors of people referred for treatment (age, diagnosis, disability type and referral source). See Table 4.

The results indicate that generally rehabilitation services at facilities are more likely to be individual based, and serving the adult population with physical conditions and or disabilities. While PTs predominantly treat acute neuromuscular conditions such as backache that cause mobility problems, more chronic physical conditions and disabilities are referred to OTs. Furthermore, OTs obtain referrals mainly for disability grant assessments from medical officers, with few requests for intervention. Of interest is that OTAs provide services mainly for people with emotional disabilities, however, the OTs have this listed as the least frequent disability type they deal with.

Young children and those with genetically related conditions are generally not seen by therapists, even though there is a developmental screening policy in the Western Cape for children under 18 months. Local authority clinics implement the screening programme, however therapists indicated that the referrals from local authority were the least likely to be received. The referral sources for each professional group correlate with their main roles, whereby facility based services are provided by PTs, home based rehabilitation by OTs and self-help groups by OTAs.

Table 4 The rehabilitation staff's responses on the profile of patients most and least commonly treated at the facilities

Categories	Sub category		PT N=11	OT N=4	OTA N=6	Total rehabilitation therapists N=21
Age seen	Most common	Adults	11	4	6	21
	Least common	Children	11	4	6	21
Diagnosis seen	Most common	Cerebral vascular accident	11	4	1	16
		Low back pain	11	-	-	11
		Schizophrenia	-	-	5	5
	Least common	Genetic related	11	4	6	21
		Spinal cord injuries	11	4	6	21
Disability type seen	Most common	Physical	11	4	1	16
		Emotional	-	-	5	5
		Functional	-	4	1	5
	Least common	Developmental	11	4	6	21
		Emotional	11	4	1	16
		Physical	-	-	5	5
Referral source	Most common	Medical officer at CHC	11	4	1	16
		Mental health nurse at CHC	-	-	5	5
		Private general practioner	11	-	-	11
		Home based care-NGO	-	4	-	4
		Other NGOs	-	4	-	4
	Least common	Local authority clinics	11	4	6	21

4.3.2 Home rehabilitation

Table 5 gives the typical clients seen by therapists. All OTs (100%) reported providing home-based rehabilitation, in comparison to only some PT (36%) (See Table 8). This is consistent with the previous findings on facility-based provision – as PTs are more facility based, providing acute rehabilitation. (See Table 4).

There were no major differences in the reporting between the occupational therapists and physiotherapists as to the nature of home based service offered and type of client receiving home based rehabilitation, as both mainly serve adult patients who have a stroke or mobility problems. However, the findings indicate that in relation to mental health clients in particular, they are most likely to access the home visiting service only when they are non-compliant with medication or have relapsed.

Table 5 The nature of home based rehabilitation services as reported by rehabilitation staff

Profile	Common Responses
Typical client referred for a home visit	▪ Cerebral vascular accident ▪ Mobility problems ▪ Bedridden ▪ Lack of transport and inability to visit the CHC
Reasons for determining a home visit	▪ Client is bedridden ▪ Family training needed ▪ Hospital referral indicating need ▪ Medication non-compliance by mental health client
Range of activities provided by therapists	▪ Assessment ▪ Intervention plan ▪ Support to main caregiver, home-based carer and client to implement plan ▪ Teach and train caregiver, home-based carer and client ▪ Referral to other sources ▪ Checking safety and precautions in the home

4.3.3   Provision of self-help groups

Table 6 describes the type of group each staff category provides. There are two broad categories of groups – condition specific and activity related. The range of activities provided in a group include an element of training and support to the members, for example the stroke groups trains its members to do exercises, while the mental health groups are taught coping skills. All OTAs provide group based services, while only one PT and OT provide groups. OTAs are mainly involved in providing mental health groups.

Table 6 The provision of self help groups per professional category

Involvement in groups	Type of group provided	Range of activities provided			No of PTs providing groups N=11	No of OTs providing groups N=4	No of OTAs providing groups N=6
		Training [7]	Education [8]	Support[9]			
YES	Chronic diseases	$\sqrt{}$[10]	$\sqrt{}$	$\sqrt{}$	-	-	2
	Mental illness	$\sqrt{}$	$\sqrt{}$	$\sqrt{}$	-	-	5
	Strokes	$\sqrt{}$	-	$\sqrt{}$	1	-	1
	Activity	$\sqrt{}$	-	$\sqrt{}$	-	1	1
NO	-	-	-	-	10	3	0

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[7] Training refers to the activities where the therapist is involved in teaching and transferring skills to the client.
[8] Education refers to health education on illnesses, medication and health services
[9] Support refers to any activity where the therapist assists the client other than training, education and therapy services.
[10] KEY: $\sqrt{}$ indicates that it is provided.
            – indicates activity not provided

4.3.4 Training activities

Home-based rehabilitation training activities are provided to individuals and organizations. Individual training sessions are mainly directed to patients, family members and assisting the home based carer. Activities include education on disease, physical handling of the patient and techniques to improve activities of daily living and mobility exercises. The rehabilitation staff reported during the interviews that 36% of PTs provide training in comparison to all OTs, and one OTA. (See Table 8).

4.3.5 Networking activities

The main type of networking activities was explored. Although therapists generally viewed networking activities outside the health sector as non-essential, a significant proportion of therapists were involved in some form of external networking activities. (See Table 7).

Secondly, the types of networks were found to be linked to the type of service provided. PT services (100%) show a particularly high level of networking within the health sector, which relates to their role in acute work at facility level, thus referrals between levels of care is expected. In contrast, OTs show a high level of networking outside of the health sector, with organizations and forums, which relates to their role in working with clients that may have multiple needs due to chronic functional problems.   Trends amongst the OTAs show a high level of internal networking within the health sector mainly with mental health staff at the CHCs and psychiatric hospital level.

Table 7 The main internal and external networking activities by staff category

NETWORKING SOURCES	PT N=11	OT N=4	OTA N=6
INTERNAL			
Mental health nurses	-	-	5
Orthopedic nurse	-	-	1
Psychiatric hospital catchment area meetings	-	-	5
General Level 2 and 3 hospitals	11	4	1
EXTERNAL			
Home based care	6	4	1
Institutions: learners with special educational needs, old age homes, sheltered workshops	-	4	-
Forums: community- based care forums	-	4	1
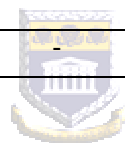
4.3.6 Disability forum involvement

As indicated in Table 7, very few of the respondents reported having established networks with community-based forums. However, on reporting on their involvement in disability forums, all six (100%) OTAs were involved in a disability forum for either mental health users or general disability.   Most commonly reported were that rehabilitation staff were unsure of their responsibilities or roles within the local disability forums, but saw it mainly as a forum for exchange of information and sharing ideas.

4.3.7 Sub district co-ordination

This element examined whether rehabilitation was co-ordinated formally or informally at sub district level. Firstly, formal co-ordination within the health sector was reported as non-existent, especially amongst the various professional groups at PHC level. Where co-ordination existed at this level it was on an informal basis as the need arose within the health sector. Secondly, no formal or informal co-ordination existed with other government departments, specifically to address rehabilitation issues.

4.3.8   Availability of the seven selected elements

Table 8 summarizes the availability of the seven selected elements of the service package as reported by staff category.

Table 8   A summary table on the availability of the seven selected elements of the rehabilitation primary level service package per professional group.

Element		Coordination of rehabilitation services		Provision of facility based services		Provision of home based rehabilitation		Provision of self help group		Provision of training		Networking		Disability forum involvement	
Status		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Staff Category	PT N(11)	-	11	11	-	4	7	1	10	4	7	11	-	4	7
	OT (4)	-	4	4	-	4	-	1	3	4	-	4	-	2	2
	OTA (6)	-	6	1	5	1	5	6	-	1	5	6	-	3	3
	Total N21	-	21	16	5	9	12	8	13	9	12	21	-	9	12

The trends indicate that all respondents reported co-ordination activities as non-existent across the Metropole sub-districts.   Despite this, all respondents reported being involved in informal networking activities related to their area of work. Of significance is that less than half (43%) of the respondents were involved in disability forums at local level.

Service delivery trends indicate that OTs provide both facility-based services and community based services such as home based rehabilitation and training. OTAs are more community based, providing group services for mental health clients, except for one OTA that is trained in general physical rehabilitation and provides facility-based, home based and training service.

4.4 Factors that hinder or support the rehabilitation programme

This section describes the experiences and perceptions of therapists in relation to the development of the rehabilitation programme in the Metropole DHS. Firstly, the profile of the participants is described, followed by the five themes that emerged from the focus group discussions.

4.4.1 Respondent work profile

Table 9 depicts the profile of the nine key respondents by describing their years of work experience.

Table 9: A description of key respondents work experience

Years of experience in profession	PT (n=2)	OT (n=2	OTA (n=5)	Total rehabilitation staff (n=9)
< and including 5	0	1	0	1
6-10	1	0	0	1
11-20	1	1	5	7
Total	2	2	5	9
Years of experience at PHC level				
< and including 5	1	2	5	8
6-10	0	0	0	0
11-20	1	0	0	1
Total	2	2	5	9

Most of the key respondents had between six and 20 years work experience in their profession, with less than five years work experience at PHC level.

During the focus groups, there was openness amongst the participants to discuss their experiences and views. This is likely to be due to the familiarity of the participants with the researcher based on being colleagues in the DHS.

Participants were asked exploratory questions related to their experiences of working within the DHS. Several themes emerged from the focus group and workshop that were clustered into two broad categories: barriers and expectations.   A number of barriers to implementation were found to hinder the programme at local level. These include the following:

4.4.2   Co-ordination

The informants suggested that one of the main problems was that there was no formal co-ordination of rehabilitation services at sub district level between various role-players: therapists, health programmes, and broader community structures, and that this created problems with accountability.

Two participants indicated that internally within the health department at sub district level co-ordination and collaboration between various programmes and health staff was not in existence.

> **There isn't that much kind of collaboration as far as health programmes are (is) concerned, they are focusing on nursing issues**
> **openly, but not specifically rehabilitation as far as our sub district.**

> **There is no official co-ordination between OTA, Mental Health Sisters,**
> **OTA and PT, OTA and Health promoter and OTA and social worker.**

One participant indicated that rehabilitation staff work in isolation, by focusing on their own services, resulting in no co-ordination.

We make it an OT, physio thing. We're all doing our own thing.

Another participant indicated that liaison exists with NGOs, but that there was difficulty in co-ordination, as these organizations were not catering solely for disabled people.

> **You're on your own in the district, you may liaise with NGOs, its not exactly the same because it's not as if they are all working for disabled organizations**

In contrast to the above experiences, two participants indicated that co-ordination was possible with a wider range of role-players within the sub district but that the accountability and reporting of the co-ordinating body was unclear.

> **From our district, we are also very limited in numbers, from provincial staff…**
> **We established a rehab task team for the sub district…we got NGOs,**
> **universities, and special schools. We tried to establish it. With the accountability, we did not have a mandate, we tried to report to the**
> **Metropole rehabilitation forum, but that had disappeared at the time.**

Another participant indicated that:

> **There was a network for disabled in the past, for everybody concerned with the disabled, but that fell part, but now the third of June they will be starting it again, there will be various role-players together to just get that co-ordination with groups in the district.**

4.4.3   Organisational management

When participants were asked about management and its relationship to the rehabilitation programme, some suggested that in the current context the management structures were not able to provide sufficient support to rehabilitation services for a number of reasons. For example, a participant indicated that:

> *…the district tried to appoint a PHC co-ordinator to try and get a representative from each of the programmes together, but it only lasted two to three meetings. The co-ordinator has a different role, so it just fell apart, but we basically have to create our own support and structure within the sub district. There isn't much as far as management about implementing these rehabilitation programme.*

Another participant voiced frustration by stating the following:

> *You are accountable to different people for different things...report to different people for different things…structures are not well established.*

A few participants indicated that although they reported on their service, there was no feedback from management and that this had an effect on his motivation.

> **They don't want extra reports to read and things like that. I'm not motivated to write reports because you don't get feedback on it.**

Despite all the problems encountered with management, there was acknowledgement that at a facility level communication and positive feedback were provided to rehabilitation staff.

> *There are so many fires to put out, I mean, I think, on a day to day basis*

within your CHC you get very good report backs, people can see, you get

good feedback, but on a district basis I'm not that sure. There are many

fires to put out, too little nurses on duty.

Most people have communication with facility managers (which) is good.
Everyone knows the facility managers. That has improved.

4.4.4 Supervision and mentorship

When participants were asked how they were supported within the district, a few participants indicated that clinical support was available within the organization either via consultation with colleagues or within a structured meeting. However, some participants indicated that their clinical supervision needs were not adequately addressed.

In relation to supervision, participants particularly valued the structured meeting process.

We try and meet regularly enough for people to support each other through that
process,…because we find it very difficult, we work in different areas to get
together, to support each other.

The meetings are good…if you are running on your own all the time…
but you could get going on your own little track, but then you come here
and someone says we've got a stroke club for the whole sub district and
you start to think…I have actually seen it happen in our meetings.

Other participants indicated the value of receiving more technical support from other levels of care.

When I'm not sure, I just phone my colleagues at secondary and tertiary level.

…especially, like Karl Bremer, because they are experts in wheelchairs, specializing in it, we cannot be experts in it.

Despite the good network for clinical consultation and support a number of participants indicated that there was a lack of structure and responsibility for someone to co-ordinate.

Nobody who is really coordinating, doing clinical work and supervision, the system is not in place.

Although the facility management supervision system was in place, a participant expressed that this was not adequately meeting their need for technical supervision.

It's only the facility manager… you just give her a monthly programme, and what you are doing, where you are going to be. It's more in terms of authority than what you are doing.

Particularly within the OT structure, the supervision of OTAs were seen as problematic - mainly due to time constraints.

For us it's just the supervision of OTA staff that would be a sort of monitoring at sub district.

According to me it is going with them enough (OTAs). The time aspect, sometimes, is the only hindrance, but we should be going to their groups, visiting.

4.4.5 Limited resources for rehabilitation

When participants were asked about issues that directly impact on the rehabilitation service, access to services and resources generally within health and even other sectors was found to be most challenging.

The lack of sufficient rehabilitation staff at primary level resulted in patients having to access other services as indicated by two participants.

> *In our district, there is no OT and Speech. All our OT patient referrals are sent to other levels as well as speech - where there are long waiting lists.*

> We have to refer to the tertiary or secondary level for them to provide for the clients as there is no service.

Two participants indicated that referrals to other sectors were difficult due to the lack of resources.

> *A lack of resources makes it difficult...one problem is the lack of protected workshops for children over 18years, there are eager people who want to do something…but there is nothing there.*

In particular participants identified the lack of equipment and devices as impacting directly on clients.

> *Basic OT devices were not available, we are not winning. Patients have to get it from secondary level.*

> *The OT departments don't have equipment…(they) need standardized tests and toys.*

4.4.6   Expectations

Towards the end of the focus group discussion, participants were asked to describe the support necessary to implement the rehabilitation programme at sub-district level.   The support that they identified was mainly related to planning, accessing resources and to be part of decision-making processes.

Someone to help monitor the plans as well and to give us feedback on where we are going.

To help, if we get stuck with plans.

Workshops with staff on the ground on policies, interpretation of policies.

Budget for wheelchairs and OT devices.

I know that it cannot happen overnight, but someone to help get more posts, we desperately need more staff, and we are too thinly spread.

Someone who will stand up for us, there is a voice.

The results in this chapter indicate the distribution of rehabilitation staff and the coverage provided by them across the Metropole. The elements of the service package are described as provided by the each of the therapy services. The last section focuses on the context within which services are delivered in the Metropole DHS. The experiences of therapists working in the setting are reported as factors that hinder or facilitate the development of the programme.

Chapter 5:   **Discussion**

5.1 Introduction

This study formed part of the rehabilitation programme development in the Metropole by aiming to determine gaps in service provision and to understand the complex management systems and support required from the DHS. The background for services and therapy practices in the future is important to consider in any planning exercises.

A number of gaps were identified in both facility and community level services through telephonic interviews. Whilst the focus group interviews identified key barriers to service provision and highlighted therapists expectations for support from management level. The study broadly outlines the constraints with implementing the service package in the Metropole and raises the importance of well-functioning management systems at various levels to support the implementation at PHC level.

5.2 The implementation of the elements of the package within the social model and CBR approaches

It is important to continually reflect on the models of practice adopted in the South African policies as they have a direct bearing on health workers practices and roles. Internationally, the debates amongst the British and American OT professionals on the social model support a change in the role of therapists to become consultants. The debate extends to the investigation of appropriate intervention practices that fit with the social model. There is however support from WHO that both models are adopted and that the core issue is the interaction and the relationship between therapist and service user.

In South Africa, Schneider (1998) has evaluated the adherence to the social model by closely examining the power relationships between therapists and recipients of the services. Although this study did not directly explore whether therapists were adhering to the different models and approaches in the provision of the selected elements, it is important to note that certain elements lean towards promoting the acceptance of the

social model in practice (disability forum involvement, networking) while (home visits and training) form part of CBR activities and facility based services fit with the medical model approach.

If one examines the elements involving networking, disability forum involvement and co-ordination of rehabilitation, in the current study, as process indicators to gauge current practices, the OT services had a number of external networking activities with institutions and community forums and in particular the OTAs were involved in mental health consumer advocacy bodies at local level. However, there was a smaller involvement of PT services - as the nature of the service is more facility based, focused on treating patients with acute conditions. Thus PT services are less likely to comply with the social model. Of interest is that therapists were unable to describe the nature of their involvement in disability forums and this may indicate their need to better understand their roles - as potential facilitators and advocates of change. Managing change has been defined as taking control, shaping direction and influencing the outcome of change (Smith; Webster, 1998). It appears that therapists are in a transitional phase as demonstrated in their work experience, where although the years of experience range between six to 11 years, there was less than five years work exposure at PHC level.

O'Toole (1998) identifies the future role of therapists as catalysts to community development where they increase awareness of needs through advocating for the removal of barriers in the community, neighbourhood, workplace and schools. However if one examines the limited availability of staff in the Metropole to carry out activities that involve networking and working with disability forums as well as provision of facility-based services, it is a challenge to engage in advocacy work and provide a high quality of care.

There is sufficient evidence in the study to show that the elements that have a clinical component such as home rehabilitation, group–based services and training, have the potential for developing practices that adopt the social model. Therapists' activities included transferring of skills to carers and families through teaching and training. It is

however necessary to reorientate therapists to the social model, as Werner (1998) cautions that these activities could become "*pre-determined recipes*" rather than "*liberating solution*". Werner's statements are supported by Schneider's (1998) study that show that even when NGOs provide home rehabilitation the adherence to the social model was still a challenge as therapists often directed services. Thus it is important that staff are not only orientated towards the social model of disability and CBR approaches, but also assisted to put these principles into practice.

5.3 Accessibility and availability

A key gap in the service provision is the limited access to services due to the poor level of rehabilitation staff. It should also be noted that at any one time 25% of the disabled population require some form of rehabilitation services. The National Rehabilitation Policy clearly states the importance of restructuring and strengthening rehabilitation services to improve access at PHC level to those who may develop a disability or already have a disability (DOH, 2000). Approximately 73% of the population in the Metropole is dependent on public health services (Equity Gauge, 2004). Although the purpose of this study was not to quantify the percentage of the population receiving services, but rather on the distribution and availability of the current services, it is important to note that the Metropole staffing is nowhere near the national norm for therapist to population for the provision of rehabilitation services. The national norm is 1: 30 000 in the short term, with an aim of 1: 15000 DOH (2000) in the longer term, while the ratio in the Metropole is only 1: 139 189. The results seem to fit with the estimates by the UN Development Programme (1993) that only 2 to 3% of the population requiring services in developing countries have access to any meaningful rehabilitation.

Furthermore, geographical inequities exist in that certain sub districts have no public rehabilitation services. The National PHC service package stipulates that services are to be available on a daily basis at CHC level by 2005, however, the results show that only 27% of the facilities have a daily service – and only 14% of facilities have both OT and PT. Therapists report that the impact of this on service users is that they have to be on a

waiting list at another level of care in order to access services. Although the National Rehabilitation Policy emphasizes the importance of a co-ordinated service, especially between levels of care, the lack of availability of sufficient services in the Metropole at PHC level implies that inappropriate referrals are sent to a higher level of care, further increasing the cost to both the user and the health sector.

5.4 Integration into the district health system

The study finds that many of the barriers to integration of rehabilitation into PHC were related to systemic organizational problems, common in changing organizations, and not specific to rehabilitation.

Firstly, there is a sense, from the focus groups, that therapists perceive that their voices are not being heard, and that rehabilitation is not a priority, given that there were so many other problems at PHC level such as limited availability of nursing staff.

The National Rehabilitation policy DOH (2000) proposes the decentralization of programmes to district level to improve services as recommended by the WHO where vertical programmes integrate so that resources and activities can respond to local needs and be used more efficiently. However, therapists experienced a number of problems relating to poor organizational management manifesting in the rehabilitation programme. These include issues related to an unco-ordinated approach to rehabilitation within all the sub-districts, and experiences of limited collaboration between health programmes, and unclear lines of accountability.

Secondly, although therapists raised their concerns about the lack of integration with other programmes, there is sufficient evidence to show that some informal links have occurred, in particular with the mental health and home based care programmes.

However, the lack of formal co-ordination can hinder efforts. Bamford (1999) proposes that programmes work through facilities as this fosters teamwork and provides

opportunities for staff to be supported in their work. Also, technical support can be accessed from the facility, while the facility management in turn can directly monitor the quality of care provided.

Thirdly, the need for a formalized supervision system has been highlighted in this study where therapists voiced their concerns on the different reporting structures and the lack of a supervisory and monitoring system. This situation appears to exist in a number of studies on disability and rehabilitation services within a few districts in Kwazulu Natal where a lack of a formal working relationship was identified. The studies recommend that management provide support for the rehabilitation programme to prevent therapists from working in isolation (McLaren, 2001). Pillay (2003) reports on the major decisions taken at the national district health systems committee meeting – where priority was given to strengthen supervisory systems as it is seen to be directly related to improving the quality of care.

5.5 Appropriate capacity building

Much is expected from therapists in order to be in line with government's philosophy on disability and rehabilitation. There is a need for additional skills as therapists have indicated the need for assistance with planning services and understanding policies and its implications for practice. Lehmann and Sanders (2003) suggest that staff develop public health skills for PHC work and have particularly identified planning, advocacy, programme design and implementation. The National Rehabilitation policy has identified the importance of building management capacity within rehabilitation so that the service can reform, but has not been descriptive in the type of skills required.

Worldwide the changing context of rehabilitation practice from institution based to community based, from tertiary level to PHC level and from the medical to the social model also influences the roles and scope of practice of therapists. The direct line management system in the Metropole DHS for rehabilitation staff is the facility manager.

Although an OT and PT co-ordinator exists, the working relationship between the co-ordinators and facility management level has not been clearly determined as reported by therapists when they identified that supervisory systems are not in place. The additional problem of having to compete for resources at sub district level, when there are so many other priorities has resulted in the therapists feeling that they were fighting a losing battle as nobody at management level was listening to their needs.

The above discussion highlights the complexity of integrating a service at PHC level within the Metropole DHS, especially since the DHS is not fully functional. Issues related to the lack of clear management structures, limited resource allocation and even the current utilization of human resources highlight the negative impact of having a poorly functional district system. Although rehabilitation staff are involved in the rendering of certain elements of the study, the lack of formal co-ordination and direction at sub district level is a strong indication for the need to facilitate change at this level. Although the study did not purposefully explore whether staff were adhering to the social model of disability and community based rehabilitation approaches, the availability and nature of the certain elements such as disability forum involvement and networking show the transition.

Chapter 6:   **Conclusion and recommendations**

The study aimed to establish and explore the extent to which the current rehabilitation service has implemented selected elements of the PHC policy. It also considered the barriers that therapists experienced when working within the Metropole's partially decentralized DHS.

The main problem identified at PHC in the Metropole remains access to rehabilitation services. Services are limited to only few CHCs. The range of services is also limited to the management of acute conditions at facilities, with some facilities providing community based support such as home based rehabilitation and training of families and carers. Another problem identified is that rehabilitation personnel work in isolation, as there is no co-ordination of services. The results, through comparison to the policy, show that rehabilitation services are under resourced and management support is required to provide strategic direction and keep therapists accountable, particularly within the transforming health system. In particular, the challenge of changing practices to reflect the paradigms of the social model of disability and CBR approaches - also requires support and development.

In conclusion, the study highlights the struggle with integration of the rehabilitation programme into the Metropole DHS. It is very important to consider the context within which services are rendered when examining what is available. As resource allocation and management is located at CHC and sub district level, much work is required at this level to facilitate change to the status of rehabilitation.

6.2 Recommendations

The recommendations have been categorized into three levels; management, clinical and research.

Management

1. Strategic leadership is required from the rehabilitation programme manager in the Metropole region to facilitate integration and strengthening of particular services already provided in mental health, home-based rehabilitation and acute physical rehabilitation at facility level. A 3-year strategic plan should be developed with rehabilitation staff, therapy co-odinators and district management level to guide implementation

2. Liaise with district management and advocate for the improved coverage and distribution of services i.e. more posts for therapists and assistants based on the gaps identified.

3. A formal relationship should be established between the therapy staff at facility level and the interim district management teams so that OT and PT services form part of the team to assist in supporting their need for equipment and resources and more importantly to integrate their planning at sub-district.

4. A formal relationship should be established with various government departments such as education and labour in the Metropole region so as to improve access to various services.

5. Investigate the accessing of funding to support the development of partnerships between the DOH and NGOs for the rendering of CBR programmes.

6. Develop an advocacy campaign for rehabilitation, to highlight the crosscutting nature of rehabilitation and its impact on other programmes.

7. Staff should be oriented to core policies, and the paradigms of the social model and CBR approaches that guide service provision so that they can become equipped with the skills and tools to manage change, and render a more appropriate service.

Clinical

8. The OT and PT co-ordinators should review the existing rehabilitation service delivery system per sub district and reorganize the rehabilitation staff into teams to improve coverage at facility level and co-ordinated support and outreach at community level.

9. The programme manager, and OT and PT co-ordinators should develop community based clinical protocols to guide service provision for both OT and PT, particularly for the rendering of services based outside the CHC such as home rehabilitation, self help group, networking activities and training activities.

10. The programme manager, and OT and PT co-ordinators should improve the referral process for home based rehabilitation between OT and PT services so as to improve effectiveness - given that PTs are more facility based and OTs more community-based.

11. Pilot the rendering of various elements of the service package at sub district in partnership with NGOs and persons with disabilities.

12. The PT co-ordinator should investigate the possibility of providing a more cost effective structured programme for back care management that includes

educational and practical skills as this is the most commonly treated condition seen by physiotherapists at facility level.

13. The role of the PT and OT co-ordinators should be strengthened to assist in the supervision and mentoring of therapists and to work with facilities to improve the quality of care.

Research

14. Further investigation should be undertaken to inform the improvement of the service for children, particularly less than 18 months, - given that there is a developmental screening policy in place in the Metropole. This should entail clear referral pathways for rehabilitation services.

15. An investigation should be done to review various CBR programmes and PHC rehabilitation services to explore options for improving and directing service delivery in the Metropole DHS.

16. Explore the range of skills and knowledge required from therapists to provide the rehabilitation services as stated in the PHC policy.

The study has shown the limited availability of rehabilitation services, as well as attempted to highlight the complex nature of service integration into the DHS within the Metropole region. The main recommendations made show the importance of tackling health programme issues on multiple levels so as to facilitate and promote integration. Although the formal establishment of the DHS may take a while, there is a need to establish interim measures to specifically address issues of strategic planning, budgeting, prioritizing focus areas for service provision, organization of a rehabilitation service delivery system per sub district and mentorship and supervision of rehabilitation staff.

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Appendix: 1

Semi-structured telephonic interview guideline

Respondent: No

Introduction:
- Purpose
- Confidentiality, Anonymity
- Availability to conduct the interview

|		
A.	**Permission granted for interview:**	**YES/NO**
B.	**CHC:**	
C.	**Sub district:**	
D.	**PT/OT/OTA:**	
E.	**No of years of experience in profession field:**	
F.	**No of years of experience of working at PHC level:**	

SELECTED ELEMENTS OF THE PACKAGE

1.   Is there a (OT/OTA/PT) service at this CHC?

YES/NO

1.2   How often do you provide a service at this CHC?   Daily/Weekly/Monthly

1.3   At which other CHCs do you provide a service?
             CHC:
             How often: Daily/Weekly/Monthly

1.4   Describe the typical patient you see at the CHC:

1.5. **In your estimation of the service – which clients do you think are commonly and least likely seen – in the following categories:**

Prompts: How would you describe a typical client?
            How would you describe a not so typical client – cases you miss, but think you should be seeing at the CHC.

	Commonly seen	Least seen
Age:	_____	_____
Diagnosis:	_____	_____
Disability type:	_____	_____
Referral source:	_____	_____
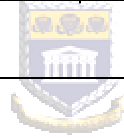
2. Are home visits part of the service you offer?

YES/NO

Prompts

2.1 Describe the clients/patients that are seen?

_____
_____

2.2 Describe what you would do on a home visit?

_____

2.3 How do you decide on doing home visit?
Prompts: What is the process – who refers to you and how do you judge whether a home visit is needed?

_____

3. Are you involved in any self-help groups?

YES/NO

Prompts:

Describe the groups you are involved in and what is your role?

_____

3.1   What type of groups do you provide?

3.2   What activities are provided in the group?

4. Do you provide any training?

YES/NO

Prompts: Is there anyone that you train as part of the service?

4.1   Who do you train?

4.2   Describe the training that is provided?

5. Are the rehabilitation services coordinated in the district?

YES/NO

Prompts: Are the co-ordination activities in the health sector or outside the health
sector or both?

Describe how is it done?

Who is involved?

6. Is networking with organizations/forums part of your service?

YES/NO

Prompts: Which organizations do you interact with?

Describe your interaction with them.

7. Are you involved in any disability related committees/forums?
YES/NO

Prompts: How would you describe you relationship with the committees?

Describe your involvement.

Thank you for participating in the study.

Are there any questions you'd like to ask?

Comments on reflections on the interview process

Appendix: 2

Focus group interview guideline

Introduction:

- Thank you for being willing to participate.
- Purpose: In this session we will be discussing your experiences of working within the district health system in the Metropole to get an understanding of how the rehabilitation programme works at this level.
- Anonymity and confidentiality
- Recording of proceedings (tape/newsprint)

1. Please describe your experiences within the district health system

2. How are services currently being co-ordinated at subdistrict level?

3. How do you work with (other levels of care, therapists, PHC staff, other sectors, NGOs etc

4. What is your relationship with the management team?

5. How is planning done at sub district level?

6. If you require resources, what is the process you go through?

7. How would you describe the support from the district management team?

8. Are there any problems or anything you wish to discuss about your experiences at district level?

Thank you for participating in the study.

Appendix: 3

List of tables