

**PERCEPTIONS AND EXPECTATIONS OF PATIENTS REGARDING A NEWLY
DEVELOPED REHABILITATION MODEL TO ENCOMPASS THE VISION OF
THE NEW HEALTH PLAN 2030**

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Western Cape, in fulfilment of the requirements for Master of Science degree in
Physiotherapy



DECLARATION

I hereby declare that “**Perceptions and expectations of patients regarding a newly developed rehabilitation model to encompass the vision of the new health plan 2030**” is my own work and that it has not been submitted, in part or in its entirety, for any degree or examination at any other university; and that all sources used or quoted have been indicated and acknowledged by means of complete reference.

Signature:

Rochelle Louisa Petersen

December 2017

Supervisor (s): Prof Mlenzana & Prof Frantz



DEDICATION

I dedicate my thesis to my family, partner and friends who always believed in me, showed continuous support and motivated me to do my utmost best. I thank you so much!

I love you!



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ABSTRACT

Background: people with disabilities face many challenges. Some are made to feel inferior by others because of their physical or mental disabilities. Primary healthcare described by the Alma Ata Declaration as “health for all”, is a process of care which encompasses a comprehensive approach to meet the basic healthcare needs of all, including people with disabilities. The main focus of the primary healthcare approach is to put people at the centre of healthcare. Primary healthcare utilises rehabilitation as a service. Rehabilitation services worldwide are set to improve the standard that the United Nations Convention of the Rights of People with Disabilities and National Committee of Rights People with Disabilities aims to achieve. There are however, gaps in the delivery of healthcare services at a primary level, as identified by the Western Cape Department of Health in South Africa.

The 2030 healthcare plan was developed to fill the gaps at this level of service. The plan builds on the comprehensive service plan of healthcare 2010 which aimed to strengthen community-based services, primary healthcare and district hospitals. The plan also looks at how the Department of Health will operate using this platform. The framework was established to focus on changes inclusive of threats in the environment such as technological advances and the availability of resources, building on lessons learned in the Comprehensive Service Plan 2010 as well as a reimagined future to improve healthcare services for all. Key stakeholders in the Western Cape aim to improve these health services by providing patient-centred care, moving towards a goal orientated outcome, improving services at a district health level, improvement of equity, affordable health services and establishing premeditated partnerships.

A model developed by Mlenzana to guide rehabilitation within the context of the 2030 healthcare plan forms the basis of this study. The model highlights five distinct areas, namely access to rehabilitation services, patient-centred rehabilitation, caregiver and family involvement, stakeholder education and rehabilitation interventions that will improve rehabilitation services within the Western Cape. The purpose of this study was thus to explore perceptions and expectations of patients regarding the newly developed rehabilitation model that encompasses the vision of the healthcare plan 2030. **Objectives:** the objectives of this study were (a) to create awareness of the proposed rehabilitation model among patients who are currently attending rehabilitation services at three selected community health centres in the Western Cape province, (b) to explore patients’ perceptions regarding the newly

developed rehabilitation model and (c) to explore patients' expectations regarding the newly developed rehabilitation model.

Methods: this study employed a descriptive, exploratory approach using quantitative and qualitative methods of data collection. Purposive sampling was used to include patients receiving rehabilitation services from two or more rehabilitation professionals at the selected community health centres. A total of 31 participants chose to partake in this study.

Workshops were conducted at these centres to inform participants about the new rehabilitation model. Data was collected through focus group discussions using an interview guide to obtain information from the participants. Qualitative data analysis was used to interpret the data. Themes that emerged were categorised to make sense of the data obtained in the focus group discussions. **Results:** the emergent themes were the need for change and resources. **Conclusion:** the need for a new rehabilitation model to be implemented is of importance as patients' experience rehabilitation services to a negative extent. Participants in this study emphasised the need for change to improve the way they see and experience rehabilitation services.



KEYWORDS

Disability, health, healthcare, people with disabilities, primary health care, rehabilitation, rehabilitation services



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ABBREVIATIONS

CBR	Community Based Rehabilitation
CHC	Community health centre
CSP	Comprehensive Service Plan
SADoH	South African Department of Health
FGD	Focus group discussion
ILO	International Labour Organization
NCRPD	National Committee on Rights of People with Disabilities
NRP	National Rehabilitation Policy
PHC	Primary healthcare
PWDs	People with disabilities
UNCRPD	United Nations Convention on Rights of People with Disabilities
UNESCO	United Nations Education, Scientific and Cultural Organization
WCDoH	Western Cape Department of Health
WHO	World Health Organisation

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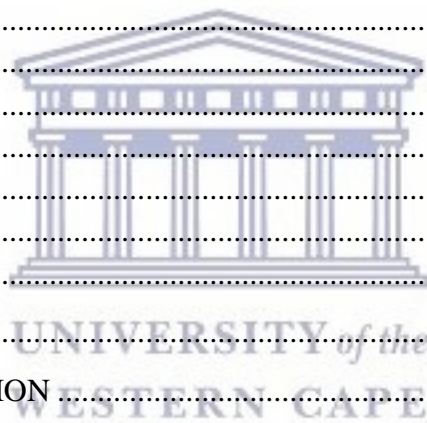
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CHAPTER 1

INTRODUCTION

1.1 Orientation

This research study focuses on exploring and describing perceptions and expectations of patients regarding a newly developed rehabilitation model that encompasses the vision of the healthcare plan 2030. The problem statement, research question, aim and objectives as well as the significance of the study are presented. An overview of the methodology, an outline of chapters and definition of terms are included in this chapter.

1.2 Background

The United Nations Convention on Rights of People with Disabilities (UNCRPD) was developed globally in 2006 to cater for all individuals with a disability. The UNCRPD highlights that people with disabilities should be treated and valued the same as any other person. This represents a shift from a model in which people with disabilities (PWDs) are treated as objects of medical treatment, charity and social protection, to one in which PWDs are recognised as individuals who have equal basic human rights as others in society (Nizar, 2011). According to the World Health Organisation (WHO), “a disability serves as an umbrella term for impairments, activity limitation and participation restriction” (WHO, 2001, pg. 1). This in turn refers to a disability having a limitation on an individual’s general and cognitive functioning, mobility, dexterity or stamina; the limitation can be short-term or long-term (Rothman, 2018).

The UNCRPD provides for a wide range of basic rights to PWDs as it recognises the inherent human dignity of all people. The UNCRPD also conditions the right to life, freedom from torture or cruel, inhuman or degrading treatment or punishment, freedom from exploitation, violence and abuse, protecting the integrity of persons, and respect for privacy (Nizar, 2011). The UNCRPD (2006) is an approach which tries to enhance and improve the lives of PWDs. In addition, the South African National Committee on the Rights of People with Disabilities (NCRPD) was developed in 2000 to articulate and structure rehabilitation services to help change attitudes and approaches to persons with disabilities. In order to completely achieve this aim, the National Rehabilitation Policy (NRP) was established. The NRP was implemented in 2000 to give rise to primary healthcare (PHC) and community-based

rehabilitation (CBR) services. These services use rehabilitation as a goal to enable PWDs to achieve their goals of independence and enhance their quality of life. The UNCRPD and NRP's main goals are to focus on persons with disabilities reaching and achieving their own goals and rights.

PWDs face challenges of being made to feel inferior by other people owing to being physically or mentally incapacitated by a medical problem or a disease (Philips & Noubissi, 2004; Uromi & Mazagwa, 2014). Kahonde, Mlenzana and Rhoda, (2010) reveal that PWDs struggle to access rehabilitation facilities and to obtain information regarding support services. Based on these literature findings, it is seemingly apparent that in the Western Cape, PWDs are not satisfied with service delivery in healthcare services. However, these barriers may be addressed by using a patient-centred rehabilitation approach. This approach allows the patient to be part of the rehabilitation process thereby respecting and acknowledging them (Mangset, Dahl, Ford & Wyller, 2008).

The Alma Ata Declaration established in 1978 serves as a conference which strongly affirms that all human beings have the right to access basic health services globally (WHO, 1978). PHC as illustrated by the Alma Ata Declaration which means "health for all" is seen as a process of care that encompasses a comprehensive approach that responds more equitably and effectively to the basic health needs of the population (Saunders, 2003).

PHC was envisioned to deliver comprehensive preventive and restorative services. It was seen as system to help develop healthcare centres in urban and rural areas. These curative and preventive healthcare services were incorporated into a comprehensive community-based package. This approach was used to eliminate fragmentation and the duplication of services by integrating all health services under a single Ministry of Health by decentralising the organisation and management of healthcare services through a well-coordinated district health system (WCDoH, 2014). Through the establishment of PHC centres within South Africa, community-based care was to be made accessible as the foundation of the national health system (Kautzky & Tollman, 2008). To build dynamic programmes for PHC facilities, the Reconstruction and Development Programme (1994) introduced free maternal and child healthcare, which later included free PHC for all using the public health sector (Kautzky & Tollman, 2008). However, the transformation of health systems and implementation of PHC has created challenges for every government attempting a health system reform. Factors which currently limit the provision of PHC are high rates of medical relocation and severe

health worker shortages, inequity of resources and distribution of personnel, the multifaceted and evolving burden of diseases, and deficiencies in managerial capacity and health system (Schaay & Sanders, 2008). These deficiencies also affect policies towards PWDs (Mji, Chappell, Mlenzana, Goliath, De Wet & Rhoda, 2013). The necessity to develop new models of PHC is clear.

Schaay and Saunders (2008) state that the health system requires the development of advanced health system designs; integrated district-based health worker training initiatives; and a work effort that builds on global efforts in health system development. The main focus of PHC is to aim for the provision of better health for all, by putting people at the centre of healthcare. Strategies that aim to address this comprehensive approach are promotion of health, prevention of disease and an inter-sectoral approach which includes community participation and rehabilitation (Kautzky & Tollman, 2008).

Rehabilitation in PHC as a service is deemed a necessity to improve an individual's quality of life. The rehabilitation process is achieved in restoring a persons' ability to live and work as normally as possible after a disabling injury or illness. Rehabilitation aims to help PWDs accomplish maximum physical and psychological fitness to recover optimal independence (Rubin & Roessler, 2001). This process aids in gaining of knowledge relevant to medical conditions, learning or relearning of skills and activities, occupational training and guidance, and psychological readjustment. Well-trained rehabilitation professionals who meet the needs of these individuals can help to efficiently and effectively restore the patient's quality of life. These rehabilitation professionals can be doctors, nurses, physiotherapists, occupational therapists, dieticians, speech therapists and audiologists (Arena, Williams, Forman, Cahalin, Coker & Meyers, 2012). Rehabilitation services are set to be improved to what the UNCRPD and NCRPD, aim to achieve by the continuous structuring and remodelling of healthcare to improve services at a PHC level. In conjunction with the PHC approach, the NCRPD aims to structure and formulate rehabilitation services to help change attitudes and approaches to persons with disabilities, to make services efficient and effective for those living with disabilities.

1.3 Context

This study explores and describes perceptions and expectations of patients regarding a new rehabilitation model developed by Mlenzana (2013) that encompasses the vision of the new healthcare plan 2030. The rehabilitation model proposed by Mlenzana (2013) is aligned with

the healthcare plan 2030, which was developed by the Western Cape Department of Health (WCDoH) and has been an ongoing discussion set in place since 1995. This was an initiative started by the government to find ways to improve services in the PHC setup. The development of the healthcare plan 2030 was initiated with consideration of external environment changes such as demography, socioeconomic determinants of health burden of diseases, climate changes, advances in technology and limited resources (WCDoH, 2011). According to Naidoo (2012), the National Health Insurance Policy for healthcare delivery in South Africa aims to ensure equity and to address inequalities in healthcare by presenting an ambitious healthcare plan to be implemented for 2030. This plan will help to improve the South African health system over the next 14 years.

Currently, there are gaps in the delivery of healthcare services at a PHC level as identified by the WCDoH. The 2030 healthcare plan was intended to fill the gaps at this level of service (WCDoH, 2007). The development of the healthcare 2030 plan builds on the Comprehensive Service Plan (CSP) of Healthcare 2010, which aimed to strengthen community-based services, PHC and district hospitals. The healthcare 2030 plan also looks at how the WCDoH will operate using this platform, by ensuring that the policy addresses patient-centred quality care, integrated provisioning, and continuity of care throughout the life of the patient.

The framework of the healthcare 2030 plan was established to focus on threats in the environment such as technological advances and the availability of resources, building on lessons that have been learned from the previous plan, as well as on a reimagined future to improve healthcare services for all (WCDoH, 2014).

Key stakeholders in the Western Cape aim to improve these health services by providing patient-centred care, goal orientated outcomes, the PHC philosophy, improving health services at a district level, improving equity, affordable health services and building strategic partnerships (WCDoH, 2007).

Hart and Macnee (2007) mention that the requirements of PWDs should be met accordingly at a primary health level of care. The authors state that having a relationship with PWDs, family members and their communities' attributes to addressing health issues. The WCDoH's 2030 vision of a patient-centred approach to healthcare should recognise that the relationship between the rehabilitation professional or service provider, patient and caregiver is essential in delivering quality care (Mlenzana, 2013). Patient-centred rehabilitation should individualise programmes to suit the needs of the patient in the rehabilitation process and in

the patient's community. Sharing of information and education should be on an appropriate level and according to patients' wishes, and there should be clear family involvement and support. Coordination and stability of rehabilitation should include outcomes that are significant to the patient (Mlenzana, 2013).

The present study has been conducted at the same rehabilitation centres previously selected in the Mlenzana (2013) study. These rehabilitation centres are in the Western Cape province, which also falls within the contextual framework and operation of the NRP, NCRPD and the UNCRPD.

Mlenzana (2013) has developed a new rehabilitation model that aims to improve rehabilitation services within the contextual framework of the NRP and the UNCRPD in South Africa. In addition, the model suggests that health promotion and education from service providers is needed to assist in facilitating the rehabilitation process. This is a necessary tool to inform PWDs of referral systems and services available in their catchment areas. Family involvement also contributes to improved quality of care of the PWDs when good and clear communication exists.

If the goals of the new rehabilitation model are put into practice, rehabilitation professionals will be responsible for health promotion, goal-setting and shared decision-making in treatment sessions with their patients. Patients will have an improvement of service delivery as there will be improved referral systems, access to rehabilitation services, improved health and policy knowledge, and a patient-centred approach. Caregivers will have the benefit to be included in shared decision-making of patients' rehabilitation as well as improved knowledge regarding health and health services to accommodate to the needs of the patient.

In this way, CBR services will be fostered to assist in rehabilitation service delivery at a PHC level. Mlenzana's study is in line with strict policies of the UNCRPD (2006) for the newly proposed model to be put into place for future operations. It is hoped that the healthcare plan 2030 will help to provide a more patient-centred approach and be more accessible to maintain effective and efficient services provided to the public.

In correlation with the healthcare plan for 2030 and the health plan guide titled "Road to Wellness" (WCDoH, 2014), the new model of rehabilitation by Mlenzana (2013) offers key suggestions which lead to achieving a patient-centred approach and service by re-energising the rehabilitation workers.

1.4 Problem statement

The healthcare 2030 guide discusses the challenges the government is likely to experience before the new health plan 2030 can be implemented. To achieve the vision of the new health plan 2030, priorities must be to strengthen health systems, address social determinants affecting health and diseases, improve health information systems, prevent and reduce disease burdens and promote health, financing universal healthcare coverage, improve human resources in the health sector, strengthen accountability mechanisms, improve quality by using evidence and use meaningful public partnerships.

Mlenzana's (2013) study which relates to the development of a new rehabilitation model has been produced with the intention of facilitating the move towards a healthcare plan 2020 which was extended to 2030. It addresses aspects of access to rehabilitation services, patient-centred rehabilitation, caregiver and family involvement, stakeholder education and rehabilitation interventions. Accessibility and communication are lacking for patients attending rehabilitation services at PHC level (Mlenzana, 2013). The model of Mlenzana (2013) reaches the goal of delivering an effective rehabilitation service through shared decision-making between patients and rehabilitation professionals. Caregiver and patient education is thus very important to develop the skills and methods needed for the patients to live with their condition. A recent study has, however, shown that a shortage of rehabilitation professionals could lead to an overlapping of healthcare protocols. This situation forces rehabilitation professionals to perform duties falling out of their scope of practice to see to patients' needs (Board of Governors of American College of Healthcare Executives, 2015).

The current research study addresses a gap in research, specifically to obtain patients' views at three community health centres (CHCs) in the Western Cape Province, South Africa regarding the newly developed rehabilitation model to improve rehabilitation services. This model, which aims to encompass the vision of the healthcare plan 2030, is still poorly understood and investigated. Understanding patients' perceptions and expectations of the new model can serve to adjust and update policies in the future to accommodate patients.

1.5 Research question

What are the perceptions and expectations of the patients regarding the proposed rehabilitation model that aims to encompass the vision of the new healthcare plan 2030?

1.6 Aim of the study

The aim of the study is to explore and describe perceptions and expectations of patients regarding a newly developed rehabilitation model.

1.7 Objectives

The objectives of the study are as follows:

- (a) To explore patients' perceptions of the newly developed rehabilitation model;
- (b) To explore patients' expectations regarding the newly developed rehabilitation model.

1.8 Significance of the study

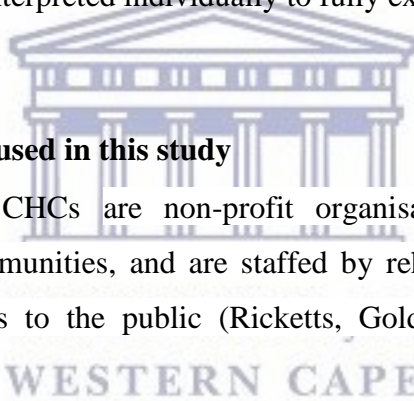
In order to improve service delivery at PHC level, the South African government's Department of Health at national level needs to ensure the successful implementation of strategies related to the 2030 healthcare plan. To understand the process of care, outcomes identified in this study will aid help to clarify strategies by which better service delivery and rehabilitation services can be obtained. The feedback obtained in this study will add to the knowledge base which will in turn aid in the identification of gaps found in policies (healthcare 2010). This will help to improve the quality of rehabilitation services provided to and received by patients. It will also help to identify the barriers rehabilitation professionals experience in delivering their services at the selected CHCs.

It is important to clearly identify the clinical area evaluated, choose components to be evaluated and identify the people who could best contribute the information (Rubin, Pronovost & Diette, 2001). In this way, clear strategies can be put into place to help enhance and improve quality rehabilitation services being delivered. The new data collected in this research study may help to improve overall patient satisfaction, improve policies and advance community health sciences and operations.

1.9 Methodology to address research question

In this chapter, a brief summary of the methodology is presented. This research study used a descriptive, exploratory study design with qualitative methods of data collection to answer the research question. The study was conducted at three selected CHCs in the Western Cape

province of South Africa. Participants in this study were patients receiving rehabilitation services from two or more rehabilitation professionals. Data was collected by means of focus group discussions following informative workshops. A trained research assistant was used to conduct the workshops and focus group discussions. The research assistant informed participants of the purpose of the study, as well as to obtain their willingness to partake. Workshops were conducted at the selected CHCs to inform participants of the new proposed rehabilitation model. The focus group discussions took place at the same selected centres. An interview guide was used by the research assistant with a list of questions to obtain the perceptions and expectations of participants regarding the new rehabilitation model. The focus group discussions were recorded using an audio-recording device. Following this process, the data collected in focus group discussions was later transcribed verbatim in English; three transcripts were derived from this process, one for each focus group discussion conducted. Using additional peer-review of the transcripts, themes were grouped and categorised which were then interpreted individually to fully explain and understand the current research question.



1.10 Operational definitions used in this study

Community health centre: CHCs are non-profit organisations that provide PHC to individuals, families and communities, and are staffed by rehabilitation professionals who provide rehabilitation services to the public (Ricketts, Goldsmith, Holmes, Randy, Lee, Taylor & Ostermann, 2007).

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

Health: According to WHO (1995), health is defined as a state of complete physical, mental and social well-being and not merely the absence of illnesses or injuries.

Patient: A patient is a person receiving, or who is registered to receive, medical treatment for an illness or injury at a healthcare facility (WHO, 1995).

Primary healthcare: PHC refers to healthcare provided in the community to people making an initial approach to a medical practitioner or clinic for advice or treatment (Van Lerberghe, 2008).

Rehabilitation: Rehabilitation is a set of measures that assist individuals with illness or disability, to achieve and maintain optimum functioning in interaction with their environments (WHO, 2011). It thus includes promotion of disabled people's rights by providing relevant information to facilitate their decision-making regarding services needed for enhanced participation (International Labour Organization, United Nations Educational, Scientific and Cultural Organization & WHO, 2004).

Rehabilitation professional: This is an individual specialised in a health profession to assist a person in the recovery of an illness or injury (WHO, 1995).

Rehabilitation services: Rehabilitation services are recognised as key components of healthcare especially to those with disabilities (WHO, 1995). These services are provided by audiologists, occupational therapists, physiotherapists, speech language pathologists, nurses and doctors (McKell, 2000).

1.11 Outline of chapters

Chapter 1

In this chapter, the reader is informed about policies relevant to the study, namely the UNCRPD and NRP. These policies aim to improve health for all South Africans, especially for those struggling with disabilities. It aims to improve access to healthcare and rehabilitation services in consideration of the needs and rights of PWDs. The new healthcare plan 2030 is explained, from which a newly developed rehabilitation model has been derived to improve rehabilitation services, experiences and operations. This chapter also defines the problem statement, the aim of the study, research question and the objectives and significance of the study.

Chapter 2

In this chapter, information relating to Chapter 1 is elaborated on. The literature review focuses on the healthcare plan 2030, current perceptions of patients regarding rehabilitation services, current challenges faced in rehabilitation services, UNCRPD (2006), rehabilitation and rehabilitation services and an introduction to the newly proposed rehabilitation model by Mlenzana (2013).

Chapter 3

In this chapter, the research methodology is further explained in detail. Aspects of research methodology discussed are the study design, setting, population and sampling, data collection methods, tools and procedures, data analysis, trustworthiness, and ethics.

Chapter 4

In this chapter the results of the study are explained. The demographic profile of participants, overview of utilised services at centres, and overview of themes are presented and discussed.

Chapter 5

This chapter concludes the study by examining its limitations as well as its overall significance. Recommendations for further research are made and final conclusions are drawn.



CHAPTER 2

LITERATURE REVIEW

2.0 Introduction

This chapter reviews the literature on the prevalence of PWDs, healthcare services for PWDs, the importance of rehabilitation in patient-centred care and challenges faced in rehabilitation services. Models of care, the proposed rehabilitation model and the importance of stakeholder views in healthcare are also discussed.

2.1 Prevalence of people with disabilities

Disability statistics play a critical role in monitoring and evaluating programmes addressing the requirements of PWDs. A lack of accurate statistics can delay operative planning and measuring the impact of programmes relating to mainstreaming disability. Types of disabilities, access to assistive devices, disaggregated statistics on prevalence of disabilities and the socioeconomic profile of PWDs are the key indicators essential to address their needs and challenges (Statistics South Africa, 2015).

An in-depth report was released by Stats South Africa (2015) to report on the prevalence of people with disabilities in South Africa, using Census 2011 data. This report ranges in variables such as ageing and education at both individual and household levels. The methods used to profile the disability prevalence are based on six domains, namely seeing, hearing, communication, concentration, walking and self-care. The South African national disability prevalence rate (according to Statistics South Africa, 2015) is 7.5% in which females with disabilities (8.3%) are more common than males (6.5%). The rate of PWDs increases with age, with more than half (53.2%) of the total number of PWDs being 85 years and older, while the prevalence of a specific type of disability shows that 11% of the population aged five years and above have difficulties with vision, 4.2% have cognitive difficulties (remembering/concentrating), 3.6% have hearing difficulties, and about 2% have communication, self-care and walking difficulties (Statistics South Africa, 2015).

2.2 Healthcare services for people with disabilities

According to WHO (2001), a disability is classified as an impairment, activity limitation and participation restriction. This is a result of a disease or injury and contextual factors inclusive

of environmental and personal factors (WHO, 2001). WHO recognises that PWDs are often disregarded and their lives are characterised by prejudice, social isolation, poverty and discrimination in almost all societies. Rehabilitation services are thus recognised as a key component of healthcare, especially to those with disabilities (WHO, 1995). Rehabilitation is used to reduce and remove barriers to participation of PWDs to ensure social integration. This includes promotion of disabled people's rights by providing relevant information to facilitate their decision-making regarding services needed for enhanced participation (ILO, UNESCO & WHO, 2004).

According to a recent study, rehabilitation services provided at PHC level are not fully used by PWDs in the South African context (Mlenzana, 2013). South Africa's most recent challenge to address rehabilitation services is summarised in the National Rehabilitation Policy (South African Department of Health, 2000). The National Rehabilitation Policy (NRP) was developed in 2000, in order to facilitate every citizen basic human right to having access to healthcare services (SADoH, 2000). This policy was designed to bring about equality and to enhance human rights for PWDs regarding rehabilitation services (SADoH, 2007). The NRP mainly focuses on PHC and CBR services within the context of South Africa. The PHC service section of the health system is the most critical component, as it serves as the first channel of admission into the healthcare segment in which it caters for the vast majority of patient contacts. PHC consists of two delivery platforms which are community based services and primary care services (SADoH, 2007). The outline of the intended 2030 service policy maintains the original arrangement of 2010 with a strengthening of community-based services, PHC and district hospitals.

The four PHC conceptual pillars of patient-centred care are the person-centred approach, integrated provisions of care, continuity of care, and a life course outlook (WCDoH, 2007). PHC implementation is still a challenge; it remains as a shortcoming for patients and individuals with disabilities (Mji, Chappell, Mlenzana, Goliath, De Wet & Rhoda, 2013). Chapelle and Johannsmeier (2009) discuss the gaps in service delivery perceived by PWDs, specifically the poor identification of the needs of the individual, basic needs that were not met, social circumstances in family not taken into account, and inadequate community interventions.

2.3 Importance of rehabilitation in patient-centred care

Rehabilitation aims to deliver a full recovery in the sense of treating a patient holistically, incorporating all rehabilitation professionals and services to provide the best possible care for an individual (Riggan & Maki, 2004). The main objective of rehabilitation in the South African healthcare system is to enable individuals to return to their communities with an optimal level of functional independence and the best possible quality of life at PHC level.

Oates, Weston and Jordan (2000) suggests that patient-centred care is associated with improved patients' health status and amplified efficiency of care through rehabilitation services. The patient-centred care approach refers to a way of thinking and achieving goals that sees the patient using health and social services as equal partners in planning, developing and monitoring care to make sure their needs are met (Gill, 2013). This means putting the patient and their families at the centre of decisions, working alongside professionals to get the best outcome.

Being patient-centred does not mean that rehabilitation professionals renounce control of the patients, but rather that the professionals respond to patients' unique needs and find common ground in the rehabilitation process. The benefits of being patient-centred are improved patient-professional satisfaction, fewer malpractice complaints, duration of rehabilitation sessions remaining the same (Oates et al., 2000).

2.4 Challenge facing people with disabilities in accessing rehabilitation facilities

It is apparent that context plays a main role in understanding the influence of disability and the need for rehabilitation services (Joseph, 2012). Barriers should be addressed to reinforce rehabilitation programmes. In the absence of existing South African studies relating to rehabilitation services, further investigation is needed in order to improve the health system (Joseph, 2012). Rule, Lorenzo and Wolmarans (2008) contend that a broader understanding must recognise rehabilitation as an enabling service which promotes poverty alleviation, community participation, economic empowerment and development and survival of PWDs.

Abdi, Arab, Khankeh, Kamli, Rashidian, Farahani and Shemshadi (2016) reveal that proper rehabilitation services require a full understanding of the challenges in providing rehabilitation to PWDs. Understanding these challenges will help policy makers, providers,

and PWDs and their families consider rehabilitation as an effective component of service provision in the health system.

According to Jesus and Silva (2016) a patient's motivation for care and the rehabilitation process varies according to the perceived significance of the rehabilitation goals, especially if they are conducive to key goals. Collaborative communication towards defining relevant, yet feasible, rehabilitation goals can improve a patient's fundamental motivation for care.

Through participation and inclusion in the process of rehabilitation, the needs and concerns of PWDs are elucidated for the rehabilitation professionals (Mlenzana, 2013). This emphasises that rehabilitation professionals can make key improvements within the rehabilitation service. It is important that rehabilitation professionals evaluate the satisfaction of the PWDs receiving rehabilitation services, as well as evaluating the goals accomplished in treatments.

Brez, Margo, Malcolm, Izzi, Maranger, Liddy, Keely and Ooi (2009) describe communication between PWDs and rehabilitation professionals as a key component of the patient-centred approach as it provides clarity and better understanding of current and ongoing rehabilitation services. This statement is supported by another study which suggests that poor communication and lack of information are often barriers for rehabilitation professionals when managing patients with chronic illnesses (Harris, Hayter & Allender, 2008). In Williams and Bowie's (1993) study, it was established that communication had positive and negative outcomes at rehabilitation centres included in their study. The authors mentioned that participants found some rehabilitation professionals to be exchanging sufficient information during treatment sessions, while others lacked communication skills.

Jesus and Silva (2016) propose that four important elements of rehabilitation communication are knowing the person and building a supportive relationship, effective information exchange, shared goal- and action-planning, and fostering a positive yet realistic cognitive and self-reframing outlook. However, multiple actions are required in order to improve methods of communication in rehabilitation to systematically achieve outcomes within rehabilitation. In addition to the many societal, socio-demographic and behavioural factors affecting utilisation of PHC services, it has been widely shown that geographical accessibility

of the health services has a direct bearing on utilisation of these services (Arcury, Gesler, Preisser, Sherman, Spencer & Perin (2005).

The challenges discussed in Mlenzanas' (2013) study include aspects of access to rehabilitation services which are affected by personal and environmental factors. Patients in the study reported that the facilities were easy to find in the user-friendly buildings, but that transportation to the buildings was inadequate. Transport services were not wheelchair-friendly and study participants were not always able to access transport to get to CHCs. This resulted in patients being late for their appointments and having to reschedule. Patients in the study also mentioned lengthy waiting times, although signage provided details of approximate waiting periods.

Healthcare clinics have a worrying shortfall of adequate equipment needed by patients to assist them with their rehabilitation needs and progress. An understanding of why these shortfalls exist in medical facilities is needed in order to develop strategies to eliminate these barriers and improve access to healthcare for PWDs. The goal is also to understand specific characteristics of the equipment that affect accessibility and patient safety, and to propose changes for future models (Story, Schwier & Kailes, 2009). Lack of equipment is a great challenge to people with physical disabilities as they struggle to monitor their progress and positive outcomes of their rehabilitation (Brez et al., 2009).

In order to provide sustainable and effective rehabilitation services in the PHC context, multidisciplinary approaches are needed in the management of PWDs. In this way, rehabilitation professionals are able to holistically and adequately meet the needs of patients.

2.5 Models of care

In the PHC setup, rehabilitation professionals focus on the medical, social and biopsychosocial models of care within rehabilitation to holistically treat every patient. This may be achieved by a rehabilitation worker directly approaching the problem, or referring to an appropriate rehabilitation professional in order to treat that patient with a particular need or problem (Ogden, 2007).

The **medical model** is a socio-political model in which illness or disability is the result of a physical condition intrinsic to the individual, which reduces quality of life, and causes fear

and disadvantages for the individual (Smeltzer, 2007). However, this approach to disability has been rejected by many individuals with disability and by disability support groups, because it does not cover the full field of issues related to living with a disability. It ignores the ability of many individuals to live full and successful lives and to be independent, the impact of a disability on access to healthcare, and the need to adapt to the way in which care is delivered because of a disability (Smeltzer, 2007). The medical model supports the view that physicians, nurses and other healthcare professionals are the most capable to make important decisions about health issues.

The **social model** refers to the idea of society disabling the individual by designing everything to meet the needs of the majority of people who are not disabled. In this model, society needs to reduce some of the disabling barriers; this is solely the responsibility of society rather than of the disabled individual (Smeltzer, 2007). The social model has been criticised because it ignores or dismisses disease or injury as part of the full spectrum. In this view, PWDs are encouraged to see any problems they encounter as emerging from barriers and negative attitudes of others in their social environment (Smeltzer, 2007).

The **biopsychosocial model** refers to viewing disability as arising from a combination of factors at the physical, emotional and environmental levels. It thus takes the focus beyond the individual and addresses interacting issues which affect the ability of the individual to maintain a high level of health and well-being to function in society. It also recognises that disabilities are often the result of the impact of biological, emotional and environmental issues on health, well-being and function in society (Smeltzer, 2007).

2.6 The shift towards healthcare in 2030

In 2002 the WCDoH shaped a strategic plan, healthcare 2010, as a provincial initiative that represented the way forward in terms of healthcare delivery. It was based on the PHC approach which aimed to bring better and more appropriate levels of care to patients. Healthcare 2010 was developed to significantly improve the quality of care of health services and simultaneously bring expenditure to within budget (WCDoH, 2007). This led to the 2020 health plan, to aid in enhancing systematic efficiencies to focus on improving health outcomes and information systems.

The healthcare plan 2020 focuses on improvement of health services in terms of client-centred quality of care, moving towards an outcome-based approach, retention of PHC philosophy, strengthening district services models, equity, and building strategic partnerships (WCDoh, 2011). This document envisions a wide range of participation from all stakeholders, to partnering with the National Health Department to improve the health status of the population in the Western Cape Province. The WCDoh has strengthened its capability to measure the impact of various initiatives on the health status of the population, including health programmes, the package of services being delivered, and the upstream interventions being embarked upon through the Provincial Transversal Management System (WCDoh, 2011).

Healthcare plan 2030

The healthcare plan 2030, developed by the WCDoh, has been an ongoing discussion for the government to find ways to improve services in the PHC setup. Two main factors which provide a framework for change are continuous improvement in patient experience, and the provision of quality of healthcare services on a sustainable basis. The document in which healthcare 2030 is discussed, sets out its vision, values and principles correlating to those of the UNCRPD and NRPD, thus guiding the WCDoh to a suitable healthcare plan for 2030. The document also provides a set of planning considerations and tools that will be applied to PHC. The strategic plan is to help re-design PHC services to reduce the frustration and complaints made by PWDs.

The WCDoh has put the vision of the health plan 2030 into a context of adhering to the Batho Pele principles by making the policy patient-centred, accessible and a tool of delivering good-quality care (WCDoh, 2011).

The Batho Pele principles were developed in 1995 with the set goal of “people first” to encourage public servants to find ways to improve service delivery, as the actual provision of services and products constitutes moral governance in South Africa. This relates to outcomes measured by public administration which are aimed to deliver quality services to improve the well-being of all individuals. The implementation of the Batho Pele principles are through consultation, setting service standards, increasing access, ensuring courtesy, providing more and better information, increasing openness and transparency, remedying mistakes and failures and value for money when providing customer care (Crous, 2004). To ensure the

sustainability of these concepts and principles, ongoing improvements and changes need to be put into place to make systems run efficiently that will result in satisfied clients (Crous, 2004; Smeltzer, 2007).

The Batho Pele principles are meant to make individuals' lives easier and better by moving the public service from a rule-bound approach that hinders the delivery of services, to an approach that encourages innovation and is results-driven (Kaisara & Pather, 2011). This is not always possible and unfortunately there will be downfalls in every public service facility because certain public servants may feel overworked, undervalued, underrated and underpaid (Public Service Commission, 2000; Crous, 2004). However, there are also ongoing changes and improvements being put into place. Changes within the WCDoH include an increased number of health and rehabilitation professionals at district levels of care, improvement of human resources as well as strategic development of acute and mental hospitals and rehabilitation centres. There needs to be an approach that promotes continuity from the Comprehensive Service Plan of 2010 to be adapted in 2020, to the new healthcare plan 2030. Major constraints to moving forward in South Africa's health system are poverty and inequality. Raising the living standards to a minimum level, as proposed in the healthcare plan 2030, will help to increase national employment, higher incomes through productivity growth, social wages and good-quality public services (WCDoH, 2011). These challenges remain interlinked.

According to WHO (2011), health systems in South Africa face challenges; the overall health performance has been poor since 1994 although good policies were developed, and extra finances were allocated to health systems. The importance of complete participation and community involvement along with the role of society has been underplayed and the focus of "people first" has been weakened (WHO, 2011). The health system was split with predominant disorders and multiple consequences which give rise to poor authority, feeble accountability, marginalised clinical processes and low staff allocation (WHO, 2010). Progressive policies were formulated in the first years of democratic dispensation and public health systems were transformed into an integrated, comprehensive national health system (WCDoH, 2011). However, poor leadership, inconsistent management and inadequate capacity meant that implementation and health outcomes fell short of expectations (WHO, 2010).

The South African Department of Health refers to PHC re-engineering as being key to achieving quality service delivery. It seeks to shift the PHC system from a fundamentally passive, curative, vertically and individually orientated system to one with a more positive, integrated and population-based approach (WCDoH, 2014).

The Negotiated Service Delivery Agreement established and signed in 2010 by national government, follows through with an outcome-based approach which have been approved and agreed upon by the President (WCDoH, 2014). The proposed health outcome is to improve healthcare and life expectancy of all South Africans. The key outputs of the Negotiated Service Delivery Agreement are: increasing life expectancy; decreasing maternal and child mortality; combating HIV and AIDS and decreasing the burden of disease from tuberculosis; strengthening health system effectiveness with a particular focus on PHC; and financing healthcare and management (WCDoH, 2014).

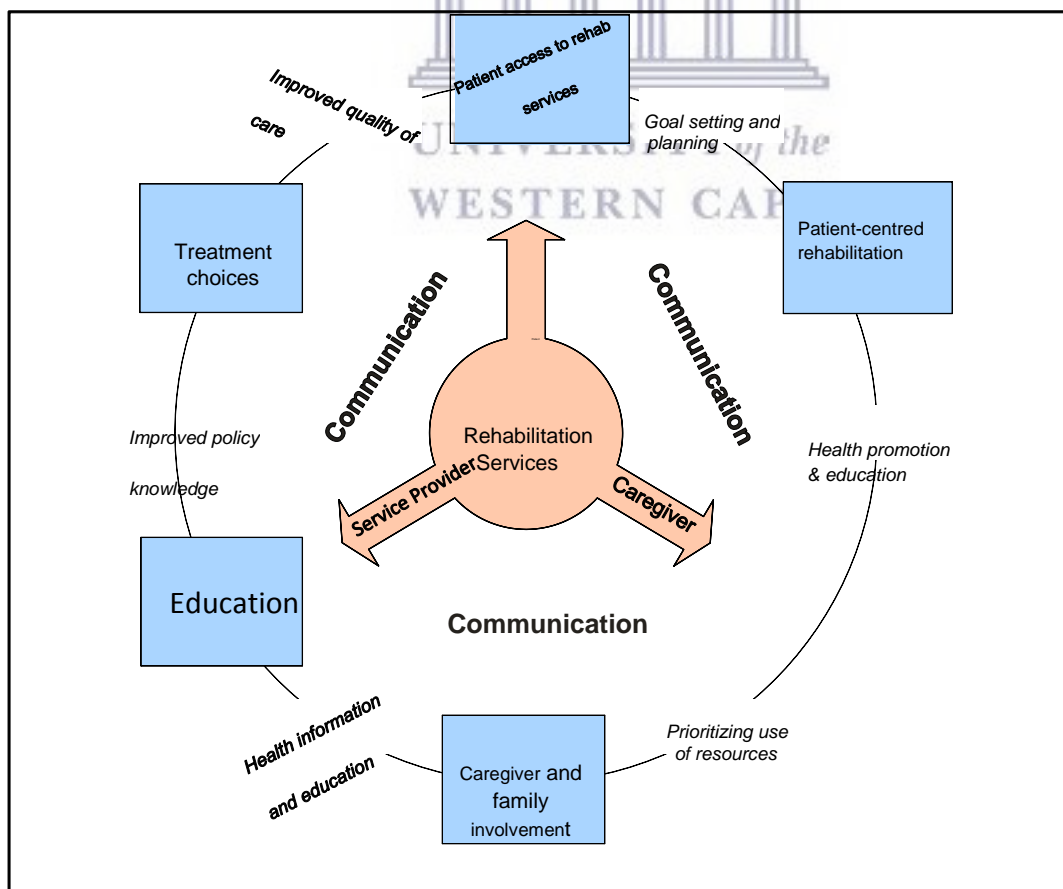
2.7 Proposed rehabilitation model

In rehabilitation services, there is a direct connection between the rehabilitation professional, patient and the caregiver. Patient-centred care is the primary focus for healthcare services, but the study done by Mlenzana (2013) shows that rehabilitation services are challenged in this aspect. To achieve the goal of a patient-centred approach, client–clinician relationships need to be improved and all stakeholders need to be involved to manage a patient’s condition.

The greatest challenge currently faced has been identified as insufficient time being allocated to health education during the rehabilitation process. Another significant finding of Mlenzana’s (2013) study is the lack of informed consent and decision-making regarding treatment options. Service providers and patients in the study also stated that lack of resources was a problem in providing holistic management within rehabilitation services. The process of receiving care was also compromised by long waiting times at the centres, and inadequate referral systems among rehabilitation professionals. To meet the needs of patients, patient-centred rehabilitation should include individualisation of programmes which will assist the patient with rehabilitation programmes and community participation. The patient-centred rehabilitation will aid the patient with shared information and education that is appropriate and time efficient and relevant to the patients needs. This will also enhance family and peer involvement in the rehabilitation process to outcomes that are meaningful.

Based on all the perceptions that were obtained from patients in Mlenzanas' (2013) study, moving towards a patient-centred approach in rehabilitation services, Mlenzana developed a new rehabilitation model (see Figure 2.1) which includes access to rehabilitation services, patient-centred rehabilitation, caregiver and family involvement, stakeholder education and rehabilitation interventions. Accessibility was shown to be lacking for patients attending rehabilitation services at PHC level in Mlenzanas' (2013) study. The study stresses the need to obtain patients' perceptions of healthcare in order to identify deficits in care and to examine more specifically the problems rehabilitation patients' experience. Health promotion and education should also be included as contributing to physical and psychosocial well-being of an individual. Caregiver and patient education is very important to develop skills and methods for PWDs to live with their condition. In addition, education of the service providers will assist in facilitating the rehabilitation process if they are aware of the referral systems and of services available in catchment areas. Family involvement will also improve quality of care of the patients.

Figure 2.1: Mlenzana's (2013) proposed model of rehabilitation



2.8 Importance of stakeholder views in healthcare system

2.8.1 National and International conventions for people with disabilities

In South Africa, the NCRPD was developed in 2000. It formulates and structures rehabilitation services to help change attitudes and approaches to PWDs. To achieve this aim, the NRP (2000) was set in place to motivate PHC and CBR services to enable PWDs to achieve their goals of independence and enhance their quality of life. In turn, the UNCRPD was developed globally in 2006. The UNCRPD spearheaded the movement from viewing PWDs as “objects” of charity, medical treatment and social protection – towards viewing them as “subjects” with rights, who are capable of claiming those rights and making decisions for their lives based on their free will and informed consent, allowing them to be socially interactive in their communities.

The UNCRPD and NRP’s goals are to solely focus on PWDs reaching and achieving their own goals. Rehabilitation services are accordingly set to continuously structure and remodel healthcare in order to improve services at a PHC level.

Articles 19 of UNCRPD (2006) states that all disabled people have the right to participate in the community as equal citizens. This article seeks to provide a clear explanation of the scope and recommendations of this right to facilitate its effective implementation. It ensures that persons with disabilities have the opportunity to choose their place of residence and where and with whom they choose to live on an equal basis, and not be obliged to live in a particular living arrangement. It also states that PWDs have the access to community sport services including personal assistance necessary to support their inclusion in the community.

Article 25 of the UNCRPD (2006) refers to health. It states that PWDs have the right to enjoy the highest attainable standard of health without discrimination on the basis of their disability, while the following Article refers to PWDs’ rights to attain and maintain maximum independence, full physical, mental, social and vocational ability and full inclusion and participation through all aspects of life. Article 26 calls on governing parties to strengthen, organise, and extend comprehensive habilitation and rehabilitation services and programmes particularly in areas of health, employment, education and social services.

2.8.2 Importance of caregivers' views in healthcare

An important aspect of rehabilitation is to include the rehabilitation professionals and caregivers in order to attain a successful rehabilitation outcome (Witness, 2010). Caregivers sometimes experience having to care for a patient as a burden, in terms of it being emotionally, mentally and task-orientated (Mlenzana, 2013). Tasks that need to be performed are patient-dependent and driven by the actual mental status and orientation of that patient. According to Mlenzana (2013), caregivers who took care of PWDs were mostly unemployed as they took care of their family members or neighbours.

Kahonde et al., 2010 found that caregivers that attend rehabilitation services along with patients experienced problems accessing rehabilitation facilities and getting adequate information regarding support services. However, the bulk of caregivers in Mlenzana's (2013) study had received education and had been involved in the rehabilitation process. Caregivers reported having pleasant relationships with rehabilitation professionals as well as receiving adequate education regarding the patients' health and further rehabilitation methods (Mlenzana, 2013).

The caregiver–therapist relationship helps to preserve the patient's highest functional mobility by training both the patient and the caregiver (Turner, Seiger & Devine, 2013). The therapist is able to make recommendations for necessary adaptive equipment to maximise the patient's safety in the home. In this way, specific patient and caregiver concerns are addressed to help patients achieve their highest quality of life and thus maintain their dignity. Currently, no intervention exists in the rehabilitation setting that addresses the needs of caregivers. There remains a need for caregivers to partake in the rehabilitation process, but there is a lack of support for restoration back into society (Mlenzana, 2013).

2.8.3 Importance of patients' views in the health system

It is important to understand patients' views in relation to the health system in order to assist with change (SADoH, 2000), in that rehabilitation professionals and patients could have different views on outcomes of the rehabilitation process (Hewlett, 2003). Wain, Kneebone and Billings (2005) observe that patients experience rehabilitation positively if they are in a calm environment with friendly and understanding staff. It is clear that if there is good communication, there will be effective understanding between client and professional, which will lessen the experience of being disabled (William, Jessie Schutt-Ainé & Cuca, 2000).

Kahonde et al. (2010) found that patients feel respected emotionally and included in their rehabilitation when having direct contact with the rehabilitation professional. These findings are however, contrary to those of other research studies. Crisp (2000) as well as Swain and French (2001) report that PWDs can experience their rehabilitation as negative and the patient–professional relationship can be ineffectual and dehumanising. Kahonde et al. (2010) and De al Cornillere (2007) note the challenges patients face in health systems with a lack of appropriate transport and problems accessing CHC in order to attend to their rehabilitation appointments. The inability to access the CHC can lead to patients not keeping appointments for rehabilitation, which in turn leads to patients getting “lost” in the health system.



CHAPTER 3

METHODOLOGY

3.1 Introduction

This chapter discusses the methodology of the study. The researcher provides a description of the study design, setting, study population, sampling method, data collection methods and tools used in the study. The data collection procedure is explained followed by the analysis of the study. Finally, ethical considerations pertaining to the study are discussed.

3.2 Research design

This study employed a descriptive, exploratory study design that used qualitative methods of data collection to answer the research question. Qualitative methods of data collection involve the views or perceptions of participants and may include data generated using interviews or focus group discussions (LUMS Effective Learning, 2016). It is appropriate for situations in which a detailed understanding is required (Creswell, 2001).

The descriptive, exploratory study design was used to explore the perceptions and expectations of participants who are currently receiving rehabilitation services from two or more rehabilitation workers at three selected CHCs. The explorative study design is suitable to the research topic as it is used to elicit, understand and describe personal perceptions, ideas, beliefs and values of the participants (Wisker, 2007). Exploratory designs are useful to initiate a preliminary investigation to further analyse significant components of data into relatively unknown areas of the research study. According to Collis and Hussey (2013), exploratory designs utilise an open, flexible and inductive approach to understand new findings of a phenomenon. These qualities made the design applicable and appropriate to use in the present study.

3.3 Study setting

This study was conducted at three selected CHCs in the Western Cape province of South Africa. These centres were chosen because the primary data used in this study related to informing participants of the development of a new rehabilitation model at the three centres included in Mlenzanas' (2013) study. These centres were purposefully selected based on the fact that each centre contains various kinds and numbers of rehabilitation professionals.

Centre A primarily serves an urban population that is mostly unemployed. At this centre, patients access the rehabilitation unit through a referral from other institutions or by self-referral. This rehabilitation unit is inclusive of a physiotherapist, an orthopaedics sister, a sessional occupational therapist and a nutrition advisor.

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

The final centre (C) is a semi-independent rehabilitation centre linked to a community health centre and an academic university. Referrals to this centre occur primarily via the community health centre and walk-ins from private doctors and other referring hospitals. The centre provides physiotherapy and occupational therapy services, while students from a local university provide speech therapy on a part-time basis.

3.4 Population and sampling

The population for this study were PWDs who were receiving rehabilitation services from two or more rehabilitation professionals at the three selected CHCs. This condition was set in order to reduce any possible bias relating to one rehabilitation professional.

Participants were selected using a purposive sampling method to seek out those individuals who met the inclusion criteria of this study. Palys (2008) states that purposive sampling is a non-probability sample that is selected based on the characteristics of a population, convenient availability as well as the aim of a study.

At each centre, patients' folders were gathered and scrutinised in order to obtain information of rehabilitation services they had received and from whom. The sample size of participants came to a total of 31. Of the 31 participants, 10 were from centre A, 13 were from centre B and the remaining eight participants were drawn from centre C.

3.4.1 Inclusion criteria

Criteria considered for inclusion in the study were the following:

- Patients currently receiving rehabilitation from two or more rehabilitation workers at the selected CHCs;
- Participants who are able to read, write and speak;
- Participants aged 18 years and above, in order to be able to give personal consent;
- Participants who were willing to partake in the study.

3.4.2 Exclusion criteria

Criteria considered for exclusion in the study were the following:

- Rehabilitation professionals, rehabilitation assistants, rehabilitation community care workers;
- Children under the age of 18 years.

3.5 Data collection methods

Data collection methods are explained in two phases, namely document reviews, followed by workshop and focus group discussions (FGDs).

Document reviews, workshops and focus group discussions were conducted by an appointed research assistant. This was done to reduce any possible bias by the researcher. The researcher trained the research assistant by means of formal meetings and training sessions to discuss the data collection methods of the study, namely folder collection and document reviews, communication with participants and execution of workshops and FGDs. The research assistant received specific training on how to conduct the document reviews, workshops and FGDs (see Appendix A).

3.5.1 Phase 1: Document reviews

At each selected CHC, patient folders were used as the primary source of data collection. The information was extracted from clinical folders of potential patients to be included in the study to confirm whether they have been seen by two or more rehabilitation professionals as well as to check what their current medical conditions were. Record and document review involves systematic data collection from existing records. Documents that may be used for systematic evaluation as part of a study take a variety of forms. The analytic procedure entails finding, selecting, appraising (making sense of), and synthesising data contained in

documents (Bowen 2009). Documents provide background information as well as past insight. This information and understanding can help researchers recognise the historical roots of detailed issues and can indicate the conditions that impose upon the phenomena presently under investigation (Gill, Stewart, Treasure & Chadwick 2008).

3.5.2 Phase 2: Workshops and focus group discussions

Workshops

In order to engage stakeholders, workshops are a common strategy used in the research cycle (Hennink, Hutter & Bailey, 2010). During this phase of the present study, a workshop was agreed upon by the researcher and supervisors. Before the commencement of the workshops at each centre, information sheets about the study (see Appendix B) were distributed and explained to participants. The workshops were held to inform participants about the current healthcare plan 2030, as a basis to describe and explain the new rehabilitation model proposed by Mlenzana (2013) and how it could benefit the public in the future. The workshops were facilitated using question-and-answer sessions for participants to understand the concepts and engage in the workshops. Participants were advised that this research study was not designed to help them personally, but that study results may help the investigator learn more about the problems faced in rehabilitation services as experienced by patients themselves.

Focus group discussions

The research assistant received training from the researcher on the interview guide to be used to answer questions in the FGDs. In this phase, the research assistant developed the necessary skills to successfully lead an FGD in isiXhosa, English or Afrikaans. Each FGD lasted for approximately 30 to 45 minutes and was conducted between February and March 2017 at the three selected CHCs. The workshop and FGDs were conducted on the same day. FGDs were suitable and relevant to the research topic, as communication and data collection in a group setting was easier than in an individual setting. According to Verd (2004), participants' responses are easily measured through social engagement as individuals are more comfortable to engage in a larger group of people. FGDs are as beneficial as the interaction between individuals, to explore a specific set of issues (Kitzinger, 1994). They are thus helpful to generate an overall understanding of participants' experiences and beliefs (Watts &

Clifton 2006). The focus groups were conducted in an environment which was familiar to the participants. This helped them to feel comfortable as the setting of the FGDs was informal and relaxed.

At the start of the discussion, the participants were informed (information sheets) about the confidential nature of the discussions, that there was no harm associated with the study, and that they could leave the discussion at any time. The FGDs were recorded using an audio-recording device in order to be transcribed and qualitatively interpreted from isiXhosa and Afrikaans to English. A backup audio-recording device was also used in case the other device became faulty. In this way, data collected could be played and listened to several times by researcher, research assistant and supervisors. Saturation was ensured as FGD participants were asked the same questions that appeared on the standard interview guideline (see Appendix C). According to Guest, Bunce & Johnson (2006) interview questions should be structured to facilitate asking multiple participants the same questions, otherwise one would not be able to achieve data saturation, as it would be a constantly moving target.

3.6 Data collection tools

Data collection tools used in this study were document reviews, workshops and focus group discussions. These tools were used by the trained research assistant to obtain demographical and qualitative data to be used in this study.

3.6.1 Document review

The document review consisted of a data-capturing sheet in order to obtain the demographics of participants of this study (see Appendix D). This tool helped with obtaining demographic data for statistical purposes, namely age, gender, diagnosis and rehabilitation professionals who were involved in the management of the participants. The data-gathering instrument was developed by the researcher based on the study objectives and the researcher's experience.

3.6.2 Workshop

A lecture format guide (see Appendix E) was used in the workshop to engage participants by explaining healthcare 2030 in relation to the new rehabilitation model, in the simplest possible manner. Layman's terms were used as a style of communication to ensure understanding, in that terms were in plain language with an emphasis on clarity, brevity, and avoidance of overly complex vocabulary (Zarcadoolas, Pleasant & Greer 2009).

3.6.3 Focus group discussion

Each focus group followed the same structure. In order to explore perceptions and expectations of participants regarding the new rehabilitation model, open-ended and non-directive questions were employed. Probing questions following the open ended and non-directive questions were used to attain detailed and comprehensive descriptions of their perceptions. The order of the discussion and the number of questions discussed was dependant on the dynamics within the group and the time available, although an interview guide was used in the FGDs as previously explained (see Appendix C). The use of open-ended questions was appropriate for the research study. This is because this style of questioning allows the participant to fully supply an answer without prompts or options. According to Babbie and Mouton (2009), exploratory studies should use open and flexible strategies in order to collect data.

3.7 Data collection procedure

Permission and ethics clearance (see Appendix F) from the Ethics Committee of the University of the Western Cape (project no. 15/7/91) and the WCDoH (see Appendix G) was obtained to conduct the research study. Following this procedure, the facilities and facility managers were contacted to schedule information sessions in order to explain to them the aim of the study, what it would entail and how the facilities would be used. These sessions were also used to gain permission from the facility managers for access to patient folders in order to obtain the relevant information to recruit participants for workshops and FGDs happening on the same day.

Participant information had to be obtained from the patient folders to ensure participants met the inclusion criteria. However, details of patient contact information had not been updated; therefore, patients had to be accessed directly. While patients sat in waiting rooms and other quiet areas of the CHCs, they were approached by the research assistant to ask whether they were willing to partake in the study.

On days of the workshops and FGDs, patients were asked to complete consent forms and focus group confidentiality binding forms (see Appendices H and I). Participants were informed about the research study, data collection methods and about their choice to participate in the study. The consent forms, information sheets and focus group confidentiality binding forms (see Appendices H, B and I) were language-appropriate and easy to read in isiXhosa, English or Afrikaans. Participants were made aware that their

participation may stop at any time if they chose to withdraw, without any negative consequences. They were reassured that their choice to partake or discontinue would not affect their rehabilitation services at the CHCs.

Workshops were conducted by the appointed and trained research assistant as explained under section 3.6.2. Following the workshop, after a short break of 15 minutes, the FGD commenced. The research assistant used a standardised interview guide to lead the focus group that consisted of open-ended and non-directive questions with the use of necessary probes to produce descriptive responses from participants.

3.8 Data analysis

The data analysis of this study was compromised of two sections namely, quantitative and qualitative data analysis which was used to interpret the findings of this study.

3.8.1 Quantitative data analysis

The files of participants were obtained at each CHC by which the research assistant gained information relating to the participants' medical condition, age, gender and rehabilitation services accessed at each centre. The data obtained was documented on a data collection sheet (see Appendix D).

Quantitative analysis aids to allow for enrichment of the results of a study to support the generalisations of the singularity in the study (O'Neil, 2006). It generally involves counting or quantifying of variables to draw conclusions. Owing to the descriptive nature of this study, data obtained was presented in the form of standard tables. The advantage of standard tables assists with the ability to structure, summarise and display large amounts of data (Lozovsky, 2008). The tables assisted with the representation of participant, age, medical condition and rehabilitation attendances to each rehabilitation professional. These values were represented in frequencies and percentages which were then descriptively interpreted.

3.8.2 Qualitative data analysis

Content analysis was used as a method of analysing the data obtained from participants. This method aids with making speculations by analytically and objectively recognizing distinct components in data (Groves, Burns & Gray, 2012). In this way, the technique deemed to be effective as it used valid and replicable clarifications to interpret and code textual material. It is essentially a "coding operation" with coding being a process of transforming raw data into

a standardised form (Kohlbacher, 2006). The data analysis was completed according to Creswell (2003) operative method of qualitative data analysis by making sense of transcript data continually. During the data analysis phase, data was collected and obtained through having FGDs at each CHC included in this study. The FGDs were audio-recorded on each occasion. In order to make sense of data obtained, audio-recording machinery was played numerous times in order to understand what was being perceived from the patients as well as to understand their expectations. The data obtained was transcribed verbatim in isiXhosa, Afrikaans and English, followed by a procedure of qualitative interpretation into English. The data transcription was read carefully to identify words, phrases and sentences that were labelled with codes that captured meaning and that was in line with the objectives of this study. According to Marshall and Rossman (1999), content of the transcribed notes needs to be read repeatedly, and the audio tapes need to be listened to several times in order to understand the data.

Following this procedure, the data was screened and checked for errors before following a trustworthiness process to ensure that meaning of data obtained was not lost in the analysis process. In this analysis phase, the raw qualitative data is collected as part of the research and is used to provide explanations, understandings and interpretations of the phenomena of the participants and current situation (Gil et al., 2008). In this way, themes and categories were grouped. Direct quotes were obtained for qualitative and narrative purposes to gain a direct feel for patients' perceptions regarding the newly proposed rehabilitation model. The analysis was initiated by asking practical questions in order for the researcher to understand the message implanted in the data collected. Practical questions were: "What is going on?" and "What are the main issues and concerns participants are facing in the CHC?".

These questions helped as an investigative tool when identifying processes and disparities to recognize and link the codes and categories of the data. The analysis method was checked and reassured by the supervisors assigned to the study in order to continue with thesis the write up.

The use of memos played a key part in every step of the analysis process as short memos were made initially to capture first impressions of the FGDs. Memos were used to track the emerging categories. After continuous analysis by researcher and research assistant, no further data was obtained, signifying theoretical saturation.

3.9 Trustworthiness of qualitative data

Lincoln and Guba (1985) mention the four criteria which are used to ensure the trustworthiness process of qualitative data collection. These are credibility, transferability, dependability and confirmability as discussed below.

3.9.1 Credibility

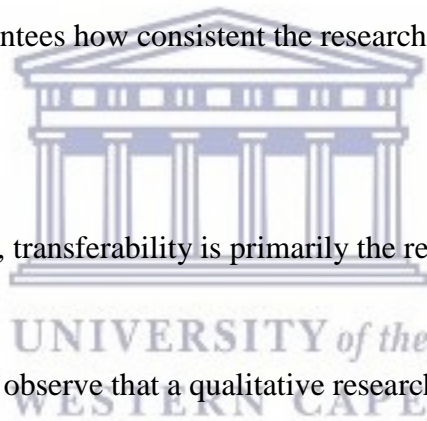
Audio tapes were played back to participants at the end of each FGD to ensure credibility of this study. Field notes were documented while FGDs were conducted and information was probed during interviews until data was saturated. A descriptive summary of each FGD was documented by the research assistant to clarify the data obtained from participants as well as confirmation of the data collected.

According to Smith (2004), this process allows for the reassurance of data provided. The qualitative data was believable from the viewpoints obtained from the participants in the research. The credibility guarantees how consistent the research findings are with reality (Shenton, 2004).

3.9.2 Transferability

From a qualitative perspective, transferability is primarily the responsibility of the researcher (Marshall & Rossman, 1995).

Marshall and Rossman (1995) observe that a qualitative researcher is able to improve and enrich transferability by comprehensively describing the research context and expectations that are essential to the research. This means that if a researcher wants to transfer the results to a different context, the researcher is then responsible for the judgment of how sensible data is. The qualitative data is usually specific to a small group of individuals in a setting (Shenton, 2004). The participants in the current study were purposively selected with diverse characteristics. The FGDs were used to strengthen the qualitative part of this study in order to gain perceptions, expectations and opinions from participants regarding their experiences of rehabilitation service delivery and the newly proposed rehabilitation model. The findings and outcomes of this study are not applicable to any other population, setting or to a broader population.



3.9.3 Dependability

Dependability refers to evidential similarity of findings if the process were to be repeated. This aspect of trustworthiness provides evidence that similar findings would be obtained if the process was to be repeated. Dependability in qualitative research is defined as the stability of data over time and over conditions (Lincoln & Guba, 1985). Shenton (2004) observes that this method would be plausible if the same participants and approaches were to be used in a similar setting. It is an evaluation of the integrated processes of data collection, data analysis and theory generation (Lincoln & Guba, 1985). A code-recode procedure of interpreting the data is used to ensure dependability. The code-recode procedure refers to how the researcher codes the same data twice by giving it at least two weeks maturation periods between each coding (Anney, 2014). This is then followed by comparing the two results to see which ones are the same and which differed (Chilisa & Preece, 2005). The researcher scrutinized the recorded interviews and transcripts using this procedure to improve understanding of participant narrations. Clarification of results is then provided to deliver descriptive recommendations of the research study. According to Shelton (2004), the same study should produce similar results, if repeated by another researcher using similar procedures. The idea of dependability emphasises the need for the researcher to account for ever-changing contexts within which research occurs.

3.9.4 Confirmability

Confirmability refers to the degree to which the results could be confirmed or verified by others (Lincoln & Guba, 1985). Qualitative research assumes that every researcher brings a unique aspect to a study.

To ensure confirmability of the study, field notes, recorded data and analysis of qualitative findings were submitted to the study supervisors. Reviews were conducted by the study supervisors at all stages of analysis of findings. The data collection and analysis procedure were described in detail so that the research trail could be followed easily. The findings and conclusions were therefore reasonable in relation to the research material (De Vos, 2002).

3.10 Ethics

As previously noted, this project received ethics clearance from the University of the Western Cape Research Ethics Committee, and the required permissions from the WCDoH, facility managers and participants. The participants were well informed that their participation was

entirely voluntary and that they could withdraw at any time without influencing their treatment in any way.

The purpose of the study was explained to the participants; an information sheet regarding the study was provided for clarity regarding any questions they had. Participant consent was obtained in the recording of FGDs. Anonymity and confidentiality was maintained by omitting the names of any participants or centres during the interviews. Participants were assured that the information obtained in FGDs was strictly confidential and would be kept locked in a safe after the interviews.

The results of this study will be made available to all stakeholders at the three rehabilitation centres and to the District and Provincial Health Offices of the Western Cape.

3.11 Report of centres

A research assistant was appointed to conduct the data collection in this study. The research assistant was required to give feedback regarding the context of each of the CHCs relating to the atmosphere, setup and response of each centre. These reports are presented below.

Centre A:

On approaching the centre, the research assistant could see patients queuing outside to obtain their medical folders. Inside the clinic, patients and participants were seated in waiting rooms, awaiting their treatments. Patients willing to partake in the study moved to the waiting room of the physiotherapy department which was chosen as a quiet and comfortable environment to conduct the workshop and FGD. Following the workshop, a break was taken before continuing with the FGD. Participants were predominantly Afrikaans-speaking individuals over 35 years of age. The participants at the centre were unhappy about the services at the centre but felt they had no right to complain as patients at other clinics in the area were worse off. They understood what the new rehabilitation model was but were not convinced that the current situation would ever change.

Centre B:

This centre was extremely full; some patients were standing, and some were sitting on the benches or on the floor. Patients participating in the workshop and FGD were all seated in a health promotion room, waiting for rehabilitation services. This group was predominantly Afrikaans-speaking with one English-speaking individual; all were more than 40 years of

age. Patients at this centre were preoccupied with their own problems in addition to being frustrated with the long waiting times at the centre. Although initially they were not eager to partake in the workshop and FDG, participants were encouraged by motivation from the research assistant, explaining why their feedback would be beneficial.

Centre C:

This centre was moderately full; there were several empty seats and a few queues of patients waiting to receive their folders. The participating patients were all sitting in the physiotherapy waiting room when the research assistant approached them. They were predominantly isiXhosa- and English-speaking, over the age of 40 years. One participant was wheelchair-bound. These participants were very pleased with the rehabilitation services they were receiving at the centre. They understood and appreciated the new rehabilitation model but were despondent about their current health problems and day-to-day situations. These patients were frustrated that doctors were not listening to them – a point that was emphasised repeatedly in the FGD.

3.12 Summary

This study employed an explorative study design using qualitative methods of data collection. This method was utilised to qualitatively respond to the study objectives which cover the aim of the study. The study was conducted at three selected CHCs in the Western Cape province of South Africa. Participants were purposefully selected as having been attended to by a minimum of two rehabilitation professionals to reduce possible bias. The sample size of the group was 31 participants. These participants attended information workshops prior to FGDs in which qualitative data was recorded. The data described their expectations and perceptions regarding a newly developed rehabilitation model encompassing the vision of healthcare plan 2030. The data recorded in FGDs was transcribed and analysed. The themes which emerged from this analysis are discussed in Chapter 4.

CHAPTER 4

RESULTS AND DISCUSSION

4.1 Introduction

This chapter details the findings in terms of the objectives of the study, namely to obtain perceptions and expectations of patients regarding a newly developed rehabilitation model. The findings are presented in two sections. First, the quantitative report - profiling and demographic characteristics of participants are presented; thereafter, qualitative report - the emerging themes and categories developed from the qualitative data analysis are explored.

4.2 Characteristic profile of the participants

Of the folders accessed, 31 records were identified as being suitable to be included in the study. The identified participants were 16 males (52%) and 15 females (48%). The participant's ages ranged from 35 to 65 years with a mean age of 44 years. Disabilities ranged from fractures, right or left hemiplegia, amputations, osteoarthritis and neuromuscular conditions. The characteristics of the participants are listed in table format (see Appendix J). The rehabilitation professionals who attended to the needs of the participants at the selected three CHCs were doctors, nurses, pharmacologists, occupational therapists and physiotherapists.

4.3 Treatments and management of conditions according to literature

In order to understand the access patients have to rehabilitation professionals at community health centres; treatments and management is relevant to gain the importance of rehabilitation services. Below, treatments and management received by participants are highlighted, supported by the relevant literature indicating what the management of these conditions should be. The management according to literature below show why there is a need for rehabilitation professionals to fulfil patients' functional capacity for social integration back into their homes and communities. Conditions relating to amputation, osteoarthritis, fracture, left or right hemiplegia and neuromuscular conditions are discussed in terms of their treatments and management according to literature.

4.3.1 Amputation

Management

Doctor – is responsible for standard check-ups, pain management, follow-ups after surgical intervention.

If a referral is needed for further surgical intervention, the doctor refers patient back to tertiary hospital institutions to vascular surgeons.

Nurse – administering of medication, mobility, assistance with activities of daily living.

Physiotherapist – functional mobility and strengthening, assisting in the use of teaching how to utilise assistive devices, general exercises to maintain good blood flow and joint range of movement.

Orthopaedic nurse – assisting in the issuing of orthotic devices.

Occupational therapist – teaching activities of daily living, work assessments, general mobilisation and teaching of stump bandaging

Social worker – helping patient deal with social issues, making provision for finding a rehabilitation facility if needed, making the needed arrangements at patient's place of employment.

Dietitian – assisting with proper guidelines of food intake, diet and future dietary goals.

Management according to literature

According to Esquenazi (2004), functional and optimal rehabilitation of the amputee begins prior to the amputation which should be provided by a specialised multidisciplinary rehabilitation team. The rehabilitation team is then needed to effectively communicate with one another, with the patient as well as the caregivers in order to provide the necessary information to develop a holistic treatment plan from amputation to home discharge.

4.3.2 Osteoarthritis

Management

Doctor – is responsible for administering conservative management (pain management). If surgical intervention is needed, doctor will refer patient to orthopaedic surgeon at a tertiary hospital institution.

Nurse - administering of medication plus necessary tests (blood tests).

Physiotherapist – general strengthening and mobility exercises, such as hydrotherapy. The physiotherapist is also responsible for assisting with exercises in order to deal with daily pain experienced.

Occupational therapist – assisting with braces or splinting, adjusting home environments to make activities of daily living much easier.

Dietitian – providing dietary guidelines.

Management according to literature

Davis and McKay (2013) refer to physiotherapists, nurses, orthopaedic sisters and surgeons predominantly being in a rehabilitation team to work out an exercise plan pre- and post-operatively in order to maintain function, improve muscle strength and reduce pain. Nurses manage the pain with the administering of medication as prescribed by doctors or surgeons; orthopaedic sisters help with fittings of braces as well as functional orthopaedic devices, while orthopaedic surgeons surgically manage the patient's medical condition if other methods of treatment have not been viable.

4.3.3 Fracture

Management

Doctor – prescribe pain management, standard check-ups to follow up whether fractures are healed.

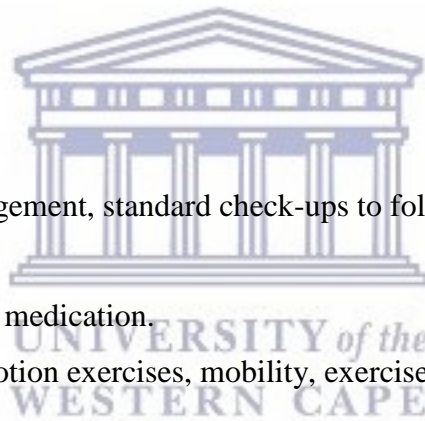
Nurse – administering of pain medication.

Physiotherapist – range of motion exercises, mobility, exercises, home exercise programmes.

Occupational therapist – improvement of activities of daily living; splinting if needed.

Management according to literature

Crotty, Whitehead, Gray and Finucane (2002) recommend doctors, surgeons, physiotherapists and occupational therapists as the main members of the rehabilitation team. These authors state that, after the commencement of a surgical or conservative intervention to this injury, patients should be able to improve their functional capacity in terms of mobility with the help of a physiotherapist. In order to be discharged home, home environments will need to be adjusted to achieve the best outcome of the patient's rehabilitation goals.



4.3.4 Left or right hemiplegia

Management

Doctor – administering standard follow-ups necessary for management of risk factors (smoking, cholesterol, hypertension, diabetes etc.), pain management and needed referrals for necessary follow-up appointments with multidisciplinary team, and referrals to tertiary hospital institutions if further medical intervention is needed.

Nurse – administering of pain medication, necessary blood tests, blood pressure tests, blood sugar tests etc.

Physiotherapist – rehabilitation in the aspect of mobility, strengthening, independent activities executed with the maintenance and improvement range of movement in all limbs.

Speech therapist – improving necessary speech deficits such as aphasia, swallowing, chewing of food, speaking, exercising the facial muscles.

Dietitian – providing patients with the necessary dietary guidelines to sustain a healthier lifestyle; improving dietary habits; assisting with the necessary information needed for patient's diet.

Occupational therapist – assists with improving patient's strength to perform and re-learning of activities of daily living such as brushing hair, eating and dressing.

Social worker – assisting patient with social issues, with disability welfare grants if patient is unable to return to work, and with placement for rehabilitation if patient's family/caregivers are unable to assist patient at home.

Management according to literature

Langhorne, Bernhardt and Kwakkel (2011) state that a full rehabilitation team is needed to manage a hemiplegia patient efficiently. Substantial evidence supports multidisciplinary team care as the basis for delivery of stroke rehabilitation.

The study by these researchers concludes that treatment from a physiotherapist, occupational therapist, speech therapist or multidisciplinary team in patients with strokes who live at home could prevent deterioration in activities of daily living.

4.3.5 Neuromuscular condition

Management

Doctor – provides standard follow-up consultation, pain management, assists in referring patient to physiotherapist for rehabilitation. If rehabilitation fails, patient is referred from the doctor to the orthopaedic surgeon at a tertiary hospital institution.

Nurse – administering of pain medications, blood tests, blood pressure tests, blood sugar tests etc.

Physiotherapist – responsible for rehabilitation in the sense of improving mobility, decreasing pain, strengthening muscular structures, home exercise programmes.

Management according to literature

Following optional surgery intervention, Tyler and McHugh (2001) recommend physiotherapy as the best source of rehabilitation in the restoration of muscular structures to return to previous level of functioning through strengthening mobility, proprioceptive and weight-bearing training.

4.4 Overview of utilisation of rehabilitation professionals at selected community health centres

To fully understand how rehabilitation services were used at the centres, Table 4.1 below indicates the how many of the participants made use of each type of rehabilitation professional percentage of rehabilitation professionals utilised at each centre. This was represented according to each centre's sample size.

Study participants at all CHCs had access to a medical doctor; nursing was also commonly accessed at each of the centres, but physiotherapists and physiotherapy assistants were not equally called upon at all CHCs. At centres A and B physiotherapists were underused, while at centre C, physiotherapy services were fully utilised. However, this finding may be linked to a poor referral system which is not inclusive of all the necessary services that would benefit a patient. The occupational therapist and occupational therapy assistants were underused by all three centres. This may once again be the result of a weak referral system, as occupational therapy would greatly benefit these patients.

Speech therapy as a service was not provided at centre A. However, no participants at centres B or C made use of this service, perhaps owing to a weak or non-existent referral system. Similarly, dietetics services were not used at centres A or B, possibly for the same reason, while centre C did not provide this rehabilitation option. The orthopaedic sister was accessed

only at centre C. At centre A, the orthopaedic sister was not called on, while centre B offered no orthopaedic assistance.

Table 4.1: Analysis of participants' use of rehabilitation according to type of rehabilitation service

Centre	Doctor	Nurse	Physio-therapist	Occupational therapist	Speech therapist	Orthopaedic sister	Dietician
A	100% (n=10)	100% (n=10)	50% (n=5)	50% (n=5)	N/A	0%	0%
B	100% (n=13)	92% (n=12)	46% (n=6)	46% (n=6)	0%	N/A	N/A
C	100% (n=8)	87% (n=7)	100% (n=8)	37% (n=3)	0%	37% (n=3)	N/A

4.5 Qualitative report - Overview of identified themes

The purpose of this study was to explore **perceptions** and **expectations** of patients regarding a new rehabilitation model to encompass the vision of the healthcare plan 2030. At each centre in which FGDs were conducted, participants engaged in groups to give feedback according to a standardised interview guide used by the research assistant. The audio recorded FGDs was played numerous times to understand the raw data. The data was transcribed verbatim to be qualitatively interpreted into English. The transcription was read cautiously in order to recognize words, phrases and sentences that were labelled with codes that captured meaning and rendered with the aim of the study. The data was then screened and checked for errors before following a trustworthiness process. In this way, themes and categories were grouped which accorded with the aim of this study. Following the analysis of the qualitative data collected, two themes emerged. These themes are: the need for change and resources.

4.5.1 Perceptions of patients towards the new rehabilitation model

Overall, responses from participants were positive; participants expressed excitement about a change being implemented in the future. Participants made sure to mention the need for change and an improvement in services received at their community health centres.

“...Yes please, it will improve the services at the clinic...”. (P2)

“...Yes, yes, yes! We need change...”. (P4)

4.5.2 Participants’ expectations of the new rehabilitation model

It was evident that patients had high expectations of this model and were looking forward to seeing a change in the way services were delivered at the CHCs.

The main themes that emerged were the need for change and resources in terms of patients’ expectations of the new model. These findings are discussed under the following themes and categories identified in Table 4.3.

Table 4.2: Themes and categories identified

Themes	Categories
The need for change	Waiting time Outreach to the community Attitudes Patient-centred approach
Resources	Government funding Clinical management

4.5.2.1 The need for change

The need for change was emphasised intrinsically in terms of attitudes and a patient-centred approach, and extrinsically in terms of waiting times at the centres and outreach to communities.

Attitudes

Participants reported that staff members working at the centres were impolite and disrespectful. Concerns were voiced in relation to the lack of people skills demonstrated by clinical staff in their approach and handling of patients attending the clinics. Participants said they had experienced feelings of being disrespected and belittled. Some were frustrated by being “spoken down to” by staff.

“... We people have rights; they can respect us and treat us like people. I am not a child. They shout at big people, you understand?”. (P6)

“... The receptionist shouts at you for being five minutes late! They should have more respect...”. (P12)

Participants complained that the “first come, first serve” principle was ignored, which was patently unfair treatment from a government institution. An excerpt from a participant's comment follows.

“... When I go to get my treatment, the sister tells me to wait when I'm before other people. It should not work that way!”. (P9)

To have a good operating system in any domain, equality in service delivery should be valued. The results of this study in relation to the theme indicate a crisis in the rehabilitation services faced at these centres. According to Crisp (2000) and Swain and French (2001), findings of their studies showed that PWDs can experience their rehabilitation services negatively if the relationship between the patients and rehabilitation professionals are ineffectual, dehumanising or abusing. If service providers show negativity to the patients, service delivery will in turn be poorly rated by the patients (Cockcroft, Milne, Oelofsen, Karim & Andersson, 2011). Argentero, Dell'Olivo, Santa Ferretti and Burnout (2008) agree that patients' satisfaction with rehabilitation services will be affected if rehabilitation staff are in poor emotional states. This suggests that rehabilitation professionals should always try to have a positive attitude towards patients which will help to improve and uplift the patients

and quality of services delivered (Satchidanand, Gunukula, Lam, McGuigan, New, Symons & Akl, 2012).

Henderson and Tulloch (2008) emphasise the need for service providers to have a good attitude and to be knowledgeable and skilled to deliver quality care to the patients. Patients want to feel appreciated and treated with respect and dignity, especially when they need rehabilitation services. According to York, Ruediger and Volkenberg (2017), attitudes of healthcare professionals towards people with disability can impact on their healthcare. The authors also conclude that educational strategies can be used in professional curricula to facilitate the development of positive attitudes.

Severson (2017) suggests methods to improve attitudes within the workplace. Some of these are: establishing goals for all members of the team, constructive delegation of ownership of projects to staff members, incorporation of regular meetings for feedback sessions, verbal recognition for work completed, team-building exercises and inclusion of an external consultant to boost workplace attitude if there are time constraints.

Saari and Judge (2004) point out the need for human resource management to develop effective research-based employee attitude measures, to understand and derive valuable insights from data and to use the results to improve employee attitudes and service delivery. The need to improve, understand and measure attitudes in the workplace is essential for an efficient operating system. In addition, WHO suggests providing training sessions on the social determinants of health to policy actors, stakeholders, practitioners and promoting public awareness. The improvement of social determinants of health will help to improve health and help move in the direction of meeting the needs of all human beings (Marmot, 2005).

Patient-centred approach

Participants said that rehabilitation professionals need to listen to their concerns and to address their main medical problem. Participants felt that with the new rehabilitation model and patient-centred approach, respectable and stronger client–professional relationships could be built to reinforce improved treatment and delivery of quality care.

Participants felt hopeful and excited that the new rehabilitation model could benefit them if rehabilitation professionals take the necessary time to listen to their patients. Participants noted that not all rehabilitation professionals involved them in education about their illness,

decision-making process and progression of treatment. Participants fully understood how the new model could benefit them in the future with making treatments patient-centred and more focused around the problems they dealt with daily, as the quotations below indicate.

“...The new programme? I recommend it, it’s good. Only if the doctors will listen to us...”. (P2)

“...It’s also the understanding between you and your doctor ‘cause with this now [new rehabilitation model] you got the platform to negotiate what you feel is good for your health...”. (P5)

“... When you get in that relationship, your doctor now becomes sort of a friend to you...”. (P3)

In relation to the new rehabilitation model, participants were extremely hopeful and excited about having a more patient-centred approach in which there would be shared decision-making. Having participated in the workshops, participants understood how the new rehabilitation model would benefit them, making the treatments they received more patient-centred. They expected that if there was more teamwork, quality care would be executed in the clinical setting. This in turn would satisfy all parties. The UNCRPD (2006) states that PWDs have the right to knowledge and education of their medical conditions. Cott (2004) also mentions that a patient-centred philosophy takes goals and expectations of the patient into consideration to reflect the individual’s life circumstances. The attitudes of service providers in addition to patient’s responses are the determining factors in the outcome of delivering knowledge and advice to patients (Bergsten, Bergman, Fridlund & Arvidsson, 2011).

Jesus and Silva (2016) and Brez et al. (2009) maintain that communication is key within the rehabilitation setting as it provides clarity and a respectable understanding of rehabilitation. The four most important elements to rehabilitation communication are knowing the person and building a supportive relationship in relation to their treatment, effective information exchange, shared goal and action planning as well as fostering a positive, yet realistic attitude within the clinical setting (Jesus & Silva, 2016). A positive consultation according to Bergsten et al. (2011) consists of an involved relationship which focuses on mutual respect and shared decision-making.

Epping-Jordon, Pruitt, Bengoa and Wagner (2004) point out that the burden of chronic diseases in healthcare organisations is continuously increasing; organisations are not fully equipped to meeting the needs of care owing to time constraints, patient overload and limited staff. Mead (2000) reports that there is no standard measure for patient-centredness; further interventions are needed to improve and promote patient-centred care. Training rehabilitation professionals in patient-centred approaches may assist in patient satisfaction with rehabilitation services (Lewin, Skea, Entwistle, Zwarenstein & Dick, 2001). Meeting the new demands of healthcare by putting patients at the centre of care, will help to achieve goals of self-management for patients. To fully achieve patient-centred care, discussions throughout the entire healthcare organisation are needed, not being limited only to the patient-provider interaction (Bergsten et al., 2011).

The researcher recommends that participants in this study should be allowed the needed time and attention relating to their medical conditions to have functional rehabilitation. If decent communication, appropriate goal-setting and adequate information exchange can happen, change can occur for the patient as well as for rehabilitation services at these clinics.

Waiting times

There was a general concern among the participants when asked what they disliked about the services at the centres. Most participants considered the waiting times to be far too long before their treatments and service delivery. This was emphasised in all the FGDs, especially by participants who had to return to work later in the day.

“...We sit whole day (at the clinic) and the boss gets angry because I take long when my appointment was early morning...”. (P13)

Participants were frustrated about having to take a leave of absence the next day if they could not be helped on the day of their appointments. Some great frustrations were voiced as participants were not helped on the very same day of their appointment date owing to patient overload at the CHCs. In some cases, participants had to take two days' leave from employment to be helped by a rehabilitation professional at the centres. Difficulties were also caused by restrictive operating times at the CHCs.

“...It’s bad and now I need to take off from work tomorrow. The boss gets angry...”. (P5)

Participants also raised concerns of clinical staff that never apologised or explained why their appointment times ran late or were set to continue into the next day.

“... A person comes early morning and sits for hours. No one says anything. You just wait whole time...”. (P4)

A study by Hardon, Akurut, Comoro, Ekezie, Irunde, Gerrits and Moroka (2007) showed that health workers have heavy workloads and waiting times are lengthy.

Reagon (2006) and Mavuso (2008) note that in addition to staff overload, waiting times at PHC facilities are long as a consequence of poor prioritising of patients, lack of equipment, patients arriving in large numbers, patients arriving earlier than the rehabilitation professionals, lack of equipment and supplies (logistic problems), illogical order of attending to patients at a high service time (Mavuso, 2008; Reagon, 2006).

As possible solutions, Mavuso (2008) proposes that spare capacity can be used to increase service time and therefore improve quality of care, reviewing of the policy of limiting daily intake of patients, and that clinical management could take advantage of staff capacity to improve quality of care with updated training. An additional approach suggested by Hardon et al. (2007) is to have evening and early morning clinics. However, this would burden healthcare workers as they would be extremely overworked. Hardon et al. (2007) also refer to having workplace policies implemented to include provisions for patients to take time off work to attend to their treatment needs. Waiting times at CHCs are of great concern. Extended clinical hours, closer appointment dates and additional appointment of administrative and rehabilitation professionals should be considered to address this challenge and deliver the best possible care at an acceptable rate.

Outreach to the community

Participants felt that rehabilitation services needed to go out into the community as some patients are not always able to reach the clinic as they are too sick to walk or do not have the necessary resources to get to the clinic.

“...And they can come out into the community a bit more. The people are too sick to come all the way to the clinic...”. (P4)

Patients in the community who need to attend the clinics do not always have caregivers and helpers to assist them to attend the CHC.

“...Yes, people are too sick to come all the way to the clinic just to wait for hours before being helped...”. (P9)

“...If it is so [the new rehabilitation model], then it will benefit a lot in the community...”. (P1)

Rule, Lorenzo and Wolmarans, (2008) state that a broader understanding must recognise rehabilitation as an enabling service to promote poverty alleviation, community participation, economic empowerment and development and survival of PWDs to improve services at all levels of care. When visiting a CHC, different dimensions need to be taken into consideration, namely availability, geographic accessibility, affordability and acceptability (Eldar, 2004). Some patients are unfortunately not able to utilise CHCs owing to these factors.

It is however evident that rehabilitation is more effective and efficient when the patients are in their own environment (Wade 2003). Wade (2003) suggests that there should be a balance of advantages in the delivery of services in the patient's home to weigh against problems that may arise concerning the practicality and the equitable use of professional staff time. Stressors and challenges of patients should be addressed in their communities to improve their social integration and their rehabilitation progress (Jones, Charlesworth & Hendra, 2000). Le Roux, Le Roux, Mbewu and Davis (2015) suggest mention that using a community health worker home intervention would be beneficial as a model to re-engineer the PHC system in South Africa.

The community health workers providing rehabilitation services in the community should have supportive and structured supervision from rehabilitation professionals to efficiently deliver a good service (Gilmore, MacLachlan, McVeigh, McClean, Carr, Duttine & Hem, 2017). Le Roux et al. (2015) specify that success can be achieved through the building of relationships with health teams at various levels and sharing goals and supportive clinic and hospital leadership. This could achieve the goal of having well trained, supervised and supported community health workers to deliver quality care within the PHC system.

Under-resourced CHCs require a cohesive system which assists community health workers to formalise services for quality service delivery. Gilmore et al. (2017) observes that task-shifting is a necessary tool for community health workers to bring services into the community, especially in under-resourced areas. Community health workers do however require training in medical and clinical knowledge, referral techniques, record keeping, case management, counselling techniques, mental health referral mechanisms and community advocacy and empowerment (Gilmore et al., 2017).

Community health workers are managed by various non-governmental organisations which are sponsored by different donors. There is however still minimal standardisation of the roles of these community health workers or of their training and supervision.

Coovadia, Jewkes, Barron, Sanders and McIntyre (2009) mention that disagreement remains evident whether community health workers should be volunteers or remunerated workers. In addition, the National Community Health Worker Policy framework, implemented in 2004, makes provision for community health workers who are paid an income by provinces through non-governmental organisations (SADoH, 2009). Despite implementation of models, community workers require appropriate resources and compensation for job performance (Gilmore et al., 2017). There has, however, been a shortage of community health workers owing to geographical inequities in the distribution of health workforces. Rural regions and poor regions end up suffering because qualified health professionals are primarily based in urban areas (El Arifeen, Christou, Reichenbach, Osman, Azad, Islam & Peters, 2013). As a result, this has led to proliferation of informal and unqualified health workers who now serve most of the rural population.

Fuzikawa (2008) states that the benefit of rehabilitation in the community is limited to persons with moderate disabilities who can communicate with the rehabilitation worker. The patients with severe disabilities are not always able to state what their problems are and need the help of the caregiver, who is not always able to understand the medical problem.

There is an immense need for volunteers, community workers and rehabilitation professionals to reach out and go into communities to provide the necessary quality care which patients are entitled to. Equal distribution of qualified health professionals means that patients in rural and urban areas need to be cared for, by providing a wide range of community outreach programmes at an attainable level.

4.5.2.2 Resources

Clinical management

Participants commented that CHCs were short-staffed, lacking skills and training. It was understood that a specific set of skills was needed by staff in file management, to help patients in the centres to reduce their long periods of waiting in line. They believed the filing system was part of the problem, causing long delays before they could move on with their clinical visit for rehabilitation services.

“...The filing, I think, they must get some people that are specialising especially on the file ‘cause that is where people wait a long time... maybe get more people to do the filing...”. (P12)

“.... Before you go see the doctor, then you first have to wait in line, and you wait so long just to get the file then wait in another queue for the doctor to help you...”. (P16)

Participants mentioned that clinics are short-staffed and that rehabilitation professionals may be absent from work, leaving the patients unattended and waiting for another appointment date to commence treatment.

“...Here they simply say the people [rehabilitation professionals] are sick today and that we need to return tomorrow just to wait long once again...”. (P10)

The public health sector has been critically affected by maldistribution of staff and inadequate skills training of clinical staff which has compromised the delivery of acceptable services (Coovadia et al., 2009). This affected policy decisions such as the voluntary compensation packages given to the public-sector staff in the mid-1990s, and moving skilled staff out of the public sector into the private sector, internal agencies or optional early retirement (Coovadia et al., 2009). The health system faces challenges as there has been a reluctance to strengthen human resource management. Patients attending CHCs have difficulty with services they receive in terms of dealing with clinical management. According to Gilmore et al. (2007) there remains a global deficit of more than four million trained rehabilitation professionals, predominantly in low-income countries. Regardless of the development of the South African human resource policy in 1999/2000 and a human resource plan in 2006, there have been few tangible proposals with minimal actions to address the human resources crisis, especially at the community and primary levels of care (Coovadia et

al., 2009). There are however, positive policies which have increased the uptake by medical schools, legislated community service for health professional graduates, and the introduction of mid-level health workers in the form of clinical associates. Coovadia et al. (2009) mention that with inexperienced clinical facility managers, major challenges are associated with transformation, and competent and operative management of human resources. The public-sector deals with incompetence in which limited capacity is a problem at every level of the health sector. It derives from the disastrous education situation which has led to most individuals emerging from secondary and tertiary education with limited numeracy, literacy and problem-solving skills (Coovadia et al., 2009).

WHO (2011) states that if human resources are focused at a community level, this will be a way of expanding and reorganising service delivery, increasing access to human resources for rehabilitation. MacLachlan, Mannan and McAuliffe (2011) describe the need for investing in the community as having an immediate, large increase in human resources at this level, including the training of mid-level health workers, increasing and addressing skill imbalances and scaling up of education and training of the health workers. To maintain workforce competencies at a community level, what is needed are clear job descriptions, roles and responsibilities, refresher training which encourages problem-solving, supportive supervision and trained supervisors, incorporated worker self-efficacy, and appropriate support structures for workers such as counselling services (Gilmore et al., 2017).

To address the problem at hand, the government needs to put a strategic plan in place to train, facilitate and educate staff to manage patients efficiently and effectively. Currently, there is a staff shortage problem at community centres. The necessary rehabilitation workers and clinical staff need to be appointed and trained to facilitate a clinical facility at optimal level.

Government funding

Participants mentioned being frustrated by “empty promises” made by rehabilitation professionals concerning certain procedures and treatments needed by patients. Due to a lack of funding from the government, patients are not receiving the equipment, treatments and surgeries they were promised. It was mentioned that the lack of government funding and

resources limits participants in delaying their rehabilitation services, obtaining of equipment and ongoing surgeries.

“...I just have a problem with what they said last year. They wanted to give me a knee cap ... but they told me the government does not have money to make that knee cap...”. (P11)

“...I am still waiting for my wheelchair, and every month I come to the therapist then they tell me, they still waiting on the government to supply them with the wheelchairs. It has been a year now...”. (P14)

“...They promise you a wheelchair and you wait so long...”. (P8)

Equipment

The UNCRPD (2006) states that assistive devices help to compensate for a functional loss in the rehabilitation process. An appropriate assistive device such as a wheelchair helps to enhance the quality of life of a patient in realising the basic human rights of that individual. These are rights to healthcare, education, self-economic sufficiency and participation in their community and social life. (Borg, Lindstrom & Larsson, 2009; South African Department of Health, 2003; UNCRPD, 2006; WHO, 2008). Having enough appropriate wheelchairs should be one of the priorities of a rehabilitation programme. According to Visagie, Scheffler and Schneider (2013) remote rural areas in South Africa rely on government subsidised healthcare services to provide wheelchairs. It is however documented, that rehabilitation service provision is inadequate in rural areas due to maldistribution of resources (Bateman, 2012).

Delays in supplies of wheelchairs may result in a loss of function, loss of mobility and of participation in social, community and economic life (Visagie et al., 2013). Children should however receive priority in the receiving of wheelchairs for rehabilitation interventions owing to a high-risk target group (South African Department of Health 2000, 2003; UN 2006b; WHO 2008). The main explanations for delayed provision and long waiting lists for wheelchairs are due to budget constraints and unpredictable annual budgets (Visagie et al., 2013).

Non-governmental organisations try to make donations of wheelchairs to accommodate the shortfall of assistive devices in the community and rural areas. However, evidence has shown

that the donations of wheelchairs may have a negative impact on user function, may cause injuries as well as secondary complications (Mukerjee & Samanta, 2005). Wheelchair assessment and prescriptions are essential clinical interventions to consider, as various factors need to be measured for wheelchair users (Di Marco, Russell & Masters, 2003). This assessment includes the necessary information about the patient's lifestyle, social integration, level of functioning, environment and postural needs, cognitive and health needs, body measurements as well as safety and stability to determine the specification of the wheelchair user (WHO, 2008).

Surgical interventions

Surgical interventions cost a great deal of money and patients are not always able to afford these procedures. Instead, government institutions place these allocated patients on an elective list for surgeries. There are multiple factors which limit the access to surgical interventions which include insufficient health resources, infrastructure, medicines, equipment, financing, logistic and information reporting (Linden, Sekidde, Galukande, Knowlton, Chackungal & McQueen, 2012). These challenges arise when attempting to provide all-inclusive, safe surgical care to populations in low-income countries, especially provided by the public sector.

Worldwide, there are limited funds available for surgeries, resulting in patients waiting for long periods of time for the allocated funding to be available to them (Kruk, Wladis, Mbembati, Ndao-Brumblay, Hsia, Galukande & Quiñones, 2010).

According to Everett (2002) a decision support model is utilised for the management and scheduling (“urgent” and “semi-urgent”) of elective surgery cases in the public hospital system. This model entails patients being nominated by doctors according to urgency and type of operation.

Money is an immense barrier to accessing better quality healthcare. According to Coomer's (2013) findings, private healthcare is preferable to state care facilities. Fortunately, between 1997 and 2002, the government gave added financial support to improve healthcare services by 26%; however, most of the funding was allocated to disease-specific projects such as HIV/AIDS (De Maeseneer, Van Weel, Egilman, Mfenyana, Kaufman, Sewankambo & Flinkenflögel, 2008). These funds would have been more beneficial in the allocation of investments in health infrastructure, human resources and community PHC services.

Different policies and guidelines have been adopted by African countries to ensure the delivery of surgical interventions in district hospitals (Kruk et al., 2010). The surgical productivity according to Kruk et al. (2010) included very low staffing ratios and limited expenditure for surgeries. Most of the surgical and anaesthesia services involved in Kruk's study were provided by generalist doctors, mid-level health practitioners and nurses. Validating the training of mid-level health practitioners could yield a cost-effective way to make basic surgical services available. District hospitals should entirely be able to make provision for surgical interventions but the deficiency of resources as well as qualified staff are the main shortfalls in surgical service delivery (Kruk et al., 2010). Literature shows that there is a necessity for financial and human resource investment to strengthen the capacity of district hospitals in order to deliver essential surgical care in low-income communities (Kruk et al., 2010). It is critical for all units of providers to ensure improvements in access to quality surgical care.

Healthcare facilities are over-capacitated owing to large numbers of patients requiring surgical intervention to optimise their quality of life. As a result of the lack of government funding allocated for needed surgical intervention, departments are forced to set elective surgical dates for every patient who qualifies. There is however a need for a suitable system to allocate patients efficiently to receive the needed funding for their surgical interventions. The budget for healthcare needs to be revised to determine where costs can be reduced to assist in the management of patients surgically.

4.6 Summary of findings

From the emerging themes of this study, it is evident that participants experienced various challenges in relation to the rehabilitation services they receive at the CHCs. In many cases, these challenges did not occur individually, but rather as a combination of factors. The findings of this study as interpreted qualitatively are that change and resources are needed. The participants stressed that they needed change in reduced waiting times at the centres, outreach into the community, a change in clinical staffs' attitudes, and a patient-centred approach. Resources were lacking in terms of clinical management staff and there was a lack of skills and training, as well as the clear lack in government funding.

Table 4.3 below lists the challenges that patients experienced in 2013 (according to Mlenzana's study) in relation to the 2017 challenges faced by patients at the same selected CHCs. Some of the issues arising in Mlenzana's (2013) study, specifically those of transport,

accessibility, treatment sessions and equipment, were addressed and improved. However, the challenges of long waiting times and a need for a patient-centred approach to rehabilitation remain a problem in 2017. Thus, there remains a need for a way to address these challenges. It is of utmost importance that the new rehabilitation model is implemented.

Table 4.3: Challenges faced by patients in rehabilitation services in 2013 and 2017

Challenges 2013	Challenges 2017
Waiting time	Waiting time
Accessibility	Outreach into community
Transport	Attitudes
Patient-centred approach	Patient-centred approach
Treatment sessions and equipment	Lack of clinical management training
	Lack of government funding

4.7 Summary

This chapter of the study focused on descriptively expanding on the results obtained during FGDs. The aim of this study was to explore perceptions and expectations of patients regarding the new rehabilitation model to encompass the vision of the healthcare plan 2030. Workshops were conducted to educate participants about the healthcare 2030 plan as well as the new rehabilitation plan as proposed by Mlenzana (2013).

FGDs were conducted to obtain patients' perceptions and expectations regarding the new rehabilitation model. A total of 31 participants were included in this study, 52% of who were male and 48% female. The most frequently seen rehabilitation professionals by the participants at the three CHCs were doctors, nurses, occupational therapists and physiotherapists. The least often utilised services were from speech therapists, dietitians (including nutritional advisors) and the orthopaedic sister. It was noted that a poor referral system at the CHCs may have affected the latter result.

The findings of this study focus on the negative and positive feedback surrounding the themes generated. Study participants believed that the new rehabilitation model would answer many of their problems in that it would improve access to rehabilitation services,

patient-centred rehabilitation, caregiver and family involvement, stakeholder education and rehabilitation interventions.



CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

5.1. Introduction

This chapter concludes the study by briefly discussing the implications of the research findings, noting limitations of the study and making recommendations for future improvements in rehabilitation services.

5.2 Summary of the study

The objectives of this study were (a) to explore patients' perceptions of the newly developed model and; (b) to explore patients' expectations regarding the newly developed model. These objectives were answered following our FGDs at each CHC. Responses were elicited from participants to provide the researcher elaborative outcomes in with themes and categories were generated in the research process.

The perceptions of participants regarding the newly proposed rehabilitation model were of positive outcome whereby responses elicited to requiring a need for a systematic operating system (new rehabilitation model) to improve services received at their respective CHCs. One of the expectations the participants voiced was the need for change in in healthcare service delivery by improving staff/ rehabilitation professional attitudes, patient-centred approach, waiting times at CHCs and further outreach of rehabilitation professionals into the communities.

Attitudes: participants in general felt that the attitudes of clinical staff were of demeaning nature whereby attendances were experienced negatively.

Patient-centred approach: participants mentioned that they want to feel included in their rehabilitation in order to build trust and a stronger client-professional relationship to have a patient-centred approach.

Waiting times: most participants considered the waiting times to be too lengthy before commencing their actual medical treatments. There was a immense concern relating to this

factor as most participants had to take off from work the next day if they were not helped on the first day of clinical attendance due to overflow of patients at their CHCs.

Outreach into community: responses from participants elicited the need for rehabilitation services to go out into the community as some patients are not always able to reach the clinic as they are too sick to walk or experience financial constraints getting to the clinic.

The second expectation participants expressed related to limited resources within the CHCs which were poor clinical management and lack in government funding for surgeries or equipment. These constraints have led to frustrations experienced by patients as CHCs are constantly short staffed due to poor clinical management as well as underskilled training. Lack of government funding has led to patients experiencing a delay in their rehabilitation process which in turn not receiving equipment or getting the needed surgical procedures as guaranteed to them.

Overall, there has been a major shortfall in health care which participants have received at the three CHCs included in this study. In the FGDs conducted, participants have with great frustration voiced what they would expect the new rehabilitation model to provide to PWDs. The perception of the new rehabilitation model is seen in a positive light as participants feel that it could improve the clinical health system at their CHCs. There is an expectation that participants are hoping to have improved with the new rehabilitation model. These are: staff attitudes, patient-centred approach, outreach into the community, waiting times, government funding and clinical management.

5.3 Implications for service delivery

Understanding patient perceptions of service delivery is an important aspect of any movement to improve these services. If patients are dissatisfied with services they receive at a CHC, it will ultimately affect the entire CHC from clinical staff to the environment of the centre. Patients can ruin the reputation of a CHC by sharing their negative experiences; in turn, CHCs may lose more patients attending these centres. Negative attitudes of staff result in patients taking matters further by reporting to other outlets such as the media. Patients want to know that they are at the centre of their own treatments; they prefer to be spoken to rather than spoken about, when there is a team-based approach to treating a patient. Waiting times which are lengthy result in reluctance of patients to attend appointments for their follow-up visits. As a result, patients may be unable to partake in the rehabilitation process.

5.4 Research limitations

The patient folders at the centres had not been updated with the relevant information to contact participants telephonically to make appointments for their participation in workshops and FGDs. This necessitated consulting with clinicians to confirm patient details and current rehabilitation appointments for that day. This changed the initial methodology as set out in the research proposal for the study, in which patients would have been contacted telephonically to ascertain their willingness to participate. In turn, this led to changing the research sampling method, by recruiting participants in the waiting rooms to partake in the workshops and FGDs on the same day.

5.5 Recommendations

The recommendations for improvement of service delivery are as follows:

- The findings of this study can act as base for creating awareness regarding concerns of patients at a PHC level to improve health care needs of PWDs in order to globally strengthen healthcare core standards.
- The new rehabilitation model needs to be implemented to improve the perceptions and expectations of patients regarding the rehabilitation services that they are currently receiving. Perceptions regarding health care and attending clinics are currently seen in a negative light due to undesirable experiences at CHCs. This needs to be changed in order for PWDs to feel that their needs are being met.
- Patients need more insight into health care education on the development and improvement of service delivery on a primary health care level. Government therefore needs to start facilitating outreach home-based health care education programmes in the communities.
- Government facilities need to appoint skilled and trained staff in order to facilitate and manage CHCs comprehensively. CHCs were at most short-staffed and underskilled in which patients felt frustrated when staff were not always capable of handling a certain task in order to assist the patients. Clinical staff needs adequate skills training and information sessions on how to manage facilities efficiently in order to avoid lengthy waiting periods for folder/file queuing before attending their rehabilitation professional.
- Clinical hours need to be extended so that all patients can be attended to. In which case this may or may not result to working overtime for clinical staff. However,

government financial constraints to compensate clinical staff workers may be a problem.

- The need for a better referral system needs to be implemented at a PHC level in order for patients to have adequate rehabilitation professionals attending to their needs.
- More rehabilitation professionals should be appointed, in case of absenteeism or a system should be reworked in which locum doctors/physiotherapists/occupational therapists etc. become available if need be to accommodate for absenteeism.
- Further research is needed to focus on other provinces of South Africa in order to obtain a wider sense of the current perceptions and expectations patients have regarding the new rehabilitation model.

5.6 Conclusion

The previous chapter has discussed the findings of this study and has made relevant recommendations for ways in which PWDs can have better access to services, as well as way to reduce challenges they currently face.

The participants in this study were dissatisfied with the overall service received at the three selected CHCs. Many challenges identified in this study were related to general problems in the in South Africa healthcare system (at CHCs) such as poor attitudes, lack of patient-centred care, long waiting times, lack of skilled staff, lack of government funding for equipment and surgeries. Thus, the need for a new rehabilitation model to be implemented is of importance as patients experience rehabilitation services to a negative extent. Participants in this study emphasised the need for change to improve the way they see and experience rehabilitation services. This study has clearly identified the urgent need for change in order for services to be efficient and effective at a PHC level. Participants urgently stated the need for services at CHCs to be more patient-centred in order to be included and involved in the rehabilitation process and the treatment they receive. Overall, patients need to see changes in the rehabilitation setting at a PHC level in order to feel that their medical needs are being met. With the new rehabilitation model, change to improve the health care system at a PHC level will help PWDs to see an improvement in general service delivery, healthcare education, a patient-centred approach for patients to achieve a full sense of well-being.

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APPENDICES



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Research Assistant Training Guide

What is a research assistant?

A research assistant is a researcher employed, often on a temporary contract, by a university or a research institute, for the purpose of assisting in academic research (Hoskinsons, 2005).

What is the role of a research assistant?

A research assistant repairs other articles, reports, presentations and performs routine clerical duties as instructed, if essential to the research activities of the supervisor or project to which the research assistant is assigned (Wodak & Meyer, 2009). Research assistants are responsible for the accuracy, validity and integrity of the research on which they are working. The quality of the research reflects on the student, the faculty supervisor, and the university. Deliberate falsification of research results may result in dismissal from the university. Research assistants must maintain the confidentiality of the faculty mentor's professional activities and research prior to presentation or publication, in accordance with existing practices and policies in the area of research activity. In publication and presentation of work produced as research assistants, the student must acknowledge the contributions of the faculty supervisor and other members of the research team. Research assistants should assume responsibility for making proper use of the intellectual, instructional and physical environment in which they are conducting research (Eaton, 2017).

How to be a good research assistant

- Be reliable and on time
- Communicate

- Take initiative
- Ask for help if you get lost
- Don't try to take on too much
- Be positive
- Show good judgment
- Be organized
- Be discreet
- Treat your research assistant's work like a real job and have good time managing your skills
- Simplify the scope and jurisdiction of the research project
- Clarify how long to work on the project and when any work product is due
- Check in regularly to report findings
- Ask questions about the material, style, and organizing of any research results to be submitted to the researcher

The Research process according to Thompson (2015)

Step 1: Formulate and clarify the research problem

Ask initial questions of the professor

Conduct some background research and make a list of additional questions to ask

Refine your statement of the problem as you take in new information

Step 2: Break down the problem into discrete issues to be researched

Step 3: Identify search terms and connectors, identify preliminary sources for each issue, and engage in research

Brainstorm search terms and relationships between them (connectors)

Identify preliminary sources for research, tailoring your choice of sources to the issue

Conduct searches and engage in research, *paying attention to* references to related material in footnotes and bibliographies

Step 4: Start and maintain a research log

Reflective journals for each setting and environment to conduct research in

Step 5: Capture information and organize it for later retrieval

Spreadsheets, tables, charts, transcripts, audio-recordings and backups

Avoid plagiarism

Critically analyse any website you would want to recommend. Make sure it is a reliable source.

Step 6: Update your research

Re-run searches at end of research process

Replay audio-recordings in order transcribe correctly

Step 7: Know when to stop research

What is a workshop?

A workshop is a meeting at which a group of people engage in intensive discussion and activity on a specific subject or project.

How to lead a workshop:

Choose a calm and relaxing environment in which you will be able to relay your topic to the participants

Give the participants hand-outs of the consent forms and information sheets of the study

Explain these hand-outs' to the participants

Ensure participants that their participation is completely voluntary in which it will not affect their future treatments

Ensure willing participants, sign consent forms

Know your topic

Rearrange your topic and its contents in the simplest way for participants to understand.

Make use of layman's terms for the audience to understand, in the avoidance of confusion.

Be clear and concise

Ask audience if they understand the concept

Keep it brief; do not speak for too long without a needed break. 15-20 then have a break

What Is a Focus Group?

Focus groups are also called “group interviews” or “group conversations” conducted mainly for research studies. A focus group is a group of people who engage in a discussion guided by a set of questions and moderated by a facilitator. The objective for the focus group is to gather qualitative data from human subject.

Two criteria make these group discussions “focused”:

- A clear and defined topic
- A common set of characteristics among participants (e.g. demographic, professional or other commonalities).

A focus group is comprised of invited participants, a facilitator, and a recorder; the participants should range from 12-15 maximally. The larger the group, the more challenging it can be to moderate. Well written focus group discussions are explanatory and open-ended as they are intended to allow participants to share their ideas, thoughts and beliefs without judgement or influence. The questions in relation to the study are free from jargon or complicated technical terms.

Leading a focus group discussion

Choose a calm, relaxed environment in which to conduct the focus group discussion in

Make sure you have an audio-recorder as well as back up device in case the primary one is faulty

Give the participants hand-outs of the focus group binding forms and have them sign for it if they are willing to participate

Explain these hand-outs’ to the participants

Ensure participants that their participation is completely voluntary in which it will not affect their future treatments

Ask open ended questions in order to elicit the necessary responses from participants

A focus group discussion normally lasts between 45-90 minutes.

References:

Hoskinson, A. (2005). Creating the ultimate research assistant. *Computer*, 38(11), 97-99.

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(APPENDIX B)



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Revised: September 2016

INFORMATION SHEET

Project Title: Perceptions and expectations of patients regarding a newly developed rehabilitation model to encompass the vision of the new health plan 2030

What is this study about?

This is a research project being conducted by Rochelle Petersen at the University of the Western Cape. We are inviting you to participate in this research project because you are a candidate receiving rehabilitation services at this current clinic. It was found necessary to explore your perceptions regarding a newly proposed rehabilitation model that will be introduced and explained to you to obtain your perceptions and expectations going forward with the rehabilitation services you are currently receiving. The purpose of this research project is to improve quality rehabilitation services being provided and to aid in strategies in which quality rehabilitation services can be delivered. Your participation will be used to aid in improving rehabilitation services by knowing from a patient perspective how you may be experiencing rehabilitation services and how the proposed rehabilitation model will help aid in improvement of current rehabilitation services being received.

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

You will be asked to partake in a workshop in which the newly proposed rehabilitation model will be introduced to you and explained in order for you to understand how this may improve your rehabilitation services in the future. Following this procedure, discussions will take

place and be audio-recorded in order to gain feedback on how you may feel about this newly proposed rehabilitation model as well as how it may improve your current struggles you may be experiencing. Each procedure will not take longer than 30 minutes and will be language appropriate in isiXhosa, Afrikaans and English. Questions that may be included in the discussions are: “Have you heard about the new health plan 2030”, “how do you feel the new rehabilitation model will work for you”, “do you think this is a good method of rehabilitation”, “how will it benefit you?”

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To ensure your confidentiality the information obtained in discussions will be locked in a filing cabinet and storage areas. Only identification codes will be used on data forms. And only password protected computer files will be used.

If we write a report or article about this research project, your identity will be protected. In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities’ information that comes to our attention concerning verbal abuse or neglect or potential harm to you or others. In this event, we will inform you that we have to break confidentiality to fulfil our legal responsibility to report to the designated authorities.

This study will use focus groups therefore the extent to which your identity will remain confidential is dependent on participants’ in the Focus Group maintaining confidentiality.

What are the risks of this research?

There may be some risks from participating in this research study.

All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

The benefits to you include improvement in rehabilitation services in the near future. This research is not designed to help you personally, but the results may help the investigator learn more about the problems faced in rehabilitation services as experienced by patients attending these rehabilitation services. We hope that, in the future, other people might benefit from this study through improved understanding of the newly proposed rehabilitation model and methods on which rehabilitation services can be improved to attend to patients needs through quality healthcare rehabilitation services provided.

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

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

What if I have questions?

This research is being conducted by Rochelle Petersen from the Department of Physiotherapy at the University of the Western Cape. If you have any questions about the research study itself, please contact Rochelle Petersen at: (021) 959 2542 or visit the Department of Physiotherapy at the University of the Western Cape in Bellville, Cape Town.

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

Prof N Mlenzana
Head of Department
University of the Western Cape
Private Bag X17
Bellville 7535
nmlenzana@uwc.ac.za

Prof José Frantz
Deputy Vice Chancellor of The University of the Western Cape
University of the Western Cape

Private Bag X17

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josefrantz@uwc.ac.za

This research has been approved by the University of the Western Cape's Senate Research Committee. (REFERENCE NUMBER: *15/7/91*)



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Title of Research Project: Perceptions and expectations of patients regarding a newly developed rehabilitation model to encompass the vision of the new health plan 2030

Focus Group Discussion

Interview Guide

What do you think about the newly developed rehabilitation model?

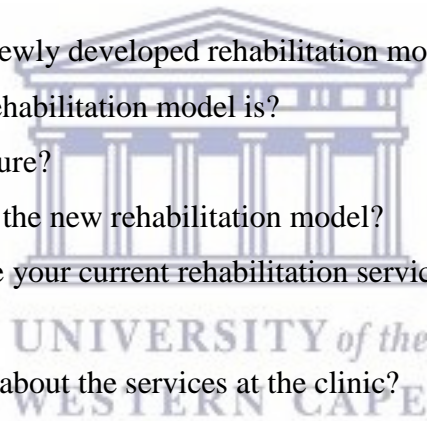
Do you understand what the rehabilitation model is?

Will this benefit you in the future?

What are your expectations of the new rehabilitation model?

How will it benefit and change your current rehabilitation services you are receiving at the clinic?

What do you currently dislike about the services at the clinic?



(APPENDIX D)



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DATA CAPTURING SHEET

DEMOGRAPHIC DATA

Centre:

Age:

Gender:

Male
Female



MEDICAL DATA

Type of disability

Left hemiplegia

Right hemiplegia

Amputation

Fracture

Osteoarthritis

Neuromusculoskeletal

Rehabilitation professionals involved in patient management:

Physiotherapist 1. Yes 2.No

Occupational therapist 1. Yes 2.No

Speech and language therapist	1. Yes 2.No
Dietician	1. Yes 2.No
Medical doctor	1. Yes 2.No
Nurse	1. Yes 2.No
Orthopaedic sister	1. Yes 2.No



(APPENDIX E)



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Title of Research Project:

Perceptions and expectations of patients regarding a newly developed rehabilitation model to encompass the vision of the new health plan 2030

Workshop Guide

Healthcare 2030 plan and proposed new rehabilitation model

Within rehabilitation services there is a direct connection between the rehabilitation professional, patient and the care-giver.

It is very important as we would like to meet the aim of the new health plan 2030 of a patient-centred approach.

Patient-centred care is the primary focus for healthcare services

A study shows that healthcare services face many challenges to meet this need.

To achieve the goal of a patient-centred approach, an improvement of patient-clinician relationships and involvement of all people is needed to manage a patient's condition.

The largest challenge faced to this day has been identified as being time allocated to health education during the rehabilitation process.

A study showed that lack of informed consent and decision making regarding treatment options was also a problem.

Service providers and patients also stated that lack of resources were a problem in providing adequate management within rehabilitation services.

Within rehabilitation services the process of receiving care from rehabilitation was compromised by:

Long waiting times within the centres,

Inadequate referral systems amongst rehabilitation professionals,

Respect between rehabilitation professionals and patients, waiting long for next appointments,

Time allocated to health education being minimal.

Patient-centred rehabilitation should thus include:

Individualization of programmes that meet the needs of the patients and community;

Sharing information and education that is appropriate, timely and accordingly to patient's wishes;

Family and peer involvement in rehabilitation processes and outcomes that are meaningful.

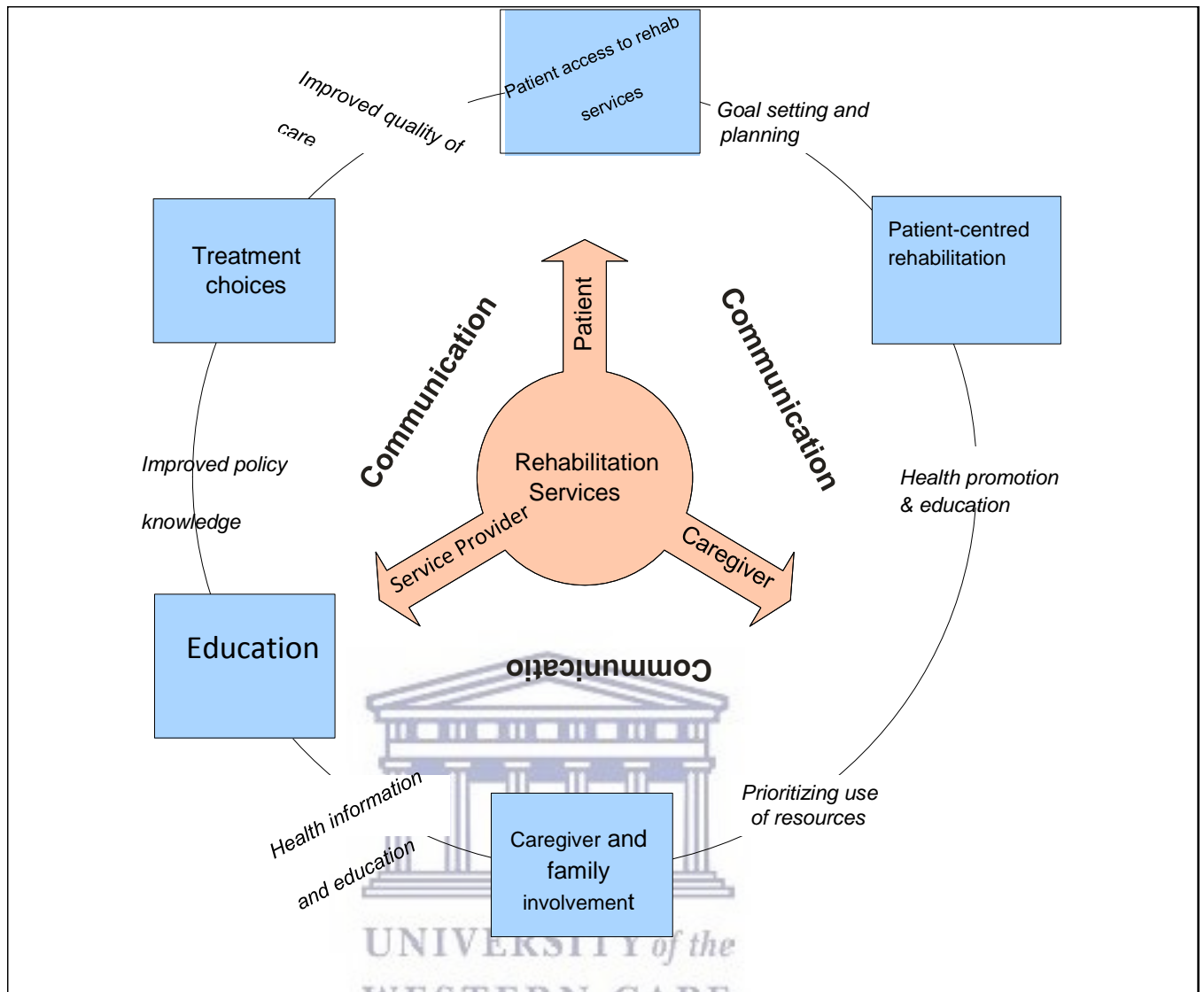
Moving towards a patient-centred approach in rehabilitation services, a **new rehabilitation model was developed** which includes access to rehabilitation services, patient-centred rehabilitation, caregiver and family involvement, education and rehabilitation interventions.

To make clinics and health care centres more accessible in this way forward.

Processes of care are important and besides individual interventions; health promotion and education should also be included through contributing to physical and psychosocial well-being of an individual.

Family involvement will also improve quality of care of the patients.

Figure below shows the proposed model of rehabilitation as developed by Mlenzana (2013)



(APPENDIX F)



DEPARTMENT OF RESEARCH DEVELOPMENT

13 January 2016

To Whom It May Concern

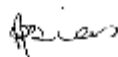
I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Ms R Petersen (Physiotherapy)

Research Project: Perceptions and expectations of patients regarding a newly developed rehabilitation model that would encompass the vision of the new health plan 2030.

Registration no: 15/7/91

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.



*Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape*

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

(APPENDIX G)



STRATEGY & HEALTH SUPPORT

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5th Floor, Norton Rose House,, 8 Riebeeck Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_2016RP19_742
ENQUIRIES: Ms Charlene Roderick

University of Western Cape

Robert Sobukwe Road

Bellville

Cape Town

7535

For attention: Dr Nondwe Bongokazi Mlenzana, Ms Luzaan Kock, Ms Rochelle Petersen

Re: **To explore and describe the perceptions of rehabilitation service providers in the implementation of a rehabilitation model at primary health care level.**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact following people to assist you with any further enquiries in accessing the following sites:

Gugulethu CHC

Lunga Makamba

021 637 1280

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of

(APPENDIX H)

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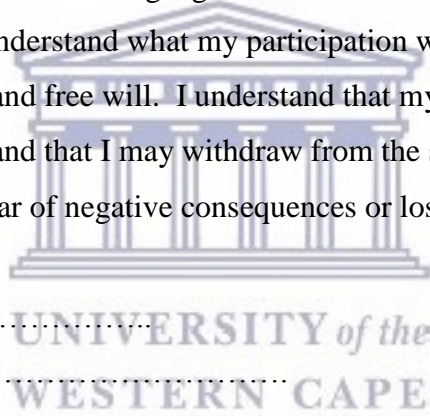


CONSENT FORM

Title of Research Project: Perceptions and expectations of patients regarding a newly developed rehabilitation model to encompass the vision of the new health plan 2030.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve, and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Participant's name.....
Participant's signature.....
Date.....



(APPENDIX I)



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FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: Perceptions and expectations of patients regarding a newly developed rehabilitation model to encompass the vision of the new health plan 2030

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve, and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone by the researchers. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I understand that confidentiality is dependent on participants' in the Focus Group maintaining confidentiality.

I hereby agree to uphold the confidentiality of the discussions in the focus group by not disclosing the identity of other participants or any aspects of their contributions to members outside of the group.

Participant's name.....

Participant's signature.....

Date.....

(APPENDIX J)

Demographic details of participants

Participant	Age	Gender	Disability	CHC
P1	40	Female	Fracture	Centre A
P2	42	Female	Fracture	Centre A
P3	35	Male	Neuromuscular condition	Centre A
P4	37	Male	Right hemiplegia	Centre A
P5	40	Male	Neuromuscular	Centre A
P6	50	Male	Fracture	Centre A
P7	60	Female	Left hemiplegia	Centre A
P8	59	Female	Fracture	Centre A
P9	61	Male	Osteoarthritis	Centre A
P10	35	Male	Fracture	Centre A
P11	36	Female	Neuromuscular	Centre C
P12	39	Female	Left Hemiplegia	Centre C
P13	42	Female	Neuromuscular condition	Centre C
P14	45	Male	Left hemiplegia	Centre C
P15	49	Male	Neuromuscular	Centre C
P16	50	Male	Osteoarthritis	Centre C
P17	35	Female	Neuromuscular	Centre C
P18	42	Male	Right Hemiplegia	Centre C
P19	37	Male	Neuromuscular	Centre B
P20	35	Male	Fracture	Centre B

Participant	Age	Gender	Disability	CHC
P21	50	Female	Left Hemiplegia	Centre B
P22	36	Male	Right hemiplegia	Centre B
P23	50	Female	Left hemiplegia	Centre B
P24	65	Male	Neuromuscular	Centre B
P25	52	Female	Fracture	Centre B
P26	32	Male	Amputation	Centre B
P27	37	Female	Fracture	Centre B
P28	34	Male	Fracture	Centre B
P29	45	Female	Neuromuscular	Centre B
P30	46	Female	Fracture	Centre B
P31	48	Female	Right Hemiplegia	Centre B

