

UNIVERSITY OF THE WESTERN CAPE

DEPARTMENT OF PHYSIOTHERAPY

**Rehabilitation Professionals' Views on the Experiences of Patients with Physical
Disabilities Accessing Community Health Centres**

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KEYWORDS

Rehabilitation

Rehabilitation professionals

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Disability

Attitude

ABSTRACT

Rehabilitation services have been described as being necessary to maximize patient independence in order to enable them to participate fully in their communities. The **Aim** of the study was based on the problem statement and the research question, this study aims at exploring rehabilitation professionals' views on the experiences of patients with physical disabilities accessing CHCs in the Western. The **objectives** of the study were to explore the views of rehabilitation professionals regarding experiences by patients accessing rehabilitation services at the Community Health Centres (CHCs) in the Western Cape and to reach health experts consensus on how rehabilitation services should be provided at the CHCs based on the outcomes of objective 1. **Methodology:** This study used an exploratory design that used qualitative methods for data collection (workshops and focus group discussions (FGDs) and a Delphi study. The study was conducted at purposively selected CHCs in the Western Cape. The population in this study included all rehabilitation professionals who provide rehabilitation services in the CHCs, who were invited to participate in the study. **Data collection:** In the qualitative and the Delphi study, data was collected through workshops, focus group discussions and emails respectively. **Data analysis:** The workshops and the FGDs were audio recorded and then transcribed verbatim for content analysis. Transcripts were read through several times by the researcher, data was analysed in relation to six predetermined themes. For the Delphi study the researcher captured data in emails through google form. The researcher used Excel programme to determine percentage of consensus at 65% of response rate, and then analysed the findings descriptively. **Result and conclusion:** There were challenges regarding accessibility, resources, and workload in providing rehabilitation services at CHCs in the Western Cape. The study identified positive attitude towards the referral system, communication, and accessibility, which were clearly present in health professionals' awareness. Rehabilitation competencies in this study reached consensus on attitudes,

information sharing, and referral systems and not for resources (area and space), access (transportation), and waiting times (penalty fee for delays in collecting medication). Based on the outcomes of this study it is recommended that enough staff, necessary equipment, raising patients' awareness as well as maintaining positive attitudes are key factors to improve rehabilitation professionals and rehabilitation centres.

DECLARATION

I hereby declare that **“Rehabilitation Professionals’ Views On The Experiences Of Patients With Physical Disabilities Accessing Community Health Centres”** is my own work, that it has not been submitted, or part of it, for any degree of examination at any other university, and that all sources I have used or quoted have been indicated and acknowledged by means of complete references.

Ayiman Abdulqadir

Signature.....

March 2018

DEDICATION

To my beloved husband and son, and my beloved mother and father. My father, you are first love and only inspiration, may Allah bless you. My husband, you are my love, thank you for your support and caring over all these years in alienation from our families. My Allah please bless this work.

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LIST OF ABBREVIATIONS

ABS	Australian Bureau of Statistics
CBR	Community-based rehabilitation
CDU	collection/delivery units
CHCs	Community Health Centres
CREATE	CBR Education and Training for Empowerment
CRFs	Community Rehabilitation Facilitators
CRW	Community rehabilitation Workers
DoH	Department of Health
EMR	Electronic Medical Records
FGDs	Focus Group Discussions
ICF	International Classification of Functioning, Disability and Health
ILO	International labour Organization
NGOs	Non-Governmental Organizations
PHC	Public Health Care
PWDs	Persons with disabilities
TRIAGE	quick assessment
UK	United Kingdom
UN	United Nations
UNESCO	The United Nations Educational Scientific and Cultural Organization
USA	The United States of America
WHO	World Health Organization

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CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter contains the background of this study which serves to establish the context in which the research project took place. The rest of the chapter includes the statement of the problem, the study aims and objectives, definition of key terms, and a summary of the subsequent chapters.

1.2 Background

Injury to a person may result in the loss of certain abilities, leading to challenges completing basic daily activities, and rehabilitation is often necessary. Rehabilitation does not return back or undo the damage caused by disease or injury but instead it aims to help the individual enhance their quality of life and achieve the highest level of function that they are capable of (WHO, 2011). Rehabilitation services are provided in various settings including clinical and office practices, hospitals, care nursing homes, and some health maintenance organizations (WHO, 2011). Some therapists also make home visits and provide advice to clients with respect to choosing an appropriate form of therapy (Nsemo, 2016).

The goal of a rehabilitation programme has been described as the maximization of the patient's role independence in his or her environment, all within the limitations imposed by the underlying pathology and impairment, as well as the availability of resources (Wottrich, Von Koch & Tham, 2007). Rehabilitation is targeted at patients who are present with physical dysfunction that affects their daily life. Therefore therapists need to a framework such as the International Classification of Functioning, Health and Disability (ICF) to help adopt a more holistic view of patient management (World Health Organization (WHO), (2007). This can be

achieved through full assessment of the patient, accompanied by supporting documentation, evaluation of quality of patient life by considering patient's social and environmental aspects, and rehabilitation service delivery. Working at the primary health care level means that therapists can provide health promotion, prevention, curative, and rehabilitation services for those in need of the services (Maleka, Franzsen & Stewart, 2008; Myezwa & van Niekerk, 2013).

On the other hand, those patients attending rehabilitation centres sometimes complain about service provision, and are not sure how to manage this problem (Ntsiea, Van Aswegen, Lord & Olorunju, 2012). Studies have shown that patients also complain about the quality of the service provided as well as the long waiting times, which can extend from two days to two weeks before being seen by a healthcare provider (Mlenzana, 2013). Moreover, the difficulty of accessing rehabilitation services in rural areas is a challenge, as patients need to book transport and then pay extra for it to wait for them when going to a CHC. In addition, Mlenzana (2013) noted that some service providers do not ask patients if they understand what therapy is about, and that they simply do what they think is right for patients.

In South Africa, there is a substantial evidence describing the shortage of rehabilitation services for people with disabilities. According to Kumurenzi (2011), the most important problems facing patients with disabilities in the Western Cape are transportation that is either not available or out of reach, a lack of therapists, and a lack of training for staff. This situation also contributes to the lack of development of community-based rehabilitation (CBR) programmes. These organizations aim to provide rehabilitation services, and serve a particular need in Africa, Asia and South American countries. These programmes help persons with disabilities to cope with their special needs following rehabilitation when they return to their communities. The Western Cape Government (2013) claims that the rehabilitation system in the Western Cape

offers services at primary, secondary, and tertiary level which run through a referral system that leads from one level to other.

In general, rehabilitation services that are provided to persons with disabilities in the community often enhance their quality of life, and may also include input from both governmental and non-governmental organizations.

1.3 Problem statement

Community health centres are overcrowded with patients who come with different ailments. Amongst these patients are persons with disabilities who are still struggling to access health care centres. Several studies have been done in South Africa focusing on the experiences of patients regarding rehabilitation services. For example, Mlenzana thesis (2013) completed a systematic review that looked at the barriers and facilitators of rehabilitation services and found that patients had a perception that health professionals lacked an understanding of rehabilitation for people with disabilities, and that there was a lack of information-sharing from health professionals about the rehabilitation process. Mlenzana (2013) also noted that patients expressed shock when they were referred to rehabilitation services as they were not aware of what to expect when they arrived. This was further evident when patients reported being angry with service delivery as they received the same treatment when coming for follow-up sessions which demonstrated a lack of communication between patients and service providers. Therefore, lack of understanding of rehabilitation and rehabilitation process from both patients and service providers, lack of information-sharing between patients and staff, access to rehabilitation centres and services, waiting periods as well as service delivery are issues that need to be carefully considered to improve rehabilitation centres, professionals and service.

1.4 Research Question

What are the views of rehabilitation professionals regarding the experiences of patients with physical disabilities accessing Community Health Centres (CHCs) for rehabilitation services in the Western Cape?

1.5 Aim of the study

Based on the problem statement and the research question, this study aims at exploring rehabilitation professionals' views on the experiences of patients with physical disabilities accessing CHCs for rehabilitation services in the Western Cape.

1.6 Objectives

- To explore the views of rehabilitation professionals regarding experiences by patients accessing rehabilitation services at the Community Health Centres (CHCs) in the Western Cape.
- To reach consensus with rehabilitation experts on how rehabilitation services should be provided at the CHCs based on the outcomes of objective 1.

1.7 Definition of key terms:

Attitude: refers to one's point of view, thinking or feeling towards certain situations or things. (Wilson & Scior, 2014).

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

Patient: refers in this study to an individual receiving primary health care services at a community health Centre (McKague, 2000).

Rehabilitation: The attempt to try to improve the ability of people living with disability to live their daily lifestyle and the service provided to the patient to facilitate the process of recovery from illness or disability in a shorter period of time (Menon, Korner-Bitensky, Kastner, McKibbon & Straus, 2009).

Rehabilitation professionals: Persons who help people recover from the impairment that is manifest as a result of an injury or disease process (Menon et al., 2009).

Rehabilitation services: Provided for individuals following an in-patient service where the activity and participation limitations and environmental barriers related to the patient do not require hospitalization (Graham & Cameron, 2008).

1.8 Significance of the study

This study would be a valuable contribution in the field of rehabilitation since it will provide an understanding of rehabilitation professionals' views on the experiences of PWDs community health centres in the Western Cape which in turn may assist in better understanding the challenges with the delivery of rehabilitation services. This may also help to enhance patient care by decreasing gaps in service delivery. The outcomes and the information brought to light in this study may influence the attitudes of both patients and rehabilitation professionals as well as rehabilitation policy in the Western Cape and possibly also nationally.

1.9 Outline of chapters

Chapter one

Chapter one provides the background for the study by highlighting rehabilitation professionals' views on the experiences of patients with physical disabilities who access community health centres. It also presents the problem that the study aims to address. This chapter also presents the problem statement, the aim and the objectives of the study. Finally, the significance of the study is described.

Chapter two

This chapter presents a literature review of rehabilitation and disability from a global perspective as well as the challenges faced by rehabilitation services during the rehabilitation process. This is the role the community based rehabilitation professionals must play to provide services to the people with disabilities. It also provides an overview of how public health care is an integral part of the country's health system. It includes the community based rehabilitation facilitators who have a big role to play in raising awareness of disability and disability rights in South Africa. Therefore, it is important to understand the level of satisfaction among people with disabilities and healthcare providers in order to improve rehabilitation services.

Chapter three

This chapter focuses on the research methods. This study used qualitative exploratory design using workshops, FGDs and a Delphi study to obtain a better understanding of rehabilitation professionals' views on the experiences of patients with physical disabilities who access community health care centres. Also the study design, study setting, sampling strategy, data collection technique, and data analysis processes are described. Trustworthiness and ethics considerations are also discussed.

Chapter four

This chapter includes the results and discussion of the FGDs that were used to explore the views of rehabilitation professionals regarding the provision of rehabilitation services at three Community Health Centres (CHCs) providing rehabilitation services in the Western Cape. Through the analysis process the patterns, trends and relationships identified in the study are described. The findings are presented in themes and subthemes.

Chapter five

This chapter includes the results and discussion of the Delphi study that was conducted in order to reach consensus on how rehabilitation services should be provided at the CHCs. Excel programme was used to analyse data and results were presented descriptively as expressed by rehabilitation services experts.

Chapter six

This chapter presents the conclusion of the study that is based on the findings. Limitations to the study are also provided, as well as recommendations that are based on the main findings of the study.

Since the aim of this study was to explore rehabilitation professionals' views on the experiences of patients with physical disabilities accessing CHCs in the Western Cape, it was of great importance to first consider the literature of rehabilitation at both a global and continental level, disability, Community-based Rehabilitation (CBR), and Primary Health Care (PHC). Therefore, chapter two will be devoted to discuss the literature overview as well as highlighting the gaps in literature.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews the literature on rehabilitation as a first step to explore and understand professionals' views on the experiences of patients with physical disabilities accessing CHCs in the Western Cape. This includes an overview of disability, rehabilitation at a global level and then focuses on rehabilitation in Africa, Community-based Rehabilitation (CBR), as well as Primary Health Care (PHC) as well as. It also highlights the gaps in the literature.

2.2 Disability

As mentioned earlier in chapter 1, injury to a person may result in the loss of certain abilities leading to challenges completing even basic daily activities. Such injuries may cause disability which has a significant impact on not only on the individual who has the impairment but also at the level of the community. According to the World Health Organization (WHO) (2011), there are many barriers for persons with disabilities (PWDs) as it relates to their social participation. Knowledge around disability, motivation of health workers, and the state of facilities can play an important role in the affordability of services for people with disability. Budgets are one of the important components of service delivery for PWD's. Involving PWD's in decision-making is also important as they are aware of their own needs and the problems they face, including information about health, education, transportation, and housing, which all involve both the government and private sectors.

There are both social and health barriers that affect PWDs, which make it important that we not only consider them from a medical perspective but should also include a social component in management and care (WHO, 2011). The environment of a PWD has a significant impact

on their daily experiences. The barriers faced by PWD can be also related to finance, transport accessibility, and education.

2.2.1 Definition of disability

Disability is complex, dynamic, multidimensional and contested, and has been defined as an umbrella term for impairment, activity limitation, and participation restrictions (WHO, 2011).

Disability is characterized as the result of a complex relationship between an individual's health condition and personal factors, and of the external factors that represent the circumstances in which the individual lives (Schalock, Borthwick-Duffy, Bradley, Buntinx, Coulter, Craig & Yeager, 2010).

According to MacLachlan and Mannan (2014), the WHO's report on disability sends a clear message.

According to WHO (2001), the International Classification of Function has defined disability as those injuries that affect the body and lead to restrictions on the life experience of a person. Disability can also present differently based on the external environment, as well as the norms and culture of society.

2.2.2 Prevalence of disability

Reports and studies have been conducted to measure the disability prevalence. According to the study done by United Nations (UN) (2007) on disability statistic, 10% of the global population are living with disability. The incidence of disability differs between developed countries, such as the United States of America (20% of the population) and Canada (18.5%), and developing countries like Bangladesh (0.8%) and Kenya (0.7%). It may therefore appear as though developed countries have a higher incidence of PWDs than developing countries, but

the low rate may be because there are limited resources for conducting household surveys (Mont, 2007). According to the WHO (2011), PWDs of any variety number one billion globally.

Globally in 2004 the prevalence of disability was around 785 (15.6%) to 975 (19.4%) per million are persons living with disability.

According to Kumurenzi (2011), Statistics South Africa (2005) reported that the prevalence of disability was between 5.9% and 12% of the population. Of these, 52% were women, 47% were men, 82% were African, 8% were White, 7% were coloured and 1.8% were Indian/Asian.

2.2.3 Types of disability

There are different types of disabilities, but the most common one is physical disability (for example, congenital deformities, paralysis and amputation). Physical disability has a greater impact on those affected and therefore causes more long term suffering. Other types of disability include visual and hearing disabilities (for example, being blind, dumb or deaf). Intellectual disability has been shown to have a direct impact on the family and community of the PWD (WHO, 2006; Motghare, Venugopalan & Kulkarni, 2008). Physical disability can occur due to trauma such as brain injury, spinal cord injury, amputation, and stroke. It can also occur due to some diseases such as diabetes, hypertension, rheumatoid arthritis, and poliomyelitis (Kumurenzi, 2011).

Other studies showed that there are visual disability (32%), followed by physical disability (30%), hearing (20%), emotional (16%), intellectual (12%) and communication (7%). In the Western Cape 4.7% of the population were disabled. The most prevalent disability in this province was visual disability (28%), followed by physical disability (24%), then 20.8% who

did report a specific disability, then hearing (13%), mental (9.6%) and multiple disability (4.5%) (Kumurenzi, 2011).

One of the main challenges facing PWDs is that rehabilitation services are usually designed to serve adults, and often do not provide appropriate services for young people (those aged 10-24 years) (Groce, 2004). Children with disabilities in many rural areas receive no education or rehabilitation care and will continue to be disabled throughout their lives as their potentials for personal development go unrealized (Groce, 2004).

2.2.3 Coverage for people with disabilities

It is important to provide health services in the community and it is common for the provincial and local government to make decisions about the best way to provide those services. The standard of service is not commonly the same in all communities and there are different facilities that provide the same services in different conditions. For example, the use of mobile clinics in isolated rural areas may be compared to polyclinics in high-density urban areas (DOH, 2000).

There are 4,200 public health facilities clinics in South Africa each clinic serving about 13,718 people, which means that, on average there are 2.5 visits per year to public health facilities, while between 65% and 77% are admitted to hospital (Jobson, 2015). There are 376 public hospitals in South Africa, with 143 in urban areas and 233 in rural areas. According to the Health Professions Council of South Africa there are 165,371 qualified health care practitioners, including 38,236 doctors and 5,560 dentists. This means that there is one doctor for every 4,219 people in the public sector, taking into account the 73% of general practitioners who work in the private sector (Jobson, 2015).

There are 238 private hospitals in the country, with 188 in urban areas and 50 in rural areas. Medial aid schemes provide health insurance for 16.2% of the population (about 8.2 million people). The private sector spends about R120.8 billion annually. There are around 3.4 million principal members and 7.8 million beneficiaries (Jobson, 2015). The public healthcare system still delivers health services even though there are inefficiencies, inadequate quality of care in some services, and poor infrastructure in some areas.

Injuries may cause disabilities which prevent or challenge completing even basic daily activities. In such a situation rehabilitation is often necessary. According to the WHO (2011) rehabilitation does not return back or undo the damage caused by disease or injury but instead it aims to help the individual enhance their quality of life and achieve the highest level of function that they are capable of. In the following section, an overview of rehabilitation as well as the challenges faced at global and continental levels will be discussed.

2.3 Rehabilitation

The rehabilitation strategy aims to help PWDs and to remove barriers to getting an education and finding suitable employment opportunities. The WHO report on disability identified that there are partnerships, for example, with the World Bank Group that aim to provide appropriate solutions to remove these barriers (WHO, 2011).

2.3.1 Rehabilitation in Africa

According to the United Nations (2007), every PWD should have an equal opportunity to access available services, such as transport, information, and the physical environment.

Rehabilitation services include different health professions such as physiotherapy, doctors, nurses, social workers, psychologists, and occupational therapists. However, there is a limited

number of therapists and other health professionals in hospitals and CHCs in Africa, and also a shortage of these staff in the community. This leads to the failure to provide appropriate services to a large proportion of the population, in addition to the lack of resources that exposes patients to danger (Gona, Newton, Geere & Hartley, 2013).

In study by Masasa, Irwin-Carruthers & Faure, (2005), health professionals need to be trained to be culture-sensitive and to respect the beliefs and views of their patients. It is important that there is a level of understanding and respect between health professionals and patients who believe in the value of traditional medicine, while at the same time, trying to increase awareness of rehabilitation services.

In a study by Praet, Speybroeck, Manzanedo, Berkvens, Nsame Nforinwe, Zoli & Geerts, (2009), the percentage of people with disability in North-West Cameroon is higher than any other area in Cameroon. Even though there have been attempts to provide treatment and rehabilitation for PWDs in Cameroon, these attempts are insufficient.

Rehabilitation services in the Eastern Cape in South Africa provide assistance to many people requiring rehabilitation. This includes patients with burn trauma, head injury, trauma, hand injury, stroke, cardio-respiratory and other disorders (Grut, Mji, Braathen & Ingstad, 2012). These necessary services focused on urban areas and therefore do not reach all PWDs, many of whom live in rural areas. In an attempt to overcome this problem and increase the number of rehabilitation services in rural areas, there are six new rehabilitation units in Gauteng, KwaZulu-Natal and the Free State. This includes various rehabilitation physiotherapy services, and there is an attempt to expand these services to the local areas, as well as to include all other regions of South Africa (Chappell & Johannsmeier, 2009).

According to Grut et al. (2012), while people in affluent countries have the ability to take advantage of more health services, in developing countries, poor service delivery means that PWDs do not see or feel the results of the effective and speedy treatment services that are available in other countries. People with disabilities are one of the most vulnerable populations and as a result, face exclusion from other aspects of society (Ingstad & Whyte, 2007; Saloojee, Phohole, Saloojee & IJsselmuiden, 2007; McColl, Jarzynowska & Shortt, 2010).

One of rehabilitation services that needs to be developed and must be available is the psychological rehabilitation services. In a study by Simpson and Sambuko (2012), it was found that psychological rehabilitation services in South Africa were not consistent because of the lack of coherent policies around mental health.

Poor people are usually the ones who most need physiotherapy and rehabilitation services, but despite the progress in service provision and access to more resources, they are still not accessing services for poverty-related reasons (Maleka et al., 2008).

According to a study by Steyn, Kazenellenbogen, Lombard & Bourne (1997), in the Cape Peninsula of South Africa the period of the segregation, were found that people who have lived longer periods of their lives in urban areas tend to live unhealthy lifestyles more than in rural areas.

In a study carried out by Chappell and Johannsmeier (2009) in South Africa, they highlighted the existence of gaps in the provision of services, which did not take into account the basic needs and the social circumstances of the family, such as the provision of transport. The same study showed that the provision of rehabilitation services differs from one region to another and that these problems encompass community development, poverty, the lack of equal opportunities, despair, and isolation.

South Africa is a multicultural, multiracial and multilingual nation with many different values, traditions and cultural practices. This may lead to different attitudes and practices around disability. These different contexts may affect the type and quality of rehabilitation services that are provided, and lead to misunderstandings between professionals and clients due to these differing points of view (Groce, 1993; Masasa et al., 2005). An understanding of these differences in cultures may help rehabilitation professionals understand the views of families who are concerned about healthcare and rehabilitation (Groce 1993, Masasa et al., 2005).

Patients who have undergone rehabilitation services have reported both positive and negative experiences. This reduces the attainment of functional independence for patients and the lack of opportunities to improve their lives.

In order to improve the quality of rehabilitation services, stakeholders must take into account the views of the patients and their unique challenges and attempt to integrate them into the provision of rehabilitation services (Kahonde, Mlenzana & Rhoda, 2010). By drawing on the expertise and experience of patients, there is a better chance of improving the quality of services provided, rather than relying solely on reports from service providers (DOH, 2000).

Patients' satisfaction with rehabilitation services depends on many factors including: their personal experiences with the service, the emotional and psychological support that is offered by the service providers, family participation and level of encouragement, access to services provided, and the level of attention and respect paid to the patient by the service provider. In addition, in some areas of the Western Cape, public transport options are limited for PWDs (Kahonde et al., 2010).

The problem of transport constitutes a psychological, physical and financial burden on PWDs, which may negatively impact their rehabilitation. Because of the public transport problems,

PWDs are often required to hire cars from neighbours, which is expensive. This often impacts on their ability to regularly attend rehabilitation appointments (Kahonde et al., 2010).

Another problem is that service users are not always aware of their rights to access rehabilitation services (DOH, 2000). They often do not receive information about their situation, how to resolve their challenges, or have their support options explained to them.

Therapists have an important role to play in teaching patients how to mitigate their loss of function, and how to adapt and adjust to the use of compensation methods related to their disability that would enable them to return to productive lives (Maqway, 2012; Mlenzana, 2013).

Physiotherapy rehabilitation in the Western Cape covers different types of rehabilitation, including patients with heart and lung disease, neurological impairment, occupational health, gerontology, paediatrics, orthopaedics, sport, women's health, and a variety of other medical specialities. Occupational therapists in the Western Cape reported that the development of vocational rehabilitation services is essential to the development of PWDs (Coetzee, Goliath, van der Westhuizen & Van Niekerk, 2011).

The national health policy in South Africa has issued a resolution in support of primary health care (PHC) and its effects on the nature of treatment available (Rhoda, Mpofu & Weerd, 2011). Stroke patients in the Western Cape have shown improvements in their daily lives from two to six months following the initial injury, but even so they were not able to participate fully in society (Rhoda et al., 2011).

According to Rhoda et al. (2011) 50% of stroke patients in the study are unable to use public transport, shop independently and climb stairs. That related to 80.7% of the participants

classified in the lower income, which means that most of them had to make use of public transport.

2.3.2 Global challenges for rehabilitation

Even though there has been an improvement in rehabilitation services it is still not easily accessible for most people, especially in developing countries compared to the significant developments in rehabilitation services in developed countries, largely as a result of the use of technology.

The National Rehabilitation Policy (2000), which describes the enhanced delivery of rehabilitation services to all individuals, was not implemented. This policy was developed in order to facilitate the realisation of every citizen's constitutional right to access rehabilitation services, and yet patients still struggle to access rehabilitation services in the Western Cape (Mlenzana, 2013). In 2002, the Ministry of Health put a strategy in place in the Western Cape in order to raise and improve rehabilitation services by 2010. That plan has now been extended to 2020 (Mlenzana, 2013). This 2020 document was developed because of the problems that were experienced with the previous system by both patients and health care professionals. Mlenzana (2013) identified a gap between the needs of the patient and the rehabilitation services they accessed, and that a lack of information in their medical files led to suboptimal outcomes. There was also a lack of rehabilitation service providers and, while some centres had permanent staff, others only had seasonal staff.

Most people with disabilities in South Africa face barriers in their daily lives, making it difficult for them to access work, education, and social activities, which leads to poverty (Mlenzana, 2013).

The World Bank reports that up to 14% of people are considered to be affected with some degree of disability (Wade & de Jong, 2000). This increases the pressure on and use of rehabilitation services.

Globally, studies on rehabilitation have been conducted in order to explore the underlying knowledge and factors that affect the delivery of rehabilitation services on the part of both patients and professionals. For example, a study carried out by Horner, Swanson, Bosworth & Matchar (2003) looked at the effects of race and poverty on the process and results of patient rehabilitation in the United States. The study differences in outcomes were based on patients' racial characteristics. Furthermore, delays in receiving rehabilitation services were observed with low-income patients in the study. This highlights the relationship between patients' socio-economic status and the barriers they face in accessing rehabilitation services.

The sharing of information between the patient and health care provider may improve diagnoses, promote self-care and patient education, which has been hastened by the use of electronic medical records (EMR) in Canada, America and Britain (Perera, Holbrook, Thabane, Foster & Willison, 2011).

According to Graham and Cameron (2008), the Australian Bureau of Statistics (ABS) carried out a survey assessing the restrictions and limitations of all individuals across Australia who having disabilities. According to this survey of ageing, disability and carers, about 20% of Australians have a disability, which was defined as a "limitation, restriction or impairment which has lasted or is likely to last for at least 6 months and restricts everyday activities." About 17% of respondents had specific restrictions or limitations, and 15% reported core activity restrictions (with 6.3% having profound or severe restrictions, and 8.8% reporting mild or moderate restrictions). The disability rate was 19.2 per 100 people in major cities, 21.2 per 100

in inner regional areas, and 22.1 per 100 in other areas in Australian (Graham & Cameron, 2008).

The challenges facing the majority of cases of disability include a lack of services in hospitals, lack of development opportunities for providers of services because of the limited time for each patient per week, and a lack of transport for patients (Rose, Ferguson, Power, Togher & Worrall, 2014). Stroke patients in South Africa were found to receive treatment at a rate of once a week in 2011 (Rhoda et al., 2011).

In France, the United Kingdom (UK), New Zealand, and the United States of America (USA) there is a high incidence of death from the cardiovascular disease (Walters, Sarela, Fairfull, Neighbour, Cowen, Stephens & Francis, 2010). Walters et al. (2010) conducted a study in Australia on the rehabilitation of patients with myocardial infarction through the use of mobile phone and the Internet. The study explored the use of cell phones and the Internet to send reminders to patients about appointment and exercises as part of the rehabilitation programme. It was found that the benefit of this method was to improve the provision of rehabilitation at home. In addition, it may also be used to monitor the follow-up of the patient's condition, which will serve to reduce the mortality rate.

In India, there are many kinds of disabilities in evidence across the country (Kumar, Roy & Kar, 2012). Poverty is a very important barrier when it comes to accessing rehabilitation services in the community, especially in developing countries and rural communities. The lack of service availability is one of the biggest problems faced by Indian populations. In a study done by Kumar et al. (2012) it was found that the main problem in India is the cost of rehabilitation services, and that the majority of people in need of these services live in rural areas.

Patients who have suffered from a stroke are exposed to different complications that lead to challenges in their functional activities, and returning them to their previous functional status has been the aim of several studies and research projects.

The integration of those with disabilities in society will not come about until the barriers between PWDs and the community is addressed. These barriers are most often in form of attitudes of service providers, specialists and teachers, co-workers, employers, parents and even the disabled themselves. It is important to know the attitudes of the non-disabled and health service providers, because knowing whether they are negative or positive will help to determine which aspects of programmes to correct in order to improve community integration during the rehabilitation programme.

2.3.3 The experiences of rehabilitation staff

The experience of caregivers is usually dependent on the physical dependency of the patient, and the mental and emotional health of the patient. According to Mlenzana (2013), the rehabilitation staff experienced financial challenges that were associated with transportation. On the other hands, they experienced a good interaction with their therapists in terms of sharing the necessary information. Caregivers highlighted that access to rehabilitation services was not a problem, even when using assistive devices.

2.4 Community based rehabilitation (CBR)

Reaching health experts' censuses on how rehabilitation service should be provided is one of the objectives of this study. To do so, it is important to understand the concept of CBR, its components and guidelines.

2.4.1 Definition of CBR

CBR is a strategy within general community development for the rehabilitation, equalization of opportunities and social inclusion of all people with disabilities. CBR is implemented through the combined efforts of people with disabilities, their families, organizations and communities, and the relevant governmental and non-governmental health, educational, vocational, social and other services (WHO, 2005).

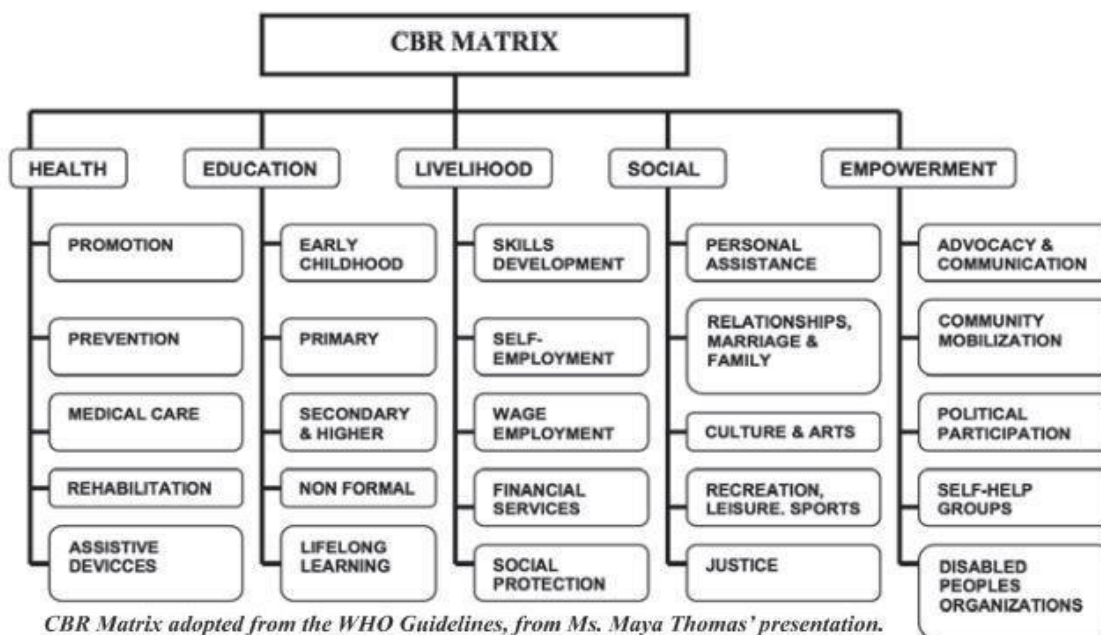
2.4.2 Components of CBR

The idea of the CBR matrix is based on a strategy of disability development and underlying participation, inclusion, sustainability and empowerment through self-advocacy. The CBR matrix consists of five components including: Health, Education, Livelihood, Social and Empowerment. PWDs and their families should be able to control the resources and decisions that are made in the programmes that are developed for them. This means that PWDs should take opportunities to make decisions with respect to how CBR programmes are implemented (Motsch, 2008).

Even when CBR programmes are in place, many PWD are still not able to access essential rehabilitation services, as well as not participate equally in many activities in their communities (WHO, 2005). CBR has been promoted for more than 30 years as an important component for improving quality of life and to provide rehabilitation services for PWDs. The main role of CBR was to provide rehabilitation services in countries with limited resources (WHO, 2011), and to promote cooperation between community leaders, PWDs and their families, and other people in the community (WHO, 2005). Currently, more than 90 countries around the world developed CBR programmes (WHO, 2011). In South Africa, CBR was initially developed in 1985 by rehabilitation professionals and PWDs. It also initiated a set of programmes

implemented by the professional associations of occupational therapy, physiotherapy and speech therapy, who oversaw the training of community rehabilitation workers (CRWs) (CREATE, 2015). These training programmes started in three places in South Africa; Khayelitsha in Cape Town (SACLA1), Alexandra Township in Johannesburg (IUPHC2), and in Acornhoek in rural Limpopo Province (CORRE3). Most of the staff who were trained in CBR programmes did not have disabilities, although some of them had relatives who were disabled. In 1998 CBR was further developed in Mpumalanga Province, and today has finally been integrated into the National Rehabilitation Policy of the Department of Health as a philosophy that underpins rehabilitation services (CORRE3).

Figure 1 Figure to CBR matrix display table



With respect to health, CBR aims to increase the awareness of society regarding health promotion as a primary prevention strategy. It also targets the provision of medical care within the community including medical care for PWDs which is an important part of rehabilitation.

The education component of the CBR matrix aims to expand early childhood care and education, provide free compulsory primary education for all, and improve the quality of education. These aims are part of a global movement led by The United Nations Educational, Scientific and Cultural Organization (UNESCO) in order to provide quality basic education for all children (WHO, 2011).

Livelihood in the CBR matrix means securing basic needs for survival, like food. For that, CBR aims to improve the skills of PWD in order to secure employment and to increase their chances of being employed, whether it is self-employment or salaried employment. The improvement of financial status of PWD's is also one of the CBR matrix concerns in order to support disabled individual to secure their basic needs. The lack of social protection, funds, and support leads to problems in the livelihood of PWDs. Over time, these challenges has made it economically difficult in both high and low income societies.

The social component of the CBR matrix strengthens PWD's participation in society and improves their social situation. For example, justice in their social life is required; they have the right to marry, raise a family, and to be involved in sports without any political, cultural, and social challenges.

2.4.3 Guidelines of CBR

As shown in the previous section on CBR matrix, it includes multi-dimensional sectors and needs. Therefore, targeting one or two sectors is not enough to apply all the needs of PWD's.

Another issue is to access the services by PWD's. It is one of the main challenges for CBR (Motsch, 2008). CBR guidelines (WHO, ILO and UNESCO) can be used to insure that rehabilitation and health services are provided to all people who are in need (Motsch, 2008).

The CBR guidelines are flexible, which means that they can accommodate different ideas, different experiences and different examples in order to promote and describe practical strategies. The guidelines provide ways to achieve the aims through a focus on inclusive development for CBR (Motsch, 2008).

The guidelines contain four sections, the core components (which include Health, Education, Livelihood, Social and Empowerment), CBR management, and supplementary chapters.

According to WHO (2011) we can summarise the CBR guidelines as:

- (1) Provide guidance on how to develop and strengthen CBR programmes,
- (2) promote CBR as a strategy for community-based development involving PWDs,
- (3) support stakeholders to meet their basic needs and enhance the quality of life of PWDs and their families,
- (4) encourage the empowerment of PWDs and their families.

2.5 Community rehabilitation facilitators (CRFs)

Community Rehabilitation Facilitators form one of three programmes of CBR. It is the major programme of CBR in South Africa because of the difficulties in getting health professionals to work in the community (Chappell & Johannsmeier, 2009). The CRFs also have a big role to play in raising awareness of disability and disability rights, as more than a quarter of CRFs in South Africa have disabilities or have family members who are disabled (Chappell & Johannsmeier, 2009). According to Chappell and Johannsmeier (2009), CRFs play an important role in the lives of PWD and increase community understanding and awareness of

disability. According to Chappell and Johannsmeier (2009), CRFs do not solve all problems and challenges such as poor identification of the needs of PWD, basic needs that are not met, and a lack of social awareness of family situations. These gaps are different in each area, and are also influenced by external factors such as transport and local infrastructure.

2.6 Public health care (PHC)

PHC is an integral aspect of rehabilitation services. In South Africa, public health care was historically located within secondary or tertiary institutions. These services focused on individual therapy using a biomedical approach. Community Health Centres (CHCs) were designed to position primary health care services within communities, offered by, for example, physiotherapists and occupational therapy services (Kahonde et al., 2010).

Primary health care is the first point of contact that individuals, families and communities have with the health care system. Selective primary health care is concerned with which medical interventions are most cost-effective for improving the health status of the majority of people in developing countries (Rifkin & Walt, 1986).

Primary Health Care is essential health care that is made universally accessible for individuals and families in the community, by means that are acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part of the country's health system, of which it is the nucleus, and of the overall social and economic development of the community (WHO & UNICEF, 1978).

2.6.1 Structure of PHC in South Africa

There are some factors that affect the PHC's structure in any community, such as the availability of local staff to assess their own performance and that of their clinic, a community

that is able to recognise the services that they need, planning by provincial health services, and provincial governments to guide resource allocation (DOH, 2000).

According to Kautzky and Tollman (2008), there are six important structures of PHC in South Africa, starting with the national Department of Health which is responsible for the national health policy. After that each Provincial Department of Health is responsible for developing provincial policy within the national policy framework. There are then three tiers of hospital within each province: Tertiary, Regional, and District. In the district hospital and community health centres the primary health care is driven by nurses. Preventive and promotive services are therefore the responsibility of the government. The private health system includes private hospitals that are funded by medical aid schemes.

2.7 Community health centres (CHCs)

Community health centres in South Africa are seen as first-line centres for all patients who are in need of health services. CHCs are defined as facilities that are given to the other PHC services, and provides 24 hour accident and maternity and emergency services, and up to 30 beds where patients can be observed for a maximum of 48 hours (Cullinan, 2006). There is some confusion of roles and services in certain places where CHCs are similar to district hospitals, for example, for the services there is a procedure room but not an operating theatre, and no general anaesthetics given to the patient at CHCs (Cullinan, 2006).

They offer services at CHCs such as mother and child care, immunisation, family planning, treatment for sexually transmitted infections, minor trauma, and care for those with chronic illnesses such as diabetes and hypertension and all rehabilitation services that improve quality of patients live. They also provide services namely prevention, curative, promotive and accessibility, reporting of illness in early stages and delivery systems (Cullinan, 2006; Mlenzana, 2013).

The rehabilitation programs should at least have a physiotherapist, an occupational therapist, a nurse, counsellors, speech therapist and therapy assistants to provide continuity of care (Mlenzana, 2013). According to Mlenzana (2013), there are large gaps in access to various types of rehabilitation professionals, with the consequence that most patients visited only one or two rehabilitation professionals. The CHCs include doctors and a clinical nurse's practitioner, physiotherapies, occupational therapies, nurses, occupational therapists, orthopaedic nurses, social workers, health promoters, home-based carer, speech therapists, dieticians, psychologists, radiographers and pharmacists (Mlenzana, 2013).

2.8 Patient and professionals' satisfaction

Patient satisfaction is considered to be a measurement of the quality of health care (Ng, Tey, Yew, Sia & Long, (2012). Some studies found that testing or measuring the satisfaction of those who attend rehabilitation services is very difficult, mainly because it is too hard to find general or global measurements. For example, according to Kieth (1998), evaluating the patient's satisfaction with rehabilitation services is an extremely difficult task, due to the fact that there are no standard measurement tools in place. Petrie, Cameron, Ellis, Buick & Weinman, (2002) conducted a study on patients' perceptions on their rehabilitation before and after myocardial infarction. The study found that patients were satisfied with the outcome, which resulted in patients' improvement and faster return to work. The factors affected patient satisfaction with rehabilitation services were not only about the centres themselves but could also be related to the patients', for example sex, age, level of education, and culture. These factors have been show to represent the varying rates and differences in the level of satisfaction of patients who attended rehabilitation services (Medina-Mirapeix, Jimeno-Serrano, Escolar-Reina & Del Baño-Aledo, 2013).

Extended waiting times for out-patient care is one of the main issues that patients complain about. In a study by King, Cathers, King & Rosenbaum (2001), parents responsible for their children's treatments were not satisfied with the waiting time for their children to be treated. Maini and Mannan (2004) conducted a study in the Netherlands which aimed at understanding the satisfaction of patients suffering from chronic rheumatic diseases, as well as the therapists' satisfaction. The study noted the efforts made by the therapists, who did their best to increase patients' satisfaction with treatment and to improve ways to achieve this. Patients' satisfaction with the treatment and the extent of their knowledge of the therapist's duties were presented in the study. The dissatisfaction reported by patients was with the time required for the completion of treatment, which was due to the long waiting period. Therapists' satisfaction of the programme and the services they provided was clearly presented, and they recommended the presence of more communication between team members.

According to Kamau (2005) patients' satisfaction in Kenya was good, as a result of the polite interactions with patients undergoing treatment for lower back pain. Patients' degree of satisfaction depends on the extent and depth of their interaction with the therapists. Successful rehabilitation depends on patients' satisfaction with the services they receive. According to Roberts, Stiller & Dichiera (2012), the services that provided at rehabilitation centres differ from one provider to another. One of the most important things that contributed to the dissatisfaction of the patient and provider was the lack of understanding between stakeholders as it led to a reduction of contact between them.

This could be attributed to a few reasons one of which is the poor availability of adequate rehabilitation services. Secondly, even where rehabilitation services exist, PWDs must often rely on family members or friends in their communities for support (Roberts et al., 2012).

According to a study on the satisfaction of stroke patients conducted by Mangset, Dahl, Førde & Wyller (2008), treating a patient with dignity and respect had a positive impact on the rehabilitation process, because it affected the confidence of the patient. When the service provider was indifferent, patients showed resentment and were dissatisfied.

Patients' satisfaction is considered as an important indicator of the quality of rehabilitation services and health care. But some patients are hesitant to criticise the providers of health care, especially around the most frequent problem found by researchers, which is the failure to meet the psychosocial and emotional needs of patients, as these are important in order to improve outcomes. When patients experience depression before or during rehabilitation it impedes their continued improvements even after rehabilitation has ended. When psychiatric treatment is included it may reduce the patients' setback by up to twenty-three percent (Beckman & Clark, 2015).

2.9 Gaps in the literature

This review of the literature included several aspects that may contribute to improved patient and service provider satisfaction in the health care system. The elements that contribute towards patient and health professions satisfaction are not clear at community health centres in the Western Cape.

According to Mlenzana (2013) there is a gap between the needs of the patient and their rehabilitation and that a lack of information may lead to poor outcomes. Shortage in rehabilitation service providers has been noted in the Western Cape health centres, which has also been linked to both patient and health professionals' satisfaction. The sharing of information between the patient and health care provider may improve diagnoses, promote self-care and educate the patient, and the use of electronic medical records (EMR) has been shown

to address some of these challenges. Another study by Mwansa (2010) showed that the factors that most affected patients' satisfaction are associated with non-compliance, and that the overall level of satisfaction was linked to professional competence, care providers, and the client-professional relationship.

The challenges facing the majority of PWDs include a lack of services in hospital, lack of development opportunities for the providers of services, high work load of health professionals leading to limited time for each patient per week, and a lack of transport for patients (Rose et al., 2014). The long waiting time for out-patient care is another major problem that concerns patients.

2.10 Summary of the chapter

This chapter presented the literature with respect to disability and rehabilitation both globally and in South Africa. It described various components of service delivery, including CBR, and discussed the policy and structure of PHC in South Africa. Finally, the chapter presented findings related to the perceived level of satisfaction of PWDs as it relates to health providers and relates this to the gaps found in the literature.

As a second step to achieve the aim of the study, research methodology will be discussed and explained in chapter three; methodology, where a description of the design of the study, research setting, population, sampling and data collection tools as well as the ethical consideration will be provided.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter discusses the methods and the description of the study design. Several methods were used to obtain the information, including workshop, focus group discussions and then a Delphi study that was used to reach consensus on the outcome from the focus group discussions. It will present a description of the research setting, study design, population, sampling and methods to enhance trustworthiness of the findings. The chapter also describes the method of data collection and analysis used, as well as all ethical considerations during the study.

3.2 Study Setting

The study was conducted at three of the CHCs that were selected based on their geographical location, including Centre 1 in the Metropole District, Centre 2 in the Drakenstein District and Centre 3 in the Metropole District. The centres were purposefully selected based on their different contexts.

The first centre was a community health centre that primarily served an urban population who were mostly unemployed. At this centre, patients accessed the Rehabilitation Unit either through referrals from other institutions or self-referral. The Rehabilitation Unit is run by a doctor and of the rest of the team including a physiotherapist, an orthopaedics sister, an occupational therapist, a seasonal dietician, doctors, pharmacists and nurses.

The second centre is a community day centre rendering rehabilitation services to both urban and rural communities. The patients at this centre are referred by primary health clinics in the

catchment areas and through outreach programmes. Doctors from the secondary hospital in the area also refer patients to the centre. A physiotherapist and two occupational therapists are based in this unit. A community service physiotherapist had not been appointed in the year of the study (2017) despite a vacant post. Doctors, nurses and pharmacists also play a role in the rehabilitation team at the centre.

The third centre is a semi-independent rehabilitation centre linked to a community health centre and an academic university in a rural area. Referral to this centre occurred primarily through the community health centre and walk in from private doctors and other referring hospitals. This rehabilitation team is run by a doctor specialising in family medicine. The centre provides physiotherapy, occupational therapy and social work services, while students from a local university provide speech therapy on a part-time basis. Doctors, pharmacists and nurses play a role in the rehabilitation of patients. There is a health promotion officer who plays a key role in the promotion of good health in the area.

3.3 Study design

Due to the nature of the study and its aim which was to explore the views of rehabilitation professionals regarding provision of rehabilitation services experienced by patients attending Community Health Centres in the Western Cape, an exploratory qualitative design was used. According to Creswell and Clark (2017), qualitative methodology was used to explain human behaviour. In addition, the qualitative method gave participants an opportunity to provide richer data than with quantitative methods and to explain their views openly. In this study, the qualitative approach was used to give rehabilitation professionals an opportunity to share their views on what might be done in order to address the concerns raised by participants in the 2013 study by Mlenzana (attitudes of rehabilitation professionals towards people with disability, information sharing between patient and health professional, lack of physical, financial and

human resources in the rehabilitation centres, access by patients to rehabilitation centres and access by service providers for CBR, referral systems, limited time and long waiting periods). An exploratory research design was conducted because a clear problem had not been defined. This approach allowed the researcher to familiarise herself with the problem or case or concept to be researched (Meyers, Gamst & Guarino, 2016). After sharing information with the rehabilitation professionals and getting their views on how to improve the services provided at the centres where they worked, the researcher analysed the information and conducted a Delphi study. A Delphi study is defined as a process where experts in the specific field of knowledge are taken through the process of reaching consensus on an issue at hand. In this context, the experts were rehabilitation professionals with the knowledge and experience of working in the rehabilitation sector. All participants were involved in three phase cycles of answering questions until they reached agreement with the statements provided (Helmer & Rescher, 1959). The first phase was based on the outcomes of FGD's. The second and third phase were based on consensus gained in the first phase.

In the Delphi study the researcher sent invitations to local, national and international rehabilitation experts in order to obtain input from a wide variety of experts.

3.4 Data collection method for the qualitative phase 1

The aim of this research was to explore rehabilitation professionals' views on the experiences of patients with physical disabilities accessing CHCs. A workshop was conducted to inform the participants about what patients shared regarding rehabilitation services at the CHCs. The information was related to how the recommended model of rehabilitation services came about as shown in (appendix 16). After the presentation, focus group discussions were used to collect data from the selected participants of this study based on what was presented in a workshop. The researcher invited the participants through the facility managers of the selected CHCs. The

three workshops and three focus group discussions were completed with participants in a venue that was convenient for them. Workshops and focus group discussions were conducted in English as most participants were comfortable with this language. The workshops and focus group discussion were audio-recorded after receiving permission from participants. The data collection methods for the FGDs and Delphi study are presented below and details about the workshops are provided in Appendix 16.

3.4.1 Population

The population in this study involved all rehabilitation professionals who were employed and available at the centres at the time the study was conducted. This included doctors, nurses, physiotherapists, occupational therapists, pharmacists, trauma specialists, clinical nurse practitioners, the administrators, facility managers, operation managers, orthopaedics nurses. Participants were invited to attend a workshop and focus group discussions where they were informed of the outcomes of the data collected at these centres in 2013, specifically the findings around the feelings of patients who had attended rehabilitation services at these centres.

3.4.2 Sampling

Rehabilitation professionals from the three centres were purposively selected. The sample composed of 34 participants who attended the workshops. There were twenty three participants from Centre 1, six from Centre 2 and five from Centre 3.

For the FGDs, there were seventeen participants. There were six participants from Centre 1, six participants from Centre 2 and five participants from Centre 3, and. All were approached individually and invited to participate as a result of their experiences with working with PWDs.

3.4.3 Data analysis

The audio from the workshop and FGDs were transcribed verbatim for analysis. The analysis began with the researcher listening to the voice recordings in order to become familiar with the data. Then transcription of the information from the audio recordings produced transcripts that were read through several times by the researcher, and the researcher analysed the data manually by using the Microsoft word. Data was analysed in relation to the six predetermined themes adopted from the workshop. Notes when reading the transcripts were done, followed by identification of categories linked to predetermined themes. Categories had internal convergence and external divergence which means that the categories were internally consistent but distinct from one another (Marshall & Rossman, 2014). After the identification of themes, an independent researcher reviewed the transcripts and generated their own themes independently in line with the predetermined themes, thus increasing the credibility and dependability of the themes. The lists of themes and categories of both the researcher and independent reviewer were then compared and discussed.

3.4.4 Trustworthiness of data

According to Lincoln and Guba (1985) trustworthiness in qualitative data is measured partly by its credibility, which is determined by the match between the assembled realisms of the participants, and the data drawn from the participants that are presented by the researcher.

Validity in qualitative research is inherent in the researchers' use of procedures of authenticity and trustworthiness (Lincoln & Guba, 1985). The trustworthiness of these qualitative data were increased by the researcher including the following components in the process.

3.4.4.1 Credibility

There are different ways to enhance the credibility of the data collected (Creswell, 2008). In the context of this study, the researcher used member checking and peer debriefing sessions. This was done by engaging the participants in the workshops to be familiar with the research problem and asking them to give feedback on the summarized data (Lincoln & Guba, 1985). Notes were taken during the recorded workshops and FGDs to check whether the researcher and the supervisor had the same understanding of the findings (Shenton, 2004). Thereafter the participants were given the summary of the transcripts to confirm the accuracy and clarity of the information (Shenton 2004).

According to Shenton (2004), credibility is a measure of how congruent the findings are with reality. The transcribed quotations of the data from the FGD were categorized into themes to ensure the credibility of the data (Graneheim & Lundman, 2004). Member checking for this study was done to improve the credibility of the information that was obtained from the FGDs. This was done by summarising the information from the field notes and presenting it to the participants at the end of the workshops and FGDs.

3.4.4.2 Confirmability

Confirmability refers to the objectivity of the study where the outcomes are supported by the collected data (Lincoln & Guba, 1985). To ensure confirmability, the researcher kept a record of all baseline data safely for further analysis, and provided enough substantiation that the findings and their interpretation were grounded in the data.

3.5 Delphi study Phase 2

The Delphi study population consisted of rehabilitation services experts as well as academics who had experience in rehabilitation services. To suit the purpose of the study, experts nominated from organizations such as the WHO, academics at universities and the experts working at CHCs were selected to be my research participants in Delphi study Phase 2. Experts were contacted individually by e-mails to determine their willingness to participate in the study. An information sheet outlining the purpose of the study and a consent form was signed and emailed back to researcher. The identities of the research participants were protected by not mentioning their names to the rest of the group when information about the outcomes was shared. Data collection was done by e-mails and the researcher used google form as a tool to collect data. The total number (N=40) of experts were identified and were all invited to participate in the study. The total number of participants who responded in the first round were seventeen (see sampling p. 32), and the total number of participants who responded in the second round were twenty (two doctors, two dentists, three occupational therapists, one clinical nurse practitioner, two professional nurses, three pharmacists, four physiotherapists, one rehabilitation manger, and two lecturers).

Round Three was conducted with the same twenty respondents who participated in Round Two. Each round took four weeks for participants to respond via e-mail. Consensus was reached after the second round of the Delphi study as at this point they had reached the target of 65% and above. Statements regarding the best way of providing rehabilitation services to patients with physical disabilities were based on the outcome of the first phase of the study. The Delphi study was originally designed to “obtain the most reliable consensus of opinion of a group of experts by a series of intensive questionnaires interspersed with a controlled feedback” (Ludwig & Starr, 2005; 93). Participants were given two weeks to complete the survey and

reminders were sent individually to all participants after one week. Each member was asked to comment on a range of statements that were rated disagree or agree. This process was repeated until consensus was reached regarding the relevance of the statements or when it became clear that no new information was forthcoming.

3.5.1 Data analysis

Data from the Delphi study was entered in Excel programme to get the average and the percentage of the feedback and analysed using tables in Microsoft programme. This process was applied to responses from each round of the Delphi study, with the level of agreement set at 65% in an attempt to reach agreement between the expert participants (Ludwig & Starr, 2005).

3.6 Procedure

Ethics approval for the study was obtained from the University of the Western Cape Senate Higher Degrees and Research Ethics Committees (appendix 1), the Western Cape Department of Health (appendices 3,4,5), and the Facility managers of the selected CHCs (appendices 6,7,8). Each participant in this study received an information sheet (appendix 15) and consent form (appendix 14) to sign before they participate in the study. Qualitative data was collected from participants through three workshops (appendix 16) and three focus group discussions. Three focus groups discussions were conducted in English by the researcher and one research assistant. The workshops and focus group discussions were conducted in three different health centres on three separate occasions. Each focus group discussion lasted an average of forty-five minutes and was conducted in a private quiet room within each community health centre. The room was private, comfortable, and nonthreatening to the participants. The workshops were based on the outcomes of the study that was completed in 2013 at the same CHCs.

Participants were allowed to ask questions and give suggestions for way forward that would address the challenges highlighted in the 2013 study. The 5, 6, and 23 participants from each centre who participated in each workshop respectively were selected based on their expertise in the field of rehabilitation. An audio recorder was used to record both the workshops and focus group discussions. Gathering information stopped when the researcher determined that participants were providing the same information. The researcher then developed questions based on the outcomes of the workshop for the focus group discussions which aimed to clarify the issues that were raised in the workshop. Finally, the Delphi study was conducted using questions that were developed based on the outcomes of the FGDs (appendix 11). Experts were invited to participate in the Delphi study and were asked to determine guidelines for how rehabilitation services CHCs should be offered (appendices 12, 13).

3.7 Ethics considerations

Ethics clearance and approval was obtained from the University of the Western Cape Senate Higher Degrees Committee (Appendix 1), the University of the Western Cape Research Ethics Committee, the Department of Health (Appendix 2). In addition, permission was obtained from the three CHC managers (Appendices 6, 7, 8). Furthermore, all participants received an information sheet providing details of the study (Appendices 10, 15), and informed consent was obtained from each participant voluntarily (Appendices 9, 14). The aim of the study was explained to the relevant administrative bodies as well as the participants.

Participants were assured that all information collected from the study would be kept confidential when reporting on the findings of the study, and that unique codes would be used rather than participant names. Participants were informed of their right to withdraw from the study at any time during the process of data collection with no negative consequences. Access to primary data was limited to the researcher and supervisor. The tape recorders and data were kept in a locked filing cabinet and storage area, and identification codes for participants were

only accessible by the researcher. All data was kept on a password-protected computer. The data will be destroyed after five years (2021). Participants and information from the Delphi study (appendices 11, 12, 13) has also been protected as the anonymity of participants was ensured by using unique identifiers for respondents. The anonymity of participants was protected as the emails were sent individually to participants. During the feedback sessions for the Delphi study no names were shared among participants as information was shared with the group via emails. All participant data will be protected in any articles or reports that are produced following this research project. The research findings will be made available to all stakeholders.

3.8 Summary of the chapter

An outline of the methodology of the current study was provided in this chapter. The research setting for the study was described, including the tools used to collect and analyse the data, as well as the procedures that were followed. Finally, the ethical considerations of the study were presented. The next chapter presents the findings of the study.

CHAPTER FOUR

RESULTS AND DISCUSSION OF FGDs

4.1 Introduction

This chapter presents the findings of the qualitative of the study which used the workshop and focus group discussions (FGDs) as data collection tools. Findings that relate to participants' experiences with patients will be presented as direct quotations of the participants' statements. Analysis of the data with verbatim transcriptions of all focus group discussions was coded into the predetermined themes and categories. In the presentation of the findings, verbatim quotations from discussions are used to illustrate the themes and sub-themes that emerged from the data. For the purpose of anonymity and confidentiality, the transcribed quotations from participants in the focus groups are cited in the cryptogram **FGDs1** to **FGDs3** for settings and **P1** to **P6** for participants. The demographic information for participants presented in table 2 below, the themes and categories are presented in table 1 below.

Table 1 Demographic information for participants

Setting	FGDs	Professionals	Years' experience	Age
Centre 1	FGDs1	Pharmacist	13	49
		Clinical nurse Practitioner	18	55
		Physiotherapist	9	31
		Trauma specialist	12	51
		Orthopaedic	18	43
		Doctor	7	32
Centre 2	FGDs2	Physiotherapist	13	39
		Clinical nurse Practitioner	17	54
		The administrator	10	40
		Occupational therapist	9	39
		Nurse	13	43
		Doctor	15	45
Centre 3	FGDs3	Pharmacist	10	44
		Physiotherapist	7	30
		Facility manager	19	56
		Nurse	15	50
		Occupational therapist	6	33

Table 2 Themes and sub-themes for focus group discussions (FGDs)

Themes	Category
Attitudes of rehabilitation professionals	<ul style="list-style-type: none"> - Reflections on bad attitudes - Hindrances to improve attitudes - Strategies for developing positive attitude - Component towards positive attitudes
Information sharing between patient and health professional	<ul style="list-style-type: none"> - Barriers to sharing information - Education and information sharing with patients - Communication challenges
Resources at the rehabilitation centres	<ul style="list-style-type: none"> - Human resource barriers - Physical space barriers - Financial resources
Access system	- System in place and difficulties
Referral systems	
Limited time and long waiting periods	<ul style="list-style-type: none"> - System in place - Spend time with patients

4.2 Attitudes of rehabilitation professionals

4.2.1 Reflections on bad attitudes

Health professionals in this study take responsibility of ensuring that they will work towards having positive attitude to their patients but they also report that it is difficult to maintain this attitude. In the views of participants their attitudes reflected factors such as long waiting times, no professional support and high load patient loads. In addition, some even complained about the behaviour of patients, which led to important barriers between the professionals and patients. This is what they expressed when they were asked about their attitudes towards the patients:

“So it is very hard to maintain a positive attitude that you would like to have, when you do not have enough support”. **FGDs2 P3**

“All you have to do is to maintain a positive attitude and be calm”. **FGDs3 P5**

“Unfortunately it does not always happen...because of the load of patients that must be seen every day. We would like to see things getting better”. **FGDs3 P1**

Health care professionals reported that it was difficult to maintain a positive attitude towards their work, as they had no support and high patient load, even sometimes the rude behaviours of patients to health professionals was one of the challenges for participants. The attitude of health and rehabilitation professionals has been determined to be one of the barriers that negatively affects disabled people to achieve their goals (Wilson et al., (2014). According to Cockcroft, Milne, Oelofsen, Karim, Andersson, (2011) health workers have many challenges when it comes to achieving their goals, including a lack of supplies, poor infrastructure, negative behaviour of patients, lack of professional support, low salaries, and a lack of motivation to do good work. Also, the high patient load at rehabilitation centres adds to the difficulties involved in achieving the rehabilitation needs of patients, which may lead to health care professional dissatisfaction (Kahode et al., 2010). It is evident that some of the health care professionals in this study found it difficult to remain positive in what they perceived as a stressful environment. They reported that one needs to be positive towards patients. Health professionals need to have a positive attitude towards their patients, and to respect them in order for them to receive positive feedback about the service provision.

4.2.2 Hindrances to improved attitudes

There are many obstacles to improving the attitudes of health professionals, including significant patient loads, lack of time, and a shortage of staff. Other participants also reported that the workplace environment is not adequately equipped.

“...they are so many (patients) and the staff can't serve them all”. **FGDs2 P3**

“...understand why patients are complaining....the main thing they complain about is the time factor, which is waiting long hours...shortage of staff and other little things that come in between”. **FGDs3 P1**

“...when I want to dispense to a wheelchair patient, the window is not wheelchair friendly so some facilities do have a cubicle that is lower, and we don't have that facility”. **FGDs1 P3**

Staff shortage increases the challenge when there is a high patient load, which in turn increases the staff workload which consequently increases waiting times for patients. Added to that, the lack of equipment increases the barriers to improved service providers' attitudes (Mlenzana 2013; Cockcroft et al., 2011). The rehabilitation centres have to be available and accessible for all PWDs (Kahode et al., 2010).

Rehabilitation professionals need sufficient physical and human resources, as well as have enough time to serve all patients who need treatment. Having these resources available will help to maintain a positive attitude.

4.2.3 Strategies for developing positive attitudes

Positive attitudes are not only premised on how rehabilitation professionals treat or work with patients. Inclusion, rapport, motivation, communication with patients as well as a balanced lifestyle are highlighted by research respondents as recommended practices and strategies by that can develop positive attitude among staff. In other words, improved communication with patients may also help them to understand and obtain better rehabilitation results.

“...start with the staff first, see that they are happy and not exhausted; if they are happy they will be able to give their all because they have the skills to take care of their patients”. **FGDs3 P2**

“...important to take care of your body, exercise, eat healthy and get enough sleep; a healthy body is a healthy mind”. **FGDs3 P5**

“So like with communication to the patients to make them understand exactly why they have to motivate not that we want them to be delayed but we have this process”. **FGDs1 P5**

Health care professionals reported that their lifestyles are stressful and that they understand what patients want. According to Satchidanand, Gunukula, Lam, McGuigan, New, Symons & Akl (2012) taking good care of PWD takes time and energy, and is exhausting for the health care provider. Hence Cockcroft et al., (2011) adds by saying that doctors and nurses also need to improve the poor interaction and attitudes towards patients. That is why they have to focus on taking care of their health in order to prevent the side effects of stress (Henderson & Tulloch, 2008). However, there are challenges with respect to developing staff health as it is evident that there are limited resources (Henderson & Tulloch, 2008). Attitudes of health care professionals are inter-linked with lifestyle as they switch off when they are dealing with patients when not at work. Therefore, health care professionals need to avoid stressful situations and focus on creating a more effective split between their daily lives and their work.

4.2.4 Component towards positive attitudes

The participants in this study reported that there are lines of communication between managers and staff that need to be followed if these are issues that need to be addressed. Improved communication between health care professionals and patients is one component of developing positive attitudes. Participants reflected on this by saying the following:

“If there is something wrong, one needs to communicate with the Operations Manager to see if things can be done in a different way or manner”. **FGDs3 P4**

“The health professional must listen to the patient, but it does not happen like that, not that you don't want to, but we do try”. **FGDs3 P1**

“Wheelchair patients usually get priority more than the others when they get to the pharmacy we always ask the security to put their folders on top”. **FGDs1 P3**

Health care professionals reported that communication is the key to a good relationship between patients and rehabilitation professionals. Communication is important when it comes to developing positive attitudes, whether with the patient or managers with respect to service delivery. Communication opens opportunities for employees to connect with managers so as to encourage professionals to achieve their objectives (Fillion, Rochette & Girard, 2014). In another study it was evident that good communication between patients with physical disability and professionals’ led to positive attitudes from both groups (Satchidanand et al., 2012). On the other hand, a study done by Cockcroft et al. (2011) found that nurses who spent too little time communicating with patients limited the amount of information shared, which had a negative impact on patient outcomes. According to Kumurenzi (2011) health professionals must make time to listen and talk to their patients even if they are overwhelmed with work, if they want to achieve positive attitudes. One of the strategies for health professionals is to prioritise patients in wheelchairs when they visit the rehabilitation centre (Kilonzo, 2004). It is evident that health care professionals struggle to adjust their methods of communication due to high patient loads. Having said this they are willing to change their communication skills to accommodate all patients even if it is only by a few minutes. There are a wide variety of strategies that can be implemented in order to satisfy all patients who are presenting with disabilities.

4.3 Information sharing between patients and health professionals

4.3.1 Barriers to sharing information

The health professionals in this study highlighted that there are important challenges with respect to sharing information with patients. Amongst these, they highlighted language as a significant challenge, especially when communicating with deaf people. Participants further

highlighted the limited time they had to address patients' social and health problems due to the limited number of social workers available in the CHCs.

"...the first and the biggest one is the language barrier". FGDs1 P1

"...it's quite difficult to get the message across if the patient is deaf". FGDs1 P3

"...the fact that a lot of patients that come to this facility are facing social challenges...expect us to look into these social problems before we deal with their health issues or concerns". FGDs3 P1

The wide variation in culture and language in South Africa is a big challenge to delivering health care services. According to Masasa et al. (2005), South Africa is a multi-cultural, lingual and -racial society, and all these differences may impact on rehabilitation service delivery. Masasa et al. (2005) says that the diversity of patients forces health care professionals to try and better understand the beliefs and cultures of their patients so as to be able to address their health issues. Another study determined that if health care professionals ignore the social circumstances of the patients then rehabilitation will be ineffective (Chappell & Johannsmeier, 2009). In addition to barriers that are due to language and cultural differences there are also important challenges when communicating with deaf people. The absence of social workers also hinders the process of care, leading to their identification as key members of the multidisciplinary team (Roberts et al., 2012). With enough social workers, it is easier to communicate, share information, and help patients more effectively.

Because language is an important barrier to be overcome, efforts should be made to accommodate all South African languages, including sign language, so that health care services are accessible to all.

4.3.2 Education and information sharing with patients

Health professionals do their best to help patients by sharing information and engaging them, sometimes by drawing pictures, or otherwise creatively using what is available. The other skill that they use to ensure that patients understand the rehabilitation process is to use pictures, repeat explanations, discuss concepts with patients, and use a translator or sign language. All of this helps to engage patients so that they may understand their treatment.

“I keep it simple in the beginning so that they get a clear understanding of what I am saying...draw pictures to illustrate the subject...repeat the explanation so that everyone can be sure of what is going on”. **FGDs3 P5**

“...but there is group sharing as well, so there is group talks while patients are waiting ... they do peer to peer education”. **FGDs2 P5**

“We could just learn basics of sign language”. **FGDs1 P3**

Health care professionals reported that if they use creative methods to share information it may help minimise communication barriers. This is evident from the information they shared where they discussed the possibility of learning sign language. Information and knowledge sharing are important for patients involved in the rehabilitation process (Mlenzana, 2013). Education and information sharing with patients and the community are important for preventing the complications of disability, as well as increasing awareness about disability (Masasa et al., 2005; Henderson & Tulloch, 2008; Mlenzana, 2013). However, health care professionals should learn sign language in order for them to share information with patients using a language of their choice. This is especially important when working in environments interpreters are unavailable (Kumurenzi, 2011). Therefore, education programmes are important in order that patients come to better understand their treatment rather than simply accept what is provided to them (Kahonde et al., 2010). This approach encourages patients to get more information

about their process of care. In addition, staff will be encouraged to share more information with patients as part of educating them about their condition.

4.3.3 Communication challenges

The challenge of communication was a problem for all centres in this study. Communication with patients in order to share information takes time, as does learning about the background of patients in order to better understand them. Communication barriers can occur with patients who cannot read or with those who have other challenges with language.

“...must know the background of the patient, and if the patient will be able to understand the instructions given on taking the medication”. **FGDs3 P3**

“Maybe if we could get translators, we don't have the funds for”. **FGDs1 P1**

“I think there is little time for information sharing”. **FGDs2 P5**

Health care professionals reported their concerns around communication with patients, especially during consultation. Language was the main barrier as patients did not understand simple instructions regarding exercise or taking medication. Rehabilitation professionals know that communication is the key to improved health care, but patients are not always aware of their right to communicate in a language of their preference, nor do they have enough confidence to ask (Kahode et al., 2010; DOH, 2000). As a result, patients often have difficulty sharing information as part of open communication about their conditions (Fillion et al., 2014). There are several factors that affect the communication process, including personal background and culture of the patients (Masasa et al., 2005), as well as the lack of time and limited availability of translators at rehabilitation centres (Drainoni, Lee-Hood, Tobias, Bachman, Andrew & Maisels, 2006; Mlenzana, 2013). It is clear that health professionals need to have time to communicate effectively with their patients, including being able to learn about the

background and the social and community environments of their patients in order to facilitate the communication process.

4.4 Resources at the rehabilitation centres

4.4.1 Human resource barrier

There are challenges with respect to the provision of resources, especially human resources. The participants in this study identified the relationship between staff shortages and workload as the most important barrier to an effective rehabilitation process. Both staff shortage and workloads were strongly connected to budget constraints. In other words, staff shortage is a challenge that is also connected to patient load. . Therefore, more staff are needed in such cases as highlighted in the following participant's opinion.

“The problem with that is the work load...we get people from all over...they want to come here. They can go somewhere else but they want to be here”. **FGDs1 P3**

”more staff at the rehabilitation centre can definitely help”. **FGDs2 P3**

“The shortage of staff, it still is going to a problem because you always hear that they are cutting down at some post because of budget constraints”. **FGDs1 P5**

In South Africa, there are high numbers of patients who need access to health services relative to the number of the rehabilitation workers who are available to manage them. Therefore, alternative workers in rural areas must form part of rehabilitation services in order to meet the increased demand and economic and social crisis (Gamiet, 2015).

Health care professionals in this study reported that they needed more staff because of the high patient workload but the associated budget constraints were overwhelming. The shortage of staff due to budget constraints may influence the outward migration of health workers as a

result of poor working conditions (Henderson & Tulloch, 2008). In South Africa, the shortage of health professionals is one of the main challenges to effective patient management (Mlenzana, 2013). Kahonde et al. (2010) identified several obstacles to successfully addressing the problems of staff shortage and high workload. Increasing the number of health professionals in the rehabilitation centres was advised by the study participants, which would help the centre in accommodating the high numbers of patients who arrive to access services. In addition, this will also reduce the workload on staff.

4.4.2 Physical space barrier

In addition, participants reported challenges with the provision of equipment and having adequate space to use and store it. The necessity of keeping a lot of equipment in very small spaces leads to inaccessibility, as reported by the following participants.

“Space is always a problem, but it’s possible to work from a small space, do your thing and still get your targets...but if there is a bed and a desk, it’s still ok, because it’s not about you, but the patient”. **FGDs3 P2**

“We can try and motivate ourselves to alleviate the challenges that we have and that’s basically the only thing we can do, and then follow up, beg for the equipment to be provided”. **FGDs2 P3**

“I think when you think of other structures when you walk in here it’s crowded and inaccessible”. **FGDs1 P3**

Making sure that the physical space available for equipment storage and use is essential for a safe and effective working environment (WHO, 2016). In other words, having equipment’s in enough space will help in easy access which allow health workers and patients to have better working and functional environment. Therefore, having better and successful rehabilitation process will be facilitated (Henderson & Tulloch, 2008; Mlenzana, 2013). According to

Drainoni et al. (2006) there are structural barriers facing PWDs, including inadequate space and lack of equipment. These are important factors to consider in order to improve and the provision of health services.

4.4.3 Financial resources

Financial resources are a major challenge that was mentioned by participants in this study, as it often prevented them from having their needs met within the centre. Due to these financial challenges, the government does not pay overtime to health professionals, which further reduces their motivation for working overtime.

“... If the director says there is no money to fill in a post, or a post is closing, then we are stuck, there is nothing one can say or do”. **FGDs3 P2**

“...but in terms of the structure I don't think, we will need some funding in order to provide a service”. **FGDs1 P4**

“...in the government sector we do not get paid overtime, ...so people end up not being able to go the extra mile because they know there is no compensation for any of the things they do”. **FGDs3 P4**

Health care professionals in this study reported that, while they were satisfied with the centre structures, they were not satisfied with the non-payment of overtime. Centre directors reported that, due to budget constraints, they were not able to supply all of the necessary equipment.

Financial barriers have previously been identified as one of the challenges facing the health care system (Phethlu, 2017). According to the National Rehabilitation Policy document, there are financial resources and available budgets for each health centre, and health professionals have the right to access it in order to address their needs (Mlenzana, 2013). From this perspective it seems that the government is responsible for overtime payment for eligible workers, which would encourage them to maintain and improve the services they provide

(WHO, 2016). The question of income is an important one for health workers who have questions about whether to remain in the health sector (Henderson & Tulloch, 2008). Therefore, government should seek to encourage health workers to improve their services by paying overtime for any extra work that is performed.

4.5 Access System

4.5.1 System in place and difficulties

Participants in this study focused on the physical infrastructure when discussing accessibility, including patient comfort and wheelchair access.

“We use a booking system. If a patients needs crutches ...that one can be helped on the day. If a patient needs to be assessed, they get a date they must come on”. **FGDs3 P5**

“I think we have a policy where persons with disabilities or wheel chair bound patients are seen first or quicker, but they are so many and the staff can’t serve them all, they still wait on the line for the persons with disabilities”. **FGDs2 P3**

“Environment really needs to improve, make the place a little bit comfortable and warm”. **FGDs1 P1**

Health care professionals reported that the booking systems and policies helped when trying to supply assistive devices and wheelchair accessibility. This is aligned with aims to improve the quality of access and patient outcomes (WHO, 2016). However, it should also be noted that it is difficult for patients to keep their appointments when they don’t have own transport, so even if the physical infrastructure in rehabilitation centres facilitated access, it would not address all of the concerns (Masasa et al., 2005, Mlenzana, 2013). This negatively affects patients’ ability and motivation to try and access health services. This study identified a relationship between

the daily workload and the space required in order to reduce patient waiting times and facilitate access.

4.6 Referral system

This study showed that there is a need for patient referral during the rehabilitation process, which can be made either within or outside the centre, depending on the availability of appropriate healthcare professionals. In this study, the referral system was not highlighted as a challenge and the communication between staff members were reported as being good.

“We do know about each other’s referral processes and the communication between the staff has improved. The referral system is not a challenge because we are practising it”. **FGDs2 P6**

“There are cases that you have to refer outside, our scope is limited, and we will need to refer”. **FGDs2 P3**

“It depends on the problem of the patient”. **FGDs1 P4**

Health care professionals reported that there were no challenges in the referral system due to good communication between rehabilitation team members. Referral also depended on the patient’s condition, which influenced whether or not the referral was made to health care professions within the centre or outside of it. Understanding of the referral system assists health providers in facilitating the rehabilitation process (Mlenzana, 2013). In this study the participants at one centre confirmed that referral system it is well understood and that communication between staff had improved. This seems to indicate that staff development had occurred since the 2013 study in the same centre. The availability of resources at the same centres made the referral and associated treatment easier.

4.7 Limited time and long waiting periods

4.7.1 Systems in place

This study identified several systems that were used in order to minimise waiting times and to better accommodate large numbers of patients. These centres used appointment systems, triage, and CDU (collection/delivery units).

“I think that appointment system can then also work because the reason why the time is limited is because of large number of patients that need to be seen”. FGDs1 P5

“We’ve got the CDU (collection/delivery units)...to reduce the waiting time so they don’t sit and wait long for the medication”. FGDs1 P3

“You have processes in place to minimize the waiting period by using TRIAGE (quick assessment). We stream the patients”. FGDs2 P3

Health care professionals reported that the use of an appointment system, triage and CDU were helpful systems to reduce the waiting times of patients. Long waiting times are an important problem in healthcare centres as patients are seen as overcrowding the centres (Mlenzana, 2013). It is strongly related to the increase in patient numbers and reduction of staff. This study showed that there is development in the system that is used to minimise long waiting times.

This study also showed that health professionals were aware of appropriate strategies for addressing the problem of long patient waiting times, a positive finding in South African CHCs.

4.7.2 Spent time with patients

The time spent with patients depended on their condition. Some patients’ needs only required a few minutes of attention, while others needed 10 to 15 minutes. Urgent patients were

prioritised with respect to accessing services. Education was also highlighted as being important during consultation with patients, as it helped with good time management.

”Patients differ; there are those you spend 3 minutes with, and the next one 10 or 15 minutes...There is no easy way of saying you spend so much time with a patient”.

FGDs3 P1

“it depends on the condition you have...It is still a challenge, but if you really need the help, you will get it...Urgent patients still get the care they need”. **FGDs2 P5**

“if we involve more stakeholders from outside like the NGOs, the support groups so that they explain to these patients that the importance of attending to their dates to collect their medication”. **FGDs1 P5**

Health care professionals reported that they spent different amounts of time with different patients and again mentioned that there were challenges with respect to helping all patients on the same day. Mlenzana (2013) also found that health professionals spent different amounts of time with their patients, depending on the specific case and situation (Kumurenzi, 2011). This means that health professionals can spend more time with patients who require more intensive treatment, although this means that fewer patients can be seen (Gamiet, 2015). According to Mlenzana (2013) health professionals spent less time with patients than expected, and some activities that were expected to be included in treatment sessions were not. This study identified the importance of collaboration by NGOs in the rehabilitation services. According to Henderson and Tulloch (2008), integration between government and non-governmental organisations ensured that better services were provided in order to serve patients as soon as possible.

4.9 Summary of the chapter

This chapter presented and discussed the underlying facts related to rehabilitation services at Western Cape CHCs, including some findings from a previous study that was conducted at the

same centre. The chapter identified health professionals' views based on the patients' experience and how it could be better managed. Professionals showed good awareness regarding the challenges in the rehabilitation services and what was needed in order to improve them.

As mentioned in the methodology chapter, a Delphi study was also used as a research method. Therefore, the following chapter; chapter five, is devoted to present and discuss the findings of the Delphi study.

CHAPTER FIVE

RESULTS AND DISCUSSION OF DELPHI STUDY

5.1 Introduction

This chapter presents the findings and discussion of the Delphi study, which was described in Chapter Three. The objective that this chapter aims to address is: to reach consensus on how rehabilitation services should be provided at the CHCs, based on the outcomes of objective one (explore the views of rehabilitation professionals regarding provision of rehabilitation services experienced by patients attending Community Health Centres (CHCs) in the Western Cape). The Delphi study had three rounds, beginning with the around about how rehabilitation services should be provided.

5.2 Results of Round One (appendix 11)

For the first round of the Delphi, six open-ended questions were asked to the seventeen Participants in FGDs, as outlined in chapter three and the demographic information outlined in chapter four. The summary of the responses in FGDs according to the emerging themes for each of the six open-ended questions is presented in table 3 format below.

The emerging themes are related to the reach of health experts' consensus on how rehabilitation services should be provided at the CHCs.

Table 3 Items, Questions, and Emerging themes for round one

Item	Question	Emerging themes
Attitudes of rehabilitation professionals	How to maintain a positive attitude?	<ul style="list-style-type: none"> - Good support - Enough staff - Enough time to respond to patients' queries - Accessible buildings and appropriate equipment for PWDs - Staff members who are happy and not exhausted - Staff who communicate well and listen to patients
Sharing information	How to share information with patients?	<ul style="list-style-type: none"> - Employ translators to address the language barrier - Provide pamphlets for patients to read - Learn the basics of sign language for patients who are deaf - Get promoter to educate patients - Provide television programmes in waiting rooms - Have discussions with your patients - Advise your patients about prevention measures - Draw pictures and repeat the explanations of the management process - Talks while patients are waiting - Ensure that there is enough time for patients to ask questions - Know the background of patients - Ensure that you see patients who were seen previously
Resources	What is the solution for the lack of physical, financial and human resources?	<ul style="list-style-type: none"> - Provide a bigger building to accommodate all staff - Request more equipment for assessment - Request more equipment for assessment - Use what you have for service delivery - Hire more staff - Create more space specifically for patients - Write motivations
Reducing waiting time	How to minimise waiting times?	<ul style="list-style-type: none"> - An appointment system - health information in the waiting room to reduce patient anxiety - An electronic board to provide queue information - Clear dates for collecting medication - A penalty charge per packet if patient did not collect - A TRIAGE system - Greater use of services provided by NGOs

Access system	How to improve access to services?	<ul style="list-style-type: none"> - Use a booking system - Have information boards for disabled or wheelchair bound patients - Attend to people who have disabilities first - Provide transport to the clinic - Make the clinic comfortable, clean and warm
Referral system	How to improve referrals system?	<ul style="list-style-type: none"> - Understand the referral system used in the health sector - Understand the roles that all health care professionals play - Follow-up on patients - Have all contact details of institutions you are referring to

5.3 Result of Round Two (appendix 12)

5.3.1 The experts' demographic information

The average age of the participants was 40 years old and the average number of years of experience was 12 years. Regarding the experience with rehabilitation, 60% (12/20) had between six and ten years of experience and 40% (8/20) had between eleven and thirty-six years of experience. Forty participants were invited and only twenty responded; ten females and ten males.

5.3.2 Description of respondents

The intervention programme described in the second round of the Delphi study was designed based on the emerging themes from the Round One of the Delphi study. The consensus for agreement in the Delphi was set at 65% or more (Sumison, 1998; McKenna & Hasson, 2002).

5.3.3 Consensus of attitude of rehabilitation professionals Round Two

All experts who participated in the study reached a consensus regarding the importance of positive attitude to improve rehabilitation services at the CHCs. The level of agreement for each item in the section is presented in table 4 below.

Table 4 attitude of rehabilitation professionals round two

Item	Consensus reached Agree/ disagree	Level of Consensus reached	Delphi round
To maintain a positive attitude you have to have			
Good support	Agree	100%	Round 2
Enough staff	Agree	95%	Round 2
Enough time to respond to patients' queries	Agree	100%	Round 2
Accessible buildings and appropriate equipments for PWDs	Agree	95%	Round 2
Staff members who are happy and not exhausted	Agree	95%	Round 2
Staff who communicate well and listen to patients	Agree	100%	Round 2

5.3.4 Consensus of sharing information Round Two

All participants agreed that the sections on information sharing (see Table 5 below) should be included in order to improve the quality of rehabilitation services at the CHCs.

Table 5 Sharing Information Round Two

Item	Consensus reached Agree/ disagree	Level of Consensus reached	Delphi round
To share information with patients you should			
Employ translators to address the language barrier	Agree	90%	Round 2
Provide pamphlets for patients to read	Agree	85%	Round 2
Learn the basics of sign language for patients who are deaf	Agree	80%	Round 2
Get health promoter to educate patients	Agree	90%	Round 2
provide television programmes in waiting rooms	Agree	85%	Round 2
Have discussions with your patients	Agree	100%	Round 2
Advise your patients about prevention measures	Agree	100%	Round 2
Draw pictures and repeat the explanations of the management process	Agree	95%	Round 2
Talk while patients are waiting	Agree	70%	Round 2
Ensure that there is enough time for	Agree	100%	Round 2
Allow patients to ask questions			
Know the background of patients	Agree	90%	Round 2
Ensure that you see patients who were seen previously	Agree	85%	Round 2

5.3.5 Consensus of resources Round Two

There was a variety of responses around consensus in the resources section on resources in the Delphi (see Table 6 below for the differences in agreement).

Table 6 Resources Round Two

Item	Consensus reached Agree/ disagree	Level of Consensus reached	Delphi round
The solution for the lack of physical, financial and human resources is to			
Provide a bigger building to accommodate all staff	Disagree	35%	Round 2
Request more equipment for assessment	Agree	85%	Round 2
Use what you have for service delivery	Agree	90%	Round 2
Hire more staff	Disagree	60%	Round 2
Create more space specifically for patients	Agree	75%	Round 2
Write motivations	Agree	85%	Round 2

5.3.6 Consensus access system Round Two

Participants reached a range of consensus around statements related to the issue of access system for PWDs (see Table 7 below).

Table 7 Access System Round Two

Item	Consensus reached Agree/ disagree	Level of Consensus reached	Delphi round
To improve access to services			
Use a booking system	Agree	90%	Round 2
Have information boards for disabled or wheelchair-bound patients	Agree	100%	Round 2
Attend to people who have disabilities first	Agree	95%	Round 2
Provide transport to the clinic	Disagree	55%	Round 2
Make the clinic a comfortable, clean and warm environment	Agree	100%	Round 2

5.3.7 Consensus the referral system round two

All participants reached consensus with respect to statements on the referral system (see Table 8 below).

Table 8 Referral System Round Two

Item	Consensus reached Agree/ disagree	Level of Consensus reached	Delphi round
To improve referrals you should			
Understand the referral system used in the health sector	Agree	100%	Round 2
Understand the roles that all health care professionals play	Agree	95%	Round 2
Follow-up on patients	Agree	100%	Round 2
Have all contact details of institutions you are referring to	Agree	95%	Round 2

5.3.8 Consensus reducing waiting time round two

Participants also achieved variation in agreement in the section of statements around reducing waiting times (see Table 9 below).

Table 9 reducing waiting time round two

Item	Consensus reached Agree/ disagree	Level of Consensus reached	Delphi round
In order to minimise waiting times there should be			
An appointment system	Agree	95%	Round 2
Health information in the waiting room to reduce patient anxiety	Agree	70%	Round 2
An electronic board to provide queue information	Agree	100%	Round 2
Clear dates for collecting medication	Agree	100%	Round 2
A penalty charge per packet if patient does not collect	Disagree	30%	Round 2
A TRIAGE system	Agree	95%	Round 2
Greater use of services provided by NGOs	Agree	90%	Round 2

5.4 Results Round Three (appendix 13)

The aim of this round was to reach consensus on the statements where there was disagreement in Round Two. This round of statements was e-mailed to the same twenty participants in order to get the opportunity to reconsider their initial responses. The consensus point was (65%) and higher.

5.4.1 Consensus of resources round three

Consensus was not reached regarding the statement around Build bigger buildings that accommodate all staff, and the consensus was reached regarding the statement around Hire more staff (see Table 11 below).

Table 10 resources round three

Item	Consensus reached Agree/ disagree	Level of Consensus reached	Delphi round
The solution for the lack of physical, financial and human resources is to			
Build bigger buildings that accommodate all staff	Disagree	60%	Round 3
Hire more staff	Agree	80%	Round 3

5.4.2 Consensus reducing waiting times round three

Consensus was not reached regarding the statement around implementing a penalty charge per packet of medication if the patient did not collect (see Table 12 below).

Table 11 reducing waiting time round three

Item	Consensus reached Agree/ disagree	Level of Consensus reached	Delphi round
To minimise waiting times consider implementing			
A penalty charge per packet if the patient does not collect	Disagree	40%	Round 3

5.4.3 Consensus access system round three

Consensus was not reached regarding the provision of transport to the clinic (see Table 13 below).

Table 12 access system round three

Item	Consensus reached Agree/ disagree	Level of Consensus reached	Delphi round
To improve access to services			
Provide transport to the clinic	Disagree	55%	Round 3

5.5 Discussion

5.5.1 Attitudes of rehabilitation professionals towards people with disability

All experts agreed that having a positive attitude is important when providing rehabilitation services. They also agreed on the importance of having an adequate number of staff members in order to maintain a positive attitude while providing rehabilitation services. The availability of human resources is therefore a big concern in healthcare delivery (Galarneau, 2004).

Health care service providers working in CHCs need good support in order to provide quality service. This support can be provided by higher level administrators and managers who are aware of the needs of health care workers and patients. According to Kahonde et al (2010) information regarding support groups, disability grants, vocational training and other support services are important to the patient.

Environmental factors also influence the positive attitude of health care workers. For example, appropriate physical infrastructure is important for facilitating physical access to clinics for PWDs. This improves perceptions of satisfaction of both health workers and PWDs, while an inability to access them has a negative influence on the interactions between patients and health workers (Kumurenzi, 2011; Mlenzana, Frantz, Rhoda & Eide, 2013).

Communication between health providers and patients were agreed to be one of the most important factors in the rehabilitation process. It helps to facilitate the process positively (Kumurenzi, 2011, Mlenzana et al., 2013). It is well known that service providers should communicate effectively and also listen to their patients (Kumurenzi, 2011). According to Matsika (2009) and Kahonde et al. (2010) in some Cape Town CHCs patients reported that

service providers respected, communicated effectively and provided emotional support for them.

5.5.2 Information sharing between patients and health professionals

Information sharing is one of the processes that occurs when providing rehabilitation services. Patients need to know about their rehabilitation processes in a language that they can understand. In this study, experts agreed that using pictures or repetition could help the patient during the rehabilitation process. According to Kumurenzi (2011), patients often complain about the use of complex terminology used by service providers, which they do not understand.

Discussion and communication between patients and service providers is an important factor in providing health services (Kumurenzi, 2011; Stiggelbout, Van der Weijden, De Wit, Frosch, Légaré, Montori & Elwyn, 2012). In addition, it is important to include patients in their management planning (Kumurenzi 2011; Kahonde et al., 2010; Stiggelbout et al., 2012).

However, there are still problems with communication and information sharing with non-English speakers and patients who use sign language. In both cases, the availability of interpreters was an important challenge that needed to be overcome (Kumurenzi, 2011).

Participants in this study agreed that health promoters are important with respect to patients' education and information sharing. According to Kumurenzi (2011), the lack of the rehabilitation service providers has led to poor communication between patients and service providers. This is due to the fact that service providers dedicate their time to treating patients rather than improving communication and answering patients' questions (Kumurenzi, 2011).

Knowing about the patients' background helps in understanding the socio-economic limitations and facilitators of the patients (Mlenzana et al., 2013).

Several different ways can be used to provide information for patients. For example, the use of audio visual materials in the patient's waiting room, and group education using pamphlets could also be considered (Mlenzana, 2013).

5.5.3 Lack of physical, financial and human resources in rehabilitation centres

Resources are an important component when trying to provide health care services. This includes human resources, as was reported by participants in this study, as well as those in the previous studies (Galarneau, 2004; Sherif, 2010; Rhoda, 2010).

Having adequate assessment equipment was reported in this study as being an important resource in the rehabilitation centres. According to Grut et al. (2012) providing equipment that patients need can help to enable them to reach and maintain optimal functional levels.

Using available resources for the delivery of services is a good way to improve community based rehabilitation. Here, the attention is focused on curative services, as mentioned by Mlenzana (2013).

Experts in this study agreed that motivation and adequate space were important components of providing rehabilitation services. According to Mlenzana (2013), space is important for accommodating health services and patients.

However, in this study experts disagreed on the appropriateness of having a bigger building to accommodate all staff as important to improve health services. Previous studies have shown that some health workers were satisfied with space (Mlenzana, 2013), which may explain the findings of this study. It is therefore suggested that more research is conducted in the future Mlenzana (2013).

5.5.4 Access to rehabilitation centres

Experts in this study agreed on the use of a booking system to facilitate improvements in rehabilitation services. However there are still challenges related to this system which may require patients to wait long periods in order to see rehabilitation professionals (Mlenzana, 2013). Experts also agreed that it was important to provide clean, comfortable, and warm waiting and treatment rooms (Mlenzana, 2013).

According to Kumurenzi (2011), wheelchair accessibility is a priority for patients with mobility restrictions. Experts in this study also agreed that information boards for disabled patients or wheelchair bound patients would be important to consider.

The experts in this study disagreed that providing transport to the clinic would be an appropriate way to enhance the service (55%). The reason why they disagreed is unknown. Other studies have shown that transport is one of the challenges that affect access to rehabilitation services for PWDs. Mlenzana (2013) reported that patients were dissatisfied with transport services, which was leading to patients either missing their appointments or arriving late. These challenges with transport were related to financial barriers (Thobias, 2008).

5.5.5 Referral systems

The referral system is an important step in the delivery of healthcare. All the experts in this study agreed on the need for understanding the referral system being used in the health sector. This also requires an understanding of the roles of all health care professionals in the rehabilitation services. The referral system aims to ensure effective patient outcomes as well as facilitating planning for effective use of health

services (Scheepers, 2012). According to Mlenzana (2013) poor health referral systems can lead to poor health service delivery.

Expert consensus in this study suggested that patient follow-up requires that the contact details of institutions involved in referral are necessary for improved rehabilitation services. According to Scheepers (2012), it is important that information regarding follow-up booking and access to service delivery is provided to the patient before the referral is implemented. This is to ensure that the patient can be followed up.

5.5.6 Limited time and long waiting periods

Long waiting periods and limited rehabilitation times affect the quality of services provided to patients, as well as patients' satisfaction. In this study experts agreed that appointment and triage systems would decrease barriers affecting how patients access healthcare services.

Education sessions in the waiting room showed a reduction in patients' anxiety (Mlenzana, 2013), which is similar to the findings by Sherif (2010), who found that limited time and long queues had a negative effect on patients' satisfaction with the rehabilitation services provided.

Participants in this study agreed that the use of an electronic board for updating patients on their status in the queue would be useful. In addition, giving patients the date and time for collecting medication reduces the time spent waiting at the pharmacy.

Non-governmental-organisations (NGOs) play a significant role in reducing the waiting time for patients at the community level (Scheepers, 2012).

The experts in the Delphi study disagreed on whether it was appropriate to charge penalty fees if the patient did not collect his or her medication on time. It should be noted that this was a strategy that was used by some CHCs in this study.

5.6 Summary of the chapter

This aspect of the study was conducted in order to reach consensus on how experts believed that rehabilitation services should be provided at CHCs. Three rounds were conducted and the level of consensus was set at 65% or above. Consensus was reached on attitudes, information sharing, and the referral system. Consensus was not reached with respect to resources (area and space), access (transportation), and waiting time reduction (penalty fee for delays in medication collection).

After presenting and discussing the results of both FGDs and Delphi Study in chapters four and five, a summary of the conclusions of the study as well as recommendations and limitations will be presented in the following chapter.

CHAPTER SIX

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

6.1 Introduction

This final chapter includes an introduction, conclusion, and recommendations based on the study findings. The conclusion draws a closing statement on the discussion chapter, while the recommendations highlights the gaps identified in the study.

6.2 Conclusions

The first objective of this study was to explore the views of rehabilitation professionals regarding the provision of rehabilitation services at three of the Community Health Centres (CHCs) in the Western Cape, based on the following challenges experienced by patients who attended them.

The health professionals in this study reported difficulties with maintaining a positive attitude towards achieving their goals under stressful environments that were associated with patient behaviour, poor salaries, and patient overload. One of the finding in the study was that staff shortage, high patient workloads, and lack of equipment and appropriate buildings negatively affected staff members' attitudes. Workload and stress affect health professionals' attitude and patients care as well.

Regarding sharing information, effective communication was highlighted as being important for the development of a positive attitude between professionals and their managers. The study also found that health professionals spent too little time communicating with patients. Finally, although health professionals provided assistance for patients in wheelchairs, it was still not enough to be effective. There are

significant challenges with respect to information sharing, including language barriers and deafness in some patients. Communication is therefore very important in the sharing information process. Health team members play important roles in facilitating and reducing these challenges. For example, social and cultural issues should be handled by the social worker in the rehabilitation team. Team members therefore need to increase the patients' awareness in order to have more effective health services. Even though the language barrier is still a challenge, this study showed that there was an improvement in terms of communication and the importance of sharing information on the side of rehabilitation professionals.

Another finding that the study drew is related to staff shortage and work overload. This was one of the main challenges that negatively affected the provision of rehabilitation services. This was linked to budget restrictions on employing more staff or paying overtime to the health team members. And one way to overcome such a challenge is to provide enough staff in these centres.

In addition to staff shortage and work overload, high patient workloads and the physical structure of facilities were considered to be barriers with respect to restricting patients' access to rehabilitation services. This problem was strongly connected with the appointment system.

Long waiting times and overcrowded waiting rooms were considered to be significant obstacles in the rehabilitation process. Therefore, it was suggested that appointment systems be used in these centres in order to reduce long waiting times. Good communication between health team members assists with appropriate referrals. This needs good knowledge and an understanding of the roles of each health professional in the rehabilitation team.

In this study the researcher found the Health care plan 2030 was unrealistic with respect to real world clinical contexts for the health care professional. The plan included several objectives to improve rehabilitation and quality of life for PWDs but the current challenge is to ensure that these are realistic.

Rehabilitation professionals in this study reached consensus on attitudes, information sharing, and referral systems. Consensus was not reached in the areas of resources (area and space), access (transportation), and waiting times (penalty fee for delays in collecting medication).

6.3. Recommendations

6.3.1. Recommendations for rehabilitation professionals and rehabilitation centres

- Health professionals should aim to maintain positive attitudes when trying to achieve their goals, even under stressful conditions by reporting factor that affect their attitude. For example, provide enough staff, paying overtime for professionals, physical inaccessibility, availability and convenience of the environment in terms of buildings and equipment for people with disabilities which can create a positive attitude towards health providers.
- Professionals should try to spend more time communicating with patients in order to maintain better understanding to patients' conditions by providing enough staff and social workers who listen to patients and manage large patient loads that help in reducing the work load and patient overcrowd.

- Reduce language barriers which affect the communication in the rehabilitation process by employing language translators and providing training in sign language.
- Increase patients' awareness of their rights in an attempt to increase confidence and maintain the right of PWD's in equal access to health services by educated patients. For example workshops, draw pictures or repeat explanations while using the health promoter and other training programmes for them.
- Health care plan 2030 was unrealistic with respect to real world clinical contexts for the health care professional for that stakeholders in development of the Health care plan 2030 should visit rehabilitation centres in order to learn what the reality of care provision is.
- Education of service providers with respect to national and provincial health policies
Implementation of workshops for service providers.

6.4. Limitations of the study

- The time available for data collection was a limiting factor in this study. The time spent obtaining permission from the Department of Health and facility managers was considerable.
- Due to the fact that the study findings were based on a qualitative component and Delphi study means that the findings cannot be representative of all health service providers.
- Focus group discussions could have been more appropriate for service providers and conducted during lunch breaks. During the FGDs some of the participants were rushing to go back to work.

- Some participants felt that the FGDs and workshops took too long, which may have impacted on their attention to details.

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Appendices



**OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION**

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E: research-ethics@uwc.ac.za
www.uwc.ac.za

28 September 2016

Mrs A Abdulquadir
Physiotherapy
Faculty of Community and Health Science

Ethics Reference Number HS16/5/34

Project Title: Rehabilitation professionals' views on the experiences of patients with physical disabilities accessing community health centres.

Approval Period: 28 September 2016 – 28 September 2017

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval. Please remember to submit a progress report in good time for annual renewal.

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

A handwritten signature in blue ink, appearing to read 'Patricia Josias', is written over a large, faint watermark of a sunflower.

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

PROVISIONAL REC NUMBER - 130416-049

ANNEXURE 2 PROPOSAL SUMMARY	
Name of Institution/organisation conducting research	University of the Western Cape
Name of Investigators	<p>Nondwe Mlenzana</p> <p>Luzaan Kock (masters student)</p> <p>Rochelle Petersen (masters student)</p> <p>Ayiman Abdulqadir (masters student)</p>
Postal Address	<p>University of the Western Cape</p> <p>Department of Physiotherapy</p> <p>Private Bag x 17</p> <p>Bellville</p> <p>7535</p> <p>OR</p> <p>48 De Kuilen Street</p> <p>De Kuilen</p> <p>Kuils River</p> <p>7580</p>
Telephone Number	021-9064233(H) 021-9592542(W)

Fax number	021-9591217(W)
Appendix 2 ANNEXURE 2 PROPOSAL SUMMARY	
Mobile Number	0832261916
Email Address	nmlenzana@uwc.ac.za
Institution which gave ethical approval	University of the Western Cape
Date of Ethical approval	July 2015
Date research expected to commence	June 2016
Date research expected to end	December 2017
Date research reports should be expected	2018
Western Cape Districts where research will be done: (Please mark with an X)	Metro X Westcoast Cape Winelands X Overberg Central Karoo Eden

Appendix 2 ANNEXURE 2 PROPOSAL SUMMARY	
Other facilities in the WC DOH where	

research will be done (Please specify)

N/A

Psychiatric Hospitals:

TB Hospitals

Other:

Appendix 2 ANNEXURE 2 PROPOSAL SUMMARY

	Databases :
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ANNEXURE 2 PROPOSAL SUMMARY

Research title	TO EXPLORE AND DESCRIBE THE PERCEPTIONS OF REHABILITATION SERVICE PROVIDERS IN THE IMPLEMENTATION OF A REHABILITATION MODEL AT PRIMARY HEALTH CARE LEVEL.
Research aim	TO EXPLORE AND DESCRIBE THE PERCEPTIONS OF REHABILITATION SERVICE PROVIDERS IN IMPLEMENTING A REHABILITATION MODEL AT PRIMARY HEALTH CARE LEVEL.
Research objectives	<ol style="list-style-type: none">1. To determine the understanding of rehabilitation professionals as to their role in the new health plan 2020 and health plan 20302. To explore the rehabilitation professionals responses to the views of patients regarding rehabilitation services

	<p>3. To explore and describe their perception of a rehabilitation model that</p>
<p>Appendix 2 ANNEXURE 2 PROPOSAL SUMMARY</p>	
	<p>would encompass the vision of the new health plan and the expectations of the patients</p>

Appendix 2 ANNEXURE 2 PROPOSAL SUMMARY	
---	--

Key Words	PERCEPTIONS, REHABILITATION, PRIMARY HEALTH CARE LEVEL
------------------	---

<p>Brief description of methodology</p> <p>(Please specify estimated sample size and duration of contact with each participant e.g. interview length, clinical exams)</p>	<p>Sample size for focus group discussions for rehabilitation professionals will comprise of one professional representing each category of service providers in one centre e.g physiotherapist, OT, doctor, nurse, prosthetist, speech therapist, peer supporters.</p> <p>Sample size for clients:</p> <p>In-depth interviews: the clients will also be categorised into different types of disabilities and the study will target one client from each category to be part of the interview.</p> <p>In-depth interviews will be conducted for clients until data saturation is</p>
<p>Appendix 2 ANNEXURE 2 PROPOSAL SUMMARY</p>	

	reached and for focus group discussions too.	
Type of Study Design: e.g. Case Control, RCT, Survey	Explorative design using In-depth interviews with clients, focus group discussions and Delphi study and workshops for service providers will be conducted	
Budget for research	R30000.00	
Source of funding for the research	National Research Fund	
The research will have implications for the requested facilities regarding:	Yes or NO	If Yes what are these implications and how does your project plan to mitigate the impact
1. Additional load on nursing	NO	
2. Support services	NO	

Appendix 2 ANNEXURE 2 PROPOSAL SUMMARY		
3. Consumables	NO	
4. Laboratory tests	NO	
5. Equipment	NO	
6. Space	YES	To conduct focus groups and workshops with the service providers they need to be interviewed in a comfortable space
7. Communications	NO	

8. Additional OPD visits	NO	
Appendix 2 ANNEXURE 2 PROPOSAL SUMMARY		
9. Admission of patients	NO	

Appendix 2 ANNEXURE 2 PROPOSAL SUMMARY

<p>How will the sites be prepared to participate in your research?</p>	<p>By informing them of the research that I intend to conduct. No preparations to be done for this research, data will be conducted at convenient times for participants.</p>
<p>Results dissemination plan</p> <p>1. Tick which groups will be affected by your research findings</p>	<p>Provincial managers <input checked="" type="checkbox"/></p> <p>District Directors <input checked="" type="checkbox"/></p> <p>Facility manager and staff <input checked="" type="checkbox"/></p> <p>Patients <input checked="" type="checkbox"/></p> <p>Community <input type="checkbox"/></p> <p>Other</p> <p>(please specify)</p> <hr/>

<p>2. What is the earliest date or time frame from the end of research collection</p>	<p>Within one month <input type="checkbox"/></p>
<p>Appendix 2 ANNEXURE 2 PROPOSAL SUMMARY</p>	
<p>that the feedback (at least the minimum requirements*) will be expected?</p> <p>* Minimum research findings feedback template</p>	<p>Within one to three months <input checked="" type="checkbox"/></p> <p>Within three to six months <input type="checkbox"/></p> <p>Longer than six months <input type="checkbox"/></p>

-
3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
 4. The reference number above should be quoted in all future correspondence.

Yours sincerely



Dr Hawkridge

DR A HAWKRIDGE

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 31 Aug 2011

CC

L PHILLIPS

DIRECTOR: CAPE WINELANDS



STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 9895
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

completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely



Dr Hawkridge.

DR A HAWKRIDGE

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 11/16/2016.

CC

P OLCKERS

DIRECTOR: MITCHELLS PLAIN/ KLIPFONTEIN



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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:

Bishop Lavis CDC	Rachel Carelse	021 934 6129
-------------------------	-----------------------	---------------------

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 completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely



DR A HAWKRIDGE

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 4/04/2017

CC

J ARENDSE

DIRECTOR: NORTHERN TYGERBERG

On Thu, May 25, 2017 at 12:27 PM, Steflene F Mostert <Steflene.Mostert@westerncape.gov.za> wrote:

Dear

The only time we can accommodate you is Monday morning, the 29th at our Staff meeting holding at 08h00 the morning.

We can give you 30 minutes for your presentation.

Kind Regards

Stevelien Mostert

"All views or opinions expressed in this electronic message and its attachments are the view of the sender and do not necessarily reflect the views and opinions of the Western Cape Government (the WCG). No employee of the WCG is entitled to conclude a binding contract on behalf of the WCG unless he/she is an accounting officer of the WCG, or his or her authorised representative. The information contained in this message and its attachments may be confidential or privileged and is for the use of the named recipient only, except where the sender specifically states otherwise. If you are not the intended recipient you may not copy or deliver this message to anyone."



Patricia Van Wyk

caroli...،Chanray،Janine، إلى أنا،

١١ مايو عرض التفاصيل



Hi

Next week Thursday 11-12 ?

Regards

Dr Patricia Van Wyk

Family Physician

TC Newman CDC

Drakenstein Sub District
Cape Winelands

Tel: 021 877 6449

Mobile: 084 970 2883

Fax2email: 0866673430

Patricia.vanWyk@westerncape.gov.za



Jennie Morgan

إلى أنا، Nondwe

١٩ يوليو عرض التفاصيل



Dear Ayiman,

I am sorry for the delay.

Can you make it here on the 26th July at 2pm?

Kind regards

Jennie

From: AYIMAN ABDULQADIR
[mailto:3581956@myuwc.ac.za]

Sent: 21 June 2017 10:57 AM

To: Nondwe Mlenzana; Jennie Morgan



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
 Tel: +27 21-959 2542, Fax: 27 21-959 1217
 E-mail: nmlenzana@uwc.ac.za

DELPHI STUDY CONSENT FORM

Participant identification number:

Title of Research Project: REHABILITATION PROFESSIONALS' VIEWS ON THE EXPERIENCES OF PATIENTS WITH PHYSICAL DISABILITIES ACCESSING COMMUNITY HEALTH CENTRES.

Tick if yes and x if no

		Yes	No
1	I confirm that I have read and understood the information sheet dated for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	<input type="checkbox"/>	<input type="checkbox"/>
2	I am willing to participate in all the rounds of the Delphi study and the follow-up stage	<input type="checkbox"/>	<input type="checkbox"/>
3	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. However, I understand that the success of this study depends on all participants completing all the Delphi rounds.	<input type="checkbox"/>	<input type="checkbox"/>
4	I understand that I will remain anonymous to other participants (or experts) throughout this Delphi study and only the researcher will be able to identify my specific answers.	<input type="checkbox"/>	<input type="checkbox"/>
5	I understand that the researcher will keep all information and data collected in a secure and confidential manner.	<input type="checkbox"/>	<input type="checkbox"/>

 Name of participant

 Date

 Signature

Not consenting

1	I am NOT willing to participate in this study	<input type="checkbox"/>
---	--	--------------------------



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 2542, Fax: 27 21-959 1217
E-mail: nmlenzana@uwc.ac.za

DELPHI STUDY INFORMATION SHEET

Study Title: REHABILITATION PROFESSIONALS' VIEWS ON THE EXPERIENCES OF PATIENTS WITH PHYSICAL DISABILITIES ACCESSING COMMUNITY HEALTH CENTRES

Invitation

You are being invited to take part in a research study conducted by Ayiman Abdulqadir (Masters Candidate) of the University of the Western Cape. Before you decide to participate in this study, it is important for you to understand why the research is being done and what it will entail. Please read carefully the following information. Please ask me questions if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

Goal of rehabilitation program has been described as the maximization of patient's independence in order to allow them to participate fully in their communities. This will be achieved if patients have no limitations that will be imposed by the underlying pathology, impairments and by the availability of resources. Rehabilitation requires rehabilitation professionals to be aware of patients' circumstances at home. Aim of this study is to explore rehabilitation professionals' views on the experiences of patients with physical disabilities accessing CHCs in the Western Cape. Objectives are 1) To explore the views of rehabilitation professionals regarding provision of rehabilitation services at the Community Health Centres (CHCs) in the Western Cape based on the following challenges experienced by patients attending CHCs: -Attitudes of rehabilitation professionals towards people with disability - Information sharing between patient and health professional -Lack of physical, financial and human resources in the rehabilitation centres -Access by patients to rehabilitation centres and access by service providers for CBR -Referral systems -Limited time and long waiting periods. 2) To reach consensus on how should rehabilitation services be provided at the CHCs based on the outcomes of objective.

Why have I been chosen?

You have been asked to participate in this research project because you have been identified as an expert in rehabilitation profession. Rehabilitation professionals' views will be beneficial in improving service delivery at CHCs as patients in a study by Mlenzana (2013) indicated challenges with service delivery. There were rehabilitation health care professionals that participated in answering these challenges through focus group discussions and workshops. Your participation in this phase of the study, Delphi study, will assist in reaching consensus on how rehabilitation services should be provided at the CHCs.

Do I have to participate?

Participation is voluntary as it will add value to rehabilitation service delivery at the primary health care level. If you decide to participate you will be given the information sheet to keep and you will be asked to sign a consent form. You are free to withdraw at any time without giving a reason. A decision not to participate or to withdraw at any time, will not affect you in any way.

What will happen to me if I participate?

If you agree to participate in the study you will firstly be asked to complete a consent form and return it via e-mail. This research will be carried out using the Delphi technique consisting of two to three rounds using questionnaires that are aimed to achieve consensus of appropriate rehabilitation service delivery. With your permission, the questionnaires will be e-mailed to you. Simple and specific instructions will be provided for each questionnaire. The amount of time necessary for completion of each questionnaire will vary with each panellist, but should range between 10- 15 minutes per round. There are no right or wrong answers to the questions. This study is seeking your opinion.

The following points are important for you to remember:

- Your participation is entirely voluntary.
- You may decline or withdraw from the study at any time.
- You will remain anonymous to other participants (or experts) throughout this Delphi study and only the researcher will be able to identify your specific answers.
- All records are confidential. Your name will only be recorded on the consent form; it will not be recorded on any questionnaire. All information will only be available to members of the research team. All information will be destroyed 5 years after the research is complete.
- Any information that you will provide will be confidential and when the results of the study are reported you will not be identifiable in the finding.
- Following the study, information gathered will be sent for publication in professional journals and will also be presented at conferences. All details of people who participated in the study will be kept anonymous.
- You will only have to complete the consent form once; return of completed Delphi rounds implies your consent to participate.

What if something goes wrong?

I am not aware of any complications or risks that could arise from participating in this study. However, if you decide to participate in the study you will be given written information detailing the names and telephone number to contact should you have any complaints or difficulties with any aspect of the study.

Will my participation in the study be kept confidential?

If you consent to participate in the study, your name will not be disclosed and would not be revealed in any reports or publications resulting from this study. Apart from your consent form, your name will not be recorded on Delphi rounds. Each participant will be allocated an unique code. You will remain anonymous to the other participants (or experts) throughout this Delphi study and only the researcher will be able to identify your specific answers. All information will be destroyed 5 years after the research is complete.

What happens when the research study stops?

This research is being conducted by *Ayiman Abdulqadir, Department of Physiotherapy*, at the University of the Western Cape. If you have any questions about the research study itself, please contact Ayiman Abdulqadir at:

University of the Western Cape
Department of Physiotherapy
Robert Sobukhwe Road
Bellville, 7535
Cell: 0840752256
E-mail: abood.abado@gmail.com

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

Head of Department: Dr N. B. Mlenzana
University of the Western Cape
Department of Physiotherapy
Robert Sobukhwe Road
Bellville, 7535
Office: 021-9592542

Dean of the Faculty of Community and Health Sciences: Prof. J. Frantz
University of the Western Cape
Private Bag X17
Bellville, 7535

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

DELPHI STUDY QUESTIONS – ROUND 1

Asked with FGDs

- **Attitude of rehabilitation professionals**

Q1: How to maintain a positive attitude have to have?

- **Sharing information**

Q2: How to share information with patients should?

- **Resources**

Q3: What the solution for the lack of physical, financial and human resources?

- **Reducing waiting time**

Q4: How to minimise waiting times?

- **Access system**

Q5: How to improve access to services?

- **Referral system**

Q6: How to improve referrals system?

DELPHI STUDY – ROUND 2

**TITLE OF STUDY: REHABILITATION PROFESSIONALS' VIEWS
ON THE EXPERIENCES OF PATIENTS WITH PHYSICAL
DISABILITIES ACCESSING COMMUNITY HEALTH CENTRES**

Tick (x) that all appropriate answer/s

DEMOGRAPHIC DETAILS

Age:years

Gender: male female

Current profession:

Years' experience:years

Attitude of rehabilitation professionals

1. To maintain a positive attitude you have to get have

- Good support Agree Disagree
- Enough staff Agree Disagree
- Enough time to respond to patients' queries Agree Disagree
- Accessible building and appropriate equipment for PWDs Agree Disagree
- Staff members who are happy and not exhausted Agree Disagree
- Staff who communicate well and listen to patients Agree Disagree

Sharing information

2. To share information with patients you should

- Employ translators to address the language barrier Agree Disagree
- Provide pamphlets for patients to read Agree Disagree
- Learn the basics of sign language for patients how deaf Agree Disagree
- Get health promoter to educate patients Agree Disagree
- Provide television programmes in waiting rooms Agree Disagree
- Have discussion with your patients Agree Disagree
- Advise your patients about prevention measures Agree Disagree
- Draw pictures and repeat the explanation of the management process Agree Disagree
- Talks while patients are waiting Agree Disagree
- Ensure that there is enough time for patients to ask questions Agree Disagree
- know the background of patients Agree Disagree
- Ensure that you see patients who were seen previously Agree Disagree

Resources

3. The solution for the lack of physical, financial and human resources is to

- Provide a bigger building that accommodate all staff Agree Disagree
- Request for more equipment for assessment Agree Disagree
- Use what you have for service delivery Agree Disagree
- Hire more staff Agree Disagree
- Create more space specifically for patients Agree Disagree
- Write motivations Agree Disagree

Reducing waiting time

4. To minimize waiting times have

- An appointment system Agree Disagree
- Health information's in the waiting room to reduce patient anxiety Agree Disagree
- An electronic board to provide queue information Agree Disagree
- Clear dates for collecting medication Agree Disagree
- A penalty charge per packet if patient does not collect Agree Disagree
- A TRIAGE system Agree Disagree
- Greater use of services provided by NGOs Agree Disagree

Access system

5. To improve access to services

- use a booking system Agree Disagree
- Have information boards for disabled or wheelchair-bound patients Agree Disagree
- Attend to people who have disabilities first Agree Disagree
- Provide transport to the clinic Agree Disagree
- Make the clinic comfortable, clean and warm Agree Disagree

Referral system

6. To get better with referral system you must

- Understand referral system used in health sector Agree Disagree
- Understand the roles that all health care professionals play Agree Disagree
- Follow-up on patients Agree Disagree
- Have all contact details of institutions you are referring Agree Disagree

Thank you for taking time to complete this survey

Resources

1. The solution for lack of physical, financial and human resources is to

- Build bigger building that accommodate all staff Agree Disagree
- Hire more staff Agree Disagree

Waiting time

2. To minimize waiting times have

- A penalty charge per medication packet if the patient does not collect Agree Disagree

Access

3. To improve access to services

- provide transport to the clinic Agree Disagree

Thank you for taking time to complete this survey



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592542, Fax: 27 21-9591217

E-mail: abood.abado@gmail.com

CONSENT FORM FGDs

Title of Research Project: REHABILITATION PROFESSIONALS' VIEWS ON THE EXPERIENCES OF PATIENTS WITH PHYSICAL DISABILITIES ACCESSING COMMUNITY HEALTH CENTRES

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

This research project involves making audiotapes of you. These audiotapes will be used to collect information from focus group discussion and Delphi study. They will be locked in a locked cupboard and will only be accessible to the researcher. These tapes will be destroyed after 7 years when the publications are all done and published.

___ I agree to be [videotaped/audiotaped/photographed] during my participation in this study.

___ I do not agree to be [videotaped/audiotaped/photographed] during my participation in this study.

Participant's name.....

Participant's signature.....

Date.....

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

Study Coordinator's Name: Dr Nondwe Mlenzana

University of the Western Cape

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INFORMATION SHEET FOCUS GROUP DISCUSSION |

Project Title:

**REHABILITATION PROFESSIONALS' VIEWS ON THE EXPERIENCES OF PATIENTS
WITH PHYSICAL DISABILITIES ACCESSING COMMUNITY HEALTH CENTRES**

What is this study about?

This is a research project being conducted by Ayiman Abdulqadir at the University of the Western Cape. We are inviting you to participate in this research project because you are a health provider at community health center. The purpose of this research project is to explore rehabilitation professionals' views on the experiences of patients with physical disabilities accessing community health centres.

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

You will be asked to be participating in focus group discussions in your centre and workshop in one of the Community Health Centers (CHC's). This will only take more or less one hour.

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. To help protect your confidentiality, we will be using identification codes only on data forms, and using password-protected computer files. The surveys are anonymous and will not contain information that may personally identify you. If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

What are the risks of this research?

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

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about Rehabilitation Service. We hope that, in the future, other people might benefit from this study through improved understanding of Rehabilitation Service.

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

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

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

If participants are experiencing emotional problem regarding questions that are going to be asked they will be assured of being referred to a psychologist to assist them with emotional issues that will be triggered by this study.

What if I have questions?

This research is being conducted by *Ayiman Abdulqadir, Department of Physiotherapy*, at the University of the Western Cape. If you have any questions about the research study itself, please contact Ayiman Abdulqadir at:

University of the Western Cape
Department of Physiotherapy
Robert Sobukhwe Road
Bellville, 7535
Cell: 0840752256
E-mail: abood.abado@gmail.com

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

Head of Department: Dr N. B. Mlenzana
University of the Western Cape
Department of Physiotherapy
Robert Sobukhwe Road
Bellville, 7535
Office: 021-9592542

Dean of the Faculty of Community and Health Sciences: Prof. Frantz
University of the Western Cape
Private Bag X17
Bellville 7535

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

**APPENDIX
UNIVERSITY OF THE WESTERN CAPE
INFORMATION SHEET TEMPLATE
ADDITIONAL GUIDANCE FOR SPECIFIC ISSUES**

Informed Consent

Informed consent is a process, not just a form. Information must be presented to enable persons to voluntarily decide whether or not to participate as a research subject. Therefore, informed consent language and its documentation must be written in language that is understandable to the people being asked to participate.

Research Involving Minors

For research involving individuals under the age of 18, include a Parental Permission Form to ask parents for consent to the participation of their child and an Assent Form to ask the minors if they agree to participate in the research, depending on whether the children are capable of assenting. The Parental Permission form should contain all of the elements of the sample consent form. However, the parental permission form should be written in language appropriate for parents granting permission for their child's involvement rather than as though they themselves will be participating (e.g. we are inviting your child to participate the risks to your child's participation include). When determining whether the children are capable of assenting, take into account the ages, maturity, and psychological state of the children involved. Assent forms should be written in age-appropriate language.

Research Involving Individuals with Impaired Decision-making Capacity

Using the Informed Consent Form Template, prepare a consent form to ask the research subject's authorized representative for consent to the participation of the research subject. Prepare an assent form to ask the research subjects if they agree to participate in the research, depending on whether the subjects are capable of assenting. When determining whether the subjects are capable of assenting, take into account the decision-making capacity of the research subjects.

SUGGESTED WORDING

Instructions: You should cut and paste these paragraphs, where applicable, into the appropriate area of the Informed Consent Form. However, the suggested wording below should be modified appropriately for the specifics of your study.

Audio taping/Videotaping/Photographs/Digital Recordings

[Include the following information in the What about confidentiality? section]

INTRODUCTION

- There were lessons learnt regarding gaps in the delivery of healthcare services in the Western Cape Province.
- Western Cape Department of Health aimed to improve patient experience and quality of life, operational efficiencies focusing on improvement of health outcomes and information systems.

PURPOSE

- The aim was to develop a rehabilitation service model based on the gap identified at primary health care level.

INTRODUCTION

- The Western Cape Department of Health with the new 2030 plan aimed to redesign the public health sector.
- The working document drafted by the Department of Health (WCDoH, 2011) primarily highlighted that improving the patient experience and the quality of care is at the heart of the vision for 2030.

PURPOSE

- The aim was to develop a rehabilitation service model based on the gap identified at primary health care level.

METHODS

- This was an evaluation study that used mixed methods.
- The study was conducted at three rehabilitation centres in the Western Cape Province.
- Service providers, clients with physical disabilities and caregivers.

METHODS

- Qualitative data was gathered from focus group discussions and were analysed manually
- Quantitative data was gathered via a survey and analysed on SPSS version 20.

RESULTS

- Large majority (99%) of patients (n=365) missed out on interdisciplinary consultation.
- 12% of the service providers did not ask permission to consult their patients. Patients were dissatisfied with rehabilitation service delivery.

CURRENT SITUATION

Current facilitators towards 2030

- Basic rehabilitation professionals and service is available
- Patients access the service within their means
- Rehabilitation professionals understand the needs of the patient

Current challenges for 2030

- Attitudes of rehabilitation professionals towards people with disability
- Information sharing between patient and health professional
- Lack of physical, financial and human resources in the rehabilitation centres
- Access by patients to rehabilitation centres and CBR
- Referral systems
- Limited time and long waiting periods

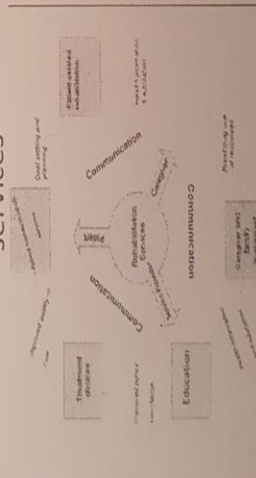
CURRENT SITUATION IN MOVING FROM A MEDICAL MODEL TO A PATIENT CENTRED MODEL

- MEDICAL MODEL**
- Patient's role is passive
 - Patient receives treatment
 - Rehab professional dominates the process of care
 - Care is disease centred
 - Physician gives all the advice
- PATIENT CENTRED MODEL**
- Patient's role is active
 - Patient is a partner in the treatment plan
 - Rehab professional collaborates with the patient – offers options
 - Care is quality of life centred and includes family
 - Physician listens to the patient and talks less

DISCUSSION AND CONCLUSION

- Patients were not happy with rehabilitation services,
- Rehabilitation service providers did not focus on patient-centred approach.
- Resultant recommended development of a rehabilitation model based on health care plan 2030 document.

Model for recommended rehabilitation services



IMPLICATIONS

- Rehabilitation services will need to shift from therapist-centred to a patient-centred approach and in order to improve the perception from patients about the services.

REFERENCE

- Western Cape Department of Health (2011). 2020 The Future of Healthcare in the Western Cape: 5.
- **Acknowledgements**
SANPAD, SANPAD group

18 December 2017

**RE: Editing of MSc thesis
Ayiman Abdulqadir (3581956)**

To whom it may concern:

This is to confirm that the MSc thesis of Ms Ayiman Abdulqadir, "*Rehabilitation Professionals' Views on the Experiences of Patients with Physical Disabilities Accessing Community Health Centres*", has been proofread and edited for submission to the University of the Western Cape.

Kind regards



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