A DESCRIPTION AND ANALYSIS OF THE ORGANISATIONAL CAPACITY OF THE REHABILITATION SERVICES AT TC NEWMAN COMMUNITY DAY CENTRE

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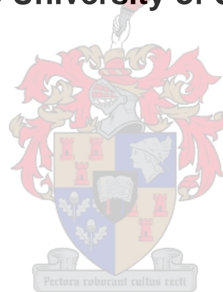
Thesis submitted in fulfillment of the requirements of the degree of MPhil Majoring in Rehabilitation at the University of Stellenbosch.



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I, the undersigned, hereby declare that the work contained in this thesis is my original work, and that it has not been submitted in its entirety or in part to any other University for a degree, and that all the sources used have been acknowledged by references.

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Date ………………………………………

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Abstract

Rehabilitation services, mainly rendered by therapists employed by the Department of Health, forms a critical part of the Primary Health Care (PHC) package of care. Different policies, within the Department of Health (DOH), provide guidance on rehabilitation service delivery. However, implementation of these policies remains a challenge.

The current study aimed to describe and analyse the organisational capacity of rehabilitation services at the study site and to assess how congruent the rehabilitation service at the study site was with existing rehabilitation policy.

A descriptive methodology was applied making use of both quantitative and qualitative methods in analyzing the organisational capacity of this study site and the alignment of rehabilitation services offered, with the National Rehabilitation Policy (NRP). The study used the Kaplan framework, the objectives of the NRP and specific selected articles of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) to develop indicators to be used for the description and analysis of the organisational capacity of the rehabilitation services at TC Newman Community Day Centre.

Questionnaires based on seven objectives from the NRP were developed to collect quantitative data from five service providers, the facility manager of TC Newman CDC and the managers of two Non- Governmental Organisations (NGO) working in the drainage site. Face to face, audio recorded, semi- structured interviews were used to collect qualitative data from the five service providers. A folder audit and document review was used to enhance quantitative findings. After analysis of the data, I still felt the need for additional information and thus developed an open ended questionnaire for participants to complete.

Barriers (e.g. defaulting of clients, a lack of standard documentation, poor monitoring and evaluation) and facilitators (e.g. outreach and support, competent staff and multi-disciplinary team) were identified in implementing the NRP. Participants highlighted the importance of accessing rehabilitation services with a focus on the outreach to peripheral clinics and funded NGO's. Intersectoral collaboration is evident, but mainly with funded NGO's. A lack of standardised documentation, inadequate monitoring and evaluation systems and uniformed documentation were

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some of the challenges identified by participants. The absence of participation by persons with disabilities was noted by all participants.

With reference to the organisational capacity, the participants had a good understanding of rehabilitation within the PHC context. Participants felt confident in delivering rehabilitation services and were able to identify shortcomings in service delivery. It is concluded that rehabilitation services are not delivered exactly in accordance with the objectives of the NRP. However the organisation demonstrated capacity to deliver rehabilitation services at PHC level, but there is still a need to enhance service delivery on community based level.

The results of this study gave me as a manager and implementer of health policy in the District Health System the opportunity to gain deeper insight as to how rehabilitation services are currently rendered. Results from the study highlighted how coherent rehabilitation service delivery is with current policy in health and the capacity of the organisation to deliver rehabilitation services.

This gave me the opportunity to adjust and review current rehabilitation service delivery and implement changes, as the study progressed.

Key Terms:

Organisational capacity, Rehabilitation, National Rehabilitation Policy, Rural, Primary health care, Policy Implementation.

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Abstrak

Rehabilitasie word hoofsaaklik deur terapeute in die departement van gesondheid gelewer binne fasiliteite en vorm ‘n belangrike deel van die Primêre Gesondheid Sorg dienste (PGS). Daar is verskillende beleid binne die Departement van Gesondheid beskikbaar, wat rehabilitasie definieer. Ten spyte van beleid, bly die implimentering van hierdie beleide ‘n uitdaging.

Hierdie studie het ontstaan om the kapasiteit van die organisasie te beskryf, om rehabilitasie dienste te implimenteer en ook te bepaal hoe hierdie dienste ooreenstem met die Nasionale Rehabilitasie Beleid (NRB).

‘n Beskrywende metodologie was gebruik, wat uit ‘n kwantitatiewe en kwalitatiewe deel bestaan het. ‘n Vraelys is ontwikkel op grond van die 7 doelwitte beskryf binne die NRB. Dit is gebruik vir die versameling van kwantitatiewe data, by vyf diensversakffers, `n gesondheidsbestuurder en die bestuurders van twee nie-regerings organisasies. Kwalitatiewe data is verkry deur onderhoude met die vyf diensverskaffers. ‘n Oudit van pasiënt lêers en die evaluering van dokumente het kwantitatiewe data versterk.

Na die analisering van data en die behoefte vir addisionele inligting, is ‘n oop-end vraelys ontwikkel en versprei na deelnemers om te voltooi.

Die studie het die organisatoriese kapasiteit van die organisasie ontleed deur gebruik te maak van Kaplan se raamwerk vir organisasie kapasiteit en die doelwitte van die NRB, asook sekere geselekteerde artikels uit die “United Nations Convention of the Rights of Persons with Disabilities” UNCRPD.

Deelnemers het belangrikheid van toegang tot rehabilitasie dienste bevestig, met ‘n fokus op uitreik na perifêre klinieke in die sub distrik en befondse Nie-Regerings Organisasies (NRO). Intersektorale skakeling was beskryf, maar beperk tot befondse NRO’s. Verskillende uitdagings soos bv. gestandardiseerde dokumentasie, onvoldoende monitering en evalueringssisteme en die dokumentering van inligting was geïdentifiseer. Die afwesigheid van persone met gestremdhede en hulle deelname by terapie was genoem deur deelnemers. Verskillende uitdagings asook fasiliteerders was geïdentifiseer deur deelnemers t.o.v die implementering van bestaande beleid.

Met betrekking tot die organisatoriese kapasiteit het die deelnemers ‘n goeie begrip van rehabilitasie in die primêre gesondheidssorg konteks. Deelnemers het selfvertroue getoon om rehabilitasie dienste te lewer en kon tekortkominge indentifiseer in dienslewering.

Ten einde was bevind dat rehabilitasie dienste nie 100% in lyn met die doelwitte van die NRB en die ontwikkelde 7 indikatore vir die studie, gelewer word nie. Die organisasie het wel getoon dat hulle die kapasiteit het om rehabilitasie dienste te implimenteer op primêre gesondheidsvlak, maar dat daar nog ‘n leemte is rondom gemeenskapsgebaseerde rehabilitasie.

Die resultate van hierdie studie het my as ‘n bestuurder en implementeerder van gesondheidsbeleid in Distrikgesondheid die geleentheid gegee om dieper insig te kry rondom rehabilitasie dienslewering. Resulte het uitgewys hoe vergelyk rehabilitasie dienste met huidige beleid in gesondheid en wat is die kapasiteit van die organisasie om hierdie beleid te implimenteer.

Hierdie studie het my die geleentheid gebied om huidige rehabilitasie dienste aan te pas, te hersien en om veranderinge te implementeer, soos wat die studie ontvou het.

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Finally I wish to thank the University of Stellenbosch for the opportunity to be part of this study, which allowed me to delve deeper into rehabilitation and gain in-depth knowledge of the challenge that rehabilitation professionals struggle with daily.

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Glossary of terms

Accessibility: "is the degree to which a product, device, service, or environment is available to as many people as possible. Accessibility can be viewed as the "ability to access" and benefit from some system or entity. The concept often focuses on people with disabilities or special needs (such as the Convention on the Rights of Persons with Disabilities) and their right of access, enabling the use of assistive technology" [1]

Community-based rehabilitation: "is a strategy within community development for the rehabilitation, equalization of opportunities and social integration of people with disabilities. CBR is implemented through the combined efforts of disabled people themselves, their families and communities and the appropriate health, education, vocational and social services .[2 (page 6)]

Disability: is an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and the individual's contextual factors (environmental and personal factors) [3 (page 3)]

Environmental factors: constitute a component of the International Classification of Functioning, Disability and Health and refers to all aspects of the external or intrinsic world that form the contact of an individual's life and, as such have an impact on that person's functioning. Environmental factors include the physical world and its features, the human-made physical world, other people in different relationships and roles, attitudes and values, social systems and services and policies, rules and laws. 3 (page171)

Funded Daycare Centre: This is a centre offering day care and stimulation for adults and children with severe to profound Intellectual Disability. The aim of the service is to ensure quality care, optimizing functionality and re integration into community living. It is managed by an NPO with government support via transfer payments.[4]

Networking: "Creating a group of acquaintances and associates and keeping it active through regular communication for mutual benefit. Networking is based on the question "How can I help?" and not with "What can I get?" [5]

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Organisational capacity: "Ability and capacity of an organisation expressed in terms of its (1) Human resources: their number, quality, skills, and experience, (2) Physical and material resources: machines, land, buildings, (3) Financial resources: money and credit, (4) Information resources: pool of knowledge, databases, and (5) Intellectual resources: copyrights, designs, patents, etc." [5]

Organisational structure: "Hierarchy with in which an organisation arranges its lines of authority and communications and allocates rights and duties. Organisational structure determines the manner and extent to which roles, power, and responsibilities are delegated, controlled, and coordinated, and how information flows between levels of management. A good organisational structure can often spell the difference between a smooth operating organisation and one in chaos." [5]

Policy Implementation: involves the translation of policy into managerial activities, putting these activities into managerial parts and methods and routinely administrate these activities or service. [6]

Primary Health Care: "is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process." [7(page 1: V)]

Procedure: "Written procedure prescribed for repetitive use as a practice, in accordance with agreed upon specifications aimed at obtaining a desired outcome"[5]

Rehabilitation: "Rehabilitation means a goal-oriented and time-limited process aimed at enabling an impaired person to reach an optimum mental, physical and / social functional level, thus providing her or him with the tools to change her or his own life. It can involve measures intended to compensate for a loss of function or a functional limitation (for example by technical aids) and other measures intended to facilitate social adjustment or readjustment. [2 (page31)]

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Service Inputs: These include all resources namely human resources, financial resources, materials, equipment and facilities used in providing a service.[2 (page 27)]

South African Netherlands Research Program on Alternatives in Development (SANPAD): is a collaborative research program financed by the Netherlands Ministry of Foreign affairs and has facilitated and financed research projects, research capacity building and research support activities over the past fifteen years in South Africa.[8]

Vision:" An aspirational description of what an organisation would like to achieve or accomplish in the mid-term or long-term future. It is intended to serve as a clear guide for choosing current and future courses of action" [5]

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List of abbreviations

ANC	African National Congress
APP	Annual Performance Plan
ART	Antiretroviral Therapy
CBR	Community Based Rehabilitation
CBS	Community Based Services
CDC	Community Day Centre
CSP	Comprehensive Service Plan
CVA	Cerebra Vascular Accident
CWD	Cape Winelands District
CP	Cerebral Palsy
DHS	District Health System
DOH	Department of Health
HBC	Home Based Care
HIV	Human Immunodeficiency virus
HPCSA	Health Professional Council of South Africa
ICF	International Classification of Functioning, Disability and Health (ICF)
INDS	Integrated National Disability Strategy
LDADY	Lost Disability-adjusted life years
M&E	Monitoring and Evaluation
NGO	Non-Government Organisation

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NRP	National Rehabilitation Policy
OBS	Outcome Based Study
OT	Occupational therapist
PA	Performance Agreement
PHC	Primary Health Care
PGWC	Provincial Government Western Cape
PT	Physiotherapist
SANPAD	South African Netherlands Research Program on Alternatives in Development
SETA	South African Education and Training Authority
ST	Speech Therapist
TDA	Trans Disciplinary Approach
TB	Tuberculosis
UN	United Nations
UNCRPD	United Nation Convention on the Rights of People with Disabilities
US	University of Stellenbosch
WCRC	Western Cape Rehabilitation Centre
WHO	World Health Organisation

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CHAPTER 1: INTRODUCTION

1.1 Study outline

The focus of the study was to describe and analyse the organisational capacity of the selected research site and to determine to what extent rehabilitation services provided at the site were in line with National and International policy. Chapter 1 situates the study within the bigger SANPAD study of which this study is a part. In addition it provides an introduction to the background of the study, the study problem, the aims and objectives of the study and a discussion on the motivation for the study and significance of the study. Chapter 2 provided a review of the literature relevant to the study. Chapter 3 describes the methodology used for the study and explains the development process of the research questionnaires, which were used as tools at all four selected research sites within the SANPAD study. Chapter 4 presents the data obtained from questionnaires, results from a folder audit and face to face interviews. In chapter 5 the main findings and their implications are discussed. Chapter 6 provides a conclusion to the study as well as recommendations based on the study findings.

1.2 Background to the study

According to the South African Health Act of 2003, health care services in South Africa must be provided in accordance to District Health Services framework and including the philosophy of Primary Health Care (PHC).[9] PHC consists of four pillars i.e. promotive, preventive, curative and rehabilitative services.[7] Rehabilitation services in South Africa and the Western Cape Province are subjected to different International, National and Provincial policies. The principal policies being the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), Community Based Rehabilitation (CBR) Strategy, the National Rehabilitation Policy (NRP) and the Health Care 2020 strategic plan of the Western Cape.[2,10, 11]

The focus of all four these policies are to ensure, promote and protect the human rights of people with disabilities. They state that client centered health services and rehabilitation of good quality should be accessible and affordable to all persons with disabilities. According to these policies rehabilitation programs should be provided

according to the social model of disability and its core focus on social inclusion and economic self-sufficiency for persons with disabilities. Rehabilitation programs must address both the needs of individual persons with disabilities and societal barriers in general to advance towards an inclusive society.[2,10,11]

While support for the formulation and adoption of policy in South Africa has been excellent, policy implementation remains a challenge. It is evident that there are capacity constraints at program level that negatively affect the implementation of policy. Implementation challenges are not addressed at different levels in government. Reasons being: limited theoretical understanding, poor support, inadequate measures, and a general lack of ability and capacity. [12]

Within the Western Cape different models of rehabilitation service delivery were developed over the past few years. However, there is little or no evidence that these models are aligned with the National Rehabilitation Policy and the other policies mentioned above. Pre-proposal workshops with the South African Netherlands Research Program on Alternatives in Development (SANPAD) group at the University of Stellenbosch (US) in 2008/2009 highlighted the need for a thorough evaluation of rehabilitation services in the Western Cape. [13] Funding for the project was obtained towards end of 2008 and the study was implemented in March of 2009.

1.2.1 The SANPAD study

A small team of researchers started planning the evaluation of rehabilitation services in the Western Cape in 2009. As the process developed, the research team grew and became a comprehensive team representing rehabilitation professionals from the public and private sector as well as from the academic field. Frequent discussions were held at the Centre for Rehabilitation studies, University of Stellenbosch, to develop key indicators based on the NRP and select articles in the UNCRPD for this research study. In developing the indicators, consensus was reached on three key areas that need to be evaluated:

- the organisational capacity of various institutions in the Western Cape to deliver rehabilitation services
- the outcomes of patients receiving these services

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- the extent to which rehabilitation services were aligned with the National Rehabilitation Policy (NRP) and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

Thus the aims of the SANPAD study were to:

- Describe and analyse the implementation of rehabilitation services in the Western Cape, through assessing the capacity of various institutions that delivered rehabilitation services,
- Evaluate the impact of these services on clients
- Determine to what extent rehabilitation services were aligned with seven key indicators from the NRPand five selected UNCRPD articles. The seven key indicators form the NRP were developed by the SANPAD team. The five selected UNCRPD articles were articles 9,19,20,25 and 26. Development of the key indicators as well as the reasons why the specific articles of the UNCRP were chosen is described in chapter 2.

The SANPAD aims were to be realized through a combination of studies at four different sites in the Western Cape as indicated in figure 1.1. The current study, indicated in bold in figure 1.1, was one of them. These sites were purposively selected and each represents a different level of care and intervention within a different population.

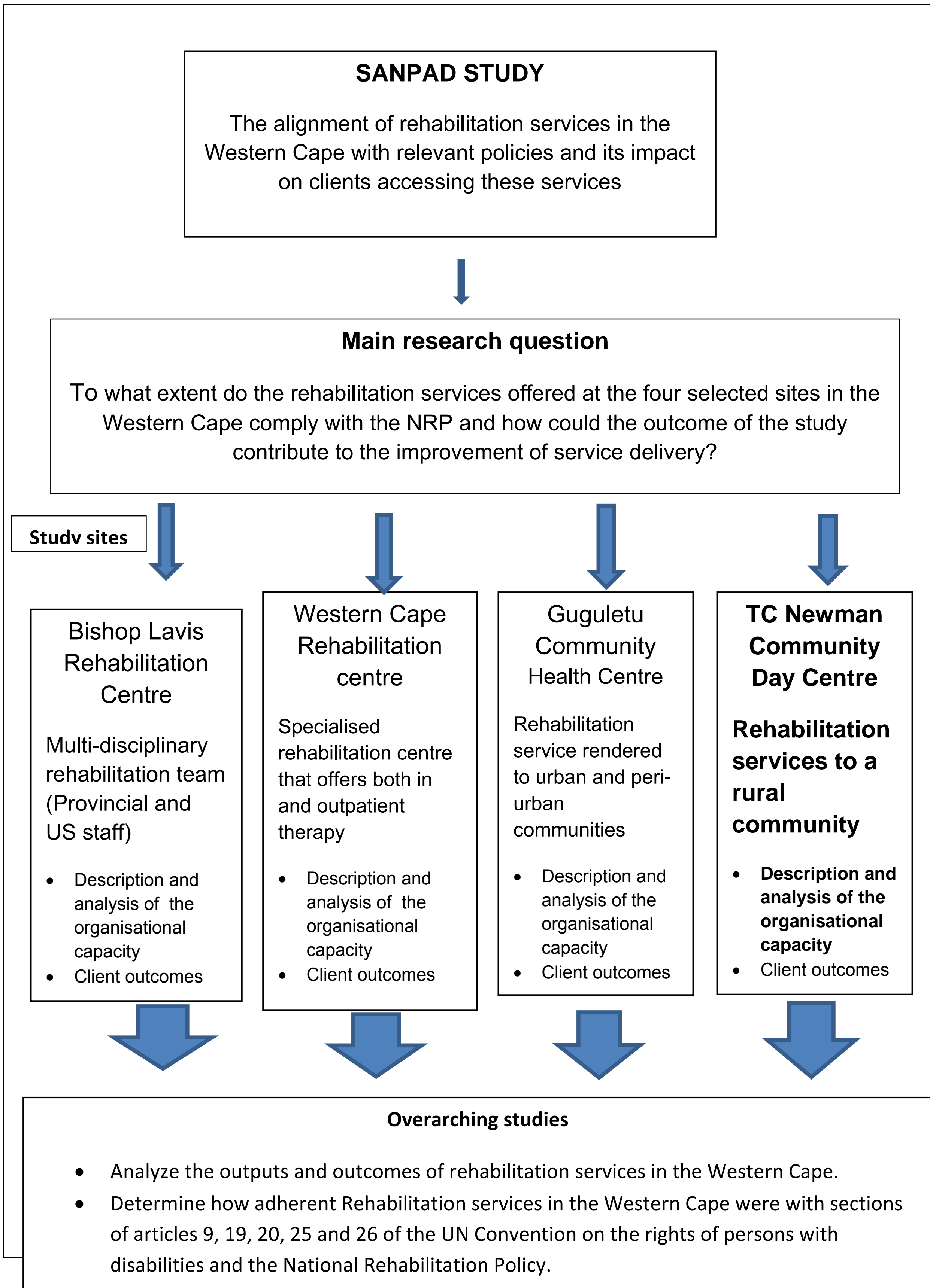

Figure 1.1: Description of the SANPAD research project

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TC Newman CDC previously known as Elangeni Rehabilitation Centre was selected to be part of the bigger SANPAD study, based on its location in a rural setting. This will allow the SANPAD study to gain a rural perspective on the capacity of rehabilitation services, the outcomes of users of rehabilitation services in a rural setting and the extent to which rural rehabilitation services are aligned to the NRP and UNCRPD.

The focus of the current study is specifically on the organisational capacity of TC Newman CDC to provide rehabilitation services to the communities it serves.

1.2.2 TC Newman Community Day Centre (CDC)

The TC Newman CDC, with its rehabilitation component, renders outpatient rehabilitation services to the Drakenstein sub district, including farming communities, and is based in Paarl. The towns in the Drakenstein Municipality are Paarl, Wellington, Saron, and Gouda as shown in Figure 1.2.

Figure 1.2: Map of the Drakenstein Sub district

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The Drakenstein is a sub district of the Cape Winelands District. The Cape Winelands District is the largest rural health district in the Western Cape. The Drakenstein Sub District is approximately 1 538 km^2 in size. The area stretches from Simondium in the south up to Saron and Gouda in the north with a distance of 85km between the two points.[14]

1.3 Theoretical framework

The SANPAD team decided to use Kaplan`s organisational framework to evaluate the organisational capacity at the various research sites. This choice was based on a senior member of the SANPAD team`s experience with the Kaplan framework. Mji and colleagues used the Kaplan framework to evaluate the partnership between Disabled Children's Action Group (DICAG), South Africa and a Norwegian advocacy organisation for people with disabilities).[15] They used the Kaplan Framework to review DICAG's development as an organization, and to assess the organisations capacity as an advocacy organization to make appropriate recommendations.

Similarly this study will also evaluate the capacity of the organization (DOH) at TC Newman CDC to deliver rehabilitation services that are aligned with the objectives of the NRP and selected articles of the UNCRPD.

While no reference could be found of the Kaplan Framework being used to evaluate rehabilitation services the SANPAD team recognized that it would be suitable for this purpose and will provide a robust framework for the SANPAD study.

Kaplan described a number of organisational elements, which must be present and coherent for an organization to have capacity and to be effective.[16] These elements, arranged sequentially in a hierarchy of importance are presented in Figure 1.3.

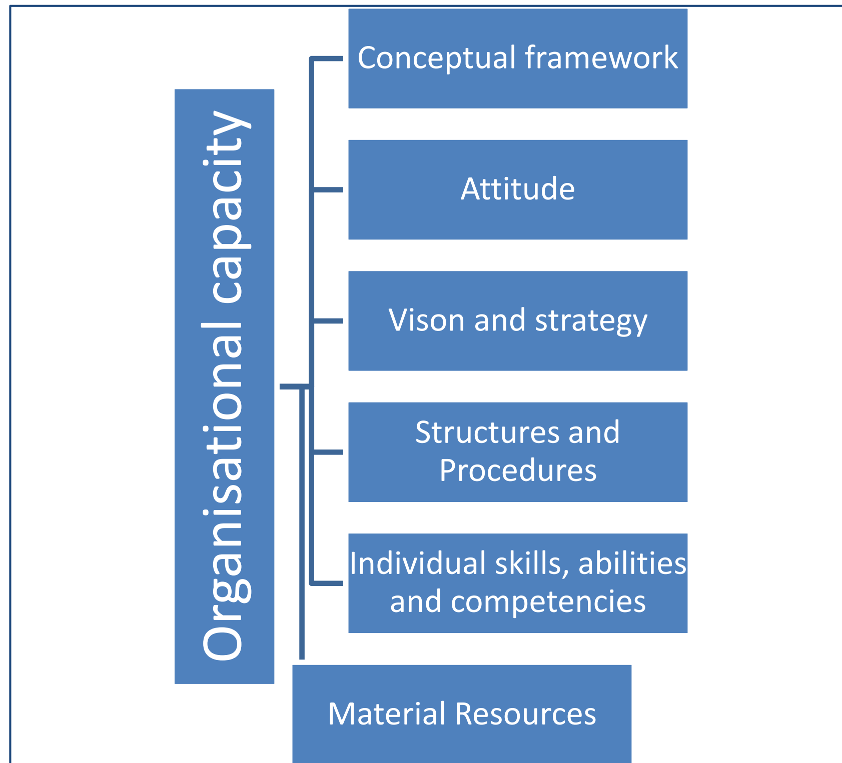

Figure 1.3: Kaplan`s framework of organisational capacity[16]

It is important to note that when one looks at the bottom of the hierarchy, it represents inputs that are relatively easy to quantify and measure. The elements at the top cannot be so easily assessed and are sometimes only observed by the effects they have. However, these top elements are very important and largely determine the capacity within an organisation. While the elements can be separated for the purpose of understanding or analysis they continuously affect and are affected by each other. [16] The separate elements and the specific focus in the study setting are further unpacked in the literature review section of this document to determine the ability of the organisational to deliver rehabilitation services in line with the NRP and UNCRPD.

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1.4 Study Problem

Policy must guide and reflect what government has decided, and it must hold government responsible and accountable for services delivered and record progress and change over time. Policies are the backbone of democracies. [17] The background discussion indicated that National legislation and policies have been developed and adopted for health care and more specifically rehabilitation services. In addition the background discussion indicated that general policy implementation in South Africa is largely unsuccessful. [17,18,19] This will further be highlighted in the literature review.

However, it is unknown to what extent policy implementation is unsuccessful in the provision of rehabilitation services in the Western Cape, what the challenges to policy implementation in this setting are, if any, and what the outcomes of rehabilitation services in this setting are. Therefore, the SANPAD study, and this one as a part of it, evolved to determine to what extent rehabilitation services in the study setting align with policy, what the outcomes of rehabilitation services in the study setting are and what issues are standing in the way of realizing policies and putting policy into practice.

1.5 Motivation for undertaking the study

As a Manager within the District Health System of the Department of Health, and also being a qualified rehabilitation professional, the importance of identifying barriers and facilitators that influence policy implementation and service delivery within the rehabilitation and health field has become evident to me.

It is of utmost importance as one of the facilitators in implementing the Primary Health Care Package in the Cape Winelands District (CWD), and my colleagues working at different levels of care within the DOH to unpack the above legislation and policies in order to evaluate current service delivery against it and to identify possible barriers that hinder policy implementation.

The research site was purposively selected as a rural research site for the SANPAD study. The selection of this site gave me, a health manager in the Cape Winelands

district under which this site falls the opportunity to become an active participant in this study.

Study findings should provide evidence based input into the programs and policies surrounding rehabilitation services within the Western Cape and in that manner improve rehabilitation program capacity, outputs and outcomes.

1.6 Aims and Objectives of the study

Primary Aim:

To describe and analyse the capacity of the organization to deliver rehabilitation services at the selected research site.

Secondary Aim:

To determine through analysis of findings the extent of alignment of rehabilitation services at the selected research site, with the seven key indicators developed from the National Rehabilitation Policy.

Objectives of the study:

1. To conduct, in conjunction with other members of the SANPAD study group, a literature review on models of best practice for disability and rehabilitation programs. This review will assist the research team to:
   - 1.1. Develop instruments for the evaluation study
   - 1.2. Develop key indicators that will be used to evaluate the extent of alignment of the Rehabilitation services at the selected research site with the objectives of the National Rehabilitation Policy.

2. Describe the demographic context of the research site according to literature and data collected during the study
   - 2.1 Catchment area
   - 2.2 Community profile
   - 2.3 Socio-economic profile
   - 2.4 Health and rehabilitation services offered

   2.5 Conditions treated by rehabilitation service providers
   2.6 Rehabilitation service outputs

3. Describe the profile of service providers including skills, abilities and professional development.

4. To determine the extent of alignment of the rehabilitation services at the selected research site with the 7 key indicators developed from the National Rehabilitation Policy.
   4.1. Describe access to rehabilitation services for persons with disabilities
   4.2. Describe the development of human resources
   4.3. Describe resource allocation to the service
   4.4. Describe partnerships and networking with stakeholders
   4.5. Describe monitoring and evaluation procedures and practices
   4.6. Describe the role of persons with disabilities in services
   4.7. Describe research activities at the setting

5. To analyse findings and determine organisational capacity based on Kaplan's framework for organisational capacity.

6. To make recommendations towards improving services rendered to persons with disabilities and future service planning.

1.7 Significance and contribution of the study

It is hoped that the evidence from this research study will help in a small way to address the current lack of evidence with regards to the capacity of rehabilitation services to address the needs of persons with disabilities. A lack of evidence can negatively impact on resource allocation by government policy implementers. It is also the intention of this research study that the evidence obtained will result in recommendations that will influence policy formulation, allocation of resources and implementation of standardised monitoring and evaluation tools regarding rehabilitation services in the Western Cape DOH.

I have searched through literature, and could not find any studies that specifically analysed or described the impact of the organisational capacity and its systems on physical rehabilitation services in the Western Cape thus it seems this study and similar SANPAD studies is a first of its kind.

In addition rehabilitation services at this site have only to a very limited extent been evaluated and measured against the objectives of the National Rehabilitation Policy.[2] Furthermore this evaluation was done when services were delivered through a different model to the one that is currently being implemented.

It is important to look at the organisational capacity of the organisation delivering rehabilitation services to people to ensure that barriers that hinder service delivery and challenges implementation of policies, like the NRP and UNCRPD are identified and addressed. It is thus important to answer the following questions:

1. Does the organization have enough capacity to deliver a rehabilitation service aligned with the seven key indicators from the NRP?
2. How does the organizational framework of the setting impact on the rehabilitation services provided at the research site;
3. How will the evidence that is provided through this study contribute to the improvement of service delivery to persons with disabilities?

This study endeavors to address the above 3 questions. It is important to note that I am an employee of the DOH and it is not the intention of this research study to criticize government, but rather to help to improve current rehabilitation service delivery and future service planning.

1.8 Summary

Rehabilitation services are rendered at different levels of care within the Department of Health. The research site is one of those service delivery sites, where people of the Drakenstein Sub District can access health services and specifically rehabilitation services. This rehabilitation service, and specifically the capacity to deliver the service, has only to a very limited extent been researched and documented, thus the current study evolved to see how congruent this service is with

rehabilitation policy and to provide information on possible improvements in rehabilitation to clients of the service.

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CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter presents an overview of the literature on disability, rehabilitation and policy implementation. Disability models, definitions, prevalence and the challenges in determining disability prevalence are discussed. I will present and discuss policies relevant to disability and rehabilitation and the provision of rehabilitation services in South Africa. Practical policy implementation will also be presented.

Finally, the Kaplan framework will be explored.

2.2 Disability definitions and models

Various conceptual frameworks and models of disability have been developed to describe, measure and understand factors associated with disability through the years.[20] Each of these different models of disability represents a different perspective on health, functioning, disability and disease. These models can to an extent be categorized into two groups i.e. those that focus on the individual such as the Biomedical model of disability, and those that focus on society like the Social model of disability.[20,21]

The Biomedical model focuses on the individual, health condition and impairment and describes disability as the result of trauma, disease or a health condition. Thus the focus is on treatment of the impairment or the health condition and assisting the person with the disability to fit into society as best as possible. This model is limited in that it only looks at disability as a health condition and does not acknowledge the impact of society and the environment on disability. [21] Looking at disability from a biomedical perspective will guide one in developing disability definitions that is impairment focused. An example is the definition of disability used in the South African National Rehabilitation Policy which states that: " disability is any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being (for example, difficulty in speaking, hearing or walking)" [2]

The Biomedical model received increasing criticism because it ignored the impact of society and the environment on disability. This led to the development of the Social

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model of disability which considers disability to be a socially –created problem, where limitations are due to environmental factors and societal barriers which range from attitudes to inaccessible buildings.[21] Advocates of the social model acknowledge impairments, but do not see them as playing a role in disability.[20]

The difference of views between the two approaches is perhaps best juxtaposed by two studies.[22,23] In the one, participants felt the impairment was a positive experience and they did not want a cure in the other, participants felt the impairment created severe barriers to their daily participation and they were actively seeking a cure. [22,23] While this difference in opinions from participants provides an example of how different views of the impairment can lead to different approaches to disability, the differences in the methodologies of the two studies might also have played a role in the findings. Taylor (2005) [23] performed a qualitative study and participants were all diagnosed with chronic fatigue syndrome, a condition that left them feeling tired and sick most of the time. Hahn & Belt (2009) [22] did a quantitative study in which 165 disability activists participated. No information on medical conditions or impairments was included, but it is possible that the participants had more varied impairments and that some of the impairments did not make participants feel sick. In addition being a disability activist might mean that the participants supported the social approach of disability. However, as the difference in findings from these two studies shows and as argued by authors like Shakespeare (2008) [24], neither of the two models fully encompass the complexity of disability.

Society and the environment are disabling and barriers such as inaccessible buildings, a lack of rehabilitation and stereotypes regarding disability can cause or aggravate disability.[25] However, the impairment can also cause disability. Experiences of pain and fatigue for example are real and can hamper a person's ability to participate in social life Taylor (2005).[23] Therefore, disability should be seen as neither medical nor social, but rather as a complex combination of the two. In addition no one person's experience of disability is the same as the next person's, even in instances where both may have the same health condition and impairment.[26] Therefore defining disability with any single concept are difficult.

However, there is a need to define disability and disability-related concepts in order to ensure that persons with disability, rehabilitation professionals and other

stakeholders, can communicate using a common language. This means that a broad, multidimensional classification framework should exist that can be used across different healthcare disciplines, countries, and cultures, giving them a common language and structure for a variety of purposes, such as service provision and research.[27] The International Classification of Functioning, Disability and Health (ICF), in which disability is defined as "an umbrella term for impairments, activity limitations or participation"[28 (page 14)] provides such a multi-purpose, multi-disciplinary classification system that can be used by various disciplines and across different sectors.

According to the ICF, disability can be seen as the result of a complex interaction between the person's health condition, impairment and/or activity limitations, participation and contextual factors, as can be seen in Figure 2.1 The ICF defines impairment as a problem with body functions and structures (anatomic parts of the body such as organs, limbs and their physiological function). [25,27] Activities in the ICF refer to a range of actions carried out by an individual and participation in activities integral to social roles and economic life of an individual. Contextual factors consist of environmental and personal factors. Environmental factors refer to the physical, social and attitudinal environment and include aspects like assistive devices, physical accessibility and societal attitudes.[28] Personal factors are inherent to a person and include aspects like sex, age, coping skills and personality.[28]

The impairment can vary in nature for different people, for example, comparing being blind to being unable to walk. The impairment can also be regressive (Traumatic Brain Injury), progressive (Multiple Sclerosis) or static (Spinal Cord Injury). Life roles and participation also vary from person to person. One person might need to access education, another to do a specific type of work and another to perform activities as a volunteer. Some activity limitations have a bigger impact on some type of employment for instance a person diagnosed as a having Quadriplegia can be a lawyer if the environment allows it but not be a miner.[3,29,30] Similarly environmental barriers and facilitators, which affect people in their daily lives, varies .

Thus disability is a result of an impairment and activity limitations and restrictions in participation caused by the interaction between body structure and functional limitations and an unaccommodating environment and personal factors.[30] The WHO

2011and ICF refers to disability as a part of the human condition, where at some point most people will experience an impairment of some sort.[30]

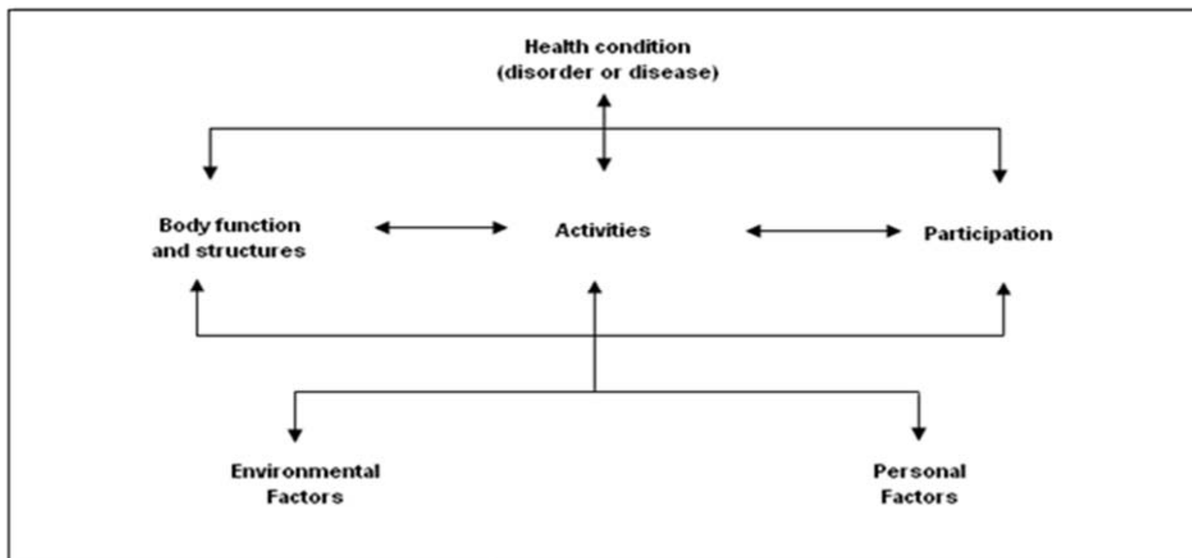

Figure 2.1: International Classification of Functioning, Disability and Health (ICF) [3]

For the purpose of this research study, the ICF framework will be used to classify disability. Rehabilitation service delivery at the study setting will be described with regards to how it addresses all the components of the ICF.

2.3 Disability prevalence internationally

The World Report on disability 2011 used two sources of information in estimating global disability prevalence: The World Health Survey and the Global Burden of Disease. [30]

The World Health Survey, 2002-2004, used the ICF to develop a conceptual framework and functioning domains. [30] Countries were surveyed and data sets from 59 countries were used to estimate disability prevalence. The adult population (18 years and older) from the countries had an average prevalence rate of 15.6%. This ranged between 11.8% and 18%, with 11.8% in developed countries and 18% in developing countries. Data reflected prevalence rates of disability among older people aged 60 years and above, to be 43.4% for developing countries and 29.5% for developed countries. If seen in the context of the ICF, the environmental and

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personal factors such as poor infrastructure and poverty may have a direct influence on disability prevalence in developing countries with limited resources.[30] Risk factors associated with disability that are also linked with poverty include: low birth weight, malnutrition, lack of clean water, inadequate sanitation, unsafe work and living conditions and injuries. In addition poverty can create a disabling environment for persons with impairments since underdeveloped infrastructure in impoverished communities creates accessibility challenges.[30]

The Global Burden of Disease data from 2004 estimated that 15.3% of the global population had a "moderate or severe disability". This is similar to figures from the World Health Survey.[30]

2.4 Disability Prevalence in South Africa and the Western Cape Province

Recent data on disability prevalence in South Africa comes from the 2011 census. Census 2011, defined disability as difficulties encountered in functioning with or without the use of assistive devices. Questions regarding activity limitations focussed on sight, hearing, communication, walking / climbing stairs, concentrating/remembering and self-care.[31] As summarised in table 2.1 results indicate that most people had no difficulty or limitation that prevented them from carrying out the functions in the above categories at the time of the Census. [31]

Table 2.1: Percentage distribution of population aged 5 years and older by type and degree of difficulty

	Seeing	Hearing	Communication	Walking/ Climbing stairs	Remembering/ Concentrating	Self-care
Cannot do at all	0.2	0.1	0.2	0.2	0.2	0.8
A lot of difficulty	1.5	0.5	0.3	0.7	0.9	0.6
Some difficulty	9.4	2.9	1.1	2.6	3.3	2.0
No difficulty	88.9	96.4	98.5	96.5	95.7	96.6

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Census 2011 provides no interpretation of the above table and figures. I did some interpretation of the results, and postulated "that cannot do at all" can be seen as severe or profound disability, "a lot of difficulty" as moderate disability and "some difficulty" as mild disability. This gives the reader the impression that 6.2% of persons that participated in the census presented with a moderate to severe disability. It should be noted that the census figures do not clarify whether one person gave a positive answer in more than one category which would mean a figure lower than 6.2%.

Table 2.2 provides figures on the use of assistive devices and chronic medication according to census 2011 findings.[31] The most frequently used assistive device was eye glasses.

Table 2.2: Percentage distribution of population aged 5 years and older using assistive devices

Eye glasses	14.0
Chronic Medication	12.3
Walking stick	3.2
Hearing Aid	2.8
Wheelchair	2.3

No provincial data on activity limitations were presented in the census 2011 findings. Provincial data were provided in census 1996 and 2001 and the community survey of 2007. However, since the questions used in Census 2011 focussed on activity limitations and differed a lot from questions used in previous census and surveys in South Africa, findings cannot be compared.

Census 1996, Census 2001 and the Community Survey 2007 data indicates that the disability prevalence figure in the Western Cape Province was around 3.5% to 4%.

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Table 2.3: Comparing Census 1996, Community Survey 2007 and Census 2011 data on disability prevalence in South Africa [31,32,33]

Census and Community Survey	Definition and Questions asked:	Disability prevalence in Western Cape Province
Census 1996	Respondents were asked to indicate whether or not there were any people with serious visual, hearing, physical or mental disabilities in the household. The seriousness of the disability was not clearly defined.	3.7%
Census 2001	Respondents were asked if any person had any serious disability which prevents the person from participating fully in educational, economic or social activities.	4.1%
Community Survey 2007	Participants were asked if a person had any kind of disability	3.4%

It appears that in Census 1996 and Community Survey 2007, questions regarding disability were mainly focussed on the health condition, whereas in Census 2001, the definition and questions relating to disability took into account the health condition and participation in social roles. This might account for the slightly higher figures in 2001. Schneider (2009) advises that the wording used in Censuses and surveys should be consistent, to ensure accuracy when comparing and measuring data. More inclusive definitions and questions can lead to higher disability figures.[34]

No disability prevalence data could be found for the Drakenstein area. However, information on the burden of disease in this area provides some indication as to the possible causes of disability in this area and thus where prevention and early detection, integral parts of rehabilitation service delivery at primary level, should focus.

2.5 Burden of disease in the Drakenstein area

Table 2.4 presents the Top 5 causes of premature mortality in Drakenstein area according to the Annual Health Status Report of 2008/2009.[35]

Table 2.4: Top five causes of mortality in the Drakenstein

Rank	Drakenstein
1	HIV / AIDS (13.5 %)
2	Homicide (11.2 %)
3	Tuberculosis (9.8%)
4	Road Traffic accidents (5.5%)
5	Stroke (4.9%)

While Table 2.4 indicated mortality causes, one can surmise high levels of morbidity and a need for rehabilitation in each of these causes. The link between HIV and disability has not received enough attention.[36] However, HIV carries with it a stigma and persons suffering from this might be prevented to perform social roles such as being employed because of discrimination, thus the condition can lead to a disability even if no activity limitation is present.[37] On the other hand, as HIV progresses people may develop activity limitations which in its turn can cause disability, when their social, political and economic participation are hindered due to the activity limitation. [38,39] A study by Ferguson and Jelsma (2009), on the prevalence on motor delay among HIV infected children living in Cape Town, examined functional limitations experienced by children who are HIV positive.[38] The study reported 77.6% of children had a physical delay, 63.5% a cognitive delay and 49.2% a language delay, these can lead to disability. Children suffering from these conditions require rehabilitation input to optimise their function. The availability of antiretroviral therapy results in people with HIV, living longer. However, side effects of treatment and or progression of the disease may result in activity limitations and/or participation restrictions. Thus HIV can lead to increased morbidity and disability, and rehabilitation plays an important role in slowing the deterioration of the individual's condition and maintaining independence and participation, in the continuum of HIV care. [38]

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In South Africa, the second leading cause of death and lost disability-adjusted life years (LDALY) are violence and injuries. [39] The overall injury death rate of 157.8 per 100 000 population in South Africa is estimated at nearly twice the global average. [39] Examples of social undercurrents in South African communities that support violence include: income inequality, poverty, unemployment, alcohol misuse (substance abuse) and exposure to child abuse and poor parenting.[39] Studies on violence and injuries causing disability are not well documented, but injury-related impairments resulting in disabilities can include: "Physical and/or cognitive limitations due to neuro trauma, paralysis due to spinal cord trauma, partial or complete amputation of limbs, physical limb deformation resulting in mobility impairments, psychological trauma, sensory disability such as blindness and deafness".[40] All of these conditions may require some form of rehabilitation.

Worldwide South Africa has the third highest level of TB. Approximately 1% of the South African population develops TB annually. [41,42]In the Drakenstein the incidence of TB is 9.8%. [35] HIV also appears to be a driver of TB. [41,42] The Burden of TB in South Africa is described as one of the worst TB epidemics in the world. The rates are up to 60 times higher than those seen in the USA or Europe. [42] Types of TB includes Pulmonary Tuberculosis, that can result in lung dysfunction, Genitourinary TB, that causes kidney and urinary problems, Skeletal TB, that can lead to the destruction of joints and paraplegia and, Nervous System Involvement which may also lead to paraplegia and long term neurological complications. Again, many of these conditions can cause activity limitations and participation restrictions that may require rehabilitation.[41,42] In addition ototoxicity, due to second line drugs used in the treatment of TB, can lead to hearing loss and may require rehabilitation interventions from specialists in this field.[41,42,43]

Road Traffic accidents are ranked as the 4th leading cause of death in the Drakenstein.[35] In South Africa more than 11 000 people died in road traffic accidents during the period: 2001 – 2010. Every day at least 30 people are left disabled in South Africa as a result of road traffic accidents and may require rehabilitation intervention. [44]

In South Africa, stroke is one of the front runners of vascular disease and is a devastating condition that leads to high levels of disability and case fatality.[45]As

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indicated in table 2.2, strokes are one of the top 5 causes of death in the Drakenstein with an incidence of 4.9%.[35] However, strokes are often not fatal, but can cause through neurological damage numerous impairments and activity limitations that requires rehabiliation.[45,46,47]

2.6 Rehabilitation

Rehabilitation can be described as a range of responses to disability, ranging from interventions to improve body functions to more wide-ranging measures designed to promote inclusion.[30] Rehabilitation is essential for some people to be able to participate fully in society e.g. participate in education and the labour market, etc.[30] The WHO 2011 Health Report defines rehabilitation as: "a set of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environments". The South African National Rehabilitation policy define rehabilitation as: "a goal oriented and time limited process aimed at enabling an impaired person to reach an optimum mental, physical and / or social functional level, thus providing her/him with the tools to change her or his own life." [2]

Thus on an individual level, rehabilitation involves the identification and addressing of problems and needs, specific for an individual person. These should include any and all impairments, activity limitations, environmental barriers and personal factors that hamper function and participation in life roles. Once the problems have been identified, rehabilitation goals to address them should be set through a client centred interactive process. [30] This interactive process would include both the therapist and client identifying personal and environmental problems, related to their functioning. Joint planning and decision making, may lead to better health and functioning when they are partners in rehabilitation. [48] This process should be monitored and assessed throughout to determine its effects and outcomes. [30]

The Western Cape Departmental Health has a Comprehensive Service Plan (CSP) that distinguishes between high intensity and low intensity rehabilitation services. Low intensity rehabilitation services are described as rehabilitation services provided by at least one rehabilitation professional / mid-level worker, 1-2 hours per person per day, not necessarily every day.[49] Rehabilitation at PHC level is classified as low

intensity. At service points in the Drakenstein sub district where rehabilitation services are available, a low intensity package is offered.

Rehabilitation services can be provided through inpatient, outpatient, outreach, independent living of community based rehabilitation models.[50] Traditionally rehabilitation services were provided in urban hospitals on an in or outpatient basis. Services were usually based on a medical approach and impairment focussed. In addition rehabilitation was often not available close to where the person with the disability lives, even though most people required fairly basic, low cost rehabilitation services that could be provided in a primary or secondary health care setting. This causes rehabilitation to be expensive, inappropriate in some instances and inaccessible for many. [50]

Outreach rehabilitation services were implemented as a way to address this problem.[50] In outreach services, the therapist from a more central service point visit more distant points of service delivery such as clinics, community centres, NGO`s and people's homes. Outreach rehabilitation services are provided in the Western Cape Province, through therapists visiting community day centres and primary health care clinics in the community.[51] This is also described in the 2012/2013 Annual Performance Plan of the Western Cape`s Department of Health, where rehabilitation services are described as services delivered at community health centres. [52] However, authors have criticised these forms of outreach because in their opinion rehabilitation service delivery was still mainly facility based and provided within the medical model approach. This can result in unmet needs amongst people with disabilities. [53]

Rehabilitation services are often delivered by health care professionals who work together in teams. A team is referred to as a small group of people committed to the same purpose and they share common goals and overlapping skills. [54] Professionals providing rehabilitation can work according to a multi-, inter- or trans disciplinary teamwork approach. When comparing the three types of teamwork: multidisciplinary is working with several disciplines on the same project, but independently; interdisciplinary is working between several disciplines, when members from different disciplines work together on the same project; transdisciplinary is working across several disciplines where members from different disciplines work together

using a shared conceptual framework. It often means working across professional boundaries. [110] Comparing the different definitions of teams, transdisciplinary teams appear relevant for the rehabilitation setting, because it facilitates role release and role expansion to different professional and non-professional health staff.

Some authors argue that Community Based Rehabilitation (CBR) would be a more effective way of providing rehabilitation at community level.[50,53,55] Similarly the NRP has as its goal to make rehabilitation services accessible to all through implementing the principles of Community Based Rehabilitation (CBR) as a component of PHC in South Africa.[2]

Community Based Rehabilitation

Community Based Rehabilitation can be viewed as an approach in service delivery, which takes services to the people in a way that is relevant to them and the environment in which they live. The CBR approach is patient centred and facilitates the transfer of skills, ensuring empowerment of persons with disabilities, their families and caregivers.[2] Helender's definition of community based rehabilitation echoes this: "CBR is a strategy for enhancing the quality of life of disabled people by improving service delivery, by providing more equitable opportunities and by promoting and protecting their human rights" [56] This approach, places emphasis on and suggests that the highest goal of rehabilitation is full integration of the disabled person into the community. Disabled people's organisations, who describe access to rehabilitation services as a human right, also echo this.[57] They see rehabilitation as a tool that improves equity for disabled people. They are concerned about the lack of community-based rehabilitation as they feel the greatest effort should be put towards community integration of the disabled person, supporting their families and especially mothers of disabled children.[57]

CBR is described as an approach to rendering services to people with disabilities and not a service itself. [2] Very appropriately stated in the NRP as "not what we do, but how we do it." [2] CBR is way of delivering services, where there are limited resources and the focus is facilitating the utilisation of the available resources in the community. [58] The NRP and the WHO CBR Matrix provides guidelines for the implementation of CBR, however diversity in communities and resources within

communities makes it challenging to implement CBR in an attempt to fully meet the needs of people with disabilities. [58] Outcomes of a CBR programme is difficult to compare as these programmes are developed to address specific needs in communities and therefore different outcomes are measured. [59,60]

In his document, "Strengthening the role of the Disabled people in community based rehabilitation programs", David Werner [55], said: "Governments do launch CBR programs, these programs do reach out to many people, but they still tend to be structured from the top down, in ways that normalize rather than empower."[55] Without the active involvement of local communities the sustainability of CBR projects is often limited.[61] It was also acknowledged by Helander (2000) that it is difficult to develop a system that covers all needs. Helander states that management in government needs to start addressing the formulation of clear policies, quantifying the need for rehabilitation services, developing strategies and policies to provide services and ensure national planning, monitoring and evaluation, finance and budget systems to ensure effective and efficient rehabilitation services. [56]

There are various national and international policies that guide the implementation of rehabilitation programs in South Africa. The next section will explore some of these policies.

2.7 Relevant Policy and Legislation that impact on rehabilitation services

International Policy

The most important international document to guide rehabilitation and disability practices in South Africa is the United Nations Convention, on the Rights of Persons with Disabilities (UNCRPD).[10] Article 1 states that the purpose of this document is to "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity". When a country signs and ratifies the convention, it becomes a legal undertaking to stand by it and the convention should then direct the actions of the government of that country.[10] The UNCRPD was ratified by 129 countries. This commitment was also made by the South Africa government and approved during 2007. Subsequently the convention was entered into power on 3 May 2008.

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The UNCRPD has 50 articles that all directly or indirectly relate to rehabilitation. The articles in the convention speaks largely to access which includes: Justice (article 13), Information and communication services (article 21), Education (article 24), Work and employment (article27) - human resource policies and practices, Adequate standard of living and social protection (article 28), Participation in political and social life (article 29), Participation in cultural life, recreation, leisure and sport (article 30). Other articles that indirectly relates to rehabilitation is articles 33-40, which speaks to both national and international monitoring mechanism.[10]

Of these 50 articles, the SANPAD group identified Articles 9, 19, 20, 25 and 26 as particularly relevant to the SANPAD studies based on their strong focus on health and rehabilitation.[10,62]

Article 9: Accessibility

“Governments agree to make it possible for people with disabilities to live independently and participate in their communities. Any place that is open to the public, including buildings, roads, schools as well as health facilities, must be accessible to persons with disabilities, including children. If you are in a public building and need help, a guide, reader or professional sign language interpreter should be there to assist you.” (page 9)

This article gives government direction to prioritise the revamping of public buildings in order to meet the diverse needs of persons with disabilities. In ensuring access to rehabilitation services government should ensure that health facilities comply to accessibility standards for persons with disabilities.[62]

Article 19: Living independently and being included in the community.

“People have the right to make choices about where they live, whether or not they have a disability. In addition they have the right to live independently if they prefer and to be included in their communities. You must have access to support services if you need help to live in the community, such as care in your home and personal assistance.” (page 22)

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Government should ensure that support services are available in the communities where people live, to promote independent living and participation in that community.[62]

Article 20: Personal Mobility.

"States Parties shall take effective measures to ensure personal mobility with the greatest possible independence for persons with disabilities" (page 25)

Access to free and appropriate assistive devices can ensure greater mobility and independence for persons with disabilities. Waiting periods for assistive devices must be limited. [62]

Article 25: Health.

"Persons with disabilities have the right to enjoy the highest attainable standard of health. Persons with disabilities should not experience discrimination in any aspect of health access. Health services include health related rehabilitation services."(page 39)

People with disabilities have the right to the same range and quality of free health care and rehabilitation or affordable health care and rehabilitation as provided to other people in a country.[62]

Article 26: Habilitation and Rehabilitation.

"Persons with disabilities should have access to habilitation and rehabilitation services that will allow them to attain and maintain maximum independence. Services must be available to persons with disabilities living in local communities, including rural areas." (page 43)

Rehabilitation services in South Africa are guided by the National Rehabilitation Policy (NRP). This policy adopted Community Based Rehabilitation (CBR) as an approach in taking rehabilitation services to communities. Even though rehabilitation services are available in all 9 Provinces of South Africa, service delivery approaches differs from one province to the next. [62]

The above articles were identified as relevant for the SANPAD study and various ones were addressed to a bigger or lesser extent in various studies. The current study focused more on rehabilitation at Primary Health Care level and its capacity, as an organisational structure to deliver rehabilitation services. The emphasis was placed on access, specifically access to rehabilitation on a primary level.

The progress on the implementation of specific articles of the UNCRPD is highlighted in the UNCRPD First Country Report. [62] Progress on accessibility (article 9) highlighted that government has prioritized the revamping of public buildings in order to address the needs of persons with disabilities. An accessibility audit highlighted that health institutions scored more than 60% according to the health accessibility tool. Seventy five buildings were prioritized by government to ensure that they adhered to accessibility standards for people with disabilities. Progress on the implementation of article 25 (Health), highlights that protocols and policies have been developed to address the health needs of persons with disabilities, but a lack of human resources, inadequate training, high turnover of staff, inadequate budgets and monitoring and evaluation systems hinders the implementation of these protocols. Article 26 (Habilitation and Rehabilitation) reported that there is progress on the implementation of rehabilitation programmes, allocation of human resources and availability of assistive devices, but that it is still mainly facility based. [62]

While the UNCRPD is important to the current study since it provides international guidance to disability management and rehabilitation services, the specific impact of services on the UNCRPD articles will not be addressed in this study. However, some of the other studies within the SANPAD project will assess the alignment of services with these articles.

National Policy

Nationally in South Africa rehabilitation services are guided by the National Rehabilitation Policy, a document that was published in 2000, and based on the Integrated National Disability Strategy (INDS) of 1997.[2,63] The purpose of the INDS was to activate processes and recommendations, made by disabled people in developing and implementing specific policies and legislation. [63]

The main goal of the NRP is to improve accessibility to rehabilitation services for all persons with disabilities. The NRP has seven objectives and focus on access, collaboration, resource allocation and development, monitoring and evaluation, inclusion of persons with disabilities in all aspects of service delivery and research. The objectives of the NRP are summarized in Table 2.5. [2]

Table 2.5: Objectives of the NRP (DOH, 2000)

- To improve accessibility of rehabilitation services for people suffering from conditions that can lead to disability as well as those living with disabilities.
- To establish mechanisms for intersectoral collaboration in order to implement a comprehensive rehabilitation programme.
- To facilitate appropriate allocation of resources, and encourage their optimal utilisation.
- To facilitate human resource development which takes into account the needs of both the service providers and the consumers?
- To encourage the development and implementation of monitoring and evaluation strategies for rehabilitation programmes.
- To ensure participation of persons with disabilities in planning, implementation and monitoring of rehabilitation programmes.
- To encourage research initiatives in rehabilitation and related areas

These objectives provided seven key indicators for the current study against which rehabilitation service delivery in the study setting will be compared to determine if it adheres to the NRP.

The NRP is the guiding policy for rehabilitation service delivery in South Africa. When compared to the UNCRPD and specifically the 5 articles selected for this study, similarities exist with regards to accessibility and resource allocation. Both policies speak to access to rehabilitation at health facilities in the community and also access at community level. The UNCRPD focus mainly on what should be in place for persons with disabilities in their communities and the rights of persons with disabilities. In comparison, the NRP, has specific objectives that should guide implementation of services and assists the development of Provincial and operational policies to make in rehabilitation more accessible for persons with disabilities.

The NRP emphasises the value of CBR as an approach to rehabilitation service delivery. The involvement of persons with disabilities in policy planning, implementation and evaluation are emphasised. In addition rehabilitation is placed within the realm of PHC. The NRP proposes that the CBR approach as a part of PHC should be followed to ensure accessible, affordable, appropriate and acceptable rehabilitation services to all communities. [2] This is also echoed by Bury (2003) that CBR is an approach that extend beyond health care arena. It is also important to understand that rehabilitation in the context of CBR extends beyond a purely medical model.[64]

Primary Health Care

Primary Health Care can be seen as the key element in transforming health services in South Africa as stated in the African National Congress (ANC) Health Plan of 1994, where the PHC approach is the underlying philosophy for the restructuring of health systems.[65] A comprehensive package of primary health care services was developed to provide the foundation for an equitable health system after democracy in 1994 and over the past 19 years there was a focus on PHC service delivery in South Africa.

The idea of Primary health care (PHC), first developed in South Africa in the early nineteen forties. It resurfaced in the 1970's, when perceptions of health care began to change worldwide. [66] The 1978 Alma Ata conference emphasized the underlying principles and characteristics of PHC and approved it as a strategy to achieve the WHO's vision of "Health for All" in the year 2000. The PHC package provides a vision for health service delivery to health workers and managers at district level. [65] The proposed package of care should be seen as a guide for implementation and not a rigid set of norms and standards.

Three different approaches to implementing PHC have developed. These are: primary care, comprehensive PHC and selective PHC.[67] The three approaches are presented in Table 2.6.

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Table 2.6: Approaches to Primary Health Care [67]

Approach	Primary Health Care Definition	Emphasis
Primary Care	Primary care (PC) is the health care service that is made available as near as possible to where people live and work. It is enhanced by effective referral systems to more specialised levels of care. The Alma Ata Declaration calls for primary care to supply eight essential elements, including adequate food supply and proper nutrition, water and basic sanitation, as well as appropriate and acceptable health education.[68] • "Refers to the first point of contact with, or the entry point into, the health system"[67] • Primary care focuses on personal health or individual health care and is predominantly curative (or therapeutic), preventive and rehabilitative in nature.	Level of care in a health services system.
Comprehensive PHC	PHC is a strategy that responds equitably, appropriately and effectively to the basic health needs of a group of people and which also addresses the underlying social, economic and political causes of poor health. It is underpinned by the principles of universal accessibility and coverage of the basic needs, with an emphasis on disease prevention and health promotion, community participation, self-reliance and intersectoral collaboration.[69] • "The comprehensive PHC approach, as elaborated at Alma Ata, embodies a set of five key principles: o comprehensive care ; o intersectoral collaboration and action; o active community participation and support of empowerment; o appropriate care and use of technology; o and equity. o an integrated referral system, which facilitates the delivery of a continuum of care to clients, across different levels and places of care in the health care system without interruption; • and the notion of multidisciplinary health teams, including community-based health care workers." [67]	Philosophy of health care to be incorporated at all levels of care and through all means of service delivery

Selective PHC	Selective PHC was an interim strategy that was used to begin the process of PHC implementation in developing countries. The focus was on four vertical programmes: growth monitoring; oral rehydration therapy; breastfeeding and immunisation (GOBI). Family planning, female education, and food supplementation (FFF) were added later. The interventions targeted only women of childbearing age (regarded as being 15−45 years of age) and children from birth through to age five. "Focuses on a limited number of high-impact interventions to address some of the most prevalent health challenges"[70]	Specific set of health service activities geared towards the poor.

In my opinion, only a comprehensive approach to primary health care can begin to ensure a health care system that addresses all the health care needs of the communities it serves. However, a series of challenges and obstacles limit the full implementation of PHC in South Africa. These obstacles include the HIV and AIDS pandemic, health worker shortages, inequitable resource distribution, political shortcomings, leadership challenges and a complex health system. [67]

Although definitions exist for PHC and community based rehabilitation (CBR), the interpretation differs and the nature of services refers to differs. Rehabilitation services should be positioned stronger within PHC, with the emphasis on disease prevention and health promotion. Based on the needs of local communities, rehabilitation services in its approach should be flexible, responsive and innovative. Training and orientation of therapists should equip them with skills and knowledge to render rehabilitation services in the PHC setting with a CBR approach. [64]

It was the intention of the National Health Plan to restructure PHC, by eliminating fragmentation and duplication of services. This could be achieved by integrating health services under one Ministry of Health, implementation of the District Health system and focus comprehensive, community based health care that would be accessible to all South Africans. The establishment of PHC facilities formed the foundation of accessibility. [66]

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Kautszky and Tollman maintains that a renewed commitment to PHC is justifiable, but suggested that a more innovative health system, which can be responsive and flexible to the ever-changing conditions and demands of the communities, will achieve better outcomes. Thus a re-design of the current rigid PHC system is needed.[66]

In October 2010 a review was commissioned by the Ministerial PHC revitalization team. The review was aimed at conducting an analysis of the current PHC package of health and services, as well as the PHC norms and standards, and to make recommendations for a revised PHC package of care. [67] During November 2010, a discussion document was launched, titled: Re-engineering Primary Health Care in South Africa, from which the following statement was made: “Much has been done to gear up the health system to implement PHC; however, insufficient attention has been given to the implementation of the PHC approach that includes taking comprehensive services to communities emphasizing disease prevention, health promotion and community participation. For the most part, there has not been a population focus and insufficient attention has been given to the improvement and the measurement of health outcomes.” The document puts a lot of emphasis on the re-thinking and re-engineering of the whole package of Primary Health Care (PHC).[67]

Naledi in her discussion document November 2010 on Re-engineering PHC shows that there are two fundamental differences between the Re-engineered approach and the present PHC approach: Firstly the District Health System (DHS) should be strengthened and District Management Teams should be accountable for district management and secondly the interaction and participation of communities with their own health and the health workers implementing team approach. [71]

Rehabilitation forms an integral part of health services rendered at PHC level. The clinic is the first point of entry for people with disabilities. [67] The purpose of rehabilitation at clinic level is to provide a service to prevent disabling conditions, to detect disabilities early so as to prevent complications and the worsening of the effects of a disability on a person’s functional ability, to treat disabling and potentially disabling conditions and to provide access to rehabilitative services for people with disabilities, making them appropriate and acceptable. [49]

Rehabilitation at primary level in South Africa is divided into three key areas of service delivery i.e. community based rehabilitation services, clinic based services and community health clinics. Table 2.7 gives a comprehensive overview of the package of care that needs to be rendered within each key area as summarized in the review.[67]

Table 2.7: Rehabilitation Package of Care[67]

Community Based Rehabilitation Services	
Conduct structured household visits to: • identify at-risk households and individuals • assess need for services • facilitate access to health and social services	• Identify vulnerable households, including people hidden because of physical disabilities Facilitate access to social grants (child care, disability, old age) and other social services (e.g. OVC) • Facilitate access to assistive devices • Assist with registration of births and deaths • Screen for domestic violence & substance abuse
Promote equal opportunities for people with disabilities	• Raise awareness in educational institutions, places of employment, sports and recreation facilities, religious institutions, etc. • Supply of up to date information on accessible programs and services to persons with disabilities, their families, professionals in the field and the overall public. • Facilitate establishment of self help and support groups with full participation of people with disabilities • Create awareness and provide knowledge regarding mental illness and anti-stigma and non-discrimination
Provide information, education & support for safety, healthy behaviour and appropriate home care	• Provide information on substance abuse, adherence to health and safety regulations, road safety tips, prevention of burns in the home
Provide psychosocial support and facilitate and support the development of self-help groups	• Provide counselling • Networking with rehabilitation and disability forums, CBOs and NGOs

Conduct community assessments & mobilise around community needs	• Address inter-sectoral issues, especially access for disabled individuals, equal opportunities, etc • Support community campaigns which aim to promote human rights, improve coverage of key interventions, safety, etc.
	• Support pedestrian and other safety initiatives (e.g. for children, women • Support campaigns to reduce the availability of drugs and alcohol
Clinic-Based Services	
Screening	Early detection of people with disabilities through screening and observations at the clinic and/or home visits
	Assessment of physical, emotional, sensory or communication disorders
Assessment	Basic assessment by means of formal diagnosis by visiting professional team and issue of basic assistive devices
	Early detection, assessment and treatment of impairment
Counselling and/or education	Of client and family/care giver
	Receiving and sending out referral to local resources and CHC
Community Health Centres	
	• Identification, assessment, management and referral • Screening for complications e.g. contractures, pressure sores, • Establishment of rehabilitation management plans for patients • Provision of free assistive devices, including wheelchairs, walking aids, hearing aids, prostheses

Provincial Policy and Documents

Primary Health Care is also highlighted in the Western Cape Department of Health's Comprehensive Service Plan (CSP) for the implementation of Health Care. [49] The CSP was developed by the Western Cape Provincial Government Department of

Health to provide a framework for the reshaping of services that are necessary to achieve the goals of Healthcare 2010. [49] The main aim of this plan was to improve the quality of health services and to ensure sustainable health services in the Western Cape Province. In the CSP of the Department of Health Western Cape, rehabilitation is an integral part of all service plans. The rehabilitation service plan within the CSP focuses mainly on services rendered to persons with physical disabilities within the District Health System (DHS). The aim of the CSP is to expand services at PHC level, which should improve access to rehabilitation services, as well through low intensity rehabilitation as an outpatient, decrease pressure on bed utilisation in acute health settings. The CSP stipulated that by 2010, 90% of the people will be cared for at PHC level.[49] The CSP laid a strong foundation and framework for health services in the Western Cape. After 2010, Healthcare 2020 replaced Health care 2010.[11] Healthcare 2020 build on the existing foundation of 2010 to improve the patient experience, improve quality of care and strive for operational efficiencies.[11]

An Annual Performance Plan (APP) is drafted to guide the Western Cape Department of Health in achieving its targets within the allocated budget. The APP helps to realise the goals set within Health Care 2010 and now Health Care 2020. The Annual Performance Plan aims to give strategic direction to management within the Department of Health. In this plan, rehabilitation services within the (DHS) are referred to as services being rendered at community health centre level as listed above in Table 2.7.

Priorities in the 2012/13 APP for rehabilitation are: [52]

1. **Address the Burden of Disease by:** delivering an interdisciplinary outcome-based rehabilitation service within the International Classification of Function and health framework, interventions for the prevention of secondary complications in persons with disabilities, ensuring quality rehabilitation services and rendering on-site, off-site and outreach orthotic and prosthetic service.
2. **Optimal financial management to maximise health outcomes by:** allocating sufficient funds and monitor the Public Private partnerships.

3. **Ensure and maintain organisational strategic management capacity and synergy.**
4. **Improve the quality of health services and the patient experience by:** improving the quality of rehabilitation services in terms of the client's experience, facilitating appropriate behaviour in staff through the use of champions as change agents, holding regular meetings, evaluating staff and client satisfaction surveys and assessing adherence.

2.8 Policy Implementation

Policy implementation involves the translation of policy into managerial activities, putting these activities into managerial parts and methods and routinely administrates these activities or service.[6] Policy implementation is a dynamic, complex process that is influenced by social, economic and political interactions. It has to be done through those responsible for service delivery and those who benefit from the policy and cannot be forced on anybody. [71] In addition, policy implementation is dependent on continuous interaction between different role players and stakeholders.

Gilson and Walt developed a policy implementation model that looked at the relationship between context, content, process and actors. By analysing each of the components of the model, it can assist one to understand and clarify why policies were implemented in a certain way. It takes into account the values and interest of stakeholders (actors), how these will be affected by the change (content) to be brought about through the policy, and the setting in which the change is taking place (context). Walt and Gilson highlighted that in policy implementation one cannot only focus on policy content, but the other components such as actors, context and processes should also be taken into account.[72]

Gilson and Erasmus (2004) propose that actors such as health managers and frontline health workers can directly determine the shape that policy takes in the routine health care system by their words and actions. They are also an important group in the implementation of policy and must be consulted during policy

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development and implementation, for implementation to be successful.[73] The views of the health workers are influenced by the organisational culture and society.[74]

Policy and change in policy is often challenged in the public arena, creating opposition that can prevent policy from being implemented. The actors involved are not only those responsible for policy development, but may include those likely to be affected by the policy developments. Other weaknesses identified in policy implementation includes: analytical weakness, a lack of explicit explanatory focus, generalisation, not amending policy according to identified barriers, and a lack of community participation. [75]

The role of all actors is critical in influencing the implementation of policy. Role clarification of actors at all levels and the organisations role in implementing a policy or programs must be clear. If roles are clear it can assist with identifying where barriers to implementation are occurring. The relationship between actors at different levels in the organisation and the realisation of their interdependency is critical in improving policy implementation. [76]

2.9 Policy Implementation in health care service delivery in South Africa

South Africa and the Western Cape have comprehensive policies on rehabilitation and in addition are guided by international policy. However, recent studies and articles published in South Africa shows that there are challenges when it comes to the implementation of policy in health care services.

Some of the factors that contribute to policy implementation challenges are limited resources, specifically human [77,78] , managerial incapacity [79,80] continuity of care, a lack of political will and poor team work.[77] Post 1994, health systems have been transformed to an integrated and comprehensive service. However leadership, stewardship and weak management, have led to inadequate implementation of policy. [79] Efforts have been made to address challenges with in health systems. For instance the successes and management of epidemics such as HIV/AIDS and TB, since 2009, demonstrates the impact of determined leadership. [80] In contrast: “Poor stewardship at policy level, weak management and supportive supervision are major obstacles to improving health systems in South Africa.” [79]

The 2011 South Africa Health Review showed that political will is critical in transforming health systems. An inadequate resource, uncommitted leaderships and irregular engagement with relevant stakeholders, hinders implementation. The importance of accurate data and reporting to inform policy is also highlighted. [78]

An assessment of mental health policy in Ghana, South Africa, Uganda and Zambia provides an example of the evaluation of policy implementation. Nearly half the countries on the African continent had a mental health policy by 2005, however, little is known regarding the quality of these policies, in terms of their content and processes. Examination of the policies revealed six barriers for policy implementation:

- Lack of internal consistency, in terms of structure and content of policy. This may lead to inconsistency and reducing the strength of the policy.
- Political correctness vs. political will to implement the policy. This may lead to policies with correct wording, but a lack of action.
- Lack of evidence and data. Decisions should be based on information on the existing situation.
- Political support. Strong support and active participation is needed from high level officials in government e.g. Ministry and cabinet. Other important actors should include health care professionals responsible for implementation.
- Poor integration on a specific policy into overall national policy and legislative framework.
- Lack of funding [81]

In order to address these barriers, 3 strategies will need to be employed, namely:

a) Developing the capacity of key stakeholders in technical policy skills
b) A new culture of policy implementation must be developed which is inclusive of diverse experiences and expertise and not only restricted to a group of experts
c) Policy must be responsive and constantly monitored to ensure good governance.[81]

In summary, the recurrence of similar findings indicates that stewardship/political will, engagement with all relevant stakeholders, monitoring and evaluation systems,

increased resources and a responsive and adaptive health care system is needed to ensure policy implementation that is relevant.

2.10 Monitoring and Evaluation of rehabilitation services in South Africa

The implementation of Rehabilitation services in South Africa are challenged by factors similar to overall health care policy implementation. The First Country Report on the implementation of the UNCRPD, Article 26 (Habilitation and Rehabilitation), highlighted a lack of human and financial resources, as well as competing priorities within provinces as constraints to policy implementation. [62]

Bateman indicated serious challenges with regards to rehabilitation service delivery in rural South Africa. [82] The challenges faced by rural therapists include: insufficiently skilled or motivated service providers, unclear operational mandates from the DOH and the Department of Education, weak multi-sectoral approaches and insufficient budgets for assistive devices.[82,83] A study conducted by Rhoda et al (2009) on the rehabilitation of stroke patients at CHCs in the Western Cape Metro Health District also revealed that human resources specifically related to the rehabilitation of stroke patients were lacking and that therapy services were poorly coordinated. [84]

An article by Miles Connor and Allan Bryer,[45] on the need for a community-based rehabilitation model for stroke patients, share similar findings.[45] Bryer emphasises the need to develop a model of community based stroke care especially in under resourced areas for example a rural setting such as the Drakenstein Sub district, where rehabilitation depends largely on family and community commitment, because of a lack of financial and human resources.[45,46]

A research study on lower limb amputations at Elangeni, Paarl (the site previously responsible for rehabilitation services in the Drakenstein sub district), South Africa, showed that rehabilitation was provided through a medical model approach.[85] Little attention was given to community integration and participation. This study concluded that amputee rehabilitation and possibly other rehabilitation services at the setting was at that stage (2011) not provided according to national and international policy such as the, NRP and CBR principles.[85]

In South Africa CBR programmes are often initiated by the Department of Health and mainly focus on the health needs of the community instead of community integration of person with disabilities.[51] Bury indicated that there are a number of rehabilitation programmes that claim to be CBR programmes, but are more descriptive of an outreach programme.[50] This is also echoed by de la Cornillere (2007) where community rehabilitation is seen as an outreach from a Community Health Centre.[51]

Monitoring and evaluation strategies of rehabilitation services are one of the seven key objectives of the NRP, but the NRP does not provide guidance on how this should be done. [2] Literature provides guidance and a number of evaluation strategies that could be implemented with success in rehabilitation service delivery. These include the process of Outcome mapping, the Systems model and measuring Quality of life. [60] Outcome mapping was specifically developed to evaluate services delivered in complex social systems where cause and effect is difficult to prove because of many influencing factors. It is a participatory, empowering and reflective process, which requires the involvement of all partners throughout the planning, monitoring and evaluation stages. The outcomes of the program are defined as changes in relationships, behaviour or actions of participants. Progress is measured through a set of graduated indicators of changing behaviour, with depth and quality of change as focal points. The systems model proposes an evaluation framework where quality of service, client satisfaction, programme outputs (efficiency) and programme outcomes (effectiveness) are continuously evaluated according to predetermined benchmarks. The results of the evaluation process are fed back into the programme to facilitate programme improvement. [60]

In addition to above evaluation strategies Velema and Cornielje (2003) provide a detailed framework for the evaluation of CBR programmes.[86] They argue that assessment of CBR programmes should include assessment of the programme and its environment, of services offered and their use and quality, of client outcomes, and of the relationship between the user and provider. These authors provide extensive examples of aspects to be covered in each area and possible ways of measuring each aspect. In a more theoretical discourse based on a review of the literature Mannan & Turnbull (2007) argues that the evaluation of CBR programmes can focus

on four features of CBR i.e. service delivery systems, transfer of technology, community involvement and service organisation and management.[60]

Information systems and monitoring is essential for good evaluation. Monitoring is an on-going process that makes use of systematic data collection and describes where a policy or programme is at with regards to targets and outcomes.[87]Evaluation is more subjective and gives reasons why objectives and targets are not met. Monitoring and evaluation (M&E) seeks to provide critical information enabling policy makers and managers to make informed decisions. In the context of CBR, M&E should focus on measuring development.[87]

Reg Mitchell in his book “The research base of community base rehabilitation”, states that evaluation is useful when planning services to help planners to see whether or not their goals are fulfilled and to make adjustments accordingly .[88] So too, is the evaluation of rehabilitation services necessary to determine its impact. To evaluate a program, information needs to be gathered systematically, with the purpose of being able to compare the development of the programme at a specific time. [86] If desired outcomes are clearly defined, evaluation of programmes is not difficult. [86] The importance of client’s expectations needs to be taken into account when outcomes are planned. [89]

The monitoring and evaluation of rehabilitation services appear to be increasingly researched over the past ten years. Studies in the Western Cape by Wendy Lynn de la Cornillere on the participants experience of the Bishop Lavis Stroke group(2007)[51], Rhoda et al, the rehabilitation of stroke patients at community health centres in the Western Cape (2009)[47], Jerome Fredericks, description and evaluation of the rehabilitation programme for persons with lower limb amputations at Elangeni Rehabilitation Centre (2011)[85] and Cawood, rehabilitation outcomes and barriers to rehabilitation of stroke survivors in the Helderberg basin (2012) [90] are examples of research studies measuring rehabilitation service delivery. The question remains, does the organisation have the capacity to implement the recommendations provided. Naledi`s discussion document emphasises monitoring and evaluation at every level of health care service delivery in order to ensure effectiveness, quality and efficiency. Monitoring and Evaluation should form part of the manager’s job description and should become part of their daily work. [71]

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When looking at the rehabilitation site's capacity to deliver rehabilitation services in line with the NRP, the SANPAD study group, decided to use the Kaplan model of evaluating organisational capacity at all four sites in the Western Cape.

2.11 Organisational Capacity

According to Jack & Powers (2009) authors often link capacity to resources and define an organisations capacity in terms of whether it has access to the necessary resources (human, equipment, facilities, financial and information) to perform its function.[91] Business dictionary.com gives a similar definition: "Ability and capacity of an organisation is expressed in terms of its (1) Human resources: their number, quality, skills, and experience, (2) Physical and material resources: machines, land, buildings, (3) Financial resources: money and credit, (4) Information resources: pool of knowledge, databases, and (5) Intellectual resources: copyrights, designs, patents, etc." [5]

However capacity is much more multifaceted and cannot simply be equated with resources as this quote by Fowler and Ubels suggest: "Experienced practitioners know that capacity has many, often confusing, faces. Pinning it down, is like trying to nail a multi coloured jelly to the wall." [92] Acknowledging this multi-faceted nature of capacity Fowler and Ubels felt that the framework provided by Kaplan can be useful in assessing capacity. Kaplan's framework is grounded on six hierarchical elements to help organisations "unpack" themselves and see their roles in organising. It contains both tangible and intangible elements.[92]

Kaplan`s framework for organisational capacity was selected as the framework for the larger SANPAD study and by extension this study. This choice was based on the following arguments:

- The Centre for Rehabilitation studies (CRS, US), were the current study was hosted, had just completed an evaluation of the Disabled Children's Action Group (DICAG).[15] In this evaluation the Kaplan framework was used successfully. DIGAG and rehabilitation services have common ground such as:
  - being underpinned by the concepts of CBR
  - adhering to a rights based approach

- being influenced by the constitution of South Africa with the aim of equalization of opportunities for all including persons with disabilities
- and dealing with disability issues.

Thus the research team felt confident that Kaplan`s six elements of organizational structure will provide a coherent framework to evaluate the capacity of the four sites to deliver rehabilitation services.

- The research was performed in different areas (urban, peri urban and rural) and for different type of service (inpatient and outpatient rehabilitation, rehabilitation at primary, secondary and tertiary level as well as low, medium and high intensity rehabilitation). Thus the team needed a tool that would be fluid enough to accommodate these differences, but still provide a comprehensive structure through which rehabilitation could be evaluated. The team felt that the six layers of the Kaplan framework would allow them to cover the spectrum of what was needed to assess rehabilitation services and allow for comparison between sites
- The team wanted to determine which variables (i.e. human resources, budgets) had to be in place to deliver rehabilitation in accordance to policy.
- Finally the opinion of a variety of stakeholders was to be sought. The team felt that the Kaplan framework would allow them to do this.

All elements, in Kaplan's framework as presented in table 2.8, must be present to say that an organisation has capacity.

Table 2.8: A brief description of the elements as contained in Kaplan Framework [16]

Elements of Kaplan's Framework	Description of the Elements
1. A conceptual framework	The first requirement of an organisation with capacity is the understanding of its "world". In other words, how does the organisation function in their particular setting or situation?
2. Organisational attitude	The confidence of the organisation that it can act effectively and have an impact on people in need of the service. It must be flexible and able to answer to the needs of the people it serves.

Elements of Kaplan's Framework	Description of the Elements
3. Clear strategy and vision	This offers a sense of purpose and will. Individuals need to know what the vision of the organisation is and what strategies to follow in ensuring the fulfillment of this vision.
4. Organisational structures and procedures	Structures and procedures are defined and differentiated to reflect and support the vision and strategy of the organisation. Clear structures and procedures need to be in place to give guidance to everybody. A framework needs to be in place to ensure accountability. This framework must include the structures within the organisation and the procedures and policies that guide service delivery.
5. Relevant individual skills, abilities and competencies	Training and skills must be specific to the organisation. It must support the skills and competencies that are needed within the organisation to reach its goals. Practitioners need to be developed, that they do not work primarily out of the specifications of the world from which they have been sent but rather out of an accurate and sensitive reading of the particular situation with which they are faced." Not necessarily teach them new skills, but rather foster their development through their reflection on actions, self-critique, good mentoring and peer reviews.
6. Sufficient and appropriate material resources	Human resources Material resources are important in capacitating an organisation.

2.12 Integration of NRP Objectives and the Kaplan Framework

According to the Kaplan Framework, organisational capacity depends foremost on subtle and less easily quantifiable concepts such as a conceptual framework, attitude, vision and strategy. This is followed by more concrete concepts such as

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structures and procedures, skills, abilities and capabilities as well as material resources.[16]

The seven objectives from the NRP are: [2]

- Accessibility
- Partnership and networking
- Resource allocation
- Human resource development
- Monitoring and evaluation
- Participation
- Research

While some aspects of Kaplan's framework, such as resources and skills development, connects directly to NRP objectives others have less direct connections, but can be linked. For instance, the organisational structures and procedures will provide information on accessibility, partnership and networking as well as monitoring and evaluation practices. In addition the conceptual framework, attitude, vision and strategy of the organisation will determine the extent to which all the NRP objectives are implemented during service delivery. For instance, if the vision of the service does not include intersectoral collaboration, the objective of partnership and networking contained in the NRP might be neglected.

2.13 Summary

This chapter provides the reader with an overview of the two most commonly referred to disability approaches i.e. the medical and social model. It then indicates why a more comprehensive model of disability than these two is required and continue to motivate why the ICF can be that approach. From there the chapter moves towards presenting international and national disability prevalence figures and a discussion on HIV/AIDS, homicide, TB, road traffic accidents and stroke as the most prevalent causes of mortality in the study setting. The relation of these causes of mortality to disability and rehabilitation is explored.

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Approaches to rehabilitation service delivery are presented with a focus on low intensity therapy and CBR. In addition the role of the UNCRPD, the NRP and provincial policies in rehabilitation service delivery is explored. I then showed that there is a lack of policy implementation in health care service delivery in South Africa and exposes a lack of political will, managerial challenges and human resources as three of the most important causes of this gap. Finally, the six elements of the Kaplan framework (conceptual framework, organisational attitude, strategy and vision, structures and procedures, individual skills and material resources) are described and I motivated why this framework was chosen for the study.

Based on the literature review, the next chapter will provide the reader with a research methodology that aims to present a picture of what is currently happening at the research site.

CHAPTER 3: Study Methodology

3.1 Introduction

Chapter 3 describes the study design. It gives a description of: the research setting, the study population and the participants in the study. This will be followed by a discussion on the data collection instruments used in the study, the data collection process and analysis of the data. In addition, this chapter will show to what extent the design suggested by the bigger SANPAD group was followed and what design features were included by me and might thus be unique to this study.

3.2 Study Design

A descriptive methodology was applied making use of both quantitative and qualitative methods.[93] A descriptive research "is designed to provide a picture of a situation as it naturally happens". It may be used to substantiate current practice, evaluate these practises and develop principles/models for future use.[94] This methodology will allow me to provide the reader with a picture of how rehabilitation services are currently rendered, what impacts on service delivery and make recommendations.

The SANPAD proposal called for a quantitative design only. However, I incorporated qualitative methods of data collection and analyses since through integrating qualitative and quantitative the study was better able to answer its aim and objectives .[95] Qualitative data is in the form of words and provides more depth, than quantitative data that is in the form of numbers. In this study qualitative data was used to enhance quantitative findings through the provision of subtle descriptions and individual perspectives in addition to the factual evidence found in the quantitative data.[96]

3.3 Study Setting

The Cape Winelands District (CWD) is the largest rural health district in the Western Cape Province. Drakenstein is a sub district of the Cape Winelands district. The Drakenstein sub district is approximately 1 538 km^2 in size. The area stretches from Simondium in the south up to Saron and Gouda in the north with a distance of 85km

between the two points. The towns in the municipal area are Paarl, Wellington, Saron and Gouda.

The 2007 Community Survey highlighted Drakenstein as being the most populate municipality in the Cape Winelands Region with an estimated population of 217 089.[14] Paarl and Wellington are the most densely populated areas. Paarl has130 000 inhabitants and Wellington follows with nearly 62 000.[14,97]

Public health services in the Drakenstein are rendered at two levels of care namely primary and secondary. Primary health care services are provided by two Community Day Centres i.e. TC Newman CDC and Wellington CDC, fourteen PHC clinics, six Mobile clinics and one satellite service point. Paarl hospital is the referral hospital to access specialist services. Paarl Medic Clinic is the private hospital in the area and mainly serves the insured population.

TC Newman Community Day Centre (CDC) was selected as one of the four rehabilitation sites in the Western Cape by the SANPAD research group and is the focus of this study. The initial site, previously known as Elangeni Rehabilitation Centre was established in 2000 and at the time of the study was the only outpatient rural rehabilitation facility. It functioned as a vertical rehabilitation program and was managed by the Department of Health, West Coast Winelands District. With the Provincialisation process and rezoning of municipal boundaries in 2009, Drakenstein sub district become part of the CWD. Management of the CWD then decided to reposition Elangeni Rehabilitation services within TC Newman CDC, which then made rehabilitation services a part of the comprehensive package of PHC delivered at a CDC. This amplified rehabilitation services in the PHC arena at TC Newman CDC.

The management and daily supervision of the rehabilitation component became part of the TC Newman Community Day Centre (CDC) management structure. The facility manager of TC Newman CDC became the direct supervisor of rehabilitation service deliverers with the Cape Winelands District (CWD) office providing technical support. This changed rehabilitation services from functioning as a vertical programme at Elangeni Rehabilitation Centre, to form part of an integrated package of PHC service delivery, and managed as any other health programme within PHC.

Clients that require rehabilitation enter the service via self-referral or referral from health facilities in the Drakenstein, mainly PHC facilities and Paarl hospital (Regional Hospital). Community organisations and non-governmental organisations in the Drakenstein also refer clients for rehabilitation.

Clients are treated by a multi-disciplinary team of qualified therapists that includes occupational therapists (OT), physiotherapists (PT) and a speech therapist (ST). Clients receive follow up rehabilitation / visits at the CDC or the most accessible health care clinic. These clinics are Mbekweni, Wellington CDC, Huis McCrone, Nieuwedrift and Simondium clinic. Rehabilitation services offered include: individual therapy, group therapy, home visits where required, as well as in-service training and support to Non-Governmental Organisations funded by the Department of Health.

Clients accessing the services at TC Newman are mainly uninsured and are from low socio economic backgrounds. The main form of patient transport is the utilization of public taxis; clients from the farming community are dependent on the availability of the owner's transport and goodwill, while some clients are able to reach TC Newman CDC using their own mode of transport or walking to the centre.

3.4 Study Population, sampling and participants

The participants that were selected for the study were felt to be the most informed, regarding rehabilitation services in the Drakenstein, how these services are provided and the problems encountered to deliver rehabilitation services.

The study population consisted of four groups:

Group 1:

The manager responsible for managing the Rehabilitation program at TC Newman CDC (the facility manager), and the Rehabilitation Program coordinator at the Cape Winelands District Office.

Inclusion Criteria:

Managers directly responsible for the implementation of rehabilitation services in the Drakenstein.

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Exclusion Criteria:

Any manager who was also a researcher in the project

No sampling was done since there were only two managers in the study population. The one had to be excluded since she was involved in the SANPAD study thus one manager participated in this study.

Group 2:

Rehabilitation Staff members working at TC Newman CDC at the time of the study, November 2010. This included:

- 2 Physiotherapists (1 full time and 1 community service therapist)
- 2 Occupational Therapists (1 full time and 1 community service therapist)
- 1 Full time Speech Therapist
- 1 Senior Administration Clerk

This group of participants was selected because of their role as clinicians that delivered rehabilitation services at PHC level of the Drakenstein area.

Inclusion Criteria:

All staff members employed by DOH, at TC Newman CDC responsible for rehabilitation services: November 2010.

Exclusion Criteria:

Students working at TC Newman CDC

No sampling was done since the group was small enough so that all six could participate in the study.

Group 3:

Patient folders of clients seen at TC Newman CDC for rehabilitation during the period November 2010 - April 2011.

Inclusion Criteria:

The client outcomes study (See figure 1.1) at TC Newman CDC determined the five conditions for which clients seek rehabilitation most often during the study period, November 2010-April 2011. These conditions were arthritis, stroke, lower back pain, developmental delays in children and injuries to the hand and upper limbs. Folders from clients suffering from those conditions were included.

Again no sampling was done. Eighty six of the 114 folders could be found and these 86 were included in the study.

Exclusion Criteria:

- All clients seen at TC Newman CDC before November 2010 and after April 2011.
- Clients treated during the study period for conditions different than the above mentioned five.

Group 4:

The Non-Governmental Organisations (NGO's) in the Drakenstein Sub District that received funding from the Department of Health, Cape Winelands District. This group of participants was selected based on their role in the community and their relationship as funded NGO's between the Department of Health and the community.

Inclusion Criteria:

NGO's must have received funds from by the Department of Health (DOH) Cape Winelands District in the period1 April 2010 to March 2011.

Exclusion Criteria:

NGO's not funded by the Department of Health – Cape Winelands District

Six NGO`s were identified. Three declined to complete the questionnaire thus three participated in the study.

Information on the number of participants, in each group to complete the various data collection instruments are provided in Table 3.1 later in this chapter.

3.5 Data Collection instruments:

3.5.1 The development of instruments to collect quantitative data

The bigger SANPAD team consisted of seven Masters Students, three PhD students, two representatives from the Centre for Rehabilitation Studies (CRS) at the University of Stellenbosch and one representative from the University of the Western Cape, Physiotherapy Department. The team met on predetermined dates at the CRS. Initial meetings focussed on decisions regarding the study methodology and were facilitated by the representatives from the CRS, Mss G Mji and S. Gcaza. Decisions were taken through collaboration of all participants.

Through this process the SANPAD team developed seven key indicators from the objectives of the NRP, and the 5 selected articles from the UNRCPD which were assessed in the various studies in order to determine the SANPAD study objectives.

The seven indicators were:

Indicator 1 – Accessibility

Indicator 2 – Partnerships and networking

Indicator 3 – Resource allocation

Indicator 4 – Human Resources Development

Indicator 5 – Monitoring and Evaluation Strategies

Indicator 6 – Participation

Indicator 7 – Research

The study design centered on describing the ability of the four sites organizational structures to deliver rehabilitation services. The key question was the ability of the organizational structure to deliver rehabilitation services as promised by the 7 objectives of the NRP. The team operated in two groups:

One group focused on describing the organisational structure and rehabilitation service delivery and the alignment of these services with the 7 objectives of the NRP. The seven objectives were translated into seven indicators that were

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interpreted and aligned with the six elements contained within the Kaplan Framework. This formed the basis of the questionnaires developed for the study.

The second group focused on client outcomes. The five most prevalent conditions within a period of 1 financial year (2009/10) that required rehabilitation within the sites of the study area were chosen. Researchers that were part of this component of the study would conduct an initial assessment of the clients with these conditions using validated outcome measures. Then the clients would continue receiving rehabilitation services for a period of three to four months. After this period an assessment would be conducted to evaluate the pre and post treatment changes. Though each group conducted its research activities separately, workshops were used to bring the two groups together to instil the sense being one study that was focusing on the alignment of rehabilitation services in the Western Cape with relevant policies and the impact of these services on clients accessing these services.

The group focussing on organisational structure conducted a literature review on evaluation studies and models of best practice for disability and rehabilitation but could not find any standardised instruments that could be used to collect data on the above seven indicators and their alignment with the Kaplan framework. Thus the team set about developing questionnaires for the study.

The questionnaires were developed in the following way:

Scheduled meetings always had a focal point for discussion based on either the objectives of the NRP, the UNCRPD articles or the Kaplan Framework. Group members individually wrote down all questions that they thought could be used to determine if that specific objective was addressed. Once the questions were drafted team members did individual visual presentations to the rest of the team. Questions were then debated by the group to determine if it was relevant to the specific objective. Following this process group members added additional questions that were not yet part of the initial list, but only if these questions added value to the objectives. Final decisions were based on the group reaching consensus. The questions for each objective to be studied were then listed on an excel spread sheet. The group decided which study participants will be able to answer the specific

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questions. (Appendix 4) Researchers from the SANPAD study developed the draft questionnaires. These questionnaires were sent to an expert in rehabilitation and a fellow researcher at the University of Stellenbosch to compile and format the final questionnaires.

The three Questionnaires developed were used to collect the quantitative data for the current study.

3.5.1.1 Structured questionnaire for the manager on demographic details, the management of rehabilitation services and the processes followed.

(Appendix 1)

The questionnaire consisted of 7 parts to collect data pertaining to accessibility and demographics, partnerships and networking, resource allocation, human resource development, monitoring and evaluation strategies, participation and research. The questionnaire was developed to gain insight on the manager's knowledge of rehabilitation services

3.5.1.2 Structured questionnaire for service providers on the demographic details, relationship with clients and satisfaction of rehabilitation services provided. (Appendix 2)

As with the questionnaire for managers, the questionnaire for service providers consisted of 7 sections to collect data pertaining to accessibility and demographics, partnerships and networking, resource allocation, human resource development, monitoring and evaluation strategies, participation and research, relationship with clients and satisfaction of rehabilitation services. The main goal of the questionnaire was to gather information on the services providers' knowledge and perceptions on rehabilitation services provided.

3.5.1.3 Structured questionnaire for funded NGO's on the demographics, services rendered by the NGO and support from rehabilitation therapists. (Appendix 3)

The questionnaire consisted of 5 main questions relating to the catchment area, the type of services rendered by the NGO, HR component, support from DOH (excluding funding) and referral pathways.

3.5.1.4 Translation of questionnaires

Questionnaires were developed in English and translated into Afrikaans by the Translation Unit at the University of the Western Cape, as Afrikaans is the predominantly spoken language of the Drakenstein with 76.7% of residents speaking Afrikaans.[88]

3.5.1.5 Pilot study

The questionnaires were piloted at a site similar to that of the research site. Two therapists in the field of rehabilitation (an occupational therapist and a physiotherapist) and the facility manager of the Community Day Centre (CDC) completed the questionnaires. I approached the aforementioned therapists and manager, explained the study to them and obtained verbal consent with regards to completing the questionnaires and participating in the pilot study. The questionnaires took an average of 45 minutes to complete.

After this process minor adjustments needed to be made to the initial questionnaires. These adjustments included the following: the layout of the form was changed so that it read easier and questions were grouped accordingly. No questions were found redundant.

The pilot study highlighted that the questionnaires did not provide sufficient information to answer all the objectives of the study. Additional information was needed to fully answer the objectives of the study. Two additional tools for the study were added: a folder audit form, an interview schedule and later, a third one in the form of an open ended questionnaire.

3.5.1.6 Folder audit form (Appendix 6)

Folder audits were not part of the bigger SANPAD methodology. After the pilot study it was found that questions relating to structures and procedures and monitoring and evaluation were not answered adequately. It was decided to do a folder audit using the folders of clients seen by therapists in the Outcomes Based Study. The folder audit enabled me to determine whether or not standardized documentation procedures and assessment tools were used.

The folder audits were done using an audit tool that was developed by a rehabilitation professional in the Metropolitan area of the Western Cape (Appendix 6). This area was also part of the SANPAD study group. This tool is currently being used in the Metropolitan area to audit patient folders where physiotherapists provided treatment, by supervisors in the field of rehabilitation to assess the quality of documentation with regards to patient details, assessment and treatment plans.

3.5.2 Qualitative data collection instruments

Qualitative data was collected through semi structured interviews guided by an interview schedule and open-ended questionnaires.

3.5.2.1 Interview schedule for service providers (Appendix 5)

In addition to the SANPAD data collection tools I developed an interview schedule which was used as a guide in the semi-structured interviews with the two occupational therapists, two physiotherapists and the speech therapist. The purpose of this process was to gain more insight and greater depth of the therapist’s perceptions of the services.

3.5.2.2 Open-ended questionnaire to Managers, therapists and NGO’s

After analysis of the data, there was still the need for additional information and an open ended questionnaire for participants to complete was developed. Table 3.1 provides information on the open ended questionnaires.

Table 3.1 Information on open-ended questionnaires

Questionnaire 1: Managers and therapists (Appendix 8)	The questionnaire consists of 18 open ended questions relating to knowledge and insight of health and rehabilitation policies as well as access to the relevant policies.
Questionnaire 2: NGO's (Appendix 9)	The questionnaire consists of 11 open-ended questions on rehabilitation and rehabilitation service delivery.

3.6 Data collection

3.6.1 Data collection from therapists at TC Newman CDC

Therapists were invited to participate in the research study verbally and were issued with a typed memo that contained information on the study. This was followed by a personal visit. During this visit, the study was explained to them in detail. They were given the opportunity to ask questions and asked to sign an informed consent form. After they signed the consent form, the questionnaire was given. The context and the content of the questionnaire was explained to the therapists. The questionnaires were left with the therapists for two weeks in which they could complete the forms. This allowed them to complete the questionnaires, at a time that was convenient to them, without interfering with clinical client time.

Therapists notified me upon completion of the questionnaires, which were then collected. This process helped to maintain the integrity and confidentiality of the process and the questionnaires completed. The questionnaires were not discussed or shown to anyone else, thus maintaining confidentiality.

Appointments were made with the 5 therapists from TC Newman CDC to conduct the interviews. The interviews took place at TC Newman CDC in a private room. The interviews were done with the individual therapists on a one-to-one basis. I performed all the interviews. The purpose of the study was again explained to each

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therapist, after which verbal consent to participate in the interviews was obtained as well as to have the interview audio recorded. Participants were thanked for their voluntary participation in the process.

After analyzing and discussing the gaps in the data with the supervisor of the study, it was decided to do a follow up interview. However, four of the five therapists were no longer employed at the centre. Thus information was gathered by an open ended questionnaire which was emailed to them, however, only two therapists from the original group replied.

3.6.2 Data collection from the facility manager at TC Newman CDC

An appointment was scheduled with the facility manager for a time and date that was most suitable for both parties. Written informed consent was obtained from the facility manager to participate in the process. Due to time constraints and institutional responsibilities, the facility manager was only able to complete the questionnaire and unable to participate in an interview. I was present at the time that the manager completed the questionnaire. During this process the manager provided additional insights which were documented. The manager viewed the research process positively and was very helpful.

The open ended questionnaire was emailed to the manager for completion. She completed it and emailed it back within 2 weeks.

3.6.3 Data collection from NGO's

All 6 NGO's were contacted to arrange appointments. On the day of the scheduled appointment the research and their participation in the process was explained to them. Each of the questionnaires and the informed consent forms were hand delivered to the managers of the NGO's. The NGO's were also given two weeks within which to complete the questionnaires. Only three of the six NGO's completed the questionnaires. Telephonic contact was made with the three NGO's who did not complete the questionnaires and an alternative date for completion of the questionnaires was negotiated. The three NGO's with whom I negotiated alternative dates, again failed to respond, which led me to omit them from the study and only use the questionnaires from the three NGO's who participated in the study. The forms were collected from the three participating NGO's by me.

All three NGO's who participated in the study were asked to complete the additional open-ended questionnaire. Only two of the three NGO's chose to participate in this aspect.

3.6.4 Data collection from the Administration clerk at TC Newman

An appointment with the administration clerk was scheduled that was convenient for both parties. The research and the purpose of the study were explained and written informed consent was obtained. The administration clerk completed the questionnaire on the same day and needed support from me to complete the questionnaire. I supported him by clarifying questions that he did not fully understand.

3.6.5 Folder audits

The folder audit was included to provide an objective view on whether or not standardised procedures for rehabilitation are in place and applied by therapist and to validate responses from the interviews and questionnaires.

Patient files used in the audit were those of the 114 clients who participated in the outcomes based study at TC Newman. The audit process took place in the records department at the research site, thus always maintaining the integrity of the patient files. The list of names of clients participating in the research was obtained from the senior admin clerk, who made appointments for these clients.

The list was then forwarded to the facility manager, who requested the chief administrative clerk of the records department to extract the files for the audit. Only 86 files of the 114 names forwarded were available on the day of the audit. I audited the patient files individually with the support of a research assistant. The assistant was from the TC Newman site and was trained by me, in using the Metropolitan audit tool. To ensure that answers were entered correctly the assistant was only required to identify the personal details e.g. name, address and telephone number. This information was confirmed while auditing the content of the folder, thus ensuring the correctness of the information.

Both the management and the administrative staff at the TC Newman CDC were very helpful in facilitating the audit process.

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3.6.6 Documents sourced for information

Various documents, as indicated below, were sourced for additional information.

- Job descriptions: I contacted the Rehabilitation coordinator of the Cape Winelands district office to obtain job descriptions of the therapists that participated in the study. This was used mainly to see to what extent job descriptions of therapists were aligned with NRP objectives and what procedures and strategies were called for in job descriptions. (Appendix 10)
- Budget: The budget was forwarded electronically by the Rehabilitation coordinator to me. The budget was accessed to provide information on the availability of financial resources for service delivery.
- Data: The information office of the CWD DOH office provided me with information pertaining to the PHC data and a list of PHC facilities.
- Vision and mission: This was faxed to me by the occupational therapists at TC Newman CDC.
- Policy documents: The only policy documents relating to how rehabilitation services should be rendered was the CSP and the APP. Both of which were provided from the CWD office in Worcester.

Table 3.2 Data collection methods and sources used in this study.

Objective	**Data Collection Method**		**Source of Information**	
	Quantitative	**Qualitative**	**Participant Group**	**No of Participants**
Demographic context: • Socio-economic profile • Health and rehabilitation services • Conditions treated • Type of services • Outputs	Quantitative questionnaire		Manager Therapists Clerk NGO`s	1 5 1 3
		Interview	Therapists	5
		Document review	Documents	
Profile of service providers	Quantitative questionnaire		Manager Therapist's	1 5

			Administrative Clerk	1
Policy implementation	Quantitative questionnaire	Open ended questionnaire	Manager Therapists NGOs	1 2 2
Alignment with objectives of National Rehabilitation Policy	Quantitative questionnaire		Manager Therapists Clerk NGO`s	1 5 1 3
		Interview	Therapists	5
		Open ended questionnaire	Manager Therapists NGO`s	1 2 2
Organisational capacity	Quantitative questionnaire		Manager Therapists Clerk NGO`s	1 5 1 3
		Interview	Therapists	5
		Open ended questionnaire	Manager Therapists NGO`s	1 2 2
	Folder audit		Client folders	86
	Documents			

3.7 Data analysis

3.7.1 Quantitative data

The data was entered onto an Excel spread sheet with the variables recorded in columns. The titles were recorded on the top row of the variables and participants responses were entered as rows. The objectives of the study were used as a guide to analyse the data. Each objective was selected and data was extracted from the spreadsheet in relation to the objective.

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3.7.2 Qualitative data

The audio recordings were transcribed from the interviews and the open-ended questionnaires. The data was thematically analysed using pre-determined themes, which was related to the aim and objectives of the research study. These themes were: the demographic context of the research site, catchment area, referral system, services offered in the centre and community, vision and mission, structures and procedures, human resource development and monitoring and evaluation.

3.8 Data Verification and trustworthiness

Data was verified through a process of triangulation. Information from various participants and various data collection methods were compared to each other. In addition information was verified by reviewing documentation, policies and registers. NGO's and therapists that completed the questionnaires on their own were contacted telephonically to confirm or clarify any uncertainties or duplication of a response to a question.[93,98]

Wise, V.L (2011) denotes the trustworthiness of qualitative research using terms which includes credibility, transferability, dependability and confirmability.

Credibility refers to the accuracy of identifying and describing the subject of the research study. The credibility of my study was done by obtaining information from participants that are employed at the research site and from non-governmental organisations that utilize these services. Literature that informed the study was documentation that was in use and available at the time of the study.

I tried to ensure transferability by providing the best possible description of the research site and the organization, and made use of triangulation and peer reviewing, with other researchers in the SANPAD study group.

Being an employee of the Department of Health in the Cape Winelands District was an added advantage for me, in that I was aware of policy changes and changes at the research site. As these changes unfolded I was able to draft additional questionnaires for my study and contact participants to complete these questionnaires to enrich my study.

Confirmability was ensured by different researchers using questionnaires developed for the study. To control bias, I used information from participants at the site and reviewed documentation that was available at the site e.g. job descriptions, headcounts and patient folders.

Quantitative tools were self-designed and not tested for reliability and validity.

3.9 Ethical Consideration

Ethical approval to conduct this research study was given by the University of Stellenbosch and the study was registered with the Committee for Human Research at the University of Stellenbosch. (Reference Number: NO09/11/322)

Further approval was obtained from the Provincial Department of Health in the Western Cape to conduct the study at the four selected sites.

Verbal consent was obtained from the Director of Health Cape Winelands District.

Prior to their participation in the research, participants were provided with an explanation of the purpose and process of the research. Participation was voluntary and refusal to participate would not have influenced their status as employees of the DOH in any way. Written consent was received from each participant before commencing with the questionnaires and recorded face to face interviews (audio recorded). All participants were assured confidentiality. (Appendix 7)

After the completion of the questionnaires and audio recordings all documentation and recordings were kept in a secured cabinet at the Department of Health CWD office for safe keeping. After completion of the research study, all data will be kept secure for a period of at least five years. All documentation and data will be printed and saved electronically.

The results of the study will be made available to all participants and the management of the Cape Winelands District Office (Department of Health). The Department of Health, Cape Winelands District, together with external partners hosts an annual research day. Study findings will be presented and debated at one of these research days. If translation is required, the translation unit within the Department of Health will assist.

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3.10 Summary

A descriptive mixed method design was used to analyse the organisational capacity and the alignment of services with the seven objectives of the NRP. TC Newman CDC was selected as one of the four rehabilitation sites and was the focus of this study. The study population consisted of four groups: manager, rehabilitation staff, NGO's and folders of clients entering the rehabilitation services. Questionnaires based on the objectives of the NRP were developed to collect quantitative data. Face to face audio recorded interviews were held with participants. A folder audit and sourced documents were used to enhance qualitative findings. An additional open-ended questionnaire was completed by two therapists, the manager and two NGO's. Qualitative and Quantitative data were analysed simultaneously.

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Chapter 4

Results

4.1 Introduction

In this chapter the results from the quantitative questionnaires, document review, folder audit, semi structured interviews and open ended questionnaires with participants are presented. The results of the study are presented in chapter 4 according to study objectives 2, 3 and 4. As described in chapter three, qualitative and quantitative data was collected. The qualitative and quantitative data is presented in an integrated manner so as to enrich the research study.

4.2 Demographic context of the research site

4.2.1 Socio economic profile

During the interviews with therapists and the manager, they described the population that they served in terms of race, age ranges and diagnoses:

> "*I see a majority in terms of races, coloured, and also black individuals, minimum of white individuals"*

> *"All races include, most of the patients are coloured, and also from the black communities."*

They described the population as having low socio economic and educational backgrounds.

> "*Low socio economic groups, low, most carers have low education, low scholastic abilities, and I see mostly children, with a variety, as a result of socio economic environment or associated problems, such as birth problems, birth defects and cognitive functioning."*

> *"Yes, Yes a lot there are 300 children in one house, mainly adult working and granny looking after the children."*

4.2.2 Health and rehabilitation services to the community

Health services to the Drakenstein Community were rendered at two levels of care namely primary and secondary. Primary health care services were provided by two Community Day Centres i.e. TC Newman and Wellington CDC, fourteen PHC clinics, six Mobile clinics and one satellite service point. Secondary health care services were provided at Paarl Hospital, a government subsidised, secondary referral hospital. Paarl Medic Clinic is a Private hospital in the area and mainly serves the ensured population.

Table 4.1: Public Health Care service provision in Drakenstein: Quarter 3 2010/11

Facility	Capacity	Patients seen by Prof Nurse	Rehab Headcount	Physiotherapist	Occupational therapist	Speech therapist
Paarl Hospital	327 beds			2	Sessional	0
TC Newman		16475	1030	2	2	1
Wellington CDC		24292	246	*	*	*
Simondium		5875	143	*	*	
Saron		7360	87	*	*	
Gouda		2921	37	*	*	
Mbekweni		22761	122	*	*	
Nuwedrift		7382	117	*	*	
Huis McCrone		7473	145	*	*	
Dalevale		12122		0	0	0
JJ Du Preez		6222		0	0	0
Klein Drakenstein		5605		0	0	0
Klein Nederburg		11844		0	0	0
Patriot Plain		6736		0	0	0
Pola Park		12365		0	0	0
Hermon		6315		0	0	0
Windmeul		3987		0	0	0

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Facility	Capacity	Patients seen by Prof Nurse	Rehab Headcount	Physiotherapist	Occupational therapist	Speech therapist
Hexberg Satelite		1317		0	0	0
6 X Mobile routes		0		0	0	0
Sonstraal TB hospital			12			
Stellenbosch						*

***Patients seen through outreach services**

Table 4.1 reflects the health facilities in the Drakenstein where clients were able to access health care. It shows that rehabilitation services were rendered at eight of the facilities in the Drakenstein. Stellenbosch accounts for an additional one outreach site. According to Table 4.1 the majority of clients access rehabilitation services at TC Newman CDC.

According to the structured questionnaire and the interviews occupational therapists did outreach to Nuwedrift, Windmeul, Mbekweni, Wellington CDC, Saron, Gouda and Simondium. The physiotherapists provided outreach to Paarl clinics, Mbekweni, Wellington CDC, Saron, Gouda and Simondium. The speech therapist did outreach to all the above and Stellenbosch. Except for speech therapy, Wellington and Mbekweni were outreach sites that received services from all rehabilitation therapists working at TC Newman CDC, while other sites were divided between therapists.

Both the occupational therapist and the speech therapist indicated in the questionnaire, that Stellenbosch was not part of the catchment area; however the speech therapist from TC Newman CDC rendered an outreach service at Stellenbosch Hospital in the absence of a speech therapist.

> *"I do Stellenbosch Hospital, but it is not part of our sub district"*

The therapists indicated that they also do outreach to NGO's in the area. These NGO`s included Rusthof Old Age Home, Paarl Stimulation Centre, for children with

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mental and physical disabilities and Luthando, the intermediate care facility in the Drakenstein. The community service occupational and physiotherapist as well as the speech therapist were mainly responsible for outreach to NGO's.

4.2.3 Main conditions treated by rehabilitation service providers

The conditions mainly treated according to therapists were cerebral vascular accidents/stroke (CVA), lower back pain and developmental delays in children. **I**t seemed as if back pain was the most common condition treated by the physiotherapists:

> *"Everyone has back pain…; it is the condition that we see the most. Everyone has back pain, goes to the doctor for back pain, and referrals coming from the doctors, which needs physio."*

4.2.4 Type of rehabilitation services offered

Participants rendered rehabilitation services through individual therapy, group therapy and training. Looking at the responses from the different participants the physiotherapists appeared to be more inclined towards individual and clinical therapeutic intervention.

> *"Basically we take the patient from where he is now, trying to solve his problem, by rehab him, and try to return him to his previous level."*

Occupational therapy services included individual therapy, training and group work. The occupational therapists also mentioned that they rendered services at old age homes (OAH), crèches, Home Based Care (HBC) groups and to teachers.

> "*I do a lot of training, I have done crèche training, HBC training, I have done teacher training at Paarl stimulation centre, and also leisure group at the OAH, so a lot of group work as well, and had a CP class here, a lot of training, and group work".*

Training by the occupational therapist focused on the empowering and transfer of skills to crèche teachers, community care workers and teachers at Paarl Stimulation

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centre. The group work appeared to be centred on therapeutic intervention for larger numbers of clients with the same diagnoses e.g. Back classes, and CP groups.

Responses indicated that occupational therapists were more involved in group therapy especially in the paediatric arena e.g. CP classes. The physiotherapist was to a lesser extent involved in group work, with the exception of back classes.

> "*Yes we have back classes at Elangeni, the other therapist she has back classes at the CDC. Generally the OT sees the CP and Neuro groups"*

It appeared that the Occupational Therapists and the Speech Therapist were more prominent when it came to training, especially in the community:

> "*We have crèche training for volunteers that work in the community and stroke training for the Community care workers that are funded by DOH"*

The physiotherapists were to a lesser extent involved with training in the community and where they did training, the training appeared to be part of a therapeutic intervention:

> *"We start a program this year. We have done CP, we done back care, CVA's. We have done this so far. We will add next year. O, yes and we have done spinal cord injuries."*

From the interviews it appeared that individual therapy remained a bigger focus:

> *"60% individual therapy and 40% training and groups."*

4.2.5 Rehabilitation service outputs

During the financial period 2010/11 a total of 1927 client's access rehabilitation services in the Drakenstein at PHC facilities. Most of these clients were seen at TC Newman CDC as shown in Figure 4.1

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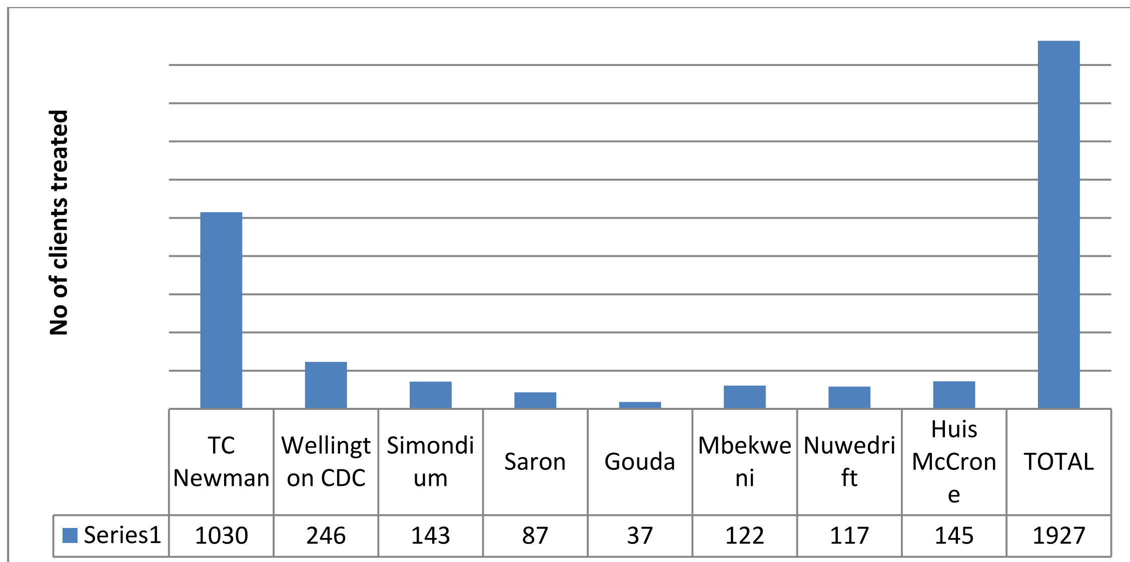

Figure 4.1: Number of rehabilitation clients seen during the financial period 2010/11

Therapists had the following to say on appointments procedures and number of clients.

> "*Depends on the setting, for clinics we know what clinics are busy and what clinics are not. So we usually give the clinics a total of how many patients, we want to see. Sometimes the clinics exceed totals, that happen a lot, where we say 15, and they book 20. But if 20 people arrive on the day, we see 20; I would not show people away. You have your busy days and you have your slower ones. You try to push up numbers as much as you can, to accommodate everyone, people come from far, and they don't have money to always come*" "*Yes, sometimes, it varies, as the year progresses, the patient load increase and certain time of the year it decreases again. So we wait for referrals and if we see referrals coming in, we try to squeeze in as much as possible. We try a different approach, which was responded to with negativity, they say that we should change it back to the old system, currently we see 10 patients a day in a single block from 7 o'clock when patients arrive, yes so, that ensures that we have 10 patients booked every day, doesn't matter what day it is, you see 10 patients every day.*"

4.3 Profile of service providers

Figure 4.2 shows that the rehabilitation staff consisted of five clinical staff members and two administrative personnel.

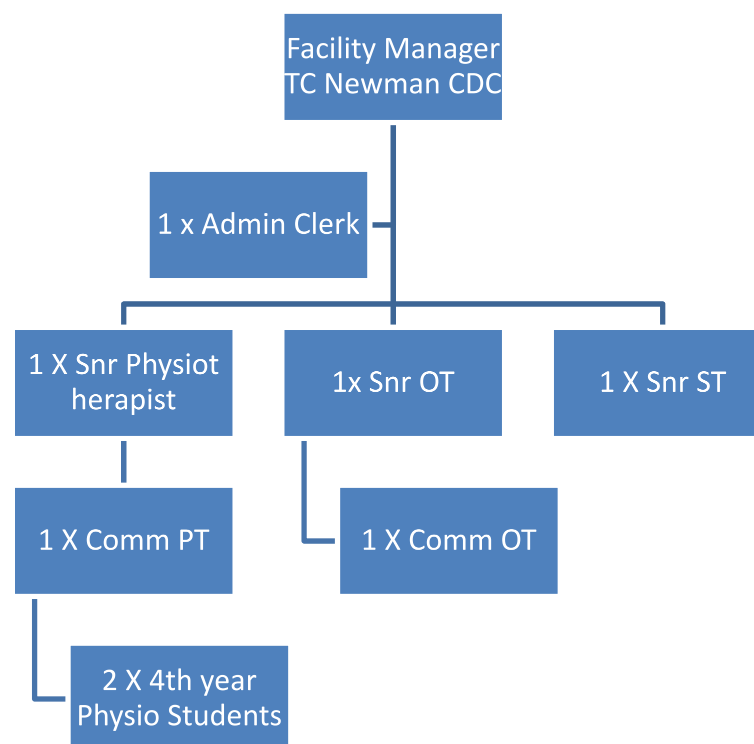

Figure 4.2 Rehabilitation organogram

Table 4.2 Relevant employment and education information of service providers

Qualification	Position at Facility	Working Experience in Years	Rehabilitation Experience in Years	Relevant Courses Attended
Diploma in Nursing	Participant 1	20	1	Managerial Courses
Diploma in HR	Participant 2	10	10	Computer Courses
Degree in Physiotherapy	Participant 3	5	4	Basic and Intermediate Seating
Degree in Occupational Therapy	Participant 4	5	4	Basic and Intermediate Seating Hand Injuries
Degree in Speech Therapy	Participant 5	3	3	None
Degree in Occupational Therapy	Participant 6	0	0	None
Degree in Physiotherapy	Participant 7	0	0	None

All participants indicated that rehabilitation posts were filled according to the Comprehensive Service Plan and that students were utilised by the rehabilitation department. The human resource allocation for rehabilitation services were deemed adequate, by most participants however the need for addition physiotherapists were raised by management and therapists. The facility manager was the only participant that indicated the use of volunteers at the centre.

The age of the service providers were between 22 and 40 years. All participants indicated working experience in the field of rehabilitation. The community service therapists and the facility manager had the least working experience in the field of rehabilitation. However, the facility manager had the most working experience of all the participants. The speech therapist, occupational therapist and physiotherapist had between 3 and 5 years' rehabilitation experience. The administration clerk had the most experience (10 years) working in the field of rehabilitation.

4.3.1 Induction of new staff

With regards to orientation of new staff, current staff felt that they are able to orientate new staff members, despite having no written protocols. There was no standardised orientation/induction program for students or new staff, except for the orientation program provided by the Worcester district office for new staff.

> "No *formal, except for the one that Worcester presents to the community service. Try to orientate them with regard to admin, take them to the facility manager and the different departments. Student orientation is done by their supervisors."*

4.4 Policy implementation:

Participant's responses in the open ended questionnaire indicated some knowledge of policies in health. The following acts, policies and guiding documents were mentioned: Batho Pele, Declaration of Alma Ata, National Health Act, National Rehabilitation Policy (NRP), Health Care 2020, Millennium Development Goals, Comprehensive Service Plan(CSP) and Provincial Strategic Objectives.

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With specific reference to rehabilitation the NRP, CSP and Health Care 2020 were mentioned. One participant mentioned the ICF and described it as:

> *"a framework, however it applies more to the planning and execution of a goal based rehabilitation plan"*

Participants understanding of the documents are expressed in the following quotes:

On the National Rehabilitation Policy:

> *"…I know the NRP guides the department on how to effectively and efficiently implement the rehabilitation strategies within our department. Looking at making rehabilitation services more accessible and being integrated into the PHC package of care. The objectives include improved accessibility of rehabilitation services, enhancing intersectoral collaborations with other governmental spheres, appropriate allocation of resources, developing skills needed by staff in order to be more efficient at the occupations, regular monitoring and evaluation to identify and rectify challenges and the encouragement of research in collaboration with tertiary institution and the private sector."*

On the Comprehensive Service Plan:

> "*Norms and standards are aligned to policy, ensuring dedicated resource allocation, and revision of structure to realign strategic intent. It also highlights the need for research and training interventions to identify and address gaps."*

One participant was able to list seven key principles of Health Care 2020.

Policy was accessible for management, but less accessible for therapists.

> "*Unfortunately having access to these documents is a bit of a hassle …"*

It appears that therapists and management are more familiar with health related policies e.g. the CSP and Health Care 2020 than the NRP. They could provide detailed information on the content of these policies.

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All participants were aware of the National Rehabilitation Policy, even though answers indicated that it was not part of their undergraduate training. However, their exposure to it seemed limited as one indicated that she had not read it or seen a copy and another said the department does not have a copy:

> *"I have seen a copy of the NRP when I started working within this district but because of numerous changes within our section it has gone missing. However the only copy I saw was in 2007 and I do not even have any idea if it was amended thereafter*".

Two of them could not say what the NRP was about. The third said:

> *"Addressing inequalities in the services by realigning service delivery model from being hospital based to community based thus addressing the gap in reintegration of clients within their homes and community. The policy also acknowledges and dictates the need for interdisciplinary/ -governmental approach as well as involvement of the disabled in service planning."*

According to participants, CBR is:

> *"That the rehabilitation team goes into the communities where rehabilitation services are either scarce or non-existent, and work with the community to establish a sustainable, yet community based initiative to drive the rehabilitation process within the respective community."*

> *"Improving access to services for all communities, involvement of the client, family and community in services and the planning thereof, training of care givers and the community to enable reintegration"*

> *"The CBR approach focuses on to re-integrate persons with disabilities back into their communities and home environment while being treated by a multi-disciplinary team aimed at improving the person's overall functioning. Integral to this approach is the training and skills development of family as well as the client to ensure optimal health maintenance when at home. Off course CBR aim to build healthy, strong partnerships with other sectors in order to reach the outcomes of the NRP with social mobilization being regarded as one of*

the key activities. Getting our communities actively involved in the care of its people."

"Community based rehabilitation is delivered by development of programs and effective monitoring and evaluation for planning. At an organizational level there is a need for transformational human resource management and networking and referral system enabling continuity of care."

4.5 Objectives of the National Rehabilitation Policy

4.5.1 Accessibility

All therapists agreed that physical space to do therapy was not enough. In addition they were in agreement that access was hampered by a lack of physical access to the building, poor signage and insufficient equipment. In contrast the facility manager and the administration clerk felt that space for therapy was adequate, the service was accessible to the client, and signage was present and adequate. Only the administration clerk indicated that interpreters were available at the centre. Therapists indicated that patients were able to get an appointment for therapy within one week.

However, transport was a challenge for clients who needed to access rehabilitation services, hence outreach services were put in place:

"*Most patients come from the immediate area, because, people struggle with transport, and that is why the clinics are held where they are"*

Therapists could give an indication of how far clients lived from the various facilities. The manager and the clerk were the only two participants who responded to the question on how far clients had to travel. They felt that clients travelled 3 – 5 kilometres and 10 – 20 kilometres respectively to reach rehabilitation services.

Participants felt that services were made more accessible through outreach from TC Newman CDC, constant re assessing of service points and community training:

"By using the T.C Newman facility as a "hub" and driving out to the various community health centres and clinics, the rehabilitation service is made more

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available, however due to the possible lack of human resources this might not service the need within these various areas within the Drakenstein."

"The services within our district have always been planned to be provided closest to our client's residential area, mostly at their nearby clinic. In some instances we do provide home visits to those too weak to attend or travel to their clinic, this is done in collaboration with our HBC. We also provide outreach NGO's, old age homes and respite centers."

"Service points are re - evaluated annually to deliver cost effective quality care. By interacting with communities and training of primary caregivers and community workers we expect reintegration of clients in their homes as well as their community."

NGO managers who participated in the study indicated that they have access to the available rehabilitation services.

4.5.2 Intersectoral Collaboration

The multi-disciplinary team approach and holistic care was emphasised by all participants, even while they were able to identify challenges within the teamwork process:

"By collaborating and working as a rehabilitation team, consisting of physio-therapists, OT's speech therapists, and the like, we are able to holistically approach the client's rehabilitative needs. This being said however, due to the lack of time and the large demand for rehabilitation services, it is not always possible to collaborate or rather discuss each client in depth as a team. The referral process however is sound and the client is then able to have interaction with the various members of the rehabilitation team."

Collaboration with Home Based Care and the involvement of NGO's were also mentioned.

"HBC, NGO's and families"

Management and therapists were aware of the value of intersectoral collaboration.

"*Collaboration with other government departments (Education, Social Development), Cape Winelands District Municipality (local government structures), Various Non Profit Organisations, Intermediate Care Facilities are engaged with on different platforms"*

"In our sub-district I have been a part of and have observed how beneficial the building of relationships with other sectors can be in order to provide a more comprehensive service to our communities. We have entered into partnerships with the CWD municipality, various NGO's, the tertiary sector and Drakenstein municipality."

In a continuum of care, therapists can refer clients to community based services (CBS). During the interviews one participant indicated that they do not utilise the CBS service optimally.

"*Only a few attempts were made to link with Community Based services in terms of tracing clients who do not adhere". "We try to follow up via HBC, but it is not that brilliant as it should be, we are working on that."*

When asking Participants about volunteer and community workers, they responded that they were aware of HBC services, but do not optimally utilise these services, even though they train carers:

"*I think there is actually a gap, it could probably be minimized easily, for example we know that a lot of the HBC, we have connection with the sisters, I think there could be a lot more follow up, I know for dealing with the Saron and Gouda HBC, the training that we did there, we also tried to do follow up visits, but also time constraints was a little bit difficult, yes there is definitely space, to do a lot more follow up with them,"*

"it's usually it is only the family, and even in those cases, we find very little or noncompliance, because the family have their lives or jobs, etc. "

"So the people are very dependent on the therapist"

The three NGO's who participated indicated that they received financial support from the department of health, as well as outreach and support from health professionals such as care workers, doctors, physio-, occupational-, speech therapists and the dietician.

Of the three NGO's that participated, NORSA was the only one that received referrals from and referred to other departments. Luthando received referrals to and from the hospital, clinic and the community; however, it appeared that they did not refer back to the community. Paarl Stimulation centre received referrals from social development, the clinic and the hospital. It appeared that Paarl Stimulation centre only referred clients to Social Development.

The speech therapist was the only participant that indicated that she received referrals from primary schools.

> *"I don't see a lot of scholars, the most scholars that I see, are children that stutter."*

Referral sources

The majority of patients (78%) were referred from Paarl Hospital to TC Newman CDC. All participants indicated in the questionnaire that health professionals, mainly professional nurses, other allied health therapists and doctors were the primary source of referral. Two indicated that they received referrals from NGO's or HBC as well:

> *"Because I do not render a service at all the clinics, I get a lot of referrals from the sister. In the Health aspect they are the biggest referrers."*

> "*The clinics gave most of our referrals and Paarl hospital, very few referrals from TBH, GSH, RXH, because they refer to Paarl Hospital, and then the specialist clinics refer to us."*

Participants reported that health promotion and training plays an important role in creating awareness of the services and thus referrals:

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> "*We get our referrals from our training that we do. HBC, crèche training that is how the people get the most information about the service. Then also information sessions with the families, so we always get someone whose neighbour has one or other disability or need. Health promotion goes through our training and HP days at the clinics."*

> "*We inform referring staff, basically the nurse about the type of conditions we want to see"*

The appropriateness of the referrals was found to be good by the speech therapist:

> "Yes I do get quality referrals; I must say the nursing staff is quite good, especially with the developmental delays. They know, that on 18 months the child must be able to speak a word, if he cannot, they will refer to me".

The community physiotherapist found the referrals from the doctors to be fair:

> "*On a scale of good, fair, poor. I will say fair. The reason being we still find the referral based on the subjective description of a person's symptoms, so the patient goes to the doctor and this is where I find that all patients say: doctor I have a pain, and immediately it is referred to physio. Dr. I have a pain in my hip, patient gets referred to physio and the patient got a leg length discrepancy and it is an incorrect referral. So we do find those types of conditions."*

Continuum of care

Participants were knowledgeable on the different referral pathways and systems that they could access should they need to refer a client for specialist services. They also highlighted that PHC is the point of entry into health care service provision and that only a small percentage of clients were referred to the next level of care.

> *"this is the level, that we basically start the patient"*

> *"We handle 95% of clients at this level. We refer specialist cases that we can't handle"*

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"we treat 80-90% of clients at this level"

From the participants responses they appeared to be knowledgeable about Western Cape Rehabilitation Centre (WCRC), the specialist rehabilitation unit in the Western Cape Province, and what the centre is able to offer clients. However, parallel to this, participants also indicated that they found it difficult to refer clients to WCRC:

"*Western Cape Rehabilitation Centre has own referral framework for referrals or the patients that they actually see.*"

"*We very seldom do we refer for WCRC"*

The participant further explained that WCRC has a lengthy referral form that needs to be completed and the availability of beds is sometimes a challenge as referrals does not necessarily indicate prompt admission. In addition participants indicated waiting times for surgery at secondary hospitals can be challenging:

"*Yes, we do find that, especially with orthopaedic cases. For example we reached a stage where we find that we are not effective anymore, we need to refer to the next level, then we refer back to the orthopaedic surgeon at Paarl hospital, if they can't do anything, patient will get referred back, saying that we have to continue, they have planned and scheduled operations or so, but we have to continue. Personally I feel, that is, is not the best way to manage the pt. But once again the also have back logs"*

4.5.3 Resources

Financial Resources

There is no dedicated budget for rehabilitation services, other than a dedicated assistive device budget. The budget made provision for mobility assistive devices which includes: crutches, wheelchairs and buggies for children with disabilities. In addition to mobility assistive devices this budget also made provision for optical and hearing items, although the allocation was very limited. Allocation of the budget is based on the previous financial year's expenditure.

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All participants were aware of this budget, even though some felt that the allocation was inadequate. Even though participants indicated that the budget was inadequate the budget allocated for assistive devices in 2010/11 was not utilised optimally, resulting in under expenditure as indicated in table 4.3.

Table 4.3 Assistive device budget 2011

Budget		
Drakenstein Sub District		
	FINANCIAL YEAR 10/11	
CRUTCHES	**Budget**	**Spent**
TC Newman CHC	R 30 000.00	R 11 342.10
TC Newman Clinics	R 0.00	R 650.50
TOTAL	**R 30 000.00**	**R 11 992.60**
OPTICAL ITEMS & HEARING AIDS		
TC Newman Clinics	R 2 000.00	R 34 500.00
TOTAL	**R 2 000.00**	**R 34 500.00**
WHEELCHAIRS		
Drakenstein SD Office	R 0.00	R 0.00
TC Newman CHC	R 92 000.00	R 42 245.20
TOTAL	**R 92 000.00**	**R 42 245.20**

One of the participant's response to the budget allocation:

> *"Of course there will always be shortcomings, financially and with our human resources, but I must admit we are coping under the hand we are dealt. There will always be the need for more money or more hands to help out…"*

Communication

A landline telephone and fax facility was available to all participants. The facility manager was the only participant that had direct access to e-mail and seemed to be the only one aware of public phones for staff and clients.

Equipment

The facility manager and the administration clerk indicated that rehabilitation and administration equipment was adequate. This sentiment was not shared by any of the therapists. A follow up session with one therapist regarding adequate equipment highlighted that it was mainly the outreach sites that lacked relevant rehabilitation equipment. In addition to equipment, the infrastructure at outreach sites did not adequately accommodate rehabilitation professionals. Most outreach sites could

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only accommodate one therapist per visit as infrastructure at primary health care facilities was not designed and built, taking into account rehabilitation services.

4.5.4 Human Resource Development

All participants indicated that training was aligned with their performance agreement (PA) and the needs of the community. There was also consensus from all participants that students were trained at the centre. Only the facility manager and the community service occupational therapist indicated that there was on-going training for rehabilitation staff. None of the participants felt that there was career pathing in the rehabilitation field and that the developmental plans with regards to training were executed.

Participants were not in agreement on training opportunities. One felt that training opportunities were available, but very limited and not communicated well to them:

> "*For us as therapists? It is what we get from OTASA, or from other therapists. Western Cape is actually worse than the other provinces."*

Another indicated that training was available:

> "*Sometimes it is difficult to attend courses but our district has come up with an approach to allow therapist to regularly attend courses, most of the times for free. Our skills development is linked with our quarterly meetings and thus provides a platform to catch upon our CPD's. Apart from that I must admit that I have not experienced any difficulty with applying for courses, if my schedule allows it and there is no interference with my clinics I will almost always be approved for it*'

The participants also appeared to be knowledgeable with regards to the processes of applying for training and were willing to finance the cost if necessary.

> "*There is, but basically it depends on when the courses come along. So if you are interested in a course, you do that Cape Winelands form and if it is approved you go on the training courses, depending on the finances. Otherwise we just go on our own courses.*"

The facility manager when asked about training interventions appeared to be knowledgeable about the relevance of Continuous Professional Development (CPD) activities and mentioned that CPD, as prescribed by the Health Professions Council of South Africa (HPCSA), is each therapists own responsibility. The training interventions like Junior Management (an accredited SETA training, but not CPD accredited as prescribed by the HPCSA) are routinely offered by the Provincial Government of the Western Cape (PGWC) as part of professional development.

> "*They go on CPD, Junior Management and seating"*

4.5.5 Monitoring and Evaluation Strategies

According to the results of the structured questionnaire the facility manager felt that service monitoring and evaluation strategies were in place, but none of the therapists agreed with this sentiment. On the other hand, the therapists indicated that they had set targets and indicators which they must achieve, but they feel that the manager was not aware of what these targets and indicators entailed. In the follow up questionnaire, participants mentioned monthly statistical analysis, quarterly report reviews, staff performance management review (face to face), file audits and site visits as monitoring and evaluation practices at the site.

Participants indicated a need for monitoring and evaluation:

> "*yes, definitely. I don't know that M&E"*.

> "*Yes, shoe that will be very nice. Yes and also if it can be like a computer system, where you can put stuff down and you can actually see what you have achieved, for example, if we can see our quarterly stats, we have it on paper, but it will be nice to have it on the computer of something"*

> "*There is no good M and E of the stats. The stats are not integrated, and you are not told what to do*"

Responses from the participants indicated that there were mechanisms in place for reporting and administration. However, it appears reporting procedures were not implemented consistently and that therapist's interpretation differs.

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> "*I think our quarterly is the only report that we do, we send it to the coordinator. We are also going to send our reports to the facility manager, because there is a big communication gap, because they do not know what we do and where we are going"*

All therapists indicated that there were definite indicators; for example outreach sites, frequency of visits by a rehabilitation professional, average number of clients seen per outreach and the focus areas for rehabilitation. On the questions relating to target, indicators or objectives, a participant responded as follows:

> "*Yes, our area was paediatrics. In the beginning the coordinator from Worcester, met with us and discussed our performance plans, how many patients we should see, how many outreach, HBC, there is clear guidelines as to what we should do per quarter and for the year."*

The manager at TC Newman indicated that she was not aware of these indicators.

4.5.6 Participation of persons with disability

In the initial structured questionnaire all therapists indicated that persons with disabilities were involved in planning their individual therapy programmes. In contrast, information from the open ended questions in the follow up questionnaire indicated no participation of persons with disabilities in planning, implementation and monitoring of rehabilitation programmes:

> "*There is no participation of persons with disabilities in planning of services. We look retrospectively at the Burden of Disease and case load."*

> *"The district does not have a disability forum where people with disabilities can voice their opinions on how they would like their treatment to be managed. If there is such a forum, rehabilitation in our sub-district have not been involved in this initiative."*

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4.5.7 Research initiatives in rehabilitation

All participants indicated that they were aware of some research at the centre. Whether participants referred to the current research or were referring to other research was not explored. Only the manager said that persons with disabilities were involved in research at the facility and none of the participants felt that research was being disseminated back to the facility.

4.6 Barriers and facilitators in implementing the National Rehabilitation Policy

Participants felt that services at the study site were delivered according to NRP principles. However, they did not comment on why they thought that. They did provide barriers and facilitators to the implementation of NRP objectives as presented in table 4.4.

Table 4.4 Barriers and facilitators mentioned by participants

BARRIERS	FACILITATORS
• Inadequate allocation and distribution of human resources, specifically physiotherapy • Defaulting of clients • Follow up of clients • The link with Community Based services • Feedback from research • Broad / Comprehensive service • Communication with management • Standardised documentation • Poor monitoring and evaluation • No clear treatment guidelines • Workload	• Outreach to health facilities • Competent and Skilled staff • Good orientation program • Students at centre • Multi-disciplinary team

Therapists and management felt that the lack of human resources was one of the biggest challenges:

> *"Even though these services are rendered across most of the Drakenstein sub district, and even though assistive devices, and other resources are made*

available, it still does not ensure a largely effective service due to the shortfall in human resources.”

“Financial, human and some physical resources, too much red tape, rehabilitation services being spread out too widely. “

“Our highest caseload is physiotherapy related and we have only one permanent physiotherapist supported by community service physiotherapist as well as students from Higher Education Institution on the service platform. Although they deliver a vital contribution to service delivery; these categories of staff need supervision, which could burden an already strained the service.“

One of the other barriers mentioned was the adherence and follow up of clients.

“The therapist lack to link with CBS for defaulter tracing”

“Default – no system “sometimes when I remember”

Clear guidelines and standardised documentation was mentioned by all therapists as a barrier.

“Guidelines we try to display in the notes, Protocol only for hands, with strokes, we look at progress and then the next session.”

“Not clear. No uniform clinic notes,”

“Each therapist has their own way of basically writing”

These challenges were also identified in the folder audit.

The outreach program, as well as competent and skilled staff was facilitators mentioned by therapists and the manager.

“Also all rehabilitation staff is geared at ensuring the best service is rendered within their ability and resources.”

“Improved access – facility based outreach, Skilled staff.”

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"I do have the necessary drive, experience and knowledge to render a comprehensive service."

"With planning, resource allocation and skilled staff we are rendering a comprehensive service"

4.7 Organisational Capacity

4.7.1 Understanding Rehabilitation within the PHC setting

According to participants rehabilitation in a primary setting must focus on function and return to previous activities:

"It is an integrated, and team based rehabilitation services driven towards return to previous function and "work" integration"

Participants indicated that low intensity rehabilitation services (Level 3 CSP), with outreach to peripheral health facilities and funded NGO's to enhance accessibility, were offered. They felt the service focussed on community based rehabilitation.

In addition participants had some suggestions for improvement of services:

"I do believe however that if a single objective template could be implemented under a peer review process, we would see a more efficient service being delivered and more clients would be serviced."

4.7.2 Organisational attitude

Participants felt confident that they were effective in delivering rehabilitation services and flexible enough to adapt to the changing needs of the community:

"*Yes. I do have the necessary drive, experience and knowledge to render a comprehensive service."*

"Yes. With planning, resource allocation and skilled staff we are rendering a comprehensive service, which can be improved with active research. Shortfalls in service delivery and capacity are identified and addressed with

relevant disciplines by means of aligning performance plan as well as continuous professional development."

"Yes, I feel I have the necessary resources and skills to provide my patients the best possible level of care they need. I am also able to identify where my shortcomings are and ask for help if needed. I feel that I have had adequate training in my field and through the years have built up my knowledge to be in line with the skills needed in my profession."

Furthermore the participants were able to identify shortcomings within the organisation's capacity to deliver rehabilitation services, these included:

- A lack of clear guidelines and procedures (e.g. targets and indicators)
- A need for greater involvement of people with disabilities at planning level
- Equitable allocation and distribution of resources
- Evidence based research and feedback

4.7.3 Vision and Mission

A copy of the vision, mission and objectives of the previous Elangeni Rehabilitation centre was provided by the administration clerk to me. The document reads as follows:

<u>Vision:</u>

We aim to be the most comprehensive, dynamic physical rehabilitation service in the West Coast Region as well as the Western Cape.

<u>Mission:</u>

Our mission is to be so far possible a dynamic comprehensive physical out-patient rehabilitation service, with high quality services to the community of Paarl and the larger West Coast Winelands Region.

During the interviews, some participants indicated that they were aware of a vision and mission, but not entirely sure what it entailed. Three participants indicated that they did not know about it.

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"I know, they have this frame with the vision and mission in it, they do have one, but we never have really seen it. They do have one"

"*I will say our vision is to deliver a comprehensive service and stance, don't want to say stance, because it sounds so wha!!!" But to give quality services to the patients, one will always want the patients to feel that they are always getting the best when they walk in here. So I would say to give patients a comprehensive service is the equivalent of the quality at private level, so that they don't have to go there. And our mission is to live by and to include that in all our tasks. I think that sometimes that when we are involved in in service, we neglect our admin, but I think quality must be throughout at all levels, if I can say so*."

"*No formal vision or mission. We follow the hospitals; will be good if we have our own*."

The manager indicated that she thinks that it is: "*accessible service for all*".

4.7.4 Organisational structures and procedures

Some aspects of structures and procedures such as monitoring and evaluation procedures have been discussed. Additional information is presented here. All participants indicated that there was no clear policy and protocols according to which they should work. This could also be linked to a lack of vision and strategy for rehabilitation services. The occupational therapist indicated that they had treatment guidelines available for hand treatment and the issuing of assistive devices; they did not have specific guidelines for treatment of other conditions:

"*Except for hands, no, we use the hands protocol from TBH."*

Other responses:

"*Therapist makes use of clinical notes, clinical presentation of the client and previous experience to treat clients.* "

> "*No clear guidelines. Come down to your patient folder and notes. It is important to use standard terms, signs. For so when the next physio comes, he immediately gets a full picture of the condition as well as the history of the patient."*

> "*Largely the patient notes give guidelines*"

> "*Yes, that is usually what you study and the experience that you have over the years. But there is not a set thing, you still evaluate people and decide what is best for them, depending on the presentation, not every patient is the same*"

> *"No, I have a lot of home programs, when it comes to guidelines, I don't have any."*

Three therapists indicated that they have clear guidelines for administrative procedures. However it was not standardised.

> "*No clear guidelines, everyone, except for what we receive from Worcester or from therapists that do everything together, example stats. Everyone write their notes as they were taught, our patient notes, we have a standard that everyone uses, but it is not on par with what is used at Paarl Hospital and TBH. So we have one for Elangeni that we use, but it is not uniform.* "

All participants indicated on the questionnaire that the following documentation was uniform: patient documentation, patient register, leave forms, referral forms, performance appraisal and policy documents. The community service occupational therapist was the only participant that was not aware of her job description. None of the participants were aware of uniform forms to keep statistical records or an annual report.

The participant's responses indicated a clear understanding of whom they should report to. They also indicated that they provide information as requested but it appeared that there is still a lack of understanding with regards to their needs.

> "*I think we will continue to complain and if they say they do not know what we do, and then we can tell them, we have reported and they can't say that they*

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don't know what we do. Then it probably will improve." "I report to the facility manager at TC Newman, and if I have questions regarding rehabilitation issues, I ask the coordinator from Worcester." "I report to the senior Occupational Therapist"

"I think there should be a bit more accountability. If we forwarded that through, some feedback has to come back. Listen why is this stats low, listen why have you focus your efforts on this, for this month. Although there is the relay of info from the senior therapist to the coordinators, there has to be some feedback also, with regards to the stats specifically, I think there should be a return feedback"

Additional information on procedures comes from the folder audit. Figure 4.3 illustrates results of the 86 client folders that were audited.

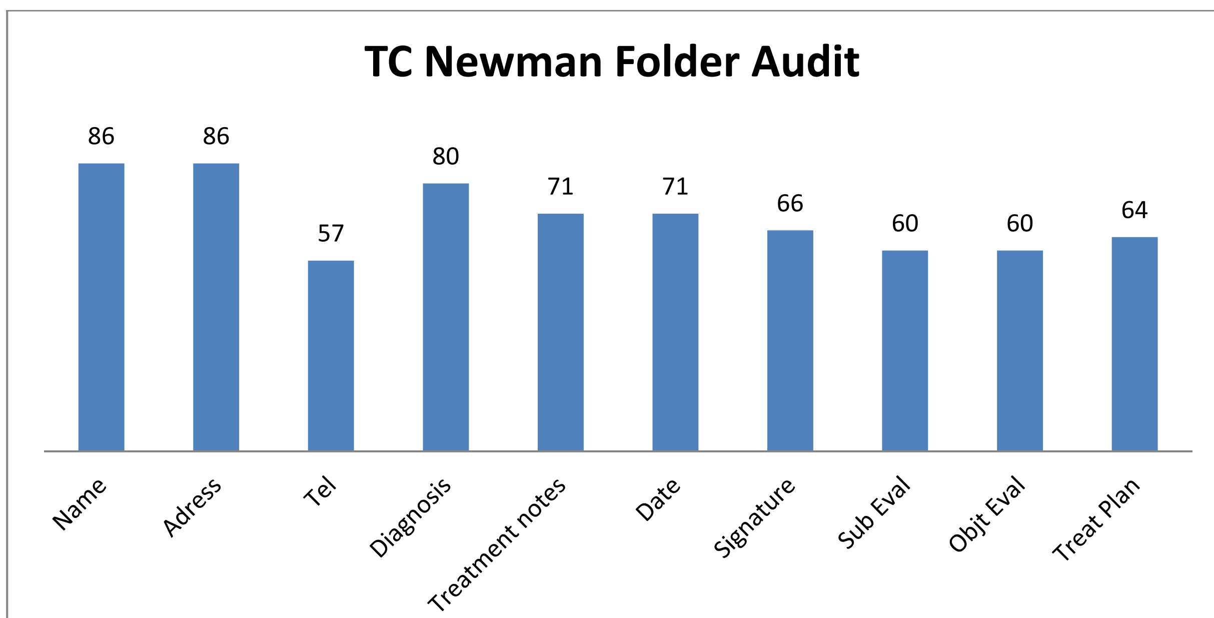

Figure 4.3: Results of the 86 client folders audited

The folder audit reflected inconsistencies in documentation and recording such as:

- Illegible signatures
- Subjective assessments done with no evidence of the use of standardised evaluation tools
- Treatment plans were vague
- Documented treatment sessions were not always dated
- Only one participant documented that she asked consent prior to the onset of treatment
- Paarl Hospital referral forms were used for referrals
- Acronyms and abbreviations were not standardised and I did not understand all of them
- The student's documentation with regards to patient assessment, treatment plan, follow up notes and discharge were very thorough
- Only the signature of the students were clear and legible
- Most clients referred for lower back pain, from Paarl Hospital were entered into a back class, without any assessment and clinical documentation
- A follow up date was not always documented, and in most folders one could not clearly see if patients came back for therapy.

Elements of the Kaplan Framework, regarding organisational structures and procedures, relevant individual skills, abilities and competencies and sufficient and appropriate material resources are reflected in earlier sections.

4.8 Summary

It was noted that participants were knowledgeable of policies in health but to a lesser extent policies on rehabilitation.

Participants highlighted the importance of accessing rehabilitation services with a focus on the outreach to peripheral clinics and funded NGO's. Intersectoral collaboration is evident, but mainly with funded NGO's.

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A Multi-disciplinary team approach is emphasised in the provision of rehabilitation services. There appears to be no dedicated budget for rehabilitation, except for a dedicated assistive device budget.

There are opportunities for skills development. A lack of standardised documentation, inadequate monitoring and evaluation systems and uniformed documentation were some of the challenges identified by participants.

There absence of participation by persons with disabilities was noted by all participants. Barriers and facilitators were identified in implementing policy.

Regards to the organisational capacity, the participants had a good understanding of rehabilitation within the PHC context. They also felt confident in delivering rehabilitation services and were able to identify shortcomings in service delivery, which included poor documentation and evidence on outcomes.

Participants had no knowledge of the vision and mission for rehabilitation services.

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Chapter 5 Discussion

5.1 Introduction

In this chapter the results of the study will be discussed in terms of the organisations capacity to deliver rehabilitation services in line with the seven indicators developed for the study and National Rehabilitation policy.

Organisational capacity depends first and foremost on more subtle and less easily quantifiable concepts such as attitude, vision and strategy. This is followed by more concrete concepts such as structures and procedures, skills, abilities and capabilities as well as material resources.[16] The seven key indicators developed from the NRP were: [2]

Indicators:

- Accessibility
- Partnership and networking
- Resource allocation
- Human resource development
- Monitoring and evaluation
- Participation
- Research

Findings will be discussed through combining key indicators and capacity where possible, or separately where not possible.

5.2 Organisational capacity

5.2.1 Conceptual framework and attitude

Kaplan's framework states that for an organisation to have capacity, it needs to have an understanding of its world and its role in it. In terms of the organisation being studied one would thus require the service providers as well as management to have a clear understanding of rehabilitation and how rehabilitation services at primary health care level should be implemented in line with existing legislation and policy. Thus ensuring a common understanding of the "world" of rehabilitation as well as their role as rehabilitation providers in this community.[16]

All participants showed an awareness of relevant health care and rehabilitation policies and could name most of them. However, they were not very knowledgeable about the content / objectives of these policies. Thus one might argue that it would be hard for them to work in line with policy, except if their job descriptions were based on it. Knowledge of the content of policy is important, but to effectively implement policy the context in which service delivery takes place is equally as important. [71] The question then is, are students at higher education institutions trained in relevant policies and how are they able to adapt service delivery according to the context in which they work.

While the study did not explore participants understanding of rehabilitation in general or the role of rehabilitation at primary level in depth, the results in Chapter 4 with regards to organisational capacity indicated that all participants had an understanding of what the focus of individual rehabilitation should be and how outreach rehabilitation services should be rendered at PHC clinics and Community Health Centres (CHC). [67] However, the picture that emerged of services through the results was one of rehabilitation services rendered mainly at facilities, based on the medical model, with a big focus on impairment. I am not sure whether or not participants have an understanding of CBR as an approach to service delivery.

While outreach services were provided within the Drakenstein sub district, it was mainly focussed on individual assessment and treatment of clients at the facilities or at selected NGO's in the community. The rehabilitation package of care at primary level, specifically community based rehabilitation, calls for a proactive approach to rehabilitation with health promotion, prevention, screening and early detection of

conditions that can lead to disability, as an integral part of rehabilitation.[67] It is also important to include elements of CBR and PHC that includes: support of families of disabled people, vulnerable groups such as orphans to HIV/AIDS and the protection of rights, human dignity, empowerment and self-determination of persons and families with disabilities.

In addition, the Revitalisation of PHC document [67] calls for the promotion of equal opportunities for persons with disabilities and networking with other departments, local government, communities and private enterprise. Very little of these activities was evident in the data and it seems as if these areas of rehabilitation at primary level were neglected. But then these aspects were also not covered in the job description of therapists as prescribed in Table 2.7. Their job description focussed on screening, assessment and treatment with some reference to networking and support of health campaigns. The rehabilitation provided by therapists was mostly in line with their job descriptions. However, the job descriptions were not completely in line with policy, specifically, what rehabilitation should entail at primary level and specifically the community (CBR) level. The management structure responsible for rehabilitation services at TC Newman CDC might not have a complete understanding of the role of rehabilitation at primary level. In the absence of a clearly defined framework, services were rendered in a manner that was familiar to the therapists and deemed appropriate for the client. If rehabilitation is only reactive as presented in findings, the services will struggle to make an impact on the needs of the community.

With regards to knowledge of the community which they serve, therapists were aware that rehabilitation services at TC Newman CDC served mainly an uninsured population who are challenged with socio economic barriers resulting in dependency on government grants and on accessing free health care services from government. All rehabilitation services including the provision and issuing of assistive devices offered at PHC level, are free of charge. The only cost for the client may be for transport; hence outreach services were put in place to ensure that services are as far as possible accessible and affordable for the client. De La Corniellere (2007) share similar findings, where accessibility to rehabilitation services are primarily confined to outreach from CDC's to primary health care facilities in the community,

due to transport challenges.[51] In planning rehabilitation services and in ensuring access, a clearly defined package of care for service delivery, appropriate to the level of care and the cadre of health professionals should be in place, so to ensure continuity of care and appropriate care pathways for people with disabilities.

Looking at the National Rehabilitation Policy and the definition of CBR in this policy, therapists and the manager indicated a good understanding of CBR, but services were still confined, mainly to health facilities as discussed above. Participants indicated knowledge of the existing Community Based Service (CBS) model, and acknowledge a lack of utilising CBS to its fullest extent.

Findings indicated that at least some of the therapists felt that the community had no role to play in rehabilitation services. This is an unfortunate viewpoint since it will not facilitate interaction with the community in order to determine their rehabilitation needs and discover the strengths in the community that can be utilised to enhance rehabilitation services. This lack of liaison could have led to the current situation where therapists indicated that patients had little support at home and were dependent on them.

Finally, the conditions treated did not reflect the burden of disease of the Drakenstein area, as will be discussed under access to health care. This might be a further indication that community rehabilitation needs were not fully met and that services were not adapted to the needs of the community and that an expansion of the conceptual framework and attitude of service providers might cause rehabilitation services to have a bigger impact on the community.

5.2.2 Vision and Strategy

A clear strategy and vision for rehabilitation services provides a sense of purpose and will. Individuals need to know what the vision of the organisation is and what strategies to follow to meet this vision.[16] It will lead to confidence of the organisation to perform rehabilitation services that are in line with the needs of the community and will ensure that the organisation can be responsive and adapt services to the burden of disease of the community they are serving.[2]

The DOH has a clear vision and mission for health care services in the Western Cape. The focus of this vision is on quality health for all and a responsibility to provide equitable access to quality health services. These services must be in co-operation with the relevant stakeholders, within a balanced and well managed health system. [99] The vision and mission of the department of health speaks to the goal of the National Rehabilitation Policy in improving accessibility to services and facilitating access to health care services.[2]

Under the jurisdiction of the DOH the vision and mission of rehabilitation services at TC Newman CDC should reflect the above, while it provides specific focus for the service in that community. Thus in aligning rehabilitation services at PHC level with the vision and mission for comprehensive health care services in the Western Cape and the NRP, rehabilitation services should be rendered at all health facilities and within the community, thus facilitating a balance between institution and community based rehabilitation services.[2] Close collaboration between service providers (multi-disciplinary teams) and inter-sectoral collaboration between government departments, together with an integrated referral system to ensure continuity of care is required.[100]

Both the vision and mission focus on a comprehensive, dynamic service with a reference to quality. However, this is rather vague and provides no guidance as to what the service should entail and how the vision and mission is to be achieved. A lack of clear objectives or strategies hampers the realisation of the vision and mission. In addition this vision and mission belonged to the previous Elangeni Rehabilitation Centre (ERC) that does not exist anymore.

The document containing the vision and mission of ERC was compiled under the supervision and governance of the former West Coast Winelands District. In 2009 municipal boundaries were re-demarcated. Drakenstein then became part of the Cape Winelands district. In aligning PHC services with the District Health System (DHS), the service offered at Elangeni (ERC) became an integrated part of the PHC service package at TC Newman CDC. This placed rehabilitation services under the direct management of the facility manager at TC Newman CDC. Previously PHC services within TC Newman CDC were mainly nurse and doctor driven and ERC functioned vertically to what was offered at TC Newman CDC. Now the two service

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provision points have integrated and a new vision, mission and service objectives are called for.

In conclusion there is no clear vision or strategy on how the mission was translated to drive rehabilitation services in this area. No clear rehabilitation service model that is underpinned by the vision and strategy of the organization exists. This point to an organizational attitude that is neither here nor there to its core agenda. This raises questions with regard to what was the basis/what was used to make other lower decisions of the organizational framework.

5.2.3 Structures and procedures

Clear structures and procedures need to be in place to give guidance.[13] This includes policies and procedures that guide service delivery, access, monitoring, staff development and service evaluation. The current package of rehabilitation services offered at TC Newman CDC is in line with what is prescribed in literature for a community health centre which ranges from the identification, assessment and treatment of persons with disabilities to the provision of assistive devices.[51] However, services are not in line with the NRP and CBR policy since they are mainly institution based and reactive in nature.

In addition results indicated that there were no clear policies or guidelines to steer the implementation of services. The only documentation that was available was the Comprehensive Service Plan and the Annual Performance Plan of the Western Cape DOH and this was only available from management.[49] Therapists had no guiding documentation for rehabilitation services. Treatment guidelines that were available, such as the treatment of hand conditions by occupational therapists, were from tertiary institutions and not specific for PHC. Rehabilitation services for every category of therapists needs to have a clearly defined package of care, with accompanying protocols, to ensure that services are rendered uniformly and in a standardised manner at every health facility.

Procedural challenges might have caused the delivered services to be suboptimal. For instance, while assessments were done no objective assessment tools were utilised. Thus therapists had no way of telling objectively whether the treatment led

to improvement. In addition a standardised measurement tool serves as a reminder to ensure that all aspects are evaluated. When one thinks of the ICF and the multitude of factors that might impact function and participation, it is important to have a structured way of doing assessments and re assessments in order to ensure that nothing is accidently forgotten.[3,21]

The study revealed that not all the folders contained information on the assessment and its findings, a treatment plan and treatment notes. This is challenging since without clinical notes therapists have to remember different patients and their specific problems and treatment requirements since they cannot refer to the notes. This can lead to overlap, repetition and a waste of time or to some aspects of rehabilitation not being addressed. Where another therapist has to treat a patient due to the primary therapist being on leave or sick time will be wasted with lengthy re-evaluations because the therapist does not have notes to refer back to.

Documented referral and management procedures will ensure that people referring clients will know how to refer, what conditions to refer, to whom, when and where to refer clients. In addition a clearly defined package of care will ensure that clients have access to a detailed assessment with the appropriate therapist, a clear treatment plan indicating the type of treatment, a pre-test with the onset of therapy, a post-test with discharge, the expected duration of treatment, follow up dates and clear discharge or referral.[11] The above was seen to be lacking with the folder audits. Results showed that therapists incorporate a CBR approach by establishing partnerships with selected NGO's.[3] It was, however, limited and there was no clear strategy on how to adequately render services on the community platform. To ensure accessible and equitable services, the Community Based services program in DOH must be integrated and aligned with rehabilitation services at community level. This will facilitate continuity of care, sustainability and better adherence to the treatment plan. To ensure this, rehabilitation service provision must also be re-orientated towards the principles of CBR. [2] This further entails empowering community care workers to have a more direct and meaningful role in the rehabilitation process. The community worker would be required to assume some of the functions and roles normally reserved for recognised health professionals e.g. pressure care screening. Improvements in quality and accessible health services

will be maximized .[100] To ensure that community care workers are competent to deliver rehabilitation services within the community, there must be transfer of skills between the rehabilitation professional to the community care worker. Therapists should also offer clinical mentoring and support.

Therapists indicated that there were clear guidelines for administration. . The patients register, where patient appointments were recorded, was visible, but hand documented and managed by the administrative clerk of the facility. This register seemed to be more of an appointment book than a patient registers, since it did not contain information on how long patients were treated, their conditions and date of referral. It did not always indicate whether patients booked actually kept the appointment and were treated. This lack of a comprehensive patient register led to discrepancies in information. According to the therapists, ten clients were booked per day per therapist for individual therapy. However, the administration clerk indicated that he booked twelve clients per day per therapist. Therapists were not very clear as to how many patients actually arrived for therapy in relation to the number of clients booked. Furthermore, therapists indicated that they saw patients for six hours a day and spent between thirty and forty minutes per individual client in therapy. On calculating the actual time spent with clients, there was a difference of between one and two hours that was unaccounted for. This illustrated the lack of good data management and specific targets and indicators for rehabilitation, which made it difficult to measure service outputs and to accurately account for therapist's time in the facility. Thus service outputs and effectiveness cannot be determined. A lack of information like this will make it very difficult to motivate for additional posts. The NRP states that efficiency of services should be measured against specific quantitative and qualitative standards.[2]

Leave forms and job descriptions were standardised as per human resource guidelines of the government of the Western Cape. All therapists had a tangible performance plan with key performance areas and indicators for service delivery. Therapists are guided by these plans and results reflected that service delivery by therapists was in line with what was expected from them. Looking at the objectives in the NRP, accessibility to rehabilitation services was addressed by implementing outreach to peripheral PHC facilities and resources for rehabilitation services were

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allocated and decentralised. However, what was lacking in the performance plans was intersectoral collaboration, monitoring and evaluation, research and the participations of persons with disabilities in service delivery.[2] This could be because management not having a good understanding of the concept of community based rehabilitation.

In addition to documentation there was no standardised orientation or induction program for orientating new staff. A structured orientation program will ensure that the new employee is familiar with the organisation and becomes effective in the shortest time.[101]

Results from the eighty six client folders audited, illustrated numerous inconsistencies with regards to clinical documentation and recording. Maintaining medical records ensures continuity of care and may also be required for legal purposes. The standard of recordkeeping can make a world of difference with regards to clinical negligence claims and successful defence.[102] Referral forms were not standardised and not always utilised.

With regards to the procurement of assistive devices, rehabilitation professionals were responsible for completing the requisition and submitting it to management for approval. Management further facilitates the process, by submitting the approved requisition to the head of the finance department, who would then route the requisition to the appropriate clerk. The clerk is then responsible for capturing this request on an electronic system, while therapists remain responsible for the follow up of the requisition and receiving of items ordered. This procedure is not clearly documented and communicated with all role players, as there was no written standardised operational procedure (SOP) for ordering assistive devices or any written feedback regarding expenditure. The multitude of role-players in the process, no written SOP and the lack of feedback could have resulted in the perception that budgets were not adequate or that orders for items were not generated.

5.2.3.1 Accessibility

One of the key indicators developed from the NRP for this study is accessibility of services. According to the NRP rehabilitation services must be accessible to all

people suffering from conditions that may lead to a disability and those living with disability. [2]

Results indicated that rehabilitation services were provided both at TC Newman CDC and at various other points by means of outreach services. It appears as though service providers took distance and population density into account when outreach was planned. However, it seemed as if the entire demographic context of the Drakenstein with regards to population density was not taken into account. Some of the outreach points seemed to have been selected with a view of improving access to rehabilitation for the community of the Drakenstein. For instance, Wellington CDC and Mbekweni clinics saw a high number of clients. The outreach to Saron/ Gouda and Simondium clinics where fewer clients were seen can be justified as these facilities are furthest from TC Newman CDC. However, the failure to include some other clinics with PHC head counts above 11 000 patients per quarter such as Dalevale, Klein Nederburgh and Pola Park is more difficult to explain. It is uncertain why no outreach services were provided at these sites.

It is important to note that outreach to health facilities beyond TC Newman CDC, was initiated only towards the latter part of the 2009/10 financial year. This concept of outreach and support was new and not easily accepted by therapists. Therapists were used to working within a facility, with a multi-disciplinary team, assistive devices and equipment at hand and clients accessing one service point for rehabilitation services. Outreach rehabilitation services from TC Newman CDC, was initiated by management from the Cape Winelands District office after the re-demarcation of the municipal boundaries. These outreach services were based on the rehabilitation service model in the Cape Winelands District east.

Looking at the type of conditions of clients who accessed rehabilitation, it seems as if there was a difference in what the therapists reported and what was seen at TC Newman CDC according to the register kept by the administration clerk. This difference could possibly be attributed to the difference in diagnosis between clients accessing services at TC Newman CDC and the clients accessing some of the outreach services. For instance, Paarl Stimulation Centre is a facility that renders services for children with mental and physical disabilities and drains to TC Newman CDC, this could have attributed to the increased number of CP and children with

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developmental delays mentioned by therapists. In addition before 2010, Paediatric and Orthopaedic services from Paarl hospital was part of the package of services offered at TC Newman CDC. It might also be possible that therapist's perception on the type of clients seen was still partly based on the past.

HIV/AIDS, homicide and TB currently present a large portion of the disease profile of the Drakenstein.[35] The Literature review showed that clients with a disease profile that includes HIV, homicide related injuries and TB may require rehabilitation services at some point during the course of the illness or injury.[36,42,43,44,103] It is concerning to see that the clients accessing rehabilitation services did not represent the current recorded burden of disease.

It might be possible that some patients who were treated indeed suffered from these conditions, but that it was not documented or referred to. Studies by Ferguson and Jelsma (2009) showed that children who are HIV positive presented with developmental delays and functional limitations, both which required rehabilitation. Therapists indicated that they saw children with developmental delays. [38] The finding did not explore the cause of these developmental delays and it might have been HIV.

TC Newman CDC has the largest fully functioning PHC infectious disease clinic in the Drakenstein, where children and adults with communicable diseases such as HIV and TB are treated. It seems as if these patients were not referred for rehabilitation or did not access rehabilitation. One of the contributing factors may be because these programs (HIV/AIDS and TB) are managed as vertical/specialised programs, with little integration into rehabilitation programs. The current HIV and TB programs are more focused on curative treatment and increasing longevity, with a lesser focus on quality of life. The National Strategic Plan for HIV, TB and STI is guided by the following goals: [43]

- reducing new HIV infections by at least 50%
- starting 80% of eligible patients on ART
- reducing the number of new TB infections
- reducing the number of TB deaths by 50%

To improve the quality of life for clients with HIV and TB, there needs to be an equal focus on prevention/promotion, early detection, screening and the referral of clients to rehabilitation services to ensure that secondary complications due to these diagnoses do not impair the patient's quality of life. [36,42,43,44,103] However, early detection and screening while part of rehabilitation at primary level according to policy documents were not provided in the current setting.

Homicide was next to HIV/AIDS the second leading cause of death and lost disability-adjusted life years in the setting as confirmed in a study by Prof Mohammed Seedat.[39] Paarl has a violent crime incidence rate of between 12.36% and 18.98% which could be one of the reasons why homicide is the second cause of premature mortality in the Drakenstein.[104] Unfortunately it is not possible to explore this further since rehabilitation data and the folder audit did not adequately reflect whether or not violent crime was the cause of disability or injury.

The current conditions seen by rehabilitation professionals could be as a result of the referring parties' perception of rehabilitation and also as dictated by rehabilitation professionals. The participants indicated that they informed nurses who refer to them on the conditions that should be referred. PHC nurses were the main source of referral. It seemed from findings as if doctors mainly referred clients with orthopaedic problems such as lower back pain. The fact that doctors referred clients for rehabilitation is heartening since it indicated an awareness of rehabilitation services and utilisation of these services amongst them.

It is, however, concerning that the conditions which were referred did not represent the burden of disease in the area. This could be due to a limited perception on the side of those referring as to what rehabilitation services entail and who can benefit from it. This limited perception might be shared by therapists, who indicated that they tell people who refer to them what type of conditions they want to see. A limitation of the study was that I did not adequately explore participant's knowledge of the Drakenstein's burden of disease. The type of training and health promotion offered by therapists was limited to what they perceived as the burden of disease.

Findings indicated that this is an economically poor community for who transport and the cost connected to it was a challenge. This was also found by Fredericks (2011)

in his study at Elangeni Rehabilitation centre. [84] Rehabilitation services will remain inaccessible if there are any costs related to transport for the client. Public transport was a challenge within the Drakenstein, and was mainly confined to taxis, thus creating a barrier if rehabilitation services are not rendered close to the community where the patient lives. Therapists also indicated that they realised that transport was a challenge for clients who need to access rehabilitation services and as a result outreach services were put into place.

Finally, health care access is not limited to the point of entry into the system. Primary health care can only be successful if supported by a strong referral system. A public inquiry into the right to access to health care services stated that health care services for the poor is severely constrained by costly or inadequate transport and lengthy waiting times at health facilities and for surgery at referral hospitals.[72] Recommendations from the inquiry were to generate greater awareness amongst the community of the services at PHC level, improved communication to employees regarding roles and responsibilities at every level of care and ensure that all facilities are adequately resourced to deal with clients accessing services. [9,104]

The department of health has a three tier system of service delivery, namely primary, secondary and tertiary. TC Newman CDC is seated on a PHC platform, Paarl hospital is a secondary /regional (specialized) hospital, the Western Cape Rehabilitation Centre (WCRC) the specialized rehabilitation centre in Cape Town. Results indicated that clients were mainly referred to Paarl Hospital and less often to WCRC for more specialised rehabilitation care.

WCRC is the only specialised rehabilitation centre in the Western Cape Province and accepts appropriate referrals from all levels of health care.[106] Therapists indicated that they did not often refer to WCRC as it appeared that admission is a challenge, with lengthy referral forms and waiting times prior to admission. This finding is in accordance with that of Cawood who did a study on stroke rehabilitation at primary level in the Helderberg basin.[90] According to findings, WCRC also did not refer clients to TC Newman CDC for continued rehabilitation after discharge. It seems as if the relationship with WCRC, the premier inpatient rehabilitation facility in the province, might have been suboptimal. One would have liked co-operation between the two levels of service where acute, comprehensive rehabilitation

services at WCRC is complemented by community integration of the same client through rehabilitation at primary level. This is especially important since WCRC policy dictates that they should discharge clients when they can integrate into a residential setting, expecting the final two levels of integration, i.e. community integration and economic participation, to be done at primary level. [107]

Results showed that therapists incorporate a CBR approach by establishing partnerships with selected NGO's.[3] It was, however, limited and there was no clear strategy on how to adequately render services on the community platform. To ensure accessible and equitable services, the Community Based services program in DOH must be integrated and aligned with rehabilitation services at community level. This will facilitate continuity of care, sustainability and better adherence to the treatment plan. To ensure this, rehabilitation service provision must also be re-orientated towards the principles of CBR. [2] This further entails empowering community care workers to have a more direct and meaningful role in the rehabilitation process. The community worker would be required to assume some of the functions and roles normally reserved for recognised health professionals e.g. pressure care screening. Improvements in quality and accessible health services will be maximized .[108] To ensure that community care workers are competent to deliver rehabilitation services within the community, there must be transfer of skills between the rehabilitation professional to the community care worker. Therapists should also offer clinical mentoring and support.

Accessibility in this study focussed largely on access to health care, specifically, rehabilitation. Management and therapists, in creating accessible rehabilitation services facilitated outreach to mainly health facilities and selected NGO's. It appears that accessibility was limited to facility level and to a lesser extent the community and the environment where the clients live e.g. patient homes, community care workers. This might hamper full integration and participation of the disabled person in the community.

5.2.3.2 Partnership and networking

Partnerships and networking are essential to ensure well-co-ordinated rehabilitation services in a resource limited environment. Communication between various

sectors, government departments and local government can make a significant contribution towards achieving a seamless rehabilitation service and realising the objectives of the NRP. [2]

Another service provider unit, that one would want close liaison with, is Community Based services (CBS). CBS are well distributed throughout the Drakenstein in the form of NGO`s and Home based care. Home Community-Based Care (HCBC) services in the Western Cape are provided by non-profit organisations, which are funded by the provincial government. Patients who need care at home when discharge from hospital is referred to a health facility at primary healthcare level in the area in which they live. The research indicated that rehabilitation professionals were aware of CBS, but were not utilising this resource optimally. To ensure full re-integration of people with disabilities into the community and in ensuring continuity of care, the collaboration between service providers and a clearly defined referral system to CBS needs to be managed effectively.[2] CBS is able to provide health services at the home of the client with the aim of helping to restore and maintain client's health and functional status. This service is offered to clients with a physical impairment and clients who need support with medication adherence. [4,109]

Community interaction was limited and mainly involved outreach and support to funded NGO's. The NGO's that participated in the research indicated that they received support from the DOH as well as outreach and support from health professionals, but it was limited to one professional supporting them at a time. This could indicate the scarcity of therapists, or that therapists may not have had a good understanding of what the NGO entails and the type of services available and the role they can play.

Rehabilitation service providers include the public sector, NGO's and the private sector. Government provides most services for people with disabilities. [2] The main provider for medical rehabilitation is the department of health. Quality services cannot be rendered without effective inter-sectoral collaboration between government sectors. A lack of inter-sectoral collaboration may result in exclusion of persons with disabilities and decreased participation in the community. For example a child with a disability may struggle to access quality education if departments such as education, transport, social development and health do not work together. Inter-

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departmental collaboration is promoted in the South African policy.[110] However, policy is not always implemented as prescribed. Services appeared to remain fragmented and delivered in silos by various government departments.[110]

In addition, the Western Cape Government's Healthcare 2020 vision is patient centred and speaks to public private partnerships, which encourages utilisation of the inherent strengths of private partners.[11] This is also echoed in the NRP stating that resources could be better utilised if partnerships can be formed, rather than rendering services parallel to each other. [2] The private sector provides medical services mainly to the insured and full paying population.[2] The research study showed little reference to utilisation of rehabilitation services in the private sector. In planning rehabilitation services, CBR principles should be taken into account. There should be a balance between institutional and community based service delivery and practises to improve access to services at primary level. It is, therefore, important that rehabilitation services should be fluid but structured so as to meet the changing demand and populace for rehabilitation services.

5.2.3.3 Monitoring and evaluation

According to the National Rehabilitation Policy (NRP) monitoring and evaluation of all rehabilitation programs, projects and activities is essential to establish efficiency and effectiveness of services and to maximise the potential in future planning and implementation of similar or new programs.[2] The appropriateness, relevance and adequacy of the program should be evaluated at pre-determined intervals and measured against specific standards.[2]

From the participant's responses, monitoring and evaluation within the rehabilitation program was lacking. There was no written procedure for monitoring and evaluation, which includes documentation, reporting and feedback to service providers. Fredericks (2001) found the same limitations in his study at Elangeni.[85]

In addition, formal structured communication between service providers and management seemed to be lacking. The absence of clear guidelines led to much frustration as indicated through quotes in the results.

Therapists indicated that they see high volumes of clients. They attempt to address these high volumes by trying to accommodate all clients that are referred for therapy. It appears as though therapists are mainly output driven. The high patient numbers could create the perception that there is very little time for proactive health promotion/prevention and community interaction. Thus it is essential that there are set targets and indicators for all service areas within rehabilitation and those outcomes are communicated formally with therapists and management. This will ensure that management and policy makers are enabled to make informed decisions that are evidence based. [87]

5.2.3.4 Skills, abilities and capabilities and human resource development

Kaplan suggested that training should be specific to the organisation. Training must support the skills and competencies needed for the organisation to reach its goals. Practitioners need to be developed to face the “reality” in which they work and within the priorities of the organisation.[16]

Participants indicated that training was aligned with their individual performance plans and the needs of the community. The group of therapists at TC Newman CDC were young with between one and five years working and rehabilitation experience, and the training that they referred to could be related to tertiary/university training. Findings indicated therapists provided treatment mainly on an individual basis and focused on impairments. This could be a result of the way that students are trained and the practices they are exposed to.[111] However, a limitation of the research was that I did not determine whether the training interventions offered and attended were focussed on CBR principles and proactive health promotion and prevention of disabilities, early screening, inclusion of persons with disabilities and aligned with the burden of disease in the community. Participants were aware of training opportunities, and felt that these were limited and not well communicated to them.

The facility manager’s perception of training interventions for therapists was deemed relevant, but limited. The manager indicated that CPD was the responsibility of individual therapists. That may be so, but management has a responsibility in guiding therapists on what skills are needed to address the BOD, and CPD would ensure suitable skills to enable them to fulfil their roles as rehabilitation providers in

the community. None of the training mentioned by either management or the therapists related to the burden of disease of the Drakenstein, or implementation of CBR principles. In addition to a lack of clinical skills in certain areas, results from the study indicated that time management and administration skills were areas that needed to be developed to ensure effective service delivery.

When looking at individual skills and abilities of the service providers, their development should be nurtured through reflection, good mentoring and review. This highlights the need for improved communication between management and service providers.

5.2.3.5 Resources

Kaplan and Jack and Powers (2009) suggested that sufficient and appropriate human and material resources are important in capacitating the organisation.[16,91]

The allocation of rehabilitation professionals in the Drakenstein sub district compared to any other rural setting within the Western Cape showed that the Drakenstein is a well-resourced rehabilitation site. [49] In terms of the current workload, the allocated human resources appeared adequate, looking at patient/therapist ratios. However, in light of the need to re-engineer rehabilitation in PHC towards making services more accessible and affordable, (towards proactive prevention and collaboration, the demographic context of the Drakenstein and the burden of disease), human resources may be inadequate as the demand for future health care is ever increasing. In fully implementing the NRP and specifically the CBR approach in service delivery, the utilisation and transfer of skills to caregivers and a different cadre of health worker may become more important. [58] For this organisation that has not fully unpacked their vision and structure into processes, including proper budgets to implement these processes and the changing context of the community, urged rehabilitation professionals to develop outreach programs with no proper venues nor equipment.

Looking at definitions of teamwork in literature, therapists in the Drakenstein follow a multi-disciplinary approach, where members from different disciplines work independently on different aspects of a client at different sites, individual goals are

set and therapists maintain independent disciplinary roles. [54] There is thus a need to analyse what would be an appropriate, affordable, yet comprehensive rehabilitation service model for the Drakenstein. "It is not what we do, but how we do it." [2] Both management and therapists mentioned the lack of utilisation of CBS.

With regards to material resources, infrastructure and equipment, most PHC facilities could not accommodate more than one rehabilitation professional at a time. This led to the fragmentation of services since teamwork was hampered. Thus if therapists treating a client would like to refer them to another team member, the patient will have to be scheduled for another appointment, which may only be in a week or two. Health facilities and infrastructure in the Drakenstein was planned and built to accommodate mainly curative services. With the evolution of health services, a more comprehensive package of care is rendered at PHC services, which includes rehabilitation services. [112] Infrastructure, however, remained unchanged, except for the revitalisation of TC Newman CDC and the newly built Wellington CDC. Both these facilities are able to comfortably accommodate rehabilitation services. In planning health infrastructure (building new clinics / putting down pre-fab buildings), health planners should be knowledgeable of the type of service to be rendered and the specifications of that service at each facility.

Communication resources were available, but limited with regards to direct accessibility. Technology within DOH has evolved to the extent that the main form of communication is e-mail and fax to e-mail. The lack of direct access to these resources impacts on effective communication between health professionals and limits effective administration (data collection, referrals and report writing). This could have a direct impact on the responsiveness and accountability of both management and the rehabilitation professionals. In addition the administration clerk needs full fax and email access as this is the person planning the therapist's appointments.

The written patient appointment system for rehabilitation at TC Newman CDC as managed by the administration clerk, showed inconsistencies in patient bookings e.g. patients not arriving for therapy, actual patient numbers seen and poor follow up of clients. Inconsistencies in patient bookings could be as a result of no clear guidelines on how many clients should be booked per therapist per day as well as the type of clients booked. Other factors that could have influenced the inconsistency

in patient bookings are the lack of availability and direct accessibility of information technology, and the level of insight of staff scheduling the appointments. In the absence of information technology good communication systems need to be in place for example: therapists need to be informed, daily, about the patient load for the day and client list for the given day. This could improve the follow up of clients and referral to CBS for adherence and support as therapist will be immediately aware which patients did not keep appointments.

TC Newman CDC has a dedicated assistive devices budget, that appeared to be substantial and managed relatively well by the rehabilitation professionals. This finding showed an improvement on the findings in the previous study at Elangeni where patients were waiting for wheelchairs and therapists said no money was available for these. [85] One participant indicated that even though funding was adequate, not all devices ordered were received. This appeared to be a problem within the procurement and supply chain department at TC Newman CDC.

5.2.3.6 Participation

"The participation of persons with disabilities is integral to the planning, implementation and monitoring of rehabilitation programs." [2] As indicated by the results no evidence of this was found in the current study. With the Department of Health's, Western Cape, renewed focus on patient centred care (PCE), the integrated approach to health care must include persons with disabilities to participate in rehabilitation and other health programmes. [11] Patients must serve on the health committees of the health facilities. The health committees are the structures through which members of the community can participate and voice their needs for health services. The absence of a health committee might mean the needs of the community and especially persons with disabilities cannot be voiced adequately.

5.2.3.7 Research

For rehabilitation services to be recognised as an essential part of health care service delivery, especially at PHC level, evidence is needed to ensure that rehabilitation services are developed. The results should be utilised appropriately.[2]

No documented evidence of any research related to rehabilitation at TC Newman CDC could be found in literature, except for the study by Fredericks (2011) which was performed at Elangeni. [85] This current study has provided me with an opportunity to look objectively at the research site from a different perspective other than being a part of the organisation. I have found this process of standing back and developing new perspectives has led to gainful insights that I can implement to improve future service delivery. Feedback on the outcomes of the research is important to facilitate improvement of the programme. [60]

5.3 Summary

Rehabilitation services in the Drakenstein sub district are still mainly rendered from health facilities such as TC Newman CDC, with an outreach to PHC facilities and selected NGO's funded by Cape Winelands (CWD) District Department of Health. Clients that were treated were mainly diagnosed with chronic orthopaedic problems and this was not representative of the burden of disease with in the CWD. Rehabilitation at TC Newman CDC was lacking in areas such as a clear vision and mission, clear structures and procedures, individual skills, abilities and competencies in relation to the burden of disease. Limited collaboration raises questions related to the attitude of the organisation which is largely based on the principle of a medical model with a vertical approach to patient care.

Record keeping, administration and good data management was an area of concern. There was familiarity with the content and context of health policies, however there is a need to operationalize policy within the context of the Drakenstein sub district with a specific focus and approach to implement community based rehabilitation.

Chapter 6

Conclusion and recommendations

6.1 Conclusion to the study

In conclusion rehabilitation services were not yet delivered as an integral part of PHC services and in accordance with the principles of PHC, the NRP and CBR in the study setting. While some inroads have been made with regards to access to services, assistive device provision and outreach to NGO`s, other aspects, such as health promotion and preventative strategies, collaboration with other stakeholders, monitoring and evaluation, were not addressed to improve organisational capacity.

As stated by Kaplan [16] it was easier to quantify and assess strategies, procedures and resource allocation than conceptual framework attitude and vision. Kaplan describes an organisation as a system that is greater than the sum of its parts. The parts are continuously interacting and relating to each other and are affected by each other. It is out of the relationship between these parts that an organisation arises.

To understand the system, one must look to the whole, rather than to reduce one's understanding to the component parts. [16] In the previous chapter the results were discussed in the light of various parts of Kaplan`s framework. When one combines and integrates these, the findings highlighted that there was a lack of engagement between the various role-players. Rehabilitation at TC Newman CDC was not fully integrated into the comprehensive PHC services rendered. Rehabilitation professionals functioned in a silo, and participation from them was only visible when clients were referred or requests were made. Thus therapists reacted to existing rehabilitation needs, instead of proactively implementing health promotion, disability prevention and early identification strategies. As long as they provide a reactive service, the service will struggle to make an impact on the needs of the community. They must respond proactively through networking, health promotion and preventative strategies based on the burden of disease in the setting. Management's involvement with rehabilitation was limited to addressing and responding to requests from therapists. They did not play a guiding role to ensure service delivery according to PHC, CBR and NRP policy. Therapist's role was

limited to therapy and mainly facility based, which lead to little or no interaction with other sectors and service delivery platforms.

Factors that could have influenced the above limitations included: no clear vision, mission and strategy for rehabilitation services and a lack of organisational structures and procedure to guide rehabilitation service delivery. This could be seen in the lack of monitoring and evaluation, poor client record keeping, poor documentation and a lack of standardised assessment tools.

Therapists performed services according to their job descriptions and performance plans and rendered rehabilitation services according to some NRP objectives such as accessibility and resource allocation. However, the extent of implementation of the NRP objectives was limited. This might be because their job descriptions did not include all relevant aspects, or because of limited understanding amongst therapists and management of the definition and role of rehabilitation in the community.

Looking at the seven key indicators from the NRP, the following was concluded:[2]

- Accessibility: The outreach service rendered by rehabilitation professionals in the Drakenstein increased access to rehabilitation services, but was limited to facilities with the infrastructure to accommodate rehabilitation services. Access within the community itself was limited to funded NGO's.
- Partnership and networking: Limited networking with other role-players and sectors was noted. However, overall this was an area that showed challenges.
- Resource allocation: Human resources were adequate for facility based rehabilitation services, but for this organisation that has not fully unpacked their vision and structure into processes, including proper budgets to implement these processes and the changing context of the community, human resources might be inadequate.
- Direct access to administrative resources was lacking and impacted on efficiency and communication. Budget allocations were adequate, but not utilised optimally.
- Monitoring and Evaluation: Service outcomes and outputs were poorly monitored. The absence of a structured tool for monitoring, evaluation and auditing of patient folders, impacts on effective monitoring and evaluation.

- Participation: The participation of persons with disabilities in the planning and development of health and rehabilitation services was absent.
- Research: Research was done, but implementation of results was lacking. This might be because results were not disseminated effectively to service providers and managers.

Continued growth and life of the organisation depends largely on its interaction with its ever changing environment. The organisation, without such interaction would become dormant and cease to function. [16] Rehabilitation services in the study setting needs to become an integral part of PHC service delivery. The community and person with the disability must voice their needs and participate in managing and planning services. Recommendations from study findings that should assist to achieve this are presented next.

6.2 Study recommendations

Stakeholders, and this includes the community and persons with disabilities, have an opportunity to re-align current services to meet their needs and increase organisational capacity. The Organisation can build on the current strengths such as reasonable access, assessment, treatment and provision of assistive devices to ensure proactive rehabilitation, networking and inclusion of persons with disabilities. Revitalising PHC in South Africa is a document that prescribes how rehabilitation services should be rendered in the PHC sector, looking at rehabilitation packages of care at community health centres, clinic based services and community based rehabilitation services.[67] This document could be used as a framework to base rehabilitation services on.

The following specific recommendations are made:

- Development of a vision, mission and objectives.

The vision and mission must align with that of the DOH, but at the same time focus on the specific community that services are being delivered to, their rehabilitation needs and burden of disease. In addition CBR and PHC policy must be integrated in that the services must develop, from the current curative focus to a proactive focus in the community that focuses on inclusion of persons with disabilities, networking,

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health promotion and disability prevention. The vision and mission must be supported by clear objectives as to how they can be achieved.

- Adaptation of job description of therapists.

In line with the newly developed vision, mission and objectives therapists current job descriptions must be expanded to include functions like the inclusion of persons with disabilities, networking, health promotion, disability prevention and the transfer of skills.

- Skills development and training of rehabilitation professionals

Every therapist's individual development plan (IDP) should be based on the needs of the community and the principles of CBR, PHC and the NRP. The plan must focus on two aspects:

First, being the clinical skills of the therapists, based on the burden of disease of the community and PHC principles and not only conventional rehabilitation training. They need to be educated on the burden of disease in the community and their specific roles with regards to rehabilitation in these diseases. Secondly, management skills of therapists with regards to administration, time management and presentation skills must be developed. Managers should play an active role and support therapists in identifying their training needs. There should be a formal training package developed for CBS workers regarding rehabilitation interventions and guidelines, to facilitate partnerships and networking.

- Training of referral sources

Professionals who refer patients for rehabilitation as well as those working in the specialised clinics, such as the infectious disease clinic, must be educated in terms of the role of rehabilitation in these conditions. Improved communication, e.g. written feedback to referring parities by therapists, can enhance the value of rehabilitation services.

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- Service accessibility

It is recommended that management from the CWD office, the Drakenstein sub district, together with the therapists, re-evaluate the PHC sites for outreach and support. During this process they should take into account: the patient numbers at the facility, infrastructure at the facility and the burden of disease per facility.

In ensuring continuity of care, greater accessibility and improved patient centred experience, rehabilitation services should be embedded in the community based services program.

With regards to infrastructure planning, management should take into account the package of service delivery (including rehabilitation services) to be offered at a specific facility. It should be mandated that every new facility (brick or pre-fab) be universally accessible and able to reasonably accommodate rehabilitation professionals.

- Partnership and networking

Currently therapists have a link with some funded NGO's in the community. However, there is a need to strengthen and enhance the relationship between community based service and rehabilitation services rendered at facilities. According to CBR policy, therapists have training and support responsibilities. They must strengthen CBS through provision of quality training to community care workers. In addition they must act as a support system and community care workers must be able to refer to them or contact them for assistance if they require help with a client or situation. It is further recommended that the multi-sectoral liaison that happens at district level be established at sub district level between departments of health, education, social development and local municipality to ensure operational efficiency.

There should be a stronger link between Paarl hospital and the Western Cape Rehabilitation centre (WCRC). Rehabilitation professionals should have quarterly meetings/ interaction with Paarl hospital. These meetings can be incorporated with the existing mutli-disciplinary rehabilitation meetings at district level. To ensure

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improved networking and access to WCRC, the rehabilitation manager of CWD must have a meeting with the director of WCRC and discuss the findings of the study and present ways of improved collaboration. To improve accessibility and utilisation of the expertise at WCRC, staff of WCRC should consider outreach and support, which includes in-service training to the therapists in the rural districts. This is part of their role as a specialist rehabilitation unit for the province.

- Resource allocation

Resource allocation should be based on identified needs. To ensure adequate allocation, data should be interrogated and managed effectively by management. Clear guidelines on procedures should be developed for the procurement of any equipment in rehabilitation. To improve efficiency and staff attitude, the following resources are strongly recommended: direct access to a telephone, a computer with e-mail access and an electronic data register. Patients accessing health services, specifically rehabilitation should be registered as part of the Primary Health Care Information System (PHCIS) at that facility.

- Monitoring and Evaluation

Service outputs and outcomes must be monitored and evaluated on an on-going basis. A quarterly folder audit and implementation of before and after client outcome measure such as the Reintegration to Normal Living index can provide a start to this process. [107] Standardised procedures for data collection on all levels of care (facility and community) must be put in place. In addition, where recommended strategies such as CBR training and support are implemented, monitoring and evaluation practices must be included from the beginning.

The M&E of rehabilitation services must form part of the following meetings: District M&E and Sub District Management Response Unit (MRU). Standardised audit tools should be developed for Rehabilitation services to ensure the quality of services. These tools should look at clinical work, folder audits, environmental factors and the patient’s perception of the services. These audits must be done annually by senior rehabilitation professionals and feedback to management at facility level.

A report on rehabilitation services provided should be included in the Annual Report of the Cape Winelands District DOH.

- A Trans disciplinary approach (TDA)

TDA as a way of working is recommended to ensure optimal accessibility and transfer of skills. A trans-disciplinary approach (TDA) could be a means of balancing the distribution of clients amongst therapists. The TDA emphasises role release by strengthening discipline specific skills, learning from other disciplines, planning services in a multi-disciplinary team and sharing best practises. This will ensure quality services and a comprehensive package of care that is available and accessible to the broader community. [113,54]

- Participation

Every health facility in the Drakenstein has a health committee. It is recommended that persons with disabilities form part of the health committees, which will ensure that the needs of the people with disabilities are voiced. Rehabilitation professionals must also form part of these committees.

- Research

The research study revealed that research was previously done at the research site and other districts in the Western Cape. It is strongly recommended, that all research upon completion, must be presented to the relevant stakeholders to ensure, if feasible, the implementation of recommendations.

Research studies in the Western Cape are approved by the Provincial Department of Health, it is imperative that recommendations from these studies are discussed at Provincial level.

- Student training

Student training at university level must put a stronger emphasis on health promotion and disability prevention strategies. In addition, students must be prepared for working in a primary setting and in rural communities. [107]

Finally, since the study population was too small to do statistical analysis of quantitative findings, recommendations should be seen as relevant for the current study setting only. While it might be possible to implement recommendations in other similar settings, it must be done with caution and only after careful comparison of contexts and demographic information.

6.3 Suggestions for further research

- It is recommended that a re-evaluation must be done of the organisational capacity of the research site after one financial year, to ensure that recommendations are implemented as far as possible and highlighting any other barriers.
- Another recommendation for a research study would be to evaluate the utilisation and capacity of community care workers in the continuum of care alongside the rehabilitation professional.

6.4 Limitations of the study

- One of the main limitations of the study was that patients and members of the community were not included as study participants. This omission is due to the original SANPAD planning where two studies per site was planned one focussing on patients and the other on service providers as participants. However, it would have been possible to better address the objectives of this study if data was collected from patients as well.
- Measuring tools used in the study were mandated and prescribed by the bigger SANPAD group. As the study progressed, the measuring tools were not adequate and researchers made individual amendments and additions to the developed tools.
- Another serious limitation was my dual role. I collected all data, but I am also a manager in the setting and this relationship could have influenced their answers since they might have wanted to please me.
- The study methodology had several limitations.
    - A quantitative design as called for the in the SANPAD study was not the best design to answer the aim and objectives of this study. While I

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did try to improve on it by adding a qualitative component, this was not entirely successful as described below.

- The number of participants was too few to gather quantitative data that could be analysed statistically.
- The quantitative questionnaire contained leading questions and was not a suitable tool to address the study aims and objectives.

- The study participants were limited to TC Newman CDC and only one manager formed part of the study. To gain a broader perspective on management's perception of rehabilitation services, operational managers at PHC facilities could also be interviewed.
- A small number of NGO's participated in the study. A limitation was that I did not determine why some of the NGO's did not want to participate.
- With the analysis of the data, I found that the self-developed questionnaire did not fully answer the study objectives and subsequent to this a folder audit and interview schedule was developed. These tools were not piloted. The qualitative data gathered during the interview lacked depth and in the end could only provide narrative examples to quantitative data, but very little explanation as to why things were as they were and relied on the perceptions of therapists. Analysis of the results revealed that more in-depth probing could have been done with the interviews and therefor an open ended questionnaire was developed at sent to participants. Only 2 therapists, the manager and 2 NGO's responded and completed the questionnaires.
- Additional information that would have enhanced findings but were not gathered included:
  - It was not determined whether training interventions attended by therapists were focussed on CBR principles, proactive health promotion and prevention of disabilities, early screening, inclusion of persons with disabilities and aligned with the burden of disease in the community
  - Identifying participants knowledge on the burden of disease in the study area
  - Whether services was cost effective

6.5 Aspects addressed to date and dissemination of findings

This research study created an enriching awareness of disability and rehabilitation. The course of this research process led to the following developments in the rehabilitation program of the Cape Winelands District to date:

- The Rehabilitation program adopted the vision, mission and values of the Department of Health as reflected in the Health Care 2020 framework
- The speech therapy job description was re-evaluated and amended
- Planning is in place to re-established the CWD Rehabilitation Forum
- Performance agreements are aligned to an extent so as to address the Burden of Disease e.g. paediatric screening of children receiving ARV's.
- Decentralisation of WCRC's outreach seating clinics led to the capacity building of rehabilitation professionals of the CWD, in intermediate wheelchair seating, positioning and orthotics and prosthetics, since late 2012.
- Skills development as of January 2012 was largely focussed on the CWD BOD and management skills to therapists.
    - Chronic Disease management – The "Hello to my health" workshop which focussed on the management of the diabetic client.
    - South to South training, addressing HIV screening in the rehabilitation arena
    - Multi Drug Resistant Tuberculosis, screening for ototoxicity by speech therapist
    - Project Management
    - ICF training in collaboration with the University of Stellenbosch
    - Community Care worker training specifically on CVA's
- The adaption and implementation of a standardised referral form based on the ICF framework
- Redistribution and identification of outreach clinics in the Drakenstein sub district
- Standardised outcome measures, data collection tools, folder audits and reporting was implemented since January 2013.
- Access to communication resources improved with a dedicated computer and access to email and fax to email facilities.

- Rehabilitation services at TC Newman CDC are fully integrated into the PHC package of services, PHCIS, with no separate patient folders and an extensive improvement of the infrastructure for rehabilitation.

The results from this research study will be presented to the management of the CWD office, management of the PHC services across the five sub districts of the CWD and the re-established rehabilitation forum.

This study concludes that the organisation, despite some limitations, has the capacity to implement rehabilitation services in line with the National Rehabilitation policy. Management welcomes the research and recommendations made during the research. This is evident in the new developments discussed above.

The biggest advantage of being part of the SANPAD study was the input from other rehabilitation professionals, academics and researchers in the field of rehabilitation and peer support.

As a health manager and rehabilitation professional in the Cape Winelands District, this research empowered me to facilitate processes of change, which are evidence based.

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Appendices

APPENDIX 1

REFERENCE NO:

SANPAD PROJECT

Questionnaire for Managers – Quantitative

INDICATOR 1: Accessibility

Definition: Ability to access rehabilitation services at this facility

Goal: To describe the accessibility of the facility and services

Outcome: Meets the aims of the NRP and the UNCRPD articles

1.1.1. What are the areas included in the catchment areas? ....

1.1.2. Please indicate the number of rehabilitation workers currently employed in this institution:

REHABILITATION WORKER	Students (number)	In facility (number)	Outreach from facility (number)	
Doctor				1
Nurse				2
Physiotherapist				3
Occupational Therapist				4
Speech Therapist				5
Prosthetist				6
Social Worker				7
Home Based Carer				8
Dietician				9
Orthopaedic Sister				10
Psychologist				11
Clinical Nurse Practitioner				12
Peer Supporter				13

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REHABILITATION WORKER	Students (number)	In facility (number)	Outreach from facility (number)	
Health Promoter eg.: Nutritional Advisor				14
Occupational Therapy Assistant				15
Physiotherapy Assistant				16
Other a) b) c) d)				17
TOTAL:				

1.1.3. Does the facilities have the following?:

Facility	Yes/No	If Yes, may staff use it?		If Yes, may patients use it?	
		Yes	No	Yes	No
A Landline					
Fax					
Email					
Public Phone					

1.1.4. What is the average distance patients have to walk to get therapy? .... kilometers

1.1.5. What are the working hours of the therapist? .... hours / day

1.1.6. How many days a week and for how many hours a day does the facility operate? …………… …………….…….. days/wk ……………………………………………. hours/day

1.1.7. How long do patients wait to get an appointment in your rehabilitation department? ………………………… days.

1.1.8. What times in the year are therapy services not available? ………………….………………………..

1.1.9. Which are the peak months? ……………………………………………………………………………….

1.1.10. Which are the quiet months?...

1.1.11. What percentage of patients is unable to pay the fees? ………………………………………………….

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1.1.12. What percentage of patients is unable to pay for their assistive devices? ………………………….

1.1.13. What is the transport policy? ………………………………………………………………………...........................

……...............................

Key for all Tables that follow - describing the component indicators evidence	Meanings
Exceeds	Exceeds the needs
Meets	Meets the needs
N/I	Not indicated
N/A	Not applicable

Strategy 1: Assess overall accessibility of service and facility						
PROCESS	COMPONENT OF INDICATOR	EVIDENCE	EXCEEDS	MEETS	N/I	N/A
1.2 Facility	1.2.1. There is enough space to do therapy					
	1.2.2. The building/room is physically accessible to all patients.					
	1.2.3. There is an emergency power generator.					
	1.2.4. There is signage at the facility.					
	1.2.5 The signs are adequate and at a suitable height.					
1.3. Equipment	1.3.1. There is sufficient equipment for therapy.					
	1.3.2. There is sufficient equip-ment for staff to perform their admin duties.					
1.4. Language	1.4.1. The language used by therapists is understood by service users.					
	1.4.2. Interpreters are readily available.					
1.5. Entry	1.5.1. The patients are given an appointment within the first week of bringing a referral.					
	1.5.2. Outreach is done to other facilities.					

Strategy 1: Assess overall accessibility of service and facility						
PROCESS	**COMPONENT OF INDICATOR**	**EVIDENCE**	**EXCEEDS**	**MEETS**	**N/I**	**N/A**
	1.5.3. There is transport (other than own) available to do outreach and/or home visits.					
	1.5.4. Transport is provided for all patients.					
1.6. Communication	**1.6.1. Patients have access to health information, e.g. booklets, posters, brochures**					
	1.6.2. This information provides for the needs of all types of disabilities.					
1.7. Costs	**1.7.1. The facility has a written guide on the fees charged.**					

INDICATOR 2: Partnerships, Networking

Definition: **Mechanisms that promote the collaboration between the centre and other sectors involved in rehabilitation of partnership and networking used at this facility.**

Goal: **To assess the mechanism of partnership and networking among the facility and other departments and sectors involved in disability field with the community at large.**

Outcome: **Meets the aims of the NRP and the UNCRPD articles**

Strategy 2 : Assess formation of partnerships an networking in the community						
PROCESS	COMPONENT OF INDICATOR	EVIDENCE	EXC	MEETS	N/I	N/A
2.1. Referrals	2.1.1. The rehabilitation service receives referrals from other sectors, other than health					
	2.1.2. The rehabilitation service does refer clients to other sectors, other than health					
2.2. Support	2.2.1. The rehabilitation service supports other sectors with rehabilitation services					
2.3. Resources	2.3.1. The rehabilitation department space is shared with other departments and NGO's					
2.4. Collaboration	2.4.1. There is inter disciplinary and professional collaboration at the facility					
	2.4.2. The rehabilitation services has formed partnerships with other government sectors					
	2.4.3. The rehabilitation service has formed partnerships with NGO's.					
	2.4.4. The rehabilitation service has formed partnerships with DPO's.					

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2.5 Please indicate all services offered at you centre? Please tick:

SERVICES	FULL TIME	PART TIME	NO SERVICE	NOT SURE
• Curative				
• Rehabilitation				
• Prevention				
• School Nursing				
• Trauma				
• Maternal Obstetric Unit				
• Dental				
• X-ray				
• Mental Health				
• Psychologist				
• Child Health				
• TB Treatment				
• Women's Health				
• Health Promotion & Education				
• Social Services				
• Nutritional Services				
• Assistive Devices (e.g. prostheses, orthoses)				
• Other				

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INDICATOR 3: Resource Allocation

Definition: **The process of allocating resources**

Goal: **To assess the availability and usage of resources for rehabilitation at the facility.**

Outcome: **Meets the aims of the NRP and the UNCRPD articles.**

Strategy : Assess resource allocation at the facility						
PROCESS	COMPONENT OF INDICATOR	EVIDENCE	EXCEEDS	MEETS	N/I	N/A
3.1. Human Resources	3.1.1. The rehabilitation posts are filled as prescribed by the CSP					
	3.1.2. There are community service therapists employed at the facility					
	3.1.3. The rehabilitation department utilizes students in the department					
	3.1.4. The rehabilitation department utilizes volunteers in the department					
3.2. Financial Resources	3.2.1. There is a dedicated budget for rehabilitation services					
	3.2.2. There is a dedicated budget for assistive devices					
	3.2.3. The assistive devices budget is adequate					
	3.2.4. The rehabilitation department has received all the assistive devices it needs					
	3.2.5. There is a budget for skills training					
	3.2.6. The training budget is used for therapists					
	3.2.7. The therapists do use their training budget.					

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3.3 What assistive devices are available for therapy? Please tick

Device	Tick
• Wheelchairs	
• Wheelchair cushions	
• Tension adjustable backs	
• Wheelchair trays	
• Walking sticks	
• Axilla crutches	
• Elbow crutches	
• Gutter crutches	
• Walking frames	
• Rollators	
• Quadrapods	
• Wrist braces	
• Ankle Foot Orthosis	
• Spectacles	
• Hearing Aids	
• Other: a) b) c) d)	

3.4. Who allocates the budget to the centre? ………………………………………………………….

3.5. Who manages the budget of the centre? ………………………………………………………….

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INDICATOR 4: Human Resource Development

Definition: **The strategies used for helping employees develop their personal and organisational skills, knowledge and abilities.**

Goal: **To assess the strategies of the human resource development at the facility**

Outcomes: **Meets the aims of the NRP and the UNCRPD articles.**

Strategy : To assess the Human Resource Development at the facility						
PROCESS	COMPONENT OF INDICATOR	EVIDENCE	EXCEEDS	MEETS	N/I	N/A
4.1. Training	4.1.1. There is ongoing training for rehabilitation staff					
	4.1.2. Training for rehabilitation staff is aligned with their performance agreement					
	4.1.3. Training for rehabilitation staff is aligned with the need of the community					
	4.1.4. There is provision for career pathing for rehabilitation staff					
	4.1.5. Volunteers are trained for rehabilitation at the facility					
	4.1.6. Therapy students are trained at the facility					
	4.1.7. The rehabilitation department trains home based carers					
	4.1.8. The rehabilitation department trains carers of patients					

NB: Human Resource Development (HRD) is the framework for helping employees develop their personal and organisational skills, knowledge and abilities. Human Resource Development includes such opportunities as employee training, employee career development, performance management and development, coaching, mentoring, succession planning, key employee identification, tuition assistance and organisation development.
http://humanresources.about.com/od/glossaryh/f/hr_development.htm 04/09/2010

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INDICATOR 5: Monitoring and Evaluation Strategies

Definition: **Evaluation is systematic determination of the rehabilitation services using criteria against a set of standards.**

Monitoring is the regular observation and recording of activities taking place in the rehabilitation facility. It is a process of routinely gathering information.

Goal: **To assess the strategies of monitoring and evaluation procedures utilized at the facility**

Outcome: **Meets the aims of the NRP and the UNCRPD articles.**

Strategy : To assess the Monitoring and Evaluation strategies used in the rehabilitation department						
PROCESS	COMPONENT OF INDICATOR	EVIDENCE	EXCEEDS	MEETS	N/I	N/A
5.1. Process	5.1.1. There are processes in place to monitor and evaluate rehabilitation services					
	5.1.2. The information obtained from monitoring and evaluation is being used by the rehabilitation services					
5.2. Documentation	5.2.1. The documentation at the centre is uniform					
5.3. Data collection	5.3.1 The mechanism for data collection is uniform					
5.4. Targets and indicators	5.4.1. The targets and indicators set out for rehabilitation are in line with the rehabilitation objectives					

INDICATOR 6: Participation

Definition: **Ensuring that persons with disabilities and the community are taking part in the different spheres of rehabilitation, participating in the planning, implementing and monitoring of rehabilitation programs.**

Goal: **Assess the level at which the community participates in the rehabilitation process.**

Outcome: **Meets the aims of the NRP and the UNCRPD articles.**

Strategy : To assess community participation in the rehabilitation process						
PROCESS	COMPONENT OF INDICATOR	EVIDENCE	EXCEEDS	MEETS	N/I	N/A
6.1. Disability sector	**6.1.1. There are disabled persons in the catchment area of the facility**					
	6.1.2. There are specific NGO's delivering services to the disabled in the community					
	6.1.3. There are specific DPO'S delivering services to the disabled in the community					
	6.1.4. There are programs specifically designed for the disabled					
6.2. Management	**6.2.1. Patients are involved and participate in their own management**					
	6.2.2. There is a functioning health committee in the community					
	6.2.3. The community is involved in the management of the facility					
	6.2.4. There are disabled people involved in the management of the facility					

6.3. Name the groups for disabled people in your catchment area.

………

………

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INDICATOR 7: Research

Definition: **The support of research initiatives in rehabilitation and any other related areas.**

Goal: **To assess the research conducted at the facility**

Outcome: **Meets the aims of the NRP and the UNCRPD articles.**

Strategy : To assess the research happening at the facility						
PROCESS	COMPONENT OF INDICATOR	EVIDENCE	EXCEEDS	MEETS	N/I	N/A
7.1. Research	7.1.1. There is research being done at this facility					
	7.1.2. Researchers do get support from the management of the facility					
	7.1.3. There are persons with disabilities involved in doing some of the research					
	7.1.4. Information learnt through research at the facility is being disseminated back to the facility					

Thank you so much for taking time to complete this questionnaire.

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APPENDIX 2

Section A: Demographic Information		
A.1	Name of institution	WCRC
		Elangeni
		Bishop Lavis
		Gugulethu
A.2	Age	Years
A.3	Gender	Male
		Female
A.4	Profession	Doctor
		Nurse
		Physiotherapist
		Occupational Therapist
		Speech Therapist
		Prosthetist
		Social Worker
		Home Based Carer
		Dietician
		Orthopaedic Sister
		Psychologist
		Clinical Nurse Practitioner
		Peer Supporter
		Health Promoter
		Occupational Therapy Assistant
		Physiotherapy Assistant
		Other
A.5	Salary Level	Level 6
		Level 7
		Level 8
		Level 9
		Level 10
		Level 11
		Level 12
A.6	How long have you been working at this institution?	Years
A.7	How long have you been working in the field of rehabilitation?	Years
A.8	Total number of years of working experience?	Years

SANPAD PROJECT

Questionnaire for Service Providers

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

B.1. The following statement address your relationship with clients during the rehabilitation process.

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

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B.2. Do you think that service users are satisfied with the services that you are offering?

Comment		Always	Sometimes	Never
B.2.1	Service users wait too long for rehabilitation service from us			
B.2.2	All rehabilitation services needed by service users are available from this institution			
B.2.3	All service providers at this institution have the necessary expertise to meet all the needs of our service users			
B.2.4	Our service users benefit from receiving our rehabilitation services			
B.2.5.	Overall, I am satisfied with the rehabilitation service that we provide for our service users			

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INDICATOR 1: Accessibility

Definition: **Ability to access rehabilitation services at this facility**

Goal: **To describe the accessibility of the facility and services**

Outcome: **Meet the aims of the NRP and the UNCRPD articles**

1.1. Demographic Information:

1.1.1. What areas are included in your catchment area? ....

1.1.2. To which areas outside of the catchment area does the rehabilitation service provide service to service users? ....

1.1.3. Please indicate the number of rehabilitation workers currently employed in this institution:

Rehabilitation Worker	Student (no.)	In Facility (no.)	Outreach from the facility (no.)	
Doctor				1
Nurse				2
Physiotherapist				3
Occupational Therapist				4
Speech Therapist				5
Prosthetist				6
Social Worker				7
Physiotherapy Assistant				8
Home Based Carer				9
Dietician				10
Orthopaedic Sister				11
Clinical Nurse Practitioner				12
Peer Supporter				13
Health Promoter				14
Occupational Therapy Assistant				15
Physiotherapy Assistant				16

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Rehabilitation Worker	Student (no.)	In Facility (no.)	Outreach from the facility (no.)	
Other a) **b)** **c)** **d)**				17
TOTAL:				

Key for all Tables that follow - describing the component indicators evidence	Meanings
Exceeds	Exceeds the needs
Meets	Meets the needs
N/I	Not indicated
N/A	Not applicable

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1.1.4. Does the centre have the following?

Facility	Yes/No	If Yes, may staff use it?		If Yes, may patients use it?	
		Yes	No	Yes	No
A Landline					
Fax					
Email					
Public Phone					

1.1.5. What is the average distance, patients have to walk to get to therapy? ………………………….. kilometers

1.1.6. To what facility is outreach done? ……………………………………………………………………………...............

1.1.7. What are the working hours of the therapists? …………………………………………… hours / day

1.1.8. How many days a week and for how many hours a day does the facility operate? ……….. days /week.

1.1.9. How long do patients wait to get an appointment in your rehabilitation department? ....

1.1.10. How many patients do you book per day? ………………………………………………….……………………

1.1.11. How many patients do you see daily on average? ………………………………………………………………

1.1.12. Of your total working hours per day what is the percentage of direct contact hours with the service user? ……………………………………………………………………………………………….…………

1.1.13. What is the usual number of hours a client spends in therapy per day? …………………….………

1.1.14. How many days per week does a client spend in therapy? ……………………………………………..

1.1.15. What times in the year are therapy services not available? ……………………………………………….

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Strategy 1: Assess overall accessibility of service and facility						
PROCESS	**COMPONENT OF INDICATOR**	**EVIDENCE**	**EXCEEDS**	**MEETS**	**N/I**	**N/A**
1.2 Facility	**1.2.1. There is enough space to do therapy**					
	1.2.2. The building/room is physically accessible to all patients.					
	1.2.3. There is an emergency power generator.					
	1.2.4. There is signage at the facility.					
	1.2.5 The signs are adequate and at a suitable height.					
1.3. Equipment	**1.3.1. There is sufficient equipment for therapy.**					
	1.3.2. There is sufficient equipment for staff to perform their admin duties.					
1.4. Language	**1.4.1. The language used by therapists is understood by service users.**					
	1.4.2. Interpreters are readily available.					
1.5. Entry	**1.5.1. The institution provides services to service users outside the catchment area**					
	1.5.2. The patients are given an appointment within the first week of bringing a referral					
	1.5.3. There is a fast-track system for vulnerable clients					
	1.5.4. The referral received are appropriate with regard to services offered at the rehabilitation department					
1.6. Privacy	**1.6.1. The personal privacy of service users is preserved at all times**					
	1.6.2. Outreach is done to other facilities in the catchment area					
	1.6.3. There is transport (other than own) available to do outreach and/or home visits					
	1.6.4. Organized transport is available for patients who need it to come to the facility					

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Strategy 1: Assess overall accessibility of service and facility						
PROCESS	COMPONENT OF INDICATOR	EVIDENCE	EXCEEDS	MEETS	N/I	N/A
1.7. Communication	**1.7.1 Patients have access to health information, e.g. booklets, posters, brochures**					
	1.7.2. This health information provides for the needs of all types of disabilities.					
1.8. Costs	**1.8.1. The facility has a written guide on the fees charged.**					
	1.8.2. There are patients who are unable to pay their fees					

1.1.16. Which are peak months? ……………………………………………………………………………………………

1.1.17. Which are the quiet months? …………………………………………………………………………………….

1.1.18. What specific rehabilitation programs do you offer? ……………………..…………………………………

1.1.19. What percentage of patients is unable to pay the fees? …………………..…………..……………….

1.1.20. What percentage of patients is unable to pay for their assistive devices? ……….……………….

1.1.21. What is the transport policy? …………………………………………………………….....................

INDICATOR 2: Partnership, Networking

Definition: **Mechanisms that promote the collaboration between the centre and other sectors involved in rehabilitation of partnership and networking used at this facility.**

Goal: **To assess the mechanism of partnership and networking among facility and other departments and involved in disability field with the community at large.**

Outcome: **Meets the aims of the NRP and the UNCRPD articles.**

Strategy : Assess formation of partnerships an networking in the community						
PROCESS	COMPONENT OF INDICATOR	EVIDENCE	EXCEEDS	MEETS	N/I	N/A
2.1. Referrals	2.1.1. The rehabilitation service receives referrals from other sectors, other than health					
	2.1.2. The rehabilitation service does refer clients to other sectors, other than health					
	2.1.3. The rehabilitation services does refer service users for legal advice or for other social structures for support					
2.2. Outreach	2.2.1. The department does outreach do outreach rehabilitation services					
2.3. Support	2.3.1. The rehabilitation service supports other sectors with rehabilitation services					
2.4. Resources	2.4.1. The rehabilitation department space is shared with other departments and NGO's					
	2.4.2. There is inter disciplinary and professional collaboration at the facility					
	2.4.3. The rehabilitation services has formed partnerships with other government sectors					
	2.4.4. The rehabilitation service has formed partnerships with NGO's.					
	2.4.5. The rehabilitation service has formed partnerships with DPO's.					
	2.4.6. The department does meet with other sectors (like Labour, Education					

2.6 Please indicate all services offered at you centre? Please tick:

SERVICES	FULL TIME	PART TIME	NO SERVICE
• Curative			
• Rehabilitation			
• Prevention			
• School Nursing			
• Trauma			
• Maternal Obstetric Unit			
• Dental			
• X-ray			
• Mental Health			
• Psychologist			
• Child Health			
• TB Treatment			
• Women's Health			
• Health Promotion & Education			
• Social Services			
• Nutritional Services			
• Assistive Devices (e.g. prostheses, orthoses)			
• Other			

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INDICATOR 3 : Resource Allocation

Definition: **The process of allocating resources**

Goal: **To assess the availability and usage of resources for rehabilitation at the facility.**

Outcome: **Meets the aims of the NRP and the UNCRPD articles.**

Strategy : Assess resource allocation at the facility						
PROCESS	COMPONENT OF INDICATOR	EVIDENCE	EXCEEDS	MEETS	N/I	N/A
3.1. Human Resources	3.1.1. The rehabilitation posts are filled as prescribed by the CSP					
	3.1.2. There are community service therapists employed at the centre					
	3.1.3. The rehabilitation department utilizes students in the department					
	3.1.4. The rehabilitation department utilizes volunteers in the department					
	3.1.5. The rehabilitation department utilizes carers of the patients in the department					
3.2. Financial Resources	3.2.1. There is a dedicated budget for rehabilitation services					
	3.2.2. There is a dedicated budget for assistive devices					
	3.2.3. The assistive devices budget is adequate					
	3.2.4. The rehabilitation department has received all the assistive devices it needs					
	3.2.5. There is a cost to the patient for assistive devices					
	3.2.6. There is a budget for skills training					
	3.2.7. The training budget is used for therapists					
	3.2.8. The therapists do use their training budget.					

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3.4 What assistive devices are available for therapy? Please tick

• Wheelchairs	
• Wheelchair cushions	
• Tension adjustable backs	
• Wheelchair trays	
• Walking sticks	
• Axilla crutches	
• Elbow crutches	
• Gutter crutches	
• Walking frames	
• Rollators	
• Quadrapods	
• Wrist braces	
• Ankle Foot Orthosis	
• Other: a) b) c) d)	

3.4. Who allocates the budget to the centre? ………………………………………………………………………….

3.5. Who manages the budget of the centre? ………………………………………………………………………….

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INDICATOR 4: Human Resource Development

Definition: **The strategies used for helping employees develop their personal and organisational skills, knowledge and abilities.**

Goal: **To assess the strategies of the human resource development at the facility**

Outcomes: **Meets the aims of the NRP and the UNCRPD articles.**

Strategy : To assess the Human Resource Development at the facility						
PROCESS	COMPONENT OF INDICATOR	EVIDENCE	EXCEEDS	MEETS	N/I	N/A
4.1. Training	4.1.1. There is ongoing training for rehabilitation staff					
	4.1.2. Training for rehabilitation staff is aligned with their performance agreement					
	4.1.3. Training for rehabilitation staff is aligned with the need of the community					
	4.1.4. Therapists developmental plan executed					
	4.1.5. There is provision for career pathing for rehabilitation staff					
	4.1.6. Volunteers are trained for rehabilitation at the facility					
	4.1.7. Therapy students are trained at the facility					
	4.1.8. The rehabilitation department trains home based carers					
	4.1.9. The rehabilitation department trains carers of patients					

NB: Human Resource Development (HRD) is the framework for helping employees develop their personal and organisational skills, knowledge and abilities. Human Resource Development includes such opportunities as employee training, employee career development, performance management and development, coaching, mentoring, succession planning, key employee identification, tuition assistance and organisation development. http://humanresources.about.com/od/glossaryh/f/hr_development.htm 04/09/2010

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INDICATOR 5: Monitoring and Evaluation Strategies

Definition: **Evaluation is systematic determination of the rehabilitation services using criteria against a set of standards.**
Monitoring is the regular observation and recording of activities taking place in the rehabilitation facility. It is a process of routinely gathering information.

Goal: **To assess the strategies of monitoring and evaluation procedures utilized at the facility**

Outcome: **Meets the aims of the NRP and the UNCRPD articles.**

Strategy : To assess the Monitoring and Evaluation strategies used in the rehabilitation department						
PROCESS	COMPONENT OF INDICATOR	EVIDENCE	EXCEEDS	MEETS	N/I	N/A
5.1. Process	5.1.1. There are processes in place to monitor and evaluate rehabilitation services					
	5.1.2. The information obtained from monitoring and evaluation is being used by the department					
5.2. Documentation	5.2.1. The documentation at the centre is uniform					
5.3. Data collection	5.3.1 The mechanism for data collection is uniform					
	5.3.2. There is a functioning computer at the centre for rehab staff to use					
5.4. Targets and indicators	5.4.1. The targets and indicators set out for rehabilitation are in line with the rehabilitation objectives					

5.5. Which of the following documents used at the centre is uniform? Please tick

Document	Tick
• Patient documentation	
• Register	
• Stats forms	
• Leave forms	
• Referral forms	
• Job Description	
• Performance Appraisal	
• Annual report	
• Policy Documents	
• Other	

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INDICATOR 6: Participation

Definition: **Ensuring that persons with disabilities and the community are taking part in the different spheres of rehabilitation, participating in the planning, implementing and monitoring of rehabilitation programs.**

Goal: **Assess the level at which the community participates in the rehabilitation process.**

Outcome: **Meets the aims of the NRP and the UNCRPD articles.**

Strategy : To assess community participation in the rehabilitation process						
PROCESS	COMPONENT OF INDICATOR	EVIDENCE	EXCEEDS	MEETS	N/I	N/A
6.1. Disability sector	6.1.1. There are disabled persons in the catchment area of the facility					
	6.1.2. There are specific NGO's delivering services to the disabled in the community					
	6.1.3. There are specific DPO's delivering services to the disabled in the community					
	6.1.4. There are programs specifically designed for the disabled					
	6.1.5. There are groups for disabled people in the facility's catchment area					
6.2. Management	6.2.1. Patients are involved and participate in their own management					
	6.2.2. There is a functioning health committee in the community					
	6.2.3. The community is involved in the management of the facility					
	6.2.4. There are disabled people involved in the management of the facility					

6.3. Name the groups for disabled people in your catchment area.

....

....

....

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INDICATOR 7: Research

Definition: **The support of research initiatives in rehabilitation and any other related areas.**

Goal: **To assess the research conducted at the facility**

Outcome: **Meets the aims of the NRP and the UNCRPD articles.**

Strategy : To assess the research happening at the facility						
PROCESS	COMPONENT OF INDICATOR	EVIDENCE	EXCEEDS	MEETS	N/I	N/A
7.1. Research	7.1.1. There is research being done at this facility					
	7.1.2. Researchers do get support from the management of the facility					
	7.1.3. There are persons with disabilities involved in doing some of the research					
	7.1.4. Information learnt through research at the facility is being disseminated back to the facility					

Thank you so much for taking time to complete this questionnaire.

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APPENDIX 3

REFERENCE NO:

SANPAD PROJECT

Questionnaire for Funded NGO's - Quantitative

INDICATOR 1: Collaboration

Definition:
Goal: To ensure well-coordinated rehabilitation services
Outcome: Collaboration between rehabilitation services and NGO's

1. What is the catchment area that your organisation works in? ....

2. Please indicate what services you deliver:

Service	No. of Clients seen per month	Funded by:	
Day Care			1
Licensed Home			2
Food Security			3
Rehabilitation			4
Home Based Care			5
Palliative Care (IPU)			6
Sub-Acute Care (IPU)			7
Nutrition			8
Psycho Social Support			9
Health Promotion			10
Adherence Support (DOTS)			11
Other a) b) c) d)			12

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3. Please indicate the number of staff employed by the NGO:

Category	Number
Admin	
Teacher / ECD	
Care Workers	
Doctor	
Physiotherapist	
Occupational therapist	
Speech Therapists	
Dietician	
Psychologist	
Social Worker	
Nursing Staff	
Other: a) b) c) d)	

Category	Describe
Admin	
Teacher / ECD	
Care Workers	
Doctor	
Physiotherapist	
Occupational therapist	
Speech Therapists	
Dietician	
Psychologist	
Social Worker	
Nursing Staff	
Other: **a)** **b)** **c)** **d)**	

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4. Please indicate what support (not financial) you receive from DOH:

5. Please indicate where do you get referrals from and to whom does the NGO refer:

Receive referrals from	YES	NO	Refer to:	YES	NO
Dept. of Education					
Dept. of Social Services					
Community					
Local Clinics					
Hospital					
Other: a) b) c) d)					

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APPENDIX 4

			Manager	Therapist	Client	Other
Accessibility	1	How large is the catchment area	X			
	2	What is the population	X			
	3	How many therapists		x		
	4	What are the hours		x		
	5	Where are the therapists placed		x		
	6	What type of rehabilitation workers		x		
	7	How far do pt. have to travel			x	
	8	Is there enough space		x		
	9	Is the room / building physically accessible			x	
	10	Is there sufficient equipment		x		
	11	Is there transport to get to therapy			x	
	12	Is the transport available at the appropriate time			x	
	13	Transport user friendly			x	
	14	Transport affordable			x	
	15	Transport appropriate			x	
	16	Transport responsive			x	
	17	Transport adequate			x	
	18	Cost per visit	X	x	x	
	19	Referral system		x	x	
	20	Language and communication barriers				
Collaboration	1	Referrals from other sectors	X	x		x
	2	Referrals to other sectors	X	x		x
	3	Do you meet with other sectors	X	x		x
	4	Role clarification between departments	X	x		x
	5	Do various role players know their responsibilities	X	x		x
	6	Are responsibilities documented	X	x		x
	7	Do you share resources with other departments/NGO	X	x		x
	8	Does the centre offer a Comprehensive Health Service	X	x	x	x
	9	Have you formed partnership with other government sectors	X	x		x
	10	Have you formed partnerships with NGO	X	x		x
	11	Have you formed partnerships with Private sector	X	x		x
Resource allocation	1	Are posts filled = CSP	X	x		
	2	Dedicated budget for rehabilitation	X	x		
	3	Budget for Assistive Devices	X	x		
	4	Budget for skills training	X	x		
	5	Training budget being used	X	x		
	6	Assistive devices been received	X	x	x	

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HR Development	1	Rehabilitation staff properly trained	X	x		
	2	On-going training for rehab staff	X	x		
	3	Training aligned with Performance Agreement	X	x	x	
	4	What do costumers want from therapists				
	5	Is there career pathing for therapists	X	x		
	6	Are volunteers trained	X	x		
	7	Does the centre train students	X	x		
	8	Does the centre train HBC	X	x		
	9	Does the centre train and utilize carers of pt.	X	x		
M&E	1	What process are in place to monitor services	X	x		
	2	Documentation standardised	X	x		
	3	Mechanisms for data collection	X	x		
	4	Stand data collection system	X	x		
	5	Indicators set out	X	x		
	6	Targets to met	X	x		
		Targets and indicators in line with objectives	X	x		
Participation	1	Groups for disabled people in the catchment area	X	x	x	x
	2	Community Health Committee	X	x	x	x
	3	Disabled people involved in Committee	X	x	x	x
	4	Community involved in Management of the centre	X	x	x	x
Research	1	Research at the facility	X	x		
	2	What kind of research	X	x		
	3	Do get researchers get any support from management	X	x		
	4	Who is conducting the research	X	x		
	5	Are the disabled involved in research	X	x		
	6	Is information learnt through research being disseminated back	X	x	x	
Conceptual framework	1	Is there a Table of the organisation	X	x		
	2	Do have therapists have a JD	X	x		
	3	Does management have an understanding of rehabilitation	X	x		
Org Attitude	1	Do the CDC have written objectives	X	x		
	2	What are they	X	x		
	3	Do the rehab dept. have written objectives	X	x		
	4	What are they	X	x		
	5	Are there inter-disciplinary meetings	X	x		
ORG Vision and strategy	1	Do they have a vision and a mission	X	x		
	2	What are they	X	x		
	3	Are there any strategies to achieve them	X	x		
	4	What are they	X	x		

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Structures and procedures	1	Guidelines in place for treatment	X	x		
	2	Guidelines in place for procurement	X	x		
	3	Guidelines in place for training	X	x		
	4	Guidelines in place for administration	X	x		
	5	Rehabilitation staff included in planning of services	X	x		
Individual skills and ability	1	Is in service training one of the priorities of the dept.	X	x		
	2	Does the dept. assist with univ student training	X	x		
Material Resources	1	Adequate space for treatment	X	x		
	2	Adequate storage space	X	x		
	3	Equipment managed	X	x		

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APPENDIX 5

INTERVIEW SCHEDULE

Demographic

1. What catchment area does Elangeni serve?
2. How would you describe the population that you serve at Elangeni?
3. What kinds of pt. make use of the service?
4. What or who are the most prominent stakeholders in your catchment area?

Referral System

1. You said there is a referral system in place – describe that system
2. Are there any procedures /ways of getting service users?
3. Do your ever refer pt. to the next level of care –where to?
4. Follow up of clients (what does that mean? Does that include home visits/ referral to NGO's?)

Type of services

1. Describe the type of service that you render at the centre
2. Do you make use of community worker, volunteers?
3. You mentioned student placement at the centre, does this enhance service delivery and if yes, how?
4. Do you do group therapy?

Vision and Mission

1. What are the vision and the mission of Elangeni?
2. What are the strategies to achieve the above?
3. Do you have written objectives at the centre?

Structure and Procedures

1. Do you have guidelines for treatment?
2. What are your strategies for orientation of new staff?
3. Do you have clear guidelines for admin?
4. How do you do you admin/reporting?

HR Development

1. What type of training is offered to rehab workers?
2. What type of training is offered to volunteers/ HBC?

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Monitoring and Evaluation

1. Describe the process of M&E
2. Is all your documentation standardised?
3. What are you mechanisms for data collection?
4. What are the indicators and targets for the centre?

Describe Elangeni Rehab centre

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APPENDIX 6

Patient Folder Audit Tool											
File nr	Name	Address	Tel	F/N	Diagnosis	Treatment notes	Date	Signature	Sub Eval	Objt Eval	Treat Plan

APPENDIX 7

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

A description and an analysis of the organisational structure at Elangeni Rehabilitation Centre.

REFERENCE NUMBER: NO9/11/322

PRINCIPAL INVESTIGATOR: **Handri Liebenberg**

ADDRESS: **Department of Health**
Cape Winelands District Office
Haarlem Street, Worcester

CONTACT NUMBER: **023-3488108**

CONTACT NUMBER - Health Research Ethics Committee (+27 21 938 9677)

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff or doctor any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee (HREC) at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

The aim of this research study is:

To describe and analyse the manner in which rehabilitation services are delivered at Elangeni Rehabilitation Centre as well as to determine if these services are in line with the

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goals and objectives as written in the National Rehabilitation Policy and selected articles of the UN Convention on the rights of persons with disabilities (UNCRPD).

This study will be conducted in the Drakenstein Sub District with Elangeni Rehabilitation Centre as the main focus. Comparative studies will be conducted at three other rehabilitation sites in the Western Cape.

All relevant role players involved in facilitating and rendering rehabilitation services in the Drakenstein will be interviewed. Rehabilitation clients seen at the Elangeni Rehabilitation Centre during the period March 2010 and June 2010 will also be interviewed. The responses from the interviews will be analysed.

Why have you been invited to participate?

In order to develop a provincial rehabilitation policy for the Western Cape, it is important to receive input from different role players and consumers in the rehabilitation field/process. This is why you have been invited to participate in this research study.

What will your responsibilities be?

To answer the questions as honestly and objectively as you can.

Will you benefit from taking part in this research?

In the absence of an enforceable provincial rehabilitation strategy, your contribution to this study will assist rehabilitation policy makers and managers to shift rehabilitation services from policy to practise and aid in the development of a Provincial Rehabilitation Policy for the Western Cape.

Are there in risks involved in your taking part in this research?

No personal risks.

Are there any costs in your taking part in this research?

No cost.

Will you be paid to take part in this study and are there any costs involved?

There will be no remuneration and your participation in this study is voluntary.

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Declaration by participant

By signing below, I …………………………………..………… agree to take part in a research study entitled *(insert title of study)*.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ....…........……………….. on (*date*) …………....………..

....

Signature of participant **Signature of witness**

Declaration by investigator

I *(name)* ……………………………declare that:………………………………………………….

- I explained the information in this document to …………………………………..
- I encouraged him/her to ask questions and took adequate time to answer them.

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- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use a interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) ....……..........…………….. on (*date*) ………….....………..

....

Signature of investigator **Signature of witness**

Declaration by interpreter

I *(name)* ………………………………………………..………. declare that:

- I assisted the investigator (*name*) …………………..……………………………… to explain the information in this document to (*name of participant*) …………..………….. …………………………………….. using the language medium of Afrikaans/Xhosa.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) ....…........…………………..….. on (*date*) …………....………………...

....

Signature of interpreter Signature of witness

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APPENDIX 8

Name:

Position:

TITLE OF QUESTIONNAIRE: MEASURING THE REHABILITATION SERVICES IN THE DRAKENSTEIN

1. Do you know of any policies in health that guide how services should be rendered?
2. Do you know of any policies relating to rehabilitation service delivery? If yes, can you name them?
3. Can you tell me more about these policies that you named and to which of these documents do you have access to?
4. Have you heard / or seen a copy of the National Rehabilitation policy?
5. Was the NRP part of the curriculum at the institution where you receive your training?
6. Do you know what the National rehabilitation policy is about?
7. Community based rehabilitation (CBR) is one of the strategies in this National rehabilitation policy, what is your understanding of CBR?
8. Do you know about the 7 specific objectives mentioned in the NRP regarding rehabilitation services?
9. Below are the 7 objectives stated in the NRP.

   Describe to what extent each of these objectives is implemented in the Drakenstein and how.

   - Improved accessibility of rehabilitation services
   - Mechanism for intersectoral collaboration
   - Appropriate allocation of resources
   - HR development
   - M&E
   - Participation of persons with disabilities in planning health services
   - Research

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10. Describe the type of rehabilitation service that is rendered at TC Newman CDC and the Drakenstein?

11. Have you heard or seen a copy of the Comprehensive Service plan?

12. What do you know about the CSP?

13. The CSP has 4 categories for rehabilitation services: Page 70

Outcome level service points		**Health care**
Levels 0 & 1	Physiological instability; and Physiological (medical) stability	High acuity: Levels 1, 2 & 3 hospitals and acute medical facilities. Role of rehabilitation professionals: • Curative services & support to medical professional's medical interventions. Rehabilitation outcome: planning towards level 2
Level 2	Basic rehabilitation outcome: Physiological maintenance	Moderate acuity: • Levels 1, 2 & 3 hospitals and out patients departments. • Home-based care. • Sub-acute care, e.g. Life Care, Booth Memorial Hospital. Role of rehabilitation professionals: • Basic rehabilitation interventions Rehabilitation outcome planning towards level 3, e.g. functional training, referrals, training of family, provision of assistive devices, etc.
Level 3	Intermediate rehabilitation outcome: Home / residential re-integration	Low acuity: Sub-acute care, e.g. • Booth Memorial Hospital • Community-based rehabilitation, e.g. Erlangeni • CHCs & home-based care • Rehabilitation OPDs, e.g. all hospitals • Specialised rehabilitation centres, e.g. WCRC Role of rehabilitation professionals • Functional skills training • Training of care-givers and home visits • Mobilisation of community resources Provision of assistive devices.
Level 4 & 5	Advance rehabilitation outcome: Community re-integration & productive activity	Low acuity / medical condition managed: • Community-based rehabilitation. • Vocational rehabilitation units. • Specialised rehabilitation centres. Role of rehabilitation professionals • Advanced functional skills training • Vocational assessment and rehabilitation • Mobilisation of community resources • Advocacy and awareness raising • Work-site / school visits Effecting reasonable accommodations in the work-place

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14. At which level of acuity do you think TC Newman's Rehabilitation service fits in best? Explain your response.

15. Do you think there are barriers in implementing rehab services according to the objectives of the NRP in the Drakenstein and if yes, what are they?

16. Do you think there are facilitators in implementing rehab services in the Drakenstein and if yes, what are they?

17. As a health professional do you have the capacity to render a comprehensive rehabilitation service in your professional field of experience, please explain?

18. Does the organization responsible for the implementation and rendering of rehabilitation services in the Drakenstein have the capacity to do so, in line with the 7 objectives of the NRP (Refer to Question 8). Please elaborate.

Thank you for taking the time and your willingness to complete the questionnaire.

All questionnaires and responses contained therein will be treated confidentially and not shared with other participants. Results will be available on request.

Handri Liebenberg

Stellenbosch University http://scholar.sun.ac.za

APPENDIX 9

Semi structured questionnaire for NGO's in Drakenstein

1. **What is your understanding of rehabilitation?**

2. **Who do you think should be part of the rehabilitation team?**

3. **Does your organization make use of Rehabilitation services?**

4. **What type of rehabilitation services do you make use of?**

5. **Where do you access rehabilitation services and is it easy to access?**

6. **Do rehabilitation professionals render a service at your organization, describe the service rendered.**

7. **Is the rehabilitation service rendered, adequate for your organization? Please explain.**

8. **Does your organization received any assistive devices and from whom?**

9. **Are these devices adequate, please explain.**

10. **Does your organization receive training from rehabilitation professionals, please explain.**

11. **Do you have recommendations for rehabilitation services?**

Thank you for participating, and help us to improve rehabilitation services.

Handri Liebenberg

APPENDIX 10

D. JOB DESCRIPTION OF THERAPIST

KRA	OUTPUT	ACTIVITIES	WEIGHT OF OUTPUT	STANDARD	EVIDENCE	COMPETENCY
To render a clinical otherapy service at health facility level	Optimal outcomes based service	• Conducting consultations • Follow Assessment Procedures • Evaluation • Plan appropriate treatment/ intervention with the client and immediate caregivers • Treatment intervention and implementation and monitoring • Appropriate referrals to the next level of care • Attend scheduled ward rounds • Prepare for group sessions • Educational talks/sessions • Render outreach services to communities in the district • Liaise with other professionals • Education and training of caregivers and clients • Update daily administration	45%	Code of good practice Scope of practice of HPCSA National Integrated Disability Strategy Batho Pele Internal and external policies Core package of primary and secondary services Occupational Health and Safety Act	Quarterly progress reports Patient files Statistics Monthly programmes Consumer feedback Ward round schedule Render OT services Routine supervision	• Assessment skills • Counseling skills • Report writing • Computer skills • Writing skills • Therapeutic knowledge and skills • Communication skills • Interpersonal skills • Conflict management and problem solving skills • Organizing skills • Liaison • Decision making • Facilitation Skills • Ability to work under pressure
Mobility Assistive Devices (MAD)	Manage resources optimally and effectively	• Assess clients for assistive devices • Positioning and seating clients • Complete relevant documentation and maintain waiting list • Issue relevant assistive devices • Request repair and maintenance of relevant devices and apparatus • Order assistive devices required • Record keeping • Management of expenditure • Liaise, network and attend clinic with orthopedic aftercare sister	10%	Assistive device protocol National Integrated Disability Strategy Internal Policies and guidelines Knowledge of procurement procedures when ordering	Utilization of budget Quarterly data Record of assistive devices Assistive device waiting list Repair and maintenance record	• Assessment skills • Counseling skills • Report writing • Computer skills • Writing skills • Therapeutic knowledge and skills • Communication skills • Interpersonal skills • Conflict management and problem solving skills • Organizing/Facilitation skills
Training	• Knowledgeable, competent and effective training	• Plan session • Provide course materials • Organize Venues • Multidisciplinary/ interdepartmental liaison and input	10%	• Service level agreement • Departmental • Procedures/policies	• Development and implementation of training programme • No of clients attending • No of sessions held	• Communication skills • Presentation skills • Facilitation skills • Interpersonal skills • Computer literacy

		• Present lectures • Provide In service training • Assist in workshop planning • Plan informal in service training • Contribute to training as required			• Training material • Training Schedule • Consumer feedback • ¼ reports • Attendance registers	• Knowledge and use of relevant equipment
Rendering a community based service	• Implemented community outreach projects	• Organization of/facilitation projects • Screening, Monitoring and supporting community structures/programs • Coordination of multisectoral projects • Participation and support to appropriate community events • Compile education material for the community(awareness and promotion) • Attend interdepartmental/ community meetings • Community based training • Relevant task teams /Forums	15%	• Service level agreements • Departmental policies and procedures	• Minutes of meetings • Written reports/feedback • Annual programme	• Communication skills • Presentation skills • Facilitation skills • Interpersonal skills • Computer literacy • Knowledge and use of relevant equipment
Disability Grants	Disability grant screening service	• Assessing/screening referred clients for disability grant eligibility • Referral to the next level of care as deemed necessary • Appeal Panel representation/participation as deemed appropriately	5%	Service level agreements Departmental policies and procedures	• Annual program • Referrals • Statistics • ¼ reports	• Assessment skills • Counseling skills • Report writing • Computer skills • Writing skills • Therapeutic knowledge and skills • Communication skills • Interpersonal skills • Conflict management and problem solving skills
Supervision/Admin	Supervise/mentor allocated students & therapists Relevant administration	• Participate in student training and evaluation as required. • Mentoring and coaching of students/ shadowing • Statistics / data(patient head counts, assistive devices • Collate therapy stats ¼ • Monthly report and clinical program. • Attend relevant meetings • Inventory of hospital and rehab assistive devices • Order dept consumables • Ordering and inventory of department equipment as needed • Year/ month program • ¼ reports	15%	Health Services policies Service level agreements with tertiary institutions	• Written quarterly reports and statistics • Service level agreement with institutions • Program for students • Feedback from institutions	• Communication skills • Facilitation skills • Interpersonal skills • Knowledge and use of relevant equipment • Assessment skills • Counseling skills • Report writing

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APPENDIX 11

Letter requesting permission to conduct a research study at Elangeni Physical Rehabilitation Centre

32 Van Goensstreet
Van Riebeeck Park
Worcester
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0836098815
hliebenb@pgwc.gov.za

February 2010

The Management of the CWD office

Attention: Ms Marvina Johnson

RE: Requesting permission to conduct a research study at Elangeni Rehabilitation Centre (ERC)

With reference to our meeting at the CWD office, I would formally like to request permission to conduct a research study in the field of rehabilitation at ERC. The aim of the study will focus on evaluating the organisational capacity influencing rehabilitation services in the Drakenstein area.

Approval has been obtained from the committee for human research at the University of Stellenbosch (Ref Number: NO09/11/322).

The results from the study highlighting both the strengths and limitations of the study, will be made available and presented to the management of the CWD office.

The purpose of this research study is not to place rehabilitation services in the public sector in a negative light, but rather to gain in-depth insight into the world of disability and rehabilitation and how these services can be aligned with policy and literature.

Your approval in granting permission to conduct the research study is appreciated.

Yours faithfully

Handri Liebenberg

Stellenbosch University http://scholar.sun.ac.za

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11 February 2010 **MAILED**

Ms H Liebenberg
Department of Rehabilitation Studies
4th Floor, Teaching building
Stellenbosch University
Tygerberg campus
7505

Dear Ms Liebenberg

"A description and an analysis of the organizational structure at Elangeni Rehabilitation Centre."

ETHICS REFERENCE NO: N09/11/322

RE : APPROVED

At a review panel of the Health Research Ethics Committee that was held on 30 November 2009, the above project was approved on condition that further information is submitted.

This information was supplied and the project was finally approved on 10 February 2010 for a period of one year from this date. This project is therefore now registered and you can proceed with the work. Notwithstanding this approval, the Committee can request that work on this project be halted temporarily in anticipation of more information that they might deem necessary to make their final decision.
Please note that the supervisor should please submit a signed investigator's declaration. The questionnaire needs to be submitted for ethics approval, once it has been developed and before it is implemented.

Please quote the above-mentioned project number in ALL future correspondence.

Please note that a progress report (obtainable on the website of our Division: www.sun.ac.za/rds should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.
Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239
The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Hélène Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is

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