AN ANALYSIS OF THE ORGANIZATIONAL FRAMEWORK OF REHABILITATION SERVICES AT A COMMUNITY HEALTH CENTRE IN THE WESTERN CAPE

by

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DECLARATION

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.

Signed:

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ABSTRACT

Background

In the past, a lack of policy guidelines in the area of rehabilitation often resulted in underdeveloped or no rehabilitation services in many areas. This led to the development of The South African National Rehabilitation Policy (NRP) which was finalised in 2000. This policy is guided by the principles of development, empowerment and the social integration of persons with disabilities. It aims to provide improved access to rehabilitation services for all and forms part of a strategy to improve the quality of life of persons with disabilities.

South Africa ratified the United Nations Convention for the Rights of Persons with Disabilities (UNCRPD) in 2001. The UNCRPD is an international rights based document and focuses on equalisation of opportunities for people with disabilities and their inclusion in development.

Aim

The aim of thestudy was to describe and analyse the organizational framework of rehabilitation services at the Gugulethu Community Health Centre (CHC) in Cape Town and to determine if the framework used complied with the objectives of the National Rehabilitation Policy.

Method

This was a case study that made use of both qualitative and quantitative methods of data collection. The Kaplan framework, the objectives of the NRP and the five relevant articles of the UNCRPD were used to design three questionnaires for data collection. The first questionnaire was for service providers and answered by seven participants. The second questionnaire was completed by the Facility Manager of Gugulethu CHC and the third questionnaire was answered by the managers of 2 purposively sampled NGOs in Gugulethu. Qualitative data was collected from interviews held with three of the service providers and the facility manager as well as from two focus groups held with service users.

Results

The results of the study showed that there was some coherence between the rehabilitation services provided and the objectives of the NRP such as good access to the service for clients coming to the Centre for rehabilitation and adequate resources to provide assistive

devices with. However, in other areas there was little or no adherence. Limited evidence of intersectoral collaboration was found. There was no evidence of the inclusion of persons with disabilities in the planning, implementation and managing of rehabilitation services. Similarly services were not monitored and evaluated in a constructive way and while the therapists did engage in skills development activities the suitability of the courses attended for their role is questioned.

Conclusion

The findings showed a facility based curative rehabilitation service that was accessible for clients who came to the facility, but did not expand to provide community based rehabilitation. Thus it was concluded that the organisation in its current form lacked the ability to effectively address the needs of the community that it served. At Gugulethu Community Health Centre rehabilitation services need to be planned according to community based rehabilitation strategies by the manager, the service providers and the community. Only when implementation of the NRP and UNCRPD takes place will the benefits become tangible to the entire community.

Key Words

Rehabilitation, Disability, National Rehabilitation Policy, UNCRPD, Organisational capacity.

ABSTRAK

Agtergrond

In die verlede het 'n gebrekaanbeleidsriglyne in die rehabilitasievelddikwelsgelei tot onderontwikkelde of geenrehabilitasiedienste in baiegebiede. Die gevolghiervan was die ontwikkeling van dieSuidAfrikaanseNasionaleRehabilitasieBeleid (NRB) wat in 2000 gefinaliseer is. Die fokusvan hierdiebeleid is ontwikkeling, bemagtiging en die sosialeintegrasie van persone met gestremdhede. Die doel van die NRB is omtoeganklikheid van rehabilitasiediensteviralmalteverbeter en ditvormdeel van die strategieom die lewensgehalte van persone met gestremdhede to verbeter.

SuidAfrika het die VerenigdeNasies se Konvensievir die Regte van Persone met Gestremdhede in 2001 bekragtig. HierdieKonvensie is 'n internasionaleregsgebaseerdedokument and fokus opgelykeregtevirpersone met gestremdhede en hulinsluiting in ontwikkeling.

Doelstelling

Die doel van die studiewas om die organisatorieseraamwerk van die rehabilitasiedienste by die GugulethuGemeenskapsGesondheidssentrum in Kaapstadtebeskryf enteontleed, ten eindevastestel of die raamwerk, in ooreenstemming is met die doelwitte van die NasionaleRehabilitasieBeleid.

Metode

`n Gevallestudie is gedoen. Data is deurmiddel van kwantitatiewe en kwalitatiewemetodesingesamel. Die Kaplanraamwerk, doelwitte van die NasionaleRehabilitasieBeleid en toepaslike 5 artikels van die VerenigdeNasie se Konvensievir die Regte van Persone met Gestremdehede is gebruikomdrievraelysteteontwerp. Die eerstevraelys was virdiensverskaffers en sewedeelnemers het ditbeantwoord. Die tweedevraelys is deur die Fasiliteitsbestuurder van GuguletuGemeenskapsGesondheidssentrumbeantwoord en die derdevraelysdeur twee bestuurders van twee doelbewustegekoseNie-staatsOrganisasies in Guguletu. Onderhoude is met drie van die diensverskaffers en die fasiliteitsbestuurdergebruikomkwalitatiewe data in tesamelsowel as twee fokusgroepe met diensverbruikers.

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Resultate

Die resultate van die studietoondatdaarwel 'n mate van belyningtussenrehabilitasiedienste by die studiesentrum en die doelwitte van die NasionaleRehabilitasieBeleid is. Ditsluit in goeietoeganklikheidna die diensvirklientewat die sentrumbesoekvirbehandeling en voldoendebronneomhulpmiddelstevoorsien.In andergebiede was daaregter min of geenbelyningnie. Daar is min bewyse van intersektoralesamewerking en geenbewyse van die insluiting van persone met gestremdhede in die beplanning, implementering en bestuur van die rehabilitasiedienstenie. Dienste is nie in 'n opbouendemaniergemonitor of ge-evalueernie en terwyl die terapeutewelaanontwikklingsprogrammedeelgeneem het, kan die toepaslikheid van die kursussebevraagteken word.

Gevolgtrekking

Die bevindingswys op 'n kuratiewerehabilitasiedienswattoeganklik is virklientewatna die sentrum toe kom. Daar word egterniegemeenskapsbaseerderehabilitasieverskafnie.Dus, is die gevolgtrekkingdat die organisasie in syhuidigevormnie die vermoe het om die behoeftes van die gemeenskapwatditdien, effektiefaantespreeknie.Dierehabilitasiedienste by GuguletuGemeenskapssentrummoetbeplan word volgensgemeenskapsgebaseerderehabilitasiestrategiee, deur die bestuurder, diensverskaffers en die gemeenskap. Eerswanneer die NasionaleRehabilitasieBeleid en die VerenigdeNasie se Konvensievir die Regte van Persone met Gestremdhedetoegepas word sal die helegemeenskapbaatvind by rehabilitasie.

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GLOSSARY OF TERMS

Accessibility

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 (Wikipaedia).

Community based Rehabilitation

Community based rehabilitation (CBR) incorporates social integration, the equalization of opportunities and community development. Participation of people with disabilities and their families is seen as an integral part of CBR (Rule, Lorenzo & Wolmarans, 2006).

Disability

Disability is an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual and that individual's contextual factors (environmental and personal factors) (WHO, 2001a).

District Health System

The District Health System is the vehicle by which Primary Health Care is delivered (DHO, 2003).

Primary Health Care

Primary Health Care (PHC) is an approach to health care that promotes the attainment by all people of a level of health that will permit them to live socially and economically productive lives. PHC is health care that is essential, scientifically sound (evidence-based), ethical, accessible, equitable, affordable, and accountable to the community (WHO, 1978). Primary Health Care addresses the main health care problems of the community by providing promotive, preventive, curative and rehabilitative services. It requires that the community participates in the planning, organization and control of the health care services. The main aim is to create a healthcare system that is cost effective and focuses on prevention, health promotion and rehabilitation rather than curative services. PHC is objectives based and it recognises that performance must be measured against a defined set of objectives. The primary objectives of the primary health care system as a whole, and of the programs and

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services within it must relate to consumers, rather than to policy makers, programmes or providers (Sibthorpe,2004)

Rehabilitation

Rehabilitation is the word used to describe ways of helping people with disabilities to become fully participating members of society, with all the benefits and opportunities of that society (OSDP, 1997).

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LIST OF ACRONYMS

AIDS	Acquired-immune Deficiency Syndrome
CBR	Community based Rehabilitation
CHC	Community Health Centre
CRPD	Convention on the Rights of Persons with Disabilities
DHS	District Health System
DOH	Department of Health
DPO	Disabled People's Organization
DPSA	Disabled Persons South Africa
HIV	Human Immunodeficiency Virus
ICF	International Classification of Functioning, Disability and Health
IYDP	International Year of Disabled Persons
ILO	International labour Organization
INDS	Integrated National Disability Strategy
KMP SSO	Klipfontein Mitchells Plain Substructure Office
MDHS	Metro District Health Service
NGO	Non-Governmental Organization
NRP	National Rehabilitation Policy

OSDP	Office of the Status of Disabled People
OT	Occupational Therapy
PGWC	Provincial Government Western Cape
PHC	Primary Health Care
PT	Physiotherapy
PWD	People living with Disabilities
SAHRC	South African Human Rights Commission
SANPAD	South Africa Netherlands Research Programme on Alternatives in Development
TB	Tuberculosis
UN	United Nations
URDR	Unit for Religion and Development Research
WHO	World Health Organization

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CHAPTER1: INTRODUCTION

1.1. Outline of Chapter

This chapter covers the aims and objectives of the study. In addition it presents the background to the study, the study problem and the motivation for the study, as well as the significance of the study and ends with an outline of the study.

1.2. Background

As early as 1997 the office of the Deputy President of South Africa released the Integrated National Disability Strategy (INDS) (OSDP, 1997) in which the South African government committed itself to treating disability as a human rights issue. According to the INDS rehabilitation services have traditionally been neglected in South Africa. Traditionally rehabilitation services have been provided by the health sector and as there was no policy on rehabilitation these services were fragmented and uncoordinated. The INDS proposed a national rehabilitation policy to provide guidance to rehabilitation services and service providers in order to create rehabilitation services that would enable people with disabilities to reach and maintain optimal functional levels (OSDP, 1997). This led to the development of the National Rehabilitation Policy (DOH, 2000).

The National Rehabilitation Policy (NRP) was finalised in 2001. Development, empowerment and social integration of people with disabilities are all addressed in this policy. The aim of the policy is to improve accessibility for all to all rehabilitation services and thereby improve the quality of life of people with disabilities. The NRP defines what rehabilitation services should be provided to meet the needs of South Africa's population, but it allows local governments to decide how they will provide the services in each location, how standards will be achieved and how services will be monitored and evaluated (DOH, 2000).

The NRP states that rehabilitation services must be delivered as part of Primary Health Care (PHC) according to Community Based Rehabilitation (CBR) principles (DOH, 2000). The PHC approach, on which health care service delivery in South Africa is based, highlights the need for services at community level to be comprehensive and of a developmental fashion (DOH, 2003). The purpose of implementing the PHC approach was to transform South African health services from a segregated, inequitable service (Kautzky & Tollman, 2008) to an equitable service.

PHC provides a single unified health system to the whole population. Community participation is essential in PHC. The provision of PHC must be at a cost that can be maintained by the community and the country (WHO, 1978). A PHC approach challenges societies to identify and address the causes of poor health in their communities and make provision for basic health needs. It encourages communities to become empowered. PHC includes promotive, preventive, curative, rehabilitative and palliative services (WHO, 1978). Although rehabilitation is considered one of the components of primary health care, it is rarely included in Primary Health Care programmes (Mpofu, 1995).

Community Based Rehabilitation was developed in the 1980s, and its aim was to give people with disabilities access to rehabilitation. According to CBR policy rehabilitation must be provided in communities and where possible using local resources. Disabled people themselves, their families and their communities were to be trained to become involved with CBR, together with health and other services. New CBR guidelines were launched on 27 October 2010 by the 4th CBR Africa Network Conference (CAN). The new guidelines support the inclusion of disabled people in health, education, employment, skills training and other community services (WHO, 2010).

Rehabilitation is the word used to describe ways of helping people with disabilities to become fully participating members of society, with all the benefits and opportunities of that society (OSDP, 1997). It is more than a physical endeavour and not only about the body or mind but about living (Hammel, 2006). Rehabilitation can occur at any time in a person's life and can be a single intervention or there can be multiple interventions. The period of the intervention is usually limited. Interventions can be specialised such as those provided by rehabilitation professionals but can also be basic, such as when provided by a community rehabilitation worker or by a family member (WHO, 2010). Rehabilitation should not be seen as a service or product supplied by professionals. It is a service or process in which all stakeholders are involved (WHO, 2010).

There are certain rehabilitation interventions that should be delivered at primary level to prevent secondary complications and to ensure that clients reach optimal outcomes (DOH, 2007). Rehabilitation services at primary level should include screening and assessment services as well as education, training and support of patients, families and caregivers. Patients discharged from district, secondary and tertiary hospitals needing rehabilitation services should be followed up and therapeutic and support groups set up. Basic seating services with wheelchair and buggy prescription and issue should be available as well as prescription and supply of required assistive devices. Finally, rehabilitation services at

primary level should facilitate a basic level of independent self-care, communication and mobility (DOH, 2007). These services should concentrate on health promotion strategies to decrease and change physical and attitudinal barriers and thereby facilitate the functionality and participation of persons with disabilities (Hammel,2006).

Certain minimum requirements must be in place to ensure that an organization such as a Community Health Care Centre has the capacity to deliver rehabilitation services. Among these requirements are physical aspects such as space and resources as well as less tangible aspects such as attitude and culture (Kaplan, 1999). Space must be available for rehabilitation intervention as well as for administrative support and storage. This space should be accessible and meet universal access standards (DOH,2007). Rehabilitation therapists need to be employed and need to form part of the primary health care team. There must be adequate budget allocations to ensure the provision of mobility and other assistive devices. If these resources, both human and physical, are not in place there will not be capacity to provide rehabilitation services. As important as resources are the understanding the organisation has of the community it serves and its role in the community as well as the attitude and culture within the organisation are very important (Kaplan, 1999).

This study aims to describe and analyse the organisational capacity of an institution that provides rehabilitation services at primary health care level in South Africa and to assess whether the practices at the organisation under study adhere to NRP principles.

Such a description and analysis must be based on sound theoretical principles. The various elements of organizational capacity do not operate in isolation from each other but rather serve to support each other(Frederickson & London,2000). Therefore when describing and analysing the capacity of an organisation to deliver the rehabilitation services, as in the current study, a theoretical framework that acknowledges the interdependence between the different elements is required. The Kaplan model, was identified as such as a framework and selected as the framework to underpin the study (Kaplan, 1999).

1.3. Theoretical Framework that Underpins the Study

This research was embarked on by the Centre for Rehabilitation studies in collaboration with South Africa Netherlands Research Programme on Alternatives in Development (SANPAD) to describe the rehabilitation services at 4 institutions in the Western Cape Province and to see if these rehabilitation services were complying with the National Rehabilitation Policy. The study needed to look at whether the mandate given by the National Department of

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Health is supported by resources at the various centres and whether these centres have the structure to deliver these services. In the past the Centre for Rehabilitation Studies had been given the mandate to evaluate an organization and had used the Kaplan framework (Lorenzo, Mji, Gcazi & McKenzie, 2006). Based on that experience the SANPAD team leaders felt that it could be used in this study too. The Kaplan framework looks at how an organization functions and explores six areas. Kaplan has ascertained that for any organization to be effective and have the capacity to impact positively on the community that it serves, six elements must be present and the researcher has represented this in a diagram (Figure 1.1)(1999). The first of these elements relates to the organization's understanding of the world in which it functions and how it is reflected in a conceptual framework. Following on the conceptual framework the organization must have an organizational attitude which includes an acceptance of responsibility for surrounding conditions and the confidence to act in a way which it feels will be effective. There must be a clear organizational vision and strategy with a sense of purpose and will. The vision and strategy of the organization must be supported by the structures and procedures used in that organization. Finally, staff must have the individual skills and abilities required to impact the needs of the community as well as sufficient and appropriate material resources.

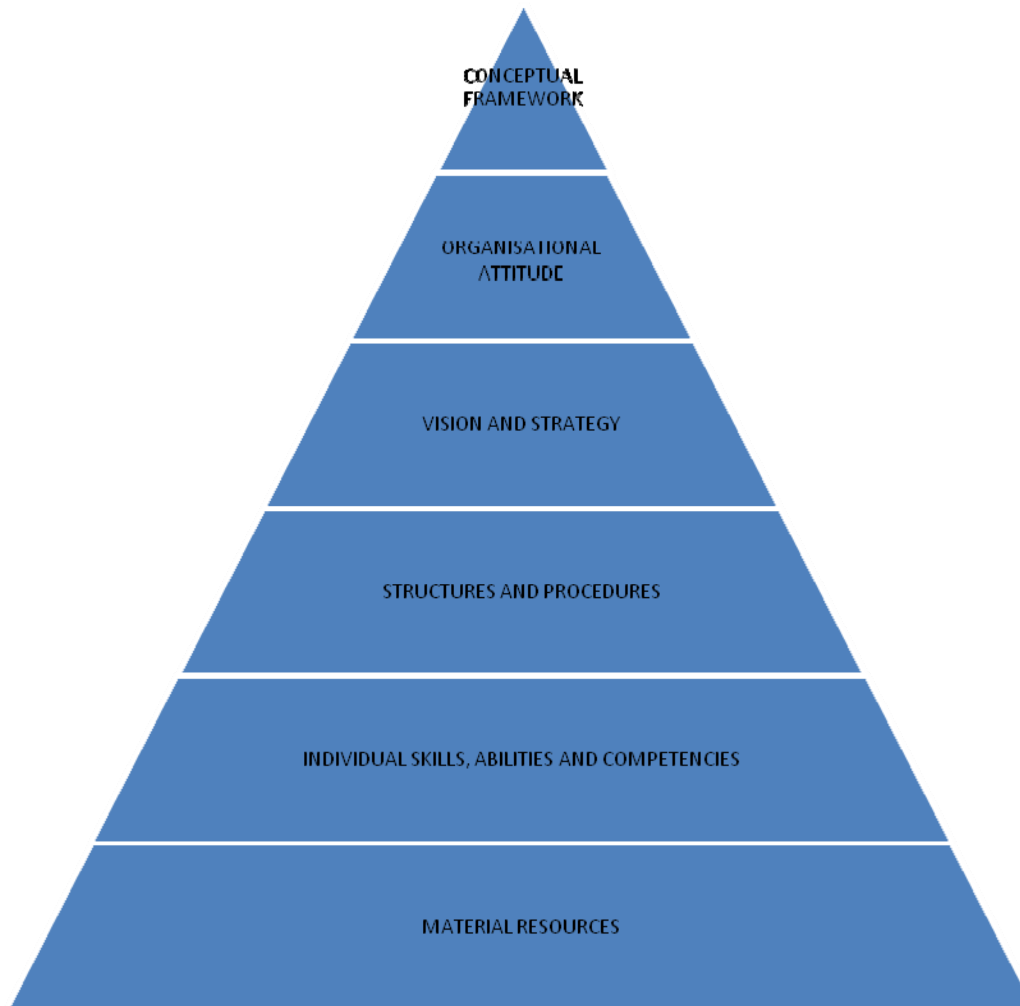

Figure 1.1 Diagrammatic Presentation of the Kaplan Framework

One is able to easily measure and quantify the elements at the bottom of the hierarchy. It is more difficult to assess the elements nearer the top of the hierarchy and they are often observable only through the effects they have. However, they largely determine capacity. The framework describes the elements of capacity but it cannot predict or determine change processes. The framework will be discussed in more detail in Chapter Two.

1.4. Evolution of the Study

This study forms part of a larger project being undertaken by the South Africa Netherlands Research Programme on Alternatives in Development (SANPAD). SANPAD facilitates and finances research projects. It also assists with capacity building and research support. The aim of the overall SANPAD project was to critically analyse the implementation of rehabilitation services at four selected rehabilitation sites in the Western Cape Province with regards to the impact of these services on clients' lives, the alignment of services with the

National Rehabilitation Policy (NRP) (DOH, 2000) and compliance of services to the relevant sections of articles 9,19,20,25 and 26 of the United Nations Convention on the Rights of People with Disabilities (UNCRPD) (UN, 2006).

The four centres chosen all differed from each other. The first centre is a specialized inpatient rehabilitation centre in an urban area which admits both private and public patients. The second is an outpatient rehabilitation centre in a semi-rural area. The third and fourth centres are rehabilitation departments within 2 community health centres in an urban area. One of the centres is managed and run by a university department and the other three by the health department.

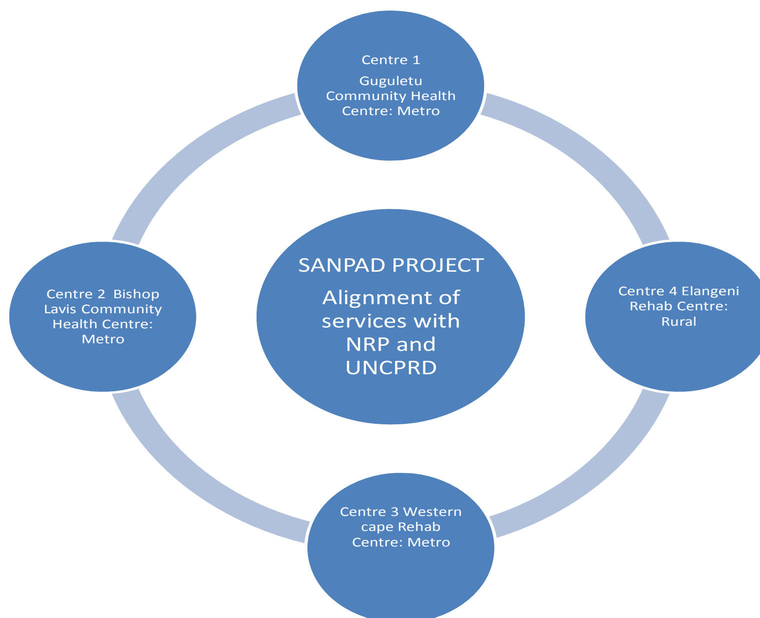

Figure 1.2 The four study centres included in the SANPAD study

The SANPAD research team consisted of two staff members of the department of rehabilitation studies at the University of Stellenbosch, one of which was the research leader, a physiotherapy lecturer from the University of the Western Cape, a physiotherapy lecturer from the Physiotherapy department of the University of Stellenbosch, who was the research co-ordinator, as well as one of the PhD students, and ten other students. The ten students consisted of two more PhD students and eight Masters students. The three PhD students were looking at three different aspects of the objectives of the SANPAD project. The first PhD candidate was analysing the gap between the Policies for Rehabilitation and the practice at the four sites. The second PhD candidate was investigating the Processes of

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Care at the four sites. The third PhD candidate planned to look at the development perspective of the occupational needs of clients during rehabilitation.

Four of the Masters students looked at evaluating the organizational structure and function of the rehabilitation services at each of the four sites identified by the project. Thus this study and three other studies had similar problems, aims and objectives and followed similar methods, but were implemented in different settings. The other four Masters students studied the outcomes of the rehabilitation services offered at the same four identified sites (Figure 1.2).

This team met fortnightly for nearly a year to design and implement the methodology of the SANPAD study. Part of this was the process of developing key indicators and designing the various questionnaires for evaluating the organizational structure and function of the rehabilitation services at each of the four sites. This was a participatory process and it involved a collaborative effort between universities and team members. The process is described in detail in Chapter 3.

When the original proposal for the SANPAD project was done the conceptual framework was based on three documents; the NRP, the 5 relevant articles of the UNCRPD and the CBR matrix. The reason for this was that it seemed as if rehabilitation service delivery in the Western Cape Province had never been measured against the objectives of the NRP and the recently ratified UNCRPD. The NRP was adopted in 2001 but there was a perception that little attention and resources had been made available to ensure a move from policy to practice in rehabilitation service delivery (Mji, Chappell, Statham, Mlenzana, Goliath, de Wet & Rhoda, 2013). The NRP emphasises the use of CBR as a strategy to deliver rehabilitation services and thereby the empowerment and full community integration and participation of disabled persons. Very little evidence exists regarding the impact and effect of this strategy. The UNCRPD is the latest instrument that raises the issues of equity for persons with a disability. Five of these articles are directly related to rehabilitation services. Results from this study can assist to identify gaps within rehabilitation services and the NRP and can use the UNCRPD as a benchmark.

This study particularly focussed on the analysis of the organizational capacity of rehabilitation services at Guguletu Community Health Centre (CHC) in Cape Town and the implementation of the National Rehabilitation Policy in services offered at this CHC.

1.5. Study Problem

As can be deducted from the glossary of terms and background discussion the definitions of rehabilitation have expanded the work of therapists to be more comprehensive and all-encompassing in recent years (DOH, 2003). Rehabilitation does not stop once a client is physically able to perform various tasks but has to include reintegration into the community and productive life. In addition it does not start with the referral of somebody with a disability, but with health promotion and disability prevention strategies in communities (Harrison, 2005).

As hospital-based rehabilitation has steadily declined, the provision of rehabilitation falls more and more on the shoulders of rehabilitation service providers in the community (Smith & Roberts, 2005).There is now pressure on therapists working at primary care to provide acute services to clients who have been discharged from tertiary and secondary hospitals as well as to provide services in the community. Due to a lack of resources these professionals are few in number and rarely comprise the full complement of professionals associated with a rehabilitation team. Of the 39 Community Health Centres in the Cape Town district only 20 employed rehabilitation professionals. All 20 offered physiotherapy but only half offered occupational therapy and only 2 had speech therapy (provided by speech therapy students) (Rhoda, Mpofu & DeWeerdt, 2009). Thus in the Western Cape primary health system it is seldom that more than one therapist forms a rehabilitation team. In research done at Bishop Lavis Community Health Centre it was also found that although a team of professionals was employed at the centre, they were not all actively involved in the rehabilitation of clients (Rhoda, 2002).

Thus there is increasing pressure on therapists working at primary level to see more clients and also expand their services into the community as stated in the objectives of the National Rehabilitation Policy. However the service is challenged by infrastructure and resource limitations and there is lack of evidence regarding the outcome and impact of these services. Thus the SANPAD study and as part of it, this study, evolved.

1.6. Study Aim

The aim of the study is to describe the rehabilitation services delivered at a Community Health Centre, located in the Cape Town Metropole Health District, and to determine if the rehabilitation services delivered at the Community Health Centre comply with the objectives of the National Rehabilitation Policy.

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1.7. Study Objectives

The objectives of the study are:

1.7.1.To conduct, in conjunction with the SANPAD team, an extensive literature review on the policy implementation in rehabilitation service delivery. This review assisted the research team to:

- develop instruments for the evaluation study
- develop key indicators to evaluate the extent of alignment of the rehabilitation services at the Community Health Centre with the objectives of the National Rehabilitation Policy

1.7.2. To describe the context of the Community Health Centre:

- catchment area
- community profile
- socio-economic profile
- disease profile
- services offered

1.7.3. To describe the rehabilitation service delivery at the Community Health Centre using the KAPLAN framework of assessing organizational capacity:

- conceptual framework
- organizational attitude
- organizational vision and strategy
- structure and procedures
    - access
    - service delivery
    - documentation
    - collaboration, partnerships and participation
    - monitoring and evaluation
- Service providers
    - skills and development
- Material resources

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1.7.4. To describe the service outputs:

- numbers of patients seen
- research
- the experiences of service users

1.7.5. To determine the extent of alignment of services at the CHC with the seven objectives from the NRP.

1.8. Significance of the Study

The National Rehabilitation Policy states the need to develop accessible and affordable rehabilitation services. It also highlights the need to adopt a primary health care approach and strengthen community rehabilitation services.However, no information could be found in the literature on the extent to which NRP objectives are implemented in CHCs in the Cape Town Metro Health District. This study addressed that gap in knowledge in part through providing an account of the extent to which the service offered at one CHC is aligned with the overall objectives of the National Rehabilitation Policy.

The study provided baseline information on rehabilitation services offered in the Community Health Centre. It provided an analysis of the service at the CHC, based on the functioning, the successes and the problems encountered. Finally the study gave recommendations for rehabilitation service planning at the study centre.

The SANPAD study aimed to capacitate the sites that were selected for the study setting, as some of the students that were doing data collection and had registered for Masters study were from the sites and some were also managers of these sites. The knowledge gained and the results of the policy analysis would be taken back to the site. The group itself consisted mainly of students involved in this research project and this strengthened the integrity of the group. The other members of the group were the team leader and two members who acted as consultants and they, as well as the doctorate students, acted as a support structure for the Masters students.

1.9. Study Plan

The study will be discussed in detail in the following chapters:

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- Chapter 2 provides a literature review focussing on the concepts of disability, functioning and participation restrictions and the policies developed around disability. Rehabilitation will be discussed with the emphasis on the concepts and merits and demerits of the planning and implementation of Primary Health Care and Community Based Rehabilitation in a district health system.
- Chapter 3 discusses the development of the key indicators and the research questionnaires.
- The methodology, including study design, setting, populations, data collection and analysis, is outlined in Chapter 4.
- The results are presented in Chapter 5.
- In Chapter 6 the research results are discussed.
- Chapter 7 contains the conclusion and recommendations of the study.

1.10. Summary

In this chapter the background of the study is reviewed. It starts with the commitment of the South African government in 1997 to treat disability as a human rights issue and the subsequent development of the National Rehabilitation Policy. It looks at how the National Rehabilitation policy was influenced by the Primary Health Care approach as well as by Community Based Rehabilitation and how these all encourage community participation and empowerment.

The study aims to analyse the organizational capacity of an institution by using the Kaplan model and in this chapter the 6 elements of the Kaplan model are described.The study forms part of a larger SANPAD project and this project and the various role players are described in this chapter.

This chapter then presents the problem being studied and the aims and objectives of the study. Lastly it describes the significance of the study and how it can provide baseline information on a rehabilitation service at a primary health care centre.

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CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

The aim of the study is to describe rehabilitation services delivered at the Guguletu Community Health Centre, and to determine if the rehabilitation services delivered at this complied with the objectives of the National Rehabilitation Policy. In order to describe rehabilitation service delivery it is necessary to place it in context through a discussion of the theory on disability and rehabilitation service delivery as presented by National and International policy documents and scientific literature. Furthermore to determine if policy implementation takes place one needs to place rehabilitation within the realm of primary health care and community based rehabilitation as required by the South African policy documents. Finally, monitoring and evaluation processes of rehabilitation services and ways to assess organisational capacity must be explored. The researcher will discuss the literature relating to these aspects in order to place the study within the bigger theoretical framework (Aveyard, 2007).

2.2. Disability

2.2.1. Disability Definitions and Approaches

Disability is often defined by society and by the extent to which disability and diversity is embraced by a particular society. One society might see disability very differently to how it is perceived in another society (Gregory, 1998, Goodley, 2011). Even while individual persons with disability such as the astrophysicist Stephen Hawking lead talented and admired lives the majority struggle to rise above societal barriers. This struggle is acknowledged by Stephen Hawking in his foreword to the World Disability Report of 2011:

> "But I realize that I am very lucky, in many ways. My success in theoretical physics has ensured that I am supported to live a worthwhile life. It is very clear that the majority of people with disabilities in the world have an extremely difficult time with everyday survival, let alone productive employment and personal fulfilment." (WHO, 2011, ix)

Therefore while we strive to see that disability is an issue of human diversity as argued by Garland-Thomson (2005) and toward an inclusive society where normal and abnormal will become statistical trends and not value laden judgements about people's capabilities (Smith, 2009) we cannot ignore the often debilitating effects of cultural considerations and societal views.

Therefore rehabilitation service providers must take cultural differences as well as economic and materialistic issues into consideration when working in a community (Bury, 2005). Different beliefs in different communities can have it that disability is a punishment and therefore not be inclined to give any financial or other support. Whether a community focuses on individual rights or on the needs of the community, will also impact how disability is viewed in a community. In a very poor and disadvantaged community, the needs of the community might be focused on their own survival, rather than the needs of its disabled members. Furthermore disability is contextual in nature and definitions often need to demarcate a group for a specific purpose such as employment equity (Bampi, Guilhem & Alves, 2010).

Disability approaches can to an extent be divided into two categories i.e. those dealing with the impairment and bodily condition and those that ascribe disability to social, environmental and attitudinal barriers and not individual limitations (Beauchamp-Prior, 2004, Goodley, 2011). The most well known of the individual models are probably the medical model / biomedial approach to disability, but include other approaches such as the philanthropic, sociological and economic approach (Coleridge, 2006).

In the medical model disability is seen as a deviation from normal and a medical phenomenon. The person with the disability is seen as ill and in need of the assistance of a medical professional who can treat and fix the problem. The role of professionals is seen as curing and the rehabilitation process will focus on treatment of impairments. There is an assumption that disabled persons are inferior and cannot take control of their own lives or the rehabilitation process (Coleridge, 2006, Goodley, 2011). It also implies that there can be no social inclusion if the impairment cannot be cured (Hammel, 2006). This model looks at changing the individual rather than a practice that might focus on changing the environment (Hammel, 2006).

The philanthropic definition of disability defines it as a human tragedy and regards persons with disabilities as victims with little control over the circumstances of their lives. It implies that the person cannot do anything to change his circumstances and must just accept his lot

(Coleridge, 2006). The sociological definition regards disability as a deviation from the social norm and holds that people with disabilities are very different and questions whether they should be part of 'normal' society (Coleridge, 2006). The economic definition defines disability as social cost and argues that persons with disabilities uses more resources and contributes less. This definition sees people with disabilities as a drain on society and does not recognise that people with disabilities have a contribution to make to society (Coleridge, 2006).

In response to these disempowering approaches, disabled people have developed the social model of disability. This approach emphasises the role played by the physical, social and political environment in disability and how these contribute to the exclusion of or limit the experiences of persons with disabilities (McColl & Bickenbach, 1998). This approach postulates that disability is caused by circumstances, some through action and others through inaction of society. Thus to ensure full inclusion and participation of persons with disabilities, society as a whole must take action to remove environmental barriers and facilitate universal access. When this approach is used rehabilitation will focus on inclusion of persons with disabilities through social action, such as laws and the removal of environmental barriers (Rule, 2011). In this approach persons with disabilities play the leading role in decision-making about disability related issues such as rehabilitation (Coleridge, 2006, Goodley, 2011).

In the light of the above it is clear that defining disability is no easy task and consequently various definitions of disability exist. In the late twentieth century the most commonly used disability definition was that of the World Health Organisation (WHO) from 1976 which says that if an activity is restricted or cannot be performed in a way which is considered normal for a human being then there is a disability (WHO, 2011). However this definition was widely criticised for its lack of inclusion of societal factors. Consequently the World Health Organisation has changed their definition of disability. The new WHO definition is based on the International Classification of Function, Disability and Health (ICF), a framework for explaining function and disability (WHO 2001a). The ICF defines the word 'disability' as an umbrella term that encompasses a complex interplay between impairments, activity limitations, participation restrictions and environmental factors.

The ICF describes the health and functional status of a person by looking at their body functions and structures as well as the influences of their environment and other personal factors as presented in figure 2.1. The ICF acknowledges that disability is complex, involving the body, the person and the environment (Davis, 2006). The ICF ensures

acknowledgement and allows recording of the impact of the environment on the person's functioning, thus giving guidance towards addressing these issues during rehabilitation (WHO, 2001a). It describes participation and function as an outcome of a complex relationship between a health condition and impairments to body structures and body functions and environmental and personal factors as indicated in figure 2.1 (Davis, 2006).

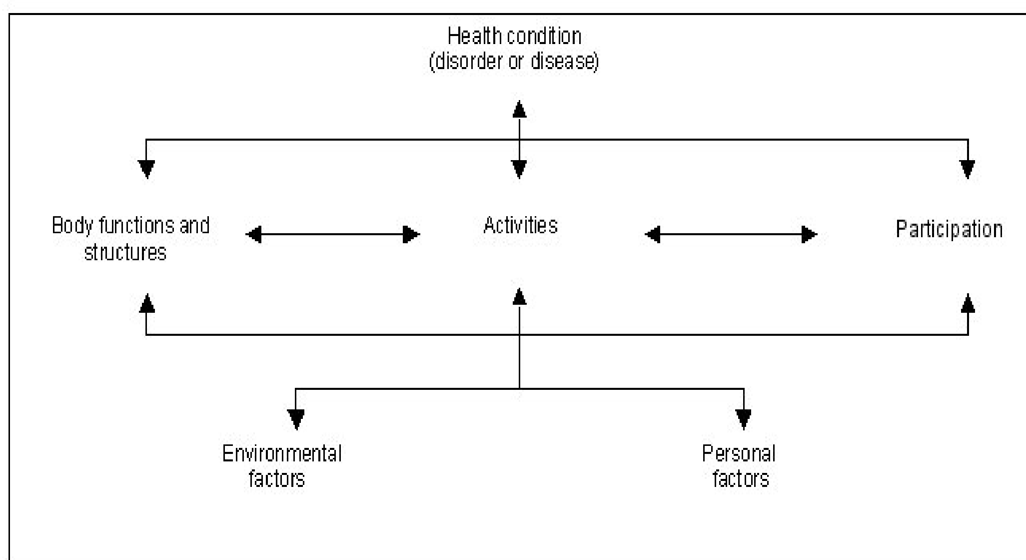

Figure 2.1 Interactions between the Components of ICF

The ICF places the concepts 'health' and 'disability' on a continuum by acknowledging that there are various levels of disability and that anyone can experience some degree of disability (WHO, 2001a).

The ICF is ideally suited to serve as a reference framework to bring order to rehabilitation outcome measurement. It can specify and describe the impact of various variables on functional outcomes through coding. This coding has internationally recognized potential to strengthen rehabilitation at large, by showing through the coding, how the therapeutic intervention can improve outcomes (WHO, 2001a).

Thus, should health professionals use the ICF as framework for rehabilitation service delivery they would focus their interventions on both the impairments, activities and contextual factors. On the one hand they would treat what can be treated and improved such as muscle strength, but at the same time they would focus on removing contextual barriers

such as steps into a house or place of work. Once the individual issues have been addressed the therapist has to look where the barriers are in the community. A natural progression of this approach would then be to address environmental barriers pro-actively through advocacy, and networking in a drive for universal access instead of addressing individual barriers as they are identified in the life of individual persons. As an example, the therapist can form partnerships with other departments and also network in the community and particularly with the people with disabilities in the community (Andrews, Fourie & Watson, 2006).

In accordance with this multifaceted nature of disability many countries are now looking at the continuum approach when measuring the prevalence of disability where the level of disability and functioning is assessed in multiple domains. The Washington Group developed a set of questions which relates to the difficulties that people may experience when carrying out certain activities such as communication, hearing, seeing, walking and self-care (StatsSA, 2011). This method of assessing does lead to higher disability estimates compared to traditional questioning (StatsSA, 2011).

2.2.2. International and National Disability Prevalence Figures

According to the World Health Organization between 15,6% and 19,4% of the world population live with a disability and of these around 2,2% to 3,8% experience significant difficulties in functioning (WHO,2011).

Arriving at a disability prevalence figure for South Africa is more complex. The latest national figures come from census 2011. In census 2011 disability status was determined through the identification of problems encountered in activities as a result of a bodily impairment or physical limitation and whether an assistive device was used or not. These activities included seeing, hearing, walking, communicating, and self-care, remembering and concentrating. Results showed that more than 90% of persons had little or no trouble or limitation when carrying out these activities (StatsSA, 2011). Census data give percentages of persons who experience complete, severe and moderate difficulties in each of these areas, but do not provide an overall disability prevalence figure.

In earlier censuses, disability was defined as a physical or mental handicap which had lasted more than six months and prevented independent daily activities and full participation in educational, economic and social activities (StatsSA, 2011). In Census 2001 in South Africa, the prevalence of disability was shown to be 5% of the population enumerated (StatsSA,

2001) and of these 30% had a physical disability. The UNCRPD country report refers to census 2011 and indicates a disability prevalence of 5,2% (Dept of Women, Children & PWD, 2012). Similarly the UNCRPD country report mentions prevalence of disability in the Western Cape as 4,4% with 3,8% males and 5% females and base their information on census 2011 data (Dept of Women, Children & PWD, 2012).

2.2.2.1. Causes of Disability in the City of Cape Town

The largest single cause of disability in Cape Town is non-communicable diseases, followed by communicable diseases, congenital disturbances and then trauma (Groenewald, Bradshaw, Daniels, Matzopoulos, Bourne, Blease, Zinyaktira & Naledi, 2008). This report done by Groenewald et al (2008) was a joint collaboration between the Western Cape Provincial Department of Health and the City of Cape Town. The data on which the report is based was collected by the City of Cape Town.

The incidence of non-communicable chronic diseases is likely to grow in importance in the next couple of years as more urbanization takes place (Naledi, Barron & Schneider, 2011). These diseases are part of the core package of PHC and yet they are poorly managed in the health system in the whole of South Africa (Naledi et al,2011). The existing prevention strategies and programmes are not successful. Many of these diseases, such as stroke and Chronic Obstructive Pulmonary Disease, can cause impairments and activity limitations which will require rehabilitation input (Pasipanodya, Miller, Vecino, Munguia, Garmon, Bae, Drewyer & Weis, 2007).

With regards to communicable diseases HIV and TB are the main contributors to premature death and disability in Cape Town (Groenewald et al, 2008). Tuberculosis continues to affect South Africa and the Western Cape greatly and Tuberculosis survivors are frequently left with chronic pulmonary disease and this is an important cause of morbidity and mortality (Bae, Drewyer, Hilsenrath, Lykens, McNabb & Miller, 2010). More than half of microbiologically cured TB patients have pulmonary impairment with 10% losing more than half their lung function (Pasipanodya et al, 2007). TB can also present as TB meningitis which can lead to disability especially in children (Kalk, Techau, Hendson & Coovadia, 2013). Also, Tuberculosis can be found in joints and the spine and this too can lead to a physical impairment requiring rehabilitation. Tuberculosis is now aggravated by increasing numbers of drug resistant cases (Health Systems Trust, 2011). It is also fatally associated with HIV and AIDS and the management of both these diseases needs to be integrated.

In 2006 HIV/AIDS was the leading cause of premature mortality in Cape Town. TB is an indicator condition for AIDS and there is evidence that the TB epidemic is being fuelled by the HIV epidemic and this dual impact has a huge impact on the premature mortality in the city of Cape Town (Groenewald et al, 2008). Besides causing increased premature mortality HIV/AIDS can lead to a number of health conditions and impairments that can cause disability and require rehabilitation. Among these are sensory and cognitive impairments. The HIV epidemic is still spreading and according to Swartz, Schneider & Rohleder (2006) there will be an increase in the number of people who develop disabilities secondary to HIV.

The early detection and treatment of children with disabilities and congenital conditions is a problem in the Cape Town area (Cummins, 2002). Many of the needs of disabled children are still not met and continue to be ignored (Saloojee , Phohole, Saloojee & Ijsselmuiden, 2007). Despite increasing public awareness of disability issues and the South African government's strong political commitment to address discrimination and inequalities experienced by children with disabilities there is still a large gap between policies and their implementation (Saloojee et al, 2007).

Accidents and violence are important causes of disability, especially in developing countries where levels of conflict and violence are often high (Emmett, 2006). Even with the huge increase in deaths caused by AIDS the number of deaths due to violence and injuries remains one of the main contributors to premature mortality in Cape Town (Groenewald et al, 2008). In these violent surroundings there are no global or regional estimates of the injury specific causes of disability. Many injuries sustained during a violent episode or as a result of a motor vehicle accident can require some rehabilitation. A study done in Guguletu in 2001 indicated that the level of crime was high and people do not feel safe. Assault and violent crimes account for the death of between 16 and 28% of all deaths in the area as well as causing severe injuries and disabilities (URDR, 2003).

In addition to improving function and inclusion of persons with disability, rehabilitation at Primary level provides the potential to reduce disability through prevention and improving human development. In a developing world persons with a disability often have to deal with poverty and inequity as well as their disability (Loeb , Eide, Jelsma, Ka Toni & Maart, 2008). The study by URDR (2003) confirms abject poverty in Guguletu. People live in poor conditions and have limited access to job opportunities.

2.2.3. Disability and Poverty

One of the environmental barriers that has a severe impact on disability and warrants a closer look, is poverty (Coulson, Napier & Matsebe, 2006).There is a definite connection and close relationship between disability and poverty. Disability causes increasing isolation and economic strain and this increases the level of poverty (Coleridge, 2006). In South Africa Loeb at al (2008) found that in a community similar to that of Guguletu, unemployment was significantly higher amongst those with a disability. However people with disabilities do have access to a disability grant which means that there are fewer disabled people with no income than nondisabled people without any income (Loeb et al, 2008, Emmet, 2006). Even so, people with impairments are more likely to be poor (Eide & Ingstad , 2011, Shakespeare, 2008). This is because the root causes of impairment such as malnutrition, violence, injustices, exploitation and lack of services have the greatest effect on the poor (Eide et Ingstad, 2011, Trani & Loeb, 2012, Yeo & Moore, 2003).

In 2012, people with disabilities made up only 1,4% of the total number of employees in South Africa. There has been a miniscule increase from 1% in 2002 to 1,4% in 2012. Government has set a target of 2% representation of people with disabilities in the Public Service by 2015. This target was originally set for 2005 but was changed to 2010 and then to 2015 because of underachievement (DOL, 2013).

Also, people with disabilities are adversely affected by a lack of access to employment, education and support services (Coleridge, 2006). Disabled people have less opportunity for access to employment and income generation which makes them more vulnerable to poverty (Andrews et al, 2006). Figures from the 2001 census illustrate this connection. The figures revealed that in South Africa only 18,6% of persons with disabilities between 15 and 65 years old were employed, while 34,6% of non-disabled people in this age group were employed. In addition nearly 30% of disabled people had no education while only 13% of non-disabled people had no education (StatsSA, 2001). Census 2011 figures for employment of disabled persons are not available yet.

Guguletu						
WORK STATUS – ECONOMICALLY ACTIVE Aged 15 to 64	Black African	Coloured	Asian	White	Other	Total
Labour Force	13834	104	8	4	69	14019
Employed	7856	56	7	2	61	7982
Unemployed	5978	48	1	2	8	6037
Unemployed%	***43,2%***	***46,1%***	***1,25%***	***50%***	***11,5%***	***43,1%***

Figure 2.2. Economically Active people living in Guguletu (Stats SA, 2011)

As can be seen in Figure 2.2 there is a 43,1% unemployment rate in Guguletu, the area where the current study was performed, according to the 2011 census. While this is lower than the national unemployment rate it is still very high and will have an effect on the employment of disabled people in Guguletu.This is why it is so important that disabled people have access to good rehabilitation services so that they can reach their full potential which will enable them better to compete on the open labour market.

Disability can cause poverty and can be as a result of poverty (Emmett, 2006). Thus it is hardly surprising that the disability movement in South Africa, consisted of mostly poor, black, lay people (Ka Toni &Kathard, 2011).

2.2.4. The Rise of the Disability Movement

The past two decades have seen a dramatic increase in organizations controlled by disabled persons. The disability movement has developed globally at all levels and maintains that disability is a human rights issue and that through discrimination and oppression, disabled persons have been systematically excluded from society and denied the rights, responsibilities and opportunities which lead to full participation in society. The significance of the human rights approach to disability is that it recognizes the fundamental needs of all people and their right to have these needs met (Howell, Chalken&Alberts, 2006).

The African Decade for Persons with Disabilities was from 1999 to 2009. Member states of the African Union were guided by a Continental Plan of Action (CPOA) on how to implement the African Decade. The CPOA has twelve objectives over a wide range of themes critically important for improvement in the lives of persons with disabilities in Africa. Among these themes are ideas and strategies that can be used to formulate and implement national policies, programmes and legislation to promote the full and equal participation of persons

with disabilities. Access to rehabilitation, education, training, employment, sports, the cultural and physical environment by all disabled persons is encouraged and it promotes and protects disability rights as human rights (SADPD, 2008).

In October 2008 it was decided by the African Union, to extend the African Decade for Persons with Disabilities to December 2019. The extension provided the opportunity to evaluate the existing decade and its plan of action. In addition to extending the decade, the African Union has committed to implementing priority strategies which will empower and provide persons with disabilities with equal opportunities, to maintain their rights and to ensure their participation in all developmental programmes (SADPD, 2008). In South Africa the experiences of black disabled people were also strongly influenced by the inequalities and oppression of the apartheid system. Loeb et al (2008) found that there was continuing exclusion of people with disabilities from society at large and before 1994 the situation of disabled people in South Africa was characterised by racially segregated services and policies. They faced inadequate rehabilitation and health services in apartheid hospitals and were discharged back into the same conditions of deprivation and discrimination which had often led to their injuries in the first place and where there was little follow up and aftercare (Du Toit, 1992). While the apartheid system impacted differently on the lives of black and white disabled persons, their experiences collectively shaped the nature and form of Disabled People South Africa (DPSA), the first organization that disabled persons set up themselves in the 1980s in South Africa (Howell et al, 2006). DPSA is controlled and led by disabled persons and has played a central role in shaping the nature of the struggles fought by disabled people in South Africa (Howell et al, 2006). As a result of the concerted efforts of DPSA, the Bill of Rights, as contained in South Africa`s constitution, highlights equality and non-discrimination for disabled people.

South Africa's Constitution of 1996 focuses on the principles of human dignity and calls for the right to freedom and equality for all (Howell et al, 2006). This includes the right to health care, education, housing, social assistance, water and a healthy environment. In spite of this, discrimination at ground level is still present (Nhlapo, Watermeyer& Schneider, 2006). South Africans need to develop a strong human rights culture to assist them in creating an accessible society that will enable full participation of all citizens, including citizens with a disability. The South African Human Rights Commission has a mandate to protect the rights of all its citizens, especially those vulnerable to the abuse of their human rights (Nhlapo et al, 2006). Disabled people fall into this category.

Lobbying, the rise of disability movements and an increased awareness of human rights have led to various national and international drives with the focus on the rights of persons with disabilities. This led to the development of policy documents on disability and rehabilitation of which the UNCRPD is arguably the flagship.It also led to the development of the National Rehabilitation Policy. Both this policy and the UNCRPD were used when designing the questionnaires for this study and the adherence to these two documents is part of the objectives of the overall SANPAD project.

2.3. International and National Disability and Rehabilitation Policy and Guidance Documents

2.3.1. United Nations Convention on the Rights of Persons with Disabilities

The Convention on the Rights of Persons with Disabilities (UNCRPD) developed through a process which started prior to 1981 which the United Nations proclaimed as the International Year of Disabled Persons (IYDP). Equalization of opportunities, rehabilitation and prevention of disabilities were to be emphasized during this year and the slogan was "a wheelchair in every home". The aim was to promote the right of persons with disabilities to participate on equal footing in society. They were to have an equal share of advantages through development and enjoy conditions equal to those of the rest of their communities. The year of the disabled was followed by the International Decade of Disabled Persons which ran from 1983 to 1993. The third of December was proclaimed the International Day of Disabled Persons (UN, 2006).

The Decade of Disabled Persons led to the adoption of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities by the General Assembly of the United Nations on 20 December 1993 (WHO, 2001b). The Standard Rules encourages governments to engage in actions that will achieve the equalization of opportunities for persons with disabilities. Even though these rules are not legally binding they can be used as a basis for policy making (Howell et al, 2006).

The International Decade of Disabled Persons is also recognized as the Preamble of the Convention on the Rights of Persons with Disabilities (UNCRPD) which was the first comprehensive human rights treaty of the 21st century. It was adopted on 13 December 2006 at the United Nations Headquarters in New York. On the 30th March 2007 it was opened for signature and came into force on 3rd May 2008. The Convention marks a shift in attitudes and approaches towards persons with disabilities. Persons with disabilities are to

be viewed as citizens with rights, who can claim those rights, make decisions and be active members of society and not as charity cases. The Convention is intended as a human rights instrument with a social development dimension. It reasserts that all persons with disabilities must enjoy all human rights and fundamental freedoms. It provides clarification on how all the rights and their different categories are applicable to persons with disabilities. It points out areas where adaptations have to be made for persons with disabilities so that their rights are ensured and promotes redress where their rights may have been violated (UN, 2006).

The South African government ratified the convention in 2008. Therefore the country must ensure that the human rights and fundamental freedoms of persons with disabilities are promoted and protected (Lorenzo, 2011). Ratification of the UNCRPD also means that South Africa has to send a report to the Committee on the Rights of Persons with Disabilities every four years (Rule, 2011). South Africa sent its first report at the end of 2012. This report states that the country remains committed to realizing the rights of persons with disabilities. The Ministry of Women, Children and Persons with Disabilities has made recommendations to various government departments and some of the UNCRPD articles have been prioritized. These include equality for persons with disability, awareness raising, accessibility and access to information (Dept of Women, Children & PWD, 2012). The report gives practical examples of how these articles have been implemented.

Implementation of the UNCRPD also means that civil societies need to be developed and capacity needs to be built for change. We also need to develop social networks. Government needs to develop legal policy frameworks that formalize relationships and develop systems that affect persons with disabilities directly. In response to signing the UNCRPD the South African government has created a Ministry for Women, Children and Persons with Disabilities but achieving the goal of equalization of opportunities for disabled people is still an aspiration (Ka Toni & Kathard, 2011). Both government and civil society need to enable disabled people's active participation.

Five articles of the UNCRPD were seen as specifically relevant for the bigger SANPAD study because of their focus on aspects important for rehabilitation service delivery. These specific articles had aspects that could be directly affected by rehabilitation and where rehabilitation services could play a role. A summary of the five articles, their relevance for South Africa and implications for rehabilitation are presented in table 2.1. and further discussed in the text.

Table 2.1. Five relevant UNCRPD articles

UNCRPD Article	Relevance to South Africa	Implication for Rehabilitation
Article 9 Accessibiity, Full participation	Many inaccessible buildings, physical barriers Decreased Mobility No equal opportunities	Access to rehabilitation service hampered
Article 19 Independent living Choose place of living	Inadequate housing. Poverty and lack of education	Dependence on others Lack of opportunities
Article 20 Personal Mobility Access to assistive devices	Availability of Assistive devices	Decreased personal mobility Decreased access Decreased independence
Article 25 High standard of health	Free health care for persons with a disability	Prevention of further disability Screening programmes
Article 26 Habilitation and Rehabilitation	Discrimination, inequities and exclusions	Maximum independence Reach full potential

Article 9

Article 9 deals with accessibility and strives to enable persons with disabilities to live independently and participate fully in all aspects of life. It strives to develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of all facilities and services open or provided to the public.

Relevance of Article 9 to South Africa

In South Africa, there are many institutions, buildings and environments that prevent access of people with disabilities and thus deny them their rights (Coulson et al, 2006). A report by

the South Africa Human Rights Commission encourages people with disabilities to raise public awareness of their rights (SAHRC, 2002). Thoughtless construction often leads to physical barriers. Awareness of the physical environment as a barrier should be heightened (Coulson et al, 2006). In South Africa universal access is necessary for individuals with disabilities to enjoy equal opportunities and benefits. In its report the Human Rights Commission has determined that the accessibility of proposed buildings, alterations and additions must be assessed and approved by local authorities before any building can start. Accessibility must be included in all planning and construction training and education. Until this happens, housing settlements that fail to include barrier-free design elements will continue to be developed and disabled people living in impoverished areas will find themselves unable to move about their communities (Coulson et al, 2006).

Article 19

Article 19 looks at living independently and being included in the community. Persons with disabilities should have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement and should have access to a range of community support services.

Relevance of Article 19 to South Africa

The South African Constitution recognizes that everyone has a right to adequate housing and health care and that the right to education should be enjoyed by all citizens. In the past, the majority of citizens with disabilities were denied basic rights and this resulted in a disproportionate number of people with disabilities affected by poverty, unemployment and lack of education and led to a dependence on social grants (McKenzie, 2011). People with disabilities are still prevented from accessing many societal benefits because of barriers to transport, health care, housing, information, education, welfare services and social security (Coulson et al, 2006).

Article 20

Article 20 looks at personal mobility and strives to ensure personal mobility to enable the greatest possible independence for persons with disabilities. This would include the facilitation of access by persons with disabilities to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost.

Relevance of Article 20 to South Africa

Mobility assistive devices are available at all levels of care and since 2003 are free to clients on a disability grant or a social pension. A policy (DOH, 2009) describes the type of assistive devices that should be available at each level of care. Basic assistive devices are available at primary level with more advanced and complicated devices available at tertiary level only. In the Western Cape the Mobility Assistive Device Advisory Committee formulated this policy and ensures it is implemented.

Article 25

Article 25 deals with health and states that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. This includes early identification and intervention and provision of services designed to minimize and prevent further disabilities.

Relevance of Article 25 to South Africa

In July 2003 the National Department of Health implemented free health care for people with disabilities who are dependent on public health care provision. This move recognizes that disabled persons may require more frequent medical treatment. Provinces differed in the way the policy was applied. In the Western Cape province it was decided to introduce free health care to all persons on a disability grant as well as the social old age pensioners. The reason was that the province did not have enough rehabilitation professionals to assess each client before deciding whether they were disabled and therefore eligible for free health care (Researcher's experience). This means that patients in the Western Cape do not need to wait for an assessment to be done to determine whether they are eligible for free health care. If they are on a disability grant or are in the process of applying for such a grant, all hospital treatments are free as well as all assistive devices. Disability grant applications are done by social workers while the patient is in hospital, but due to patients being discharged from hospitals after very short periods this often does not happen (DOH, 2007).

Article 26

Article 26 looks at Habilitation and Rehabilitation and states that effective and appropriate measures be taken to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life.

Relevance of Article 26 to South Africa

Habilitation or lack thereof is a problem which faces many South Africans, not only those with a disability. Since 1994 many moves have been made to ensure that people with disabilities will not continue to be subjected to the discrimination, inequities and exclusions of the past. These discriminations and inequities included rehabilitation services only being available in hospitals designated for certain racial groups and thereby denying others the service. However, there is still a lot of transformation of buildings, attitudes and environments that needs to take place in South Africa to ensure that people with disabilities are not denied their right to dignity, equality and freedom (Howell et al, 2006).

Rehabilitation is seen widely as an essential part of the health care package as it gives patients an opportunity to reach their full potential (DOH, 2007). Despite this, most rehabilitation programmes lack funding. There is an under-estimation of the potential of disabled people to achieve and therefore an unwillingness to fund services for disabled people (Coleridge,2006). Rehabilitation often focuses on chronic, non-communicable conditions that hold no risk to society and so there is no sense of urgency. Improvement and cure is not always feasible or realistic for rehabilitation and finally, as persons with disabilities are a small minority, they do not influence public policy (Coleridge, 2006, Leavitt,1995). South Africa`s National Rehabilitation Policy and the Alma Ata declaration placed rehabilitation within the realm of PHC.

2.3.2 Rehabilitation as Part of Primary Health Care

The first democratic government was elected in South Africa in 1994. This saw the beginning of policy reform and change in service delivery across all government sectors including health care (Gilson, 1999). With regards to health care specifically the government wanted to address equity and sustainability problems in the health care system as well as the comprehensive needs of people with disabilities at community level amongst other things (Lorenzo, 2011).

According to policy and legislation this was to be achieved through delivering health care according to the philosophy of PHC. The National Health plan for South Africa prepared in 1994 was committed to using the Primary Health Care approach as the underlying philosophy to promote health. In 2004 the National Health Act was promulgated. Its guiding principles use the PHC approach to set up a health system that sees the importance of decentralisation, community participation and good governance (Naledi et al, 2011).

According to the Alma-Ata declaration drawn up at the International Conference on Primary Health Care in 1978 all people have the right to give input into the planning of their health care. It states that governments should aim to have all their citizens reach a level of health care that will allow them to lead socially and economically productive lives. The key to attaining this target is Primary Health Care which addresses the main health care problems of the community by providing promotive, preventive, curative and rehabilitative services. It requires that the community participates in the planning, organization and control of the health care services. The main aim is to create a healthcare system that is cost effective and focuses on prevention, health promotion and rehabilitation rather than curative services (Barron, Shasha, Schneider, Naledi & Subedar, 2010). Community services and home based care should form the backbone of primary health care (DOH,2001a).

The South African Health review of 2011 reports that community health workers must be formally employed as core members of the PHC outreach team. These community health workers would be responsible for screening, education and support (Naledi et al, 2011). They will also act as a liaison between the community and the health facility. In order to provide this service, community health workers need to be trained and this will require co-operation between the health department, academic institutions and professional bodies (Naledi et al, 2011). No mention is made in the review with regard to rehabilitation services but it does recognise that community health workers are crucial in following up referrals and that each community health worker monitors a suggested 250 households in their community (Naledi et al, 2011).

However in an assessment done in 2008 it was found that the PHC system in South Africa was still weak in most places and that patients access the health system at inappropriate levels (DOH, 2009). The implementation of the PHC approach has been neglected in many areas. There has been a delay in taking comprehensive services to communities where they should be emphasising disease prevention, health promotion and community participation (Barron at al, 2010). Not enough attention has been given to the measurement of health outcomes and the massive burden of HIV has diverted much energy, time and resources from focussing on PHC and improving health systems (Barron et al, 2010). This has led to an emphasis on strengthening primary health care and the Department of Health is in the process of reshaping the provision of primary health care (Lorenzo, 2011).

Before 1994 health services were provided in a very discriminatory way. The system was bureaucratic and highly fragmented (DOH, 2001b). The White Paper for the Transformation of the Health Sector in South Africa released in April 1997 contains details on how

reconstruction could be done (DOH, 1997). The decision was made to create a unified but decentralised national health system based on the District Health System (DHS). This system is deemed to be the most appropriate vehicle for the delivery of Primary Health Care. A graphical illustration of rendering PHC services within the DHS is displayed in Figure 2.3 (Barron et al, 2010).

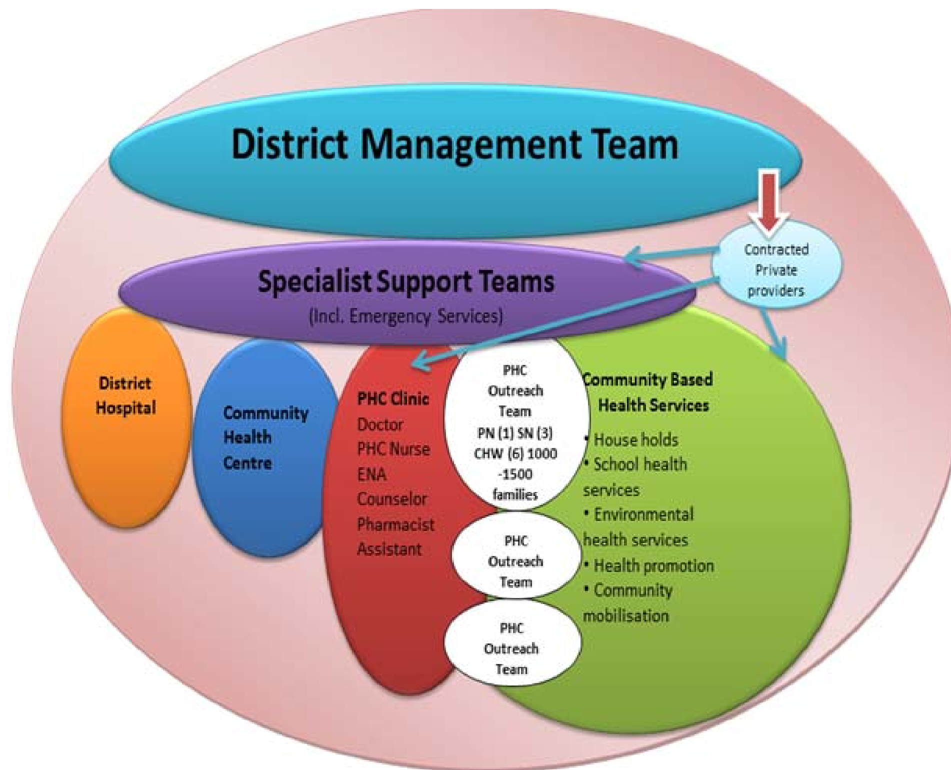

Figure 2.3 PHC model within the District Health System

According to the WHO Global Programme Committee: "A district health system based on Primary Health Care is a more or less self-contained segment of the National Health System. It comprises first and foremost a well-defined population, living in a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private or traditional. A District Health System therefore consists of a large variety of inter-related elements that contribute to health in homes, schools, work places, and communities, through the health and other related sectors. It includes self care and all health care workers and facilities, up to and including the hospital at the first referral level, and the appropriate laboratory, other diagnostic, and logistic support services" (WHO,1995:9).

There are three main types of health facilities within the district, viz district hospitals, Community Health Centres and clinics. Each of these facilities has a defined catchment population and norms and standards for the human resources allocated to each facility. Each Community Health Centre and clinic should have a PHC outreach team which will spend some of its time in the community and some of its time in the clinic. Each community outreach team is responsible for around 1500 households, approximately 6000 people (DOH, 2007). All rehabilitation in the study community was done by therapists based at the Community Health Centre. In this community there are no community rehabilitation workers or other professional rehabilitation workers working in the community.

From 1995 onwards the District Health System was introduced throughout the country. Many organizations, including NGOs and universities have cooperated with the national and provincial departments of health to implement the District Health System. It was decided early on that monitoring and evaluation is an essential and vital part of implementation and a set of indicators was set up by the Centre for Health Policy with the support of the national Department of Health in 1997, to assess each district and to watch their inputs and outputs (DOH, 1997).

However, there have been inefficiencies in the District Health Services which have compromised the ability of the provinces to deliver primary health care (Naledi at al, 2011). The competency of managers has to be improved before the financial and human resource responsibilities can be decentralised to the districts. There are also challenges in providing human resources as a result of insufficient planning and low retention of posts for health staff. The qualitative issues such as competence and knowledge of primary health care have not been assessed (Naledi et al, 2011). There has also been a lack of monitoring and evaluation which has led to suboptimal implementation of appropriate health interventions, which in turn leads to poor outcomes (Chopra, Lawn, Sanders, Barron, Karim, Bradshaw et al, 2009).

Guguletu CHC is part of the Metro District Health Services (MDHS) in Cape Town. The Metro District Health Services has no specific rehabilitation objectives but there are areas where rehabilitation can play a strong role. The eight objectives of MDHS are:

- To strengthen the District Health System
- To better utilise the district hospitals
- To improve chronic disease management
- To expand community based services

- To improve the prevention and management of HIV/AIDS
- To improve TB control
- To improve child health services
- To improve women's health services.

Based on these objectives of the Metro District Health Services the objectives of the rehabilitation services at MDHS are:

- To promote an efficient and effective rehabilitation service at primary level in the Metro and ensure that rehabilitation services are available in each subdistrict
- To improve the quality of care and to implement an appropriate package of service within the community by increasing access to home based rehabilitation
- To promote a healthy lifestyle and reduce the burden of complications of chronic diseases of lifestyle by improving preventive and promotive back care services
- To reduce the impact of condition impairments and disability by increasing the access of children to rehabilitation services (DOH, 2003).

In 2001 an audit was done in each district which highlighted the problems being experienced (DOH, 2001b). The challenges identified included:

- fragmented services
- challenges with inter-professional communication
- a negative attitude amongst professional service providers towards community involvement
- poor planning and evaluation skills
- poor referral systems.

There are limited funds and resources available to improve the situation and all of the above challenges influence the delivery of rehabilitation services. However there is a lot that can be learnt from the international experience in setting up a DHS and South Africa is in a position to learn from these other countries. Brazil has set up the Brazilian Family Health programme which has a team serving a population of 3500. These teams consist of a doctor, nurse, nurse assistant and community health workers and are responsible for PHC services and have seen a significant decline in infant mortality (Macinko, de Fatima de Souza, Guanais & da Silva Simoes, 2007). Infant mortality has declined in Thailand too after the introduction of a PHC programme (Vapattanawong, Hogan, Hanvoravongchai, Gakidou, Vos, Lopez et al, 2007).The purpose of rehabilitation at primary level is to provide a service that contributes to

the prevention of disabling conditions that detects disabilities early so as to prevent complications and to provide a service which prevents the worsening of the effects of a disability (DOH, 2000). Prevention at clinic level would be done by screening and observation at the clinics as well as basic assessments. Counselling and education of clients and family members should also be done at this level.

At a Community Health Centre clients are assessed, managed and referred if necessary. Management can include individual treatment, group treatment, provision of a home programme as well as the provision of an assistive device if necessary. At a Community Health Centre the goal of rehabilitation is to enable individuals to reach their highest possible level of functional independence and a good quality of life. The burden and responsibility of care on family members and significant others must also be reduced as much as possible (Davis, 2006).

At present all rehabilitation in the Guguletu area is being done at the Community Health Centre. Clients seen at clinics or by home based carers in the community are referred to the Community Health Centre to the rehabilitation services there. Some rehabilitation outreach from the Community Health Centre is done to old age homes in the area as well as to three workshops in the area which employ persons with disabilities (Researcher's experience).

Rehabilitation therapists at primary level have an important role to play and need to be flexible and have a wide range of skills to enable them to contribute to the community (Nualnetr, 2009). They need to develop a more client centred and community-oriented rehabilitation service. In a study done by Rhoda et al (2009) they found a shortage of therapists, especially occupation and speech therapists, at clinics in the Western Cape metro. In addition they found that the therapeutic value of rehabilitation services offered at Community Health Centres in the Western Cape was limited because of less than optimal coordination of these services (Rhoda et al, 2009).

PHC and CBR are intrinsically linked as CBR is a means of delivering health services in the primary health care setting. They both focus on the needs of individuals and the wider community. In CBR, rehabilitation extends beyond a purely medical interpretation. CBR is a community based approach to rehabilitation that emerged as an effective strategy for providing rehabilitation services to more persons with disabilities in the developing world (McColl & Bickenbach, 1998).

2.3.3. Community Based Rehabilitation

One strategy that incorporates disability and rehabilitation into an inclusive development is Community Based Rehabilitation (Chappell & Lorenzo, 2012). Community Based Rehabilitation incorporates social integration, the equalisation of opportunities and community development. Participation of people with disabilities and their families is seen as an integral part of CBR (Rule, Lorenzo & Wolmarans, 2006). Community Based Rehabilitation advocates a broader concept of rehabilitation, wider than purely medical rehabilitation. At present most rehabilitation, including the services at Guguletu CHC, the study setting, is still medically orientated (DOH, 2003).

The Community Based Rehabilitation strategy endeavours to prevent disability, provide locally based services and utilise all available resources in the community, including persons with disabilities and their caregivers. Community Based Rehabilitation gives persons with disabilities the ability and power to take action to improve their own lives, and thereby to contribute to the scarce resources available and so benefit all the community (WHO, 2010).

Through CBR people can and should take command of their own health care (Werner, Thuman, Maxwell, Cary & Pearson 1993). Persons with disabilities should be provided with a health service that supports and enables them to live in an environment suitable to their needs and that provides appropriate care, support, and if necessary, rehabilitation. Persons with disabilities and their families must be central to the problem-solving process in a rehabilitation programme and this should lead to a cooperative and equalising process. With this partnership approach, the results are more enabling than when solutions are prescribed for a person with a disability (Werner et al, 1993). According to Werner et al (1993) full integration onto the community of persons with disabilities needs rehabilitation and assistive devices as well as accessibility in terms of physical barriers and transport but it is also very important that these persons are accepted and welcomed by the general population. Whiteneck, Harrison-Felix, Mellick, Brooks, Charlifue & Gerhart (2004) found that attitudinal barriers placed a greater limitation on participation and integration than the underlying impairment.

The World Health Organization (2010) has drawn up the guidelines on how to set up and strengthen a Community Based Rehabilitation service. Programmes for CBR can be local, regional or national, but one must not forget that the services and support for disabled persons and their families need to be as close to their communities as possible (WHO, 2010).

Community Based Rehabilitation aims to:

- Provide people with disabilities equal opportunities, through inter alia, facilitating activities, ensuring access to health and rehabilitation services and supporting the establishment of self-help and support groups
- Emphasise prevention, through the development and distribution of appropriate and up-to- date media on disabilities and promoting adherence to health and safety regulations, road safety tips, prevention of burns in the home
- Provide access to rehabilitation programmes, including assessment of physical, emotional, sensory or communication disorders; provision of assistive devices; counselling and /or education of client and family or caregiver; receiving and sending out referrals to local resources and hospitals.

One CBR model is a top-down approach. This is just an extension of the traditional institution-led model of rehabilitation. This service is led and controlled by the government or NGO and only looks for the participation of people in the community in services that have already been decided on by the professionals (Lysack& Kaufert,1994). In the bottom-up model services are planned, managed and provided by members of the local population (Lysack & Kaufert, 1994). This model acknowledges that the local communities have good knowledge and understanding of their local circumstances and that these are significant strengths which must be utilised. This model is more flexible and as it is responsive to local needs, it is more likely that it will be accepted (Bury, 2005).

Many CBR programmes have been started and developed as a result of professional leadership and they have made good use of the relevant expertise and financial backing (Bury, 2005). Some CBR programmes have been developed in response to local needs. One such programme is that referred to as outreach. These programmes are run by professional health care workers who provide advanced professional care which directly addresses patients' pathology, impairments, and / or disabilities and does not look at any of the environmental factors (Kay, Newman, Cavallo, Ezrachi, & Resnick, 1992).

Another criticism of the outreach approach is that it places too much responsibility on the individual and all but ignores the barriers that prevent full intervention of people with disabilities into their communities. These barriers are not only physical such as inaccessible buildings, problems with transport or lack of interpreters but also attitudinal which often presents as discrimination (Chappell & Johannsmeier, 2009). In this case more attention should be given to facilitate integration into the community by addressing the environment.

Pollard & Sakellariou (2008) found that without full community participation it is very difficult to sustain an effective CBR programme. Therapists also realised that they have to work with whole communities not just the disabled in the community. This is not easy as they are often working in unfamiliar social and cultural environments, which can lead to misunderstandings.

It is important that therapists focus on the needs of the wider population and allow persons with disabilities to participate actively and make decisions. Therapists should be programme facilitators rather than programme leaders and in this way improve the quality of life of persons with disabilities by using a CBR strategy (Nualnetr,2009).

The South African government is planning to introduce community health workers with rehabilitation skills. Naledi et al (2011) warns that this introduction must be carefully planned as it will introduce a different level of teamwork between the professionals and these health workers. Each has a unique role and contribution and an important part to play in the health team (Naledi et al, 2011).

The White Paper on an Integrated National Disability Strategy (OSDP, 1997) proposes that Community Based Rehabilitation should serve as the basis for the Rehabilitation Strategy. It also proposes that people with disabilities, as well as their families, should be involved in rehabilitation. The political changes after 1994 in South Africa led to change in health care policy and service delivery and this health care policy underpins the delivery of rehabilitation.

2.3.4. The National Rehabilitation Policy

The National Rehabilitation Policy is a formal policy guideline to assist in the facilitation of rehabilitation programme implementation in South Africa. It aims to achieve equitable services across all provinces as well as conforming to the basic standards of rehabilitation service provision.

The objectives of the NRP are to improve accessibility of rehabilitation services for all and to establish mechanisms for intersectoral collaboration to implement a comprehensive rehabilitation programme. It also aims to facilitate appropriate allocation of resources as well as facilitate human resource development. Monitoring and evaluation strategies for rehabilitation programmes are encouraged and it aims to ensure that people with disabilities participate in the planning, implementation and monitoring of rehabilitation programmes. The NRP also encourages research projects and initiatives in rehabilitation (DOH, 2000).

The NRP has service monitoring and evaluation as one of its objectives, but McClaren, Philpott, Chappell & Roberts (2006), when doing a national audit on research into disability, found that there was no evidence of rehabilitation services being evaluated in South Africa. Without evaluation one cannot demonstrate the impact of rehabilitation and this could hamper the sustainability of a rehabilitation programme (Hartley, 2002).

The NRP was adopted in 2001 but no evidence exists that rehabilitation services have been implemented according to the objectives set out in the NRP (Mji et al, 2013).

2.4. Rehabilitation

Rehabilitation services are recognised as having fundamental importance in improving the quality of life and functionality of people with disabilities. Persons with disabilities suffer not only from discrimination because of prejudice and ignorance but also because of lack of access to essential services such as rehabilitation (Chappell & Lorenzo,2012).

Rehabilitation starts with the identification of the person’s problems and needs and relating these to relative elements regarding the person and their environment (WHO, 2011). Rehabilitation goals are then defined, planning done and then the measures are implemented and later assessed. Persons with disabilities and their families have much better outcomes and experience better functioning and health when they are partners in the rehabilitation process (WHO, 2011).

Before 1990 there was no strategy or guideline for rehabilitation in South Africa and this meant that rehabilitation services were implemented haphazardly which resulted in huge variances in rehabilitation services across the country. Services were underdeveloped or non-existent in many parts of the country and there was a disparity in resources (Naledi et al, 2011). There was also no monitoring and evaluation of services. Rehabilitation was seen as a health issue only and services and stakeholders were not clearly defined (DOH, 2000). The National Rehabilitation Policy as discussed above was conceptualised to address the shortcomings of the rehabilitation services.

Based on the definition of rehabilitation as presented in the glossary of terms, rehabilitation is an active, dynamic, continuing process concerned with the physical, social and psychological aspects of a person. Rehabilitation aims to improve an individual’s health functioning and the goals of rehabilitation will depend on the individual’s impairments, the environment he finds himself in and the attitude of the people around him. Functional

outcomes as hallmarks of patient centred care need to be emphasised (DOH, 2000). The patient needs to be involved in the planning of the treatment to reach a functional outcome which will improve the quality of his/her life.

Rehabilitation services can be provided in various settings. The services can be at a hospital, at a community health centre, at a clinic or at a specialist rehabilitation centre. The services can also be provided within the client's home or elsewhere within the community, such as old age homes or community centres. Ideally a continuum of care should provide seamless movement for clients between the various settings. Rehabilitation should start when the disabled person enters into the health system and it should continue until the individual is able to be re-integrated into their community (DOH, 2003). The point of entrance is often at primary level. In South Africa health care at primary level is often provided by Community Health Centres. Rehabilitation should thus be available at CHCs. The CHC in this study offers rehabilitation as part of a basic care package. The intensity of rehabilitation intervention at the study setting is low to moderate.

Most health care professionals recognise the models of Institution-based rehabilitation and outpatient services and these are the models that have historically influenced universities providing training for health care professionals. Health care professionals have developed and driven these services. Now there is an increasing emphasis on service user involvement when developing future models of health service delivery. However, this concept is relatively new and needs to be developed (Futter, 2003).

Rehabilitation is essentially a process of education and enablement that intrinsically involves the disabled person and their family. Rehabilitation has many benefits. There is clear evidence of functional gain and improved outcome (Smith & Roberts, 2005). There is also evidence that such functional gains are lost if rehabilitation does not continue after discharge from acute care. Short-term post-acute rehabilitation must be followed by longer-term support and follow-up (Zarb, 2004). Related to the functional gain is the avoidance of unnecessary disability and handicap and the prevention of complications.

WHO (2011) reports that there are no indicators of the numbers of people demanding but not receiving rehabilitation services, or receiving inadequate or inappropriate services. Economically disadvantaged countries have recognised that existing health and social services cannot meet the needs of disabled people and their families. Only a limited number of the population in need were able to access services.

2.5. Rehabilitation Service Delivery in South Africa

2.5.1. Barriers and Challenges to Rehabilitation Service Delivery

Decreased funding has resulted in a wide gap between the care provided at a hospital and the care received once a patient is discharged back into their community. There is under-resourcing of rehabilitation services which leads to individuals not being able to receive the support they need in their communities (Davis, 2006).

As hospital stays become shorter, patients are receiving less rehabilitation as inpatients. Once the patient is discharged from hospital there are limited rehabilitation services in the community (Rhoda et al, 2009, Wasserman, de Villiers & Bryer, 2009) and there is a downward spiral as some patients become less independent and need more support. Public transport is also inaccessible to disabled persons and this often prevents patients getting to rehabilitation departments (Lorenzo, Matau & Chappell, 2012).

Rehabilitation services need to have a co-ordinated response to problems in the community, otherwise they become fragmented. Research done by Sallojee et al (2007) found that there was little evidence of co-operation between the different government departments regarding disability.

Rehabilitation is expensive and complicated. Due to this expense and the difficulties in getting professionals to work in the community a mid-level rehabilitation worker needs to be incorporated into the delivery of community rehabilitation programmes (Rule et al, 2006). Often the needs of the disabled can be met in the community and they do not always require highly specialised professionals (Saloojee et al, 2007). As there is no general consensus on the role of mid-level rehabilitation workers, training has been done according to local needs and is still limited to certain areas of the country (Chappell & Lorenzo, 2012). Usually mid-level workers receive a minimum of two years training in CBR. At present there are no or inadequate numbers of community health workers available for rehabilitation in poorer communities and it usually falls to the caregiver to provide rehabilitation and these carers will need training to enable them to be more active in this process (Wasserman et al, 2009).

Although mobility assistive devices and equipment for disabled persons is free to users with disabilities, they are often unavailable or too expensive for the budgets of Primary Health Care programmes (Chappell & Lorenzo, 2012).

For rehabilitation to be successful at primary level it needs to have formal links with various government departments and empowerment programmes. Over the years there has been some intersectoral collaboration at a community level but not within a formalised system (Rule et al, 2006). Community rehabilitation workers can play a valuable role here by forming support groups and networking with disabled peoples' organisations (Chappell and Lorenzo, 2012).

Wasserman et al (2009) found that even though there were some functional improvements after rehabilitation interventions, disability has a huge impact on lifestyle and participation is impaired. They further found that once discharged from hospital participants in their study received no further rehabilitation. Rhoda et al (2009) found that rehabilitation services at primary level in the Western Cape are uncoordinated and that this negatively affects effective rehabilitation.

2.6. Policy Implementation and Policy Implementation Gaps in Health Care and Rehabilitation in South Africa

The implementation of policies that promote equity and social justice is often difficult as it benefits powerless groups (Duncan, Sherry and Watson, 2011). These policies intend bringing about change, but until the rights and responsibilities of those who can benefit from these policies are realised across all sectors, these policies are hard to implement. When responsibility is assumed by all stakeholders, policy can be implemented. The effective implementation of any policy depends on service providers as well as citizens being informed about its content and capacitated for its implementation (Duncan et al, 2011).

In the health sector there are many health policy reforms which should be introduced but little attention is paid to how these reforms should take place and even less, on who is likely to resist or favour these policies (Walt & Gilson, 1994). The effective implementation of policy requires a strategic balance of pressure and support (McLaughlin, 1987). Outcomes at local level are dependent on individual incentives and cannot be predicted by the policy.

For policy to be implemented the capacity of the relevant government structures must be strengthened. There needs to be skills development and the provision of job opportunities. Implementation needs ongoing support from managers (Naledi et al, 2011). The provision of PHC is also hampered by human resource and managerial challenges. These include negative growth in clinical posts, high attrition rates and the inability to retain community service posts (Naledi et al, 2011).

2.7. Monitoring and Evaluation of Policy Implementation in Rehabilitation Services

The NRP presents a guideline with regard to monitoring and evaluation of the implementation of the policy but does not offer exact evaluation criteria (DOH, 2000).There is a specific section on monitoring and evaluation but it is broad and encompasses the principles, rationale and strategies for monitoring and evaluation. It sets out that the goal of monitoring and evaluation is to provide information which can be used to develop appropriate, effective, sustainable and cost-effective rehabilitation services (DOH, 2000).

Monitoring and evaluation of the implementation of a policy needs to start as soon as implementation starts. Monitoring can be less formal than regular evaluations but can be crucial in adjusting the levels of service and improving quality of care. Evaluation can focus on finding out from the user whether the quality of the service being provided is acceptable. Monitoring and evaluation should be a proactive process so that changes can be made to improve overall efficiency and effectiveness in achieving planned objectives (DOH, 2000).

When doing monitoring it is important that the information collected is relevant, specific, feasible to collect and that it can be analysed (DOH, 1996). Data or information should be collected using indicators which are measurable (DOH, 2000). Once the information has been collected it must be analysed and the results should lead to management action.

There is very little if any evidence that CBR programmes are efficient, sustainable and appropriate (Cornielje, Velema and Finkelflugel, 2008). In evaluating a service or project effective management information systems need to be in place as well as accessible records. When evaluating a CBR programme what can be looked at is the impact the programme has on disabled people and their families as well as the community. The quality of the staff`s performance and the quality and accessibility of the service can be monitored as well as the impact of staff training (Duncan et al, 2011).

Evaluating CBR programmes poses challenges for those involved in delivering the service as well as the service users (Bury, 2005). Many claims are made by those in favour of CBR but there is no firm evidence to support these claims (Velema & Corneilje, 2003). Human resources need to be allocated specifically for the implementation of every rehabilitation programme or service (DOH, 2000).

Velema and Cornielje (2003) have developed a framework for evaluating rehabilitation programmes. They looked at the rehabilitation programme itself as well as the environment and then the relationship between the two. According to these authors evaluation of rehabilitation services should include a description of the services as well as questions to those who benefit from the service. In the framework developed by Velema and Cornielje (2003) a list of questions was drawn up and the evaluator can decide on the questions relevant to the programme being evaluated. This flexibility allows the framework to be adapted to specific programmes.

2.8. Organisational Capacity to Deliver Rehabilitation Services

In order to deliver an effective rehabilitation service an organisation must have the capacity to do so and certain elements must be in place. Where capacity is limited there must be serious questions about the ability to implement policy (Frederickson & London, 2000). Strong organisational capacities and support are needed to achieve high levels of performance. A focused policy agenda is needed to help cultivate these supports and structures (Corrigan & McNeill, 2009).

This study has used the Kaplan framework to evaluate the organisational capacity of the centre and the reasons for choosing this framework are explained in Chapter one. As presented in chapter one the Kaplan framework holds that an organisation must have a conceptual framework and understanding of its role, this is followed by organisational attitude as portrayed by a mission and strategy, which is supported by structures and procedures, competent employees and material resources. Thus in order for an organisation to have the capacity to deliver rehabilitation services, it needs to have an understanding of rehabilitation and what it means. It needs to be aware and understand the various policies that link to rehabilitation and their contribution and impact on rehabilitation. It needs to understand the policies about rehabilitation and persons with disabilities and then needs to have a conceptual framework of how these policies can be implemented through service delivery in the community. Targets and indicators need to be set for the rehabilitation service it wants to provide. It has to understand that rehabilitation will involve the community and that services will have to be integrated in the community (Lorenzo et al, 2006).

Once the organisation has an understanding of its role in the community, it has to structure its resources to deliver these rehabilitation services. The organisation will have to work closely with the community and involve the community in decision making and allow the community to give input into the services. Sometimes the community will have to be the

drivers of the service and it is important that they bring their strengths and assets and thereby enhance the rehabilitation services. It is critical that disabled persons and their families are included in community structures and their participation must be encouraged (McKenzie, 2011). In addition management must ensure that posts are made available in order to employ persons who have the vision to drive rehabilitation services and ensure the delivery of rehabilitation services.

The organisational attitude should be portrayed in the vision and strategy of the organisation. The organisation should have a written mission statement with a set of objectives. These objectives provide guidance when planning, implementing and evaluating the service (Walshe, Walsh, Schofield & Blakeway-Phillips, 2000). The centre should have a strategic plan outlining how it is going to deliver rehabilitation services to its community. A culture of planning needs to be fostered so that outcomes can be achieved and so that everyone in the system knows exactly what their role and responsibility is (Naledi et al, 2011).

Once the organisation has a strategy to deliver the required services it needs to look at structures and procedures that must be put in place to enable it to deliver this service. It should ensure access to its service for the entire community and also that the services are equitable and that there is a good quality of care. The service delivered must be not only accessible but also affordable and effective. Procedures must be put in place to ensure that all documentation is as uniform as possible and kept up to date. This would include good clinical record keeping so as to ensure quality of care. Rehabilitation services need to collaborate and form partnerships with organisations in the community and encourage participation by members of the community (DOH, 2000).

Certain structures and procedures must be in place to ensure good service delivery. Effective monitoring and evaluation systems must be in place and should be integrated with the quality of care programme of the organisation as a whole (Walshe et al, 2000). Accessibility of the service must be ensured as well as adequate referral systems.

In order to deliver effective rehabilitation services the organisation must make sure it employs an appropriately trained workforce with the correct attitude. Programmes must be in place to ensure the professional development of these workers so that the service needs of the organisation are met (Walshe et al, 2000). To provide an effective rehabilitation service, the service providers must be able to work in the community and not limit their service to an institution. Managers and therapists must realise that rehabilitation services must be client centred and this means community participation and integration(Davis,2006). There needs to

be a shift from the medical model to a community based model as described in Primary Health Care approach and this should be refelected in all the services offered at the Community Health Centre. Although there have been changes in the curricula of health professionals training to move towards a PHC approach, health workers are still not adequately prepared for the challenges of working in the community (Naledi et al, 2011).

To provide a rehabilitation service one does not only need human resources but material resources are also needed. If the vision and mission of the centre is to be accessible to all, it must ensure that structures are in place to ensure that the centre is accessible by ensuring that there is appropriate signage and that assistive devices are available for all. There must be adequate space to deliver the service and the necessary equipment must be available.

2.9. Summary

This chapter has looked at various definitions of disability as well as the prevalence and causes of disability; concluding that the ICF provided a comprehensive definition of and approach to disability. It looked at the international and national disability prevalence and at the causes of disability in the research setting. The influence of poverty and unemployment on the disability prevalence was also discussed.

It has attempted to examine the human rights of disabled persons and various guidance documents and policies focusing on disabled people, including the White Paper on the Integrated National Disability Strategy, the Standard Rules for the Equalisation of Opportunities and the United Nations Convention on the Rights of Persons with Disabilities. The researcher looked at rehabilitation and how it fits with the National Health Plan, Primary Health Care and the District Health System and what challenges and barriers affect the delivery of rehabilitation services. The National Rehabilitation Policy and Community Based Rehabilitation are also discussed, as well as policy implementation and policy implementation gaps. Monitoring and evaluation of rehabilitation services was looked at and the organisational capacity needed to deliver rehabilitation services discussed.

CHAPTER 3: DEVELOPMENT OF KEY INDICATORS AND MEASURING INSTRUMENTS

3.1. Introduction

This chapter describes the reasons for developing study indicators and questionnaires and the process followed to develop these study indicators and questionnaires . With regards to organisational structure and capacity and rehabilitation service delivery the research team developed key indicators and then designed three questionnaires; one for service providers, one for the manager of the centre and one for managers of the nongovernmental organisations in order to gather the information necessary to describe the service and to assess whether the services adhere to the objectives of the NRP (DOH, 2000).

3.2 Overall Functioning of the SANPAD Group

The overall aim of the SANPAD study was to analyse the implementation of rehabilitation services at four selected sites in the Western Cape, the impact of these services on clients and the alignment of services with the National Rehabilitation Policy and certain UNCRPD articles (UN, 2006).During the initial planning stages of the project the project leaders decided to have one group of researchers describe and analyse rehabilitation service delivery at each of the four sites and another group assess the outcomes of clients who used the services at each of the four sites. The leaders further felt that each of these studies could support a master's thesis and therefore approached candidates who were linked to the sites and who they felt were suitable to become researchers in the study and at the same time enrol as Masters students. Thus eight Masters students, of whom the researcher in the current study was one, became part of the research team. Two of these eight researchers did research at each of the four sites. One assessed and described the way rehabilitation services were delivered at the sites and determined whether it was aligned with NRP objectives and the other assessed the outcomes of the rehabilitation services through assessing client outcomes at the four sites. Thus the two studies though separate were aimed at giving a holistic picture regarding the implementation of the NRP in these four sites. Literature provides frameworks for describing and assessing service delivery and service outcomes such as the Systems Model or Outcome mapping. In addition various aspects of the service, the context and stakeholders can be assessed in various ways as described by Velema & Cornileje (2003) and Mannan & Turnbull (2007). Finally depending on the framework used and the aspects to be assessed, different measuring instruments can be

chosen (Velema & Cornileje,2003, Mannan & Turnbull,2007). Thus the first task of the research team after its assembly was to decide on a study framework, on what they wanted to measure and on how they were going to measure it.

It was decided by the team leaders that the two major aspects of the study i.e. rehabilitation service delivery and service outcomes have separate focus and can thus have different frameworks and tools. The team decided to assess service outcomes through assessing the outcomes of clients who used the service. In short the researchers looking at the outcomes of rehabilitation services determined what the five most prevalent conditions seen by rehabilitation service providers at each site were. Clients with these conditions were then assessed before receiving treatment and again after a period of three months after receiving rehabilitation treatment. The researchers searched for specific outcome measures that could be used to assess these client outcomes for each of these conditions. Because of slight differences at each of the four sites, slightly different tools were used at each site. However, the focus of this study was on rehabilitation service delivery and the rest of the discussion will focus on that.

The researchers looking at the structure of the rehabilitation services wanted to describe the overall structure of the organisation of which the rehabilitation services were a part, describe rehabilitation service delivery and determine whether the way in which services are delivered was in alignment with NRP objectives. Therefore the team had to identify a framework and tools to assess organisational structure, capacity and rehabilitation service delivery. The team decided to use the Kaplan framework to determine organisational capacity as a framework for this section of the study and to develop measuring instruments, since no measuring instrument that measured the implementation of the objectives of the NRP could be found in the literature.

At the first meeting of the team (as described in Chapter one and elaborated on above) an outside facilitator was brought in to assist with the decisions on how to structure the project. Decisions were made on how to collect the data, how the tools were to be developed and how the research was to be done. This decision making was done in a collaborative manner with facilitation by the external facilitator as well as the research leader and the research co-ordinator who all supported each other. It was decided that the research team would meet once a fortnight for 4-5 hours alternating between Friday afternoons and Saturday mornings.

Initially the focus of the team was on the development of an overall study methodology and variations as required by the specific sites as well as the writing of the various research

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proposals for the Masters studies. Though the methodology planned for each study at each site was similar there were slight differences as the structure of the organisations of which rehabilitation services are a part, differed slightly from site to site. The protocols were submitted to the relevant universities for registration and ethical approval. During this time permission for the research was also obtained from the Department of Health and each of the centres involved in the research.

Each fortnightly meeting started with a general discussion on what had been achieved at the previous meeting and what needed to be achieved at the meeting on that day. The group then split into two groups, one looking at organisational structure and rehabilitation service delivery and the other looking at outcomes. At the end of the meeting the groups would join up again and give feedback on what had been achieved.

The group looking at structure searched for key indicators and instruments to be used in this study. No indicators based on the NRP could be found and no suitable questionnaires were found which could be used to elicit the relevant information from the service providers and the managers. Various questionnaires were found which addressed some of the issues that needed to be interrogated but there were none that were able to interrogate all the objectives of the National Rehabilitation Policy. Therefore this group had to first develop key indicators and then design questionnaires to assess whether the services under evaluation adhere to the objectives of the NRP (DOH, 2000). This was done in the following way:

At the first meeting of the group looking at the structure, each member of the group looked at the first objective of the NRP and wrote down all questions they could think of, that interrogated this objective. Next, one member projected their questions onto a screen and all the members looked at each question asked and discussed whether it was relevant and whether it did interrogate that objective of the NRP. Once that was done the next member of the group added any questions that he had thought of that were not on the list being projected. The additional questions were added and then also discussed and decisions made by the group on whether it was relevant or not. This process was followed until each member had added their questions. Once this had been done the group then followed the same procedure for all the objectives of the NRP. This process took about 5 meetings to refine and finalise.

Following this, the process was repeated to determine questions for the UNCRPD and the Kaplan Framework. All members of the structure group of the SANPAD research team participated in the discussions. Each point was discussed and all suggestions and proposals

were considered and all decisions were made by consensus. The strength of the group drawing up the questionnaires is that the group members are all rehabilitation professionals who have been in the field for more than ten years. They are all in touch with the status of rehabilitation at ground level and keen to do an analysis of what is happening at ground level. There was a lot of enthusiasm in the group and this fostered cohesiveness in the group.

3.3 Specific Role of the Researcher

The role of this researcher was to bring to the team an understanding of rehabilitation services at Community Health Centres in the Western Cape. As one of the managers of this service, this researcher had insight into the Provincial Health Department and how it functions. This researcher also had knowledge of the provincial and government policies influencing the provision of rehabilitation services.

3.4. Key Study Indicators

As one of the aims of the SANPAD study was to determine if the rehabilitation services offered at the study sites were in accordance with the NRP, an instrument that could determine this was required, and had to be developed. Before such an instrument could be developed it was necessary to decide which key indicators from this policy document were to be assessed. Key indicators were identified through a process of consultation and workshops between the members of the SANPAD research group as described under 3.2. The team reached consensus that the seven objectives of the NRP would serve as the key indicators to be used in determining whether the service adheres to the principles of the NRP.

These seven objectives are:

- 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 in 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.

3.5. Questionnaire Design

The National Rehabilitation Policy

The National Rehabilitation Policy was formulated in 2000 and ratified in 2001 and no studies could be found that looked at whether rehabilitation services were being offered in accordance with this National Rehabilitation Policy (Mji et al, 2013). Since no such study had been done and there were no questionnaires that based all their questions on the objectives of the NRP, the research team had to design thequestionnaires.

Questionnaires were designed according to the collaborative process described under 3.2 until consensus was reached and a final group of questions was identified for each objective or indicator as presented in table 3.1 for issues of access.

Table 3.1. Questions on Accessibility

	ACCESSIBILITY
1	How large is the catchment area?
2	What is the population of the catchment area?
3	How many therapists?
4	What are the hours of the therapist/s?
5	Where is/are the therapist/s placed?
6	What type of therapist/rehabilitation worker?
7	How far do patients have to travel to get to therapy?
8	Is there enough space to do therapy?
9	Is the building/room physically accessible?
10	Is there sufficient equipment?
11	Is there transport to get to therapy?
12	Is the transport available at the appropriate times?
13	Is the transport user friendly?
14	Is the transport affordable?
15	Is the transport appropriate?
16	Is the transport responsive?
17	Is the transport adequate?
18	What is the cost per visit?

19	Is there an efficient referral system?
20	Is language a communication barrier?

UNCRPD

Once the structure group had completed the questions for the NRP, the five relevant articles of the UNCPRD were looked at and questions drawn up relating to each of these articles. The same process was followed as was used when looking at the NRP. A different member had an opportunity to project their questions first and then the other members of the team added their questions. In this instance the relevant 5 Articles were used as headings. Article 19 states that "Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs." Table 3.2 shows the questions drawn up to assess adherence to this article.

Table 3.2. Questions on Participation of Persons with Disabilities

	PARTICIPATION OF PERSONS WITH DISABILITIES
1	Are there groups for disabled people in your catchment area?
2	Is there a Community Health Committee?
3	Are you involved in the Health Committee?
4	Are there disabled people on the Health Committee?
5	Is there a mechanism for complaints and compliments?
6	Are complaints addressed?
7	Is the community involved in the management of the centre?

Kaplan Framework

Once the questions for the UNCRPD articles had been finalised the group then looked at the six elements of the Kaplan Framework and drew up questions for each of the elements. Once again the same process was followed with a third member of the group projecting their questions first. The headings, using the Kaplan elements, provided key themes and guidelines when devising the questions. Using these elements, meant utilising the conceptual thinking of Kaplan and this assisted in assessing in the questionnaires whether the framework of the rehabilitation service provider had the capacity to provide the service. One of the elements in the Kaplan framework is Structures and Procedures and Table 3.3 shows some of the questions drawn up to question what structures and procedures are in place at the centre.

Table 3.3. Questions on Structures and Procedures

	STRUCTURES AND PROCEDURES
1	Are there any guidelines in place for clinical treatments?
2	Are there any guidelines in place for procurement?
3	Are there any guidelines in place for training?
4	Are there any guidelines in place for administration?
5	Are rehabilitation staff included in planning of services?

Final Process

Once all questions for all aspects of the NRP, the UNCRPD articles and the Kaplan framework were developed all the questions were listed on an Excel spreadsheet with the seven objectives of the NRP, the 5 articles of the UNCRPD and the 6 elements of Kaplan as headings and the finalised questions from each of these three sections listed underneath.(Appendix A)

There was some duplication of questions and these were removed. For example accessibility is one of the objectives of the NRP and it is also an element in one of the UNCRPD articles so some questions were repeated.

Then a new spreadsheet was drawn up and the seven objectives of the NRP used as headings. The finalised NRP questions devised for these seven headings were then filled in under their heading. The group then looked at the first question under the first UNCRPD heading and decided, using a collaborative process, which NRP heading would be the most suitable for this question to be placed under. Every question for the UNCRPD and Kaplan sections was interrogated in this way and placed under a NRP heading. For example the third NRP objective is to facilitate adequate resource allocation and encourage their optimal utilisation. The questions listed here include the NRP questions on resource allocation, some of the UNCRPD questions under Article 25 that were relevant in this section and some of the questions in the material resources section of the Kaplan framework.

As these questionnaires were to be completed by not only rehabilitation professionals but also non-professionals it was decided by the group to keep the questionnaires manageable and not include open-ended questions. Interviews could be done with the rehabilitation professionals and the manager to get information that might not be available in the questionnaire.

The questionnaires were then cleaned up and sent to an expert for formatting. The questionnaires were then sent to two experts in the field of rehabilitation who checked the questionnaires for duplications and unnecessary questions. The questionnaires were also sent to a statistician for his opinion. He determined that the numbers who would be answering these questionnaires were too small to make it statistically significant. However the questionnaires could be used for information gathering.

Three key informant groups were decided upon, as explained in the methodology chapter. These three groups were the service providers, the manager of the Community Health Centre and a Non-governmental organisation manager.

The group analysed each question and decided who would be the key informant who could best provide information to answer each question. All questions were projected onto a screen and the key informant filled in on the screen. Once again this was a collaborative process with all members of the group participating. For some questions there was more than one key informant. The example given in Table 3.5 shows the questions designed for the seventh objective of the NRP which encourages research initiatives in rehabilitation and related areas. Where one of the key informants was the client this information was passed on to the group doing outcomes to ensure that the question would be covered in their questionnaire.

Table 3.4. Deciding to which key informant group each question on research should be posed

			Manager	Service Provider	Client	Other
RESEARCH	1	Is any research taking place at the centre?	X	X		
	2	What research is being done at the centre?	X	X		
	3	Do researchers get any support from management?	X	X		
	4	Who is conducting the research?	X	X		
	5	Are the disabled involved in doing any of the research?	X	X		
	6	Is the information learnt through research being disseminated back to the centre?	X	X	X	X

Draft questionnaires were then drawn for each of the three key informant groups. The piloting process for the questionnaires is presented in chapter four.

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3.6. Summary

This chapter gives a description of the SANPAD study as well as details about the members of the SANPAD study group. It gives details about the meetings held and describes the decisions made by the group as well as the steps taken in the planning as well as the designing of the questionnaires. It discusses the researcher's role and contribution.

It then describes the process followed, using the National Rehabilitation Policy, the 5 relevant articles of the UNCRPD and the Kaplan framework, to draw up the questionnaires used in this research. Lastly it describes how it was decided which questions should be included in each questionnaire.

CHAPTER 4: METHODOLOGY

4.1. Introduction

As presented in the previous chapter the SANPAD team decided on a study framework, developed key study indicators and quantitative data collection tools. Up to that point the various Masters studies focusing on describing the organisation and rehabilitation service delivery followed the same methodology. However, from thereon the various researchers developed the methodology further to suit their individual study requirements and settings.

During the research process this researcher realised that a quantitative approach as developed by the team would not provide sufficient data to provide an in-depth description of the setting and determine if the organisation has the capacity to deliver rehabilitation services in accordance with the principles of the NRP. Thus she decided to use a case study design and incorporated both the quantitative tools, whose development was described in chapter three, as well as a qualitative component for which tools were developed by the researcher. This chapter will provide the reasoning behind the choice of a case study approach.

In addition she did not only collect data from the service providers, but included service users as study participants. The identification of study populations and sampling processes is also described in this chapter. Data collection instruments, especially the qualitative ones, methods and analyses are explored. Finally ethical issues pertinent to the study and rigor are discussed.

4.2. Study Design

A case study design with qualitative and quantitative components was utilised in this study (Yin, 2009). In the health and social sciences, case study methodology has a history of use as a qualitative research approach (Yin,2009). It is a practical approach where complex issues can be comprehensively studied in context (Yin,2009). A case study can help to point out key areas of concern and can show how issues can be addressed through action and further research (Hodgetts & Stolte, 2012). A case study provides the opportunity for the researcher to interact with the participants in the specific situation and to see how they conduct themselves (Hodgetts & Stolte, 2012). Case-based research is seen more and more as a strategy to facilitate socio-political action in order to address social issues. Hodgetts & Stolte (2012) see case-based research as a crucial strategy for socially engaged and community based research and see the benefits for building better understanding of societal

issues and processes and for contributing to teaching and action. In this study the researcher hopes to use the information gained from the case-study as a basis for facilitating change.

A case study can study either a person or an organisation (Concoran, Walker & Wals, 2004). In the instance of this study an organisation and one of its components, ie rehabilitation service delivery at the Gugulethu Community Health Care Centre, was the case under study. A case study can be used to provide a record of a situation (Brynard & Erasmus, 1995) since it explores and describes (Brynard& Erasmus, 1995, Yin, 2009) and is thus suitable for a study which aims to describe a certain organisation and service. In addition, Concoran et al (2004) argue that a case study looks at an organisation and how the practitioners in that organisation act and that it can be used as a mechanism to transform and improve practice. A case study describes the organisation and then provides evidence based recommendations for application in the organisation by looking at the practice and policy application of the organisation (Zucker, 2001). In order to do this the case study design includes the main characters in the situation and the facts surrounding the situation and uses a variety of sources and evidence (Brynard & Erasmus, 1995, Yin, 2009). In this study service providers, service users, community organisations and documents will be sources of evidence that will be collected through interviews, focus group discussions, questionnaires and documentation perusal as described by Yin (2009). Case study research is usually classified as a qualitative approach but it can consist of both qualitative and quantitative data (Lawrence Neuman, 1997). In this research the qualitative component has a more important role since the purpose of the study focuses on the exploration and description of rehabilitation service delivery at the study site and the qualitative design provides an opportunity for exploration (Domholt, 2005). Quantitative and qualitative styles of research have several differences but also complement each other in some ways (Lawrence Neuman, 1997). In qualitative research the data is in the form of words and sentences whereas in quantitative it is in numbers. Therefore different research strategies and data collection techniques must be used by the researcher. The numbers from quantitative data can quantify situations such as numbers of patients treated and availability of resources, but cannot tell the researcher how patients experienced the treatment or what the attitude of therapists was. Thus the two paradigms are used in combination in this study.

The methodology of a case study has the flexibility and capacity for the research to be used as an exclusive method of inquiry or it can be used as part of a larger study (Anthony & Jack,2009). Case study methodology is an appropriate way to explore, describe and understand a situation within its own context and it also creates an opportunity for in-depth

study of specific characteristics and events which can provide evidence and information to a larger study (Anthony & Jack, 2009). In the current study this case study provides a way to explore, describe and understand rehabilitation service delivery at the study site while at the same time providing information towards the bigger SANPAD study and information for the various doctoral studies in the SANPAD study.

When looking at rehabilitation and medicine a framework can give a particular perspective on the relevant body of knowledge. When tensions arise between the needs of the health care institution and those of the team and the client, a conceptual framework can help to retain the client focus (Davis, 2006). Also when doing case study research there must be a clear conceptual framework to guide the collection and analysis of data (Bryar, 2000, Yin, 2009). In this study the Kaplan framework was used to look at the capacity of the centre to deliver a rehabilitation service.

4.3. Study Setting

The study was performed at the Gugulethu Community Health Centre in the Klipfontein Mitchells Plain Substructure, a previously disadvantaged area with a population of 340 000 (StatsSA, 2001), in the Cape Town Metropole. The Community Health Centre provides a 24 hour service. It offers comprehensive health care services including trauma, curative, preventive and rehabilitative health care. Approximately 15 000 patients are seen at this centre in a month, with about 500 seen monthly for rehabilitation services (KMPSSO).

At present there are 15 doctors working at the centre. There is a family medicine registrar who manages the medical services in the centre which consist of 4 permanent doctors, 5 community service doctors and 4 interns. The nursing component is managed by the operational manager and she has 61 nursing staff. They consist of 5 clinical nurse practitioners, 29 professional nurses, 7 staff nurses and 19 enrolled nursing assistants. The reception is managed by an administrative officer who has 19 clerks working in this area. There are 10 cleaners as well as a housekeeper. There is one social worker, one physiotherapist, one orthopaedic sister and one health promotion officer. An occupational therapist does a clinic at the centre once a week. Third year physiotherapy students, two per rotation, from the University of the Western Cape also provide services at the time of study.

The CHC was built in the mid 1970s and has been renovated and enlarged since then. When it opened in the mid 1970s it was an 8 hour day hospital with a weekly physiotherapy service. Renovations were done in 1997 and the centre became a 24 hour trauma unit and a Rehabilitation Department was built. A full time physiotherapist was employed. In 2005 an

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orthopaedic sister was employed at the Centre and in 2009 weekly occupational therapy services were started.

The Gugulethu Community Centre is the only public centre in Gugulethu providing medical services to the community. The Trauma centre is also the only one in the Gugulethu district. There is a Medical Obstetric unit on the same grounds as the centre which is open for 24 hours. Also on the grounds is the Hannon Crusiad Centre which runs the ARV clinic which is open for 8 hours daily. Lastly there is the Tembalethu Workshop where 26 people with disabilities are employed. It can be seen that many and varied services are provided in and around the Gugulethu Community Health Centre and it forms an integral part of Gugulethu.

4.4. Study Population

The study had four distinct populations from whom different but related data were gathered. These were:

- The facility manager at the CHC between 1 March 2012 and 30 April 2012. Since this pertains to one person only, no inclusion and exclusion criteria were used.
- Service providers working at the Community Health Centre
- Non-governmental Organisations (NGOs) in the catchment area of the CHC that worked with persons with disabilities
- Users of rehabilitation services at the Gugulethu CHC during the period 1 March 2012- 28 February 2013. Users were interviewed after data from service providers were analysed and found insufficient to address the aim and objectives of the study. Therefore the discrepancy in dates.

4.4.1. Inclusion and Exclusion Criteria for Service Providers

Inclusion Criteria

- Staff working in the rehabilitation centre at the Community Health Centre between 1 March 2012 and 30 April 2012. This was a physiotherapist, an occupational therapist and an orthopaedic sister.
- Doctors and professional nurses working at the CHC between 1 March 2012 and 30 April 2012

Exclusion Criteria

- Staff who refused informed consent
- Staff who had no contact with the Rehabilitation Department
- Staff who started at the CHC after 30 April 2012

4.4.2. Inclusion and Exclusion Criteria for NGOs

Inclusion Criteria

- The managers of NGOs in the catchment area who worked with persons with disabilities.

Exclusion Criteria

- NGOs in the catchment area who did not do any work with disabled persons
- NGOs that refused to participate in the study.

4.4.3. Inclusion and Exclusion Criteria for Service Users

Inclusion Criteria

- Clients who had received treatment in the Rehabilitation Department at Gugulethu CHC between 1 March 2012 and 28 February 2013
- Clients who were willing to participate in the study.

Exclusion Criteria

- Clients who had attended Gugulethu CHC but had not received treatment in the Rehabilitation Department
- Clients with cognitive or communication problems which made it difficult for them to participate in a focus group discussion
- Clients who did not wish to participate in the study.

4.5. Sampling and Participants

4.5.1. Facility Manager

The facility manager of the centre completed the quantitative questionnaire and was subsequently interviewed. No sampling of managers was done as she is the only manager employed at the centre.

4.5.2. Service Providers

All the service providers working in the rehabilitation department at the Community Health Centre, i.e. the physiotherapist, occupational therapist, orthopaedic sister, social worker and health promoter participated in the study. These participants were all holders of the relevant information needed in this study.

In the case of doctors and professional nurses, purposive sampling was used. In special situations it is acceptable to use purposive sampling. When selecting participants it uses the judgement of an expert and is used when the researcher wants to select someone who is especially informed (Lawrence Neuman, 1997). In this case the researcher obtained information from the rehabilitation workers to find out which of the doctors and which of the nurse practitioners working in the Gugulethu Community Health Centre, referred clients for rehabilitation regularly and who of them had some understanding of the rehabilitation process. One doctor and one professional nurse were identified and they participated in this study.

Thus in total seven service providers participated in the study. All seven service providers completed the questionnaire and in addition the physiotherapist, the occupational therapist and the orthopaedic sister were interviewed. These three were chosen as they work in the Rehabilitation Department at Gugulethu CHC. The health promoter has retired and could not be contacted for an interview and the social worker felt she did not have enough contact with the rehabilitation department and was unwilling to be interviewed.

4.5.3. Non-governmental Organisation Managers

When choosing a Non-governmental Organisation manager to interview, purposive sampling was used once again. The researcher identified 4 NGOs that regularly referred clients to the rehabilitation department of the CHC.

In total two managers from NGOs participated in the study by completing the questionnaire. The researcher was assisted here by one of the PhD students involved in the SANPAD study who is fluent in Xhosa. The information gathered from these two managers was very similar and the PhD student and the researcher felt that no additional information would be obtained from other NGO managers. Thus, two NGO managers completed the relevant questionnaire but were not interviewed.

4.5.4. Service Users

A convenient sample of 14 service users participated in two focus group discussions. The therapists working at Gugulethu CHC were asked to identify clients who had been seen at

the Rehabilitation Department at Gugulethu between 1 March 2012 and 28 February 2013 who in their opinion would be willing to participate in a focus group. The researcher realises that asking service providers to identify users to participate in the study brings with it an amount of bias since providers might select users which they know were satisfied with the service or neglect users who have made complaints.

Out of the fourteen service users who participated 8 had been discharged and 6 were still receiving treatment at the Rehabilitation Department. One participant had an amputation, two had strokes and the others presented with a variety of pain complaints including backache, shoulder pain and knee pain. There were five men and nine women and their ages ranged from 32 to 64.

4.6. Data Collection Instruments

4.6.1. Quantitative Questionnaires

The development of the questionnaires was described in detail in the previous chapter and will only be mentioned in short in this chapter.

Questionnaire for Service Providers (Appendix B)

The questionnaire designed for this group of key informants was based on the objectives of the National Rehabilitation Policy, the five relevant articles of the UNCPRD, the six elements of the Kaplan framework on capacity, the principles of the ICF and the objectives of Community Based Rehabilitation.

Questionnaire for Managers (Appendix C)

The next key informant was the manager of the centre. The questionnaire designed for the manager was based on the service provider questionnaire with emphasis on management issues such as financial and organisational management.

Questionnaire for NGO Managers (Appendix D)

The questionnaire for the managers of Non-governmental Organisations was the shortest of the questionnaires. It was based on the facility manager’s questionnaire.

4.6.1.1. Participants who completed the questionnaires

In total eight staff members (a manager, physiotherapist, occupational therapist, orthopaedic nurse, social worker, health promotion officer, doctor and professional nurse) and two managers from NGOs completed the quantitative questionnaire. The mean age of the

respondents was 42 with their ages ranging from 26 to 58. Six of the service providers were female and one was male.

The working experience of service providers ranged from 5 years to 36 years. The average number of years worked was 19 years, with an average of 14,5 years working in rehabilitation, ranging from 0 to 23 years. The majority of service providers had less than 10 years experience of working at the study facility. The working experience of the service providers is summarised in Figure 4.1.

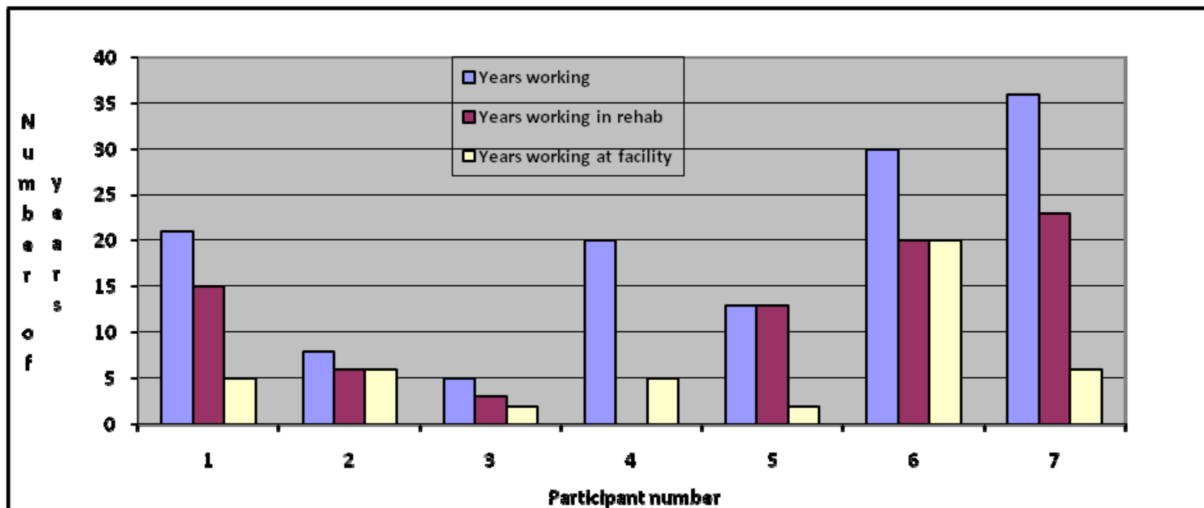

Figure 4.1: Working Experience of Service Providers.

Of the eight service providers three were directly involved in providing rehabilitation services at Gugulethu CHC. These three have 24 years of rehabilitation experience between them. The doctor who participated has specialised in family medicine and the professional nurse is a clinical nurse practitioner. The health promoter trained as a nurse many years ago.

4.6.2. Interview Schedules

An interview schedule to guide the semi-structured interviews with the facility manager and service providers was developed by the researcher. The interview questions were based on the study objectives and the qualitative questionnaire and provided an opportunity to allow for a deeper interrogation of the questions of the questionnaire. The researcher used an interview schedule that was developed by one of the Masters students at another one of the four centres involved in the SANPAD project, as a basis. With the assistance of her supervisor she adapted this interview schedule to address the issues relevant for this study. (See Appendix E)

The interview schedule for the facility manager was based on the service provider's interview schedule, but was adapted to be suited to management issues. (Appendix F)

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4.6.3. Schedule for Focus Group Discussion

The questions for the focus group (Appendix G) were also based on the qualitative questionnaire and the objectives of the study. The researcher developed questions that were relevant to service users based on the questions that were asked of the service providers in their questionnaire and the study objectives. These questions were used to get the discussion going in the focus groups and were used as prompts during the focus groups, but the focus group discussions were allowed to move freely between topics and not forced to follow the questions.

4.7. Pilot of questionnaire

The service provider questionnaire was first piloted at a Community Health Centre with a similar profile to the Gugulethu Community Health Centre where the research was being done. The physiotherapist at this centre completed the questionnaire and only one small adjustment needed to be made. The adjustment provided some clarity in a question concerning the budget for equipment. This questionnaire was piloted again in a rural area where 2 therapists completed the questionnaire and no difficulties were experienced.

The questionnaire for managers was also piloted in a rural setting and was completed without any difficulties. The pilot study focused on the questionnaire to ensure that the participants understood the questions and were able to answer them effectively.

The questionnaire for the manager of a NGO was piloted in the same rural area and many adjustments had to be made after this piloting. It was found that the questionnaire contained questions which the NGO manager was unable to answer as they were not relevant to her work. The questions that were not relevant were removed and only the relevant questions remained in the questionnaire.

Once the questionnaire had been piloted and the adjustments made they were sent to an expert in managing rehabilitation services and an expert in rehabilitation research. Both did member checking of the questionnaires and two minor changes were made for clarity. Member checking occurs when the researcher takes the questionnaires or results to experts in the field and they judge the adequacy of the product (Lawrence Neuman, 1997).

The questionnaires were then sent for formatting to a specialist. Feedback was given by the specialist and once again minor changes were made where necessary.

The interview schedules and schedule for the focus group discussions were not piloted.

4.8. Data Collection

4.8.1. Service Providers

All staff members who were sampled to participate in the study and the manager of the CHC were contacted and appointments were made with them to explain the objectives of the research to them. The researcher met with each service provider individually and explained the research which was being done. If they were happy to participate in the research after this explanation they were asked to sign an informed consent form. After this form was signed they were requested to complete the quantitative questionnaire in their own time. The questionnaires were left with the service providers for 5 days after which they were collected by the researcher.

Following that, semi structured interviews were scheduled with the physiotherapist, the occupational therapist and the orthopaedic sister. These interviews were held at the service providers' convenience at Gugulethu CHC in a venue of their choice. They were performed in English; the operational language at Gugulethu CHC. Interviews were audio recorded with the permission of the participant. Only the researcher and the relevant service provider were present and the transcription was done by the researcher. While an interview schedule was used the researcher used free flowing conversation and encouraged participants to elaborate on thoughts or provide explanations. The interviews were held in a quiet office with the door closed. The interview with the physiotherapist lasted about 90 minutes while those with the occupational therapist and orthopaedic sister lasted about an hour each.

4.8.2. Facility Manager

The researcher met with the facility manager and explained the research being done and asked the facility manager to sign an informed consent form. The researcher then left the quantitative questionnaire with the facility manager to enable her to fill in it at her own convenience. The researcher collected the form from the facility manager six days later.

The researcher then scheduled a meeting and conducted an interview with the facility manager. Only the facility manager and the researcher were present at the interview which was held in a small private office. The interview lasted about 90 minutes and was audio recorded.

4.8.3. Manager of the NGO

The questionnaire for the non-governmental manager was taken to two organisations in the area that were sampled. No appointments were made but both managers were on duty at their respective centres. The researcher explained the research to the managers and asked

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them to sign the informed consent declaration. The managers then completed the questionnaires while the researcher and other member of the SANPAD team waited for it.

Once these questionnaires were returned they were scrutinised by the researcher to check for any unanswered questions or incomplete answers. Fortunately all questionnaires were completed with no questions being omitted or incomplete.

4.8.4. Service Users

Both focus groups were held in the Rehabilitation Department at Gugulethu CHC. The department was closed for the afternoon to ensure quiet and privacy. The first group consisted of nine service users and the second, of five service users. Both focus groups were performed in Xhosa, the first language of all the participants. Both groups were facilitated by one of the PhD students from the SANPAD project. The researcher approached her to perform the focus groups since she was a first language Xhosa speaker and being part of the SANPAD study had an understanding of the aim and objectives of this specific study. The researcher further enhanced this understanding by explaining the study and its aims and objectives in minute detail to her. Thus the focus group discussion could be done without a translator. The researcher was present and because some of the participants in the focus groups sometimes spoke English or Afrikaans and the researcher has some knowledge of Xhosa she could follow the general trend of the conversation.

In both groups there was good participation by the service users. The first group ran for nearly 3 hours and needed a break halfway as they were tired but the second group ran for just more than two hours without a break. The facilitator asked questions and then gave all members of the group an opportunity to speak and probed their answers if necessary. The researcher did probe some of the replies. The purpose of the focus groups was to get the service users' opinion and experience of the Rehabilitation services at Gugulethu CHC. It was also to look at the interactions between the members of the group and at the discussion that these interactions generated. Focus groups are a good way to discover the range of views of the participants as well as agreements and disagreements among the group. It is also interesting to see how the discussions can influence members of the group (Rule & John, 2011). It can be difficult for the facilitator to pose questions, as well as listen to the answers and be aware of the group dynamics and this is why both focus group sessions were recorded and transcripted so that all the data could be captured.

Both focus group discussions were audio recorded with permission of the participants and then transcribed.

4.9. Document Perusal

The researcher perused the following documents in the rehabilitation department for additional data:

- Job descriptions of rehabilitation therapists
- Staff performance appraisal documents of rehabilitation therapists
- Patient register
- Statistic forms
- Appointment diary

These documents were used for background information to see what the job descriptions of the rehabilitation workers were and whether they was aligned with the NRP. It was also used to see the staff appraisal and to see if the therapists were being appraised regularly and whether there is triangulation with the other information gathered. Triangulation is one way of assessing the truth value of the findings and to do this multiple sources of information must be used (Yin, 2009).

4.10. Data Analysis

4.10.1. Quantitative

Quantitative data gathered through the questionnaires was entered onto a data extraction sheet, where it was summarised with the help of a statistician. Since numbers were small no statistical analysis was done. Graphs and tables were used to present it as background information to the study.

4.10.2. Qualitative

Qualitative data came from the four transcribed interviews as well as the transcription of the two focus group discussions. All four of the interviews were transcribed by the researcher and this provided an opportunity for the researcher to reflect on the interviews while doing the transcripts. As the researcher was in the field collecting the data there is continuous analysis as the researcher starts thinking about what she is seeing and hearing while she is doing the data collection (Pope, Ziebland & Mays, 2000).The focus group discussions were transcribed by a research assistant fluent in Xhosa, English and Afrikaans.
Yin (2009) identifies five techniques for data analysis in qualitative research: pattern matching, explanation building, time-series analysis, logic models, and cross-case synthesis. Pattern matching involves comparing patterns within the data and with patterns in the theory. If the patterns concur, the results help strengthen the internal validity of the case study.

Explanation building is a special type of pattern matching in which the goal of the analysis is to build an explanation about the case. The next two techniques are used in experiments and evaluations and are not relevant to this study and the fifth technique applies specifically to the analysis of multiple cases which is not appropriate here. The researcher decided to use pattern matching as it gave the opportunity to look for patterns within the data and to match these with the framework being used.
Thus data was analysed using a framework approach (Pope et al, 2000) according to the pre-existing themes of the Kaplan framework and the seven objectives of the NRP since this related to the aim and objectives of the study.

The researcher analysed the transcripts of the four interviews by taking each of the six elements of the Kaplan framework, one at a time, and looking for any mention or evidence in the transcribed interviews that related to that element. All of these were copied in narrative form onto a separate document with the specific element as a heading. Evidence of each element was listed and it was noted which of those interviewed had knowledge or experience or an opinion on that particular element and what the knowledge, experience or opinion entailed. Similar themes were then looked at among the listed evidence and also differences between the various replies given relating to the same element.

The researcher then looked at the information under each element heading and looked for evidence of alignment with the seven objectives of the NRP or, alternatively, evidence of non-alignment with the objectives of the NRP. The researcher then went on to present the elements of the framework, the themes found in each element and the relationships between the elements and the objectives of the NRP, sometimes using direct quotes to convey these relationships more vividly (Rule & John, 2011). The qualitative replies were described in interpretive narratives that provided a description of the subject being studied.

When analysing the transcripts from the focus groups the researcher took each question and listed all the participants' answers under each question. Common themes were looked for in the replies and these replies were then compared to the replies given by the service providers when they completed the relevant question in the questionnaires. The researcher then checked for correspondence and differences between the replies given by the members of the focus group with those given by the service providers.

4.10.3. Rigor

There has been criticism that a case study is not generalisable, representative of a population and that this sort of study is introspective (Corcoran et al, 2004, Hodgetts & Stolte, 2012). However, sometimes in depth information about a specific context is what is

required to understand what is happening in that context and how change can be brought about (Corcoran et al, 2004, Hodgetts & Stolte, 2012). In addition, providing detailed information of one example does not preclude using the information to inform understanding of similar services in similar contexts. Therefore there is a need for thick description of the methods and context in order to allow a reader the opportunity to decide whether aspects of the case will be applicable to a different situation (Hodgetts & Stolte, 2012). This the researcher provided through a description of the study setting and methods used.

Although the case study design has many attributes it also has many criticisms, the main criticism being the trustworthiness of the data (Bryar, 2000). Guba (1981) states that the trustworthiness must be assessed when using a case study approach and he suggested this be done by taking note of the study's transferability, credibility, dependability and conformability.

Transferability can be seen as the external validity of a study (Rule & John, 2011).

One way to assess the credibility is by triangulation where there are multiple sources of data (Yin,2009). In the current study data was sourced from service providers, service users and documents. Thus multiple sources of data could be triangulated.

There must be consistency in the data and the researcher must be confident that if the study was repeated or replicated the findings would be consistent. Consistency leads to dependability and this can be assessed by making sure that all data collection can be accurately trailed (Guba, 1981).

Conformability addresses concerns that the participants in the study and the conditions of the research must not be influenced or biased so that there is neutrality in the study (McGloin, 2008). When qualitative data is collected there is a subjective and interpretive aspect and steps need to be taken to preserve the quality of the data (Brophy, 2008). The researcher needs to minimise the bias and one of the ways to do this is to collect data from different sources of information.

When there is full disclosure about the research process and the researcher acknowledges limitations it contributes to the dependability and confirmability of a case study (Rule & John, 2011).

4.11. Ethical Considerations

The study was only commenced once it had been accepted by the Committee for Human Research of the University of Stellenbosch(N09/11/323). Consent was also obtained from

the Provincial Department of Health, the Director of the Sub District and the facility manager of the Community Health Centre to perform the study on the premises and to have access to patient folders.

The welfare of the research participants was always at the front of the researcher's mind. Participants were informed of the purpose and benefits of the study. Participation was voluntary and refusal to participate did not affect their future employment at the Community Health Centre in any way. All participants approached agreed to participate in the study. A consent form was signed by each study participant. All interview participants were fluent in English and could understand the English consent form. In the case of the focus group the consent from was explained to each member by the facilitator before they signed it.

Confidentiality was guaranteed. Research numbers and not client names were documented on questionnaires. Only the researcher has access to information. All information is stored at the Centre for Rehabilitation Studies at Stellenbosch University. Although information will be published individual identities will not be disclosed. There were no physical or emotional harm or risks involved.

4.12. Summary

This chapter on Methodology explains why the researcher decided to do a case study. A detailed description of the study setting is given. It describes the study in its context. Study participants included service providers at the CHC and managers of NGOs in the CHC catchment area, as well as service users. Purposive sampling was done in instances where sampling needed to be done. It describes the process followed for data collection. Data was collected via questionnaires, focus groups and interviews which the researcher performed. Relevant documents were also perused.The process of data analysis is explained. Lastly the trustworthiness of the study as well as ethical considerations pertinent to the study are discussed.

CHAPTER 5: RESULTS

5.1. Introduction

This chapter will present the quantitative data gathered from the questionnaires answered by the service providers, by the facility manager and by the managers of the NGOs. It will also include the qualitative data obtained from interviews with three service providers and the facility manager and two focus groups held with service users.

Results will be presented according to the objectives of the study.

5.2. The Context

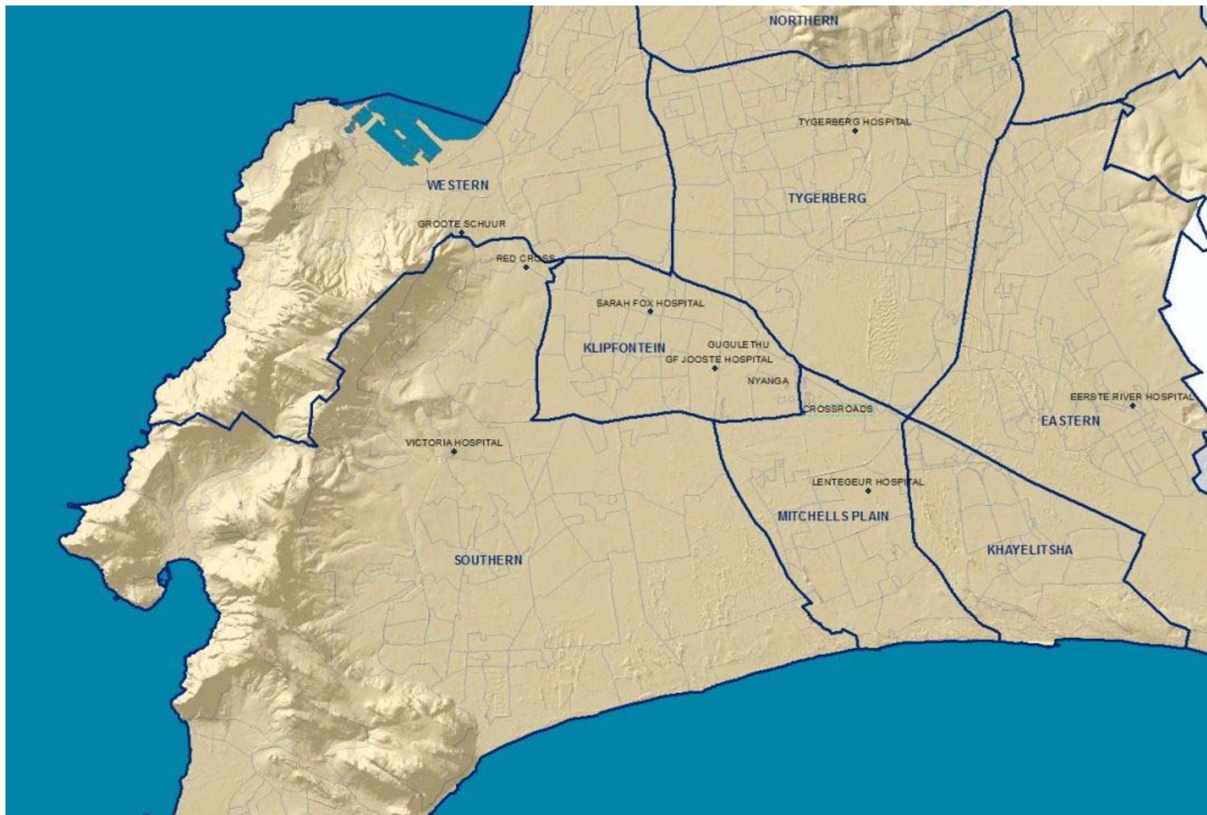

Figure 5.1. Map of the City of Cape Town with 8 subdistricts

The District of the City of Cape Town is divided into 8 subdistricts. The Gugulethu CHC is in Gugulethu in the Klipfontein subdistrict. The name Gugulethu, is a contraction of *igugulethu*, which is Xhosa for *our pride* (Wikipedia, 2012). Gugulethu was established in the 1960s due to the overcrowding of Langa, which was the only black residential area for Cape Town at the time. During the Apartheid era black South Africans were not permitted to live in the city of Cape Town, and many people were removed from areas such as District Six to

Gugulethu. This removal did have an impact on the disintegration of communities which led to poverty and high crime rates (Cristovao, 2011).

5.2.1. Catchment Area

The catchment area for the Gugulethu Community Health Centre is the suburb of Guguletu, which is about 6,24 square kilometres, as well as parts of Nyanga, Phillippi and Crossroads. Some clients come from areas well outside the catchment such as Langa, Delft and Khayelitsha.

5.2.2. Community Profile

According to the 2011 census the total population of Gugulethu is 70 159, with a density of 11,264 people per square kilometre (StatsSA, 2011). Ninety eight point six percent of the population of Gugulethu belongs to the Black African ethnic group. 47,35% of the population is male and 52,65% female. The predominant language in Gugulethu is Xhosa with 94,25% of the population using it as their first language (StatsSA, 2011).

5.2.3. Socio Economic Profile

According to the 2011 Census 56% of the labour force of Gugulethu is employed but 65% earn less than R3200 a month. The provincial average of employment is lower, at 49.7%. Only 7% of the population of Gugulethu has a University Degree and only 31.23% completed their schooling and got their Grade 12 qualification. As many as 2.3% of adults in Gugulethu, have had no schooling at all.

Sixty six percent of people in Gugulethu live in a brick house and 33,5% in an informal dwelling or shack. 98,6% use electricity for lighting and 73,7% have access to piped water inside their dwelling (StatsSA, 2011).

5.2.4. Disease Profile of the Community

The leading cause of death in the Western Cape is cardio vascular disease, accounting for 25% of all deaths (Chopra, Steyn & Lambert, 2007). Cardio vascular diseases, along with diabetes and hypertensive disorders make up most of the non-communicable diseases (NCD). In Gugulethu there is an emerging epidemic of non-communicable diseases (Puoane & Tsolekile,2008). In earlier years NCDs were regarded as being diseases of the wealthy but

this has changed and the poor are becoming the most vulnerable victims of NCDs (Chopra et al,2009). Genetics alone are not the only cause of the high incidence of NCDs but it is largely due to environmental factors and more specifically to an unhealthy lifestyle (Chopra et al, 2009). The unhealthy lifestyle can also be linked to poverty as healthy foods are usually more expensive.

The second highest cause of death in Cape Town is HIV/AIDS, as it is in Gugulethu, but 22,49% of people in Gugulethu die of HIV/AIDS while the city average is only 10,27%. TB is an indicator condition for AIDS and there is evidence that the TB epidemic is being fuelled by the HIV epidemic and this dual impact has a huge impact on the premature mortality in the city of Cape Town (Groenewald et al, 2008).

5.2.5. Other Contributors to Mortality and Morbidity in Gugulethu

Assault, at 11,95% is the third highest cause of death in Gugulethu. (City of Cape Town, 2012) Crimes such as violent assaults and abuse cause physical injury and death which have a direct influence on the health of the community (Goodwin, 2004).

Besides this there are indirect influences of crime which influence health, such as financial losses and time off work. Long term results of crime include alcohol and drug misuse, high risk sexual behaviour and neglect of personal health (Goodwin, 2004). It can be argued that lack of employment, poor job prospects, poor housing and environmental conditions also lead to alcohol and drug abuse (Matthews, 2004). The opposite can also be argued, that employment opportunities and optimal living conditions lead to increased motivation to be healthy and live a better life.

5.2.6. Services Offered at the Gugulethu Community Health Centre

The Gugulethu Community Health Centre aims to provide a comprehensive primary health care service to their community as well as a 24 hour trauma emergency service. According to study findings the services include preventative, promotive, curative and rehabilitative services. There is also a Medical Obstetric Unit at the centre, school nursing, a dental service, mental health services, nutritional services and an anti retroviral clinic.

An average of 16000 patients were seen at the Gugulethu Community Health Centre monthly in 2011 with November being the busiest month when over 19 000 patients were seen at the centre and January the quietest with just less than 14 000 patients seen (KMP SSO, 2012). In the Rehabilitation Department the average monthly number of rehabilitation

patients seen in 2011 was 533. The busiest month was September when 708 patients were seen and the quietest was December when only 290 patients were seen (KMP SSO, 2012).

Rehabilitation services are available every day at Gugulethu CHC. This are provided by one full time physiotherapist and an occupational therapist that comes once a week. In addition an orthopaedic nurse is based at the CHC where he holds a monthly clinic. The services are enhanced by the placement of three third year physiotherapy students from the University of the Western Cape.The rehabilitation department is at the back of the Community Health Centre and clients attending this department have to go through the pharmacy waiting area which is usually very busy which makes it difficult to move through.

5.3. Service Outputs

5.3.1. Numbers of Patients Treated

The physiotherapist saw 5095 patients at Gugulethu CHC in the 2011-2012 financial year. In the same period the occupational therapist saw 387 patients and the orthopaedic sister saw 917 patients at Gugulethu Community Centre and in the Gugulethu catchment area. Monthly numbers seen are shown in Figure 5.2.

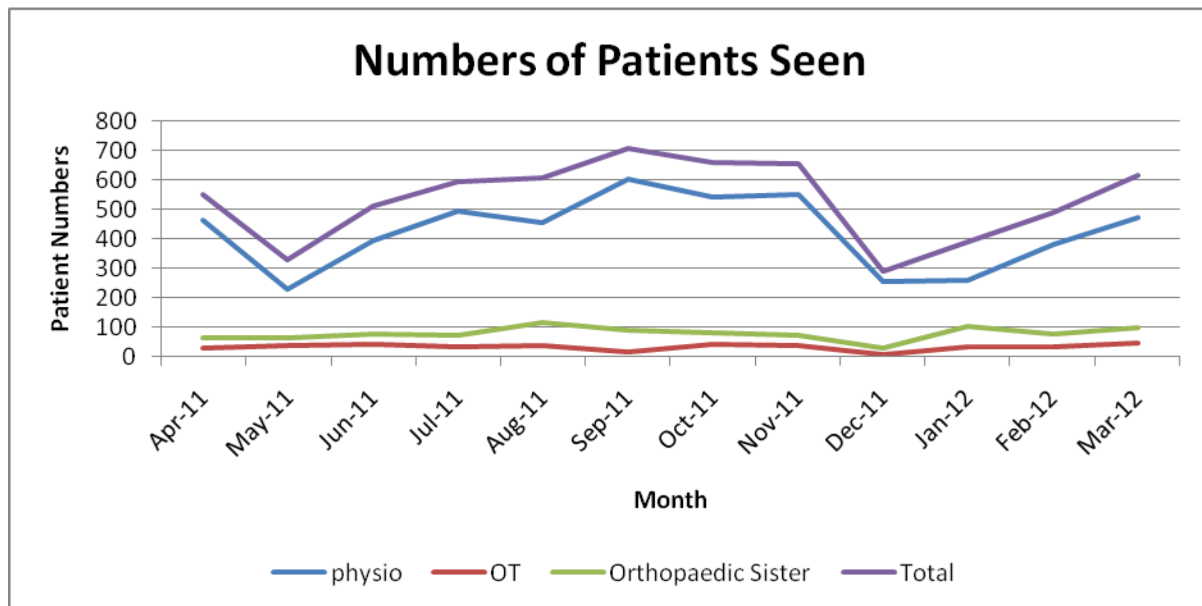

Figure 5.2: Number of patients seen by Rehabilitation Professionals per month (2011 – 2012)

Figure 5.3 illustrates information on individual treatment sessions provided by the orthopaedic nurse, physiotherapist and occupational therapist. It shows that 80% of the

physiotherapist's time was spent on direct client contact, treating on average 19 clients per day. The physiotherapist worked an eight hour day. This means three clients per hour.

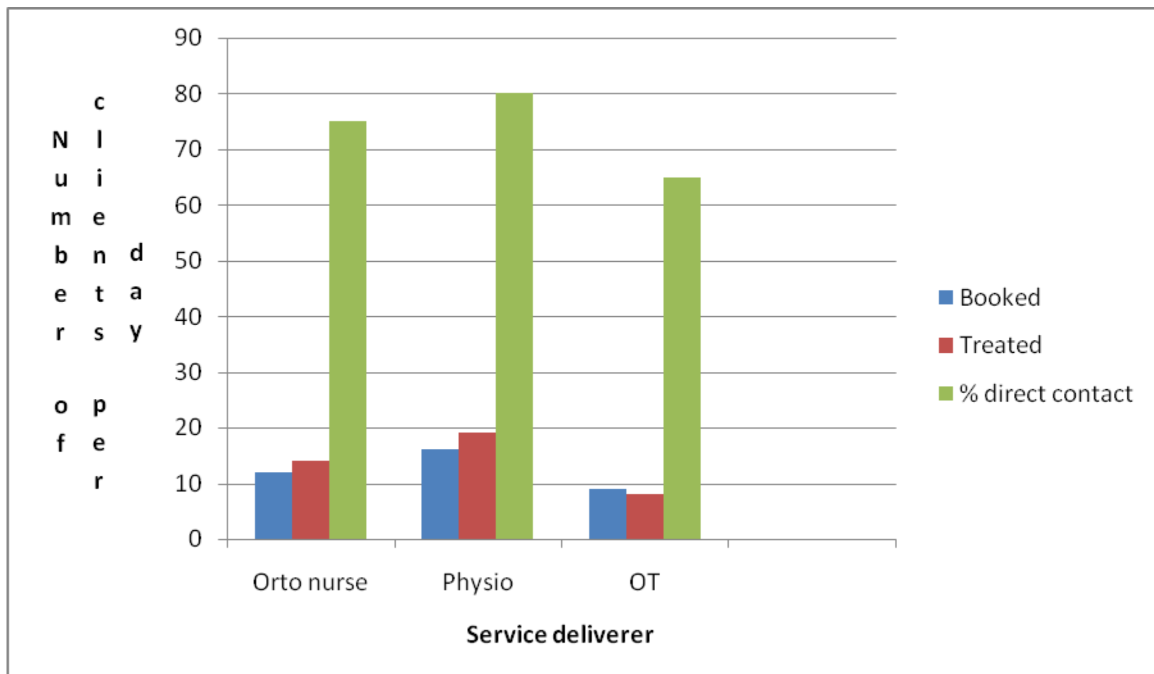

Figure 5.3: Individual treatment sessions by rehabilitation service deliverers

The occupational therapist books about 10 patients a day for individual treatments. As she is only at Gugulethu CHC once a week she sees patients who need specific occupational therapy intervention and input. Sometimes an arrangement is made to assist the physiotherapist on her visit to a Special care Centre and then fewer individual treatments will be done at Gugulethu CHC on that day.

The orthopaedic sister does a clinic once a month at Gugulethu CHC and patients are given an appointment to come in on a specific day to see the orthopaedic sister. The time spent with the patients varied as sometimes the orthopaedic sister just needs to issue and fit a device and at other times an assessment and measuring must be done.

5.4. The Mechanism of Functioning Of The Rehabilitation Service At Gugulethu Community Health Centre

5.4.1. Conceptual Framework and Organisational Attitude

The Gugulethu Community Health Centre is part of the Metro District Health services and the aim of the MDHS is to provide a comprehensive and integrated package of essential PHC services to the communities it serves (DOH, 2008). The Community Health Centre is the gateway to the service as it is the first point of contact between the patient and the health service.

In the facility manager's introductory speech to the staff at Gugulethu CHC she challenged the staff to stand together and contribute positively towards service delivery and quality care for the people of Gugulethu. She challenged the staff to work towards the well-being of the Gugulethu community, not because they feared management but for the good of the community (Mabusela, 2008).

The participants put emphasis on treating the community of Gugulethu. They recognised that they provide the only health service for most people living in Gugulethu and want to improve the quality of life of those living in Gugulethu. All those interviewed were aware that Gugulethu is a poor community with many social problems.

> *"This is a poor community with many social problems"* (Service Provider1: SP1)

> *"Many of the injuries I see are as a result of violence"* (SP 2)

> *"We see a lot of injuries as a result of gangsterism, poor parenting and accidents"* (Facility Manager:FM)

There is widespread unemployment in Gugulethu which leads to more poverty and the associated problems of violence and alcohol and drug abuse. HIV and AIDS were also named as problems in the community as well as the rising number of orphans and teenage pregnancies.

> *"There is a high rate of unemployment in the community and a high HIV/AIDS rate. Women in this community have more than one boyfriend and the men often fight over women"* (FM)

Nutrition was also singled out as a problem in this area, not only malnutrition but also bad eating habits leading to obesity and chronic diseases of lifestyle.

> *"I think the main problem in this area is bad nutrition"* (SP3)

The service providers recognised that because they were the only public health service in the area the centre was extremely busy and they all had to carry a large load. They also recognised that there should be more interaction with the community and in this way their burden at the CHC could be lightened. Instead there were so many people in the community with various diseases, often caused by preventable conditions, that they had a huge load of curative patients that had to be seen. They seemed to be paralysed by this large workload and as an organisation have not responded to this challenge.

> *"I am the only public health physiotherapist in Gugulethu so if I do not see these patients they will not receive any rehabilitation treatment, so I do not like to turn anyone away*." (SP1)

> "*Because the load at the centre is so big and there is so much pressure from the district hospitals to accommodate their patients, I do not get a chance to do home visits or to develop any programmes in the community*." (SP1)

There was recognition by the service providers that there were a lot of rehabilitation needs in the community and that there were many poor disabled people in the community who needed rehabilitation. Because no situational analysis or audit had been done in the community the service providers were not sure what these exact needs were. There is also still some stigma associated with disability which prevented some disabled people accessing rehabilitation services.

The facility manager felt that she should be a role model to her service providers as well as to the service users and that she should be accessible and have respect for all. She felt she should be empowering the Gugulethu community so that they can take care of their health.

> *"My facility must create a caring environment that delivers a good service and I must make sure that my staff has the skills to deliver a good service."* (FM)

Table 5.1: The elements of the Kaplan Framework, a description of each and what information will be sought in the current study to assess each

Elements of Kaplan's framework	Description of the elements	Information to be gathered to describe each element
1. A Conceptual framework	How does the organisation understand its "world"? Does the framework reflect the organisation's understanding of its "world"?	How do service providers see their role in the community? Do the service providers know their community? Do they know the problems presenting in their community?
2. An Organisational Attitude	Does the organisation have the confidence that it is effective and can impact positively on the needs of the community it serves? Does the organisation believe it can be effective and make an impact? Does the organisation accept the responsibility for the social and physical conditions 'out there'?	What is their understanding of the community they serve and the needs and challenges faced within the community and by them? Do they have an understanding of how they can assist the community? Do they know the support systems in the community? Are they able to work with the community?
3. Clear organisational vision and strategy	Do individuals understand the vision of the organisation and know what strategies to use to fulfill this vision? Do individuals have a sense of purpose and will which flows	What is the mission and vision of the organisation? Is it known by service providers? Do they agree with it?

	out of the understanding and responsibility?	Does it influence their service delivery?
4. Organisational structures and procedures	Are there structures and procedures that reflect and support the vision and strategy of the organisation? Can they give guidance? Can they ensure accountability? Are procedures and policies that guide service delivery included?	Are there efficient systems in place for ease of service delivery? Is their service accessible to the community? Are there good communication systems in place? Are there procedures for documentation of treatments? Are there procedures for the gathering of statistical information? Are there procedures for monitoring and evaluation?
5. Relevant individual skills, abilities and competencies	Are the training and skills available specific to the organisation in order for it to achieve its goals? Is there scope for staff development?	Are service providers competent? Can service providers cope with the work presented to them? Are there courses available to do appropriate training for service providers?
6. Sufficient and appropriate material resources	Are the human resources sufficient and appropriate? Are the material resources sufficient and appropriate?	Are there enough service providers? Are all fields of rehabilitation available?

		Do service providers have sufficient and appropriate equipment? Do service providers have sufficient space to work in?

5.4.2. Organisational Vision

The vision of the Gugulethu CHC is to deliver high quality general, trauma and maternal services with pride and confidence, today, together and always (Mabusela, 2008).

> *" We need to put meaning into the numbers of ill patients we are seeing at the centre and get the staff to own it and share in our vision." (FM)*

The mission statement of Gugulethu Community Health Centre is to deliver a high quality comprehensive primary health care service which is responsive, through active participation of the staff, to community needs. The areas of focus is promotive, preventative, curative and rehabilitative health care in an optimal environment which is conducive to health and learning (Mabusela,2008).

The facility manager at Gugulethu CHC started there in January 2008. She told staff when she started that at Gugulethu she aimed to give the best service to the Gugulethu community and provide excellent health care to the community (Mabusela, 2008).

Service provider participants are aware of the vision and mission of the CHC but the curative load is so large and patients are so ill that according to participants they demand a large percentage of staff's time and energy and there is little time left to do promotive and preventive work. They recognized that doing more promotive and preventive work should have the effect of lessening the curative and rehabilitative work at the centre.

> *" I would like to do more prevention and health promotion but at the moment most of my time is spent doing curative rehabilitation. I am sure if we could do more prevention we would see less backaches and strokes."* (SP1)

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> *"We need to do more health promotion. We need to teach patients to be more self reliant and not to come to the doctor with every complaint"* (FM)

The facility manager knows exactly what the vision and mission of her centre is and is aware that as a Primary Health Care service she needed to involve the community in their own health management. She is aware that she needs to get her staff to share in her vision but could not show any strategies that this had been done or that there were any concrete plans to facilitate this.

> *"We need to contribute to their social and good health."* (FM)

5.4.3. Strategies Structures and Procedures

5.4.3.1 Access

All patients, except emergencies, have to make appointments to be seen at the Community Health Centre and all patients have to report to the reception area at their appointment time. They are given their folders and can then proceed to the relevant department. Staff aims to manage all conditions during the same visit at the CHC. The patient should not have to attend on different days for different diagnoses (DOH, 2007). This means that a patient can be treated for his diabetes, mental illness and stroke in one visit to the CHC.

> *"She makes sure that my appointment dates fit in with days that I am coming to the hospital for my pills or to see the doctor so that I do not have to come here every day"* (Focus Group B No 4:FGB 4)

There is a policy in the Gugulethu Community Health Centre to fast-track disabled and elderly patients, as well as patients who are seriously ill. The orthopaedic sister, the physiotherapist, doctor and facility manager are aware of this policy and use it with their clients while the nursing sister and occupational therapist are unaware. The social worker and health promotions officer did not fast-track any patients.

Service providers feel that the service is accessible. The furthest anyone has to travel from within their catchment area is 5 kilometres. The Rehabilitation Department is open from eight to five daily from Monday to Friday. Patients wait a maximum of 2 weeks to get an appointment at the Rehabilitation Department.

> *"They are also able to bring dates closer if they feel it is too long to the next session."* (FGB 2)

Service users agreed that they did not wait long to get an appointment and that when they come for their appointment they are seen on time.

> *"When I arrive here for my appointment they help me immediately"* (FGB 2)

> *"That's what they tell you. If you cannot make it on time, phone because then they put someone else in your place and help you when you can come in."* (FGA 2)

> *"When I get there it is only me because they know that I am coming because we are given different appointment times. By the time you get there they know that you are coming and you do what you come for."* (FGA 1)

All the participants agreed that patients from outside the catchment area would be seen at the centre.

However, a problem with the physical accessibility of the rehabilitation service was mentioned by all those interviewed. The department is at the back of the centre and rehabilitation patients have to move through the pharmacy waiting area to get there and this waiting room is usually very busy. Service providers also se this as a problem.

> *"The rehabilitation department is right at the back of the facility and it is difficult for patients to get to."* (SP2)

> *"We need a separate entrance to the physiotherapy department since it is difficult to move through the crowded day hospital. The department is too far from the main entrance."* (FGA 5)

> *"They should build the physiotherapy department outside so that people who are in wheelchairs can enter freely without bumping into people."* (FGA 5)

All the service provider participants except one, indicated in the questionnaires that they thought that there is enough space to do rehabilitation and all but one thought the department is accessible to disabled persons. However in the interviews two service providers said that lack of space is a problem.

> "*There is not enough space to see my patients properly and there is no privacy if I want to have a confidential interview with my patient."* (SP2)

> *"I would like more space to accommodate larger groups and parallel bars."* (SP1)

> *"We need more space because the space that we currently have is very small. We need more equipment like exercise machines and bicycles like a normal gym. It would be nice if they build a swimming pool for us because other people would benefit from doing exercises in water.*"(FGA 7)

All acknowledged that there is signage in the CHC but three were not sure whether it was adequate or not. Only three service provider participants thought that patients could understand the language spoken by the rehabilitation therapist and only one thought that interpreters are available. One of the service providers admitted to using a lot of visual cues in her treatment if there was a language barrier. Some of the service users feel that they could understand what the therapist was saying and that they could express themselves but others feel that it was a pity that there were no Xhosa speaking therapists.

> *"Sometimes you are not exactly sure what is being said and you may not understand. Sometimes you have to guess what they are saying. So sometimes there is a bit of miscommunication because of the language barrier."* (FGA 5)

> *"It would help if there was a physiotherapist who could speak Xhosa."* (FGA 2)

> *"It was the way she spoke to me in a very nice and decent manner, never too fast for me to understand."* (FGB 2)

> *"The language barrier is not a reason for people to not go there. At least you can guess what is being said because your health is more important than the language barrier."* (FGA 7)

> *"There is a language barrier so I use a lot of visual cues in my treatment."* (SP 2)

The service provider participants all agreed that health information is available at the centre but only three thought it provided for the needs of all types of disabilities.

The service users agreed that they are given some information about their conditions. Some information is oral and some received written information.

> *"They gave me a piece of paper showing me what exercises to do when I am at home."*(FGA 2)

The service users felt they are given the opportunity to ask questions and are given satisfactory answers.

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> ***"****Yes we can ask questions, they do give us that opportunity because I spoke to the physiotherapist and told him that I am not getting better and I am losing balance so he decided to give me a belt. I felt very happy with his response and they try as much as they can to help us."* (FGA 3*)*

Transport

There is no policy on transport for disabled clients and transport is not available at the Community Health Centre.

> "*We do not supply any transport for patients. Most patients ask their family members or neighbours to bring them to the centre. Sometimes they have to pay for this transport."* (SP1)

According to the manager clients use their own transport and others are educated on the use of Dial a Ride. Dial a Ride is a transport system for disabled people in the City of Cape Town but it is unreliable. However, responses on transport varied. Answers to question 1.1.21 indicated that four service provider participants are uncertain while four others feel there is no transport in the community and clients have to walk or use their own transport. In a later question (1.6.4) four participants indicated that transport is available to clients.

Service users mentioned the lack of transport as a reason for missing appointments at the rehabilitation department.

> *"I missed appointments because of transport problems."* (FGA 2)

> ***"****It depends where you are. Maybe you are at home and you see the weather and you don't want to get cold and you think of the stress of getting public transport then you end up not going."* (FGA 9)

> *"On those days when your arthritis is worse it is very hard because you get a taxi and there are already three people seated in the back, obviously the space is small and you are forced to sit squashed there because the driver is shouting at you for wasting time."* (FGA 8)

There is a policy on official transport for staff members. Official vehicles are available and need to be booked in advance. If planning is done there is usually a vehicle available but this was less likely with short notice.

Health Promotion Strategies

All the respondents agreed that health information is available in the Community Health Centre, but not enough.

> *"The health promotions officer did education in the CHC waiting rooms; she organized various promotion programmes and also saw patients individually. There were weekly talks in the waiting room on relevant health issues, usually based on the health calendar."* (SP 1)

> *"It would help if we get information pamphlets written in Xhosa, English and Afrikaans so that a person can choose a pamphlet for the language that they understand."* (FGA 2)

The health calendar is a calendar published by the department of health each year. This calendar marks each week as a different promotional week for various health conditions and health issues. These weeks fit in with international health weeks where possible. In some weeks there is a special promotional day which is relevant to the week.

> *"On World Hypertension day which falls into hypertension week relevant information talks are given. These talks are given in Xhosa to either the patients waiting at the reception area, or patients waiting outside the doctors' rooms or to patients waiting at the pharmacy."* (SP 1)

Every year during Diabetic week the health promoter and the rehabilitation therapists organise a Big Walk in Gugulethu. The aim of the Big Walk is to promote a healthy lifestyle by doing some exercise. The incidence of diabetes among urban black South Africans is 22,2% (Bourne, Lambert & Steyn, 2002) and the incidence of hypertension is 24,4% (Erasmus, Blanco, Okesina, Matsha, Gqweta & Mesa, 2001) and patients suffering from these diseases can benefit from some exercise. The hypertension and diabetic clinics at Gugulethu are both very busy, with the diabetic clinic seeing an average of 1400 patients a month and the hypertension clinic seeing an average of 2500 patients a month. On the day of the Big Walk there was a lot of encouragement to exercise regularly and maintain a healthy weight. No blood pressures or blood sugars are taken as these are done 3 monthly at the respective clinics. The health promotion officer also did at least 2 health promotions in a local shopping mall during the research year. These consisted of a display, pamphlets and the health promotion officer available to answer questions.

In the CHC individual cases are referred to the health promotion officer for specific education about their disease. The health promotion officer trained originally as a nurse but has been doing health promotion for the last 17 years. She had in-service training to do health promotion and this centred on promoting a healthy lifestyle. In earlier years the concentration was also on the prevention of tuberculosis, hypertension and diabetes and in later years the prevention of HIV/AIDS has played a greater role.

According to the health promotion officer's job description her purpose is to do health promotion in the Gugulethu CHC to patients attending the CHC. There are no indicators and no targets to be met and the health promotion officer did not know of any processes in place to monitor and evaluate her services.

Physiotherapy students placed at Gugulethu CHC also have to do at least one health promotion session while they are at the centre.

> *"They speak to the patients in the general waiting room or sometimes talk to the diabetic patients in the Diabetic clinic or the hypertension patients in the Hypertension clinic."* (SP 1)

According to the therapists' performance plans they must participate in at least 2 health promotion programmes during the year. At the beginning of the year the rehabilitation therapists look at the health calendar and decide what health promotion programmes they will participate in. Examples would be a promotion on stroke prevention during stroke week or a talk on hypertension on World Hypertension Day.

During Back Week the therapist visit six schools in the area to promote back care amongst young learners.

> *"There are six schools I try to get to. As yet there have been no visible spin offs from this but I would really like to go back this year and build on my previous talk."* (SP 1)

Back Week is in September each year and the aim is to promote better back care in all communities. For the last 3 years the emphasis of Back Week has been on the promotion of back care amongst young learners in schools. The other promotion chosen during the research year was Diabetic week and the therapists assisted the health promotion officer and they worked together as a team. The physiotherapy students work at Gugulethu CHC for 4 week rotations and in this time each group must do at least 2 health promotion talks in

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the waiting room. They are encouraged to make posters relevant to their talk and these are then displayed in the centre.

> *"Most of the education and training I give is about the fitting and caring for their appliance. I do talk to them about their condition and how they need to care for themselves. I will often refer to the physiotherapist or occupational therapist if I think they can be helped by the therapists."* (SP 3)

As can be seen above the therapists do some health promotion but have limited time available and they are not able to do as much health promotion as they would like. All the service providers mentioned that they enjoyed working as part of a rehabilitation team. They would have liked to assist the students when they did their promotions but there were always patients in the rehabilitation department needing treatment. Once again it seems as if the attitude of the organisation needs to change so that it can have the framework to prioritise preventive rather than curative treatment.

5.4.3.2. Prevention

All the respondents said that they do some health prevention while treating their patients. They take care to explain the patient's condition and give advice on how to prevent complications and the condition worsening.

> *"Before or while treating the patient I discuss the condition being treated as well as other related conditions. I discuss how the patient is coping at home or work and advise how to make adaptations."* (SP 2)

5.4.3.3. Interventions Offered

Interventions from the therapists include direct hands-on treatment, weekly classes for arthritis, back pain and strokes and monthly groups for disabled children and their caregivers, various classes, groups and visits to institutions in Gugulethu, such as the old age home and care centres for children with disabilities.

The majority of patients seen at Gugulethu CHC for rehabilitation are seen individually. On average they receive treatment once a week. These are acute patients who need hands on treatment.

"*Most of the patients referred from the hospitals are post surgical or post trauma and need individual treatment. What is the point of doing a hand operation on a patient if he does not get physio afterwards? It is just a waste of money.*" (SP 1)

According to the therapists there is a lot of pressure put on the Rehabilitation Department from the referring hospitals as they want to discharge patients as quickly as possible and then these patients need to be followed up at the Community Health Centre.

The most common diagnoses treated according to the client register in the rehabilitation department from April 2011- March 2012 was lower back pain (38% of patients) as indicated in figure 5.4. Lower limb injuries consisted of osteoarthritis of the knee 12%, knee injuries 8%, fractures 4% and sprained ankles 6%. Patients with strokes accounted for 14% of patients treated and upper limb injuries, including hand injuries accounted for a further 12%. The post surgical patients were spread across these diagnoses and included back, knee, ankle, shoulder, elbow and hand operations.

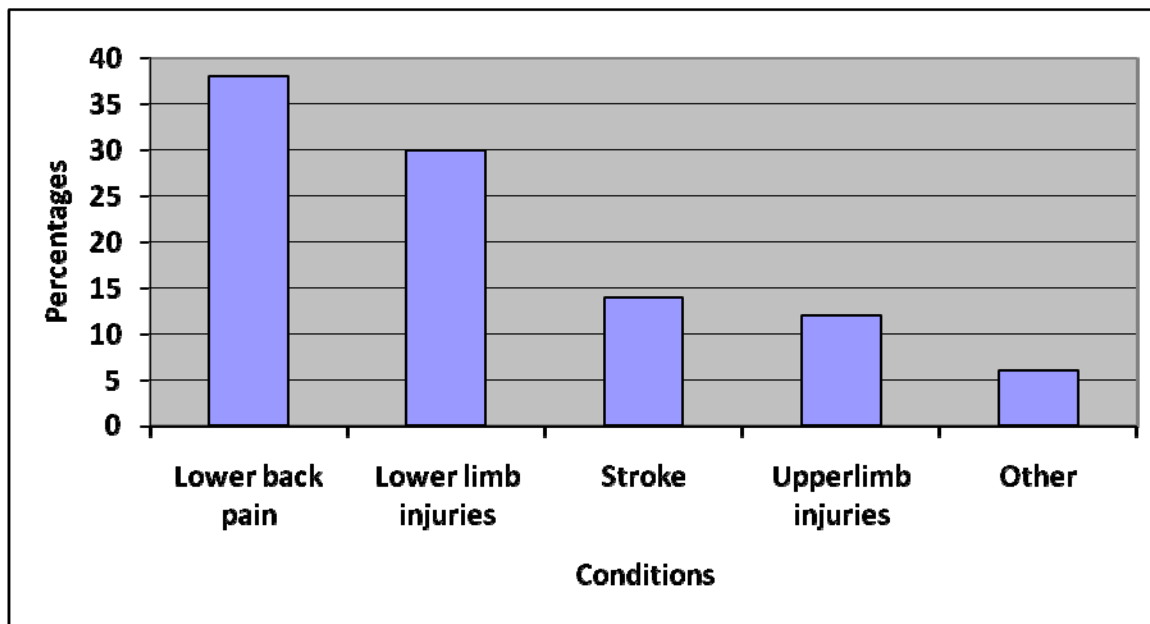

Figure 5.4: Most common conditions treated in rehabilitation

All the respondents except the professional nurse agreed that rehabilitation outreach is done by the Rehabilitation Department at Gugulethu CHC. The physiotherapist does outreach in the Gugulethu area. She visits the local old age home every Friday afternoon. She first sees to the patients who have been referred by the doctor to physiotherapy that week and then follows up on patients she has seen previously. She assesses patients for mobility assistive devices and supplies them if needed.

> *"I do individual treatments and then I try to show the nurses how they can assist the patients with exercises or by correct positioning, but they are so busy and do not often do what I ask."* (SP 1)

There are 2 Special Care Centres in Gugulethu which the physiotherapist visits every four months. The aim of these visits is to train and educate the carers working at these centres. The aim is not to treat the children as these mostly attend the CHC or Red Cross Hospital for therapy and have exercise programmes. The physiotherapist checks that the programmes are being adhered to and finds out if the carers have any questions. She also checks the seating of the children and reinforces with the carers how important the correct seating is for these children.

> *"The aim of these visits is more to educate and assist the carers rather than treat the children."* (SP 1)

The physiotherapist feels that there is room for some improvement in the physiotherapy service at Gugulethu CHC. She would like to be able to give more patients individual and more intensive treatment but she does not have the time. If she gives more individual treatments she will not be able to see as many patients as she does. She tries to ensure that every patient at the centre that needs rehabilitation will receive some treatment. Most of the patients referred need individual treatment and most are given individual treatment initially and then later slotted into a group or class. She has osteoarthritis knee classes, back classes, general arthritis classes, stroke classes and groups for disabled children.

The arthritis classes, back classes and stroke classes are held weekly and have an average attendance of 10- 12 participants. All three these classes are part of a six week programme that progresses each week and at the end of the six weeks these patients are discharged. The groups for disabled children are held monthly and are attended by an average of 6 patients. These are maintenance classes and patients and their caregivers attend as long as they feel they need the input. Because the load at the centre is so big she does not get a chance to do home visits or to develop any programmes in the community.

The occupational therapist assists the physiotherapist on visits to the Special Care Centres when she can, but her focus is on individual treatments. There are no occupational therapy students at Gugulethu CHC.

5.4.3.4. Relationship with Patients

Figure 5.5 shows that all respondents indicated that they interact with the patients on a personal level. The respondents all feel that they treat the patients with respect and allow patients to decide how they would like to participate in their treatment and then provide opportunities for them to participate. Informed consent is usually obtained from patients before treatment is commenced. Patients are encouraged to talk about their problems and are given the opportunity to participate in their treatment planning. Opportunities are also given to family members and care givers to participate in the care of the patients. Aspects on figure 5.5 that showed more ‘sometimes’ than ‘always’ responses, are allowing users a choice in terms of how much they want to participate in their treatment.

During the focus groups the service users described the various emotions they felt when they were referred to rehabilitation. Some feared the unknown as they felt there was no clear explanation given to explain what rehabilitation was.

> *“At first I was very scared but after I received treatment I became comfortable and relaxed.”* (FGA 1)

> *“When I was told to go there, I was hurt because I didn’t know where they were sending me and I was not sure if I was not gonna get killed there but when I went there I found out that people were not being killed there but they were getting help.”* (FGA 2)

> *“I was very surprised to know that we had a physiotherapist here and I was not very scared. I was impressed with the treatment I got. I do not have any complaints.”* (FGA 3)

> *“I went there because I wanted to get better. I didn’t know what they were going to do to me and I didn’t see anything that could cause panic when I went.”* (FGA 4)

> *“I was worried when I was told to see the physiotherapist because I didn’t know what to expect.”* (FGA 8)

> *“I felt happy and the physio massaged me and showed me exercises and I got better.”* (FGB 3)

Service users were very satisfied once they had attended the rehabilitation department.

*"When I went there for treatment I was made to feel relaxed and the treatment helped me a lot." (*FGA 1)

"They welcomed me in a good manner and also introduced themselves to me. They told me their names. Everything went fine." (FGA 7)

"I am happy that the people who work here treat you well." (FGB 3)

"Before I came here I could not walk but look now I have a walking frame." (FGB 1)

"One thing I can say about the physio is that she is excellent." (FGB 2)

"When I get there they know that I am coming because we are given different appointment times and they do what you came for." (FGA 1)

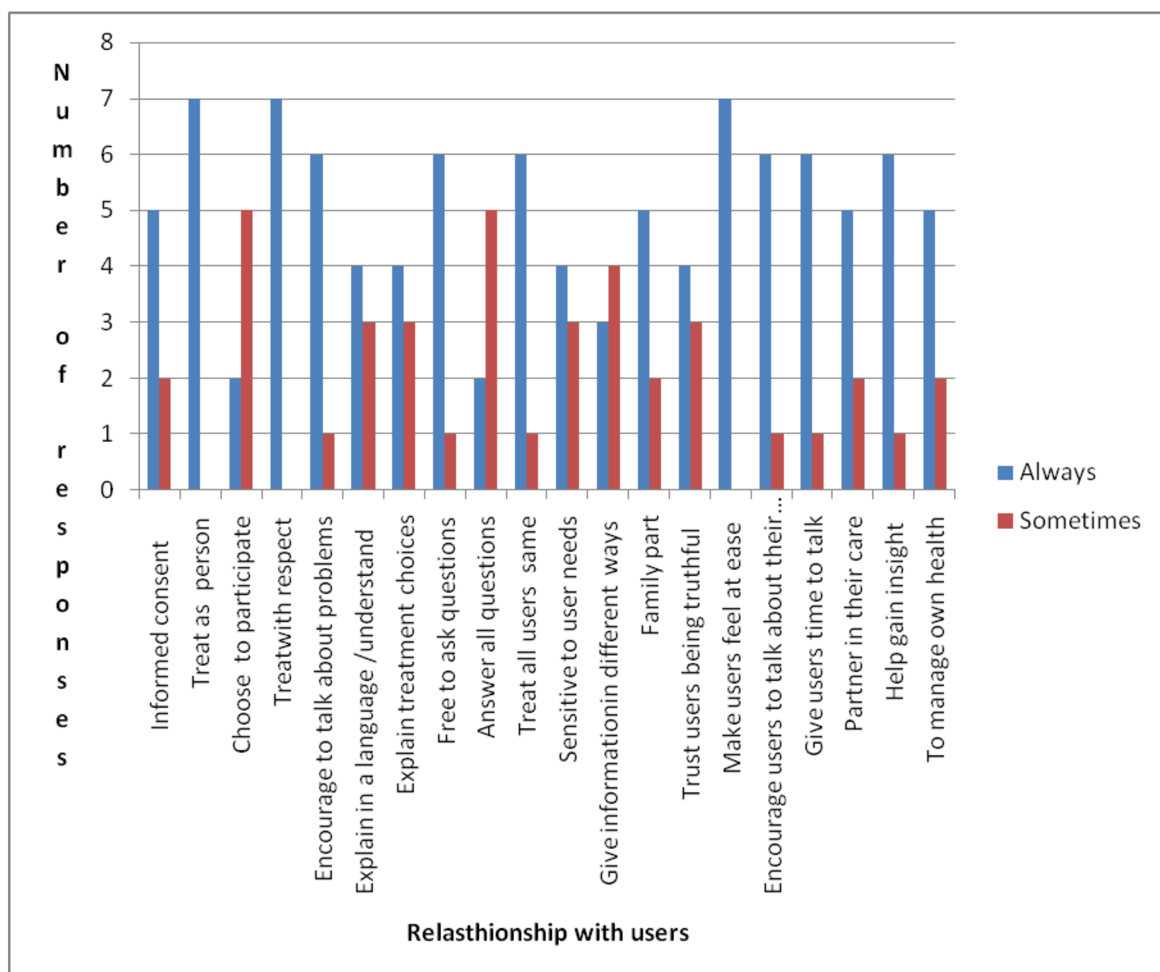

Figure 5.5: The way in which users are treated at the facility

The facility manager did not answer these questions thus there are only seven instead of the usual eight responses

5.4.3.5. Satisfaction with Services Provided

As indicated by figure 5.6 all service provider participants feel that users sometimes have to wait for rehabilitation services and that not all required services are always available. However, in spite of this they all agreed that users always benefited from the rehabilitation services. Some of them are satisfied with the service they deliver while others are not:

> "*I am very satisfied and think my patients are also satisfied. They see that I do my best to accommodate them and give them the best service. I think that my patients all benefit from the service and treatment they receive here*." (SP 1)

In the focus groups service users reported that they are satisfied with the way they were treated.

> *"They gave me treatment that was to my satisfaction, I was happy with the way I was treated. They taught me that I must be always active and I should exercise so that I can get better soon."* (FGA 2)
>
> *"The physiotherapist is nice, friendly and cooperative."* (FGA 1)
>
> *"Everyone there is nice and they treat us with respect."* (FGA 9)

The service users felt that the service they received was friendly and encouraging and that they are always made to feel comfortable even in embarrassing situations. They felt they are allowed privacy and are treated with respect. Some of the service users gave consent for the treatment but some said they had not been asked.

> *"They always told me what they were going to do and if I was okay with it. I then said yes."* (FGB 4)
>
> *"She asked very nicely for permission to treat me."* (FGB 1)

The majority of the service users felt they are not given an opportunity to give their input into decision making about their treatment, though they are told what treatment was planned for them.

> *"No I was not given a chance to decide, they just told me to get onto the bed. I was not asked anything about wanting or not."* (FGA 3)
>
> *"You are not given a chance to suggest something." (*FGA 3)

"She will then tell me that next week we are going to do this and that. That is why I always knew in advance what we were going to do." (FGA 8)

"They do give us a chance to say things that we want to say." (FGA 4)

Some service users though were asked for and gave input into what they wanted from the treatment.

"Yes, because they asked me in the beginning what I really wanted to achieve…" (FGA 3)

"I then told them what I really wanted to do, I wanted to make my own cup of tea or coffee, and I wanted to use the toilet on my own. That's when they decided to give me the chair so that I can bath myself and use the toilet on my own. They also asked me if there's anything else that I wanted to do and I told them that I really wanted to walk someday." (FGA 8)

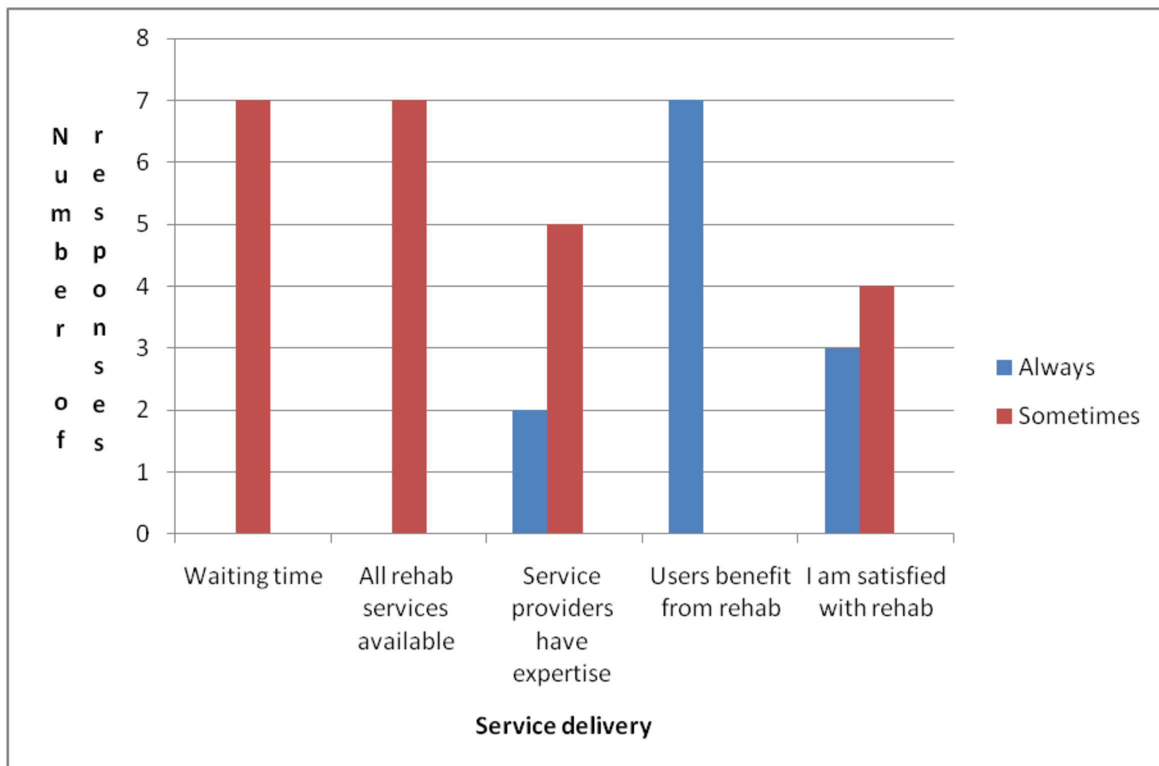

Figure 5.6: Participants opinion on the rehabilitation service they deliver

The facility manager did not answer these questions thus there are only seven instead of the usual eight responses

5.4.3.6. Documentation

In the Rehabilitation Department there is an appointment diary for appointments. This book is kept in the rehabilitation department and patients must go to the department or phone in to the department to make an appointment. All appointments for rehabilitation are written in this book together with a contact number of the patient as well as the diagnosis and origin of the referral.

> *"They take your card and check the diary that you have an appointment and you get treated."* (FGA 9)

There is a separate patient register which is completed daily for patients treated that day, and contains patient particulars including name, gender, folder number, diagnosis, origin of referral and record of rehabilitation treatments received. This record indicates whether the patient has been seen before or whether it is a new referral. It also records the length of time of the treatment. At the end of the month information from this register is collated and sent to the manager. A book which records the ordering and issuing of assistive devices is kept in the department. A record is kept of the name of the patient, the type and size of the device ordered, when it is ordered, when it is delivered and when it is issued to the patient. The serial number of wheelchairs is also documented. There is also a record of when and if assistive devices are returned to the centre.

> *"I have a book in which I keep a record of all the appliances I issue."* (SP 3)

In addition to the above documentation there is also a treatment card for each patient who receives treatment in the Rehabilitation Department. These cards are kept and filed in the Rehabilitation Department. The name, address, telephone number, folder number and date of birth of the patient are recorded on this card. Also recorded are the diagnosis and origin of the referral. Every treatment of each patient is documented on one of these cards. They are dated, signed and filled in on every visit to the Rehabilitation Department.

> *"I keep all my documentation in the rehabilitation department. My statistics for the centre are handed in weekly. I do a monthly stats count too."* (SP 1)

> *"My documentation and clinical notes stay at Gugulethu in the rehabilitation department."* (SP 2)

> *"I document my treatments in the patient's folder"* (SP 3)

"I think the physiotherapy department should have its own folders. Physiotherapy notes are not written in the folder. My hypertension doctor always asks if I attend physiotherapy and I say yes and he says there is nothing showing in the folder." (FGA 7)

Figure 5.7 shows that all service provider participants agreed that forms to keep patient statistics are available. In addition, leave forms are available according to all. However discrepancies were found with regards to the other documentation and it might be that participants not working in the Rehabilitation Department referred to forms used in their own apartments. Four participants indicated a lack of policy documents, five said that no annual report is written and three have no job description. The physiotherapist and occupational therapist both have job descriptions but the orthopaedic sister does not. All three these participants working in the Rehabilitation Department, do have performance appraisal documents.

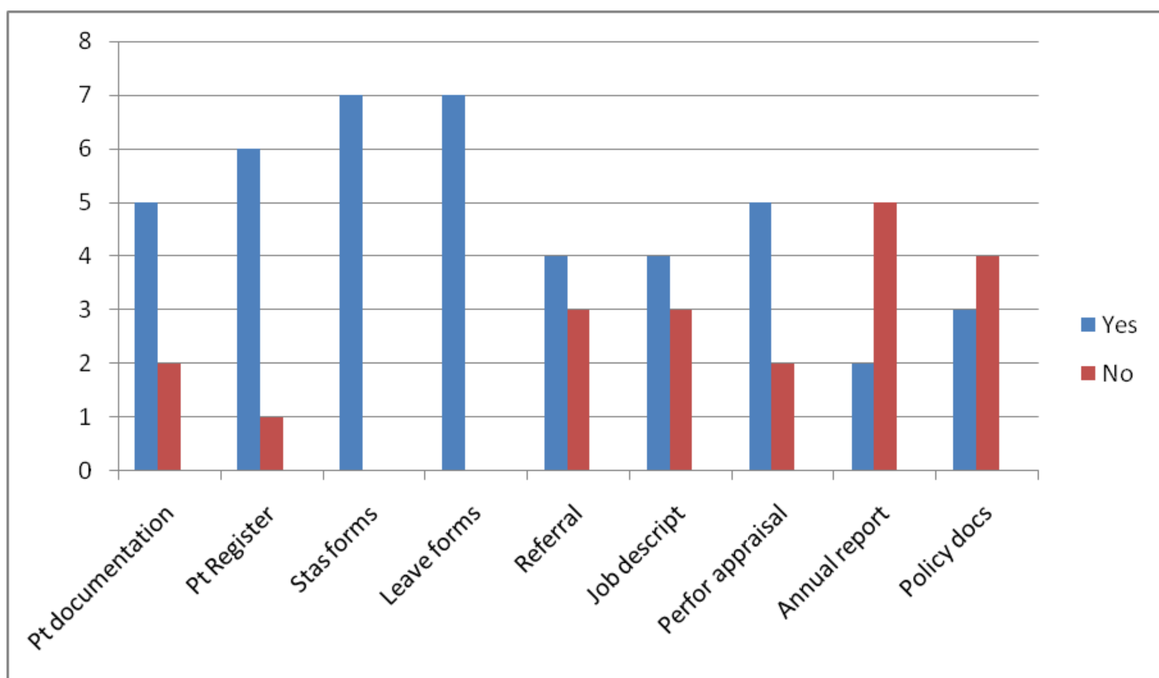

Figure 5.7: Standard documentation for rehabilitation services

The facility manager did not answer these questions thus there are only seven instead of the usual eight responses

The job purpose of the rehabilitation therapists at Gugulethu CHC, as found in the job descriptions, is to provide and manage an effective rehabilitation service within the Community Health Centre as well as to the surrounding community. The objectives are to promote an effective rehabilitation service at primary level, to reduce the impact of

impairments caused by diseases and disability, to promote a healthy lifestyle and reduce the burden of complications of chronic diseases of lifestyle and to improve the quality of care and to implement an appropriate package of service within the community.

5.4.3.7. Collaboration, Partnerships and Participation in Management

Rehabilitation service providers are aware of the need to form strategic partnerships with members of the community, non-government organisations in the community and other government departments in order to extend the rehabilitation services. Some evidence of this was found during data collection.

> *"I visit the Old Age Home weekly and also have a good relationship with the Thembalethu workshop. I also visit Sinethemba quarterly to assist the carers there."* (SP 1)

All eight municipal wards in Gugulethu have representation on the Health Forum of the centre which meets monthly. The facility manager works hand in hand with the local police.

> *"The police need to be present at our Morbidity and Mortality meetings because of the crime in this area which ends up in our trauma unit and so we are forced to work with the police."* (FM)

Seven service provider participants agreed that the rehabilitation department receives referrals from the community and sectors other than health. These referrals include those from other governmental departments such as education, labour and social services. However figure 5.8 shows this to be a small percentage of total referrals. According to the patient register an average of 72 new patients are referred monthly to the rehabilitation department and about 80% of these patients are referred from within the CHC.

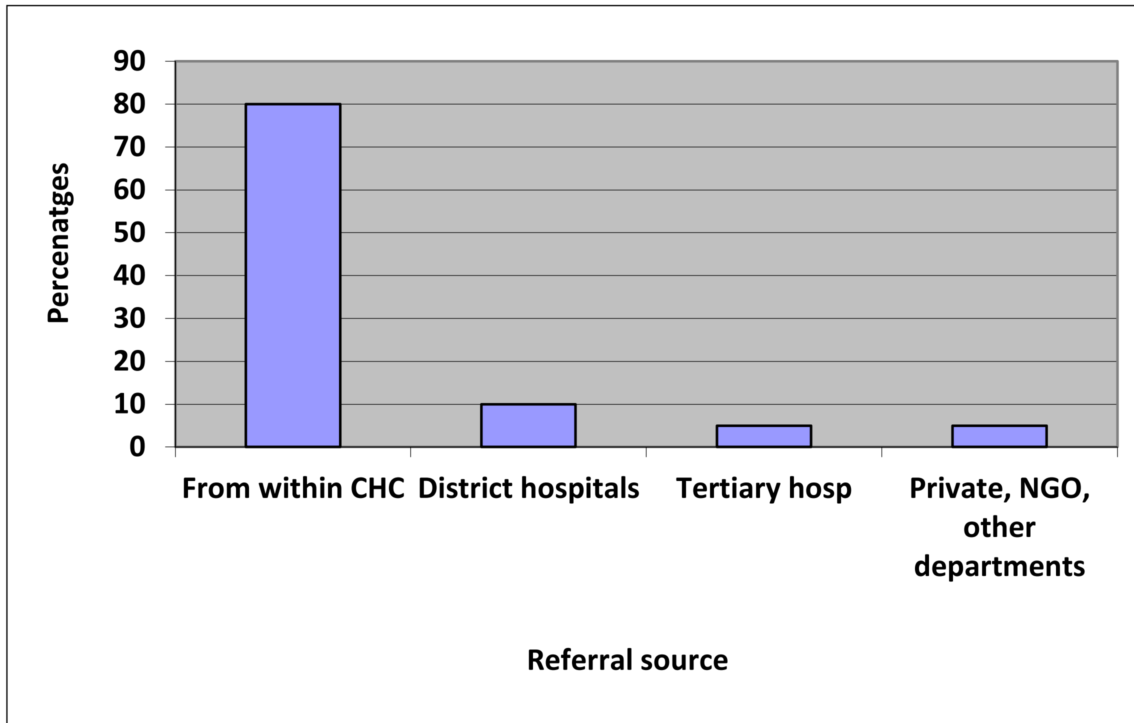

Figure 5.8: Referral sources

Service provider participants said in the questionnaire that patients are referred to sectors other than health including legal and social services. The physiotherapist sometimes referrs patients to the Department of Social Services for a disability grant or other social issues, particularly when the social worker in the CHC cannot sort out the relevant problem. This is usually only one or two patients a month. According to the client register two patients per month were referred from the rehabilitation department to other levels of health care or other governmental departments.

The majority of participants felt that partnerships are formed with NGOs, DPOs, and government departments. Referrals are accepted from Non-governmental Organisations such as disabled workshops and Special Care Centres in the community. The manager felt that the CHC has a good supportive relationship with the Department of Social Services and that there was good professional collaboration.

Table 5.2: Collaboration with other sectors (NGO respondents excluded)

	Yes	Uncertain	No	No data
Refer to services other than health	7	1		
Accept referrals from services other than health	7	1		
Users referred for legal advice or for other social structures for support	7	1		
Do outreach rehabilitation	6	1		1
Supports other sectors with rehab services	7	1		
Share space with NGOs	5	2	1	
Interdisciplinary co-operation	7	1		
Formed partnerships with other government sectors	5	2		1
Formed partnerships with NGOs.	6	2		
Formed partnerships with DPOs.	1	6	1	
Meet with other sectors (like Labour, Education)	3	4		

Both NGO managers interviewed felt that they received a lot of support from the Guguletu CHC, particularly from the orthopaedic sister. They felt they could refer their clients there and that the rehabilitation staff would assist their clients to be fast tracked through the system. One of the NGOs employs an occupational therapist but the other one depends on the CHC for all its rehabilitation needs.

Figure 5.9 indicates that all but one service provider respondent felt there are persons with disabilities living in the catchment area of the facility. Furthermore they indicated that there are both NGOs and DPOs with a focus on assisting persons with disabilities in the community. While all service provider respondents felt that the community participated in the management of the centre, there was more uncertainty with regards to the participation of

persons with disabilities in the management of the centre. Service users were also all aware of the existence of the health committee but did not know if there were any persons with disabilities on the committee. According to the manager attempts are being made to include disabled people in the management of the centre.

> *"There are no disabled people on the health forum and I should talk to them about this and suggest that they include a person with a disability in at least one of the wards."* (FM)

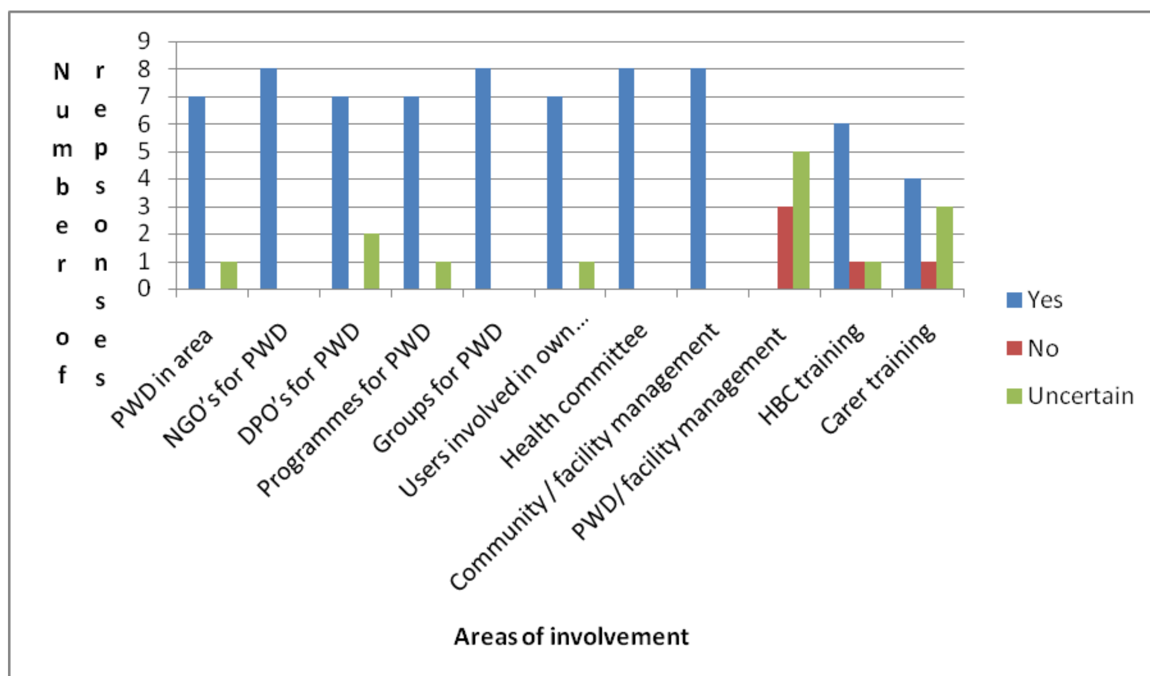

Figure 5.9: Community involvement in rehabilitation service delivery

According to the facility manager the Health Forum in Gugulethu is elected by the people living in Gugulethu. This forum meets with the Community Centre Management Committee regularly. The Community Centre Management Committee consists of a representative from each department in the centre. This means that all staff are represented and involved in the management of the centre. When the Management Committee meets with the Health Forum any problems, complaints and compliments are discussed.

In addition, there is a suggestion box in the centre where clients attending the CHC can make suggestions on how to improve the services. They can complain about the service or give credit for good service. All suggestions found in the suggestion box are discussed at the Centre's Management meetings. Solutions are then discussed and feedback given to the Health Forum when next they met.

5.4.3.8. Monitoring and Evaluation

Participants either indicated that monitoring and evaluation is done by their performance appraisal or were uncertain about it. They felt the same about the usage of the information gathered through monitoring and evaluation. The majority felt that data were collected on uniform documents (the only person to disagree was the doctor) (Figure 5.10).

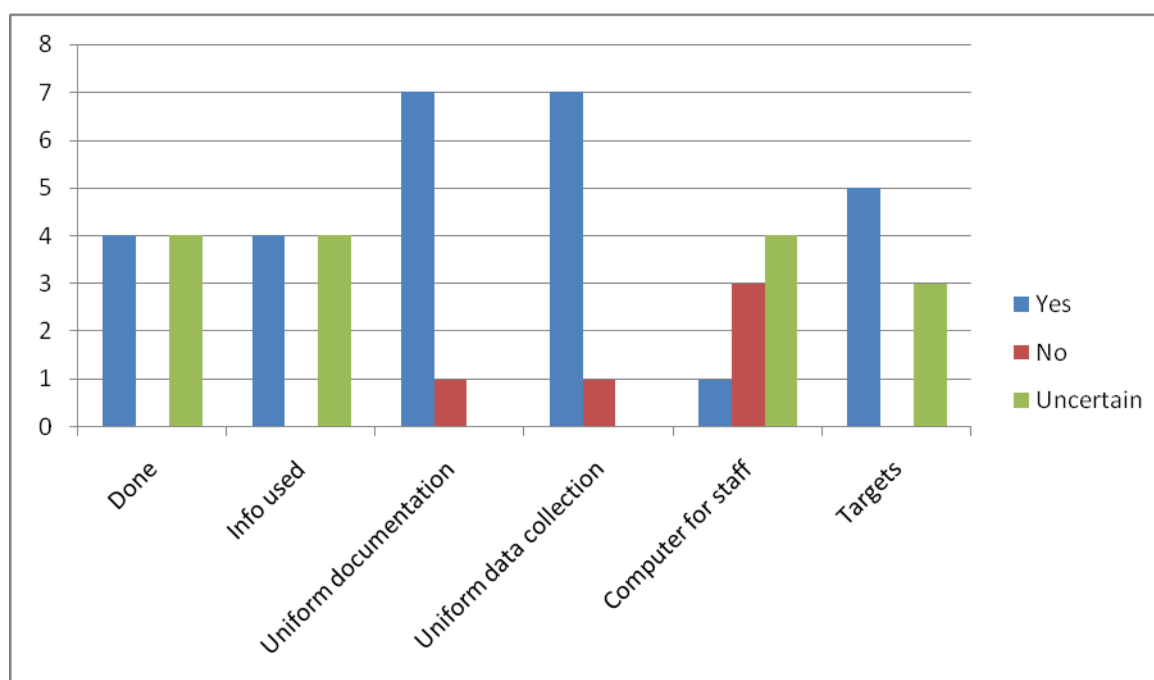

Figure 5.10: Monitoring and evaluation processes

All members of the rehabilitation team are evaluated every quarter and feedback is given individually. Targets and indicators set out for the rehabilitation services are in line with the rehabilitation objectives of the department.

5.4.3.9. Service Providers

Numbers and Adequacy

Three participants, one of whom was the facility manager, indicated that all rehabilitation posts ware filled. All agreed that students work at the facility and according to therapists and the facility manager no community service therapists are employed at the facility.

Skills, Abilities, Competencies and Development

The performance of the rehabilitation professionals is assessed quarterly by their supervisor. This assessment checks whether they are meeting the targets set for the service and a quality assurance audit is also done. The quality assurance audit is done on 5 randomly chosen treatments cards. These cards are then checked to see if each patient is assessed subjectively, whether an objective assessment has been done and whether there is a documented treatment plan on each card. Planning for the development of the skills of the rehabilitation professionals is part of this assessment.

Figure 5.11 indicates that participants have mixed opinions about the ongoing training of rehabilitation professionals. The facility manager answered in the affirmative on all the questions in this regard. However, service deliverers indicated uncertainty about whether it was happening. The only other person responding with a yes to all the questions was the clinical nurse practitioner. The doctor and orthopaedic sister are mostly uncertain about their answers.

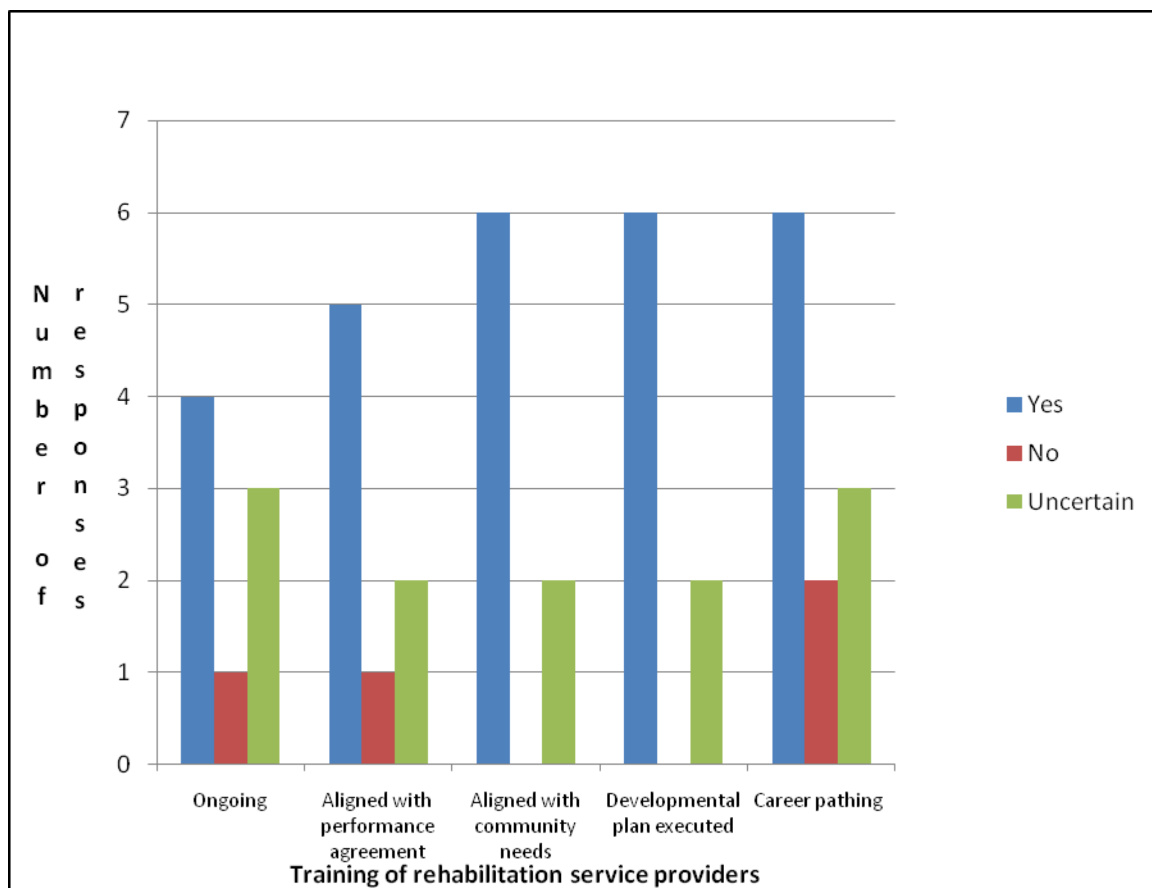

Figure 5.11: Continued training of rehabilitation service providers

The rehabilitation professionals at Gugulethu CHC do attend courses regularly. They do at least one 2 or 3 day course a year and attend about 3 in-service training sessions a year. All participants agreed that there is a budget for skills development.

> "*The facility manager is very accommodating and is willing to pay for and allow any training I wish to attend. I recently did the intermediate wheelchair seating course.*" (SP 1)

The physiotherapist agreed that the budget is used for and by therapists, while the occupational therapist disagreed.

5.4.3.10. Material Resources Available for Rehabilitation (Budgets)

When looking at material resources all service providers and the facility manager have access to telephones, faxes and e-mail. Patients have access to none of these facilities, but there is a payphone on the premises.

All service provider respondents except one felt that there is enough space to do rehabilitation and all felt that the space is accessible. When asked if there is adequate equipment to do therapy, the doctor, social worker and health information officer felt there is not enough equipment while the physiotherapist and professional nurse felt there is adequate equipment, the occupational therapist and orthopaedic sister were unsure. The manager felt that there is adequate space to do rehabilitation but not sufficient equipment.

> *" I do feel that my paediatric service is not accessible enough. It is not an ideal environment to treat children. I do not have enough tools, toys or privacy when treating children."* (SP 2)

The physiotherapist felt that the reason why the other staff felt there is insufficient equipment was because they were often not aware of the skills she is using in her treatments. There are only 2 electrical physiotherapy machines in the department and the physiotherapist felt this as quite adequate as she used only her hands for most of her treatments. The one thing she felt is lacking is a set of parallel bars. There is a dedicated budget for rehabilitation services and she is not sure why she has not received parallel bars as she has requested them.

> *"I receive most of what is asked but am still waiting for parallel bars and a wax bath. I must get round to ordering hot packs which will be supplied."* (SP 1)

Assistive Devices

The rehabilitation service supplies patients with mobility assistive devices. The orthopaedic sister, physiotherapist and occupational therapist know exactly which assistive devices are available whereas the other respondents were not sure which devices are available at the centre and which are not as indicated in table 5.3.

Table 5.3: Information on rehabilitation and assistive device budget

	Dedicated rehab budget	AD budget	AD budget adequate	ADs received	ADs cost to patient
Participant 1	U	U	U	U	Y
Participant 2	Y	Y	N	N	N
Participant 3	Y	Y	U	N	N
Participant 4	U	U	U	U	U
Participant 5	U	Y	U	U	Y
Participant 6	U	U	U	U	Y
Participant 7	U	U	U	U	Y
Participant 8	Y	Y	Y	Y	No answer

The following assistive devices were available at the facility:

- Wheelchair, wheelchair cushions, wheelchair trays and tension adjustable wheelchair backs
- Walking sticks, quadripods, axilla crutches and elbow crutches but no gutter crutches
- Walking frames but no rollators
- Wrist braces and ankle foot orthoses

The types of mobility assistive devices available at the Community Health Centre are determined by the provincial policy on mobility assistive devices (DOH, 2009). This policy determines which mobility assistive devices should be available at each level of care, with more advanced or specialised mobility assistive devices being available at tertiary level and only basic mobility assistive devices available at primary level. Table 5.4 indicates the number of mobility assistive dives issued at the CHC. It shows that walking sticks and

wheelchairs are most often issued. A peculiar finding is that about a third more wheelchairs than wheelchair cushions were issued.

Table 5.4: Mobility assistive devices issued at Gugulethu CHC March 2011- April 2012

Walking Sticks	Elbow Crutches	Walking Frames	Quadrapods	Wheelchairs	Cushions
73	14	18	5	64	43

The therapists felt that the mobility assistive devices available at the CHC are adequate, as the patients seen at primary level do not often need specialised mobility assistive devices and if do they can be referred to secondary or tertiary level for these devices. There is a dedicated budget for mobility assistive devices, although not all participants are aware of this (see figure 5.12). This budget is adequate and all assistive devices ordered have been supplied.

> "*I issue mobility assistive devices for patients who need them and usually have an adequate supply of these.*" (SP 1)
>
> *" A lot of the appliances I need are ordered from the Orthotic and Prosthetic Centre and even though it may take a while for them to arrive I do get what I order."* (SP 3)
>
> *"I got my walking stick when I came here for treatment. When they see that you need something they give it to you."* (FGA 7)
>
> *"They give you what you need. My mother got a wheelchair." (FGA 6)*
>
> *"First time I came here an elderly gentleman had a worn out wheelchair and they gave him a new one."* (FGB 2)

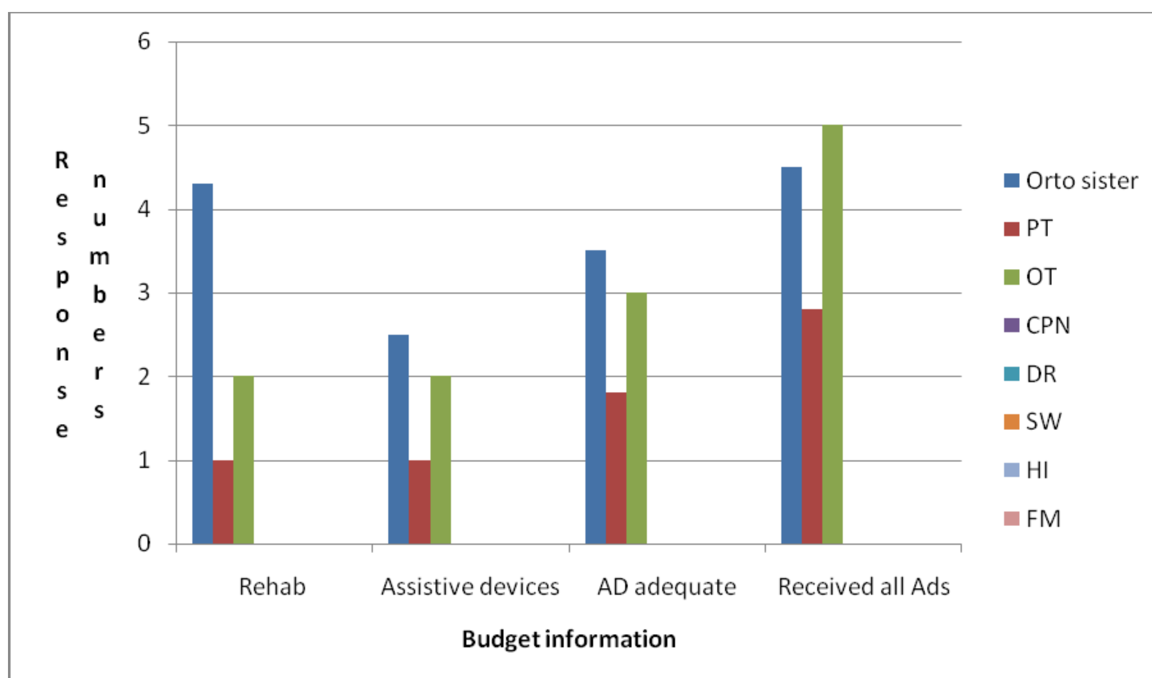

Figure 5.12: Availability and adequacy of rehabilitation and assistive devices budget

Besides the mobility assistive devices such as walking sticks and wheelchairs the orthopaedic sister is also able to supply knee braces, lumbar braces, callipers and inner soles for patients at the centre.

> *"I see mostly foot problems and quite a few knee problems that have had a brace fitted."* (SP 3)

The orthopaedic sister also assists with the fitting and adjusting of prosthetic limbs. These are prescribed, ordered and supplied by tertiary or specialist hospitals but as these patients are usually not in hospital they are followed up by the orthopaedic sister once they are home. They attend Gugulethu CHC Rehabilitation Department for their therapy, both before and after they receive their prosthetic limbs.

The occupational therapist supplies some assistive devices that assist with daily living such as washing mitts, back brushes and adapted kitchen utensils.

> *"We do get all the mobility assistive devices we ask for but would like some tray tables especially for the children"* (SP 2)

No hearing devices are supplied at Gugulethu CHC. Patients are referred to the local district hospital for these.

"We do not supply hearing aids but do not have an audiologist who would prescribe them." (FM)

Reading glasses for older patients are supplied at the centre but other patients needing glasses are also referred to the district hospital.

5.5. Research

The majority of participants indicated that research is done at the facility and supported by management. They were not sure what research has been done at the centre. However, as figure 5.13 indicates they were less sure about the involvement of persons with disabilities and the dissemination of the research back to the facility.

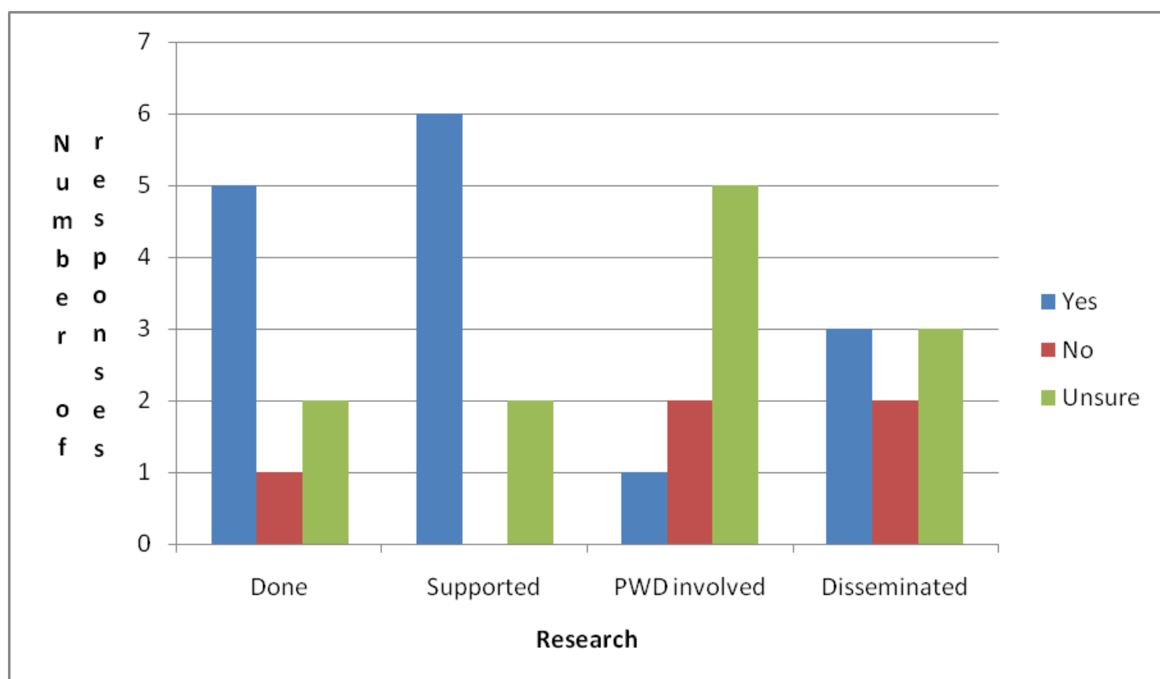

Figure 5.13: Research involvement at the facility

5.6. Summary

This chapter describes the context of the study, the community and disease profile of the community where the study was done, as well as the socio-economic status and the morbidity and mortality of the area. It then describes the services offered at Guguletu Commnunity Health Centre.

The rehabilitation department has only one full time worker and two part time workers and sees an average of 533 patients a month. Eighty percent of the rehabilitation patients are referred from within the CHC. There is enough space to accommodate the rehabilitation services and the results show that most patients seen at the rehabilitation department receive individual treatment. The majority of patients seen, complain of back pain or lower limb injuries. There is adequate equipment in the rehabilitation department and a good supply of assistive devices.

There are training opportunities for those working in the rehabilitation department. Rehabilitation therapists do have job descriptions and are assessed quarterly. The therapists do realise that there needs to be more collaboration with the community and that community participation is essential. Some attempts are made to collaborate with community organisations such as the Special Care Centres, schools and the old age home but this service is very limited. The participants recognised the need to develop strategic partnerships in the community.

The chapter then describes the six elements of Kaplan and how information pertaining to each element was gathered and what relevant information was obtained.Then the chapter describes the interventions offered at the centre as well the relationship with the service users and how service users felt about the service they received.

Results will be discussed in the next chapter.

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CHAPTER 6: DISCUSSION

6.1. Introduction

In this chapter the organisational capacity of the study setting will be analysed according to the Kaplan framework and the results of the study will be discussed with regards to the interpretation and implementation of the seven key indicators developed from the National Rehabilitation Policy in the rehabilitation services offered at the study centre.

6.2. Organisational Capacity of the Rehabilitation Services at Guguletu Community Health Centre

6.2.1. Conceptual Framework and Organisational Attitude

Kaplan`s framework in figure 1.3 indicates that in order to have capacity an organisation must first have “a conceptual framework which reflects the organisation`s understanding of its world” (Kaplan, 1999 p 36).

Gugulethu CHC is a primary level health care facility that must provide amongst other health care services, rehabilitation services to the community of Gugulethu. The first criteria for capacity of the rehabilitation services i.e. a conceptual framework, depends on the rehabilitation service providers’ understanding of the community of Gugulehtu, their context and rehabilitation needs. Secondly it depends on their understanding of what rehabilitation service delivery at a primary level entails. The service providers are aware that they are the only rehabilitation service providers to the community. They also feel that they should be a bigger presence in the community. They have some knowledge of the community and are aware of the poverty and social problems in the community. Therapists are aware that their services cannot extend to everyone if provided in a one on one fashion, but seem not able to change the situation. These findings are similar to findings by Kumurenzi (2011) who noted that many rehabilitation services in the Western Cape seem to operate within an individual, impairment approach. In order for things to change at Guguletu the organisational attitude of the centre would have to change. A survey to look at the rehabilitation service needs in the community should be done and then the organisation must find ways to meet these needs.

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It would seem that therapists are doing what is required from them by their job descriptions and if there is a need for them to do more work in the community and less curative work in the centre, this should be specified in their job descriptions. At present their job descriptions dictate how many patients need to be seen by the therapist and only prescribes minimal community involvement.

The facility manager has a very good understanding of the community she is serving and what the problems in the community are but acknowledged that the problem is that she needs to get all staff at the community centre to recognise these problems and to own them and then share in the vision of building a better service. Although the facility manager acknowledges what has to be done, there is no evidence of any action taken. Another challenge that was identified and that will make it difficult to plan and deliver services according to the needs of the community is a lack of representation of persons with disabilities (the consumers of rehabilitation services) in planning and management of rehabilitation services delivered by Gugulethu CHC.

6.2.2. Organisational Vision and Strategy

The organisational framework must be strengthened by a vision of what the organisation wishes to do and strategies on how to do it. The service providers are aware of the vision and mission of the centre and that they should be delivering a service that is responsive to the needs of the community but find the curative load so large with patients that are so ill that there is little time for promotional and preventative work. They acknowledge the needs, but they seem unable to stop the current direction of services and turn it around. The attitude at the Community Health Centre seems to be that the health promotion officer is responsible for health promotion and the therapists are responsible for rehabilitation treatments. This might be due to the fact that they do not have a clear understanding of the role of rehabilitation at primary level of care or of the burden of disease and the determinants of ill health in the community.

This brings us to the service providers' understanding of the role of rehabilitation in a community based setting. There are a number of significant differences in emphasis of the role between institution based and community-based therapists (Twible & Henley, 2002) as outlined in table 6.1.

Table 6.1: Differences in physical therapy roles

Physical Therapy in Institutions	**Physical Therapy in CBR**
Direct service provision to the client	Mainly indirect
Predominantly 1:1 therapist client ratio	1 therapist to a given population
Person receiving services usually addressed as patient	Person receiving services addressed as client
Rarely works in groups	Often works in groups
Allocates therapy time according to individual needs	Allocates time based on the needs of the population
Ideal to care for a few	Good basic care to all
Perceived higher professional status	Perceived lower professional status
Can focus on a strong biomedical model, although attitudes and approaches are changing	Uses a strong social model
	Teaches / trains local health workers and families to carry out day-to-day therapy
	Acts as an expert resource

When one compares the information in table 6.1 to the work done by therapists at Gugulethu CHC as presented in the results, their present role can be described as that of an institution based therapist, rarely crossing over to a CBR therapist. They are working very hard, and must be commended for that. However they are providing a one on one curative service to a few. In the process they do not reach the majority of the population and might not even succeed in assisting the few optimally, as treatment sessions once a week are seldom sufficient to deal with acute problems. The implication of not providing good basic care to all in the form of promotion, prevention, early detection and management is that conditions worsen before health care is sought, with a resultant more serious condition to treat that requires more time and resources. Little time is spent on education resulting in bad control of risk factors in chronic diseases such as diabetes (Van Rooijen, Viviers & Becker, 2010). Thus direct client services in a one on one scenario perpetuates the problem in that more resources are needed for a condition that could have been dealt with earlier, with less resources.

The therapists seemingly lack the vision of what is required of rehabilitation service providers in a community setting, as well as the managerial and organisational strengths to make it happen. It might be that their ways of doing things are embedded in a culture of curative care as handed down by their respective professions over decades (Kaplan, 1999). Therapists have spent years doing individual treatments and are used to doing things this way (Futter, 2003). To step out and initiate programmes in what is a culturally different community to them might seem like an overwhelming prospect to them even while they acknowledge the need.

In addition there is the current workload to consider. Therapists stay very busy because there is a constant flow of referrals to the department. And while we might argue that their time is not used optimally and the service outputs and outcomes do not address the issues that rehabilitation at primary level should address, it is not as clear cut in practice. What about the patients being referred to them? Who will treat them? How will they tell them; "Sorry you have to wait a month or two for an appointment"? As they rightly indicated some of these people had had surgery and needed intervention to ensure the success of the surgery and optimal functional outcomes. Yes, the surgery might possibly have been prevented if the person was identified early in the community, but now it was not. It cannot be expected from therapists to stand up alone and challenge the status quo. It is the responsibility of managers to guide therapists towards a more community oriented service and to intervene on their behalf with the professionals currently referring to them.

In addition several obstacles hamper the reorientation of the existing rehabilitation service toward the PHC model. One of these obstacles is poor physical infrastructure in Gugulethu as many of the roads are small and narrow and difficult to negotiate by car. Also Gugulethu is a community that has a high rate of crime and violence, so safety is an issue, particularly for those who are not part of the community. Another is that this is a community consisting of more than eighty thousand people and they have only one full time therapist working in the public sector. Currently it is expected of one full time therapist to do post-surgical and injury curative care as well as rehabilitationfor a community of 80 000. This while the norm for a community therapist is 1:6000 and the national norm is three therapists to 100 000 population (DOH, 2012). Even if this therapist could focus only on community rehabilitation she would be outnumbered. Thus the capacity of the organisation is also hampered by a lack of human resources.

However, these figures in themselves should be enough reason to convince management to guide service providers to move from direct one on one care to indirect group work with a focus on the needs of the population and basic good care to all.

6.2.3. Strategies Structures and Procedures

6.2.3.1. Accessibility of Rehabilitation Services

When one scrutinises the results, some positive findings with regards to access to services come to light. With regards to physical access the entire population the CHC served stays within 5km of the service. This close proximity is especially important in a community where transport was a challenge and most patients walked to access services.

The next positive finding with regards to access is that all services were free of charge. In a poor community this will undoubtedly facilitate access. In addition the building is physically accessible, with enough space for services to be delivered and a fast track system for users with disabilities. Thus on the face of it and when one focuses on the services provided at the CHC building it is an accessible service.

Service users however, are not happy with the physical accessibility of the rehabilitation department. They felt it is too far from the front entrance and difficult to get to when the centre is very busy. They felt that a separate building for rehabilitation would be more suitable. Service users also felt they would like even more space for rehabilitation as well as facilities for hydrotherapy. Though these ideas would be advantageous for the provision of a rehabilitation service they are unlikely to become a reality in the present economic environment and would be more suited to a specialist rehabilitation centre rather than at an outpatient primary health care centre.

Another positive finding is that the rehabilitation service works on an appointment system and service users knew that if they were on time for their appointment they would be seen almost immediately which led to very little waste of time due to waiting. Service users all found this very positive.

However, this is a rehabilitation service at primary level of care in a poor, disadvantaged community. Thus to determine its accessibility, one must explore aspects such as the type of services provided, the focus of services, the impact on the community and its burden of disease. In these areas challenges come to light. More than 80% of therapists' time is spent on reactive curative care. The challenge with this is that people often access health care

later rather than sooner in the progression of a disease i.e. they will often first use home remedies and over-the-counter medication to try and solve the problem before accessing health care. In the process the impairment might become more serious requiring more intensive and often more expensive interventions. This is especially true of individuals in lower income groups, such as the people living in the current study community, who have no income security if they are not at work every day (Helman, 2001).

Rehabilitation service providers receive referrals from within the CHC, from tertiary, secondary and district hospitals, private practitioners and NGOs and seemed to react only to referrals. They treat those who were referred to them. The therapists felt that a lot of pressure was put on the department from secondary and tertiary services to treat the patients they referr to Gugulethu. However, only 15% of all referrals are from secondary and tertiary hospitals and 80% are from within the CHC. Whether the therapists choose to see these patients rather than those in the community is not certain, but they were seen, and many patients in the community who could also benefit from rehabilitation services, were not seen. In addition very little promotive and preventative work was done. Thus the possibility that conditions that could have been dealt with easily through exercises or preventative practices such as kinetic handling in the case of back conditions now become serious impairments that might need operations and post-surgical care which require many more resources and much more time.

In addition, conditions referred and treated seem to be skewed toward orthopaedic conditions. There is little sign of other impairments that require rehabilitation such as neurological conditions. It is not sure what causes this especially in the light of literature indicating that non communicable such as cardio vascular diseases are an important part of the burden of disease in Gugulethu and the Western Cape (Puoane & Tsolekile, 2008, Chopra et al, 2007). It might be because of the referral professional's view of rehabilitation or it might have been caused because the physiotherapist is the only full time staff member who provides rehabilitation services. Conditions such as strokes, cerebral palsy and children with developmental delays, in which occupational therapists and speech therapist would play a bigger role seem to not be referred in as big numbers. And it seems from findings that no referral means no treatment. The challenge here is that persons suffering from these conditions are often severely impaired and require assistive devices, family training and education on the prevention of secondary complications. These patients might have many risk factors which are not well controlled (Van Rooijen et al, 2010). In addition they often experience bigger environmental barriers both physical and attitudinal. These attitudinal

barriers reduce full participation in society by people with disabilities and are more of a barrier than the impairment itself (Whiteneck et al, 2004). Thus it is possible that services are not equally accessible for users with various types of impairments. In a study done by Maleka, Stewart & Hale (2012) the negative experiences that patients who had a stroke had to deal with are identified. The main issue was the activity and participation limitations experienced by these patients both in an urban and a rural setting.

Therapists need to address pertinent health issues in the community such as the numbers of patients with HIV/AIDS and the number of patients affected by violence. None of these are seen in the conditions treated and rehabilitation does have a role in the treatment of these conditions, particularly in the neurological diseases that develop with HIV/AIDS. Currently health care services focus a lot of energy on HIV prevention and ART for those with HIV. CBR strategies could address the exclusion and stigma of the disease, as well as the impairments caused by the disease but from the study findings it seemed as if neither issue was addressed by rehabilitation in the study setting. Therapists and the social worker must educate other service providers on their role in these conditions and become part of the HIV team.

Violence can leave one with a myriad of impairments such as a head injury or fracture. Some of the lower limb orthopaedic conditions treated in the study could be due to violence since therapists indicated they see a lot of violence related injuries. However the cause of the condition is not documented. No promotion strategies aimed at decreasing violence were seen. Admittedly the issue of violence is related to social, economic and demographic factors and is much bigger than health care, but that is where the need for collaboration comes in. A multi sectorial team including community members must assess the determinants of violence in this community and implement strategies to reduce it (Hugo, Couper, Thigiti & Loeliger, 2010).

There are some outreach programmes run by therapists in the community but these also address impairments and apply complex therapeutic care, so once again it is curative care, just in a different location. These services are decided on by the therapists when they think they detect a need, but may not necessarily be what the community needs. O'Toole & Conkey (1998) suggested that institution based rehabilitation was helping no more than 2% of those in need. There is however an increasing shift away from delivering health services managed from institutional care facilities to primary health services, centred on the needs of the local community and delivered in the community. This is a focus in both developed and developing countries (Bury, 2005). This is needed in the current setting.

There needs to be a healthy balance between institution based services and community based services. They each have their own unique role and the two services should complement each other. One service should not be sacrificed in favour of the other (Bury,2005).

In addition to a lack of health promotion, prevention and early identification, the results showed little indication that environmental barriers (e.g. accessibility, attitudes) are addressed. Thus therapists failed to create equal opportunities through removing barriers in the environment. They seemingly did not apply the ICF model of disability through focusing on both the impairment and function as well as personal and environmental challenges (Chappell & Lorenzo, 2012).

However in a ratio of 1:80 000 this is impossible to do on a one on one basis and to ensure a more accessible service in these circumstances therapists must turn their focus towards CBR (Bury, 2005). This would provide an opportunity to liaise and collaborate with other governmental departments such as housing and transport and thereby improve access to services. Also, health promotion and prevention programmes must be their focus in the community. This must be followed by screening, early detection and management. Early detection and prevention will prevent conditions from becoming serious and requiring more time and resources for rehabilitation. If this fails and permanent impairments cause disability, medical rehabilitation and CBR projects must be initiated to create opportunities for inclusion and community participation and prevention of secondary complications (DOH, 2000).

The therapists at Gugulethu have to change their approach and role from being expert professionals in rehabilitation who decide when and what intervention is needed, to a valuable resource that can provide assistance, advice and support when asked by the community (Bury, 2005). It must be remembered that when the therapists change their approach there are consequences for other health workers as well as for the service users and they need to know that they too need to play an important role in the rehabilitation process (Bury, 2005). Both the therapists and the other health workers will need to change their view of themselves and what they are supposed to do in order to be able to make the change. As Kaplan (1999) would put it they need to change their view of the world and their role in it. In addition they need to build partnerships with the community and raise awareness of what they have to offer, so that those in the community become aware of the skills they do have. They could also learn to transfer some of their skills to persons identified in the community, as this is very valuable in the primary health care settings and is necessary

where there is a limited budget for rehabilitation services (Bury, 2005). Therapists need to teach their patients to take responsibility for their own health (Frantz, 2010).

The therapists are aware that they were working in a poor community and despite the fact that the rehabilitation service is free patients often need to pay for transport to get to the centre. Though classes and groups in the rehabilitation department have been a way of increasing access to rehabilitation these would be even more beneficial in the community rather than at the CHC. Also these classes are reactive and still focused on the impairments and do not include other factors which also have an influence on disability or the prevention of disability. The classes are also only dealing with seemingly less severe impairments such as backache and there are no classes for patients with severe impairments such as stroke.

Rehabilitation services in Gugulethu should be taken to the community. Presently rehabilitation in the community is very limited and what is done is done with the assistance of home based carers. These home based carers are a valuable resource to the therapists and can provide basic care in the community. They contact the therapists at the CHC if they have any patients who need rehabilitation therapy. The home based carer then brings the patient to the community health centre where the patient can be seen by the therapist. If the patient cannot get to the centre, the therapist then visits the patient at their home with the home based carer and shows the home based carer and carers at home how they can help the patient. These home based carers have a large patient load and their knowledge of rehabilitation is limited which does limit the amount of rehabilitation services they are able to offer but they are a resource that needs to be expanded.

To improve access at Gugulethu to rehabilitation services, there needs to be a shift away from providing and managing these services from the Community Health Centre, to delivering the services in the local community to the local community (Gilson & Schneider, 2008). To make this shift the therapists will have to be adaptable and be competent in transferring their skills and knowledge. An example of this could be peer supporters from the Guguletu community. A peer supporter is someone with a disability who has been trained to educate, support and train people with disabilities in their communities. Therapists will also need guidance and support from their managers and from colleagues working in the community (Gilson & Schneider, 2008).

6.2.3.2. Health Promotion Strategies

In addition to therapists there is the health promotion officer. This person is responsible for health promotion activities in the CHC. The concept of a member of staff dedicated to health

promotion activities is to be applauded and certainly shows a commitment from the side of management towards health promotion. Talks about health promotion on a wide variety of diseases as listed in the national health calendar (http://www.doh.gov.za/docs/webcontent/2011/2012_calendar.pdf) will raise awareness and hopefully facilitate change towards a variety of more healthy practices. However, a few things need to be addressed. The health promotion officer must be provided with a dedicated job description and measurable objectives to her activities in order to monitor and evaluate the effect of these talks in the community. Furthermore it is bothering that talks and other activities are mainly performed in the CHC. Thus again only a small part of the population is reached. In addition only those sitting there on a specific day are reached by that day`s talk. No effort is made to identify at risk target groups, for specific talks. Finally all areas addressed on the health calendar might not be equally relevant for the community of Gugulethu and promotion talks and activities should focus on the determinants of ill health in this particular community.

The challenges pointed out here by no means indicate that the researcher does not see this as a good initiative. On the contrary this is an important step in the right direction, but can be improved on. In terms of rehabilitation services, here the therapists have an existing health promotion strategy to slot in with. For instance on stroke awareness the HPO can talk about primary prevention and the therapist on the prevention of secondary complications and post stroke management of a person by the family. In this regard as in so many others, there are information booklets and CDs available that guide family and community members in the management of the condition and the assistance of the person (Scheffler & Visagie, 2012). These can ease the burden on therapists with regards to time spent in preparation and the provision of written or visual material to take home (a valuable tool that can be incorporated in promotion talks as well as in carer and community training). However, it is vital that the talks, education and training, target specific groups for whom the specific disease or situation is relevant, and that the activities are taken forward from the CHC into the community itself.

6.2.3.3. Acceptability of Rehabilitation Services

Relationship with Patients

Both service providers as well as service users felt that the therapists treat all their patients with respect. Despite being nervous or apprehensive when referred for rehabilitation service users agreed that they are put at ease and made to feel comfortable once they went for treatment. This is important as there can be no therapeutic benefits if patients are

uncomfortable or ill at ease. It is important that patients are made to feel comfortable with their therapists and that they are given the opportunity to participate in their treatment. Once patients feel they have been listened to and understood they are more likely to benefit from the treatment. Also, if service providers listen to their patients they are better able to hear things which can help them provide treatment that is tailored to the patients needs (Havranek & Allen, 2008).

Satisfaction with Services Provided

The service users were very satisfied with the treatment they received from the rehabilitation workers. They felt they were given an opportunity to give input into their treatment and to tell the therapist what their expectations of and goals for the treatment were.

6.2.3.4. Documentation

All documentation of rehabilitation treatments is kept in the rehabilitation department and although this is very convenient for the therapists as they are able to consult their notes whenever they need, it is not always advantageous to the service users. When these service users consult the doctors at the centre there is no record in their medical folder of the rehabilitation treatment they have received and so the doctor is not aware of these treatments. This means that there is not very good communication between the various services providers and this could lead to less than optimum treatment of the patients.

6.2.3.5.Service Outputs: Number of Patients Treated

Two of the service providers interviewed work part time at the centre and only one of the therapists interviewed works full time at the centre. This therapist spends 80% of her time on direct client contact treatments and sees approximately 3 clients an hour. Statistics of the other 2 therapists do not tell us what the need for more therapists is, only the number of clients they manage to see in the limited time they are at the centre. If they were able to spend more time at the centre there would be an opportunity to increase the number of patients seen as well as vary the interventions made.

6.3. Collaboration, Partnerships and Participation in Management

A further challenge is the very limited community interaction and networking that was depicted by the results. The core to the sustainability of a rehabilitation service at a CHC is effective organisational development and intersectoral collaboration (Gilson & Schneider, 2008). In South Africa there is some agreement that rehabilitation does not enjoy a common

understanding or shared value of its particular role and place (Cole, 2012). When looking at the health of a community and assessing the health risks and the performance of the service provision of the health care sector, one needs to go beyond the health sector and traditional medical approach (Wiman, Helander & Westland, 2002).

Community based approaches must be integrated into PHC strategies. Such cross-sector approaches require intersectoral collaboration, community participation and empowerment of all people, including those with disabilities (Kaseje, Olayo, Musita, Oindo, Wafula & Muga, 2010). The role of the health sector in the prevention of disabling conditions, in addressing disabling disease and limiting their effects, as well as in rehabilitation is central but other departments such as labour and education also play a role.

Therapists at Gugulethu are aware that their role should expand into the community and collaboration with other sectors and departments in the community so that the limited resources can be put to optimal use. However, besides doing the Back Week exercises at schools no more attempts are made to foster intersectoral collaboration and perhaps it is time for the managers of the service to provide some leadership and guide therapist in ways to increase this collaboration.

A start would be to make contact with a disabled peoples' organisation and find out what the needs of that community are (Kaseje et al, 2010). Partnerships and alliances are key for the sustainability and continuity of any programme. Partnerships need to be formed across the different sectors. There needs to be co-operation with organisations addressing common issues (Lorenzo et al, 2006). It would not be a good idea for professionals to decide what would be best for the community and the persons with disabilities living there. They need to co-operate with other groups already addressing disability issues.

There should be collaboration and co-operation amongst the various departments and sectors involved in the disability field in South Africa (DOH, 2000, Gilson & Schneider, 2008). While the Rehabilitation Department at Gugulethu does communicate with other departments, specifically social services and the department of education, it is limited. Liaison with the social services is mainly to assist patients in obtaining disability grants. No requests for counselling or developing of promotion programmes in the communities seemed to be made. Therapists in Gugulethu should have regular contact with the social services in Gugulethu so that if they come across a problem they do not have to start a communication process to sort the problem out but know exactly where to go and what to do. The same should account for the local housing and labour departments. In fact they should foster

relationships with these departments and ensure proactive rehabilitation such as accessible houses in new housing projects and inclusive labour practices.

An example of more proactive networking was with the department of education. The Gugulethu therapist did organise annual visits to six schools in the area to promote back care amongst the learners. Back pain is the biggest burden of disease in the rehabilitation department and these visits to schools are an attempt by the therapist to address this problem early and make a difference. The load of curative work in the rehabilitation department is so heavy that patients with back pain can only be seen once a week and this will limit the success of the treatment. One could ask if the therapist's time would not be spent more wisely doing more back care promotion in the community which could then decrease the number of patients seen with back ache at Gugulethu CHC.

The professionals need to think about where they see themselves and their role in the rehabilitation of an individual. Their role should be one of empowerment of the individual and their family and the focus should be on optimal quality of life for the individual within his community. Once the rehabilitation department starts networking with the other departments and with different organisations in the community they will find that as the communication increases the number of referrals from within the community will also increase. Hopefully with time, this increase will be offset by the successes of their promotional and preventative programmes and less people will need curative rehabilitation services. At the moment they spend practically all their time inside the rehabilitation department at Gugulethu and this serves as a constant reminder to those in the CHC to refer patients to their department and the therapists stay busy inside their department.

Two of the sectors the Rehabilitation Department should be collaborating with more, are the secondary and primary levels of rehabilitation care so that therapists at these levels can become aware that the therapists working at primary level need to do more work in the community setting and therefore will not be able to do as much curative work in the CHC. The benefits of this will be that they will be able to do more health promotion and disease prevention and this will hopefully lead to a healthier community and less admissions to the hospital.

Therapists also need to collaborate with the family members or care givers of patients attending the rehabilitation department at Guguletu CHC. Therapists encourage family members and care givers to attend treatment sessions with the patients and in this way they too can be educated about the condition and also in the treatments being done. Finkenflugel

(2007) states that family members should be involved in all aspects of the rehabilitation process and therefore this involvement would be even more effective if it was in the community in the patients' homes as the NRP sates. Once again the therapists do limited visits to homes because of the curative load at the centre.

The Rehabilitation Department has made a small start in forming networks and partnerships in the community but there is a lot more that still needs to be done.

6.3.1. Participation of Persons with Disabilities

There needs to be more involvement of disabled persons in the planning and implementation of rehabilitation services in Gugulethu.

When receiving treatment at the Gugulethu CHC Rehabilitation Department, disabled patients do participate in the planning and implementation of their own treatment in collaboration with the therapist, according to the therapists and some users. Kahonde, Mlenzana & Rhoda (2010) reported that in their research they found that participants had mixed feelings regarding their involvement in the rehabilitation sessions. Although they reported that the service providers involve them in their rehabilitation, some felt that the service providers implement their treatment without providing any explanation to the client about the treatment procedures.

While the disability movement has been critical of the health care professions (Oliver, 2006), the professions have perhaps listened and begun some fundamental changes. Through empowering people with disabilities to be active participants in individual treatment programmes, they have acknowledged that people with disabilities are not passive recipients of perceived professional wisdom, knowledge and skills.

However disabled people have no participation in health care planning, delivery and service evaluation of the Gugulethu rehabilitation services. A partnership model that includes all parties who are involved must therefore be developed (Bury, 2005). Once again the peer supporters could be an example of this as they are a resource to their peers and can be an extension of the services provided by rehabilitation professionals.

At this stage the partnership model at Gugulethu is limited to the collaboration with the three NGO workshops, the two Special Care Centres, six schools and the old age home.

The NGO workshops are visited monthly by the orthopaedic sister and though this is a form of collaboration between the rehabilitation centre and the NGOs, there is no real participation by disabled persons in these workshops, in the rehabilitation services planning or in the service delivery to the NGOs. They should participate in the planning of these services and give input into the type of rehabilitation service they would like to see delivered at their workshops.

The therapists visit two Special Care Centres in Gugulethu twice a year. These centres care for disabled children and the therapists do not treat the children but provide training for the carers. Once again there was no participation by the staff, parents or disabled children in the planning of this service. The therapists are reaching their targets by providing some rehabilitation service at an institution but do not know whether this service is meeting the needs of that centre.

Another service in the community is weekly visits by one of the therapists to the local old age home and this service was decided on by the therapist as it was often difficult for patients from the old age home to the CHC. There were acute patients referred who the referring doctor wanted to be seen and treated and this left limited time to do promotional and preventative programmes.

There is no evidence of any involvement of disabled people in any planning, implementing or monitoring of rehabilitation services in Gugulethu but there was also no evidence of any planning of rehabilitation services. Disabled people can have a representative on the Gugulethu Health committee but at this stage there are no disabled people on this committee and efforts must be made to ensure disabled people are represented at this level.

The service providers at Gugulethu CHC still have some work to do to improve the inclusion of disabled persons. There are policies such as the National Rehabilitation Policy that seek to promote equity but they challenge the status quo and are difficult to implement. Implementation of this policy can be facilitated when responsibility is assumed by all stakeholders and some stakeholders may have to make drastic changes to the ways they have been working for many years. By working together, all stakeholders, including those with disabilities, need to challenge exclusion and discrimination (Duncan et al, 2011).

At this stage people with disabilities have no input into any aspect of the rehabilitation services at Gugulethu. They are not involved in the planning, the implementation or the monitoring and evaluation of the service. A more client-centred model of rehabilitation must

be developed at Gugulethu so that the individual is central in all apects of his rehabilitation (Davis,2006).

6.4. Resource allocation: Material Resources Available for Rehabilitation: Assistive Devices

Rehabilitation is often seen as a luxury service and is given low priority when determining budgets (DOH, 2000). At Gugulethu CHC the rehabilitation posts on the establishment list are filled and the department does utilise physiotherapy students. There is a dedicated budget for rehabilitation services and although it is not a large amount it is adequate while there is only one full time therapist employed there.

Assistive devices are used to compensate for functional limitations (Wiman et al, 2002). Assistive devices can be classified based on their functions in helping individuals perform within their community and can be seen as facilitators which enable disabled persons to overcome barriers. The provision of mobility assistive devices is free at Gugulethu CHC and enables disabled patients to become mobile. With the lack of transport in Gugulethu a wheelchair or walking device can enable patients to get from one point to another. According to policy, wheelchairs must be issued by discharging hospitals which means that patients with more complicated conditions such as paraplegia or amputation would receive their wheelchairs from their discharging hospitals.

The budget for assistive devices is also adequate and the rehabilitation department receives all the assistive devices it needs for its patients. Kahonde et al (2010) reported that in the Western Cape most people with disabilities were satisfied with their access to assistive devices. Therapists at Gugulethu are happy with the assistive devices they could issue. As it is a primary care institution they can issue basic assistive devices and found that this was adequate for most of their patients. They have had no trouble referring patients who needed more advanced devices to another level.

The allocation of resources for this department as it is at the moment is sufficient but this service does need to expand into the community and this will stretch the present resources.

6.5. Human Resources and Human Resource Development

Despite all the rehabilitation posts at the centre being filled all the service providers and the service users felt there should be more posts created and more therapists employed at the centre. With the large work load in the Community Health Centre as well as in the Guguletu

community one full time therapist is not enough to deliver a comprehensive rehabilitation service.

Historically therapists have stuck to a medical approach, and with the role that is required of rehabilitation therapists when they take on PHC strategies, it is possible that they lack sufficient skills or confidence. It is important to identify the skills required to fulfil these roles and provide training in them.

6.5.1. Skills, Abilities, Competencies and Development

There is a need for more development of the present therapists to give them the capacity to expand the services into the community. Provincial departments of Health need to look at their human resource management to better address the rehabilitation needs of people with disabilities in local communities (Chappell & Lorenzo, 2012). Work in the community involves a lot of promotive and preventive work and though the pre graduate training of therapists now includes a lot of community work, it still concentrates on curative treatments and therapists often feel ill-equipped to work in the community. Therapists are also reluctant to work in disadvantaged communities because of safety issues. In Gugulethu there are high levels of crime and violence associated with the high unemployment rate (Cristavao, 2011).

The therapists at Gugulethu were younger and had less experience than the other service providers who participated in the study and may not have the high degree of flexibility and a wide range of skills needed to contribute to community rehabilitation programmes (Nualnetr, 2009). In the community, rehabilitation therapists have the potential to undertake a number of roles. These include preventing disability and disease, promoting self-care, educating, training and transferring of skills, consultancy, advice and support. Therapists also have an advocacy role for disabled people and local communities. They can also act as advisors to governments and local communities. Lastly they can also offer curative services.

Unlike institutional rehabilitation programmes, the competency of professionals in disability inclusive development programmes tends to move away from direct, hands-on interventions (Finkenfugel & Rule, 2008). At primary level the role of therapy professionals is to share their skills and educate people in the community. The health promoter at Gugulethu is also doing health promotion and education in the centre at Gugulethu and it would be advantageous for the therapist and the health promoter to collaborate to expand these programmes into the community.

In her research, Futter (2003) identified gaps in the undergraduate training of physiotherapists at the University of Cape Town that needed to be addressed in order to prepare students to be competent and confident to practise in community settings. Changes in the curriculum at the University of Cape Town have been in operation for the last 7 years.

The effects of these changes have been difficult to assess as the students at Gugulethu CHC are doing mostly individual treatments, because that is the work being allocated to them. However the therapist has noted that students do spend more time doing promotion and prevention and do treat patients holistically rather than just concentrating on their medical diagnosis. It would appear that despite universities making an effort to change their curriculum and teaching students to be more client-centred and community orientated, once they enter the clinical setting at Gugulethu they continue in the old tradition of providing mostly individual curative treatments in the centre. This might be due to the practice of the therapists employed there. Qualified therapists are very often role models for students and students would follow their lead. There are many difficulties in creating a primary care orientated vision and this needs to start during training and continued in the relevant clinical settings.

6.6. Monitoring and Evaluation

One of the objectives of the NRP is that appropriate monitoring and evaluation procedures for all rehabilitation procedures and projects be instituted.

When looking at the job descriptions of the therapists at Gugulethu CHC the job purpose is to provide a comprehensive therapy service using curative, promotive, preventive and rehabilitative programmes. There are indicators which determine that there is some involvement in all four these programmes but other than that it is open to the therapists' interpretations. The indicators which promote rehabilitation in the community are determined by the number of home visits and visits to institutions done monthly and also by monthly health promotion talks and two big health promotion programmes twice a year. Once a therapist has reached these targets the rest of her duties can be curative and based in the centre.

At Guguletu CHC these targets and indicators set for the therapists are monitored quarterly but there is no monitoring of the overall rehabilitation services and service outcomes. Even the monitoring of the therapists' targets does not give any indication of how and where services are lacking or need to be expanded.

If monitoring and evaluation of the rehabilitation services was done in the Gugulethu community there would be some idea of the effectiveness and efficiency of the service being delivered. At present monitoring would be hampered by the fact that there are no clear targets and indicators for a community rehabilitation service in Gugulethu. Progress in the delivery of a rehabilitation service can only be monitored if appropriate indicators to appraise the progress of activities and targets are developed (Van der Veen, 2011). Once one has defined targets and indicators the process of monitoring and reviewing the progress is facilitated.

Health promotion is an important strategy in the delivery of primary health care but there are no indicators at Gugulethu to monitor and evaluate the impact that is being made by health promotion. For a service to be effective it is important that the outcomes be evaluated. The outcomes that are monitored at Gugulethu are the disease profiles which could be affected by health promotion but there are too many variables to be able to determine whether any decrease or increase in disease is as a result of health promotion being present or absent.

6.7. Research Initiatives

Research needs to be done in order to develop a service which is effective and efficient and also meets the needs of the community. When the service being developed is a rehabilitation service, the disabled people in the community must be involved in this research and they need to be empowered to take the initiative and build relationships with universities and colleges which can then enable them to participate in the research process and learn and hopefully benefit from the results of research (McKenzie, 2011).

At Gugulethu there is some research being done but there are no disabled people involved in this research. When looking for data capturers for some parts of this SANPAD research the rehabilitation staff was contacted to identify some assistants from the community and they were informed that disabled people would be given preference. Despite using the rehabilitation department to make contact with the disabled people in the community there were no applicants who were disabled. More concerted efforts need to be made to involve people with disabilities.

It is important that when research is done that the results are disseminated back to the research setting. If staff are not made aware of the results of research done at the centre, they will be less inclined to partake in future research and not be aware of any benefits derived from previous research. Even if research results do not put participants in a good

light these results should still be fed back. This feedback should be done with tact, explanations should be given and there must be offers to assist in the change process.

Capacity calls for the integration of health services into the process of community development, a process that requires political commitment and intersectoral collaboration. Rehabilitation service providers need to ensure that their services are accessible to all citizens, particularly those who did not have access to rehabilitation previously and when setting up rehabilitation services the community and community organisations must be part of the decision making process (DOH, 2000). In the end this service showed the same weak capacity to implement primary health care strategy that has been described in the literature (Wiman et al, 2002).

6.8. Summary

This chapter looked at the capacity of Gugulethu CHC to deliver rehabilitation services and found it had capacity in some areas but was lacking in others. It also looked at the objectives of the National Rehabilitation Policy to see how they had been interpreted and implemented at Gugulethu CHC.

Access to services at Gugulethu was found to be limited and most rehabilitation services offered at Gugulethu are offered on site and need to be expanded into the community. Therapists still do too many individual treatments. Expansion of services into the community would improve services and for this to occur human resources will have to be increased.

There is some intersectoral collaboration with the Departments of Education and Social Services but it is limited. Provision of assistive devices is good and human resources need to be developed more.

There is some participation by persons with disabilities but this needs to increase specifically in the field of research. Monitoring of rehabilitation needs to improve.

Recommendations will be discussed in the next chapter.

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CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS

7.1. Conclusions

The main aim of this study is to describe and analyse the organisational capacity and ability of the Gugulethu CHCC to deliver rehabilitation services in accordance with seven key principles developed from the objectives of the National Rehabilitation Policy.

It is the conclusion of this study that the rehabilitation service does not currently show the organisational capacity to impact positively on the community in which it is situated.This could mainly be ascribed to the finding that services are provided according to traditional institution based delivery methods instead of the more applicable community based form of service delivery. There are gaps in the provision of rehabilitation services in Gugulethu and by not expanding the service into the community there are people, including those with disabilities who might be underserved.

According to their mission the service aims to be responsive to community needs. However an overview of the key indicators indicates that they failed to deliver on this vision. Service providers succeeded to a large extend in making services at the centre accessible to all. However, the service is not taken to the community and does not focus on the determinants of ill health in this community such as violence, stroke and HIV/AIDS. Partnerships were not established and networking is limited to some collaboration with schools in the area where some promotive work is done.

Human resource development is done, but does not focus on the needs of the community or skills that would enhance the ability of service providers to deliver rehabilitation services at a primary level of health care. Posts are full and money is available for assistive devices. However, figures indicate a serious shortage of human resources. Should these be appointed, or service delivery moved into the community as required, resources might not be enough. Services are not monitored or evaluated in a way that provides results that could be fed back into the service in order to enhance it. Persons with disabilities do not participate in planning or management of services.

Research is taking place at the centre but once again there is no involvement of persons with disabilities. Also research results are not being disseminated back to the centre.

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7.2. Critical Findings

- Rehabilitation services are largely provided at the Community Health Centre.
- Very little rehabilitation service is available in the community.
- There is little or no participation by the community or disabled people in the planning or delivery of rehabilitation services.

7.3. Recommendations

- Community rehabilitation services need to move away from traditional methods of rehabilitation service provision and accept the strategies of Community Based Rehabilitation. The services need to consider the long term needs of disabled people and integrate with the home based care services. As there are earlier discharges from hospitals and the de-institutionalisation of many patients to primary levels of care there needs to be the redeployment of rehabilitation staff or the appointment of additional staff at this level. As promotion, prevention and early detection start to have an effect through community based rehabilitation the need for curative services should decrease.
- The skills needed to plan and implement a community based rehabilitation service need to be identified and then the rehabilitation therapists need to be trained in these skills. Managers then need to assist in the planning of rehabilitation services at this level and give guidance to the therapists, so that there can be a balance between institution and community based rehabilitation services.
- Strong referral systems need to be developed to ensure a seamless rehabilitation service between all levels of care, from tertiary level down to primary level and into the community.
- In order to expand rehabilitation services in the Gugulethu community and the difficulty in getting professionals to work in the community, trained mid-level rehabilitation workers need to be included in the delivery of rehabilitation services in this community. Furthermore therapists need to make more use of the resources in the community such as family members of patients and increase their contact with home based carers. Therapists need to ensure that these carers can be an extension of their services.

- An audit or situational analysis needs to be done in the community to determine what the exact needs of the community are. These needs as well as information from other studies done should then form an important part of the planning of the service.
- All rehabilitation staff must have job descriptions and performance appraisals and these job descriptions and performance appraisals must be brought in line with the service planned, which should in turn be aligned with the objectives of the NRP. Also the organisational attitude as well as the vision and mission of the organisation must be cognisant of the objectives of the NRP.
- The Rehabilitation Department must start working to develop partnerships and to collaborate with other government departments in Gugulethu and also with other providers in the health sector. They will also be able to contribute to the planning of services and all the resources in the community must be utilised in order to provide an effective service. Therapists need to see the advantages of harnessing the potential available skills in the community and how this can strengthen the rehabilitation service.
- Good monitoring and evaluation strategies of rehabilitation services must be put in place, once indicators and targets for the services have been developed. It is very difficult to assess a service if there are no clear indicators and these indicators should be in place for all aspects of the service; planning, organisation and implementation. In addition indicators should focus on outcomes as well as outputs. Findings should be fed back into the service to continuously improve services.
- People with disabilities must be included in the planning of rehabilitation services. Many people with disabilities have the experience and knowledge to contribute to a rehabilitation programme and can be a valuable source of information and provide peer counselling and training.
- More research initiatives should be put in place, specifically in the field of rehabilitation and every effort should be made to include people with disabilities in these research projects. There is still a lack of information about people with disabilities in Gugulethu and what rehabilitation services they need.

7.4. Recommendations for Further Studies

- The effectiveness of health promotion as provided by the health promotion officer must be evaluated in order to build on its strengths.

- The outcomes of the Back Week activities in school by the physiotherapist must be assessed in terms of its impact on the behaviour of children with regards to implementing back saving activities.

7.5. Limitations

- During the development of the questionnaires not all the relevant literature was sourced by the group. More effort should have been made by the group to source all literature pertaining to the National Rehabilitation Policy, the relevant articles of the UNCRPD as well as more information around the Kaplan framework. More literature could also have been sourced with regard to the adherence of other services to other policies. Other frameworks to determine capacity could have been looked at and then more justification given on why the Kaplan framework was the most suitable for this study.
- The questions developed in the questionnaires do not fully explore the issues they set out to examine. They do cover some of the issues but there are some areas where very little relevant information is obtained from the questionnaires. Particularly with regard to the UNCRPD the questions do not address the issues raised in the relevant articles of the UNCRPD. In addition some aspects under study could not be best studied by quantitative methods. More open-ended questions could have been used in the questionnaires and thereby more qualitative information could have been gathered. This limitation of qualitative information was addressed through including qualitative methods in the form of interviews and focus group discussions in the study.
- Identifying user participants for the focus group through service providers could have led to the selection of users that the providers knew were satisfied with the service. A more neutral way of identifying users such as selecting them from the folders would have created less opportunity for this. However, since the researcher had no knowledge of users it would have been impossible to purposively sample those who could provide rich data in this manner.
- No document perusal of patients' treatment records was done to determine what the outcomes of the rehabilitation treatment was. This study concentrated on the structure of the rehabilitation services and another part of the SANPAD study will look at the outcomes.
- It would also have been useful to interview the managers of the NGOs and see the extent of these managers' knowledge of the rehabilitation services and whether they

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saw rehabilitation as a priority service or not. Also it would have been useful to see how effective they thought the rehabilitation service offered in this community was.

- The participants' knowledge and perceptions of the needs of the community and their understanding of the role of rehabilitation services at primary level were not explored. The study looked at what services were being offered by the participants but did not explore whether the participants considered their services effective for the community they were servicing.
- Only the service providers working in the rehabilitation department were interviewed. Interviews with other participants who did not work in the rehabilitation department would have provided a good overview of how the rehabilitation department was viewed by other members of staff and how they understood the rehabilitation services and whether they thought the rehabilitation services offered were effective.
- Having so few participants in the research limits the ability of the research to prove anything. More literature should have been sourced to guide the group to design a more comprehensive tool, which should have been completed by more participants which would have led to better data collection.

7.6. Dissemination of Results

The plan for the dissemination of the information gathered in this study is to first set up a meeting with the rehabilitation staff and the manager at Gugulethu CHC and discuss the results, conclusions and recommendations of the study. After this meeting another meeting will be set up with the other participants and once again the results, conclusions and recommendations will be discussed with them too.

These role players as well as community members with disabilities will then have to make some decisions on the future of the service and the researcher plans to offer her assistance in any way that it is needed.

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