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REHABILITATION SERVICES IN A DISTRICT HEALTH SYSTEM: MANAGERS' PERCEPTIONS

R.T. ZINN

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Rehabilitation Services in a District Health System: Managers' Perceptions

Richard Thebu Zinn

213467488

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at the

NELSON MANDELA UNIVERSITY

Supervisor: Dr Suzette du Rand

2019

DECLARATION

I, the undersigned hereby declare that the attached document, namely: Rehabilitation Services in a District Health System: Managers' Perceptions, dated 25 March 2019, is composed of my own work, and when other authors have been consulted, I have paraphrased and referenced accordingly. This document contains no breach of copyright.

Furthermore, I am aware that any evidence of plagiarism contained herein will render this submission, in its entirety, to be discredited, and will warrant disciplinary action.

All references and quotations have been attributed to their source, cited and included in the list of references.

Signed:

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ABSTRACT

The growth of rehabilitation services in a specific district in the Eastern Cape has been of concern to the majority of the therapists working in that setting between 2012 and 2015. With the importance of primary health care as the driver of South Africa's National Health Insurance scheme, and the need for rehabilitation services increasing, the investigation of the perceptions of managers who oversee rehabilitation services is pertinent.

The objectives of the study were to explore and describe the perceptions of managers regarding rehabilitation services in a district health system and to make recommendations to the Provincial Department of Health regarding the management of rehabilitation services at a district level based on the managers' perceptions. A qualitative, exploratory, descriptive, contextual research design was used as minimal information relating to the topic was found. The complexity of perceptions, their influence on behaviour and the environment, are well-explored using these design approaches. Purposive sampling and semi-structured interviews were used to elicit meaningful responses from managers familiar, and tasked, with the oversight of the rehabilitation service. Data analysis was performed utilising Tesch's model of thematic synthesis. To ensure rigour within the research Lincoln and Guba's model of trustworthiness was followed. The ethical principles of respect for persons, beneficence and justice were upheld in the study. A thick description was utilised when reporting the findings and a literature control was done to place the findings in the present literature on the topic.

The study has provided insights and perceptions of an important layer within the district health system. These perceptions are meaningful, as they influence the manner in which policy and plans are interpreted and implemented, and decisions are made within the environment of rehabilitation services.

Three major themes arose from the data analysis process, namely: The managers' reported positive factors regarding rehabilitation services, they identified challenges affecting the implementation of rehabilitation services in the District Health System, and they provided suggestions for the improvement of rehabilitation services in the District Health System. The positive views held by those in management positions indicate that there are strong foundations on which to build the rehabilitation service, and features of the system that need to be acknowledged, continued and strengthened. The challenges experienced by this layer of management point to aspects that need to be addressed in order to improve and optimise the impact of the inclusion of rehabilitation services in Primary Health Care. The findings in

this study clarify these challenges, and if these are not addressed, the goals of the progressive health care system which South Africa is trying to implement cannot be fully achieved. Furthermore, the discrepancies and gaps that exist between urban and rural, and better and poorer resourced districts are likely to widen.

The limitations of the study were identified and recommendations were made for practice (management), education and research.

Key Words:

Allied health services, Therapeutic services, Primary health care, Management

List of Acronyms

ACCESS	Health Access Livelihood Framework
ACFOA	Australian Council for Overseas Aid
APP	Annual Performance Plan
BRICS	Brazil, Russia, India, China, South Africa
CBR	Community-Based Rehabilitation
CEO	Chief Executive Officer
CHC	Community Health Centre
CRPD	Convention on Rights for Persons with Disabilities
DALY	Disability Adjusted Life Years
DFID	Department for International Development
DHS	District Health System
DMT	District Management Team
DOH	Department of Health
DOH	National Department of Health
EC	Eastern Cape
ECDOH	Eastern Cape Department of Health
ECHRC	Eastern Cape Health Research Committee
FPGSC	Faculty Postgraduate Studies Committee
FSDR	Framework and Strategy for Disability and Rehabilitation
GBD	Global Burden of Disease
GDP	Gross Domestic Product
GP	Gauteng Province
HPCSA	Health Professions Council of South Africa
KZN	Kwazulu-Natal
LMIC	Low-Middle Income Countries
MSK	Musculoskeletal

NCD	Non-Communicable Disease
NHA	National Health Act
NHI	National Health Insurance
NMB	Nelson Mandela Bay
NRP	National Rehabilitation Policy
OED	Oxford English Dictionary
O&P	Orthotic and Prosthetics
PHC	Primary Health Care
PIDS	Provincial Indicator Data Set
PWD	Persons with Disabilities
SA	South Africa
UHC	Universal Health Care
UN	United Nations
WC	Western Cape
WHO	World Health Organisation
YLL	Years of Life Lost (Prematurely to Mortality)

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CHAPTER 1: OVERVIEW OF THE STUDY

1.1 Introduction

"People are disabled by society, not just by their bodies."
(World Health Organisation (WHO), 2013a:1).

The growth of district level rehabilitation services in a specific district in the Eastern Cape (EC), South Africa (SA), has been of concern to the majority of the therapists working in that setting between 2012 and 2015. With the importance of primary health care (PHC) as the driver of South Africa's National Health Insurance (NHI) scheme and the need for rehabilitation services increasing, the investigation of the perceptions of managers who oversee rehabilitation services is pertinent.

The environment and resources a person with disability has, are a critical factor towards their societal integration. With the global rate of disability at 15%, and with higher rates experienced in developing countries, the barriers to and facilitators of effective and efficient rehabilitation service provision is particularly significant (WHO, 2011a:44). Primary health care is an important resource, and widely accepted as a financially viable and sustainable method for effective service delivery to the majority of the populace (WHO, 2010:13, 52; WHO, 2015:6-7). With the availability of resources and infrastructure linked to service delivery dependent on management decisions, this study aims to explore and describe the perceptions of managers associated with rehabilitation services in a district health system.

1.1.1 Study Outline

Chapter 1 will offer the background and rationale of the study, which includes a thorough review of relevant existing literature pertaining to the context and policy environment. The problem statement emerges from this review of the literature and knowledge of the current context in the EC. This informs the research question and the objectives of the study. Relevant concepts to the study will be clarified and a description of the research design and methods, as well as trustworthiness and ethical considerations, will be remarked on.

Chapter 2 will describe in detail the research design and methodology used for this study. The researcher presents the results of the study in Chapter 3, accompanied with the literature control to corroborate the findings against the available literature. Chapter 4 contains the recommendations put forward from the results of the study, as well as the limitations and conclusion.

1.2 Background and rationale of the study

In this section of the chapter, the researcher will provide an overview of existing literature that describes both the global policy environment that is of relevance to primary health care and rehabilitation services, as well as the specific context in SA and the EC. This is followed by the rationale for a focus on perceptions as a significant precursor to actions taken, especially of those in management positions.

This section will also be the background literature against which the literature control is considered, in relation to the findings from this study, which will be set out in Chapter 3.

1.2.1 Global tenets of Universal Health Care and Primary Health Care

An estimated one billion people worldwide experience some form of disability and are in need of health and rehabilitation services. The majority are in low- and middle-income countries (LMIC) and are less resourced, but experience a higher rate of disability (WHO, 2011a:44). To contextualise global health service delivery, it is useful to do so within the parameters of the universal health coverage (UHC) model. The UHC model is regarded as a dynamic process which countries can strive towards to provide their population with quality and essential health services that do not result in financial hardships (WHO, 2015:7). The UHC concept has been embraced by many countries in the world. Since 2010 over 100 countries have received technical assistance on UHC by the WHO and World Bank (WHO, 2015:6). One of the fundamental tenets of UHC, towards successfully decreasing the health burden, is the implementation of effective PHC services, with rehabilitation forming one of the four core health strategies. The PHC approach was promulgated with the Alma Ata Declaration in 1978 (WHO, 1978:1-2). Figure 1.1 below portrays the pillars of PHC as well as the foundational values and aspects which underpin them.

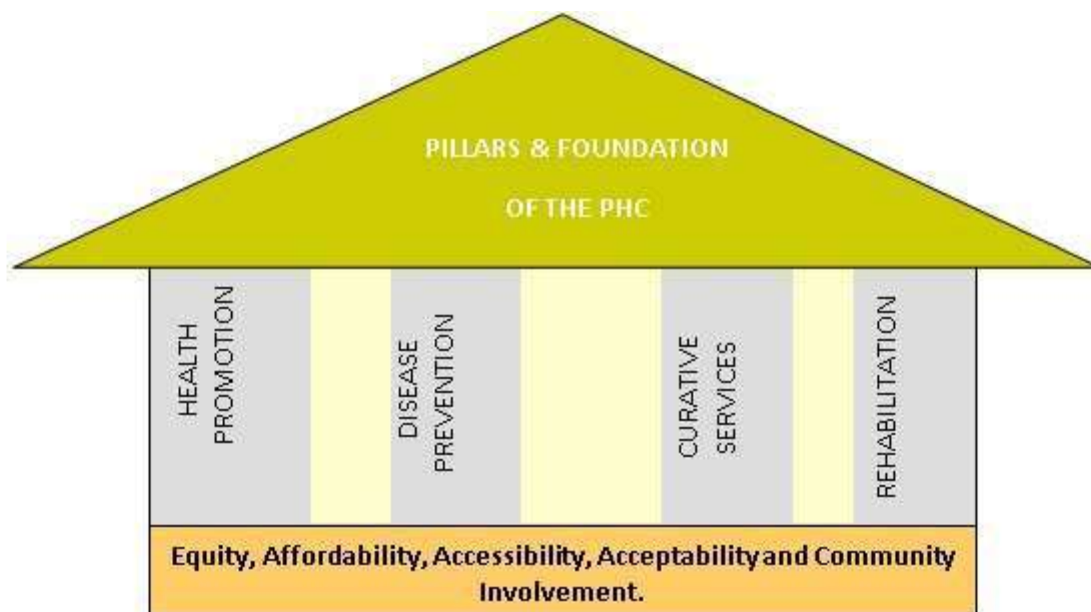

Figure 1.1 Pillars and Foundation of PHC (Namibian Ministry of Health and Social Services, 2018:1)

One of the elements of health sector reform is the concept of cost-effective and quality essential health care packages, which included rehabilitation (WHO, 2004:45). Countries were called on to consolidate and fortify comprehensive habilitation and rehabilitation services and programmes by the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) (UN, 2006:19). The convention has been ratified 177 times as of March 2018, affirming the global commitment to disability rights. South Africa's commitment to upholding these rights made through ratification on March 2007 (UN, 2018:1). The UHC framework for the monitoring and evaluation of health service coverage and financial coverage suggests two broad categories relating to health services: prevention and treatment, which includes rehabilitation (WHO, 2015:9). In a global study on monitoring intervention coverage for UHC, Boerma, AbouZahr, Evans and Evans (2014:1) noted critical measurement gaps for treatment indicators for rehabilitation such as rehabilitative surgical interventions and assistive device provision.

1.2.2 Global need for rehabilitation services

The number of persons with disabilities (PWD) is increasing due to population size, ageing, chronic diseases and medical advances that preserve and prolong life (WHO, 2005:1). The majority of population-based statistics derive from census data and household surveys which are largely based on self-reports (WHO, 2016:1). The statistics regarding disability could therefore be an underestimation as it is based on population and health facility-based sources (WHO, 2016:1). Boerma *et al.* (2014:4) suggest that these methods of data collection could prove inadequate in detecting unmet needs for treatment. The above statement is supported

by the assertion that the multi-dimensional concept of disability and the varied survey responses are highly dependent on the interview questions (WHO and UN Economic and Social Commission for Asia and the Pacific, 2008:104).

With regards to the need for rehabilitation services, it is pertinent to discuss in relation to a country's burden of disease, which establishes the demand for appropriate health services (Cobbing, Hanass-Hancock & Deane, 2013:23). Disability Adjusted Life Years (DALYs) quantify the burden of disease through a multifactorial metric of potential healthy years lived, incorporating the number of years lived with disability and years prematurely lost to mortality (YLL) (Murray, Lopez & WHO, 1996:7). Years lived with disability, the morbidity component of the measure, can be interpreted as healthy life years lost due to a reduced health state; while YLL, the mortality component, relates to years lost due to premature death (Devleesschauwer, Havelaar, De Noordhout, ,Haagsma, Praet, Dorny, Duchateau, Torgerson, Van Oyen & Speybroeck, 2014:566). In an analysis of the global supply of and need for a rehabilitation workforce, Gupta, Castillo-Laborde and Landry's (2011:6) findings suggest that 92% of the burden of disease in the world (measured in terms of YLL) are related to causes that require rehabilitation services. The burden of musculoskeletal injuries and speech, language and hearing impairments add to the need for rehabilitation services globally (Murray & Lopez, 2012:2216).

This creates an overwhelming demand for health and rehabilitation services, which is far from being met, particularly in LMIC countries (WHO, 2005:1; WHO, 2011a:57,102). DALYs due to musculoskeletal (MSK) disorders have increased globally by 45% from 1990-2010 (Murray & Lopez, 2012:2203). In a 2004 review of the DALY study, MSK disorders accounted for 2% of total DALYs, this figure increased to 6.8% by 2010. The substantial increase was attributed to a more thorough assessment of epidemiological data, discrepancies in the weighting of disability between self-reports and health-care professionals, and under-estimation of the impact of MSK disorders (Murray & Lopez, 2012: 2218). Injuries account for approximately 11% of the global burden of disease (GBD) which warrants meaningful input when discussing health-care provision and the need to address appropriate interventions (Murray & Lopez, 2012: 2203). The findings of the GBD study in 2010 acknowledge the shift from communicable to non-communicable diseases (NCD), highlight the importance of rehabilitation services and the notable increase in musculoskeletal disorders (Murray & Lopez, 2012: 2217).

The cost of disability, whether direct in seeking healthcare, or indirect in loss of productivity, is extremely high. Nearly two decades ago, a study published by the World Bank estimated the global annual Gross Domestic Product (GDP) lost due to disability at over US$ 1,3 trillion

(Metts, 2000:70). A later study by Buckup (2009:48) estimated the GDP losses due to disability to range from 3% to 7% in Africa. A paper by the International Labour Organisation found that 32.6% of the working age population of South Africa reported some form of disability and that 5% stated they could not fully participate in life activities (Buckup, 2009:38-39). The paper went on to estimate the 2006 economic losses related to disability as US$ 17,8 billion, which was 7% of South Africa's GDP of that same year.

All of the BRICS countries (Brazil, Russia, India, China and South Africa), which make up around half of the world's population, are participating in health system reforms designed to expand, develop or otherwise enhance health service coverage to their populations, while minimising the financial impact of accessing these services (Marten, McIntyre, Travassos, Shishkin, Longde, Reddy & Vega, 2014:2169). The present discourse is that the ideal setting for early intervention strategies is PHC, where prevention of the causes of disability and rehabilitation are vital in order to avoid or escape the poverty and disability cycle (Australian Council for Overseas Aid (ACFOA), 2003:2). The Department for International Development (DFID) (2000:7) support the above statement and note that relatively low-cost and simple interventions can be highly effective against many forms of disability. Furthermore, Miles (1999) in ACFOA (2003:2) notes that the majority of rehabilitation (80%) can be done at a PHC level with only 20% needing specialist referral.

The health status of South Africa is characterised by poor health outcomes, largely due to the quadruple burden of disease profile (Pillay-van Wyk *et al.*, 2016:642). The quadruple burden of disease, described as a unique manifestation of extraordinarily high burden of injuries, maternal and child health issues and communicable and non-communicable diseases, sets South Africa apart from the global health profile in public health service delivery and creating significant policy directives (Bradshaw, Schneider, Darrington, Bourne and Laubscher, 2002:622; Norman, Matzopoulos, Groenewald and Bradshaw, 2007:699; Mayosi, Flisher, Lalloo, Sitas, Tollman, and Bradshaw, 2009:934; ECDOH, 2018:21). In an Econex report on the NHI (2009:4), it is noted that SA is affected by a burden of disease double that of other developing countries such as Brazil, Tunisia and Thailand. Table 1.1 below frames the conditions or impairments treated by rehabilitation staff as they relate to the quadruple burden of disease.

Table 1.1 The quadruple burden of disease and associated impairments (Sherry, 2015:91)

Disease burden	Examples of associated impairments
rnal and child health	Birth trauma, cerebral palsy, stunting, developmental delay, mental illness, visual and hearing impairment
HIV and TB	Neurological impairments, dementia, mental illness, TB of the spine, joint disease, pain and fatigue, anti-retroviral side-effects, ototoxic side-effects of TB medication
Trauma and violence	Spinal cord injury, traumatic brain injury, amputation, orthopaedic complications, mental illness
-communicable diseases	Stroke, diabetic retinopathy, neuropathies, amputation, mental illness, visual loss

1.2.3 National Health Services in South Africa

The South African health care system sought to improve its public healthcare services after democratisation in 1994 (African National Congress, 1994:7). Section 27 of the South African Constitution affirmed the right of all to access to health care services, with the state responsible for instituting legislative and other means towards the attainment of this right (South Africa, 1996:11). To achieve the goal of UHC the NHI policy reform was promulgated in 2011 (Naidoo, 2012:149; National Department of Health (DOH), 2011a:1). The provision of primary care services is an essential characteristic of NHI and a national priority of the DOH.

The National Health Act (NHA) (DOH, 2003:38) promulgated the District Health System (DHS) as the vehicle to provide comprehensive PHC services. The DHS plays a central role in service delivery; the concept being endorsed by the WHO to improve effectiveness, responsiveness and efficiency of health systems (Segall, 2003:7). The NHA delineates the general functions of the various levels of state. The national department is tasked with the undertaking of national health policy implementation encompassing short and medium term strategic plans, norms and standards development, human resource planning and guidelines for implementation (DOH, 2003:29-30). The DOH is expected to present integrated provincial and national health plans to the National Health Council (DOH, 2003:30). The NHA defines rehabilitation as a process that is goal-orientated and time-regulated with the purpose of enabling optimal function to those with impairments (DOH, 2003:16). The National Rehabilitation Policy (NRP) (2000a:1) was developed in order to provide a framework for the provision of rehabilitation services, primarily at PHC level (Dayal, 2012:2).

Health care delivery in SA is typified by fragmentation (Integrated Support Team, 2009:10),

with rehabilitation services sharing comparable difficulties with regards to silo-driven provision. The NRP (2000a:4) noted coordination efforts of the rehabilitation service being negatively impacted due to insufficient interdepartmental and intersectoral communication. Isolation and ineffective collaboration efforts appear to have persisted (Hussey, MacLachlan & Mji, 2016:210). When searching for literature on rehabilitation services in South Africa the researcher found a paucity relating to the delineation of processes, budget, organisation and referral pathways for the service. The Norms and Standards for the District Hospital Service Package (DOH, 2002:45-47) outline the functions of the rehabilitation service in managing acute and chronic conditions, rehabilitation service provision relating to assistive devices, reintegration of PWD into the community, prevention and promotion activities and logistical matters such as resources requirements, referral pathways and collaboration with other stakeholders.

In a 2009 scoping study on Models for Integrating Rehabilitation and Primary Care, six models were defined, namely: clinic, outreach, self-management, community-based rehabilitation (CBR), shared care, and case management (McColl, Shortt, Godwin, Smith, Rowe, O'brien & Donnelly, 2009:1523). The majority of these approaches are referenced in South African health policy and within various District and PHC packages of care documents. Prior to the Framework and Strategy for Disability and Rehabilitation Services (FSDR) document released in 2015, there was a lack of clearly described roles and functions of rehabilitation within the South African healthcare setting. The FSDR is the most up-to-date strategic document regarding rehabilitation that the DOH has released since the NRP in 2000. The framework provides a comprehensive guide for rehabilitation services at all levels of care, outlining which services should be provided where and to what extent, and is the essential reference for all other policy and strategic documents as they relate to rehabilitation objectives and targets.

The primary role of this framework is ministering integration of comprehensive disability and rehabilitation services within priority health programmes (Maternal and Child Health, Nutrition, Communicable Diseases, Health Promotion, District Health and Tertiary Services, Mental Health, Substance Abuse and Human Resources) throughout all levels of care (Gray & Vawda, 2017:19). This widespread integration includes primary care initiatives in addition to rehabilitation service provision in health facilities including, inter alia, screening interventions in the school setting; home visits; integrated health promotion and disability prevention campaigns; and community health worker training (DOH, 2015b:15). Further integration strategies include advocacy and rehabilitation and consultative services to non-health facilities such as stimulation centres, day cares, old age homes, residential centres for PWD’s and halfway houses (DOH, 2015b:15). This level of integration requires significant and strategic

planning with multiple stakeholder participation.

With reference to strategic plans, objectives and targets, health information systems play a crucial role in health service management and monitoring and evaluation (DOH, 2011b:11). Performance indicators inform budget allocation, service delivery and underpin operational planning (National Treasury, 2007:2,4-5). Setting explicit health care priorities are indispensable for equitable allocation of limited resources (Alexander, Werner & Ubel, 2004:593; Fleck, 1994:435). Priority-setting requires quantifiable information of an economic, clinical and epidemiological nature relating to burden of disease and interventions (WHO, 2013b:23). While some of this information is obtained during the Census and through District Health Information Systems, there is a considerable lack of available data for analysis which impacts profoundly on adequate planning and implementation strategies for rehabilitation services.

The 2017/2018 DOH Annual Performance Plan (APP) states two strategic objectives which relate to rehabilitation services: PHC accessibility for disabled persons and an increase in provision of rehabilitative services (DOH, 2017a:32). A recent indicator established in 2017, towards the strategic objective of expanding rehabilitation services, is the number of districts with a multi-disciplinary rehabilitation team (DOH, 2017a:55). The national indicators for the rehabilitation service require reporting on wheelchairs and hearing aids only (DOH, 2016:85).

1.2.4 Challenges relating to stakeholder collaboration and other aspects of rehabilitation services

Due to the high burden of disease and the social-determinants of health in South Africa, the Department of Social Development form a significant part of intersectoral collaboration in the identification and referral of PWD and the provision of grants (DOH, 2002:48; DOH, 2017a:53). Other sectors that rehabilitation services work with include, inter alia, education services, vocational training centres, the Department of Labour, and legal services for third party claims (DOH, 2002:48). According to the District Hospital Service norms and standards package, a district rehabilitation plan should guide service delivery and be managed by a district rehabilitation coordinator. With studies showing many challenges regarding implementation of rehabilitation policy in South Africa (Dayal, 2010:26; Ned, Cloete & Mji, 2017:4), it appears as though this level of collaboration has not moved from policy to practice. Furthermore, rehabilitation care is not sufficiently recognised in key strategic and integrative documents, which includes: PHC package for South Africa - a set of Norms and Standards 2000; Primary Care 101 Guideline 2013/14; Adult Primary Care Guide 2016/2017; and District Hospital service package 2002. These have considerable

impact on planning, budgeting, staffing and norms and standards (Occupational Therapy Association of South Africa (OTASA), South African Society of Physiotherapy, South African Speech and Language Hearing Association and Rural Rehab South Africa, 2017:1). Annual Performance and Strategic Plans at both National and provincial level persist with negligible or vague mention of rehabilitation services. Possible confusion is caused by lack of continuity and emergence of rehabilitation services in key documents, and is iterated by the nomenclature, with multiple titles or groupings attributed to rehabilitative services, "therapeutic support services" (DOH, 2015a:25), "allied health professionals" (DOH, 2011c: 33) or rehabilitation services (DOH, 2002:45).

1.2.5 Rehabilitation staffing

The Human Resources for Health Strategy for the Health Sector document (DOH, 2011c:23) shows an increase in rehabilitation posts created from 2002 to 2010 but conversely notes a low absorption of rehabilitation professionals due to a lack of public sector posts (DOH, 2011c:33). Notwithstanding the progress of PHC implementation in South Africa over the last 20 years, the current challenges plaguing the efficacy of the public health sector are summed up by Rispel (2016:21) as the acceptance of incompetency and a failing of managerial structures; an inoperative DHS and the poor management of the health workforce. Additionally, the South African healthcare system is structured in such a way that the achievement, or lack of, health reforms are dependent on the assets of district management (Wolvaardt, Johnson, Cameron, Botha & Kornik, 2013:91). The EC displays a trend of non-replacement of posts and a negative turnover rate for rehabilitation professionals (ECDOH, 2013:61,63 and 2018:45). The negative turnover rates amongst rehabilitation staff ranged between 25% and 30%, which ranks in the top ten of nearly 100 occupational categories in the EC (ECDOH, 2015a:200).

There is an absence in reporting documents relating to the placement of rehabilitation staff in rural versus urban areas. The number of rehabilitation staff in public service highlight a therapist to patient ratio well below the norms and standards. Gupta, Castillo-Laborde and Landry (2011:8) note LMICs reporting rehabilitation staffing less than 2 per 10000 population as low. In South Africa, the NRP aimed for 0,66 per 10000 as the ideal ratio of staff to population, referencing a short term goal of 0,33 per 10000 (DOH, 2000a:13). When extrapolated against up to 84% of the population who utilise public health services (Benatar, 2013:2), the highest number of rehabilitation staff in the public sector, 970 physiotherapists (DOH, 2011c:22), provide a ratio of 0,26 per 10000 population (StatsSA, 2012:26), less than the short term goal set nearly two decades ago by the NRP. When looking at the comparative

distribution of all physiotherapists in the country (public and private sector), the EC has the third lowest staff per population ratio, 0,45 per 10000; with the Kwazulu-Natal (KZN), Western Cape (WC) and Gauteng Province (GP) having two, four and six times the staff density per 10000 respectively (DOH, 2011c:136,146-78).

The EC is characterised by poor socio-economic conditions and consequently, very limited medical aid coverage, with 89,2% of the population dependent on public healthcare (ECDOH, 2016:26). Utilising the same extrapolation as above with public sector physiotherapist statistics, the largest cadre, the ratio in the EC province is 0,23 per 10000, with 140 physiotherapists providing services to a population of nearly 6,1 million (ECDOH, 2016:38,63). According to the Census 2011 (StatsSA, 2012:65) profile of PWD, the EC has the fourth highest proportion of PWD and the second highest by absolute number after the Gauteng Province. The EC also has the second highest number of social grant recipients in both absolute and proportional terms (EC Department of Economic Development, Environmental Affairs and Tourism (ECDED), 2017:50).

1.2.6 Provincial and District Health Services

Organisation of rehabilitation services differ from province to province. According to the NHA (DOH, 2003:37) the provincial departments are required to, inter alia, manage human resources for health; support comprehensive PHC and hospital service provision; provide services for specific provincial health programmes; and engage with communities over health issues. The national and provincial health councils provide advisory functions, which relate to policy, legislation and norms and standards. Some specific provincial tasks include district health management guidelines and implementation of national and provincial health policy (DOH, 2003:37-38). The NHA (DOH, 2003:42) also requires each district and metropolitan health manager to develop a district health plan (DHP) in accordance with national guidelines and with appropriate consideration to national and provincial health policy. The DHS includes community-based services, clinics, community health centres (CHC), and district hospitals (DOH, 2002:3).

The rehabilitation team as described by the DOH includes physiotherapy, occupational therapy, optometry, speech and language pathology, audiology, and orthotic and prosthetic services (DOH, 2018:42). The addition of optometry is relatively new, with only one community service optometrist being allocated to the EC in 2016 and no other reference to optometry made in recent operation or performance plans (ECDOH, 2016:39; ECDOH, 2017; ECDOH, 2018). The EC provincial strategic objective for rehabilitation service supply has four

performance indicators, namely wheelchair, hearing aid and orthoses and prostheses provision (ECDOH, 2018:111). Due to the recent establishment of the national indicator for rehabilitation service expansion, the number of multi-disciplinary rehabilitation teams has not been reported on thus far, and there is also no known baseline for staffing in the districts (DOH, 2018a:42; DOH, 2017a:55,87).The researcher could not find any data relating to the distribution of rehabilitation staff between District level services, which include PHC, and secondary and tertiary care.

A substantial gap in rehabilitation service delivery is prevalent, with limited therapists available and the literature noting unmet needs for rehabilitation (Scheffler, Visagie & Schneider, 2015:8; McColl, 2009:1523; Maart & Jelsma, 2014:4). The quality and extent of service delivery are further affected by the distribution of staff favouring metropolitan areas, leaving rural areas largely underserved and with significant barriers to access (Gaede & Versteeg, 2011:99; Keeton, 2012:803; Goudge, Gilson, Russell, Gumede & Mills, 2009:12; Marten *et al.*, 2014:2168).

There are inherent geographic barriers to healthcare access in the rural environment, such as the widespread distribution of settlements and healthcare institutions and road infrastructure (Vergunst, Swartz, Mji, MacLachlan & Mannan, 2015:2). An investigation into clinic catchment areas in rural KZN estimated the median travel time to the nearest district hospital was 170 minutes (Tanser, Gijsbertensen & Herbst, 2006:692). The authors established travel time significantly influenced healthcare utilisation rates, with rural homesteads 10 times more likely to access a clinic within 30 minutes versus 90 to 120 minutes (Tanser *et al.,* 2006:692). Barriers to access are compounded by limited rehabilitation service coverage due to staff shortages and a lack of physical resources (Ennion, 2017:5; Bateman, 2012:1). Limited availability of rehabilitation services, travel time and its associated cost of access to healthcare are considerably higher for rural dwellers than their urban counterparts (Gaede & Versteeg, 2011:102; Ennion, 2017:2).

In the EC, the orthotic and prosthetic (O&P) centres are based within three hospitals, each servicing their surrounding districts which are pragmatically divided into thirds, or three regions, namely the western, central and eastern regions of the EC (ECDOH, 2018:110). Each O&P centre has varying levels of function and staffing based on the population and region they service. The rehabilitation service budget is allocated within the O&P sub-programme through wheelchair and hearing aid indicators, however, there is no budget directly related to the other therapy services (ECDOH, 2018:111,113).

With regards to conditions treated by rehabilitation staff, Table 1.1 (see page 6) outlines the more prevalent risks and impairments as they relate to the quadruple burden of disease found in South Africa (Sherry, 2015:91). All of the conditions mentioned in Table 1.1 are within the scope of service for rehabilitation therapies in South Africa (Health Professions Council of South Africa (HPCSA), 1992:1; HPCSA, 2012: 1-8; HPCSA, 1976:1-3; HPCSA, 2017:31-35; HPCSA, 1977:1). However, services offered by rehabilitation units in South Africa differ greatly depending on province, type of institution and skill mix of staff. The researcher could only find a comprehensive list of conditions treated by rehabilitation staff within the District Hospital Services: Norms and Standards document, which includes all of the above-mentioned conditions (in the table) as well as burns (DOH, 2002:45). Reported statistics for conditions treated were found on the Free State Online Resource Database and include conditions seen at a district level, where the majority of the above-mentioned conditions were mentioned (Free State Department of Health (FSDOH), 2018:1).

The role of district level rehabilitation includes, but is not limited to, management of disabling conditions, reintegration of individuals into society, provision of assistive devices in conjunction with O&P centres, health promotion, disability prevention and awareness programmes, as well as referral to specialised, secondary and tertiary institutions and other necessary care providers, including social, psychological and spiritual assistance (DOH, 2002:45). The rehabilitation service at a district level can be referred through any member of the health team and is provided for by rehabilitation therapists or therapy assistants within the district hospital, in wards or outpatient departments and in clinics or CHCs (DOH, 2002:45; Rispel, Moorman, Chersich, Goudge, Nxumalo & Ndou, 2010:71).

1.2.7 Eastern Cape Provincial Landscape and Context

The landscape of the province impacts significantly on healthcare provision and access to services. Sections of the EC were former homelands, mainly the Ciskei and Transkei, and as such, have a higher incidence of rural and previously disadvantaged communities and deprivation (Noble, Zembe & Wright, 2014a:4). Deprivation is a relative concept that is multidimensional in nature, and is described as a lack of material possessions, human and social capital, adequate housing and basic services (Townsend, 1987:128; Noble *et al.*, 2014a:2). Sixty-two percent of the EC province is classified as rural and is ranked as the most deprived in the country (Noble *et al.*, 2014a:20; Noble, Zembe, Wright & Avenell, 2014b:20). The 2011 Census statistics show a nearly identical layout of deprivation in the former homeland regions (Noble *et al.*, 2014b:25). Figure 1.2 below shows the districts of the EC.

Figure 1.2 Districts of the Eastern Cape **(Wikimedia Commons, 2017:1)**

Figure 1.3 below depicts the areas of deprivation juxtaposed with the former EC homelands, Ciskei and Transkei, in blue or dark blue. They indicate the highest levels of deprivation in the province.

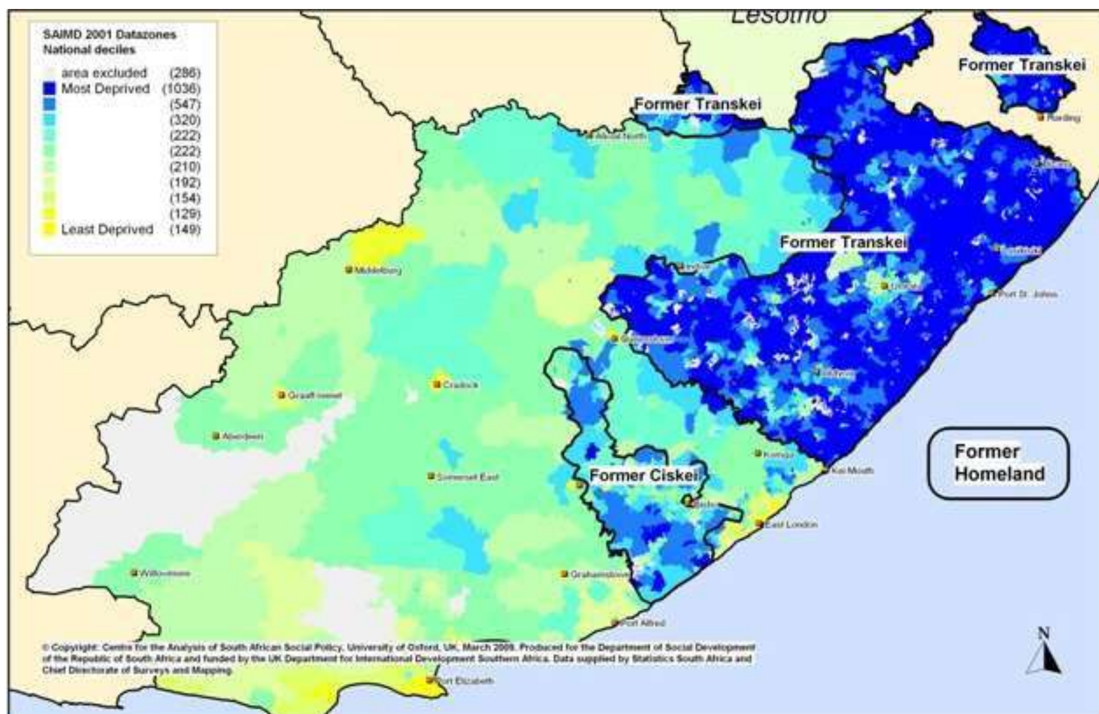

Figure 1.3 South African Index of Multiple Deprivation at Ward Level, Eastern Cape, 2011. With former Ciskei and Transkei Homeland boundaries of the Eastern Cape **(Noble et al., 2014b:25)**

The impact of deprivation and poverty on the cycle of ill-health and disability is shown below in Figure 1.4. The image depicts poverty's amplification of the risk of ill-health and impact on access to necessary healthcare. The above concepts are linked with poor health outcomes, disability and productivity restrictions, leading to a more profound burden to households and a barrier to health access (DOH, 2015b:7).

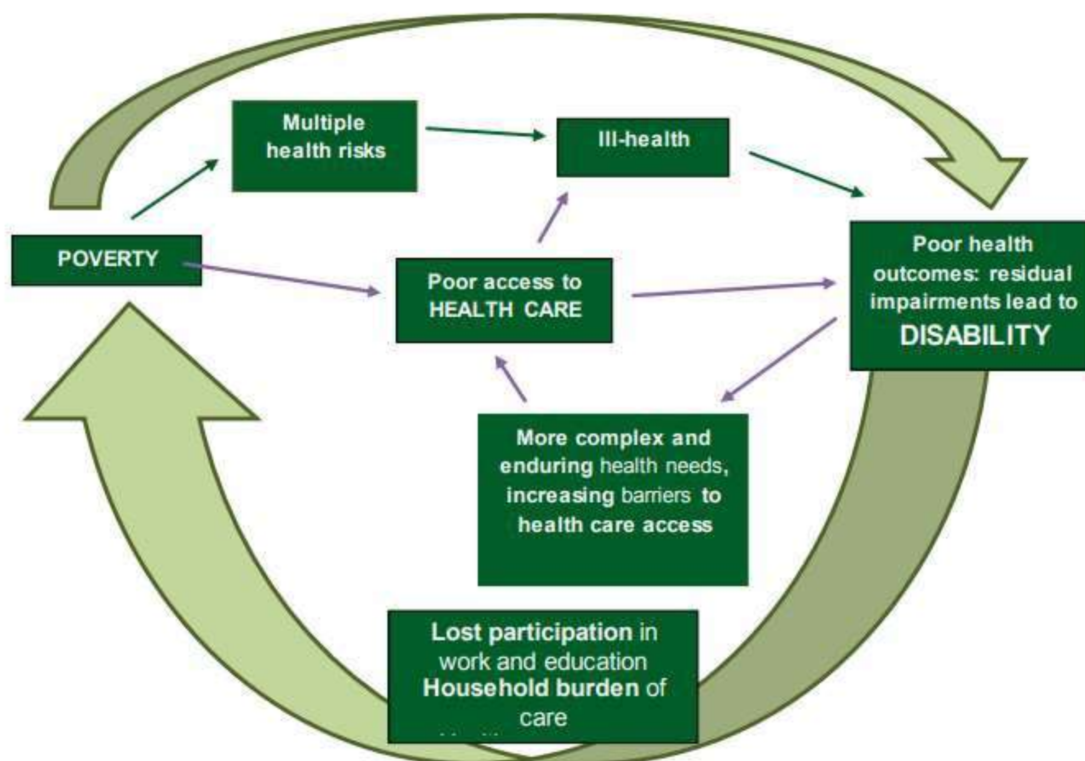

Figure 1.4 Cycle of poverty, ill-health and disability **(Sherry in DOH, 2015:7)**

1.2.8 Healthcare reform in South Africa

Prior to 2010 there has been minimal emphasis in South Africa on the significance or advantages of rehabilitation service at PHC level, with the focus having been on mortality reduction from communicable diseases such as TB, HIV/AIDS and malaria (Coovadia, Jewkes, Barron, Sanders & Mcintyre, 2009:830; Mayosi *et al.*, 2009:943-944, Dizon *et al.*, 2018:9). The re-engineering of the PHC programme in the last decade has brought about the inclusion of disability and rehabilitation into national strategic and priority setting. In a DOH commissioned review of the PHC package of care, the Centre for Health Policy (Rispel *et al.*, 2010:67-69) describe the scope of rehabilitation and access at community-based and CHC level, which is echoed in other key national strategic documents such as the Ideal Clinic Manual (DOH, 2018b:19).

The positioning of access to rehabilitation services at primary care level does not appear to translate decisively into EC strategic documents, such as the Operational Plan (ECDOH, 2018:84) and Strategic Plan (ECDOH, 2015b:58). In the EC, rehabilitation therapies fall under the ambit of Transversal Health Services, a division of budgetary Programme Seven: Heath Care Support Services (HCSS) (ECDOH, 2018: 84). This is in contrast with other provinces, such as WC, GP and KZN, which cater for rehabilitation services under District Health Services (Programme 2) (KZNDOH, 2016:89, WCDOH, 2018:56; GPDOH, 2017:54). In the aforementioned provinces, HCSS (Programme 7) contains Laundry, Engineering, Forensic, O&P and Pharmaceutical Services.

What is evident from other provincial plans is the inclusion of specific strategic objectives, indicators and reports relating to rehabilitation service targets, which extend beyond assistive device provision (KZNDOH, 2016:152; GPDOH, 2017:55). In the KZNDOH APP, improving access to rehabilitation services at all levels of care is a strategic objective under NCD incidence reduction, which is in line with the National Department (KZNDOH, 2016:18; DOH, 2017:51). The KZNDOH is noted here for their inclusion of rehabilitation in strategic provincial documents as well as their alignment with national directives. In addition to monitoring wheelchair and hearing aid indicators, the province reports on utilisation rates for rehabilitation and sets targets for population serviced and availability of rehabilitation therapies in clinics and CHCs (KZNDOH, 2016:152-153). Nationally, the wheelchair and hearing aid Issued rate are the only Core Health indicators evaluating rehabilitation service delivery (Day & Gray, 2017:219). The need for wheelchair and hearing aid provision, while necessary, are marginal indicators of the need and breadth of rehabilitation services.

1.2.9 Organisation of rehabilitation services on District and Local Level

Senior provincial health managers are responsible for supporting the Districts in their activities of planning, implementation and monitoring, including finance and information management (DOH, 2017b:19). The management of District Health Services have a number of key role-players. These role-players make up the District Management Team (DMT), form sub-DMT's and are District Hospital managers or chief executive officers (CEO); who are central to the implementation, management and re-engineering of PHC as well as the effectiveness of the health system (Pillay & Barron, 2012:1-2; DOH, 2017b:2). The DMT's core functions are the identification of client needs and critical challenges; decision-making and priority-setting relating to outcomes and targets; balancing demands and action as it relates to needs, challenges and priorities; resource allocation; capacity management and development; and monitoring and evaluation (DOH, 2017b:19-20). The recently released District Health Planning

and Monitoring Framework outline the key roles and responsibilities of various district management cadres. The District Manager provides leadership, guidance and decision-making accountability and has over-arching responsibilities relating to implementation, information management and monitoring and evaluation of services (DOH, 2017b:20). The District Health Management Information System policy states that the Provincial Head of Department is responsible for all indicators in the Provincial Indicator Data Set (PIDS), while provincial health programmes as well as District Managers are responsible for requesting the inclusion of additional indicators for performance monitoring purposes (DOH, 2011b:21).

The District Health Planner compiles and communicates comprehensive epidemiological health information; substantiates and facilitates the planning and development of DHP's; monitors implementation and reporting needs; as well as communicates with sub-DMT's on appropriateness of reported data (DOH, 2017b:20). District hospital managers or CEOs share similar roles with the District Manager in terms of implementation, information management, leadership, guidance and over-arching decision-making with regards to the management of district hospitals (DOH, 2017b:21). Programme managers are required to define needs for programme delivery and improvement as well as monitor and evaluate programme performance in relation to set indicators (DOH, 2017b:20). Rehabilitation managers, who are effectively sub-programme managers, function either within the district or sub-district. The District Rehabilitation Manager has a number of functions pertaining to rehabilitation services: the planning, monitoring and evaluation of rehabilitation services in the district; support and coordination of sub-districts; budget coordination and allocation; reporting on financial matters to regional and provincial levels; fund procurement; and strategic commentary on proposed legislature that may impact rehabilitation services (FSDOH, 2003:9). The DMT is wholly responsible for all activities within the DHS, and advancing service delivery is strengthened by decentralising decision-making functions to district management structures (Naledi, Barron & Schneider, 2011:24).

1.2.10 Challenges experiences by rehabilitation service managers

The role and function of managers as it relates to rehabilitation services is one confounded by lack of capacity and delineation of responsibilities between middle and senior management and local, provincial and national health departments (Dayal, 2010:26). Effective management for this relatively new approach to health care provision is essential to its success. According to research done by Dayal (2010:25), there is a lack of support for the provision and management of rehabilitation services in South Africa. A manager's role will vary contextually but should always include planning, organising, leading, supporting and developing the

relevant structures and controlling the financial and other resources (Kraut, McKenna & Dunette, 2005:127). Dayal (2010:26) found that multiple factors, including bureaucratic inefficiencies, led to a negative impact on the capacity to deliver rehabilitation services and the patient's right to access rehabilitation. Ineffective management and poor leadership regarding rehabilitation services leads to ineffective retention and recruitment of human resources (Dayal, 2010:24). Kabene, Orchard, Howard, Soriano and Leduc (2006:15) conclude that managing human resources effectively is critical in providing high quality health care. Turnover of skilled technical, professional and managerial staff, especially those with scarce skills, is a key issue for management, especially in a limited labour market (Batt & Valcour, 2003:214). The consequences of a lack of leadership and effective management include increased employee stress, feelings of alienation and helplessness, decreased job and work-life satisfaction, anxiety and depression (Kelloway, Sivanathan, Francis & Barling, 2005:90). Borrill, West, Shapiro and Rees (2000:366) state that obscurity regarding leadership can be a predictor of poor team effectiveness and quality teamwork. It also has a negative impact on the health and well-being of staff. Poor leadership can also be seen as a root cause of workplace stressors (Kelloway *et al.*, 2005:95).

In this next subsection, the researcher provides some insights from the literature on the significance of perceptions in management decisions. This is an important aspect to understand as part of the rationale for the study, as it is a key focus in the research design and methodology.

1.2.11 Perception and management

Efron (1969:137) describes perception as the fundamental way in which people understand the world around them, with all conceptual understanding linked to the awareness and interaction of one's surroundings. McDonald (2012:8) defined perception as an individual or group's unique way of viewing phenomena, involving the processing of stimuli, and incorporating memories and experiences in the process of understanding. Perception can also be seen as the process of attributing meaning to information received based on previous experiences (Pickens, 2005:53). Perceptions are influenced by culture, background, up-bringing and lived experience (Pickens, 2005:63). The way one thinks, behaves and the actions and decisions one makes are based on their beliefs, regardless of their validity (Heidler in Pickens, 2005:56; McDonald, 2012:4). Perceptions are thus hugely important when viewing behaviour as they are the precursors to the actions we take. McDonald (2012:2) notes that it is of utmost importance to acknowledge the development and individuality of one's perception, especially when addressing change. Hiatt, Stelle, Mulsow and Scott (2007:380) found that

multiple stakeholder perspectives add to the depth of understanding and evaluating of a care package. In a literature review on strategic management, Özleblebici and Çetin (2015:296) found that there is established recognition of the importance of managerial perception on strategic development and executive functions. Furthermore, Beyer, Chattopadhyay and George (1997:3) affirm that there is consensus amongst organisational researchers regarding the impact of managers' personal perceptions on critical, organisational decision-making. Management of human capital, leadership and client-centric approaches have been established in the literature as robust and substantial operational performance predictors (Samson & Terziovksi, 1999:393).

It is necessary to investigate the perception of those in management structures as they are the key facilitators of implementing policy reform, due to their responsibilities. While formulation of policy may be a relatively linear process, implementation brings forth the complexities of institutional capacity (Mills, Bennet & Russel, 2001:171). This becomes increasingly relevant as a lack of service delivery structure necessitates the use of personal experience and conceptual understanding for service provision (Dayal, 2010:25). Due to the variations of these experiences between managers or organisations, and for the reasons stated above, it is of specific interest to explore the viewpoints of managers regarding provision of rehabilitation services as they may be essential to developing the service.

Even though policy regarding rehabilitation and research on the requirements for this service, especially at PHC level, exists, there is a paucity in South African research exploring district level managers' perceptions regarding rehabilitation service or the impact on implementation.

Through the above discussions, the researcher has explicated the need and relevance of the study, and how it informed the problem statement and research question, which follow in the next sections.

1.3 Problem statement

Within the Nelson Mandela Bay (NMB) the concerns around the lack of resources, absence of a rehabilitation budget, lack of appropriate job descriptions and a lack of organogram structure with no career-pathing for rehabilitation personnel need to be addressed. Managers' perceptions of rehabilitation within the district health system could provide important insights in this regard.

From 2009 to 2012 the NMB District Rehabilitation service grew from one rehabilitation unit to four. Senior therapists in the NMB District Rehabilitation unit have expressed no major

development of this service since then. They reported concerns regarding staff retention and service development since the formation of the rehabilitation units in the District in 2007. Between February 2012 and March 2015 the NMB District Rehabilitation Units experienced a 30-50% yearly turnover of staff (NMB District Health Human Resource Department, 2015:1). This staff turnover included the District Rehabilitation Manager, a post that was vacant for two years. The high staff turnover rate, including the rehabilitation manager post vacancy, created a barrier to develop the rehabilitation service in the District further. As the rehabilitation manager is the link between the DMT and provision of the service, the post vacancy likely impacted on rehabilitation service input to the DMT.

When asked, the chief concerns of senior therapists were the lack of resources, absence of a rehabilitation budget, lack of appropriate job descriptions, and a lack of organogram structure with no career-pathing for rehabilitation personnel.

The concerns noted above led the researcher to explore the managers' perceptions of rehabilitation services in the district.

1.4 Research question

The researcher thus posed the following interrelated research questions:

- What are the perceptions of managers regarding rehabilitation services within a district health system?
- How can the management of rehabilitation services be improved by provincial health managers, at a district level?

1.5 The Aim of the study

The aim of this study was to explore and describe the perceptions of managers regarding rehabilitation services within a district health system and to make recommendations regarding the management of rehabilitation services to the provincial health managers.

1.6 Objectives of the study

The objectives of the study were therefore to:

- To explore and describe the perceptions of managers regarding rehabilitation services in the district health system.
- To make recommendations to the provincial health managers regarding the

management of rehabilitation services in the district.

1.7 Concept clarification

This section will clarify the concepts pertinent to the research and provide operational definitions where applicable.

1.7.1 Rehabilitation Services

Service is defined by the Oxford English Dictionary (OED) (2018a:1) as action or work performed to satisfy a need or demand. Services in healthcare are recognised through various components: there must be a provider, user and a sequence of activities which seek to produce some form of change (Lee, 2017:354). Services in this study relate to the provision of related healthcare activities.

Rehabilitation can be defined as a course of action that enables those with disabilities to attain and maintain their optimal functional levels in the physical, sensory, intellectual, psychiatric and social spheres, thus providing them with the tools to achieve a higher level of independence (WHO, 2013:4; WHO, 2011a:95). The above-mentioned scope of rehabilitation can range from basic and general rehabilitation to specific services (UN, 1993:7). In the context of this study rehabilitation services refer to the provision of Occupational Therapy, Physiotherapy and Speech, Language and Hearing Therapy services. Optometry services have yet to be fully integrated into the public sector and are largely absent within rehabilitation teams. Orthotic & Prosthetic services function outside the managerial realm of district rehabilitation services in the EC.

1.7.2 District Health System

The Health Systems Trust (McCoy & Engelbrecht, 1999:132) outlines the DHS as a suitable structure to achieve an effective, efficient and equitable health system based on the principles of PHC. The DHS is defined by Tarimo (1991:4) as an autonomous division of the national health system, consisting of a well-defined population in a demarcated physical and administrative area; including all the relevant health care activities in that area. The WHO views the DHS as a vehicle for the delivery of integrated health care (Segall, 2003:7). The above definitions are those used by the DOH (Hall, Ford-Ngomane & Barron, 2005:45). For the purpose of this study these services are community-based and are available at clinics, CHCs and district hospitals, and are provided within the PHC platform.

1.7.3 Manager

A manager is a person whose primary activities include the planning, controlling and organising of the operations of an organisation or enterprise, providing direction and coordination, and giving leadership to human efforts (Carpenter, Bauer & Erdogan, 2009:2). In this study, the managers are those persons responsible for managing and coordinating rehabilitation services, their immediate supervisors and those involved in the planning, implementation and management of the district health systems.

1.7.4 Perception

Perception has been discussed in more detail in the Background section under sub-heading Perception and Management (see 1.2.11). In the context of this study perceptions will relate to the participants' understanding and views towards rehabilitation services in a district health system.

1.8 Conceptual framework for the study

Healthcare access encompasses many dimensions and is complex by nature (Scheffler *et al.,* 2015:2). While numerous authors have attempted to encapsulate these complexities with the use of various frameworks, many authors describe the Health Access Livelihood Framework (abbreviated to ACCESS) as one of the more comprehensive tools at their disposal when exploring access to healthcare (Scheffler *et al*., 2015:2). The researcher utilised the ACCESS framework to provide a logical structure when identifying and discussing key concepts relating to healthcare access and the managers' views thereof. The ACCESS framework has five dimensions, namely: Availability, Accessibility, Affordability, Adequacy and Acceptability (Obrist, Iteba, Lengeler, Makemba, Mshana, Nathan, Alba, Dillip, Hetzel, Mayumana, Schulze & Mshinda, 2007:1585). Availability is described as meeting the clients' health needs. Accessibility relates to the distance between the user and the service, including factors such as transport means and travel time. Affordability speaks to the direct and indirect costs of healthcare access and the relationship to the client's ability to pay for services. Adequacy is meeting clients' expectations concerning the organisation of health care and Acceptability relates to the service provider characteristics corresponding with those of the client, for example, whether indigenous socio-cultural beliefs are taken into account (Obrist *et al*., 2007:1586).

1.9 Research design and method

A qualitative approach, utilising a descriptive, exploratory and contextual design, was used to enable the researcher to explore and describe the managers' perceptions of rehabilitation services in a district health system. Semi-structured interviews were used for data collection, and Tesch's method of analysis and thematic synthesis was used to yield the findings. Please see Chapter 2 for a detailed description of the process. The trustworthiness and ethical considerations are discussed in Chapter 2. A thick description of the findings with literature control was done and will be presented in Chapter 3.

1.10 Conclusion

In this chapter the researcher has presented a general overview of the study, including the background with relevant literature reviewed, and rationale of the research. The aim and objectives as well as the problem statement were presented and relevant concepts were clarified. The following chapter will present a detailed discussion on the research design and methodology of the study.

CHAPTER 2: RESEARCH DESIGN AND METHOD

The design of the study and well as the methods used to collect and analyse the data will be discussed in detail in this chapter.

2.1 Introduction

A qualitative, explorative, descriptive and contextual design was utilised to yield the results in this study. A description of the population, sampling and recruitment process was presented. A detailed account of the procedure for data collection and data analysis is also included. Lastly, the principles of trustworthiness and ethical considerations utilised for this study were discussed.

2.2 Research design

Babbie and Mouton (2008:74) describe the research design as a detailed plan for conducting a research study. A qualitative, exploratory, descriptive, contextual design was used for this study.

2.2.1 Qualitative research

Qualitative methods are primarily used to explore and describe a phenomenon where research on the topic is scarce, the context is not well-known, or the nature of the problem is unclear (Strauss & Corbin, 1990:11; Morse, 2003:833). Qualitative methods enable the researcher to focus on the topic in a profound manner. Central to this is the meaning the participants attribute to their experiences (Denzin & Lincoln, 2000:7). One of the distinguishing features of qualitative research is the analysis of narrative data, where words are used to invoke meaning rather than numeric information (Miles & Huberman, 1984:21; Saldaña, 2013:37). Narrative data is collected using a naturalistic approach (real world situations) with a broad, open-ended question to elicit the subjective viewpoints of the participants (Stuckey, 2013:2). The researcher also sought to gain an in-depth understanding of the problem, within the given context, by immersing themselves in the specified setting (Botma, Greeff, Mulaudzi & Wright, 2010: 182).

A qualitative study was used as part of the research design as there was limited knowledge on the topic, the complexity of perceptions and their influence on behaviour, to understand the environment and context from an observable viewpoint using interpersonal data collection and to explore possible associations of participant perceptions. Additionally, qualitative measures

assist to enlarge the body of knowledge for future measurable research.

2.2.2 Explorative study

Exploratory research is frequently utilised where little or no research has been done on the phenomenon and/or where a researcher has an idea, or has observed something, and seeks to understand more about it (Botma *et al.*, 2010:185; Bless & Higson-Smith, 2006:47). As there was a paucity of research concerning this topic the researcher attempted to gain new information using exploratory methods. In-depth interviews were utilised as the participants could have the opportunity to respond in their own words and evoke responses which were meaningful, rich and descriptive in nature.

2.2.3 Contextual study

In a contextual study, the findings cannot be generalised and are specific to the given population under study. The nature of this study was contextual in that managers who worked within the district health system in the ECDOH were asked to share their perceptions of rehabilitation in a district health system. As described in the background and rationale (see 1.2.11), perceptions of rehabilitation services may have a pivotal role in its planning, development, delivery and overall management.

2.2.3.1 Macro context of this study

The study was conducted in the EC Province of the Republic of South Africa. The social and healthcare environment in South Africa is one marked by inequity, with a large social grant system supporting over one quarter of the population and the majority of the population reliant on public health services (Schneider, McKenzie, Schaay, Scott & Sanders, 2017:5; ECDED, 2017:50). In the EC this is no different, with a particularly high rate of government healthcare dependence at 89,3%, in the predominantly rural districts this figure ranges from 91% to 96% (ECDOH, 2018:20). As discussed in the Background (see 1.2.7), social determinants of health have a considerable impact on the burden of disease profile in the province (Scott, Schaay, Schneider & Sanders, 2017:77; ECDOH, 2018:21). As discussed in Chapter 1, PHC is the approach of choice for addressing the burden of social determinants of health, however, PHC in rural areas have not been the exemplar of efficient, effective and accessible healthcare delivery (Neille & Penn, 2015:2; Gaede & Versteeg, 2011:100).

The EC province has eight demarcated districts (see Figure 1.2 in Chapter 1) in which health care administration, governance, and service delivery are managed and offered. Two of the

districts are metropole's, namely Nelson Mandela Bay (NMB, or Port Elizabeth) and Buffalo City (East London), which have high population densities compared with the other districts, and whose service delivery methods differ accordingly. The districts comprise of several local municipalities each with their own service structures and sub-DMT's. The various district level managers are based in a central facility from which administrative functions are run. For example, the Sarah Baartman District, situated around NMB (see Figure 1.2), has its District Health offices in NMB.

The aim of the DHS is to improve efficiency of healthcare delivery by decentralising the majority of management functions to the DMT's (Haynes, Byleveld & Bhana, 2008:17). The DMT have the responsibility of managing and coordinating all district level services in the region as well as being the functional connection between the grassroots level and province or higher structures (Chatora & Tumusiime for the WHO, 2004:24).

As described in Chapter 1, Concept Clarification (see 1.7.2), the District Health System was the framework for the study. Certain policy documents make use of the term 'District Health Services', when describing the DHS (Gilson, Pienaar, Brady, Hawkridge, Naledi, Vallabhjee & Schneider, 2017:62) The district health setting is a term also used throughout this paper, and in discussions with the participants. The district health setting represents the environment within which the participants executed their role as managers. A detailed description of the micro-context will be discussed on page 38, 3.2 Context of the study.

2.2.4 Descriptive study

Descriptive research attempts to describe reality, facts and explore a phenomenon while providing additional information about a topic for future research (Monette, Sullivan & DeJong, 2013:496; Botma *et al.*, 2010:194). The descriptive approach is used to describe rather than test or predict a relationship between variables. Descriptive studies show utility in summarising and describing a phenomena in a comprehensive and straight forward manner (Lambert & Lambert, 2012:256). The researcher presented a thick description of the views and opinions of the participants to create a better understanding of the topic being investigated.

2.3 Research method

Research methods relate to the gathering, structuring and interpreting of information (Polit & Beck, 2004:233). It provides the operational framework to better understand data placed within it (Leedy, 1993:104). According to Burns and Grove (2003:488), the research method includes the environment, sample and the data gathering and analysis techniques of a study. Through

the interaction between the researcher and the participants, the participants' experiences are uncovered and interpreted by means of qualitative method (De Vos, 2002:360).

2.3.1 Population

A population is defined as a group of persons or items a researcher has interest in obtaining information or data from (Moule & Goodman, 2009:391, Polit & Beck, 2008:337). The population for this study was the health service managers at a district level in the ECDOH. The participants were all employed by the Eastern Cape Provincial Health Department at a District or Sub-District level, executing management functions in a hospital, entire district or sub-district. The population was limited due to the specific nature of the research, where only one position per district is the norm, not all posts being populated at the time of study, and the availability of the participants being subject to their respective district issuing approval for the research to be conducted.

2.3.2 Sampling

A sample is a subcategory of the study population chosen to participate based on a set of characteristics relevant to the phenomenon under investigation (Polit & Beck, 2008:337). Morse and Field (1995:80) describe two principle tenets of qualitative sampling as appropriateness, which is the utilisation of select individuals to best inform the research, and adequacy, whereby sufficient data is gathered to develop thick descriptions.

In considering the guiding principles described by Morse and Field (1995:80) above, non-probability sampling was used, more specifically, purposive sampling. In purposive sampling, the researchers establish which participants demonstrate the specific characteristics necessary for the issue under investigation (Botma *et al*., 2010:201). The researcher used their discretion when creating inclusion criteria to identify eligible participants for the study (Botma *et al*., 2010:126). The inclusion criteria targeted specific managers for their decision-making functions and influence which directly, or indirectly, involved them in the structure and provision of rehabilitation services. The perceptions of managers may have an influence on the behaviour and decisions they make, as they relate to rehabilitation in this study (see 1.7.4). In this study those characteristics related to the involvement in the management, planning and executive decision making of rehabilitation services.

The inclusion criteria define which attributes are necessary for participants to be included in the study (Botma *et al.,* 2010:200; Polit & Beck, 2008:338).

The inclusion criteria for this study were that participants:

- were employed by the ECDOH,
- occupied one of the positions of Rehabilitation Manager, Clinical Support Services Manager, All Programmes Manager, Clinical Services Manager, District Manager; District Health Planner or District Hospital Manager/CEO, and
- had at least six months' work experience in one of the relevant managerial posts.

2.3.2.1 Sample Size:

According to Greef (2009:138) there are a multitude of factors which contribute to data saturation and the size of the sample. These include: the quality of the data, scope of the study, research design and methodology, as well as the interview approach. Data saturation is described as the point at which no new or relevant data emerges (Polit & Beck, 2008:308). The size of the sample was established on the basis of data saturation, and in this regard, a minimum of 10 managers were interviewed to warrant a trustworthy result.

2.3.2.2 Interview details:

Four interviews were done face-to-face, one used Zoom (see description in 2.4 Data Collection), and five were conducted telephonically. The interviews were recorded with permission from the participants. The length of the interviews was 24 minutes on average. The interviews were conducted at the participants place of work, where possible, and over a period of 10 months. Data saturation was reached after 10 interviews. More detail will be presented below in sub-section 2.4.1 Interview mechanisms.

2.3.3 Recruitment

Due to the disparities in service delivery provision amongst the districts, largely based on geographical area and dispersion of human settlements, a widely distributed recruitment effort was made. It was of interest to the study to incorporate the perceptions of management within the varied backdrops of healthcare in the province. Therefore, the researcher sought to include the views of those in management from both an urban and rural environment. Additionally, representation in terms of management positions and of the various health districts was pursued.

Following approval from the Nelson Mandela Metropolitan University Faculty Postgraduate Studies Committee (FPGSC) (see Appendix 1), the researcher obtained the necessary

endorsement from the Eastern Cape Health Research Committee (ECHRC) (see Appendix 2). A research request letter (Appendix 3) was emailed to the relevant Provincial Offices governing District Health, Clinical and Clinical Support Services, and consent was given to approach the district offices. The individual district gatekeepers, identified as the District Managers, were contacted via electronic mail and followed up with telephonically. After the procedure for conducting research was established, the necessary documents were forwarded to the relevant District Research Committees for approval. As district managers formed part of the sample, and were the gatekeepers for all research conducted in their district, they were requested to not review the research proposal which was sent as part of the research request process, so as to protect the integrity of the research.

A list of eligible managers was obtained through communication with the district management offices and with open-source information available on the ECDOH web portal. Potential participants were contacted telephonically to inform them of the study and request their participation. Proof of district approval was provided so as to protect their confidentiality by negating their need to contact the district office. To encourage participation the objectives of the study were explained to those that fit the inclusion criteria and they were given the opportunity to ask questions relating to the study, both during the conversation and with any further communication. A research participant pack, which consisted of the letter requesting participation in study (Appendix 4), participant information letter (Appendix 5) and participant informed consent letter (Appendix 6), was sent to those that were interested in participation. Interviews were scheduled with managers who were willing to participate and who gave consent. Confidentiality was upheld with no information regarding who was contacted for participation or who participated given to any party.

2.4 Data collection

Semi-structured interviews were the primary method of data collection. An interview is defined as a method of information exchange commonly used in exploratory and descriptive research, which can be obtained via various mediums, either face-to-face, electronic or telephonic (Brink, van der Walt & van Rensburg, 2012:157). Botma *et al.* (2010:205) state the value of semi-structured interviews in exploring perceptions, thoughts and feelings when researching a new topic with a population. Semi-structured interviews are utilised to elicit a comprehensive description of a participant's perception of, or beliefs about a specific subject in a more descriptive manner (Botma *et al.*, 2010:206-208). As there was a paucity in the research regarding this topic, and the intention of the researcher was to explore and describe the perceptions of the participants, a semi-structured interview approach was deemed to be the

most appropriate method of inquiry.

With those that agreed to participate, arrangements were made to conduct the interviews, face-to-face where possible, alternatively, interviews via the Zoom teleconferencing application were utilised. Two of the eight health districts fell within a 150km radius of the researcher, which was considered feasible in time and cost for conducting face-to-face interviews. The next two closest health district offices were approximately 300km from the researcher. The use of a video conferencing application was seen as ideal for emulating the face-to-face environment where visual cues could be observed. Zoom was chosen for its low data consumption, connectivity reliability and ease of use for the participants. The participants were requested to give a date, time and location which was convenient for them for the face-to-face interviews. The researcher enquired if they had stable internet connectivity and required data for the Zoom interviews. Where Zoom interviews were conducted, no participant indicated the need for data. To encourage confidentiality the researcher enquired whether the participants would prefer to conduct the interviews out-of-office or out-of-working hours, the same was done for the Zoom interviews. Furthermore, appointments were made directly with the participants via an e-mail address or telephone number they provided for preferred communication. In the absence of accessibility for face-to-face or Zoom interviews, telephonic interviews were conducted. The interviews were conducted in English by the researcher.

The following central question was posed to each (all) participant(s):

- What are your perceptions regarding rehabilitation services in the district health setting?

Two follow-up questions were prepared, these were:

- What is the role of rehabilitation services in a district health setting?, and
- What would you change about rehabilitation services in your district health setting if you could?

A fourth question was duly added to allow participants the opportunity to expand on or introduce any new content. This was done to facilitate a richer contribution towards the data. The fourth question asked was: “Is there anything else you’d like to add?”

2.4.1 Interviewing mechanisms

The interviews were performed in a private, comfortable setting at a time and place of convenience to the participant. With the consent of the participant, the interviews were recorded with the use of a digital voice recorder where the interview was face-to-face, or the record call feature on the Zoom application or telephonic call. Consent from participants was

obtained on the day of the interview, in the case of face-to-face interviews consent was written, where Zoom and telephonic interviews were conducted, consent was verbal and on the recording. Confidentiality of participant's responses was emphasised. Transcribed data which was shared with the independent coder made use of identifier codes to further ensure confidentiality. The interview recordings, transcripts and field notes were all kept in a safe and secure, password protected location limiting access to identifiable data.

As interviewing was the medium of data interchange, communication techniques formed the basis of the researcher's interview skillset. This skillset was necessary in order to build rapport and encourage ease of conversation (Botma *et al.,* 2010:60). Okun (1997:63) mentions frequently used communication methods to facilitate the interview process, namely: minimal verbal responses, listening, paraphrasing, reflecting, clarifying, probing, summarising, encouraging, and acknowledging.

Minimal verbal response was offered in order to facilitate the interview through acknowledging participants' responses (Okun, 1997:76), examples of this are simple affirmations such as "Mmm" and "Yes".

Paraphrasing and reflection were used to verify the researcher's understanding of what has been said through the repeating of the participants' responses in the researcher's own words (Okun, 1997:76). Probing and summarising were used by the researcher to elicit the best possible information (Brink *et al.,* 2012:158), allowing for elaboration and clarification of responses and rapport building. The following questions are an example of the phrasing used to probe: "What do you mean by…?" and "Could you tell me more about…?".

The researcher familiarised themselves with the above-mentioned techniques and reflected on their use during evaluation of the pilot study recording and subsequent interviews (Polit & Beck, 2008:401).

2.4.2 Field notes

Field notes were completed immediately after the interview in order to describe the setting, environment and non-verbal communication of the participant and the researcher's personal impressions of the interview as suggested by Botma *et al.* (2010:217). An observational protocol was used, as suggested by Cresswell (2009:181), to gather various forms of observed data, described as descriptive and reflective notes as well as demographic information (see Appendix 7).

2.5 Data analysis

Data analysis is concerned with the observation of, and enquiry into, patterns in data; and the speculation and confirmation of the data and its derivatives (Brink *et al.,* 2012:193; Botma *et al.,* 2010:221). An outcome of data analysis is to develop a rich understanding and meaningful interpretation of the data with an eventual production of themes (Brink *et al.,* 2012:227; Cresswell, 2009:183-184). Verbatim transcriptions of the interview were done by the researcher to facilitate analysis (Botma *et al.,* 2010:214).

The eight steps of thematic analysis/synthesis was used, as described by Tesch (1990) in Cresswell (2009:186), and are as follows:

1) The researcher familiarises themselves with the data through careful reading of all the interview transcripts, in order to get a sense of the whole. The researcher's impressions are written in the margin.

2) One transcript is selected at the preference of the researcher, and examined to determine the essence of what is being said, this is also written in the margins.

3) Step 2 is repeated with multiple transcripts and a list of all emerging topics is developed. Similar topics are then put into columns with a suggestion to group into major, unique and remaining sections.

4) The emerging topics from step 3 are then abbreviated into codes, these codes are then written in the margins of the appropriate section of text, while checking if new codes or categories emerge.

5) Categories are then created using the most illustrative phrasing for the topics. A reduction of codes is done by clustering associated categories. Category relationships are indicated with interconnected lines.

6) A final decision for the categories coding abbreviations are made, these are then alphabetised.

7) The data relating to each category is collated and a preliminary analysis is done.

8) Recoding of existing data can be done if required.

A confidentiality agreement was signed by the independent coder and researcher prior to the sharing of data (see Appendix 8). The independent coder and the researcher analysed the transcriptions to establish themes and categories. The researcher and independent coder then compared and discussed their analysis of the data until consensus was reached. Both sets of identified themes were then submitted to the supervisor of the study and verification took place after discussion. The themes were then reported and a literature control undertaken (see Chapter 3). The findings we used to make recommendations for practice (management), education and research.

2.6 Pilot study

A pilot study was done with one of the invited participants. The format followed the same research design and method as mentioned above and was used to evaluate the efficacy, and if need be refinement, of the research question or the interview process. The interview was transcribed and analysed as discussed above. The interview technique of the researcher was also evaluated by the supervisor. The transcriptions and coding were reviewed and discussed with the researcher's supervisor, no major changes were needed. As there was no substantial adjustment to the data collection procedure the pilot interview was included in the 10 interviews of the study.

2.7 Literature control

When the findings were reported a literature control was done to substantiate the findings and place the findings in relation to existing literature on the topic.

2.8 Trustworthiness

Lincoln and Guba's Trustworthiness model (1994:114) was used as the construct for reliability and validity during the research study. The four strategies and measures that were utilised to ensure trustworthiness in this research are discussed below.

2.8.1 Credibility

Information was obtained from ECDOH employees who formed part of the management of district level health and rehabilitation services. Triangulation was sought by interviewing personnel at various managerial levels as well as the taking of field notes. Multiple sources of data were used to consider the collective meaning of the participants' perspectives. Independent coding was performed in addition to coding done by the researcher, which included the process of cross-checking codes and reaching inter-coder agreement.

2.8.2 Transferability

The researcher ensured thick and rich descriptions of the research method and context were provided to enable replication of the study.

2.8.3 Dependability

Independent coding was done and agreement was reached regarding the themes and conclusions made through analysis of the data. Thick descriptions of the research methodology and results were provided, and a literature control was done to establish if the findings were consistent with other research findings. The recommendations that were made were in line with the findings of the study and verified by a critical reader and the supervisor.

2.8.4 Confirmability

The researcher used quotes from the participants to confirm their utterances and thereby confirm the interpretation of the data. Triangulation methods described under credibility also form part of confirmability.

The researcher utilised reflexivity in exploring possible preconceptions and biases. Bracketing was utilised prior to and during the interview process and also during data analysis and reporting of the findings. Bracketing is defined as the process where the researcher acknowledges and sets aside pre-conceived ideas and biases, or what they think they know or expect to discover; this is done in order to encourage the consideration of all possible viewpoints (Brink *et al.,* 2012:122). For research purposes, the researcher bracketed his experiences and readings regarding rehabilitation services in a district health system.

A further key tool used during the research was prolonged engagement, which refers to spending sufficient time with study participants to build trust and deepen the understanding of the group under study (Lundy, 2008:1). As expressed in the problem statement, the researcher worked in rehabilitation services and had built a rapport with the participants. The researcher was comfortable to go back to the participants to do member-checking and to clarify any queries or inconsistencies from the data collection process.

2.9 Ethical considerations

Ethics in research help to ensure that the researchers are accountable for their behaviour to the public. In order to protect the integrity, rights and safety of the research participants, the

researcher adhered to the three central ethical research principles of respect for participants, principles and the process of research, beneficence and justice (Botma *et al.*, 2010:17; Brink *et al.,* 2012:34). A fourth aspect of the ethical considerations is gaining the necessary ethical permissions to conduct the research. A detailed description of how these principles were applied is stated below:

2.9.1 Respect for persons

Respect for persons is exhibited through the principles of autonomy, anonymity and confidentiality (Botma *et al.,* 2010:17; Brink *et al.,* 2012:35). Participants were anonymised through the removal of identifiable information such as names, places and posts held. Confidentiality is concerned with the conservation of privacy and non-disclosure of sensitive information from the researcher(s) and other research partners, such as independent coders (Winkler, 2004:232). Botma *et al.* (2010:17-18) describe confidentiality in terms of the management of personal information and has four essential components, namely: data-capturing content; data access; data storage; and data reporting. These components were upheld in the following ways:

Participant interviews, transcripts and data-gathering forms were coded, and a master list made, which was only accessible to the researcher who used them for correlation purposes only. The participants' participation, identity and place of work was kept confidential throughout the research process and thereafter. The information (raw data) will be kept confidential for five years, with written documentation kept in a locked cupboard and digital information, such as the recordings and transcripts, in password protected files on the researcher's laptop. Additionally, the independent coder utilised in the data analysis process entered into a confidentiality agreement with the researcher to adhere to the principles of confidentiality as stated above.

The interviews were held in a private environment, at the participant's discretion, to ensure a level of confidentiality that the participant was comfortable with. Information and data pertaining to the study were only shared with necessary individuals directly involved with the research. Coding was utilised to ensure the participants' testimonies are unidentifiable by name and place of work.

With respects to autonomy, the participant has the right to self-determination. The participants were not coerced to take part in the study and were informed of their right to withdraw from the study at any time. The participants were informed that there was no monetary compensation for participating in the study. Informed consent from the participants was

obtained for the study and the interview recording before their participation. The researcher was open and honest towards the participants and mindful of their welfare, furthermore, information pertaining to the nature of the study was explained in a truthful, comprehensive and objective manner.

2.9.2 Beneficence

The principle of beneficence speaks to the safeguarding of the participants well-being and avoidance of harm (Botma *et al.,* 2010:20; Brink *et al.,* 2012:36). Botma *et al.* (2010:20-21) discuss the consideration of beneficence as a ratio of risk to benefit.

Direct benefits in this study were the participants' exploration of ideas, thoughts and beliefs regarding the research topic (Friedman, Robbins & Wendler, 2012:61). The research gave them an opportunity to voice their opinions and could therefore alleviate some of their stress and use their creativity to come up with ideas that could be included in the recommendations of this study. Societal benefits could be a higher level of staff satisfaction, when and if, the recommendations are implemented (Habets, van Delden & Bredenoord, 2014:68). The employer could benefit from managers having a clearer understanding of the rehabilitation service. Patients could benefit from an improved service relating to access, service provision and resource allocation due to the recommendations made as a result of this study.

Brink *et al.* (2012:36) speak of an aspect of beneficence which is often overlooked, this being reputational risk. This is an important component when conducting research within an organisation and institutions. In this study the organisation was the ECDOH with the data being gathered from various institutions or districts. Specific attention was made to not identify any institution, district or participant, during the study, report writing or with feedback sessions, to an extent which would cause harm to the reputation of the participant or institution they represent (Brink *et al.*, 2012:36).

2.9.3 Justice

The principle of justice relates to the fair handling of participants with regards to treatment and selection (Brink *et al.,* 2012:36). This was implemented through strict adherence to stipulated research methods and protocols and the preservation of agreements which were made between the researcher and participants (Botma *et al.,* 2010:19; Brink *et al.,* 2012:36-37).

The right to privacy was upheld with the gathering of data which was only performed once all the necessary information relating to the study had been discussed and informed consent had been obtained. Furthermore, the process of ensuring confidentiality as it relates to privacy was

upheld as described above (see 2.9.1 Respect for persons). Representation of the various professional cadres as well as health districts in the Eastern Cape was sought within the study. All managers that met the inclusion criteria had an equal chance of being included in the study and were contacted based on reasons directly relating to the research question.

2.9.4 Gaining ethical permission to do the study:

Prior to commencement of data collection ethical clearance was gained from the Nelson Mandela Metropolitan University (now the Nelson Mandela University) FPGSC and the ECHRC. Further consent was sought from the relevant managers at the provincial and district level of the ECDOH. A full description can be found in the recruitment section above (see 2.4.2).

2.10 Conclusion

The objectives and purpose of the research determined the research design and method that were employed in this study. A qualitative, exploratory, descriptive and contextual design was used. A non-probability, purposive sampling strategy was applied with various management cadres at the district level of the ECDOH. Semi-structured personal interviewing was the primary method of data-gathering. The ethical considerations described in the section above (see 2.9) were upheld throughout the research process. The data collected has been analysed and the research findings will be discussed in the following chapter.

CHAPTER 3: RESEARCH FINDINGS AND LITERATURE CONTROL

3.1 Introduction

The previous chapter described the research design and methodology used in the study. In this chapter the research findings will be put forward. First, the micro-context will be provided followed by a description of the participants. The themes and sub-themes identified will then be presented and discussed extensively. The interview identifier code "RDMP" was used to designate the participants' responses in quotations, RDMP was an acronym for Rehabilitation District Managers' Perceptions. The themes and sub-themes are introduced with a discussion of the managers' perceptions, followed by a direct quote and literature control to corroborate the findings with what is already known about the topic.

3.2 Context of the study

The discussion that follows is additional to Chapter 2, Section 2.2.3 Contextual study, on page 25, in which the macro-context was discussed. The micro-context is examined in this section to orientate the reader and make the findings more meaningful.

Due to the contextually specific nature of the research the target population was limited. Each Health District Office had an appointed District Manager, District Health Planner, All Programmes Manager and Clinical Services Manager. There were a sufficient number of District Hospitals in the province with the cadre of Hospital Manager/Chief Executive Officer. The District or Sub-District Rehabilitation Manager post varied across the districts and there were no appointees to the post of Clinical Support Services Manager at the time of data collection. Rehabilitation service reporting and management structures differed from district to district. The Rehabilitation Programme reported to various management cadres at the District Management Level; from the All Programmes Manager (also known as the Primary Health Care Manager), to the Clinical Services Manager, or the Clinical Support Services Manager, a post not usually found at District Office level. Within the District hospitals, some services reported to rehabilitation managers or clinical support services managers, while others reported directly to the CEO of the hospital. Figure 3.1 below was developed from the information given by the participants and the researcher's knowledge of the DHS. An official published organogram of District Health Services could not be found by the researcher.

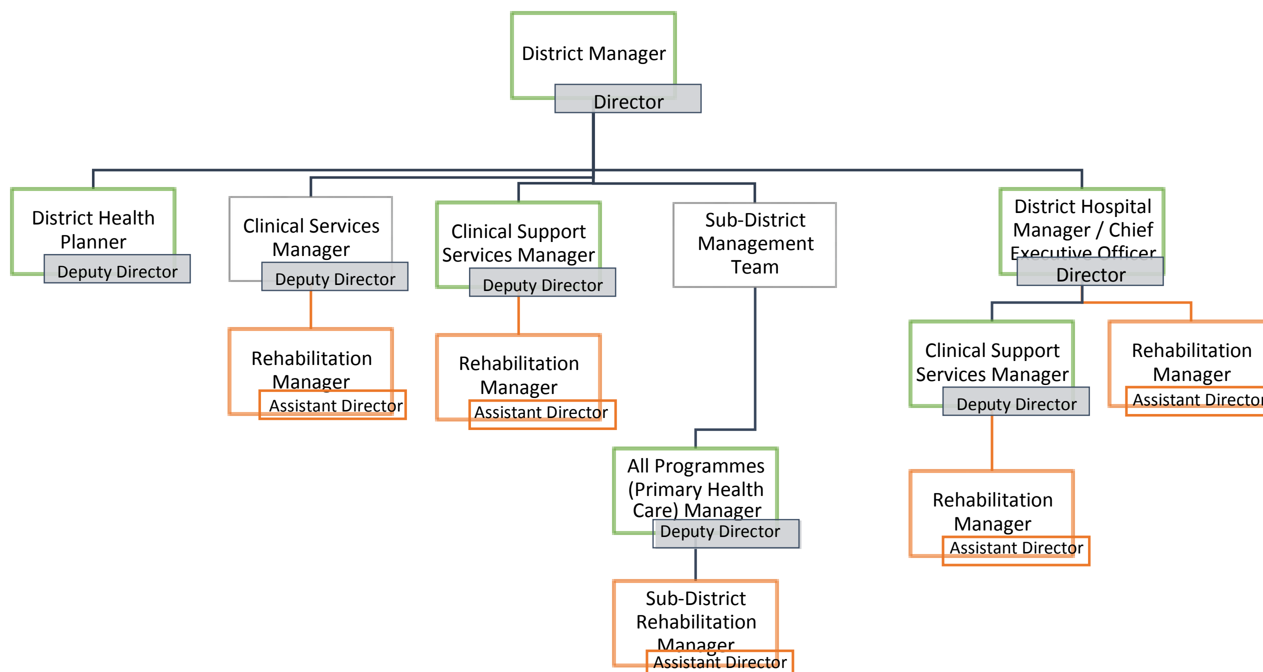

Figure 3.1 District organogram of rehabilitation lines of reporting

Rehabilitation in the primary health care setting is diverse in its case presentations, with rehabilitation staff assessing and treating a multitude of conditions spanning, inter alia, neurological, orthopaedic and paediatric cases. The most common neurological cases seen are cerebrovascular accidents, or stroke victims, which require regular multi-disciplinary therapy to manage the often life-changing residual effects. The orthopaedic caseload ranges from fracture management to broad musculoskeletal conditions such as lower back pain, neck pain, and peripheral joint injuries. Paediatric cases range from management of orthopaedic cases to congenital disorders such as developmental delay and cerebral palsy, where the management covers assistive device provision in the form of specialised wheelchairs, communication tools and splinting, amongst others. Physical, occupational and speech, language and hearing therapy, are used to facilitate the child into their highest functional level so they can engage with their environment. Assistance is also given in accessing social support structures, such as care dependency grants through the Department of Social Development, as well as assessments and reports for school placements conducted by the Department of Education. Rehabilitation professionals are in a unique position to deliver personalised patient education, health promotion and self-management tools due to the nature of the disciplines.

In the EC Province there are 66 district hospitals, 41 CHCs and 732 clinics (ECDOH, 2018:51). The primary healthcare institution numbers should reflect the need for services, as well as

opportunities for rehabilitation service provision with national policy dictating that all district hospitals and CHCs should provide access to rehab. The number of rehabilitation staff allocated to service district hospitals, CHCs and clinics was not known. Based on the total number of various cadres who would form the multi-disciplinary rehabilitation team, the EC displays a low rehabilitation staff to population ratio. When considering that all other levels of care are expected to offer rehabilitation services (DOH, 2015b:8-10), and that the total number of rehabilitation staff in the province are inclusive of all levels of care, it is likely that district level services have the least proportionate number of rehabilitation staff. The table below shows the number of permanent and contract (community service) rehabilitation staff in the EC in 2017, as well as the number of government hospitals which are all required to provide rehabilitation services.

Table 3.1 Number of public sector rehabilitation staff versus number of government hospitals in the EC, 2017

Public Sector Rehabilitation Staff Posts in the Eastern Cape (ECDOH, 2018:28)		
Profession	**Permanent Posts**	**Community Service**
Occupational Therapists	115	32
Physiotherapists	140	30
Speech, Language and Hearing Therapists	55[1]	5
Audiologist	55[1]	7
[1]Speech, Language and Hearing Therapists and Audiologists are combined in some reporting structures (ECDOH, 2017:208)		
Number of Government Hospitals in the Eastern Cape, by category (DOH, 2012:8-11)		
Level of Care	**Number**	
District Hospital (ECDOH, 2018:51)	66	
Regional (Secondary or Provincial)	3	
Tertiary	3	
Central	1	
Specialised (Psychiatric)	4	
Specialised (TB)	10	

3.3 Demographic outline of participants

In this section the researcher will give a description of the participant demographics as suited for the study. Due to the restricted number of management personnel who met the inclusion criteria for the study, and the small sample size, the researcher chose not to divulge all characteristics in the interest of protecting the anonymity and confidentiality of the participants. Examples of characteristics that could potentially identify participants include age, gender and place of work, therefore, where this information was reported on, it was done so in ranges.

3.3.1 Participant Sample

The sample group was representative of the cadres of management included in the study with one to three of each role represented, with the exception of the clinical support services manager post. There was also fair distribution in terms of an urban and rural setting. The sample group consisted of a total of ten (10) participants who were all employed in management positions within various Health District Offices or Sub-District appointments. The participants in the study displayed the following characteristics:

The participants displayed a range of experience, with four having less than five years', and six having five to ten years' experience in the relevant managerial roles within the ECDOH. All participants were fluent in English which negated the need for translation and possible loss of information. Interviewees varied in their groupings of age, race and gender. There were no participants younger than 30 years old, possibly due to middle and top management posts requiring necessary managerial experience. The majority of the managers who were invited to participate, based on availability (see 2.3.1), were either black (African) or coloured[2].

[2]The terms to denote race are current categorisations used by the State.

Table 3.2 Characteristics of the participants

Age of participants in 10 year ranges	31-40: 4 41-50: 4 51-60: 2
Racial Category	Black (African): 6 Coloured: 4
Gender	Female: 8 Male: 2
District Classification	Urban: 4 Rural: 6
Years in position in 5 year ranges	6 months to 5 years: 4 5 to 10 years: 6
Management Level	Assistant Director: 2 Deputy Director: 3 Director: 5
Management Position	District Manager: 2 District Health Planner: 2 All Programmes Manager: 1 Rehabilitation Manager: 2 District Hospital Manager/CEO: 3 Clinical Support Services Manager: 0

3.4 Data analysis and overview of the findings

3.4.1 Data analysis

The data collected through the interviews was transcribed verbatim by the researcher. The transcribed interviews were verified with a second listening and then analysed using Tesch's model of content analysis/thematic synthesis. Please see Chapter 2, Section 2.5 Data Analysis on page 32, for the steps that were followed. An independent coder was utilised to ensure the trustworthiness of the data analysis process, and also used Tesch's method as requested. The researcher and independent coder exchanged their ideas regarding the themes, sub-themes until an inter-coder agreement was met.

3.4.2 Overview of the findings

In the following discussion of findings, the terms managers and participants will be used interchangeably as all the participants were managers.

Both positive and negative views were expressed by the participants, relating to rehabilitation services in the district health setting. The fact that some managers' perceived positive aspects of rehabilitation services and others perceived and experienced many challenges could be due to the distribution and presence of rehabilitation within the various health districts or institutions where the participants were employed. The majority of the feedback related to challenges the managers encountered with service delivery implementation, or issues relating to support from higher levels of management. Alongside the challenges discussed were suggestions for improving the status of rehabilitation services in the districts and province.

Following the data analysis process three major themes were identified:

In theme one, the managers reported positive factors regarding rehabilitation services. The subthemes related to benefits of rehabilitation service availability within the DHS, community service and passionate staff.

In theme two, the managers identified challenges affecting the delivery of rehabilitation services in the District Health System. Three sub-themes of challenges spanned service delivery, insight and management-related issues.

Theme three presents the managers' suggestions regarding the improvement of rehabilitation services in the District Health System. The managers' recommendations concerned the governance of rehabilitation, marketing and advocacy of rehabilitation services.

The resultant themes and sub-themes identified are presented in Table 3.3 below. These will be discussed in detail in Section 3.5.

Table 3.3 Identified Themes Relating to Managers' Perceptions Regarding Rehabilitation Services in the District Health System

Theme	Sub-Themes
1. The managers perceived positive factors regarding rehabilitation services.	1.1 There are benefits to providing rehabilitation services in a district health setting.
	1.2 Passionate rehabilitation staff help develop and maintain the service.
	1.3 Community service of rehabilitation staff has assisted with the provision of services.
2. The managers identified challenges affecting the delivery of rehabilitation services in the District Health System.	2.1 The managers voiced challenges regarding rehabilitation service delivery in the district health setting.
	2.2 The managers recognised a lack of insight regarding rehabilitation services from various stakeholders.
	2.3 The managers identified challenges regarding the management of rehabilitation services.
3. The managers voiced suggestions for the improvement of rehabilitation services in the District Health System.	3.1 Governance of rehabilitation services needs strengthening and/or development.
	3.2 There is a need for marketing of rehabilitation services to external stakeholders.
	3.3 Advocacy of rehabilitation services is necessary for change.

3.5 Discussion of the findings

The participants expressed both positive and negative views relating to rehabilitation services in their district health setting. Participant views regarding challenges with service delivery implementation and support for rehabilitation services were voiced often. Suggestions for improving rehabilitation services were also made. The researcher will now elaborate on each of the subthemes, providing a sense of the context and framing of the managers' perceptions and suggestions. Where the participants' own words are used, these will be in quotations, italicised and indented to the centre of the document, and identified by the participant code "RDMP".

The essence of these perceptions will, wherever relevant, then be placed in the context of literature in these domains.

3.5.1 Theme 1: The managers perceived positive factors regarding rehabilitation services.

The managers identified positive factors regarding rehabilitation services. Benefits to having the rehabilitation service accessible at a primary care level were expressed in as much as they provided access to rehabilitation services that are required in a district health setting; cost containment and early identification of disability or disability-related needs and the role of rehabilitation services in facilitating clients' return to full function and reintegration into society. Aspects related to staffing were also discussed in a positive light, i.e. passionate staff and community service therapists play a strengthening role in developing and maintaining the rehabilitation services.

3.5.1.1 Sub-theme 1.1: There are benefits to providing rehabilitation services in a district health setting.

A frequent perception of the participants was the need for rehabilitation services to be accessible. The notion of accessibility was iterated throughout the managers' responses, both urban and rural, and is discussed in more detail in section 3.5.2.1. Participants expressed the opinion that it is beneficial to provide district level rehabilitation services as it improves patient management. This was mentioned in terms of cost containment and early identification of disability and disability-related needs. Further reference was made regarding the function of rehabilitation services in reintegrating individuals (clients/patients) to their highest level of function, or maximum potential, for inclusion in society.

3.5.1.1.1 There is a need for rehabilitation services at DHS-PHC level

An aspect that was highlighted by nearly all participants was the need for the rehabilitation service at a district health level. While some remarked on rehabilitation as a specialist service, they all agreed that there should be availability for patients, at a primary care level. This is reflected in the following quotes from the participants:

"The component itself, it should have been at a district level where PHC, where PHC can also, or like community can also access it." (RDMP 8:3.2)

"We have placed them in these settings [CHC's and clinics] *to make services more accessible to our patients."* (RDMP 1:3.1)

Availability of rehabilitation services at the PHC level is reiterated in legislation and health policy both nationally and internationally; from the inclusion of rehabilitation in PHC in the Alma Ata Declaration (WHO, 1978:2) and UHC as discussed in the Background (see 1.2.1), to the SA NHI White Paper and PHC Package: Norms and Standards (DOH, 2000b:43 and 2017:29). The above-mentioned comments are synonymous with the findings of Mlenzana, Frantz, Rhoda and Eide (2013:4) who affirm that rehabilitation services in PHC settings are important for the welfare of patients with physical disabilities.

Availability at PHC level was also alluded to in the context of providing a comprehensive PHC package, which should include rehabilitation as one of its core pillars:

"You should not only have doctors and nurses to provide a comprehensive [district] health service. You need these other professionals as well, which is your rehab professionals. Then you can then say you are providing comprehensive health services. Because without them, then the health that we providing for people, is kind of, halfway." (RDMP 9:5.7)

In a study examining access to health care services amongst people with chronic and disabling conditions, the authors concluded that people with chronic and disabling conditions often require a comprehensive array of health care services (Beatty, Hagglund, Neri, Dhont, Clark & Hilton, 2003:1418). Authors Hardcastle, Oosthuizen, Clarke and Lutge (2016:185) support this ideal by stating that access to rehabilitation services should be available along an efficient and effective continuum of care to undertake their reintegration to society.

3.5.1.1.2 District level services improve aspects of cost and patient management

The participants voiced that some of the specific benefits to rehabilitation service provision in the district health setting were aspects relating to cost containment and early identification of

disability and disability-related needs.

Cost Containment

Cost containment was referenced with benefits to both the patient and to service providers. As PHC services come with no direct cost to the patients, the participants remarked on reduced travel costs relating to convenience and unnecessary hospitalisations. The managers mentioned examples of cost containment to the service provider such as reduced length of stay and unnecessary hospitalisation. Reduced length of stay was two-fold with the availability of rehabilitation services in the district hospital allowing tertiary hospitals to down-refer, as well availability of rehabilitation services at community level which allowed for down-referral as soon as the patient is medically stable and only needing rehabilitation and follow-up medical care.

The following two quotes sum up the voiced opinions of the participants in this regard:

"…keeping the patient in the hospital longer is very expensive. But, if the patient therefore is discharged to home, he would be able to go to the primary health care setup then the rehabilitation professionals, based in the sub-district, would be able to see patients next to where they are staying, meaning that, at the clinic where the patient would go in for a session then would go back home. It saves the patient time, it saves the patient cost, it also saves the department funds because now we won't have a patient whose 50 years old who's just for rehabilitation, but that patient would be at home. In that sense, the continuation of care continues at that level, outside the hospital." (RDMP 8:7.6)

"…the cost of health services in tertiary hospitals, in general, is too high, keeping patients there is costly." (RDMP 9:2.9)

A number of studies support early access to rehabilitation as a predictor of reduced length of stay as well as an overall reduction in hospital costs (Munin, Rudy, Glynn, Crossett & Rubash, 1998:847; Guerra, Singh & Taylor, 2015:844; Stowers, Manuopangai, Hill, Gray, Coleman & Munro, 2016:475). The responses of the managers were in agreement with the literature. Some respondents also alluded to the care pathway or access to PHC having an impact on hospital length of stay as well as hospital readmission. Further literature notes the efficacy of primary health care to improve access to services and reduce both hospital length of stay and the use of hospital care (Blumenthal, Mort & Edwards, 1995:259,269). The WHO-CHOICE estimations of hospital costs per bed day and per outpatient visit versus health centre costs highlight the cost effectiveness of PHC interventions (WHO, 2017a:1). WHO-CHOICE is an initiative that reports on the costs and effects of health interventions to inform policy-makers (WHO, 2017b:1). The cost per outpatient visit to a tertiary level institution is calculated as 63% to 79% higher than a

visit to a CHC; while the cost per bed day at tertiary level is 85% to 92% higher than a CHC visit and 44% higher than the cost per bed day at a district hospital (WHO, 2017a:1). These calculations state the cost benefit of linear continuation of care, which is in line with the opinions expressed by the participants.

Early Identification of clients/patients needing rehabilitation

A further benefit mentioned by the participants was the early identification of cases needing rehabilitation and the prevention of secondary complications, where the absence of rehabilitation would result in the patient's condition worsening to levels requiring medical care at a secondary or tertiary level institution:

"So the benefit would be that, problems would be addressed at a very early age in children, other than wait until it is too late." (RDMP 9:6.7)

"…from a primary health care point of view, we need to provide people at clinic level, who are going to assess people whose conditions need rehabilitation…" (RDMP 7:5.9)

The sentiments above are echoed in the Integrated National Disability Strategy which acknowledges early identification and intervention services as a means to facilitate curative methods, slow disease progression or avoid complications (Office of the Deputy President, 1997:57). Furthermore, Sherry (2015:93), in the 2014/15 South African Health Review, states that if primary prevention fails and there is a lack of access to rehabilitation, barriers to further prevention and promotion activities develop, which results in negative health effects and disability, and would ultimately lead to a need for care at a higher level. In a qualitative study done in a rural region of the Northern Cape, a therapist observed that the challenge in restoring function increases with the waiting times for therapy, remarking on the impact of late referrals (Visagie & Swartz, 2016:4).

3.5.1.1.3 Reintegration into life and society

The role of rehabilitation was identified by managers as facilitating clients to their full function or their maximal potential. They noted the various spheres of life one would need to be reintegrated into after injury; from return to work to engaging with their living environment and society at large:

"Rehab is to improve the quality of life of that individual, help him integrate into his … new normal, rehab is there to assist the patient to adjust but also help that person reach his highest level of function." (RDMP 2:5.6)

This sentiment was similarly expressed by Mlenzana *et al.* (2013:3), in a systematic review on the perceptions of PWD on barriers to and facilitators of rehabilitation services. The authors

assert, to ensure that an acceptable quality of life and opportunities are afforded to PWD, investment in health and rehabilitation services are necessary, with further implications on participation and contribution to society.

3.5.1.2 Sub-theme 1.2: Passionate rehabilitation staff help develop and maintain the services.

Human resources are by and large regarded as the most valuable resource within a healthcare system (Kabene *et al.,* 2006:15; WHO, 2000:77). With passionate employees, willing to go above and beyond, the service is driven and stimulated to grow and develop. Passion is described as "An intense desire or enthusiasm for something" (OED, 2018b:1). This means rehabilitation staff who are passionate about the service have a personal interest and are eager to see the service grow. In addition to growing and developing the service, enthusiastic individuals educate those around them.

As the saying goes, "Passion is contagious". This was highlighted by one participant who delighted in re-telling a story about how one particular rehabilitation staff member used to hassle them and complain regularly about not having enough direction when it came to reporting, so they just gave all the information they could. In the context of this it seemed the participant could have been displeased with the view of being given extra work, but instead they found it commendable and made specific reference to how that passionate individual educated and interested them in the service. They went on to mention other instances of passionate individuals who drove their respective services by having the same energy:

"That's the lady that made me know what rehabilitation is." (RDMP 4:7.9)

"She was really very, passionate, and me as a [removed], she used to pester me. What, this is my report, what indicators do you want me to monitor? These are the indicators that I think should be in the district health plan. They should be in the APP [Annual Performance Plan]. You find out those are not there but she would create her own indicators. So that she can monitor her own programme, she was really good." (RDMP 4:8.6)

"So if you've got a person that is passionate about what, that is part of your team, then all of you, you take notice. And you know that you've got to give a budget that is necessary for them to function." (RDMP 4:9.2)

A similar outlook was stated by Mosadeghrad (2014:81), through his qualitative research in Iran on factors influencing healthcare service quality, he found that the nature and disposition of service providers affected the quality of care delivered. In a policy paper on Improving Government Performance in South Africa (Chabane, 2009:14), it is stated that performance must be obtained through persuasion and encouragement, with a need for buy-in throughout all service delivery mechanisms. This is in line with the participant's perceptions noted above where the interaction with the zealous colleague informed those around them and facilitated recognition of needed resources. Chabane (2009:14) also speaks about the importance of support towards producing a culture of performance where passion is focussed on production of significant outcomes. The above-mentioned concept resonates with the participant's quote relating to the passionate staff member developing necessary indicators, or outcome measures, in the interest of improved service delivery. Furthermore, in a research report in China on factors affecting work passion in community health service workers, the authors found that regarding one's work, passion stimulates innovation and spurs initiatives (Luo, Bai, Min, Tang & Fang, 2014:2). This is congruent with the sentiments expressed by the participant and with what was found in the literature.

3.5.1.3 Sub-theme 1.3: Community Service of rehabilitation staff has assisted with the provision of services.

The statutory (compulsory) community service for rehabilitation professionals was promulgated in 2003 in South Africa (Dayal, 2009:21). The purpose was to improve service delivery in areas which were underserviced. One manager observed that the community service programme has assisted with service provision; while another remarked that the service was dependent on community service personnel:

"Implementation of community service has helped a lot ... The fact that they now have to do community service to be able to register in South Africa has made it a lot easier, for us to in the first place get staff, retaining them is a different issue." (RDMP 3:2.1)

"We mainly rely on the availability, I mean the allocation of community service practitioners for that unit to run efficiently." (RDMP 8:5.9)

The perceptions mentioned above are in line with the intentions of the Community Service Initiative; the Community Service Letter to Applicants (DOH, 2007:1) states the main objective of Community Service is "to ensure improved provision of health service to all the citizens of our country." In a study on perceptions of community service in KZN the majority of participant (83,2%) agreed that the policy was good (Govender, Brysiewicz & Bhengu, 2015:7). Further

support for the quotes above is found in research conducted by Omole, Marincowitz and Ogunbanjo (2005:59) on the perceptions of hospital managers regarding community service, where the managers recognised the progressive influence the community service programme had on much-needed human resources, service provision and patient care.

Notwithstanding the benefits of community service as mentioned above in 3.5.1.3, there were setbacks which arose from the appointment of one year contracts. These obstacles were described in terms of human resource challenges, such as the difficulty in the retention of community service practitioners, ensuing high turnover of staff and with it, loss of procedural efficiencies, and poor recruitment of personnel.

3.5.2 Theme 2: The managers identified challenges affecting the delivery of rehabilitation services in the District Health System.

The participants expressed a number of challenges regarding rehabilitation service delivery in the DHS. The issues raised ranged from service delivery challenges, lack of insight regarding the rehabilitation service and challenges relating to management. The service delivery aspect related mainly to resources. The lack of insight concerning rehabilitation services featured frequently amongst the participants, from management level to the patient population. The management-related challenges consisted of participants' opinions regarding policy; strategic, financial and human resource planning and management; resources; governance; and performance management.

3.5.2.1 Sub-theme 2.1: The managers voiced challenges regarding rehabilitation service delivery of in the district health setting.

In a discussion paper on choosing strategies to improve health system performance, service delivery is widely regarded as one of the primary tools to improve outcomes such as better health, client satisfaction and financial protection (Berman, Pallas, Smith, Curry & Bradley, 2011:xi). The service delivery challenges relating to the outcomes listed above were mentioned with regards to availability and access, multiple aspects of resource availability and awareness. While many of these challenges can be linked to management of rehabilitation services (see 3.5.2.3), they will be mentioned here as they concern immediate service delivery.

Access including socio-economic barriers to access

Access to healthcare is a topic that most researchers and policy-makers attempt to address in the discourse on service delivery in/and health. The subject matter is often under debate, with many differing opinions on what constitutes acceptable access to healthcare. The researcher has chosen to utilise the ACCESS framework to structure the presentation of this sub-theme. Section 1.7 Conceptual Framework describes the ACCESS framework in more detail. ACCESS has five dimensions, namely: Availability, Accessibility, Affordability, Adequacy and Acceptability (Obrist *et al.,* 2007:1585). The Adequacy dimension was not referenced by the managers, while the Acceptability dimension will be discussed, in part, under Section 3.5.2.2.2: Lack of knowledge regarding rehabilitation services from patients. The former three dimensions, Availability, Accessibility and Affordability, will be discussed below.

Access was mentioned by all the participants and was also the most frequently discussed topic raised during the interviews. The managers' viewpoints were expressed in relation to challenges to an accessible service, the levels of care at which access should be ensured and the need for access to rehabilitation services, with the latter two points having been discussed in sub-theme 3.5.1.1: There are benefits to providing the service in a district health setting. As described in the Background (see 1.2.1), minimising the financial hardships while ensuring access to adequate services is the cornerstone of UHC (Marten *et al*, 2014:2169). Limited access was mentioned with respect to staffing, socio-economic barriers to access and placement of services.

3.5.2.1.1 Availability

Availability is described as meeting the clients' health needs (Obrist *et al.,* 2007:1585). The managers frequently mentioned the demand for and lack of services, with the observable connect to lack of human resources. Rehabilitation encompasses multiple cadres of health professionals and the participants noted the rarity of comprehensive rehabilitation services:

"There is a need and unfortunately, the package we deliver does not always have such a service [rehabilitation]*, because of scarcity of human resources to deal with it."* (RDMP 10:3.7)

"If you look at diseases of lifestyle, hypertension and those that cause strokes, to what extent are we making provision for such people to be reintegrated into society to be able to continue to work for example. In the public sector, because of the scarcity of rehab staff, it's not what it should be." (RDMP 3:2.3)

"You come to smaller hospitals like mine, I do not have a full complement of rehab services…I do not have occupational [therapists]*, I do not have speech* [therapists]*, you need all the other therapists."* (RDMP 8:3.4)

"And then you come to the district hospitals, we've got 14 district hospitals, I should think that it's less than 30% of the district hospitals that have got a physiotherapist, the rest, they do not have those people." (RDMP 8:4.3)

"…in terms of the district health setting, that level of care, it [rehabilitation] *is very much not available or even if it is available it's minimal. In the district health setting, especially in rural areas. Because you find that there aren't many of those rehab services in* [name of location]*."* (RDMP 6:3.3)

Dayal (2010:26), in her thesis on management of rehabilitation personnel, echoed the aspects highlighted in the above quotes noting that South African public sector institutions have difficulty acquiring and retaining rehabilitation staff, and that a multi-disciplinary team is required per facility for an effective service at all levels of care. Dayal (2010:57) further remarked that facilities with a full complement of rehabilitation staff were scarce and were commonly staffed by one or two professionals.

With regards to limited availability, were participant remarks on the increased cost associated with rehabilitation service restriction in the DHS, discussed in 3.5.1.1.2 under the sub-heading 'Cost Containment', but further reinforced by the below quote:

"…in the absence of [rehabilitation] *at the sub-district level or at the PHC level, that patient ends up staying longer at the hospital, thus becoming more expensive to manage…"* (RDMP 8:3.4)

Equipment, resources and assistive devices

Availability of services is also concerned with the adequate supply of goods (Scheffler *et al.*, 2015:5). The participants voiced the need for equipment, assistive devices and resources such as transport for outreach and space for service provision. The following quotes address these needs:

"So for me the perception is it's actually a good intervention, although it's not always efficient, because of lack of staff, lack of equipment…" (RDMP 1:3.1)

"…in terms of physiotherapy, speech therapy, to be rehabilitated, nothing is done so far because of non-availability of personnel and equipment." (RDMP 7:3.12)

Scheffler *et al.* (2015:5), in a study on the impact of health service variables on access in a CHC in an impoverished township in Cape Town, Western Cape, found that both users and providers of health care were of the opinion that a lack of equipment as well as consumables hampered

the availability of services. The authors went on to include a lack of human resources and disability-specific knowledge as well as service structure to the challenges facing service delivery (Scheffler *et al.*, 2015:5). This is in line with the participants' perceptions relating to a lack of necessary resources for service provision.

Assistive devices

Assistive devices are defined as any item used to improve, assist or enable an individual to accomplish an activity or task (DOH, 2015b:20). Assistive devices range from mobility aids, for example, crutches, walking sticks and orthotics and prosthetics to communication devices such as hearing aids and augmentative and alternative communication tools, amongst other products (DOH, 2015b:20). The managers reported multiple issues regarding assistive devices; these related to waiting times, unavailability of devices, the need for decentralisation of the budget associated with procuring items as well as ease of access for patients:

"…our turnaround time from the referring hospitals are not so good, when it comes to assistive devices. They are not good, some people will wait forever for the wheelchairs, and it impairs their mobility obviously. Like, a wheelchair is an absolute necessity, and if you need a wheelchair you need it like yesterday." (RDMP 4:9.7)

"We can take anything up to six months waiting for a wheelchair. You see that is half a year of immobility…" (RDMP 4:10.4)

"… the wheelchairs, the assistive devices, everything should just be at the hospital, you shouldn't have to wait for two or three months to get assistive devices, you know." (RDMP 5:10.3)

In the same study mentioned above by Scheffler *et al.* (2015:5), they found stock and availability were not an issue, noting a sufficient quantity of devices, including wheelchairs and mobility aids, in the CHC. This is contrary to the opinions held by the participants, who noted considerable challenges relating to stock availability. In a cross-sectional survey of over 1000 households in an impoverished community in Cape Town, Maart and Jelsma (2013:3) found that 34,5% of respondents reported an unmet need relating to assistive devices, such as crutches and wheelchairs. These findings seemingly contrast each other and may be multi- faceted, the FSDR (DOH, 2015:8) reported inadequate provision of assistive devices as one of the implementation challenges relating to rehabilitation services in South Africa.

Resources: outreach, transport and working space

A specific reference to the availability of transport for outreach services was made by the participants, with some managers mentioning the need for a designated working space. The managers' perceptions encompassed the low priority of transport allocation for rehabilitation outreach, to the need for outreach transport to deliver effective, efficient rehabilitation services. This is exemplified by the following quotes:

"The transport, they're giving us transport to go to the clinics…but you do have those issues where they would much rather give transport to a meeting in Bhisho than going to a clinic, then you miss a clinic for two months, do you understand what I'm saying." (RDMP 5:16.1)

"If we say there must be outreach, to the clinics, then definitely they will need to be supported with transport. Not only transport, the clinics don't have space, so they will also need space where they will be able to see their clients, separately from where the nurses are doing in the clinic." (RDMP 9:9.11)

In a Delphi survey on human resource competencies to deliver CBR in less-resourced environments, there was agreement that transport as well as material resources are strategies that should be targeted in order to create a productive working environment (Gilmore *et al*., 2017:10). The opinions researched in the study by Gilmore *et al*. (2017:10) were those of rehabilitation health care professionals, which were synonymous with the quotes above. Research by Bateman (2012:1) supports the selective nature of transport acquisition, where therapists across South Africa noted dedicated transport as one of the chief concerns in their work environment. In her research, Bateman (2012:1) reports that a participant made reference to non-clinical hospital administrators designating transport, where doctors and administrative staff were prioritised, heavily restricting rehabilitation outreach services and home-based care (Bateman, 2012:1).

3.5.2.1.2 Accessibility

Accessibility relates to the distance between the user and the service, including factors such as transport, financial means and travel time (Obrist *et al*., 2007:1585). Recurrent mention was made of PHC or the clinics and CHC's being the preferred location for service delivery due to the close proximity to clients. The quotes below represent the opinions held by the majority of the participants in this study:

"That's why we implementing DHS, because you should provide services as close to people as possible, which is where the clinic comes in…if you link it to the level of services for the

DHS, it should then be at district hospitals, when you can then down refer, and through your community based services to provide outreach services. With down referrals, even from tertiary and regional, it should be coordinated through primary health care, because that's when you're going to ensure that people have access, otherwise it's not going to happen. Also, clinics in terms of distribution and distance from people, clinics are closer to people, than even a district hospital or a CHC." (RDMP 2:3.3)

"So, ideally then we want the service closer to them [patients]*, so if you think of accessibility right now, that is ideally what we should have. We should have clinic services in the district available to the whole population, whoever needs us, the services* [rehabilitation]*…"* (RDMP 2:7.1)

In terms of accessing rehabilitation services, the perceptions in the above quotes are widely observed in the literature. In a qualitative study done on rural rehabilitation experiences in South Africa, therapists described the impact of travel time on service provision, stating that they spent up to five hours of their working day travelling to clinics, limiting service delivery (Visagie & Swartz, 2016:4). Researchers exploring barriers to accessing rural healthcare in the EC, SA, commented that having PHC services available is not enough, unless it is accessible (Vergunst *et al.*, 2015:2). Accessibility refers to the healthcare user not having to endure considerable barriers when entering the PHC system, such as geographic, financial or organisational constraints (Vergunst *et al.*, 2015:2).

Compounding the issue of proximity of services, is the reality that PWD have additional barriers relating to transport. This was expressed clearly in the following quote:

"Often our community now, they don't have the means of getting around, whether it be by public transport due to funds, or it could be due to an inability to, it's just difficult for them to move around due to illnesses and disability." (RDMP 2:6.12)

In a community-based descriptive study, researchers Maart and Jelsma (2013:3) reported that transport and finances were the main challenge for PWD when accessing healthcare. Their results showed that 70,9% of the participants expressed an inability to afford services and 72,2% stating distance to services as a barrier, as well as having no access to transport (Maart & Jelsma, 2013:3). These access barriers were mentioned by a study in a resource-poor community in the KZN province, which sought to describe people living with HIV's experience of a physiotherapy-led rehabilitation programme. A number of barriers to accessing institution- based rehabilitation services were identified, including the cost of rehabilitation, transport and accessibility issues (Cobbing, Hanass-Hancock *et al.* 2014).

3.5.2.1.3 Affordability

Affordability speaks to the direct and indirect costs of healthcare access and the client's ability to pay for services (Obrist *et al.,* 2007:1586). While all PHC services are provided free of charge in South Africa (National Health Act, 2003:18). It significantly reduces the barrier to accessing basic health care (Gray & Vawda, 2017:18). There are indirect costs associated with access such as fees for transport. Some of these themes were mentioned in the literature above in 3.5.1.2.3: Accessibility, but were reiterated with the below quote:

> *"In the clinics we need to have* [rehabilitation staff]. *Especially in the interest of the high unemployment, people not being able to travel far. And if we could, we'd have them at the clinic level as well."* (RDMP 9:6.2)

In a Canadian study on Access to Health and Support Services, the perspectives of the participants, who were spinal cord injury patients in both rural and urban areas, yielded similar sentiments to the above quote. The authors found that the issue of affordability created barriers for patients relating to participation in good health practises through comprehensive rehabilitation and health services (Goodridge, Rogers, Klassen, Jeffery, Knox, Rohatinsky & Linassi, 2015:1401). Affordability is directly linked with service users' socio-economic status, with one of the key barriers to care being unaffordability to households (Goudge *et al.*, 2009:2). The managers made specific mention of direct and indirect costs associated with availability and the compounding transport challenges PWD's face:

> *"…they cannot afford the cost of* [private] *rehab, and then at the end of the day they don't get, they don't have access to that."* (RDMP 9:2.5)

The first quote above is reaffirmed in the literature in a national survey in America on disabling conditions, which reported that patients who had compensated fee-for-service healthcare, such as medical aid coverage, were more likely to receive the necessary rehabilitation management (Beatty *et al.*, 2003:1417). In their study, patterns and predictors to accessing health care amongst persons with chronic or disabling conditions were examined. The authors went on to state that the participants with the poorest health, disabling conditions and low incomes were the least likely to received appropriate health care. (Beatty *et al.*, 2003:1417). In a comprehensive project reviewing universal and equitable access to healthcare, researchers asserted that subsidised PHC services and no fee structures for PWD did not ensure access, as the financial implications relating to transport still created a significant barrier for many (Harris, Goudge, Ataguba, McIntyre, Nxumalo, Jikwana & Chersich, 2011:113). The above literature reiterates the managers' statements regarding socio- economic barriers to accessing

healthcare in the district health services in RSA. An additional aspect the managers discussed was how insight into the service affected access. This will be discussed in more detail in the following sub-theme.

3.5.2.2 Sub-theme 2.2: The managers' recognised a lack of insight regarding rehabilitation services from various stakeholders.

Insight is defined as "An accurate and deep understanding of someone or something" (OED, 2018c:1). The participants in this study mentioned insight into the rehabilitation service as an issue, from management structures to patients. The latter is expressed as insight into availability of services as well as what the services entail. A remark that came up less frequently, but which the researcher found noteworthy, was the questionable "buy-in" from patients. Due to the nature of rehabilitation services having a different structure to the curative model (hospital-based) patients are accustomed to, compliance to therapy was noted by a participant as challenging. This sub-theme will explore the various outlooks concerning insight in further detail.

3.5.2.2.1 Lack of insight into the rehabilitation programme from management structures

Insight from management structures, or lack thereof, was described by a participant with reference to the funding of the programme being misaligned to the District Health package, as the funding was allocated under a different programme. The lack of understanding and organisation of rehabilitation services was the perception of one of the managers, who linked those views with the low prioritisation afforded to the programme.

As discussed in the background section under sub-heading 1.2.8: Healthcare Reform in RSA, rehabilitation services in the EC are not managed under the budget programme for District Health Services but rather under Transversal Health. The participant explained that funding directly impacts on management of and access to health services, and as such, the misalignment of the rehabilitation programme presented difficulties for district management structures. The participant also remarked that this misalignment meant that the platform to re-engineer rehabilitation services fell largely on deaf ears:

"So for me the perception is it's actually a good intervention, although it's not always efficient, because of … lack of insight, lack of people understanding District Health services, makes it very difficult for everybody in management, or in the department to really understand." (RDMP 1:3.1)

"Those challenges that we face like daily, and it's like… I know the importance of the

services, but it seems like everyone around us that, the setup that we work in, it seems like no one really knows what we talking about, it's like we have to struggle for everything, transport, it's not really important to anyone." (RDMP 5:4.2)

The two quotes above illustrate the perception that management structures do not fully comprehend the organisation of rehabilitation services required to provide an accessible and efficient service. This perception was echoed in a descriptive study by Dayal (2010:25) on rehabilitation managers' experiences in providing rehabilitation services within the DHS in South Africa. In the study by Dayal (2010:25) the participants reported many frustrations related to the minimal inclusion in decision-making bodies within PHC, poor rehabilitation service delivery and a general lack of management support. Dizon (2018:9) also found the perspective of certain national and provincial government managers were that rehabilitation services lacked relevance in addressing priority PHC programme needs. Sherry (2015:92,95) asserts that within the healthcare framework, rehabilitation continues to be excluded and poorly understood by healthcare managers and policy-makers.

3.5.2.2.2 Lack of knowledge regarding rehabilitation services from the patient perspective

Multiple participants mentioned the lack of awareness by the public, regarding the function and availability of rehabilitation services for patients. A mention of patients having varying expectations during therapy consultations was also made:

"Often people don't even know that the service is available, just because previously they didn't know that they needed it." (RDMP 2:7.4)

The notion of low patient awareness of services resonates in the literature. In a case study done in the rural EC, the authors noted that users of the service were not aware of what was available or how they were to access those services (Ned, Cloete & Mji, 2017:6). In the first author's post-graduate dissertation, it is stated that the community where she was stationed had low awareness of the available services and that promotion activities were required (Ned-Matiwane, 2013:14). In addition to awareness of service availability mentioned by the managers, was also education of the nature of rehabilitation services, which the below quote elaborates on:

"Most of the clients they think, they just want a tablet to get them like, to get the pain, to relieve the pain. They don't care about, no the vertebrae must be like in this way and you must, the muscles must be relaxed if it's in spasm or whatever the case may be you know. They just want relief for now, and if some, in some instances if they don't get that, you give them a lot of exercises because also, people are not used to this exercising thing, it's new for them because they didn't know about therapy for a long time and now suddenly you have to

do exercises you know. So some people don't come back so that's the thing that's why it's, it's like I said now, it's not very effective." (RDMP 5:8.5)

In a review of the PHC system in South Africa, Kautzky and Tollman (2008:24) commented on the focus toward curative measures, which was supported by Zweigenthal, London and Pick (2016:55). The relationship between patient's healthcare outcomes, their expectations and rehabilitation success was investigated over four decades ago by Albrecht and Higgins (1977:36). Multiple authors have explored the association between patient expectations, satisfaction and compliance to treatment methods (Lochman, 1983:91; Keith, 1988:1122; Geurts, Willems, Lockwood, van Kleef, Kleijnen & Dirksen, 2017:1216). In a randomised clinical trial review, the researchers suggested that hesitancy and doubt regarding treatment efficacy was a relevant factor in the maintenance of patient treatment (Kirby, Donovan-Hall & Yardley, 2014:4). Essery (2017:15-16) also found a strong correlation between patient- perceived efficacy of treatment, self-efficacy and adherence to therapy. The literature supports the participant's view that patients are accustomed to a curative-based health care system and may not subscribe to rehabilitation therapy and its treatment modalities within the primary health care setting.

3.5.2.3 Sub-theme 2.3: The managers identified challenges regarding the management of rehabilitation services.

Good management is essential for quality service delivery and achieving desired health outcomes (WHO, 2017c:1). The WHO (2017c:1) outline six broad essential management functions, within these groupings the functions are expanded on, but for the purposes of this paper the comprehensive list of items will not be stated as they are not all applicable. The six management functions are categorised as: Policy and Planning, Financial Planning and Management, Human Resource Planning and Management, Governance and Accountability, Planning and Management of Service Provision, and Managing Performance through Information (WHO, 2017c:1). The majority of the challenges raised by the participations fit the groupings stated above, however, they may have been discussed in Sub-Theme 3.5.2.1, as they pertain to service delivery implementation. Kanyane (2014:17) asserts that service delivery setbacks have a direct correlation to capacity constraints and poor governance and planning.

Where discussed under this sub-theme, the researcher sought to distinguish between the same issue having variable elements, for example, the issue of staffing is both a service delivery challenge impacting on availability of rehabilitation services, but also a challenge with respect to

the management of the rehabilitation service. The distinction is presented in the following example: a lack of service availability due to insufficient staffing present service delivery challenges, whereas lack of posts in the organogram, inappropriate staff placement or human resource-related concerns can be seen as a management impediment.

The broad management functions mentioned above make up the essence of the District Management Cycle, which begins with planning. This precedes the budgetary process and is followed by implementation and continuous monitoring until evaluation takes place, ultimately informing the planning process to continue the cycle (Engelbrecht, 2002:11).

3.5.2.3.1 Policy and Planning

Health policy, planning and implementation and the associated legislation are a vital component of a healthcare system (Gray & Vawda, 2017:20). Policy can relate to adapting national policies to increase applicability in a district setting, whilst planning can be strategic, financial or operational, and encompasses priority-setting, forecasting and guiding operations (WHO, 2017c:1). In this study, the research participants made mention of policy, and the interrelated need for inclusion of rehabilitation services into the budget and resource allocation. Frequently remarked upon was that rehabilitation struggled to find a place in operational, performance and district plans due to a lack of policy inclusion or coverage or political will. However, the managers did express differing opinions relating to policy. Some participants acknowledged that broader and suitable policies relating to rehabilitation services in the country existed, but lacked effective resource allocation, implementation and monitoring, while other participants stated that the policies themselves were lacking substance and alignment with desired outcomes:

"…it is not being implemented at all. If it is being implemented, it is not being implemented properly. Because I have already said I know in the District package there are rehabilitation services there. There are norms and standards you know, what is needed is for these services to, you know, maybe political, buy in, I don't know. Because really there is provision in terms of policies, but there is no implementation, if there is implementation it's not properly managed or monitored." (RDMP 7:11.12)

"…we need policies from province now you know, we have the national ones but we need policies from province, where we make it specific for us..." (RDMP 5:6.3)

"In that package there are norms and standards for physio, rehabilitation as a whole, depending on the level of care. It is only contained in paper but practically, it is not being practised. All those norms and standards in terms of, district health package, they are just

there on paper, they are not being- there is no provision for them at all." (RDMP 7:6.3)

The topic of policy reform is one regularly put forward in discourse amongst researchers and leaders in South Africa. The comments of the managers regarding alignment to, and implementation and monitoring of, various policies are expressed by many scholars. In an analysis of rehabilitation policy in South Africa, the researchers note that there has been negligible effort in transforming rehabilitation services from policy to practice (Mji, Chappell, Statham, Mlenzana, Goliath, De Wet & Rhoda, 2013:4). The authors further critique the disparities between practice and policy stating a contradictory relationship has formed (Mji *et al.,* 2013:4). In exploring rehabilitation experiences in South Africa, Dayal (2012:2) reiterates that provincially, there is no strategic guideline for rehabilitation care. Mji *et al.* (2013:8) follow on and maintain little has been done in South Africa towards the appraisal of rehabilitation services within a health and disability policy and legislative context.

3.5.2.3.2 Planning and Management of Service Provision

Service provision planning and management is largely concerned with the development of the service package, protocols relating to clinical and public health mechanisms and performance standards. Further components include the establishment of referral and access pathways, procurement, and facility management (WHO, 2017c:1). The participants raised matters relating to the restriction of services to secondary and tertiary levels of care, which were seen as significant barriers to healthcare access for PWD. While the managers held contrasting views relating to whether the rehabilitation service was essential or specialised, they all voiced that the organisation of service should be improved and receive a higher priority in the district:

"When we were discussing the organogram for example the other day, when we were looking at community based services, or outreach services specifically, the rehab services were not there really, they didn't make provision for a lot of the people, the posts or the categories that we require. [Name of manager] *actually had rehab services on the map. I don't think it's because the department doesn't care, I think it's just because the demands for the more curative services, are more front page, so to speak."* (RDMP 3:2.1)

"In the recent past we've been having what we call sub-districts and we would have rehabilitation officers at the sub-districts. This officer would serve the whole sub-district, meaning the whole local municipal area, hospitals, clinics and also community based services. But now that's different because that unit does not exist any longer, the sub-district, and it has been proposed that it becomes absorbed in the main district, and in the organogram of the main district, it's not catered, for rehabilitation." (RDMP 10:4.1)

As discussed in the Background (see 1.2.4 and 1.2.8), the rehabilitation programme has struggled with acknowledgement from national and provincial departments. The topic of low prioritisation of the rehabilitation service in regards to planning and placement is apparent in the second quote. The lack of descriptive documents, congruency and appearance of rehabilitation in relevant policy and operational documents have been discussed (see 1.2.8). High level rehabilitation managers and experts expressed dissatisfaction that frameworks, quality care and best practice guidelines for rehabilitation were shelved and instead attenuated when incorporated into policy, due to minimal emphasis being placed on rehabilitation within PHC (Dizon *et al.*, 2018:9). The lack of policy inclusion underpins the service delivery planning and management deficits.

<u>3.5.2.3.3 Financial Planning and Management</u>

The budgetary process follows the planning and organisation of proposed services. A budget gives structure to spending and assessing performance as well as to reflect the service priorities and policy choices of a given system (Engelbrecht, 2002:20). As discussed under the 'Lack of insight' Sub-theme in Section 3.5.2.2.1, one manager emphasised the circumstances surrounding the budgetary issues centring on the misalignment of the rehabilitation programme. The participant noted that the service fell under a cost centre not directly controlled by the District Health Management Team. The other participants made reference to services relying on budget allocation and the lack of budget the rehabilitation programme experiences:

"…if you look at District Health services we've got different programmes, and we talking funding if we want to talk access, alright. Then, clinical support services: rehabilitation forms part of clinical support services and that is a programme on its own, which is Programme Seven. Where rehabilitation, psychology, x-ray, radiology whatever everything else that is to do with clinical support, they fall under Programme Seven. But District Health Services functions in Programme Two, so we don't really cater for these services, these services, their funding comes from another bag of money, so that is why it's making it so difficult for us at the District Office to be able to offer these type of services." (RDMP 1:3.6)

"… if there is that provision [of] *their employment … the budget must also be made available so that they can run the services successfully you know."* (RDMP 7:3.2)

The first quote speaks to the issue and impact of misalignment of the rehabilitation programme within a different budgetary programme to district health services, which has been discussed in Chapter One (see 1.2.8). A lack of budget allocation was one of the barriers mentioned by therapists across the country (Sherry, 2015:93). In a study regarding rehabilitation service

guidelines in PHC, managers commented that a lack of budget allocation affected the sustainability of best practice services (Dizon *et al.*, 2018:7).

3.5.2.3.4 Human Resource Planning and Management

Management and planning of human resources encompasses many aspects but is largely associated with workforce issues, such as recruitment and career planning, job descriptions and performance management and skills, training and development (WHO, 2017c:1). Matters relating to human resources were frequently mentioned by the participants. A plethora of concerns relating to human resource acquisition and management were expressed, ranging from training needs, prioritisation and resource allocation, or lack thereof, to reliance on mandatory staffing placements. The perceptions of the managers are highlighted by the quotes below:

"… from the district side it's like it's not taken serious. It's more they will send people on training like nurses and doctors and those staff members, but not really rehab." (RDMP 5:4.4)

"My perception is that they are underrated. Judging from the resource allocation point of view, to the provision of infrastructure; when I'm talking resources I'm talking about provision of the cadres, people who are qualified in the organogram ne." (RDMP 7:2.13)

"We mainly rely on the availability, I mean the allocation of community service practitioners for that unit to run efficiently. It is thinly staffed all the time … We rely on community service which is one year contract, and now, after that one year contract they decide on their own if they want to remain or if they want to go elsewhere. And in the majority of cases they want to go elsewhere." (RDMP 10:5.9)

"There is a need and the, unfortunately the package we deliver does not always have such a service, because of the scarcity of the human resources to deal with it. And yeah, I think it's mainly because of the scarcity of the resources, and usually, even the organogram, the new proposed organogram does not cater much for rehabilitative services." (RDMP 10:3.7)

"… the rest of the management team, or the district services, should all should be involved in service delivery and know how they fit in and how…their role can play a difference. For example, I've mentioned HR, human resources, we need them to be on board, they need to fulfil their role, do what they need to do. But they need to know how they're affecting services. If staff can be employed when they need to be employed and then they need to know how they impact rehab services positively or negatively…" (RDMP 2:3.9)

In a South African mixed-methods research report on district management level challenges and constraints, data was collected from numerous operational and district managers. One of the major challenges to effective service delivery was health workforce issues. The report outlines the concerns the managers had, one being that most challenges concern fundamental areas such as strategic human resource management, which results in the DHS having less than necessary workforce to implement effective service delivery (Wolvaardt *et al.*, 2013:85). This is in line with the sentiments articulated by the research participants. Furthermore, the need for and scarcity of rehabilitation staff has been documented and expressed by many authors and managers, both nationally and internationally (Sherry, 2015:92-93; Bateman, 2012:1; Rispel, 2016:17; Gupta *et al.*, 2011:7). An article reviewing health policy in relation to rural health needs noted one of the participants identifying unmotivated or inadequately trained human resource staff posing a major challenge to staff retention, replacement and other functions (Bateman, 2012:4). The participants' quotes used in this section resonate with what was found in the literature.

3.5.2.3.5 Resources

Lack of resources were another frequent topic voiced by the managers. As human resources have been discussed above, the literature review will not be included in-depth in this sub-section. The majority of the participants made mention of the lack of resources and its subsequent impact on service provision. The effect on various services were associated with transport, such as clinic outreach and home visits, and resource allocation for immediate service provision such as treatment space and equipment. Below are a few quotes that describe the impact and connection of resources on comprehensive service delivery:

"…the quality of care you want them to have, you want to be able to provide a quality service which means having all these resources, including space, including equipment, to provide the best treatment that you can offer, but also what they need, so with that said not everyone has access to services, whether that be transport to our clinics…" (RDMP 2:7.1)

"So in terms of resources in terms of time, in terms of all sort of resources that I've mentioned previously … resources should be allocated accordingly … the district level of rehab gets neglected, in terms of resources don't follow as one would expect, so the realisation of the importance of how and why we are there as in in terms of rehab should be recognised." (RDMP 2:5.6)

"So for me, going back to the PHC approach, if we want to implement the four legs of the PHC approach then we really need to focus on rehab services and put a lot more resources towards that, especially if you look at assistive devices, it's a huge challenge for people to

access." (RDMP 3:3.1)

3.5.2.3.6 Governance and Accountability

The functions of the District Management Team as it relates to governance, and the accountability which accompanies it, are extensive. The various facets of governance begin primarily with establishing management structures, within which there is a strong community component that incorporates: inclusivity in District Health structures; seeking information and responding to community needs and ensuring the community has information on healthcare costs, delivery options and resources available (WHO, 2017c:1). Further characteristics of governance include reporting local health priorities to national authorities, intersectoral collaboration, enforcing health legislation, regulation and standards in the District and the assessment of constraints to district health performance. The research participants/managers remarked on some but not all of these above-mentioned characteristics. Some managers touched on advocacy for rehabilitation services, which will be expanded on in Section 3.5.3.3. Other issues relating to governance were the inclusion of PWD within the workforce, and in reference to the lack of representation of rehabilitation services within various structures of governance and decision-making platforms. A participant made specific reference to the link between budget, governance and community involvement and its influence on service provision, as seen in the following quote:

"District health services, you know, at the end of the day the CFO [Chief Financial Officer]*, the budget, everything goes around budget, and unfortunately, this service is a very expensive service, you know, and you need to rob Peter to pay Paul, that type of thing. And you really need to have very good motivations, and sometimes your motivations doesn't speak for itself, and I think maybe, it's maybe time that our communities must, they say the communities must also govern, you understand. So maybe it's also time that we get our governance structures on board so they can also acknowledge that the service is needed in our facilities. It's the fact that we don't have the proper facilities to have it, you understand."* (RDMP 1:7.8)

"…we do have those forums, committee forums which we are participating as health, where we interact with the disability forum and they always complain, because we find that even in the work stream, our work force, is not very much inclusive." (RDMP 6:5.1)

"… to be a spokesperson when it comes to meetings, when it comes to decision making, when it comes to the cost containment meetings … where the rehab manager can say but this is why they need that money..." (RDMP 5:14.1)

"So for me it's also a question of getting it out there to everybody, to make people aware,

health promotion, you know, the media, print media or maybe the radio or whatever, to let people know that, go to your nearest clinic so that we can be able to refer you to the relevant places. And then also regarding the referral pathways, people, also lack of communication maybe, or lack of information I would say, people don't know, maybe there is maybe a little gap in our referral system. Because people also really don't know where to go to, to have access to these types of services." (RDMP 1:3.1)

As described in the Background section (see 1.2.2), South Africa affirmed its commitment to disability rights with the UNCRPD ratification and other policy reforms. There is, however, significant gaps in the transformation of policy to practice. These themes were present in the participants' dialogue and quotes above. Hussey *et al.* (2016:216) describe attitudinal barriers as the key factor which reinforces the gaps in rehabilitation service delivery, and that attitudinal barriers affect all spheres. In their exploratory study on barriers to implementation of best disability practice, the participants remarked on a lack of commitment, coordination and political will relating to disability, social exclusion is maintained due to a lack of awareness- building activities, due to generalised limitations in budgets, low budget allocations were reported as lack of prioritisation of the rehabilitation and disability programme, which has delayed the programmes development (Hussey *et al.*, 2016:215, 210). The authors emphasise the need for advocacy an engagement with the disability community in creating strategies (Hussey *et al.*, 2016:207). In an exploration of the role of DMT's in child health strategies in South Africa, a theme that arose from the interviews conducted was the tendency for ownership aversion of the programme at a district level, as well as an absence of authority in distributing restricted resources (Doherty, Tran, Sanders, Dalglish, Hipgrave, Rasanathan, Sundararaman, Ved & Mason, 2018:2). The comments of the managers appear in line with the literature in terms of needing governance structure buy-in to address prioritisation, response to community needs, collaboration with relevant sectors and departments and raising awareness for the already existent service.

3.5.2.3.7 Managing Performance through information

Managing information for performance purposes is concerned with monitoring and evaluation of epidemiological data, service utilisation rates with specific attention to susceptible groups, client satisfaction, referrals, and coverage of services. There is also an emphasis on the appraisal and reporting of this information to higher structures (provincial and national government) (WHO, 2017c:1). The participants commented on the lack of indicators for the rehabilitation service, and the subsequent restriction to service delivery and management of the Rehabilitation Programme:

"If you look at indicators. What you are doing is you are giving the physio, and you're doing all your other activities, to your patients, but at the end of the day the indicators are very output-related, let me put it that way. What have you done, and in a way it's boxing you guys not to be able to do a fully-fledged service in the community health setting … but at the end of the day what's in the APP it's not really what you can answer. Because maybe right, for an example, the wheelchairs, we are able to do that side but when it comes to the other [services] … you not able to go full length, so it's basically, limiting you guys." (RDMP 1:6.6)

"She was really very, passionate and me as a [planner] she used to pester me. What, this is my report, what indicators do you want me to monitor? These are the indicators that I think should be in the district health plan. They should be in the APP. You find out those are not there but she would create her own indicators. So that she can monitor her own programme, she was really good." (RDMP 4:8.6)

The comments by the participants above shed light on the impression that the indicators currently used to measure and evaluate rehabilitation services are inadequate for planning, monitoring and executing efficient service delivery. The second quote draws attention to the need of one rehabilitation manager to create their own indicators to effectively measure the service they supervised. The dialogue indicates that this behaviour was well-received by the manager and that it is plausible that there is a need for improved indicators for monitoring and evaluation, amongst other purposes. The issue of lack of indicators and reporting structures were stated by half the participants. In a study on allied health (rehabilitation staff) in Australia, many professions found that without effective tools to monitor and measure services, policy and service development was impractical and unrealisable (Solomon, Graves & Catherwood, 2015:2-3).

As discussed in the Background (see 1.2.4), the professional therapy associations put forward their concerns regarding the low presence of rehabilitation in key policies and the subsequent impact on strategic planning and service development (OTASA *et al.,* 2017:1). These concerns resonate with the perceptions of the managers regarding the policy, planning, management and financial implications expressed in this sub-theme.

3.5.3 Theme 3: The managers voiced suggestions for the improvement of rehabilitation services in the District Health System.

The managers responded to one of the set questions which queried what they would change about rehabilitation in the DHS if they could. From this a variety of responses were given, these have been framed into three sub-themes, namely: strengthening and/or development of

governance of rehabilitation; marketing of rehabilitation services; and advocacy is needed for change.

3.5.3.1 Sub-theme 3.1: Governance of rehabilitation services needs strengthening and/or development.

The term governance has encompassed many definitions and usage of the term as it relates to contemporary public administration has lacked consensus (UNESCO, 2006:2). The World Bank (Talvitie, 1994:viii) and DFID (formerly known as the Overseas Development Administration) assert that good governance is exemplified through transparency, accountability, a legal framework for development and competence with regards to effective policy development and implementation as well as service delivery (UN Economic and Social Council, 2006:4). Governance can embody a complex network of actors, from international organisations to national and local government agencies (World Bank, 2017:3).

Various aspects of governance were remarked on by the participants, these included, but were not limited to: issues surrounding policy, prioritisation of rehabilitation services across various domains, inclusion into strategic planning as well as the associated reporting mechanisms. The researcher shall report back on each of these items individually as they were all decisively placed in the responses of the participants. This sub-theme makes use of the terms strengthening and development, the former relating to consolidating existing systems while the latter references the creation of necessary structures.

Many of the topics below have been discussed previously in Theme 2, in their context of implementation challenges. The current theme focusses on suggestions that have been made by the managers to improve rehabilitation services. With that in mind, some topics will be revisited, but only as they relate to the recommendations made.

3.5.3.1.1 Policy

The participants voiced potential benefits for District Rehabilitation Services which related to structural and policy reviews. Discussion regarding policy and the participants' opinions thereof has been covered in Section 3.5.2.3.1: Policy and Planning. This section will be concerned with the suggestions made relating to structural and policy review. The quote below sums up the recommendations made by the participants:

"And then also maybe bending the policies, and maybe including it in primary health care services, because we have a package, the primary health care service, we have the package

to say that…the following services we are providing. Maybe putting the rehabilitation in there as well. Because if it's included then it can be budgeted for. But if it's an extra additional service then it becomes very difficult, and also to sustain at the end of the day." (RDMP 1:11.5)

"…it's a very important programme. It has got a condition on it, remember the 2015-2020 [FSDR] *rehabilitation services. If we can show that we implemented that policy, accordingly, you know we, we can have, can run, a health system that is inclusive…"* (RDMP 6:4.5)

The consensus amongst the managers was that policy review, to the extent of inclusion of rehabilitation into PHC packages, amongst other key documents, would benefit management, accountability, monitoring and evaluation and sustainability of the service. This view has been echoed by multiple authors and professional therapy societies, with the latter having alluded to the various implications related to inclusion in key policy documents in Section 3.5.2.3.3 Financial Planning and Management. MacLachlan, Mannan, Huss, Munthali & Amin (2016:195) remarked on the need for vulnerable groups to be represented equitably into policy documents to further inclusivity and enablement. In a study on views relating to healthcare policy, van Exel *et al.* (2015:129) acknowledge the relationship between resources, healthcare provision and decision-making. Health care policy forms the fundamental basis of priority- setting relating to health care service provision (van Exel, 2015:129). Alderson, Foy, Bryant, Ahmed and House (2018:741) identified the challenging compromise and divergent views stakeholders have when considering or implementing health care policy. Current literature supports the participants views relating to policy inclusion and the assistance this could provide on a strategic and operational level. The availability of policy gives the guidance needed for development, conversely, a lack of manifestation in key policy documents make the implementation of an efficient and effective service near impossible.

3.5.3.1.2 Prioritisation

Priority-setting is an extremely worthwhile but challenging process which every health care system employs, whether formally or informally. It influences financial considerations, acknowledges resource constraints and hand in hand with policy, underpins the direction of health care service delivery (Rudan, 2010:1). Priority-setting can be described and prescribed both nationally, such as the National Development Plan 2030, and locally, which can be expressed as policy derivatives and strategic objectives, DHP's or operational plans. Primary Health Care in itself is a National priority, with rehabilitation a core component of PHC re-engineering. For the purposes of the author's research, prioritisation was described by the managers in terms of the ability to secure resources alongside the other health programmes.

While the comments made by the participants were in reference to a lack of prioritisation, they are included in this sub-section as there is an implicit correlation with improvements to governance. The lack of prioritisation spanned items such as transport allocation, training and development and staffing. These topics have been mentioned above in their respective Sub-Themes, 3.5.2.1: Challenges with Service Delivery and 3.5.2.3: Challenges with Management.

"Well I think it has not been, it is not prioritised, as much as it should by top management if I may say. Or because it has, it has, the service is not so readily available, it has tended to, you know, the system has kind of put it aside in terms of prioritising it." (RDMP 10:9.5)

Agreement was found in the literature regarding an absence of priority-setting as it relates to rehabilitation services. Senior managers expressed the opinion that rehabilitation occupies a low priority in the National department and that there is a perceived lack of significance of the programme; this was commented on in connection with marginal importance given to investing in resources and development of the service (Dizon *et al*, 2018:6).

3.5.3.1.3 Strategic planning inclusion and reporting structures

Recommendations surrounding inclusion into strategic planning covered various topics. From the geographic placement of services to the strategic placement of management of the service within governance structures. Hand in hand with strategic planning inclusion and mentions of the DHP and APP, were discussions surrounding reporting structures, such as the need for appropriate indicators as well as relevant reporting systems. The quotes below reflect these opinions:

"So the best would be then to have services at various clinics and not just the base clinics but having fully equipped stations, if I may call it that, throughout, strategically placed throughout the district to ensure better accessibility." (RDMP 2:7.1)

"If we can be able to really motivate to cater for rehab services under two point, Programme Two [District Level Services]. Then I think then your scope will really widen up much, much more." (RDMP 1:11.5)

"If I look at the district health plan, that is what we do in district health services, and what, at the moment it's not being catered in for there, then it's very difficult for you to find expression. Now when we spoke about rehab, if you look at the district health plan, there's nothing in the district health plan talking directly [to rehabilitation]*; your indicators is in Programme Seven…"* (RDMP 1:8.1)

"…she wanted her indicators to be in the operational plan, in the district health plan, she

wanted people to take notice; because if it's not in the district, operational plan, it's not budgeted for." (RDMP 4:9.2)

The notion that there is an absence of rehabilitation within strategic planning, such as district and operational plans, is referenced in the literature. OTASA *et al.* (2017:1) and Sherry (2015:93) both noted that while regarded as a constituent of PHC, rehabilitation is seldom included in PHC packages. This could impact on service provision as alluded to in the first two quotes above as the location of facility-based services is a limiting factor to access to rehabilitation services in South Africa (Fourie, 2017:54). According to the ECDOH APP (2016:63), the purpose of Programme Two (District Health Services) is to ensure PHC service delivery through implementation of the DHS. As discussed in the Background (see 1.2.8), Rehabilitation Services in the EC fall under Programme Seven: HCSS, when this placement is contrasted with the three major provincial health departments, GP, WC and KZN, it appears the EC has removed rehabilitation services from the core clinical framework in Programme Two: DHS. It is possible that the interpretation of Support Services (Programme Seven) has led to a misalignment of rehabilitation in a programme that appears to be more supportive and less clinical in terms of the operational plan, resource allocation and reporting structure. This misalignment may result in an absence of reporting under the CHC sub-programmes section. There is scant research on the implications of management of rehabilitation services falling under Programme Seven versus Programme Two. What can be alluded to is the association between the budget and management of a service, with the GP, WC and KZN provinces having specific target allocations and outcomes for rehabilitation services within their DHS reporting structures.

3.5.3.1.4 Reporting structures and relevance

A unique suggestion made by a participant related to how to go about creating strategic change with regards to management of rehabilitation at a district level. The manager outlined the strata and cadres involved and suggested the following as the way forward:

"They won't be able to, to change it at a provincial level. They will then have to have their motivations further, to it nationally. You must remember it's the different layers, we are the very lower layer, here at the district level. It's national first, alright, then we have the province, Eastern Cape, which is our DDG's [Deputy Director General] *and our General Managers, and then in Programme Two and Programme Seven, the highest level is a General Manager, for that programme. Alright, and then for Programme Seven is also General Manager. Then, in the district we have our District Managers. So the District Manager will then have to, start a process; you understand, to, to acknowledge that rehabilitation services, we having a problem*

with that, alright, and we would like to escalate it to the to the higher level, or we want to make a few changes, so that is the route of the conversation." (RDMP 1:14.6)

The researcher found a paucity in the research regarding programme alignment for rehabilitation and District Health Services. However, the link between aligning district indicators with the Provincial APP and creating meaningful localised action plans which guide implementation and monitoring, was reiterated in the DHP Monitoring Framework (DOH, 2017b:8). Appropriate, consistent and accurate indicators are described as a cornerstone of informed priority setting, decision-making and public health practice (Norman *et al.*, 2007:699).

3.5.3.1.5 Resources needed

Resources have been discussed at length. The quotes below frame the conversation surrounding resource needs as they relate to immediate service delivery and quality of care:

"…when I speak of quality of rehab care…you need resources, to be able to provide that quality care. So resources in terms of human and physical resources, that being space, that being equipment, time of course is also a resource, and then of course, you know, you want skilled rehab staff." (RDMP 2:2.7)

"If we say there must be outreach to the clinics, then definitely they will need to be supported with transport. Not only transport, the clinics don't have space, so they will also need space where they will be able to see their clients, separately from where the nurses are doing in the clinic." (RDMP 9:9.11)

3.5.3.2 Sub-theme 3.2: There is a need for marketing of rehabilitation services to external stakeholders.

Social marketing can be an approach used to developing health, environment, and social change campaigns that aim to influence target audiences to voluntarily accept, reject, modify, or abandon a behaviour for the benefit of individuals, groups, or society (Andreasen, 2002:4; Hoek & Jones, 2011:32). Marketing of rehabilitation as a health-care driver to external structures were discussed by the participants.

External stakeholders

Stakeholders are defined as any persons or group that influence or are influenced by the attainment of an organisation's goals (Freeman and Reed, 1983:91). Stakeholders in health could be seen as all parties involved in, or affected by, healthcare provision. External stakeholders are described in this study as individuals or groups external to the organisation,

such as patients, NGOs and NPOs etc. Multiple participants expressed the need for marketing activities aimed at promoting the therapy services as well as specific drives focussing on general health promotion such as improving physical activity. A recommendation was also made that health promotion activities should be aimed at persons with disabilities:

"Some people just don't know that they need services, they don't know that it's available to them. They don't know that they don't know, so with part and parcel of District Health Services is also promotion of services which will improve accessibility." (RDMP 2:7.4)

"…as the recommendation now, this department focusses on illness; I wish something could be done to…to kind of bring that awareness and, you know, this lifestyle awareness thing, is not only about healthy people who can jog and take walks and stuff like that. I wish we could have clubs, really, even for disabled people who can get that kind of a service..." (RDMP 10:10.12)

The suggestion to market health promotion activities, inclusive of PWD is reiterated in the literature. Harrison (2006:18), in a review of multiple health promotion strategies aimed at PWD, remarked on the positive impact found when PWD actively engage in health promotion activities, but also noted fatigue as a barrier as well as the higher risk PWD have in engaging in behaviours detrimental to their health, such as decreased preventative health screening. The managers' comments, with the context of the literature, support health promotion activities as beneficial for PWD at risk of developing ill-health.

3.5.3.3 Sub-theme 3.3: Advocacy of rehabilitation services is necessary for change.

The participants felt that upper management need to be aware of the needs of rehabilitation for effective functioning. Additionally, the participants mentioned the need for awareness programmes regarding the availability of rehabilitation services and the function of rehabilitation, both to the public, and other health programmes:

"So I think there already you can see the impact that rehabilitation services has already, so we can just strengthen it because you can hear it very clearly from our communities that there is an outcry for this type of service. So, I think it's important to maybe if you can, interview a few of the community members as well then you will hear from them because I'm really very, very honest to say every petition, every enquiry, every parliamentary question there is something about rehabilitation services. So I think that if we make the right noises things might just change." (RDMP 1:15.4)

"I think it's important, sometimes if something is not in your face the whole time then you tend to forget about it, we need to put it in their faces, you know, we need to make enough noise so that they can, they can hear. That there is a cry out and that is why I think the communities must also stand up, so that they can have access to these type of services."
(RDMP 1:15.4)

"It's not marketed enough to the powers that be and therefore it is not really prioritised."
(RDMP 10:9.13)

Hussey *et al.* (2016:216), in their research study on the barriers to implementation of health and rehabilitation policy in SA, emphasized that attitudes were central to the majority of barriers to implementing rehabilitation policy. They go on to suggest that a strategic and thorough advocacy plan aimed at social structures should be embedded in any operational plan. Ned *et al.* (2017:9) express the vital need for advocacy in reorganising rehabilitation services into community-based levels of care. They advocate for a CBR approach to better understand disability and the obstacles PWD encounter, thereby enabling an integrated, knowledgeable approach to improving systems for PWD.

3.6 Conclusion

The researcher has reported and discussed the results of this study relative to the aim of the study. The researcher identified the subsequent themes and sub-themes which described the managers' perceptions of rehabilitation in a district health system. A literature control was done to place the findings within the research. The results have also been linked with literature cited in previous chapters. The discussion presented both negative and positive opinions relating to rehabilitation in a district health system, revealing an incongruence between the value placed on rehabilitation and the state of service delivery. The recommendations, limitations and conclusions relating to this study, for education, practice (management) and future research, will be discussed in the following chapter.

CHAPTER 4: RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

4.1 Introduction

In the previous chapter the results of the study were presented and discussed together with the literature control. This chapter will summarise the results of the study. Furthermore, recommendations for practice (management), education and future research will be offered, based on the researcher's interpretation of the findings.

4.2 Summary and conclusions

The aim of this study was to explore and describe the perceptions of managers regarding rehabilitation services within a district health system and to make recommendations regarding the management of rehabilitation services to the provincial health managers.

The perceptions of managers' held value as perceptions are associated with behaviour and action, and the managers' held decision-making positions within the district health services in the EC. A thorough review of existing literature was provided to contextualise the issue under investigation. The research methodology was described in detail and the findings presented, accompanied with a literature control against the available literature.

The objectives and the findings will be discussed below.

The objectives of the study were:

- To explore and describe the perceptions of managers regarding rehabilitation services in the district health system.
- To make recommendations to the provincial health managers regarding the management of rehabilitation services at a district level.

The first objective was achieved by doing a qualitative, exploratory, descriptive, and contextual study. With respect to the second objective, the identified themes served as the basis of the development of recommendations to the provincial health managers regarding the management of rehabilitation at a district level.

4.2.1 Summary of the perceptions of managers regarding rehabilitation in a district health system.

From the discussion and analysis of results it can be concluded that:

4.2.1.1 **The managers perceived benefits to providing the service in a district health setting:** The managers spoke positively about the need for rehabilitation services to be accessible and positioned within the primary care. The managers felt that access to rehabilitation aided cost containment, early identification and reintegration into life and society.

4.2.1.2 **Passionate rehabilitation staff help develop the service:** Staff who went above and beyond in terms of reporting and engaging helped managers appreciate rehabilitation services and the need for resources and support.

4.2.1.3 **Community service of rehabilitation staff has assisted with the provision of service:** The participants acknowledged the vital role community service provides and that, at times, services hinge on community service personnel.

4.2.1.4 **There is a strong perception that there are many challenges affecting service delivery of rehabilitation in the district health setting:** The managers mentioned a multitude of factors affecting access, referencing long travel times to clinics or hospitals and costs relating to travel. Resources were also perceived to be a major barrier, convoluted processes to accessing assistive devices and wheelchairs or lengthy waiting times for these devices were remarked on as significant difficulties. Appropriate spaces to provide rehabilitation services, as well as equipment and necessary transport allocation to provide outreach were further issues presented. Gaps in policy, which in turn affected strategic inclusion into operational and financial plans, all having an impact on vital aspects of service delivery such as human resources and governance.

4.2.1.5 **There is a lack of understanding regarding rehabilitation services:** Some managers expressed that the rehabilitation programme was misaligned within the health programme structure, which affected budg*et al*locations and presented implementation, monitoring and evaluation challenges. The methods of rehabilitation service delivery, being rehabilitative and not curative, was poorly understood by patients and needed patient buy-in for compliance to treatment or management plans. There was also a perception that rehabilitation services were

not well understood by management structures. The participants thought marketing and advocacy of the services was necessary, to both internal and external structures, and would help both rehabilitation service uptake in addition to assisting with re-engineering of the service.

4.2.1.6 **Governance of rehabilitation services needs strengthening and/or development:** A general idea expressed by the managers was the need for rehabilitation services to have a higher priority and inclusion rate; with resource allocation and policy to planning and reporting.

4.2.1.7 **Advocacy and marketing of rehabilitation services is necessary for change:** Marketing services were described by the participants as beneficial on multiple levels; encouraging utilisation and access to services as well as the potential for improving health effects for those that needed it most. The participants voiced that advocacy was needed to facilitate awareness and buy-in regarding rehabilitation services.

The opinions held by the managers regarding the current state of service delivery, from rehabilitation care specifically, to primary health care as the delivery method, were congruent with the literature and were varied in terms of legislature. The general perception was that of recognition of the rehabilitation service as a valuable and necessary programme at PHC level, however, many challenges, from grassroots to policy, affect its provision.

4.3 Recommendations for practice/management

Emerging from this study, three sets of recommendations for practice (management) in the clinical field are suggested based on the identified themes during data analysis:

4.3.1 Recommendations to improve governance of rehabilitation services within the district health system.

4.3.2 Recommendations on marketing and advocacy of rehabilitation services within the district health system.

4.3.3 Recommendations for improving ACCESS to rehabilitation services.

4.3.1 Improving governance of rehabilitation services

4.3.1.1 Policy development and implementation

The quintessential method to ensure policy to practice transformation is with the recommendations arising from bodies who have decision-making responsibilities (Sabik & Lie, 2008:10). The need for promotion of rehabilitation services to management in district, provincial and national settings are vital, as they form those decision-making bodies.

Rehabilitation services need to be integrated with relevant PHC services and should feature prominently in strategic planning and implementation documents. The district and provincial management teams are guided by National policy and strategies, they should have a central role in integrating rehabilitation during strategic and operational plan development, for budgeting, implementation and monitoring purposes. Further linear reporting of the needs and requirements for integrating rehabilitation services also lies in the capacity of these management structures.

Persons with disabilities should play an integral role in the structuring of policy reform which directly affects them; from local, community level to District management structures through the form of Disability Health forums or other means of engagement. Furthermore, priority-setting has been described as politically charged (Sabik & Lie, 2008:1), this requires far-reaching advocacy from the community, rehabilitation staff and guiding managerial structures to emphasise the need and demand for rehabilitation.

4.3.1.2 Prioritisation of rehabilitation services

The National DOH has called for the integration of rehabilitation services into a multitude of health streams, with the FSDR as the guiding document. While institutional departments are currently undergoing this transition it requires multiple stakeholder, programme and sector involvement to aptly integrate rehabilitation services into all the priority health initiatives as described in policy.

Management should prioritise rehabilitation in relation to policy alignment, budget and resource allocation (further described below), in order to address the development and integration of rehabilitation services into district level services.

District and Provincial management teams could engage with the Provincial Directorate for

Rehabilitation Services to address the information and prioritisation gaps. A better understanding of the service, its structure, purpose and explicit function or role within the larger DHS, should underpin the programmes development.

A lack of detailed prioritisation measures result in minimal impact on policy; coordination of priority-setting has to be operational or it lacks legitimacy (Sabik & Lie, 2008:10). This links with strategic planning and inclusion, which will be considered in the next sub-section.

4.3.1.3 Strategic planning and inclusion of rehabilitation in district level structures:

The misalignment of the rehabilitation programme compared with National and other provincial department structures has been discussed in the Background section (see 1.2.8).

Due to the discrepancy between the various provinces reporting structures, in terms of alignment with the National plan, there is a lack of standardisation between service management and development. The ECDOH should revisit the placement of the rehabilitation programme, aligning it under Community Health Centres, Sub-Programme 2.3 of Programme 2: District Health Services, in line with the DOH and National Treasury guidelines (Massyn, Peer, English, Padarath, Barron & Day, 2016:2). Leaving rehabilitation indicators solely under Health Care Support Services may have negative implications on governance of rehabilitation services, as it relates to budget, planning and reporting.

4.3.1.4 Reporting structures and data management (evaluation criteria/indicators)

The NDOH requires provincial departments to monitor, evaluate and report on specific indicators (DOH, 2017:23). However, the latest ECDOH APP makes minimal reference to the Rehabilitation Programme and where it does, it is linked solely with assistive device provision.

The Rehabilitation Programme could benefit from an alignment within the DHS programme and increased indicators. District Management Teams could request the inclusion of relevant indicators for the purposes of effective monitoring and evaluation of rehabilitation services. Regarding which specific indicators are necessary for effective monitoring and evaluation of the rehabilitation service, the input of rehabilitation and epidemiological experts in the country, who have likely been integral in the development of disability and rehabilitation reforms such as the FSDR, is necessary. District Managers can make a formal request for the addition of indicators into the PIDS. Generally speaking, efficacy is underpinned by the usage of quality data, which at this stage, may need expansion. Indicators will also form the basis of capacity development for underperforming areas and can assist in highlighting gaps and strategies to

address those, the implications of which will also be discussed below as they relate to resources.

4.3.1.5 Resources

The necessity for resources to enable effective service delivery is prominent in the literature and generally a significant point in various stages of operational planning. The exclusion of rehabilitation in equitable resource allocation may have dire consequences. For this reason, if the disability programme and rehabilitation service are expected to grow, provision of various resources are required, including, inter alia: dedicated space, equipment, dedicated transport needs, budget, including and in addition to wheelchairs and hearing aids, and notably, human resources. Informing this allocation would require engaging with the data and current rehabilitation service managers and providers, and human resource methods already in use such as WISN (Workload Indicators of Staffing Need), towards appropriate workforce planning.

4.3.2 Marketing and advocacy of rehabilitation services

Marketing campaigns to address awareness of rehabilitation services could encompass, inter alia, paper publications such as pamphlets and posters in district level institutions, radio interviews, marketing by other health professionals, particularly nurses, who form the core workforce of PHC.

With regards to advocacy, management can begin or progress the dialogue, along linear lines of communication, advocating for inclusion and integration of rehabilitation into priority programmes at a provincial and national level. Where applicable, persons in positions of authority such as chief level therapists and heads of departments, or therapists running departments, to request for district level management (rehabilitation managers to district managers) to advocate upwards to the relevant programme managers on a provincial level (Programme Two and Programme Seven); to engage in discourse on integration and a way forward. This would be followed by Provincial advocacy to National departments.

Research suggests that the advocacy role potential of the health and rehabilitation workforce is underutilised and unrecognised (Ng, Lingard, Hibbert, Regan, Phelan, Stooke & Friesen, 2015:2282). Rehabilitation staff and management can improve knowledge of rehabilitation services through vocal advocacy to higher management structures of the benefits of rehabilitation services, as they relate to healthcare priorities set by national government, as well as with alignment to PHC programmes in their respective provincial and district health

plans. Persisting for inclusion into DHP's to facilitate comprehensive monitoring and evaluation processes, such as augmented indicators, even if these are not requested by provincial or National performance plans.

A suggestion is made to encourage rehabilitation staff to engage in advocacy with an understanding of their specific District's goals, DHP and disease burden, as differing population health needs may affect rehabilitation requirements and strategies.

4.3.3 Improving ACCESS to rehabilitation services

Accessibility of rehabilitation services involves both bringing services closer to the population and the population closer to the services (Bright, Felix, Kuper & Polack, 2017:14).

The Governing Health Authorities could improve ACCESS of rehabilitation services by:

- Improving referral processes between health facilities through provision or improvement of transport, communication between institutions and principally, sufficient coordination of rehabilitation services reinforced by programme integration.
- Having rehabilitation services strategically placed in primary care settings (Clinics, CHC's and District hospitals) to reduce the negative impact of transport costs and to make the services affordable for those in need with low or no income.
- Ensuring material and human resources are available, accessible, affordable, adequate and acceptable to the population needing the service; this will underpin the quality of care of rehabilitation services.

4.4 Recommendations for education

The researcher wishes to make the following recommendations with regard to education:

- Rehabilitation services should receive fair weighting for training opportunities at district level.
- The Health Authorities have a role in empowering managers through organised workshops and possibly short courses. Possible topics could include the function of rehabilitation as a care strategy versus a programme or service and the impact on strategic planning and integration methods. The purpose of these short courses are to enhance clarity on the needs and circumstances of those who would benefit from rehabilitation services. Specific training for various levels of management could include,

inter alia:

  - Policy development and implementation.
  - Data management – to ensure evidence-based decision-making with respect to available data.
  - Budget – to address the impact of an absence of an operational budget for the rehabilitation service.

- Rehabilitation cadres, from an undergraduate level, need to be educated on disability advocacy as they are the managers of the future, and as shown in the discussion change is necessary. Training is necessary in terms of:
  - The role of advocacy in improving health services and outcomes, as well as their specific role in doing so.
- Developing knowledge and understanding of public health sector priorities and how rehabilitation, as a programme and service, fits in to the National Health Plan.

4.5 Recommendations for research

Due to the fact that studies on perceptions of managers regarding rehabilitation in a district health system were not available, the researcher recommends further research in this field. The following recommendations are some suggestions with regards to further research:

- The exploratory nature of this research elicited significant information, which could be used as a basis for further quantitative studies with a larger sample which could potentially be a national study (across borders).
- The singularity and focus of rehabilitation indicators on assistive devices as a sole measure of rehabilitation leads the researcher to suggest investigation into the managers' understanding of data management, and implementation of current rehabilitation strategies and policy development in the province. Clearly the current set of indicators do not sufficiently enable real monitoring or evaluation of the implementation of current strategies and their impact.
- A further study could describe current rehabilitation practices and structures in the Eastern Cape compared with available National guidelines for rehabilitation services. In particular, given the largely rural nature of this province, the extent to which national guidelines are fully implemented in rural as opposed to urban areas is worthy of further exploration.
- A follow up study could include further exploration into managers' knowledge of

rehabilitation, as this could also impact on implementation of rehabilitation services.

4.6 Limitations of this study

Given the timeframes and level of this research, limitations were necessary in terms of breadth and scope. If the sample could include more district offices and a larger sample, the findings may have included further nuances related to different contexts, and other characteristics of the participants in this study. The number of participants and qualitative nature of the study limit the generalizability of the findings to a wider context, but the study is replicable on a larger scale. This would enable generalisability beyond the specific context(s) described in this study.

4.7 Conclusion

This study has enabled the gathering of data that has provided insights and perceptions of an important layer of managers who work in/with rehabilitation services within the PHC system in the Eastern Cape. These perceptions are meaningful, as they influence the manner in which policy and plans are interpreted and implemented, and decisions are made within the environment of rehabilitation services. The positive views held by those in management positions indicate that there are strong foundations on which to build the rehabilitation service, and aspects of the system that need to be acknowledged, continued and strengthened.

The challenges experienced by this layer of management point to aspects that need to be addressed in order to improve and optimise the impact of the inclusion of rehabilitation services in PHC. The findings in this study clarify these challenges, and if these are not addressed, the goals of the progressive health care system which SA is trying to implement cannot be fully achieved. Furthermore, the discrepancies and gaps that exist between urban and rural, and better and poorer resourced districts are likely to widen.

The recommendations that emerged from this study, as voiced by those who are responsible for the management of rehabilitation services, are thus significant and should not be ignored, as they arise from the lived experience of those who make decisions in this arena and are responsible for overseeing service delivery. It is the hope of the researcher that the recommendations are considered by the Provincial Health Directorate towards ensuring adequate, efficient and quality care are afforded to all those that require it.

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Appendix 1 – University Ethical Approval

Copies to:
Supervisor: Dr S du Rand
Co-supervisor: Mr T Nyangeni

Summerstrand South Faculty of Health Sciences

Tel. +27 (0)41 504 2956 Fax. +27 (0)41 504 9324
Marilyn.Afrikaner@nmmu.ac.za

Student number: 213467488
Contact person: Ms M Afrikaner 7 September 2016

Mr R Zinn
69 Mackay Street Richmond Hill Port Elizabeth 6001

FINAL RESEARCH/PROJECT PROPOSAL:
QUALIFICATION: MA HEALTH AND WELFARE MANAGEMENT
TITLE OF PROPOSAL: REHABILITATION SERVICES IN A DISTRICT HEALTH SYSTEM: MANAGERS' PERCEPTIONS

Please be advised that your final research proposal was approved by the Faculty Postgraduate Studies Committee (FPGSC) subject to the following amendments/recommendations being made to the satisfaction of your Supervisor/s:

<u>COMMENTS/RECOMMENDATIONS</u>

The proposal was well prepared.

In view of the fact that the researcher wants access to district management staff, it is suggested that the study rationale is more carefully worded: "the efficacy of the public health sector are summed up by Rispel (2016) as the acceptance of incompetency and a failing of managerial structures; and inoperative DHS and the poor management of the health workforce"; and in the problem setting: "The concerns noted above led FPGSC to question the manager's perceptions of the rehabilitative services in the district and their role within".
Rephrase the rationale and problem setting to not antagonize the gatekeepers.
Add the use of voice and or video recordings to consent form.
REC-H

1i) Select not applicable

2a) complete second section 2b) N/A – second section

2c) change to No
2d) Yes; voice/video recording 2e) second section N/A

4a) delete type response here 4c) No; N/A
6d) iv) data verification 6g) complete
7b) delete "type response here"
8) select N/A

Please be informed that this is a summary of deliberations that you must discuss with your Supervisor/s.

FPGSC grants ethics approval. The ethics clearance reference number is **H16-HEA-NUR-024** and is valid for three years.

We wish you well with the study. Kind regards,

Ms M Afrikaner

Faculty Postgraduate Studies Committee (FPGSC) Secretariat: Faculty of Health Sciences

Appendix 2 – Eastern Cape Health Research Committee Approval

Eastern Cape Department of Health

Enquiries:	Madoda Xokwe	Tel No: 040 608 0830
Date:	01 November 2016	Fax No: 043642 1409
e-mail address:	madoda.xokwe@echealth.gov.za	

Dear Mr. R. Zinn

Re: Rehabilitation Services in a District Health System: Managers' Perceptions **(EC_2016RP30_795)**

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTEE

Appendix 3 – Provincial Research Request Letter

Mr R Zinn
Rehabilitation Department
Walmer Gqebera CHC
Nelson Mandela Metro

To: Chief Director: District Services

Subject: Request to Conduct Master's Research Data Collection with Management Population

Thesis Title: Rehabilitation Services in a District Health System: Managers' Perceptions

This letter serves to request access to conduct research with various management cadres of the Eastern Cape Department of Health (ECDoH) district level population. Ethical approval has been granted by the Nelson Mandela Metropolitan University (NMMU) Ethics committee (Ethics Clearance Reference Number: **H16-HEA-NUR-024**). The Eastern Cape Provincial Health Research Committee (ECPHRC) has approved the research proposal and the request to conduct research has been granted. ECPHRC Reference Number: **EC_2016RP30_795**

Research overview:
I am currently studying towards a Master's degree in Health and Welfare Management through NMMU. A research project is required as partial fulfilment of the degree. Upon reviewing South African literature conducted on Rehabilitation Services in a District Health System, it became clear that the need for further research in this area is necessary. The aim of this study is to explore and describe the perceptions of managers regarding rehabilitation services within a district health system.
I would need to access the district level management population, from which approximately 15 managers will form my sample. Possible participants will be contacted by e-mail as well as telephonically to enquire about their willingness to participate.

The data for the study will be gathered in the form of semi-structured in-depths interviews. Interviews will be scheduled to the participant's convenience. Participation in this study is voluntary and all information will be treated with the strictest confidence; the data will be kept confidential.

Appendix 4 – Letter requesting participation in study

Letter requesting participation in study

Mr R Zinn
Rehabilitation Department
Walmer Gqebera CHC

Re: Rehabilitation Services in a District Health System: Managers' Perceptions

I am currently studying towards my Master's degree in Health and Welfare Management. As a part of my degree I am required to complete a research project. Upon reviewing the research already conducted on Rehabilitation Services in a District Health System, it became clear that the need for further research in this area is necessary. The aim of this study is to explore and describe the perceptions of managers regarding rehabilitation services within a district health system.

I would greatly appreciate your assistance in your participation in this project. The information for the study will be gathered in the form of a semi-structured interview which will last approximately 30-45 minutes. Interviews will be scheduled around your availability. Participation in this study is voluntary and all information will be treated with the strictest confidence. As a participant you will be asked to complete a consent form. Should you require any more information regarding the study, please do not hesitate to call me on: 0781578822 or my Supervisor: Dr S du Rand Tel: 041 5042615.

Thanking you in advance
Yours sincerely,

____

Mr R Zinn
Researcher

Appendix 5 – Participant Information Letter

Participant information letter

Mr R Zinn

Rehabilitation Department

Walmer Gqebera CHC

Title: Rehabilitation Services in a District Health System: Managers' Perceptions

I, Richard Zinn, am a registered Masters Health and Welfare Management student from the Nelson Mandela Metropolitan University.

The information which follows makes up the basis of my project:

Background, Purpose and Importance

The primary objective of this study is to explore and describe the perceptions of managers regarding rehabilitation services within a district health system. The secondary objective is to make recommendations regarding the management of this service. The information will be used for the completion of a Masters degree.

What will be required of you?

Completion of the consent form whereby you give written, informed consent and clarify any information pertaining to this project. To participate in a semi-structured interview which will be conducted between the researcher and yourself. The interview will last between 30-45 minutes and will be recorded. You will receive general feedback following the completion of the research project.

What will be the risks involved

There are no direct risks to participating in the research. Results will be displayed in the final report but these will be completely anonymous and cannot be related back to you in any way.

What benefits will there be for taking part in the study

As a result of your participation in this study you may gain further insight into role of rehabilitation in a District health system.

What payment will be received or what costs will be incurred

You will not receive any payment and you will not be required to pay anything to participate in the study.

Voluntary Participation

Participation in this study is completely voluntary and you are under no obligation to participate. No penalties will be incurred if you decide you do not wish to participate in the study, even after signing the informed consent form.

Right to withdraw from the study

Once consent has been obtained from you, you are under no obligation to complete the study and you can withdraw at any time with no penalties. I will encourage you to complete the study but should you really not want to, you will be free to withdraw at any time.

Confidentiality

Confidentiality will be maintained at all times. I, as the researcher, will know your name for means of data capturing but from the start of the study the participants will be allocated a number which will replace any personal and work-related details for the rest of the study. Full confidentiality will be maintained during publication of this thesis and your name will never be mentioned. There will be no way for anyone other than the researcher to relate any of the data back to you. All data and names will be kept on one computer in a secure environment so that there is no way for anyone but the researcher to have access to it. All data will be maintained securely for up to a year after the study has been completed.

Participant Declaration

I understand that after I have completed the consent form whereby I give written, informed consent and was provided with the opportunity for clarifying any information pertaining to this project, a semi-structured interview will be conducted between the researcher and myself. I am aware that the interview will last between 30-45 minutes and that it will be recorded. Furthermore, I am aware of the fact that I will be presented with an opportunity to view the information given by myself for the sake of clarification prior to data analysis as well as that I will receive general feedback following the completion of the research project.

Who to contact for further information

Should you have study-specific queries or want more information, you can contact me, Richard Zinn on 0781578822 / ptrzinn@gmail.com or my supervisor, Dr Suzette Du Rand, on 041 504 2615 / suzette.durand@nmmu.ac.za.

Thanking you in advance

Yours sincerely,

____

Mr R Zinn

Researcher

Appendix 6 – Participant Informed Consent Letter

Participant informed consent letter

Mr R Zinn
Rehabilitation Department
Walmer Gqebera CHC

Informed Consent Form

TITLE: Rehabilitation Services in a District Health System: Managers' Perceptions

I,______________________________have read the information sheet. I understand what is required of me and I have had all my questions answered. I do not feel that I have been coerced to participate in this study and am doing so of my own accord. I consent to the use of voice/video recording for the interview process. I know that I can withdraw at any time if I so wish to do so and that it will have no negative consequences for me.

Signed:

________________________________	________________________
Participant	Date and Place
________________________________	________________________
Researcher	Date and Place

Appendix 7 – Interview Notes Protocol

Interview Code:
Interviewer:
Location:
Date: Length (min):
District:
Job Title:

How did the interviewee appear to me:

Atmosphere / location:

Disposition to talk / motivation to take part on the interview:

Gestures, non-verbal signals, eye contact:

Interaction during the interview:

Difficult phases:

Specifics of the interview or the interview situation:

The 3 main points that you remember from the interview:

Other:

Themes identified from the interview:

Appendix 8 – Independent Coder Confidentially Agreement

Confidentiality Agreement

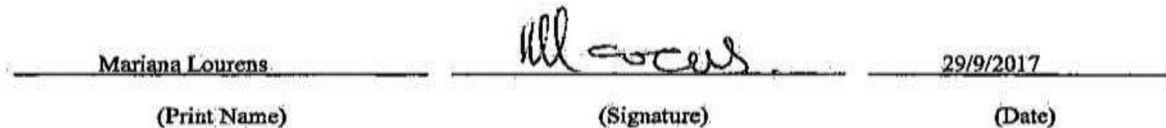
Project title- Rehabilitation Services in a District Health System: Managers' Perceptions

Researcher- Richard Zinn
Supervisor- Suzette du Rand

I, Mariana Lourens, the independent coder,

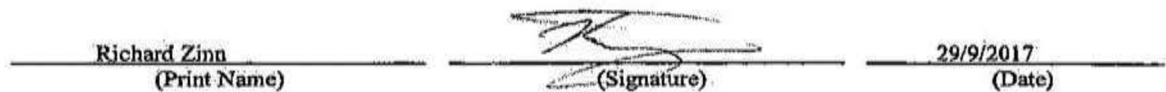
agree to:

1. keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g., recordings, transcripts) with anyone other than the *Researcher(s)*.
2. keep all research information in any form or format (e.g., disks, tapes, transcripts) secure while it is in my possession.
3. return all research information in any form or format (e.g., disks, tapes, transcripts) to the *Researcher(s)* when I have completed the research tasks.
4. after consulting with the *Researcher(s)*, erase or destroy all research information in any form or format regarding this research project that is not returnable to the *Researcher(s)* (e.g., information stored on computer hard drive).



Mariana Lourens		29/9/2017
(Print Name)	(Signature)	(Date)

Independent Coder



Richard Zinn		29/9/2017
(Print Name)	(Signature)	(Date)

Researcher

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by Research Ethics Board (Faculty Postgraduate Studies Committee) at the Nelson Mandela Metropolitan University.

Appendix 9 – Interview Transcription Excerpt

R: And that you can withdraw at any time if you wish to do so and that there'll be no negative consequences.

I: Yeah

R: Is that fine? Okay. So, basically yes I'll be asking you three questions, and it's like a conversation, you know, you're just going to be telling me, what your opinions are, what you're views are, and that will be it.

I: Okay then

R: So to start of the interview the, the main question is, what is your perception regarding rehabilitation services in the district health setting.

I: My perception is that they are underrated.

R: Okay

I: Judging from the resource allocation point of view, to the provision of infrastructure; when I'm talking resources I'm talking about provision of the cadres, people who are qualified in the organogram ne.

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Appendix 10 – Editing and Formatting Certificate

The Write Words South Africa

Corner House Offices
504 Lilian Ngoyi Road
Morningside
South Africa

EDITORIAL CERTIFICATE

6 December 2018

To whom it may concern

This document certifies that the document listed below was proofread and edited for proper English language, grammar, punctuation, spelling, and overall style by The Write Words, a division of Mardi Gras Marketing (Pty) Limited. Neither the research content nor the author's intentions were altered in any way during the editing process.

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TITLE

Rehabilitation Services in a District Health System: Managers' Perceptions

AUTHOR

Richard Thebu Zinn

Samantha L. Worthington

Director, Editor – The Write Words

The Write Words is a division of Mardi Gras Marketing (Pty) Limited

www.thewritewords.co.za | info@thewritewords.co.za | +27 (0) 79 858 9473