

BRIEF REPORTS

Pushing Down the Walls: Advocating for “Rehabilitation for All” in South Africa

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ABSTRACT

This article aims to advocate for providing rehabilitation to all South Africans in the context of achieving universal health coverage. The potential benefits of accessible rehabilitation for South Africans with chronic disease and disability are described and supported by a description of national and international policies that promote the delivery of primary healthcare services (including rehabilitation) into or near people’s homes. A discussion follows on why the ‘walls’ separating professional silos need to be broken down to ensure that rehabilitation can be provided in a cost-effective and sustainable manner. The authors also suggest ways in which advocacy efforts can be strengthened to assist in this call for “rehabilitation for all”.

INTRODUCTION

Rehabilitation is a key component of healthcare which is extremely difficult for South Africans living in resource-poor communities to access, particularly if they are people with disabilities. These challenges have been exacerbated by the Covid-19 pandemic. In the context of planning the implementation of universal health coverage (UHC), it is time for rehabilitation practitioners, researchers, disability rights group and health activists to collectively initiate and strengthen advocacy efforts to ensure that “rehabilitation for all” becomes a reality, rather than a luxury service provided to those who can afford it. To achieve truly ‘universal’ UHC, a number of structural and resourcing barriers need to be pushed down; therefore this is a call for the re-establishment of training for, and recruitment of, mid-level rehabilitation workers to provide integrated rehabilitation services.

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Providing Rehabilitation Services near People's Homes

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) defines disability as “long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder (an individual's) full and effective participation in society on an equal basis with others (United Nations, 2006). South Africa faces a quadruple burden of disease, which Mayosi et al (2012) describe as the four “colliding epidemics” of HIV/TB co-infection, maternal and child health, violence and injuries, and non-communicable diseases. Many people affected by each of these four epidemics should benefit from multi-faceted rehabilitation interventions that focus on maximising their mental and physical health. For example, while people living with HIV (PLHIV) in South Africa are living longer with the provision of free antiretroviral medication irrespective of CD4 count, they are also prone to developing a wide range of disabling conditions (Hanass-Hancock et al, 2015; Myezwa et al, 2018). There is evidence from local and international studies demonstrating that appropriate rehabilitation and exercise interventions can assist in improving the physical condition and quality of life of PLHIV (Gomes-Neto et al, 2013; Roos et al, 2014; O'Brien et al, 2016; Cobbing et al, 2017). Similarly, children with disability (e.g., cerebral palsy and developmental delay), victims of violence or accidents (e.g., traumatic brain injury and spinal cord injury) and people affected by non-communicable diseases (e.g., diabetes, obesity and various mental disorders) can all benefit from improved rehabilitation services. Due to the challenges in access and mobility for many people with disabilities, the services and care need to be provided as close to their homes as possible. While mortality and morbidity are recognised as the two established health indicators in the monitoring of any health system, functioning has recently been proposed as the *third* health indicator. Rehabilitation is vital for optimising functioning, by improving biological and mental health together with lived health (Stucki & Bickenbach, 2017). Simply put, while medical interventions (such as surgery and medication) can add years to life, rehabilitation can add quality of life to these additional years (Nixon et al, 2011).

The Current Situation in South Africa

In South Africa, however, there is a severe shortage of rehabilitation professionals. For example, there are approximately 3 physiotherapists per 10, 000 population in South Africa, as compared to 20 physiotherapists per 10, 000 population in

Finland, a country with a far lower burden of disease. Similarly, Denmark has approximately 11 occupational therapists per 10, 000 population, compared to less than 1 occupational therapist per 10, 000 population in South Africa (World Health Organisation, 2011). More recent WHO statistics show that Brazil, a country with a similar economy to South Africa, has almost three times more physiotherapists per head of population (World Health Organisation, 2016). Furthermore, the rehabilitation services that are there in the public healthcare sector are mainly based in urban hospitals and are very difficult for people in resource-poor, rural communities to access, particularly for those with disability (Gaede & Versteeg, 2011). South Africa's proposed UHC system, the National Health Insurance (NHI), promotes the rights of all South Africans to access quality healthcare services that "are affordable without exposing them to financial hardships" (Department of Health, 2015), while the White Paper on the Rights of Persons with Disabilities compels healthcare providers to ensure that treatment programmes are accessible to persons with disabilities (Department of Health, 2016). This implies that the Department of Health is obligated to include rehabilitation services as part of 'universal' health care.

The Legal, Ethical and Economic Argument for providing Rehabilitation Services

A significant obstacle to implementing rehabilitation interventions and employing appropriate levels of rehabilitation workers in the South African public sector is adequate financing for rehabilitation services. This obstacle is particularly true in the current situation of national austerity, as evidenced by the freezing of healthcare posts across many of the provincial Departments of Health. It must be argued, however, that cost cannot preclude the provision of quality healthcare, as it is a fundamental human rights issue. From a legal perspective, South Africa is a signatory to several global conventions such as the CRPD (United Nations, 2006), which compels signatories to ensure that people with disabilities attain "full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life". The principle of progressive realisation in the CRPD requires not only that signatory countries provide the services and resources to ensure these rights, but also further entails a presumption against regressive measures that remove or reduce existing rights (Uldry & Deneger, 2018). South Africa also has several national policies that ensure the right of all of its citizens to equitable access to quality healthcare and support. These policies include the Batho Pele (People First) Principles (Department of Public Service

and Administration, 1997) and the Framework and Strategy for Disability and Rehabilitation Services in South Africa (Department of Health, 2015). Key clauses within these policies highlight the fact that the provision of health services should be non-discriminatory, varied and flexible, and should take all necessary steps to include affected populations and local communities in the design and implementation of services.

Given the historical policies of South Africa pre-1994, which denied equitable healthcare to a majority of the population, it is evident how these post-apartheid policies are influenced by Section 27 of the Constitution (Republic of South Africa, 1996). The specific policies related to disability set out to ensure that this constitutional call was for *everyone* to have the right “access to healthcare services”, including marginalised populations. It is also clear that legislative steps have been taken in South Africa to ensure this access extends to the large rural population. The National Development Plan (National Planning Commission, 2013), which espouses these views, contains the blueprint for the NHI, described above. The NHI stresses the provision of services to those most in need, rather than those with the most finances (Department of Health, 2015). This principle of equity implies clearly that people with disabilities should be prioritised (in terms of funding services for them) as their need is greater, particularly in the context where curative services have been disproportionately better funded. These new developments provide a great opportunity for rehabilitation professionals and other healthcare workers to be at the vanguard of promoting and supplying quality services to people with disability, many of whom live in impoverished, rural communities and cannot afford private healthcare. Furthermore, where these services are not being provided, health professionals now have an obligation to invoke specific legislative frameworks, such as those outlined above, within advocacy efforts aimed at redressing deficient systems. The challenge remains to translate these policies into practice. In addition to this, the training institutions need to design and implement programmes to build the capacity for an inclusive healthcare workforce to be able to meet the growing demand for rehabilitation services.

It is important, however, that advocacy efforts also extend beyond the human rights narrative to include pragmatic arguments that provide public health gatekeepers and stakeholders with evidence that complementary disability and rehabilitation interventions are beneficial for people with disabilities and their families, as well as potentially cost-effective for funders and taxpayers. Kaplan

(1999) states that costs and resources are often cited as limiting factors in achieving organisational success, as they are visible and easy to measure. However, Kaplan (1999) further argues that it is the intangible elements that actually contribute more to sustainability, such as an organisation's attitude (which includes social responsibility) and its vision and strategy. The authors of the current study propose, in the context of healthcare, that providing enhanced rehabilitation provision is not only the ethical thing to do but will also result in a number of long-term benefits for South Africa. There is evidence to show that rehabilitation services can contribute to cost savings in the longer term. For example, by focusing on people's functional and social needs, occupational therapy has been shown to decrease hospital re-admissions for several health conditions (Rogers et al, 2017). The World Health Organisation states, in its Rehabilitation 2030: Call for Action Report, that rehabilitation services are essential for economic and social development, particularly in low- and middle-income countries such as South Africa (WHO, 2017).

With respect to task-shifting for HIV care in Africa, Callaghan et al (2010) argue that task-shifting may not necessarily save costs but will ensure the long-term cost-effectiveness of interventions and sustainability. It is important that researchers develop approaches to measure the costs and benefits of novel interventions in comparison to standard practice, as well as more global returns on investment, in addition to assessing outcome measures of health, quality of life and function. The initiation of these interventions will further require committed government leadership and higher education institutes together with relevant professional bodies to provide training and funding, an eventuality that can be expedited by the generation of multi-faceted evidence and concerted advocacy efforts.

Strategies to Improve Rehabilitation Provision

An appropriate strategy to ensure improved access to rehabilitation could be the provision of these services close to, or in, people's homes to mitigate the environmental, physical and financial barriers that poor South Africans with disability face. Home-based rehabilitation (HBR) can be defined as any activities that prevent or treat an individual's impairments, activity limitations and participation restrictions, delivered in or near their own home (World Health Organisation, 2010). Local and international studies of home-based rehabilitation interventions for several chronic disease populations (Collins et al, 2001; Salvetti et al, 2008; Blair et al, 2011) have shown that these interventions

are beneficial to recipients as well as equally cost-effective, if not more so, than traditional institution-based interventions. It should be noted that home-based rehabilitation is only one component of the more extensive community-based rehabilitation (CBR) guidelines, which encourage all stakeholders in health to focus on a broad range of educational, social and livelihood factors, underpinned by empowerment of all people with disabilities (World Health Organisation, 2010).

One way of ensuring that these criteria are met is to employ and train generalist rehabilitation workers in the public sector, who could assist people with disabilities in bridging the gap between health, schooling, work opportunities and social activities, including religious activities. In an effort to improve health promotion and disease prevention, the South African National Department of Health has promoted the deployment of ward-based outreach teams (WBOTs), comprising of six community health workers (CHWs) supervised by one nurse (Padayachee et al, 2013). While this initiative has shown some early success, Doherty et al (2016) argue that the role of the community health workers involved in this initiative is too narrow and their scope should be broadened to include curative functions. To achieve this, it is imperative that they be offered focused trans-professional training and structured career pathways that allow them the opportunity to upskill themselves and transition to mid-level workers.

By including community health workers who had received integrated rehabilitation training into these ward-based outreach teams, the rehabilitative options available to all people with disability in under-resourced communities would be increased. This task-shifting strategy may potentially reduce the cost burden to the public health service in the longer term, by ensuring that these individuals do not develop more severe disabilities that incur high treatment costs. By instituting task-shifting practices that are supported with appropriate training and supervision, productive efficiency of healthcare services can be achieved, while at the same time providing access to the best and most appropriate services that may otherwise not be available (Fulton et al, 2011). Task-shifting may address the current reality of rehabilitation services being unavailable to the vast majority of South Africans accessing the public healthcare sector.

Mid-level rehabilitation workers (MLRWs), known as community rehabilitation facilitators (CRFs) or community rehabilitation workers (CRWs) were trained in the 1990s/2000s, to provide integrated rehabilitation services in resource-poor communities (Hanass-Hancock et al, 2015). From 1991 to 2006 these CRFs/CRWs

were recognised by the Occupational Therapy and Medical Orthotics / Prosthetics Board of the *Health Professions Council of South Africa* (HPCSA) and employed by the Departments of Health and Social Development across a number of provinces. They made a significant contribution in addressing the needs of people with disability close to their homes, across their life course (Rule et al, 2006). Despite this significant contribution over a period of 15 years, their registration with the HPCSA was discontinued from 2006 onwards. One of the key reasons cited for discontinuance was the negative intervention of professional rehabilitation groups. Chappell and Johannsmeier (2009) describe how the “professionalisation” of disability can result in a reduction of rehabilitation services. The professional protectionism and the resulting deregistration of CRFs/CRWs with the HPCSA in 2006 contributed to the cessation of the training and recruitment of mid-level rehabilitation workers in South Africa (Chappell & Johannsmeier, 2009). While they were offered the opportunity to retrain as occupational therapy technicians, which many of them took up, this change limited the broader empowerment role they had previously fulfilled and had a negative impact on people with disabilities. Evidence has shown that youth with disabilities in communities with continued input of CRWs have better access to health services and schooling than in communities without CRWs (Lorenzo et al, 2015).

Professionals in the rehabilitation field may see a new cohort of mid-level rehabilitation workers who provide integrated rehabilitation services as a threat to the traditional “professionally-siloed” scope of practice. Given the current austerity in the South African public healthcare sector, this may indeed be an understandable concern. However the opposite appears to be true, with increased referrals to health professionals reported when employing task-shifting strategies (Hugo, 2005). Evidence from South Africa highlights how the engagement and collaboration between community rehabilitation workers and final year occupational therapy students produced excellent outcomes, resulting in the removal of barriers to the participation of young people with disabilities in economic development (Denton et al, 2015). This evidence suggests that it is not a question of employing *either* professionals *or* community rehabilitation workers (CRWs) to provide rehabilitation services, but a clear need to employ more of *both* cadres of these workers, with clear delineation of tasks and referral systems in place between rehabilitation professionals and CRWs. To achieve truly ‘universal’ UHC, the authors of the present study are calling for the re-establishment of training and recognition of CRFs/CRWs. The emergence of a new mid-level healthcare cadre has recent precedent in South Africa. In 2002, an

agreement was reached to train mid-level medical workers, known as clinical associates. The first cohort of clinical associates graduated in 2011 and quickly established themselves as important members of rural healthcare teams (Lorenzo et al, 2015). A similar recognition of mid-level rehabilitation workers can only occur if rehabilitation professionals move out of their professional silos and collaborate in designing and delivering new MLRW training programmes. It is also critical that CBR services and community-based health interventions focused on the quadruple burden of disease are meaningfully integrated – both in terms of service provisioning and clinical governance.

Strengthening Advocacy for “Rehabilitation for All”

The call for rehabilitation services to be made available to South Africans living in resource-poor communities on a sustainable basis needs to be amplified and taken up by Disabled People’s Organisations, professional bodies, policy makers, health professionals, rehabilitation practitioners and civil society. The Rural Health Advocacy Project (RHAP) is a health advocacy organisation, advocating for equitable access to quality health care for South African rural communities (RHAP, 2018). One of their four main goals is to ensure an “equitable distribution of adequately trained, supported and caring healthcare workers to underserved rural areas”. RHAP makes a strong argument against the reactive cutting of rehabilitation posts when budgets shrink. While health managers may see these services as “non-essential”, this decision is a regressive choice, creating greater inefficiency and reduced access to services for the very people who need them most - people with disabilities, especially children and the elderly (RHAP, 2017).

It is crucial that healthcare workers and community members themselves become advocates for improved health services. By learning the key principles and commitments that are central to these global and national policies, healthcare workers can become strong advocates for marginalised groups in their communities. They can also then, in turn, provide communities and service users with the knowledge that will allow them to become activists for change, a process Heywood (2015) terms “tooling-up”. RHAP offers clear advice to health science students, communities, and health professionals on how to “tool-up” and be better advocates for service users.

These education efforts must be extended to include staff involved in community-based rehabilitation programmes whose understandable focus on providing services has historically limited advocacy efforts (WHO, 2010). A collaboration of

all interested parties can then collectively decide on how to approach stakeholders and gatekeepers to advocate for improved rehabilitation services. In the event of disinterest or disengagement from local or national stakeholders, the recourse for action in each specific policy should be invoked to ensure that advocacy efforts are maintained. Should these stakeholders agree to implement changes related to practice and resources, it is vital that they are presented with a clear description of what interventions are required, as well as a thorough plan related to their implementation. Dr Prinitha Pillay, while working as a facilitator for RHAP, argues: “Unless we act, and support those who do act, we risk allowing the unacceptable to become acceptable...if we want a different healthcare system, we cannot afford indifference” (Pillay et al, 2015).

In summary, the authors of the current study argue that rehabilitation services in South Africa are walled in behind current resource allocation and system functioning structures. They are walled in by funding, requiring a shift from prioritisation of curative services to equitable funding for rehabilitation services. They are walled in behind rural–urban and intra-urban inequity of resource allocation, requiring a shift toward prioritisation based on need. They are walled in behind professional silos (traditionally based on tertiary service delivery models), requiring a shift to a focus on providing integrated and coordinated care. These advocacy efforts need to focus on pushing down the walls to radically improve equitable rehabilitation services.

CONCLUSION

Rehabilitation needs to be viewed as a critical and essential necessity and not a luxury, with the potential to improve the physical health, functioning and quality of life of the most marginalised South Africans. To ensure access to rehabilitation for all South Africans, advocacy efforts from a wide range of stakeholders have to be stepped up. This advocacy needs to include calls for the implementation of novel evidence-based strategies, such as the renewed training, registration and employment of CRFs/CRWs, who have demonstrated the potential to be both clinically and financially effective in a time of austerity. It is vital that the reintroduction and design of new training programmes include the genuine participation of local communities. This will help to ensure that these programmes are designed to be both relevant to the people they are expected to benefit, as well as to the specific local context in which they will reside. It is vital that healthcare workers push down the walls that separate their professional silos and begin a

genuine conversation that ensures that “rehabilitation for all”, in the era of UHC, is a possibility rather than a pipe dream.

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