"REHABILITATION POLICY"

FREE STATE
REHABILITATION
POLICY GUIDELINES

FREE STATE PROVINCE DEPARTMENT OF HEALTH
REHABILITATION SERVICES

VISION

Rehabilitation and wellness for all people in the province.

MISSION

Within the frame work of Primary Health Care as stipulated in the WHO findings, modern approach from researched studies and as prioritised by the National Health Plan and the RDP, to make rehabilitation services accessible to all the disabled people in the province.

According to WHO "Rehabilitation within the community should be given preference to any approach involving institutionalisation and/or long periods out of the community".

A Global Medium Term Programme developed by WHO states that "Programme" activities will aim to achieve maximum coverage with essential rehabilitation at an affordable cost through development of community – based services within the frame work of Primary Health Care. This will be achieved through identification, development and adoption of simple but effective technologies, revision of human resource structure used for service delivery and re-orientation of rehabilitation instiutions towards supporting community – level activities.

This new approach of community – based rehabilitation, integrated into the health delivery system and based on Primary Health Care, is expected to meet the needs of 70% of the disabled people in the community, as compared to traditional institution – based rehabilitation covering 10 – 20% of the disabled population in the Province.

1. PREAMBLE

The Government has committed itself to bringing health services closer to the people by adopting the Primary Health Care (PHC) approach, of which rehabilitation is an important component. Rehabilitation services should be restructured and strengthened in order to increase access to those who did not have it before. There is a need to find solutions to the many problems facing rehabilitation. Managers and rehabilitation professionals have come to realise that part of the solution is to involve clients in decision making so that they can own the process and be empowered at the same time. An ethos will thus develop in society which will ensure quality of care at all times, with respect for human dignity and the right to self-determination.

The equalisation of opportunities for persons with disabilities cannot be achieved without action oriented programmes which are designed and implemented with the involvement of the beneficiaries. The time has come for service providers to acknowledge the potential role that clients can play in their rehabilitation. It is also important that service providers pay particular attention to external factors such as environmental barriers and societal attitudes because of their

potential to limit the success of rehabilitation processes. The fewer barriers there are the more successful is the rehabilitation process. This policy document is informed by the principles of development, empowerment and the social integration of persons with disabilities. The recognition of these principles and their enshrinement in policy and service provision, will contribute to the opportunities available to persons with disabilities to reach their optimum potential as productive members of society. This policy is a bold statement on the part of the department of Health to signal a complete break with the past, a past characterized by inequality and inequity. It is also an attempt to create the right environment for quality rehabilitation services, and to articulate the policy of access to services for all in South Africa; including those living with chronic illnesses and disabilities.

2. MAIN GOAL OF THE POLICY

The goal of this policy is to increase accessibility to all rehabilitation services in order to facilitate the realisation of every citizen's constitutional right to have access to health care services, including reproductive rights. This policy should also serve as a vehicle to bring about equalization of opportunities and enhance human rights for persons with disabilities, thereby addressing issues of poverty and disparate socio-economic circumstances. Persons with disabilities are among the poorest of the poor, and are often sidelined to the fringes of society. Ability to pay for services should not be a prerequisite for accessing services.

3. INTENDED OBJECTIVES OF THE POLICY

3.1 To increase accessibility of rehabilitation services to people with conditions that can lead to disability as well as those living with disabilities.

3.2 To establish mechanisms for intersectoral collaboration in order to implement a comprehensive rehabilitation programme.

3.3 To facilitate appropriate allocation of resources, and encourage their optimal utilisation.

3.4 To facilitate human resources development which takes into account the needs of both the service providers and the consumers.

3.5 To encourage the development and implementation of monitoring and evaluation strategies for rehabilitation programmes.

3.6 To ensure participation of persons with disabilities in planning, implementation and monitoring of rehabilitation programmes.

3.7 To encourage research initiatives in rehabilitation and related areas.

4. CONTEXT OF THE POLICY

4.1 National Health Bill

4.2 Free State Provincial Health Act, 1999

4.3 White paper on An Integrated National Disability Strategy, 1999

4.4 Final Draft National Rehabilitation Policy.

5. SITUATION ANALYSIS

5.1 Rehabilitation Services

The situation analysis confirmed that rehabilitation services in Free State are largely underdeveloped and quite inaccessible to the majority of the population, especially those who are in remote rural areas. Where services exist, the focus is usually institution based and as such the needs of consumers are not completely satisfied. However, it is worth noting that all the districts have since established mechanisms to extend the coverage of rehabilitation services to the majority of the population. As is the case with other public health services, the poorest of the poor are the ones who struggle to access these services, often relying on NGOs for service delivery. Those who manage to access rehabilitation services in the public sector are often lost due to erratic referral systems.

5.2 Human Resources

The situation analysis found that there is a shortage of rehabilitation professionals in South Africa. The situation is further exarcebated by the maldistribution of the limited resources available in the country. Again Gauteng, Western Cape and KwaZulu/Natal account for close to 90% of all rehabilitation professionals in the country. Universities were also found to produce a limited number of graduates, who often lack the skills to work in and with rural communities.

Rehabilitation professionals have been reluctant to work in disadvantaged communities for lack of incentives. Those who do stay for a very short time and are often disillusioned after a short period because of a severe lack of resources.

5.3 Financial and other Resources

Most provinces were found to have limited budget allocations for rehabilitation, if any. Rehabilitation is often treated as low priority or alternatively as a luxury which is unaffordable.

Institution based services are often housed in inaccessible and inhumane environments, especially in rural and remote health facilities. This is another reason for low staff morale in those areas.

6. PRINCIPLES UNDERPINNING REHABILITATION SERVICES

6.1 Equality

All human beings are of inherently equal worth, are privy to equal rights and share the same responsibility. Human beings are born each a unique individual; each develops along different lines; each has different abilities. These differences do not make us unequal. Those who were previously treated unequally should be made to experience equality in their daily lives, by creating an environment which is conducive to acknowledgement and acceptance of differences.

6.2 Social justice and Equity

In the first analysis, social justice implies that services and opportunities provided for disabled people should be at the disposal of all and not be reserved for a numerically small group among them. It stands to reason that the ultimate goal has to be to make individualised care, training, schooling, vocational training, jobs, etc. - as vital contributory factors to integration, independence and self realisation – available to the entirely of people with disabilities. As far as possible there should be equal access to services which should be available at various levels, primary, secondary, and tertiary and in different contexts, home, community and institution. Positive attitudes should be fostered amongst professionals and employers, individuals and communities, in order to promote the optimal utilisation of rehabilitation resources and services. Achievement of this objective is, however many years away. In the mean time, guided by the principle of social justice, we should endeavour to build programmes that will eventually give all people with disabilities at least the essential services. Services should be accessible, affordable and acceptable to all people with disabilities.

6.3 Solidarity

The responsibility for fostering human life is shared by all. Solidarity should form part of the equalisation of opportunities for all people with special needs – children, older persons, and people with disabilities. Solidarity of purpose and efforts toward this end should be seen as a privilege of all and not as a charity for some. The caring ethos advocated by the Department of Health should guide service delivery. The experience of those using rehabilitation services should be one of caring and compassion.

6.4 Integration and Participation

All members of the society should join in the mainstream of community life. Integration of people with disabilities in all aspects of life will, in the long-term perspective, help them achieve friendship with and esteem by others, and finally, to attain the degree of human dignity now denied to most of them. People with disabilities have a right to equal opportunities in the social, economic, educational , political and recreational spheres of life. They should be encouraged to participate in their integration or re-integration into the mainstream, which should be the ultimate goal of all components of a rehabilitation programme.

6.5 Dignity

All disabled people should live a life in "dignity" - "the quality that earns or deserves respect". Dignity for a people with disabilities is possible when;

- It is recognised that all human beings have equal worth and equal rights;
- All re willing - in the spirit of solidarity – to share the opportunities and means needed for self-realisation;
- The person is fully participating in the life of the community.

7. GUIDELINES FOR ESTABLISHING A REHABILITATION PROGRAMME

7.1 Provision of rehabilitation services that are equitable, affordable and accessible to all. This will attempt to strike a balance between institution-based and community based service delivery and practices in order to increase access to the previously disadvantaged, vulnerable groups such as women, children and the elderly particularly in rural areas. Formerly services favoured those in the developed urban areas.

7.2 Accountability of all health workers, educators, trainers and service providers for a high standard of service which is subject to regular quality control, instituted in consultation with consumers of service.

7.3 Social re-integration and participation of people with disabilities into their community as well as society at large.

7.4 Provision of all the components of the rehabilitation process. Medical rehabilitation is an essential stage in rehabilitation and initiates the process. The full cycle of rehabilitation includes psychosocial, educational and vocational components as well as contact with people with disabilities, their families and/or caregivers, the community and the service providers. Communication of a two-way nature enables full participation of all stakeholders.

7.5 A healthy balance between institution-based services and community-based rehabilitation services. The necessary personnel should be trained and attempts should be made to empower members of the community to play a more direct and meaningful role in the rehabilitation process.

7.6 Participation of persons with disabilities in planning, implementing and monitoring rehabilitation. Persons with disabilities should be given the opportunity to influence policy formulation and to participate in the management of services.

7.7 Optimal use of all resources. Services should be co-ordinated between the various levels of service delivery and the different sectors involved. The role of the private and the NGO sectors in rehabilitation should be appreciated, and a healthy mix with the public sector should be forged for maximum benefit.

7.8 Physical, social and economic independence of persons with disabilities and re-integration into society. The necessary resources and services should be provided to ensure that this occurs.

7.9 Intersectoral collaboration is needed between the Education, Labour, Health, Housing, Transport, Welfare and relevant sectors for planning and implementing strategies to improve the quality of life for people with disabilities.

7.10 Norms, standards and indicators should form the basis of service evaluation and monitoring.

8. COMMUNITY BASED REHABILITATION

Community Based Rehabilitation (CBR) is a strategy within community development for the rehabilitation, equalisation of opportunities and social integration of people with disabilities. CBR is implemented through the combined efforts of disabled people themselves, their families and communities, and the appropriate health, education vocational and social services (ILO, UNESCO, WHO, 1994).

CBR is an approach of delivering services to the populace, and not a service in itself. It is not "what" we do, but "how" we do it. CBR principles are therefore applicable at all levels of service delivery, from community to tertiary level. CBR should ensure the empowerment of people with disabilities as well as caregivers, and parents of disabled children.

8.1 Goal

To make rehabilitation accessible to all who need it, irrespective of location or economic circumstances. CBR, as an integral part of PHC should ensure accessibility and affordability of appropriate and acceptable services to the target community.

9. REHABILITATION SERVICE PROVIDERS

Rehabilitation services are provided by three main service providers:

9.1 Public Sector

The public sector provides the bulk of all services provided in the country. The Department of Health is the main provider of medical rehabilitation services, which are largely provided by hospitals. Services are concentrated at tertiary institutions in urban areas, with poor or no services in rural areas. This situation results in rehabilitation services being out of reach for the majority of people.

9.2 NGO Sector

The NGO sector also plays a remarkable role in the provision of services, albeit at a small scale. This sector has also been able to establish programmes in the community, thereby increasing access to services. The advantage of the NGO sector is always its proximity to

the clients, as well as its ability to respond to the community needs instantly. However, a mechanism must be put in place to evaluate the input of such programmes and to ensure their sustainability.

9.3 Private sector

The private sector provides services to the full paying section of the population. Clients covered by the Workmen's Compensation Act and the Motor Vehicle Accident Fund have also made use of services provided by the private sector.

Resources could be utilized better if service providers could form partnerships rather than provide services parallel to each other, taking advantage of each provider's inherent strengths.0.2

10. STATEMENT OF GOALS AND OBJECTIVES

10.1 Service Goals and Objectives

10.1.1 Establish new and strengthen existing rehabilitation services, focusing on areas of most need.
10.1.2 Establish and provide comprehensive effective rehabilitation services which include all three levels of services delivery
10.1.3 Establish rehabilitation services at -
- district level
- CHC and clinics
- Grass root level

10.1.4 create awareness of rehabilitation at all levels.
10.1.5 Establish effective screening, referral and networking systems at all rehab levels.
10.1.6 Establishment of data base.

10.2 Personnel Goals and Objectives

10.2.1 Fill in posts created at regional levels as well as at the community health centres with suitable persons in line with affirmative action.
10.2.2 Identify accessible clinical supervisions within the existing therapy establishments.
10.2.3 Recognise the role of therapy assistants, all levels, in the rehabilitation process.
10.2.4 Where possible bring in private practitioners to contribute to public services.
10.2.5 Make room for visiting specialists
10.2.6 Relocate posts to ensure accessible services to disadvantaged communities.
10.2.7 Motivate for career advancement structures which will include management level.

10.3 Training Goals and Objectives and Proposed Actions

10.3.1 Establish standardised/uniform training for CRWs at both mid-level and grassroot level, presumptive of the existence of these post structures.
10.3.2 Develop a multifaceted approach to affirmative action in the training of all rehabilitation workers.

10.3.3 Re-orientate the thinking and approach to affirmative action in the training of all rehabilitation workers.
10.3.4 Re-align University Training of Professionals to focus on the needs of people with disabilities in the context of the Primary Health Care approach.
10.3.5 Rationalise the provision of continuing education for all levels of rehabilitation personnel in keeping with the policy and orientation of the Provincial Rehabilitation Services.

10.4 Financing: Goals, Objectives and Proposed Actions

10.4.1 Ensure that an adequate rehabilitation budget is established at Provincial, Regional, District and Local level.
10.4.2 Lobby for immediate and ongoing allocation of funds for the provision, repair and maintenance of affordable ASSISTIVE DEVICES (e.g. crutches, wheelchairs, hearing aids etc.)
10.4.3 Lobby for immediate and ongoing subsidisation of TRANSPORT to make rehabilitation services more accessible to persons with disability.

10.5 Management Structures: goals, Objectives and Proposed Action

10.5.1 Establish structures to ensure the co-ordination of rehabilitation services at National, Provincial, Regional, District and Community levels.
10.5.2 Develop clear referral system between primary, secondary and tertiary levels of rehabilitation services, health team members and services rendered by other public/ private and NGO sectors.
10.5.3 Develop procedures for network between public, private, and NGO services.
10.5.4 Ensure self-representation on all advisory, community and inter-sectorial committees and in health authorities.

11. PROVINCIAL STRUCTURE

12. ROLES

12.1 Provincial Rehab Sub-directorate

12.1.1 Monitor, evaluate and plan all rehabilitation services in the province, based on national norms, policies and guidelines, including the development of provincial policies and planning guidelines.
12.1.2 Support and co-ordinate the work of the DHS's in the province.
12.1.3 Provide for district level services where the DHS is unable to do so.
12.1.4 Co-ordinate of the budgets of the DHS's in the province in co-operation with the Regional Health Authorities.
12.1.5 Assist with allocation of budget to, and financial control over, designated provincial rehabilitation services.
12.1.6 Management and monitoring of the rehabilitation finances of the province and reporting thereon as prescribed by the DHS and by other monitoring authorities.
12.1.7 Procurement of additional funds for provincial rehabilitation projects.

12.1.8 Provision of infrastructure and services to underpin primary, secondary and tertiary rehabilitation facilities in the province.

12.1.9 Preparation of health legislation pertaining to rehabilitation for tabling in the provincial legislature, and commenting on proposed legislation in other sectors that may affect health.

12.1.10 Provision of the means of communication with rehabilitation facilities, and rehabilitation authorities within the province.

12.1.11 Collection, collation and analysis of all relevant rehabilitation data for the purpose of provincial planning, and the submission of appropriate data to the NHS.

NB: DHS = DISTRICT HEALTH SERVICES
NHS = NATIONAL HEALTH SERVICES

12.2 Role of the District Rehabilitation Manager

12.2.1 Monitor, evaluate and plan all rehabilitation services in the district.

12.2.2 Support and co-ordinate the work of district sub-structures.

12.2.3 Provide services where the district sub-structures are unable to

12.2.4 Co-ordinate the budget for all rehabilitation services in the district and its substructures.

12.2.5 Allocation of budgets to, and district control over, district rehabilitation services.

12.2.6 Reporting to both Regional and Provincial level on all financial matters.

12.2.7 Procurement of additional funds for district.

12.2.8 Provide recommendations or comments to all District Authorities on proposed legislation that may affect rehabilitation.

13. ORGANISATIONAL RESTRUCTURING OF FEHEB IN THE FREE STATE

Diagram: Rehabilitation Levels of Service Rendering

LEVEL AND DONE BY	PROCESS
TERTIARY: Multi disciplinary Team and Auxiliary Workers (Assistants)	Disability/Impairment (after illness/accident) RECOVERY AND REHABILITATION Start Start Stop Stop Or Or Continue Continue
	or Start or Start

SECONDARY: Multi disciplinary Team and Auxiliary Workers (Assistants)	Stop Or Stop Continue
PRIMARY Mid level community rehabilitation facilitators/workers based in community Health centres and Primary clinics, support provided by nearest multi-disciplinary professional including private practitioners. Referrals may be received from community health workers or PHC sisters with training in early detection	Or start Development (empowerment) stop ongoing
Community based rehabilitation (CBR) involves work broader than rehabilitation i.e. with prevention promotion of equal opportunities, rehabilitation (focusing on the disability) using multi-sectoral collaboration.	

14. REHABILITATION REFERRAL SYSTEM

LEVEL	REFERRAL
TERTIARY	DISEASE/DISABILITY/IMPAIRMENT PROMOTIVE-PREVENTIVE-CURATIVE-REHABILITATION STOP/CONTINUE OR START

	PROMOTIVE-PREVENTIVE-CURATIVE-REHABILITATIVE
SECONDARY	STOP/CONTINUE OF START
PRIMARY (COMMUNITY)	PROMOTIVE-PREVENTIVE-CURATIVE-REHABILITATIVE STOP/CONTINUE STOP

14.1 Ideal Care Rehab Teams

PHYSICAL	PSYCHOLOGICAL
Nurse P.T. O.T. Orthotist/Prosthetist Social Worker Optometrist CRWs/CRFs/SASO/SASA	Nurse Psychologist O.T. Social Worker Consultant Psychiatrist (consultation basis) CRWs/CRFs/SASO/SASA

Other services will be on consultative/referral basis.
These include doctors, radiographers, nutritionists etc.

15. LEVELS OF SERVICE DELIVERY

Level1	Where	Service	Personnel
	Community	Early detection Health Promotion Awareness Promotion Early intervention Early Referral to	1. Primary community health workers & CRW's 2. Mid-level workers 3. PHC personnel

		clinics Training of care givers Home visits Primary Prevention	mobile units
	Clinics/CHC	Health Promotion Awareness creation Intervention Prevention Primary of secondary complications Referral to CHC or District Hospitals	1. Nursing personnel 2. Mid-level workers 3. Therapists on sessional basis. (Roving)
	CHC/District Hospitals	Prevented Curative Rehabilitative Maintenance Referral to 2nd/3rd levels	1. Multi disciplinary team 2. Therapy assistants
Level 2 and 3		Specialised Curative Services Secondary prevention Restorative Rehabilitative Referral to clinics Community	1. Professional services 2. Specialised services 3. Therapy assistants

APPENDIX A

GLOSSARY OF TERMS

ASSISTIVE DEVICES

Assistive devices are any device and ergonomic solution capable of reducing the handicap experienced by an individual. (White Paper on An Integrated National Disability Strategy, 1997)

COMMUNITY BASED REHABILITATION (CBR)

Community based rehabilitation is a strategy within community development for the rehabilitation, equalisation of opportunities and social integration of all people with disabilities. It is implemented through the combined efforts of disabled people themselves, their families and communities, and the appropriate health, education, vocational and social services. (ILO.WHO/UNESCO Joint Position Paper, 1994)

IMPAIRMENT

Impairment is any loss or abnormality of psychological, physiological or anatomical structure or function (e.g. a miss or defective body part, paralysis after polio) (WHO, 1980)

DISABILITY

Disability is any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being (e.g. difficulty in speaking, hearing or walking). (WHO, 1980).

REHABILITATION

Rehabilitation means a goal-oriented and time-limited process aimed at enabling an impaired person to reach an optimum mental, physical and/or social functional level, thus providing her or him with the tools to change her or his own life. It can involve measures intended to compensate for a loss of function or a functional limitation (for example by technical aids) and other measures intended to facilitate social adjustment or readjustment (WPA, 1982).

EQUALISATION OF OPPORTUNITIES

Equalisation of opportunities means the process through which the general system of society, such as the physical and cultural environment, housing and transportation, social and health services, educational and work opportunities, cultural and social life, including sports and recreational facilities, are made accessible to all (WPA, 1982)

PREVENTION

Prevention means measures aimed at preventing the onset of mental, physical and sensory impairments (primary prevention) or at preventing impairment, when it has occurred, from having negative physical, psychological and social consequences.

APPENDIX B

GLOSSARY OF ACRONYMS

Deafsa	-	Deaf Federation of South Africa
DPO	-	Disabled People's Organisation
DPSA	-	Disabled People of South Africa
FSFCD	-	Free State Federal Council on Disabilities
ILO	-	International Labour Organisation
SAFCD	-	South African Federal Council on Disability
SAFMH	-	South African Federation for Mental Health
SANEL	-	South African National Epilepsy League
SANCB	-	South African National Council for the Blind
NCPPDSA	-	National Council for People with Physical Disabilities by South Africa
WHO	-	World Health Organisation
PHCT	-	Primary Health Care Team