THE 24TH VONA DU TOIT MEMORIAL LECTURE

Where have all the Occupational Therapy Technicians gone? Creating a responsive and inclusive Occupational Therapy workforce in Africa July 2016

PRESENTED BY:
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HOW TO CITE:
Lorenzo, T. 24th Vona du Toit Memorial Lecture: Where have all the OTT's gone? *South African Journal of Occupational Therapy*. Volume 54 Number 3. December 2024. DOIhttps://doi.org/10.17159/2310-3833/2024/vol54no3a2

ABSTRACT

This lecture places the work of occupational therapy support staff on the national workforce development agenda. It argues that the reach of occupational therapy in advancing social transformation can be extended through certified capacitation of different levels of occupational therapy staff. Evidence based perspectives of the competences of support staff are shared to foreground their contribution to disability inclusive development. Recommendations for securing their formal training and recognition in the South African health workforce are offered and suggestions are made to extend their sense of belonging to the OT profession in meaningful and purposeful ways so that their role is unequivocally addressed in practice, education, and research.

INTRODUCTION

Dear friends and colleagues, I thank you for the invitation to present the 24th Vona du Toit Memorial Lecture. It is an honour to contribute to the memory of Vona du Toit whose ground-breaking contributions put South African occupational therapy on the national and international map. Her professional focus was on theorizing the creative human and developing therapeutic practice guidelines for using activity to enable human doing and promote human well-being. As the occupational therapy profession has developed, the importance of facilitating human belonging and enabling people to become their human potential has received more attention. Such a focus by the profession is significant, especially in Africa, where the collective consciousness of 'doing together' is present in African knowledge systems. In the 23rd Vona du Toit Memorial Lecture in 2014, Professor Alfred Ramakumba[1] raised the vision of occupational therapists addressing poverty and unemployment through seeing economic occupations as the hidden key to social transformation. He challenged us to 'get our hands dirty'[1]. in the domain of work practice and to use occupations to help improve people's livelihoods.

My purpose with this lecture is to place the work of occupational therapy support staff back on the national workforce development agenda. I believe that the reach of occupational therapy in advancing social transformation can be extended through certified capacitation of different levels of occupational therapy workforce. By referring to support staff I include occupational therapy technicians (OTTs), occupational therapy assistants (OTAs) and community rehabilitation workers (CRWs) that partner with rehabilitation professionals in delivering community-based rehabilitation (CBR) services. The literature uses different terms to describe similar support staff functions[2-5]. Table I (adjacent) provides an overview of the different categories of support staff. In this lecture I will use the acronym OTT as inclusive of all these categories of support staff.

Table I : Categories of support staff

Category	Alternative titles	Description
Community rehabilitation worker (CRW)[3] or Community rehabilitation facilitator (CRF) (two year training)[4]	Rehabilitation care worker (RCW) (1 year training)[2] Community disability worker (CDW)[13]	A mid- level health worker that is trained to identify persons with disabilities at community level and facilitate intervention in the health sector. They promote the inclusion, empowerment and participation of persons with disabilities and their families[3].
Occupational Therapy Assistant (OTA)[4]	Occupational Therapy Auxilliary (OTA[4]	Person trained to assist the occupational therapist with certain tasks. They work directly under the guidance of the occupational therapist[3]. This category of occupational therapy support staff has been phased out[4].
Occupational Therapy Technician (OTT)[5]	CRWs/CRFs were registered as OTT-Community (OTT-C) for purposes of HPCSA registration[5]	Person registered with HPCSA that is trained to implement intervention prescribed by the occupational therapist for the management of individuals and group programmes within different settings. This category of worker is appointed to assist the occupational therapist in the provision of therapeutic and rehabilitative services[5].

I will share my experiences of support staff participation in occupational therapy service systems and human resource structures to address the benefits of their contribution to social change. I will also consider the challenges they face in securing formal training and recognition in the South African health workforce. By sharing my perspectives, I hope that we perceive

their need for a sense of belonging to the occupational therapy profession in meaningful and purposeful ways so that their contribution is recognized, appreciated and formalised. In short, I view this lecture as an opportunity to advocate on behalf of OTTs.

In the 1940s legendary folk singer and social activist Pete Seeger wrote songs about social change which some of us may remember singing when we were children. He wrote songs to champion the cause of people who could not speak for themselves, to promote the things he believed in, and to protest things he opposed. Social advocacy and activism are part of occupational therapy DNA. Occupational therapists and OTTs champion social action for sustained social change to promote human well-being, prevent disability and improve the lives of persons with disability. Such a vision is only possible when occupational therapists and OTTs have capacity for disability inclusion in public and private sector service programmes at all levels of society. However, where have all the OTTs gone to help this vision materialize? I have invited my young niece, nephew and one of their friends to sing a well-known Seeger melody with adapted lyrics that raise protest questions about the status of support staff.

Where have all OTTs gone, long time passing?
Where have all OTTs gone, long time ago?
Where have all OTTs gone?
Grown older everyone
Oh, when will we ever learn?
Oh, when will we ever learn?

Where has all the training gone, long time passing?
Where has all the training gone, long time ago?
Where has all the training gone?
Time for new curriculum
Oh, when will we ever learn?
Oh, when will we ever learn?

Where has all curriculum gone, long time passing?
Where has all curriculum gone, long time ago?
Where has all curricula gone?
Gone to the OT board
Oh, when will we ever learn?
Oh, when will we ever learn?

Where has OTASA gone, long time passing?
Where has OTASA gone, long time ago?
Where has OTASA gone?
Planning for the NHI
Oh, when will we ever learn?
Oh, when will we ever learn?

BEGINNINGS

This lecture is by no means a historical overview of the development or position of OTTs but rather memories of my different engagements with support staff in occupational therapy. My journey of working with OTTs started in 1983 and 1984 during my fourth-year undergraduate fieldwork placements in general hospitals for physical and psychiatric rehabilitation practice learning. My experience of the role of OTTs continued at Natalspruit Hospital where I started my working life. When I moved to a rural hospital in 1997, there was little community outreach, and the OTA was the only person running activity programmes for in-patients, a rich source of 'beginnings' in my appreciation of the contribution of support staff in occupational therapy services.

The advent of community-based rehabilitation (CBR) in the 1980s was part of the primary health care (PHC) approach championed by the World Health Organization (WHO) that generated a new cadre of mid-level health workers called CRW[s]. The occupational therapy department of the University of Witwatersrand (Wits) was the first academic programme to invest in the training of CRWs5. I was appointed in 1991 as the first CRW programme co-ordinator located at Tintswalo Hospital, Acornhoek, in the then homeland of Gazankulu, now Mpumalanga. The CRW training programme covered aspects of occupational therapy, physiotherapy and speech and hearing therapy in rehabilitation to enable graduates to work in communities and at peoples' homes. The Wits certificated programme was converted to a two-year diploma offered formally by the University in 1998[5]. It was then the intention to make this diploma part of a laddering process into the undergraduate occupational therapy degree programme. At the same time training for occupational therapy assistants (OTAs) was offered, also as part of this laddering proposal. Changes in higher education legislation and reluctance of the occupational therapy and physiotherpy Professional Boards and the Department of Health to support the training and work of support staff led to the demise of these diplomas[6]. Indeed, where have the OTTs gone?

I want to pay homage to the 'Big Five', the five occupational therapy stalwarts that championed the initial role of the profession in CBR and the inclusion of support staff in CBR.

- Dr Pam McLaren-Haynes pioneered rural rehabilitation in Manguzi in the 1980s, co-founder of Rural Action Group on Disability (RURACT) and currently still active in RuReSA.
- Prof Marj Concha had the vision in the mid-1980[s] to extend occupational therapy student fieldwork experience at Wits to rural areas of the then homelands of Lebowa and Gazankulu that has been sustained until today in Limpopo and Mpumalanga provinces.
- A/Prof. Robin Joubert started CBR in the Valley of a Thousand Hills in KwaZulu-Natal for undergraduate students at the University of Durban-Westville, now the University of KwaZulu- Natal.
- Ms. Christa Meyer and A/Prof Estelle Shipham at the Medical University of South Africa (MEDUNSA) (now Sefako Makgatho Health Sciences University) started student placements in Winterveldt in 1992, which involved the CRFs that had been trained at the Institute of Urban Primary Health Care, working with occupational therapy students.

Besides these five visionary occupational therapists, there were practitioners at three other pilot training programmes for CRWs in South Africa, namely, South African Christian Leadership Alliance (SACLA) Health Project in Khayelitsha and the Wits-Tintswalo Community Rehabilitation Worker Programme in Acornhoek, later to be renamed the Community Rehabilitation Research and Education (CORRE) programme. There was RURACT which was coordinated by Lidia Pretorius, an occupational therapist in Mpumalanga who developed a progressive and pro-active network of professionals and activists that transformed each other through dialogue, debate, and friendship with people like the late Maria Ranthu, Shuaib Chalklein, Michael Masutha, Mzoilisi ka Toni, Thulani Tshabalala, Mike du Toit, together with the late Kirstie Rendall and the rehabilitation team at Tintswalo, among many others.

The initial training of CRWs equipped them to do home based rehabilitation focused on impairment. This training evolved over time to include skills in the development of community support networks for early childhood education and skills in entrepreneurship and livelihoods development. Since those early beginnings CBR in South Africa has grown into a strategy for community-based, disability inclusive development to equalize opportunities for participation by addressing poverty reduction and social inclusion. Innovations in practice by CRWs have responded to the needs of persons with disabilities in ways that are relevant to the African context by meeting the United Nations Sustainable Development Goals (SDGs) in inclusive and responsive ways so that

initiatives are sustained. Against this background, the next part of the lecture presents my perspectives on support staff based on the stanzas of the song.

Where have all the OTTs gone? Disrupting practice through success stories

Here I share research-based stories of the ways in which support staff enable inclusive development of persons with disability, highlighting the service gap that is created when they are not included in primary level services.

The first story commenced during my seven years working in the Mhala district of then homeland Gazankulu during 1987-1993. This period produced a shift in my professional identity from being a hospital-based occupational therapist to becoming a community-based occupational development practitioner. Two highlights of disrupting conventional occupational therapy practice in partnership with support staff were firstly, starting the CBR Development Trust which spearheaded the capacity building of a network of teachers in inclusive early childhood development by two colleagues, Alison Collinson, an occupational therapist, and Judy McKenzie, a speech and hearing therapist. I created skills development programmes for youth and adults with disabilities to initiate self-help groups in collaboration with CRWs. Secondly, I was involved with the in-service training of CRWs in collaboration with the Occupational Therapy Department at Wits. I followed up the impact of these two initiatives in 1994 when I researched the continuing education needs of CRWs and their supervisors in the Mhala district (now part of Bushbuckridge)[8]. Two participatory methods for data gathering were used. These included the Nominal Group Technique (NGT) with CRWs and their supervisors at the end of training and five months after graduating and focus group discussions (FGDs) with the CRWs and disabled persons and their families. The results from both data sources revealed that community development was rated as the top priority. Spinal cord injuries and cerebral palsy were only rated in the first NGT. In the second NGT, socio-economic development and self-development were the two priorities. The priorities of the supervisors of CRWs were work organisation, problem-solving skills and time management, recordkeeping, report writing skills and facilitation skills. The findings of FGDs correlated with the NGT results, and included socio-economic needs, learning problems, mental illness, and community resources.

Table II: Results of nominal group technique by CRWs[8]

	1992		1993	
Item	**Mean of ranked scores**	***Priorities***	**Mean of ranked scores**	***Priorities***
Community development	2.2	*1*	1.5	*1*
Spinal cord injuries	3.5	*2*	4.7	*4*
Cerebral palsy	3.8	*3*	5.1	*6*
Stroke	3.8	*3*	-	
Assistive devices	4.0	*4*	5.3	*8*
Fundraising	4.1	*5*	2.7	*3*
Campaign skills	4.9	*6*	4.8	*5*
Mental illness	5.1	*7*	5.2	*7*
Manual skills	5.3	*8*	2.7	*3*
Respiratory	5.7	*9*	-	
Speech	6.0	*10*	-	
Intellectual disability	6.2	*11*	5.6	*9*
Albinos	7.3	*12*	6.9	*11*
First aid	-		6.2	*10*
English improvement	-		1.6	*2*
Parkinson's disease	-		-	

The range of in-service training needs identified by support staff and supervisors in Table II (adjacent) point to the scope of their work in the community[7]. None of these needs are addressed when OTTs are gone. Likewise, these needs are only addressed when occupational therapists prioritise the occupational dimensions of disability inclusive community development, in particular the spiritual benefits of being, having, doing, and interacting as Manfred Max-Neef, a Chilian economist, highlights in his theory of Human Scale Development[9]. Max-Neef claimed that deprivation becomes a resource to meet our fundamental human needs[9]. Becoming an occupational development practitioner paved the way for me to think about human deprivation differently and in so doing, shifting the focus of my work towards the reduction of human poverties in partnership with support staff. My doctoral research with women with disabilities investigated their participation in socio-economic development[10]. It revealed that their human occupations were synergistic satisfiers of fundamental human needs that reduce human poverties[9]. Spirituality was an integral part of being human for the women in my study[11]. I came to appreciate that CRWs recruited from and working in their own local communities contribute insights into the rich diversity of belief systems, forms of worship, alternative healing methods and occupational profiles of residents, thereby paving the way for contextually responsive and socially inclusive occupational therapy interventions.

A second success story of the contribution of support staff to inclusive development comes from a collaborative study I led between 2008-2013, titled Disabled Youth Enabling Sustainable Livelihoods (DYESL[12].

The research team consisted of occupational therapy colleagues from six universities in South Africa, together with a CRW and a disabled person from each province. We investigated the role of CRWs as catalysts for disability-inclusive youth development through service learning across five provinces where fourth year occupational therapy students did their practice learning placements. The study explored access to health, education, and livelihoods for youth with disabilities in sites with and without CRWs. A cross-sectional survey using a structured questionnaire was undertaken in nine sites, and a snowball sample of 523 youth with disabilities of both sexes, aged between 18 and 35 years, was selected. The survey found that a significantly larger proportion of youth with disabilities living in sites with CRWs were seen at home, and that there was a large difference in educational access by youth between sites with and without CRWs. The study confirmed that CRWs are well positioned to remove barriers to participation in economic development of youth with disabilities together with occupational therapy students through service learning[12]. Enabling access to work opportunities promotes the citizenship of youth, an important social and occupational development objective for the profession in South Africa and one that we cannot attain when OTTs are gone.

A third success story is a three-country study in 2013 on the competences of community disability workers in rural communities in South Africa, Botswana and Malawi[13]. Findings indicated that community disability workers helped persons with disabilities across the lifespan to negotiate numerous transitions. When faced with difficult barriers a community disability worker provided the necessary support to facilitate participation in schooling or work as well as play, sport, cultural, recreation and political activities.

A fourth story that illustrates the successful engagement of CRWs/OTT-Cs at Tintswalo hospital with persons with disability and their families, which focused on their role as disability inclusive catalysts through the implementation of community-based inclusive development projects. Nine CRWs/OTT-Cs gathered at Wits Rural Facility for a one-day narrative action reflection workshop14 to reflect on their work over a period of 25 years since their training. Participants were asked to make a creative timeline using farm animals to reflect any significant change or

achievements that they had initiated or experienced. The timeline indicated that the CRWs/OTT-Cs were able to address inequities in public sector systems through awareness-raising and advocacy at a community level. They coordinated access to resources for persons with disabilities and their family or caregivers. They were effective in removing barriers to participation through provision of assistive devices and equipment, created networks of support and relationships, and made connections between health, education, livelihoods development and family and community support systems.

Participatory research about these inclusive implementation practices provided evidence that the interventions by CRWs/OTT-Cs are more client-centred and effective when they are supported by occupational therapists, physiotherapists, speech therapists and audiologists in the district health teams. Many of the district health teams were led by nurses that had little understanding of rehabilitation from a human occupation, activity-limitation, or inclusive participation perspective. Participants reported that nurses seemed to have minimal appreciation of their contribution in the continuity of care and referral system, in particular their competences in rehabilitative and disability management when doing home visits. Respect for the role of support staff and appreciation of their expertise that was developed over years of practice was largely absent. The experiences of participants in the three-country study echoed the experiences of OTTs that were shared during OTASA National Dialogues in the Western Cape during 2015. Indeed, where have the OTTs gone? These success stories reveal a need for curriculum change and pathways for articulation so that we build a coherent and cohesive training and continuing professional development (CPD) system that generates an inclusive and responsive occupational therapy workforce, which will be discussed in the next two sections:

Where has all the training gone? Disrupting mindsets by building a coalition for curriculum change

In this section I share some thoughts on the need for a transdisciplinary approach to the training of occupational therapists and OTTs. I draw on Max-Neef's definition of transdisciplinarity[9:16] to mean an approach that is used to gain greater understanding by reaching beyond the fields outlined by strict disciplines i.e. beyond the traditional boundaries of occupational therapy knowledge. I argue that a mindset change towards inclusive development will position the profession inclusive of occupational therapists and OTTs as a significant stakeholder in helping citizens bridge the gap between ability and disability.

The students at South African institutions of higher education in 2015 and 2016 will go down in history as the generation that revitalized student activism. They are the youth that realized that while there may have been political freedom post-1994, there is still a struggle for real economic freedom from poverty and oppression of the masses. Occupational therapy has an obligation to contribute to poverty alleviation and community development in South Africa. In 2013 McConkey[15:2], writing about disability inclusion, posed the following question: "In a world that has recently seen barriers disintegrate between East and West in Europe; between black and white in Africa; is it too much to hope that in this new millennium, the barriers between ability and disability will also disappear? What is stopping us? Put simply, we lack the human resources and will-power to make it happen". With McConkey's observation in mind, I ask *"where has all the training gone"*?

The World Health Organisation policy on task shifting[16] highlights the need for a interdisciplinary approach to inform workforce training and to bridge the shortage of human resources to meet population health and inclusive development needs. There is not consensus on the roles that 'mid-level' health workers fulfill and their relationships with existing health professional staff in mainstream and specialist services. It is time for consensus to be sought. Particularly appealing is the marrying of community development functions with rehabilitation functions to create a worker who embodies the skills needed to fulfill the intentions of community-based inclusive development services to persons with disabilities. A mindset change in human resource planning is needed to re-evaluate the value for money to be gained by investing in new staffing models in health, education, employment and social development services and systems. This debate is also the sticking point in the rehabilitation strategy framework for the National Health Insurance (NHI) as the OTT-Cs expressed an ongoing struggle for a sense of belonging to a PHC team[17]. It is time to build a coalition for change in the way that training is done. One change could be to make the task shifting and task sharing synergies between undergraduate occupational therapy curricula and OTT curricula explicit.

Other examples flow from the findings of research and workshops related to the competences of OTT-Cs discussed in the previous section. These data sources provide evidence that OTTs, in collaboration with occupational therapists, can implement inclusive occupational development that seeks to equalize opportunities for persons with disabilities through:

- Rehabilitation – for example, provision of play equipment, mobility devices and Appropriate Paper Technology (APT), checking splinting, and organizing psycho-social activity-based groups.
- Poverty reduction – for example, starting poultry projects for income generation, doing needs assessment and resource mobilization related to early childhood development at creches and day care centres, where they can screen and make relevant referrals and follow up so that there is a continuum of care across public sectors. OTTs also recognize the importance of nutrition and food security. These interventions by OTTs need to be extended from the primary level of healthcare to partnering with occupational therapists working in district school-based health teams.
- Social inclusion – for example, contributing to HIV prevention, assisting orphans and vulnerable children to access promotive and preventative health and development services, promoting community disability awareness, and serving as members of School Governing Boards. OTT/Cs also engage with local tribal chiefs and local municipal structures together with community leadership structures of religious organisations or women's groups, stokvels, disabled people's organization (DPOs) to help create the political will to change health, education, and social development systems.

These and other interventions by OTT/Cs have generated agency in persons with disabilities and their families so that they experience therapy spaces as empowering themselves to meet their needs. In short, the reach of occupational therapy is extended when occupational therapists partner with OTT/Cs in service design and delivery. Reflecting on CBR within an African context and the absence of different services, Asindua[18] argued that families and communities were always a source of care and training for persons with disabilities long before the 'officialisation' of the strategy. Sustainability of training initiatives will only happen if there is agreement about the transdisciplinary conceptual frameworks that are authentically rooted in African knowledge systems to inform occupational therapy practice.

Where have all the curricula gone? Disrupting hierarchies by responding to career aspirations and creating laddering pathways

In this section, I urge the profession to continue, and where feasible, to increase its bold efforts in championing for the development of National Qualification Framework (NQF) accredited career laddering pathways for OTT-Cs.

OTT-Cs and community service occupational therapists have helped create a bridge between hospital and community practice. A challenge that has arisen is the attrition of OTAs and OTT-Cs through retirement and the fact that there are no current NQF certified OTT-C education programmes. The experiences of OTT-Cs reveal that flexibility and managing uncertainty are critical skills in dealing with the complex nature of problems faced by persons with disabilities and their families that need inter-sectoral collaboration so that they stay healthy and well. Creativity on the part of the Occupational Therapy Board of the Health Professional Council of South Africa (HPCSA) is essential in responding to the disability inclusive development needs of the population through the National Health Insurance (NHI). The Board has an opportunity to provide intentional leadership in two aspects:

- First, there is the call from the Department of Higher Education and Training (DoHET) to enable articulation of young graduates in the Technical and Vocational Education and Training (TVETS) sector that have a certificate in Primary Health Care and Early Childhood Development at NQF 4 (vocational) into the one-year NQF 5 Higher Certificate in Disability Practice (HCDP) offered at the Department of Health and Rehabilitation at the University of Cape Town. After successful completion of the HCDP, it is proposed that graduates can articulate into a NQF 6 Diploma for profession specific technicians (hospital or community), proposed to be offered by Universities of Technology. Such career articulation pathways are advocated in the White Paper for Post-school Education and Training[17]. This envisaged career laddering articulation would require the OT Board to re-open the OTT/C register to allow the registration of community development practitioners or home-based carers who have upgraded their skills to become rehabilitation care workers (RCWs). There is a need for more advanced certificates and PG diploma programmes that provide pathways of articulation. The vision of support staff career laddering is not new. As mentioned earlier, the OT Department at Wits developed and successfully implemented an accredited CRW programme in 1990s and 2000's. It enabled horizontal mobility in learning opportunities where practitioners aspired to deepen their knowledge and practice in a certain area. Such pathways created a stronger sense of belonging that disrupted hierarchies and generated respect for the meaningful contributions that OTT/Cs made to the populations being served. It is a debate that has been on the agenda of the OT Professional Board for decades and is now more relevant and urgent with the introduction of the NHI.
- Second, to date there has also been no coherent CPD programme, and little evidence of comprehensive human resource planning in the NHI. The CPD points system for OTT-Cs has addressed their career aspirations and mobility. A strong and vibrant continuing professional education (not just for the sake of gathering certificates/qualifications) can be established through a strong coalition between Universities of Technology and Universities that would be able to provide support in curriculum, teaching, research, and service development. Courses could be offered by any of the University Occupational Therapy Departments through their involvement in the practice and service-learning placements of undergraduate occupational therapy students. The Practice and Service Learning book[18] needs to have a second edition that reflects the critical role of OTT-C staff in the training of undergraduate and even postgraduate students. Such capacity building could enable OTT-Cs to be competent co-supervisors of undergraduate occupational therapy students.

Lastly, I applaud the work of the Occupational Therapy Africa Regional Group (OTARG) across the continent to implement evidence-based practice, informed by innovative teaching, research and lifelong learning. Utilization of OTT-Cs, curriculum development and career laddering should be factored into occupational therapy services across Africa. Championed by Rose Crouch and now led by younger generation of occupational therapists, OTARG is well positioned to provide the necessary leadership across the continent to disrupt role hierarchies in service delivery.

Where has OTASA gone? Transforming leadership and planning for National Health Insurance (NHI)

In this section, I consider some of the change management challenges facing OTASA and I offer suggestions to strengthen the utility of OTTs in workforce planning for the NHI.

The challenge to overcome our divided past saw the South African Association of Occupational Therapists (SAAOT) become the Occupational Therapy Association of South Africa (OTASA) in 1995, a process ably led by the late Professor Ruth Watson together with Professor Alfred Ramukumba. The profession of occupational therapy still struggles with the dominance of White privilege and power that are vested in professional hierarchies. The ongoing challenge of many occupational therapists and OTT-C^{s} to join OTASA may be more structural and cultural in nature than financial constraints.

There is a challenge for OTASA to make the interests of public sector occupational therapists and OTT-Cs more visible. A partnership between OTASA and the provincial and national occupational therapy forums needs to be strengthened as these forums seem to play a support rather than leadership role in advancing the national interests of the profession. A stronger sense of belonging in OTASA still needs to be created for OTT-Cs and occupational therapists alike. Occupational therapists in public service and private practice are well positioned to give ongoing support to the initiatives of the OTT-Cs so that these can be sustained. The World Report on Disability[20] arguably underplayed the significance of human resources as a vital component to progress. There was little critical examination in the report of staffing arrangements in disability services. OTASA can champion the role of the profession in disability inclusive community development in partnership with appropriately trained support staff.

Research needs to be part of the process so that we learn how to upscale the OTT-Cs programmes to reach a wider population. We need more documentation of experiences to look at the outcomes and impact of rehabilitation services on the quadruple burden of disease and disability prevention. OTASA and the Occupational Therapy Board at HPCSA could develop a Theory of Change as part of an integrated planning, monitoring, evaluation and learning system to effectively map the outcomes and impact of our national training programmes and services. Evidence-based advocacy by OTASA could contribute to effective disability prevention if non-communicable diseases were identified and treated earlier, as would be the case if OTT and other support staff were appropriately trained. I suggest the following components be considered in a Theory of Change:

- Emergent change – Little was known about the role or contribution of CRWs to the occupational therapy profession before the training was started by the Tintswalo Hospital rehabilitation team in collaboration with the Wits occupational therapist. In 2006, CRW training was stopped and CRWs were reregistered as OTT-C with the Occupational Therapy Board of HPCSA. OTT-Cs have appreciated the sense of belonging and that it offers them more job mobility across provinces.

- Transformative change - The stories of the OTT-Cs require many of us in academia to unlearn how we have been socialized in the values of the profession that conflict with the values and needs of the populations we are meant to serve. Sustained change will only happen if significant curricular changes are made, and staff is representative of those we serve.
- Projected change - an inclusive occupational therapy workforce with clearly articulated pathways for CPD and specialization through postgraduate diplomas and clinical Masters Programmes for OTT-Cs is required to ensure we are able to build an inclusive and responsive workforce for NHI.

Where to from here? Lighthouses for social change

To summarize the key points of this lecture, I have identified five lighthouses that could serve as beacons of hope that I believe Vona du Toit would have offered if she was alive today. A lighthouse is designed to emit light from a system of lamps and lenses to serve as a navigational aid. Lighthouses mark dangerous coastlines, hazardous shoals, reefs, and safe entries to harbours. Vona would have made a call for action by all occupational therapists and OTT-Cs to engage in addressing the environmental barriers that prevent creative participation to promote inclusion and well-being for all. Collective action is required before we become obsolete or overtaken by technology or electronic systems or new professional groupings. I pose a question for collective reflection about each lighthouse.

- **First lighthouse: Available and appropriate products and technology**
  The major challenge for occupational therapists and OTTs is the provision of assistive devices and equipment because procurement processes present unnecessary barriers. Funding and administrative staff do not seem to understand the requirements for or supply of equipment. OTT-Cs do not have offices with basic office equipment and have had to share offices with either nurses or social workers. Some of them have been working from their home. How can OTASA be supported by its members to shine a light on these structural issues in the appropriate governance forums?

- **Second lighthouse: Making natural environments accessible**
  The NHI will fail to be available, accessible, and affordable to all disabled persons, especially children and youth, unless we address the transport and mobility needs of both staff and disabled persons and their families. There is huge opportunity to forefront innovations in disability and rehabilitation in the development of the NHI system through the district teams with OTTs at community level. For example, creative and innovative partnerships with corporate and private sector could ensure disabled persons have access to health services and social development to address food security and sustainable development. Accessible and affordable transport also helps parents of disabled children to manage their child's transitions through the different life stages. Accessible and affordable transport is a synergistic satisfier of human needs. It is pivotal in overcoming human poverties across all levels of care and all sectors, including ensuring that therapists can get out into communities and OTTs are able to do home visits and work on projects across the community. Partnerships with the private sector may help to address the transport needs of occupational therai and OTT-Cs, for example, quad bikes could be donated to OTT-Cs that would enable to see more clients in their homes and visit more schools or projects for groups. In what ways can the OT fraternity become more actively involved in the transport industry to shine a light on the critical role of transport in social change?

- **Third lighthouse: Creating networks of reciprocal support and relationships**
  Coalitions for curriculum change may create pathways for specialization for OTTs across hospital and community practice. Universities could do participatory research with public sector health service managers to develop academic pathways for OTTs. There is also a collective of other occupational therapy academics, practitioners and researchers who are leading the way in Occupational Science that will undoubtedly strengthen the work of OTT-Cs and community-based occupational development, research, and practice. We also need networks of support to ensure wellness and well-being of all staff so that they can give optimal service to individuals and their families, or the different staff we work with across sectors. How can the mental health competences of occupational therapists and OTTs shine a light in the workplace?

- **Fourth lighthouse: Dismantling power, privilege, dominance, and hierarchies**
  OTTs have been on the margins of the OT profession as evident in the recent draft World Federation of Occupational Therapy Education Position Paper[21], the HPCSA graduate attributes, and the World Federation Occupational Therapy Minimum Standards for Occupational Therapy Support Staff[21]. Explicit mention of the finer details of task sharing and task shifting would bring OTTs closer to the professional fold[16]. There is also marginalization of OTTs in rural areas that warrants focused attention. Since registration as OTT-Cs, they feel that they are mobile across provinces, which will also help extend the occupational therapy profession into under-serviced and under-resourced areas in a developmental and sustainable way.

  OTASA and the HPCSA have a critical leadership role to play in creating reciprocal relationships through private-public partnerships in the NHI and coalitions for curriculum change with NGOs, government departments, and higher education institutions (HEIs) including Universities of Technology (UoTs) and Technical and Vocational Education and Training colleges (TVETs). CPD needs to be expanded by offering a wider range of academic entry points that are interdisciplinary and transdisciplinary. Focus of curriculum content should be on life course development and managing life stage transitions. In what ways could these proposed collaborations sustain and upscale the groundwork that has already been done by various occupational therapy stakeholders to shine a light that dismantles siloed action?

- **Fifth lighthouse: Embed monitoring the implementation of policies, services and systems for sustained social change**
  Two additional strategies of monitoring participation of disabled persons related to OTT/C practice have been identified.
  - Firstly communication. We need to have more conversations and dialogues about the contribution of occupational therapists and OTTs in the National Development Plan, National Health Insurance and Sustainable Development Goals. WFOT reported on the United Nations Conventions for Persons with Disability and other similar international policies. However, as collective members of OTASA we too

need to contribute to national policy development that translates these international policies into action on the ground. How could professional communication and marketing be more vibrant? What light can technology shine on sharing current stories from practice in clinical settings?

- Secondly, disability and rehabilitation information systems in the NHI. To do effective communication and reporting, we need efficient and generative disability and rehabilitation information systems. Provincial managers and universities could collaborate on human resource planning and using the evidence from practice gathered through a disability and rehabilitation information system to create posts and community, district, regional and provincial level. Having robust data systems will contribute to reciprocal learning and collective action to strengthen occupational therapy identify in the NHI and increased recognition of our active participation and the meaningful contribution we make. How could long-overdue epidemiological studies be used to strengthen and shine a light on the population-focussed approach of occupational therapy to health and wellbeing?

A final take home message.

My take home message from this lecture: Sustainability is about building relationships and mutual accountability to ensure the growth and continuing professional development of an inclusive workforce delivering occupational therapy. Our excellence will be seen in the relevance of our practice that enables the people we work with to meet and sustain their fundamental human needs through the individual and collective occupations they engage in.

My gratitude

I am forever grateful to the late Prof Marj Concha for the initial research opportunity in rural health district of Tintswalo Hospital in 1987, which lead to the development of community based rehabilitation programmes and the training of community rehabilitation workers from 1991 by the rehabilitation team at the hospital, in collaboration with the Occupational Therapy Department at Wits University.

I have enjoyed working with Emeritus Prof Madie Duncan on recrafting my paper presentation at the national OTASA congress in 2016 for this publication.

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