[OPINION PIECE]

Strengthening rehabilitation services in rural communities: Considerations for community-oriented primary care

AUTHORS

Nafisa Mayat [a]
https://orcid.org/0009-0003-6025-9487
Madeleine Duncan [a b]
https://orcid.org/0000-0002-5359-8849
Theresa Lorenzo [b c]
https://orcid.org/0000-0002-6523-8189

AFFILIATIONS

[a] Division of Disability Studies, Department of Health and Rehabilitation Sciences, Faculty of Health Sciences, University of Cape Town
[b] Division of Occupational Therapy, Department of Health and Rehabilitation Sciences, Faculty of Health Sciences, University of Cape Town
F 56, Old Main Building, Groote Schuur Hospital, Groote Schuur Drive, Observatory, Cape Town 7925.
[c]Division of Disability Studies, and Inclusive Practices Africa research unit, Department of Health and Rehabilitation Sciences; HPALS Research Centre, Faculty of Health Sciences, University of Cape Town

CORRESPONDING AUTHOR

Nafisa Mayat
Email: Nafisa.mayat@uct.ac.za

KEYWORDS

community-based rehabilitation, mid-level workers, community based disability inclusive development, health systems strengthening, community health workers, rural development

HOW TO CITE

Mayat N, Duncan M, Lorenzo T. Strengthening rehabilitation services in rural communities: Considerations for community-oriented primary care. *South African Journal of Occupational Therapy.* April 2025 Volume 55 Number 1. DOI: https://doi.org/10.17159/2310-3833/2025/vol55no1a11

ARTICLE HISTORY

Submitted: 14 May 2024
Reviewed: 15 October 2024
Revised: 20 January 2025
Accepted: 24 January 2025

EDITOR

Blanche Pretorius
https://orcid.org/0000-0002-3543-0743

DATA AVAILABILITY

Upon request, from corresponding author

FUNDING

This study was funded by the University of Cape Town, Faculty of Health Sciences Research Stimulus Grant

ISSN On-Line 2310-3833
ISSN Print 0038-2337

ABSTRACT

This opinion piece is based on a study that investigated the contribution of Rehabilitation Care Workers in strengthening rehabilitation in community-based services at the primary level of care level and a collaborative inquiry with the rehabilitation teams responsible for outreach community services in a rural district. We are of the opinion that rural contexts require a different set of community-based rehabilitation (CBR) competences than those applicable in better-resourced urban and peri-urban settings. We investigated the health system strengthening benefits of CBR as a facet of community orientated primary care (COPC), which focuses on the intersectoral services that rehabilitation care workers who are supervised by rehabilitation therapists can offer to persons with disabilities. We endorse extant public health literature on the urgent need to build rural inclusive health workforce capacity, suggesting that human resource shortages for rehabilitation in rural areas can be addressed through training mid-level, multi-skilled CBR workers who are part of the ward-based teams with rehabilitation therapists. Community health workers (CHWs) in rural areas who upgrade their skills set to include competences in community-based disability inclusive development practice can address the rehabilitation service gaps faced by persons with disabilities and their families.

Implications for practice

- Embedding community-based disability inclusive development practices in COPC will promote access to rehabilitation services in rural communities
- In addition to nurse-led ward-based teams of CHWs, ward-based teams of RCWs led by rehabilitation therapists will strengthen the primary level rural health system
- Health outcomes of rural populations with disability will be improved by access to RCWs with competences in intersectoral collaboration

INTRODUCTION

Geospatial barriers, poverty and under-resourced infrastructure in South African rural contexts present unique complexities in access to health and other intersectoral services for persons with disabilities, especially for parents of children and youth with disabilities[1,2]. Persons with impairments and activity limitations that require physical, psychosocial, educational or vocational rehabilitation are restricted by the sparse spatial dispersion of primary level public health services across vast geographical areas, under-resourced rehabilitation infrastructure and scarcity of rehabilitation therapists and rehabilitation care workers (RCWs)[3,4,5,6]. Certified upskilling in community-based disability inclusive practice and community-based rehabilitation (CBR) competences renders these mid-level workers eligible to be deployed as RCWs (one year certification) or Community Rehabilitation Workers (CRWs) (two year certification). Currently the University of Cape Town is the only tertiary institution offering the Higher Certificate in Disability Practice programme[7]. The CRW programme previously offered by the Occupational Therapy Department at the University of Witwatersrand

and the Institute of Urban Primary Health Care at Alexandra Health Centre, and its affiliate CREATE in Pietermaritzburg was discontinued in 2006 by the occupational therapy professional board of HPCSA. Intermittent rehabilitation services may be provided in some rural health districts by rehabilitation therapists that visit several primary level clinics on a rotational outreach basis[3]. While beneficial functional and participation outcomes can be achieved through brief and sporadic rehabilitation sessions scheduled at a primary level clinic, more can be accomplished by rehabilitation therapists if they adopt a policy-endorsed, home-based, inclusive development model of community orientated primary care (COPC) in partnership with appropriately trained RCWs[8,9,10] .

COPC is a strategy for universal health coverage based on the philosophy of primary healthcare[8]. A community-based disability inclusive development approach in COPC would require the upskilling of community health workers (CHWs) and home-based carers (HBCs) that are currently deployed in nurse-led primary health care outreach teams. RCWs and CRWs, working in partnership with rehabilitation therapists, are equipped to identify and address some of the functional and participation needs of persons with disabilities between clinic visits by rehabilitation therapists[9,11]. Through bidirectional task-sharing and task-shifting of basic rehabilitation competences, these proposed rehabilitation teams would be able to advance CBR as a strategy for community-based disability inclusive development in rural areas[9] . In so doing, some of the service access constraints in rural areas could be bridged and quality of life and wellbeing of persons with disabilities and their families improved.

BACKGROUND

An education initiative between the Division of Disability Studies at the University of Cape Town and the Western Cape Department of Health (WCDoH) was launched in 2012 to develop a mid-level disability inclusive health workforce in the Western Cape Province. A one-year Higher Certificate in Disability Practice (HCDP) was designed by a team of rehabilitation therapists and disability practitioners, which is registered at National Qualification Framework Level 5[7]. The first cohort of 28 students graduated in 2014. 121 RCWs have graduated to date, most of whom are employed in the Cape Metropole in government posts or by non-government organisations (NGOs) with their salaries paid by government. One RCW with HCDP resides in a rural sub-district and is unemployed due to the absence of RCW posts.

Our opinion is based on a study that investigated the contribution of these RCWs to strengthening rehabilitation in community-based services at the primary level of care. The research team comprised of five academics. We conducted a collaborative inquiry with the rehabilitation teams responsible for outreach community services in one rural and two metropolitan sub-districts[12]. Participants in the metropole included eight RCWs who are alumni of the first cohort of the HCDP programme; eight persons with disabilities who received their services, one social worker, three occupational therapists and one speech and language therapist who support and supervise the work of RCWs in the community. Besides their community-based workload the rehabilitation therapists also provide sessional facility-based rehabilitation services at primary level health clinics in a sub-district[7,13]. This paper focuses on participants in the rural sub-district that included one unemployed RCW, one community development worker (CDW), two persons with disabilities, two mothers of children with disabilities, one occupational therapist and one speech and language therapist.

We gathered textual and numerical data using recorded discussions about a Venn diagram developed by the participants about services in the designated geographic locations. They also completed and discussed a checklist of RCW services based on competences acquired through the HCDP curriculum. Data were analysed using deductive coding and categorising and triangulated with the WCDoH Position Statement on Community Oriented Primary Care[14] and the National Framework and Strategy for Disability and Rehabilitation Service[15]. The next section summarises five key findings with quotes from the rural data.

FINDINGS

1. **Rural rehabilitation services are sparsely spread between tertiary and secondary level facilities and primary level clinics where limited space and resources make continuity of care difficult.**

"We [two rehabilitation therapists] *service eight* [primary level] *clinics, and the hospital and the intermediate care facilities. The hospital has 150 bed facilities, and we are one for each discipline. And our step-down facility is also there, there is ten beds. There are some clinics that we go twice a month; those are the clinics that are a little bit closer".* **[therapist]**

"[Primary healthcare clinic] *is a small facility, they can only accommodate one therapist one at a time. That is why we need to see when there are going to be space, are we not going to pressure another therapist. Or clash with the doctor, there is a lot that needs to be done".* **[therapist]**

"Seeing a patient once a month is terrible". **[therapist]**

2. **Therapists' work focuses on the impairment(s) of individual clients as there is only one therapist per profession covering a heavy caseload across a large rural sub-district.**

"Maybe because of the large case load everyone [rehabilitation therapists] *focus on themselves* [designated job*]. That is actually terrible. Unfortunately, it* [limited teamwork*] is how it is"* **[therapist]**

"… waiting time for assistive device is about three months. Because the orthotist comes once a quarter, so, she measures you then you get your device once she comes again. And ordering assistive device is also a problem, patients wait for long for wheelchairs. **[therapist]**

"Community rehab workers would be an asset to the community but will require regular support from the rehab therapist. This will mean therapists need to change their service from a medical approach to bio-social approach". **[therapist]**

3. **There are no community-based interventions in rural areas for persons with disabilities such as home visits, support groups or wellness hubs** [as is the case in the two metro sub-districts that have dedicated community-based outreach teams of RCWs supervised by rehabilitation therapists].

"I think a lot of us [therapists] *here* [rural clinic], *if we refer to a homebased carer, it will mostly just be, "ok you* [person with disability] *need to come for appointment* [at the clinic], *you need to come get your assistive device". But none of them* [home based carers] *are receiving training to say this person* [with impairment] *has a feeding difficulty, or this person has been discharged and this home programme is not well maybe struggling with this, should I refer back? We* [rehabilitation therapists] *never get referral, that is one of the difficulties".* **[therapist]**

[In the district] *".. [there] are five children that we have identified, they are small children, they need education and development. They sit at home. They should be in a creche but the creche is not equipped to accommodate children with disability. They get nothing. These five children also live in dire circumstances".* **[RCW].**

4. **Community health workers in rural areas are not trained in disability or CBR.**

"There can be connection between us and CHWs, but [only if] *they are maybe trained in the disability, but for example with us* [in rural areas], *they are not trained through rehab. They are not trained in anything* [related to disability]*".* **[therapist]**

"I know that they [CHWs] *sometimes look at the weight and the growth of the baby, those are the things that they can identify, but with regards to rehabilitation, they can only identify whether a person is in the wheelchair, or the person is in the crutch, but all the other things they are not able to identify and refer to us. I think training for them would be very needed.* **[therapist]**

"*But now I ask, what is the availability of CHW* [for my child with disability]? *They [CHWs] ask how things are going. They have visited me a few times and asked how my baby is. I do not know what the purpose of the CHW is. Now I hear they can link me into many things. If people sit at home with a cough or TB, the CHW must talk to them or refer them to the clinic. I do not know if they can refer me for my (*disabled*) child*" **[mother of child with disability]**

5. **Therapists' engagement in intersectoral collaboration is limited by availability of services in rural areas. Intersectoral liaison activities by therapists on behalf of rehabilitation clients to promote their participation and disability inclusion are not recorded as part of rehabilitation service statistics.**

"The involvement of the community and NGOs services is poor. You can contact [NGO] *about patients and then they will assist but the support* [NGO] *is not much".* **[therapist]**

"*We are also involved with the SAPS* [South African Police Service*], so if we have a patient that is acutely psychotic, they need to be admitted to hospital so we would ask the police to assist us. If someone is aggressive who won't go to hospital voluntarily, our experience with SAPS is so, so. Their service is not consistent, and the response rate is very terrible".* **[therapist]**

"[A NGO providing disability services] *is the organisation that is supposed to work* [for persons with disability]*……when they come to* [rural town] *they may hold a little meeting but there is no education or any service delivered*" **[community development worker].**

DISCUSSION

These five findings are a summary and confirmation of the implications of human resource shortages for rehabilitation in rural areas throughout South Africa, where the needs of persons with disabilities are higher because services and resources are lower. It is our opinion that mid-level, multi-skilled RCWs and CRWs provide a cost saving approach to building a rural workforce capacity while simultaneously enhancing the lives of persons with disabilities[9,11]. RCW and CRWs can bridge gaps in continuity of care between facility-based therapeutic and rehabilitative interventions and intersectoral community-based disability inclusive development with due acknowledgement that rural contexts require a different set of CBR competencies than those applicable in better-resourced urban settings[11]. Rural practice calls for context-specific competences, importantly the ability of RCWs and CRWs to work interdependently and responsibly as members of mobile–outreach teams between supervisory consultations with rehabilitation therapists. As a scarce human resource responsible for oversubscribed services that require travelling long distances between service points, rehabilitation therapists may experience feelings of isolation and limited work satisfaction or burnout that can be alleviated by working closely through task sharing and task shifting with localised teams of RCWs[16]. CBR teamwork creates opportunities to develop locally relevant information systems to capture pertinent data on intersectoral collaboration for improved health outcomes of rural populations.

What we are proposing is nothing new.

The question is why have CBR services not been formally endorsed by health policy makers, human resource planners and clinic managers? This absence despite rehabilitation being foregrounded in the Presidential Health Summit as a critical growth area in health system planning[17]. Disability is a neglected area in public health[18] It is our opinion that this neglect in planning for rural health services is based on outdated conceptualisations of disability and rehabilitation. We argue that the rural health system will be strengthened if contemporary modelling of COPC includes the CBR guidelines[19].

Take home message

Universal health coverage inclusive of disability prevention in rural communities will be promoted when RCWs and CRWs address the needs of persons with disabilities and their families between clinic visits by rehabilitation therapists. A developmental model of COPC will require the upskilling of CHWs in community-based disability inclusive development practice. Rehabilitation therapists will require competences in bidirectional task-sharing and task-shifting with RCWs to advance CBR as a strategy for community-based disability inclusive development practice. Further research is needed to explore the challenges and needs nationally and for relevant bodies such as the Occupational Therapy Association of South Africa (OTASA) and other University training centres, Health Professional Council of South Africa (HPCSA), Departments of Health (DOH), Basic Education, Social Development, Local Government and other relevant bodies throughout the country to be more proactive in trying to find a national strategy of implementing the proposed model.

Author Contributions

All authors were involved in the conceptualisation of the study as well as data gathering and analysis and the writing up of the publication.

Conflicts of Interest

Authors declare that there are no conflicts of interest to declare.

Acknowledgements

We appreciated the active participation of the participants.

Funding

We are grateful for Faculty of Health Sciences Research Stimulus Award (2022).

REFERENCES

1. van Pletzen E, Booyens M, Lorenzo T. An exploratory analysis of community-based disability workers' potential to alleviate poverty and promote social inclusion of people with disabilities in three Southern African countries. *Disabil Soc.* 2014. Vol 29:1524–39. doi: https://doi.org/10.1080/09687599.2014.958131
2. Cramm J M, Nieboer A P, Finkenflugel H, Lorenzo T. Comparison of barriers to employment among youth with and without disabilities in South Africa. 2012. *WORK,* Vol. 46, no. 1, pp. 19-24, 2013. doi: https://doi.org/10.3233/WOR-121521
3. Ned L, Cloete L, Mji G. The experiences and challenges faced by rehabilitation community service therapists within the South African primary healthcare health system. *African Journal of Disability*, 2017. Vol 6(0). https://doi.org/10.4102/ajod.v6i0.311
4. Magaqa Q, Proochista A, Polack S. Examining the availability and access of rehabilitation services in a rural district of South Africa: a mixed methods study. *International Journal of Environmental Research & Public Health.* 2021. Vol 18: 4692. https://doi.org/doi: 10.3390/ijerph18094692
5. Louw Q, Conradie T, Soyizwapi N, et al. Rehabilitation capacity in South Africa - a situational analysis. *Environ Res Public Health* 2023 Feb 17;20(4):3579. doi: https://doi.org/10.3390/ijerph20043579.
6. Tiwari R, Ned L, Chikte U. HRH planning for rehabilitation services: a focus to reduce inter-provincial inequities. *South African Health Review.* 2020: 51–62.
7. Damonse, S., Mayat, N. and Gabriels, S., Duncan, E. (in press) The contribution of a Higher Certificate in Disability Practice alumni as members of the rehabilitation team to strengthen COPC community-orientated primary care. *African Journal of Disability*

8. Mash R, Ray S, Essuman A, Burgueno E. Community-orientated primary care: a scoping review of different models, and their effectiveness and feasibility in sub-Saharan Africa. *BMJ Global Health.* 2019. 4:e001489. https://doi.org/10.1136/bmjgh-2019-001489
9. Philpott S, McLaren P, Rule S. Toward 'Rehab 2030": building on the contribution of mid-level community-based rehabilitation workers in South Africa.' *South African Health Review*, 2020: 155–162. https://journals.co.za/doi/pdf/10.10520/ejc-healthr-v2020-n1-a19
10. Bruijn P. Disability inclusion in universal health coverage. KIT Brief. 2020. SIDA and Royal Tropical Institute. www.kit.nl [cited 14 Dec 2023].
11. Ned L, Tiwar R, Hess-April L, Lorenzo T. Chikte U. A situational mapping overview of training programmes for community-based rehabilitation workers in Southern Africa: strategies for strengthening accessible rural rehabilitation practice. *Frontiers in Public Health*. 2020. Vol 8:569279. doi: https://doi.org/10.3389/fpubh.2020.569279
12. Peters, F., Duncan, M. and Lorenzo, T. (in press) Rehabilitation in community-orientated primary care: Perspectives of rehabilitation therapists in the Western Cape province, South Africa. *South African Journal of Occupational Therapy.*
13. Mahlangu, J., Duncan, M. and Lorenzo, T. (in press) The influence of environmental factors on the capabilities of rehabilitation care workers to address the needs of persons with disabilities. *African Journal of Disability.*
14. Western Cape Department of Health *Position statement on Community Orientated Primary Care (COPC) towards universal health coverage (UHC).* 2023. Circular H11/2023.
15. Department of Health. *Framework and Strategy for Disability and Rehabilitation in South Africa 2015-2020.* Pretoria: Government. 2015.
16. Hoeft TJ, Fortney JC, Patel V, Unützer J. Task-Sharing Approaches to Improve Mental Health Care in Rural and Other Low-Resource Settings: A Systematic Review. *The Journal of Rural Health*, 2018. Vol *34*(1): 48–62. https://doi.org/10.1111/JRH.12229
17. South African Government. PILLAR 5 *Presidential Health Summit Compact 2018: Strengthening the South African health system towards an integrated and unified health system.* www.Presidential Health Compact.pdf . 2019.
18. Editorial. Disability-a neglected issue in public health. *The Lancet Public Health.* 2021. Vol 6(6) E346. https://doi.org/10.1016/S2468-2667(21)00109-2
19. World Health Organization. Community-based rehabilitation: CBR guidelines. UNESCO, International Labour Organization & International Disability Development Consortium. 2010 https://www.who.int/publications/i/item/9789241548052