FACTORS INFLUENCING THE UTILISATION OF COMMUNITY BASED REHABILITATION SERVICES BY PEOPLE WITH DISABILITY IN SOSHANGUVE AND WINTERVELDT, GAUTENG PROVINCE

By

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ABSTRACT

The aim of the study was to determine factors that influence the utilisation of services in the community based rehabilitation centres in Soshanguve and Winterveldt.

The objectives were to determine the socio-demographic characteristics of people with disabilities, to determine whether they are aware of the rehabilitation services and to identify environmental barriers affecting access to rehabilitation services.

Methodology: A retrospective quantitative descriptive design was used to gather information in the study from 89 participants from rehabilitation departments. A questionnaire was used to collect data from participants.

Results: Out of the 89 participants, 56% were males and 44% were females. 51.6% were under 10 years of age, $\mu = 2.93$ and $\alpha = 2.22$. 52.8% did not receive a disability grant. 85% were from Soshanguve and 15% from Winterveldt. Of these 44.9% had hemiplegia and 36.9% cerebral palsy. The results show no significant differences in disability distribution according to gender ($p = 0.207$). Of the participants 67% used taxis and 67.4% paid less than R50 for transport. Of the 44 adult participants, 43.18% were married, 88.62% had received formal education and 83.25% were unemployed. Of the participants 78% were not aware of the rehabilitation services whilst 22% were aware of them and only 18% of those who were aware used the services while 88% were referred internally to the rehabilitation department within the hospital.
Conclusion: Lack of awareness about the rehabilitation services in the community and the existence of barriers in the primary health care centres were the main factors that affected utilisation of community based rehabilitation services by people with disabilities.

Key words: Community based rehabilitation, awareness and utilisation, environmental barriers.
DECLARATION

I declare that the mini-thesis hereby submitted to the University of Limpopo, for the degree of Master in Public Health, **Factors influencing the utilisation of community based rehabilitation services by people with disability in Soshanguve and Winterveldt, Gauteng province** has not been submitted by me for a degree at this or any other university. I declare that, this is my work in design and in execution, and that all material contained herein has been duly acknowledged.

______________________________
FM Kotsokoane (Ms)                                                                      Date

I.    200906290
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I would like to acknowledge the heads of primary rehabilitation health centres in Soshanguve and Winterveldt for their valued time and assistance during data collection, and the director of the research and ethics committee of the Soshanguve North rehabilitation services for allowing me to conduct the research.

Lastly, I would like to thank, participants in the study, Mrs Paulina Mokale for her selfless assistance during the research project, as well as my family, colleagues and friends for the support and love they gave during this difficult time.

“Baruch Hashem Adonai”
### DEFINITION OF TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community based rehabilitation:</td>
<td>A strategy within general community development for rehabilitation, equalization of opportunities and social inclusion of all people with disability (WHO, 1994)</td>
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<td>Rehabilitation:</td>
<td>A process that assists people with disabilities to develop or strengthen their physical, mental and social skills (WHO, 1994)</td>
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<tr>
<td>Disability:</td>
<td>An umbrella term for impairments, activity limitations and participation restriction. It denotes the negative aspects of interaction between an individual with a health condition and that individual’s contextual factors (environmental and personal) (WHO, 2001).</td>
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<tr>
<td>Rehabilitation Professionals:</td>
<td>Physiotherapists, occupational therapists, occupational therapy assistants and technicians, speech and audiologists, human nutrition therapists/dieticians, social workers, psychologists and community rehabilitation workers.</td>
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<td>Caregiver:</td>
<td>An adult who brings the child to the cerebral palsy (CP) clinic being the child’s parent, sibling, relative, neighbour.</td>
</tr>
<tr>
<td>Section</td>
<td>Pages</td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
</tr>
<tr>
<td>Title page</td>
<td>i</td>
</tr>
<tr>
<td>Abstract</td>
<td>ii - iii</td>
</tr>
<tr>
<td>Declaration</td>
<td>iv</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>v</td>
</tr>
<tr>
<td>Definition of terms</td>
<td>vi</td>
</tr>
<tr>
<td>Table of contents</td>
<td>vi - x</td>
</tr>
<tr>
<td>Abbreviations</td>
<td>ix</td>
</tr>
<tr>
<td><strong>CHAPTER 1 INTRODUCTION</strong></td>
<td>1 - 5</td>
</tr>
<tr>
<td>1.1 Background</td>
<td>5 - 6</td>
</tr>
<tr>
<td>1.2 Problem statement</td>
<td>7</td>
</tr>
<tr>
<td>1.3 Research questions</td>
<td>7</td>
</tr>
<tr>
<td>1.4 Aim of study</td>
<td>7</td>
</tr>
<tr>
<td>1.5 Research objectives</td>
<td>7 - 8</td>
</tr>
<tr>
<td>1.6 Significance of the study</td>
<td>8</td>
</tr>
<tr>
<td><strong>CHAPTER II LITERATURE REVIEW</strong></td>
<td>9</td>
</tr>
<tr>
<td>2.1 Introduction</td>
<td>9</td>
</tr>
<tr>
<td>2.2 Overview of disability</td>
<td>9</td>
</tr>
<tr>
<td>2.3 Overview of rehabilitation and community based rehabilitation</td>
<td>9 - 11</td>
</tr>
<tr>
<td>2.4 Socio-demographic characteristics of people with disability</td>
<td>11 - 12</td>
</tr>
</tbody>
</table>
2.5 Accessibility of services .................................................................................................................. 12

2.5.1 Transport ................................................................................................................................. 12 - 14

2.6 Environmental barriers to rehabilitation ....................................................................................... 14 - 15

2.7 Awareness about community based rehabilitation services within communities ........... 16

2.8 Challenges faced by countries regarding community based rehabilitation ....................... 17

CHAPTER III RESEARCH DESIGN AND METHODOLOGY .................................................................. 18

3.1 Study design ................................................................................................................................. 18

3.2 Setting for the study ...................................................................................................................... 18 - 19

3.3 Study Population ......................................................................................................................... 20

3.4 Sample size ................................................................................................................................. 20

3.5 Sampling procedure ..................................................................................................................... 20

3.5.1 Inclusion criteria ....................................................................................................................... 21

3.5.2 Exclusion criteria ...................................................................................................................... 21

3.6 Data collection ............................................................................................................................. 21

3.6.1 Data collection instrument ....................................................................................................... 21 - 22

3.6.2 Data collection methods ........................................................................................................... 22 - 24

3.7 Data capturing and analysis .......................................................................................................... 24

3.7.1 Data capturing .......................................................................................................................... 24

3.7.2 Data analysis ............................................................................................................................ 24 - 25

3.8 Reliability and Validity .................................................................................................................. 25

3.9 Bias .............................................................................................................................................. 25 - 26

3.10 Ethical considerations .................................................................................................................. 26
CHAPTER IV RESULTS

4.1 Introduction ................................................................. 27
4.2 Socio-demographic characteristics of people with disabilities ...................................... 27 - 31
4.3 Awareness about rehabilitation services in the community .............................................. 31 - 32
4.4 Perceptions about rehabilitation services in the community ............................................. 33
4.5 Environmental barriers to accessing primary health centres .................................... 33 - 34

CHAPTER V: DISCUSSION

5.1 Introduction ................................................................. 35

5.1.1 The socio-demographic characteristics of participants ................................................ 35 - 39

5.1.2 Awareness about rehabilitation services in the community ........................................ 39 - 42

5.1.3 Perceptions of people with disability regarding rehabilitation services ...................... 42 - 43

5.1.4 The environmental barriers affecting access to rehabilitation areas of primary health centres ................................................................. 44 - 46

5.3 Conclusion ................................................................. 46

5.4 Limitations of the study ............................................................................................. 46 - 47

5.5 Recommendations ................................................................................................. 47 - 48

REFERENCES .............................................................................. 49 - 56
APPENDICES

APPENDIX A: English questionnaire.................................................................57 -60

APPENDIX B: Tswana questionnaire.................................................................61 - 66

APPENDIX C: Check list....................................................................................67 - 69

APPENDIX D: English consent form.................................................................70

APPENDIX E: Tswana consent form.................................................................71

APPENDIX F: English participant information leaflet.......................................72

APPENDIX G: Tswana participant information leaflet.......................................73

APPENDIX H: Letter to MREC.......................................................................74

APPENDIX I: Letter to Gauteng North Rehabilitation services manager...........75

APPENDIX J: Letter to CEO, Dr. George Mukhari hospital.............................76

APPENDIX K: Letter to heads of departments, Dr. George Mukhari hospital....77
<table>
<thead>
<tr>
<th>ABBREVIATIONS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ART</td>
<td>Antiretroviral</td>
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<tr>
<td>CBR</td>
<td>Community Based Rehabilitation</td>
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<tr>
<td>CP</td>
<td>Cerebral Palsy</td>
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<td>MREC</td>
<td>Medunsa Research Ethics Committee</td>
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<tr>
<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
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<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
CHAPTER 1
INTRODUCTION

1.1 BACKGROUND

Healthcare systems have undergone reform in both developing and developed countries. One of the reforms undertaken by countries is decentralisation of healthcare services in an attempt to achieve objectives linked to it such as efficiency, equity, accountability, local democracy and innovation (Bossert, Bowser & Corea, 2001). The scope of health services that need to reach the population include among others drugs/medicines, rehabilitation, child and women’s health (Bossert et al., 2001; Cheshire, 2010).

Decentralisation is defined as the transfer of authority, functions and/or resources from the centre to the periphery (Saltman, Bankauskaite & Vrangbaek, 2007). It may take any of the four types: “delegation which is the transfer of responsibility to a lower organizational level, devolution being the transfer of authority to a lower political level, privatization where tasks are transferred from public into private ownership and deconcentration which is the transfer of administrative responsibilities from central to local governments within a central government ministry or agency” (Muriisa, 2008).

The most commonly used types of decentralisation according to McIntyre and Klugman (2003), are devolution and deconcentration. South Africa uses both types of decentralisation. Decentralisation is also a key element of the primary care approach and community based rehabilitation (CBR), one of the service provision approaches within primary health care. CBR was introduced in South Africa as early as 1994. The aim of CBR is to focus on enhancing the quality of life for people with disabilities and their families, making health care services accessible, meeting basic needs and ensuring inclusion and participation.
Unfortunately, healthcare services are still inaccessible to vulnerable populations including people with disabilities, irrespective of types of decentralisation used in South Africa.

Decentralisation was introduced decades ago by the World Health Organization (WHO) countries in Sub-Saharan Africa such as Uganda and Cameroon implemented decentralisation as early as 2000, especially in areas of low socio-economic status (Muriisa, 2008). Post-apartheid South Africa’s health systems underwent reform and primary health care services were implemented through the decentralised district health system. The aim was to reduce disparities, increase access to improved services with emphasis placed on reaching the previously disadvantaged poor communities, the underserved, the vulnerable and generally to make health services accessible to all citizens (Local Government and Health Consortium, 2004; McIntyre & Klugman 2003).

Cheshire, 2010; Loubiere, Boyer, Protopopescu, Bonono, Abega, Spire & Moatti, 2009; Muriisa, 2008 have reported on the benefits of decentralisation in both developing and developed countries such as an increase of access to health services to vulnerable populations, expanding the reach of health services beyond large cities, improvement of service delivery, increased participation by local people in health care, public service that is speedier and more responsive to local needs, enhanced efficiency through reduced bureaucracy, reduced duplication of services, more effective use of available resources, redressing past inequalities created by the apartheid regime and bringing services nearer to the people. “When the power of health decision-making in a decentralised health system is provided directly to the officials of a local population and smaller facilities are built nearby, the personalised health issues of these groups may be addressed at the heart of the problem and directed to the affected individuals of those problems” (Cheshire, 2010:1). It means that it is important to bring health closer to people, in order to address the specific health issues affecting different communities. Bossert et al. (2003) and Cheshire (2010) also agree that
decentralisation increases equity of resource allocation between municipalities of different incomes and decreases total government health expenditure.

Community based rehabilitation has similar benefits and these include among others access of services nearest to home, responding to the needs of people with disability, reduction of pressure on resources in hospitals, participation and ownership of the services by the community, creation of awareness about disability in the community, individualising care and involving family and friends in issues relating to disability (National guidelines on home based care and community based care, South Africa, 2001). Although the benefits of community based rehabilitation services are acknowledged, the approach to disability and the rehabilitation of people with disabilities is still institution-based and in the outpatients hospital department. It is mainly initiated and under the control of health care professionals (Bury, 2005).

One success of decentralisation in Africa is demonstrated in Cameroon, with reference to HIV roll out of anti-retroviral (ART) drugs through decentralisation. District hospitals receive supervision from larger hospitals in the capital cities. This happens through 24 accredited treatment centres in these larger hospitals which are mentors and reference centres for management units of HIV at district level. This decentralised approach has been effective and has contributed to the rapid access to ART in Cameroon although it requires monitoring (Loubiere et al., 2009). According to Bossert et al. (2001) there is no ideal model for decentralisation; they maintain that each country needs to develop an approach to decentralisation that will help to achieve equity, efficiency, quality and financial soundness and be unique to the specific needs of each community.

However, decentralisation has been met with serious challenges which include poor quality of service, lack of medication, poor staffing and weak rehabilitation. This is not unique to
South Africa though; other countries like Ghana and Cameroon have also reported similar challenges to those in South Africa. In Uganda, spending on primary health care was reduced and this was due to lack of accountability, lack of transparency in resource allocation and weak budgetary procedures with regard to record keeping and auditing, lack of capacity and personnel to exercise responsibility for service delivery at subnational level, limited medical personnel and medicines, failure to cede power by politicians, conflicts between politicians and civil servants, lack of sufficient funds, shortage of staff and financial resources (McIntyre & Klugman, 2003; Muriisa, 2008).

In developing countries financial control, which at times is withheld from the local powers where central government no longer provides funds, leads to the introduction of user fees for healthcare services. This becomes a burden for some people who cannot afford the fees, thereby reducing accessibility to healthcare services (Cheshire, 2010). Developed countries also experience challenges when it comes to the decentralisation of healthcare services. China’s initial health systems reform have failed to close the gap between the poor and the wealthy in terms of health financing and have made the discrepancy worse. The poor communities therefore have been disadvantaged when it comes to health care access (Muriisa, 2008; Purves, 2000).

A challenge facing community based rehabilitation is the use of the medical model of disability to deliver services to people with disabilities. In this model professionals decide on the services that are rendered to people with disabilities who are passive recipients of health services. The family and community are little if at all involved in the rehabilitation of their loved ones who have disabilities. In this the model intervention focuses on the health sector while other sectors that can make a difference in the lives of people with disabilities are completely left out. Addressing disability in isolation does not take into account other needs of people with disabilities, let alone address them, and rarely focuses on integrating people
with disabilities into mainstream society as the outcome of rehabilitation. These services are provided by government and fail to provide comprehensive services that are not equitably distributed in both rural and urban areas (South African Integrated Disability Strategy, 1997; Wiman, Helander & Westland, 2002).

It has been argued that the medical model of disability has not brought solutions to disability related matters but compounded the problems due to the high costs of rehabilitation and poor outcomes of rehabilitation in terms of the integration of people with disabilities associated with the approach (Wiman et al., 2002). In summary, Wiman et al. (2002) report that the following challenges need to be addressed as they hamper the orientation of health services to the primary health model: weak implementation capacity of primary health care; poor physical infrastructure; urban-biased allocation of resources; centralised services and administrative structures; scarcity of financial, technical and human resources and varying skills level of health providers. Therefore, the strengthening of the primary health system can lead to these services being optimally used to curb overcrowding in public hospitals.

1.2 PROBLEM STATEMENT

South Africa’s health care system was reformed after 1994 and its primary focus moved to the improvement of primary health care facilities, in order to reduce workload from bigger healthcare facilities like public hospitals. Multiple goals and objectives were set to drive the health system plans and among those were attempts to link various levels of care through a referral system and to distribute rehabilitation professionals (i.e. physiotherapists, occupational therapists, human nutritionists and speech/language and pathology therapists) throughout the country in order to improve equity of access and utilisation of health services (White Paper for the Transformation of Health Systems of South Africa, 1997). Coupled with this, medical universities have also moved their students’ training from a hospital setting to a
community setting thereby further reinforcing primary health care as an integral part of patient care to meet the rehabilitation needs of a larger population of people with disabilities.

Despite these efforts in bringing rehabilitation services closer to communities, there has been a decline in the number of patients with disabilities who make use of these facilities, compared to an increase in the number of patients seeking rehabilitation in hospitals. The fact is that these hospitals are far from where patients live and that they have to pay for services, transport and are likely to stand in queues for long hours before they are attended (Hensher, Price & Adomakoh, 2006). Reasons for this decline are not well documented in South Africa. It is not only disabled people who find themselves in this situation. Hospitals are still overcrowded with other patients who seek services for ailments that could be managed in clinics. Also, there are no reinforced policies forcing people to use a specific health centre, irrespective of its close proximity to where they live. This has led the researcher to ask the following question: what are the factors influencing the uptake of rehabilitation services in the community based centres by patients with disability?

The researcher has also noticed a similar trend in Soshanguve and Winterveldt communities during her clinical training, whereby a considerable number of patients with disabilities continue to utilise Dr George Mukhari Hospital, a tertiary hospital located ±35km kilometres away from both townships, for rehabilitation services which are available within their communities. This prompted the researcher to investigate the factors influencing the utilisation of community based rehabilitation services by people with disability in Soshanguve and Winterveldt.

1.3 RESEARCH QUESTIONS

Are there factors influencing the uptake of rehabilitation services in the community-based rehabilitation centres by patients with disability?
• Are people with physical disability aware of available rehabilitation services in their communities?

• Are primary health centres structurally accessible to patients with physical disabilities?

• Is staffing adequate to cater for the needs of patients with physical disability?

1.4 AIM OF STUDY

The aim of the study was to determine the factors that influence utilisation of community-based rehabilitation services by people with disability in the Soshanguve and Winterveldt communities.

1.5 RESEARCH OBJECTIVES

The objectives of the study were as follows:

• To determine the socio-demographic characteristics of people with physical disability who are not utilising rehabilitation services at their own community healthcare centres (age, gender, type of disability, geographic area, source of financial income, mode and cost of transport)

• To determine whether people with disability are aware of the availability of rehabilitation services in their own community healthcare centres

• To determine the perceptions of people with disability regarding rehabilitation services at their community health centres

• To identify environmental barriers affecting access to rehabilitation services of primary healthcare centres.
1.6 SIGNIFICANCE OF THE STUDY

Currently, there are no documented factors that influence the utilisation of rehabilitation services at community level in South Africa. The researcher hopes that this research will be added to the body of knowledge and that staff managing community health centres can effect changes according to the research recommendations.
CHAPTER II
LITERATURE REVIEW

2.1 INTRODUCTION

The overview of community based rehabilitation, the socio-economic characteristics of people with disability, awareness of availability of rehabilitation services within community health care centres by people with disability and the environmental barriers affecting access to rehabilitation within primary health care centres are discussed in this chapter.

2.2 OVERVIEW OF DISABILITY

According to United Nations statistics (2002), it is estimated that over half a million of the world population has a disability resulting from intellectual, physical and sensory impairment and 80% of this population is from developing countries. South Africa is equally affected and about 5% of its total population has some form of disability, the majority of which presents with physical disability, blacks being the group more affected above other racial groups (Statistics SA, Census 2001).

2.3 OVERVIEW OF REHABILITATION AND COMMUNITY BASED REHABILITATION

Rehabilitation is a process that assists people with disabilities to develop or strengthen their physical, mental and social skills. These services may be based in an institution, an outreach service or in the community.

Rehabilitation services which are rendered in hospital, sometimes referred to as institution-based rehabilitation are an important part of the rehabilitation referral system where people with disabilities receive intensive or specialised care such as surgical interventions and other skilled services which are expensive, located in urban areas, focus on an individual with
disability, exclude family, community and social factors and are mostly inaccessible to those who live outside urban areas (Bonner, Pryor, Crockett, Pope & Beecham, 2009).

Outreach services on the other hand are provided by health professionals who are based in institutions. They manage patients in their home settings, involve family and the community to a minimal extent and bring about little if any social change. These services are, however, as costly as institution based services and are used to deliver services in remote areas (Rehabilitation WHO, 1994).

Community based rehabilitation is another strategy used to offer rehabilitation services. It was adopted by the World Health Organization (WHO) in the 1980s as an alternative to rehabilitation services which were offered in the hospital setting. This was an attempt to move services within reach of people with disabilities, involving family, organisations for people with disabilities and the community in service provision. In this strategy, people with disabilities, their families and the community play an active role in the rehabilitation process (Rule, Lorenzo & Wolmarans, 2006).

The government of South Africa has recognized the rehabilitation needs of people with disability and through the integrated national disability strategy of 1997 the needs of people with disabilities were integrated into national departments’ policies and programmes for the attainment of a good and equitable quality of life for people with disabilities. South Africa was amongst developing countries which adopted and piloted the strategy in the 1980s in provinces such Kwa-Zulu Natal and Mpumalanga (Rule, Lorenzo & Wolmarans, 2006).

The introduction of CBR led to the training and employment of community based workers and included skills in community development and aspects of physiotherapy, occupational
therapy, speech therapy and social work. They were able to offer integrated services to people with disabilities and their communities, work with disabled people’s organizations and set up support (Rule et al., 2006). The strategy was seen to be comprehensive and inter-sectoral and was planned to focus not only on the health sector but was expected to include sectors such as education, welfare and labour among others. However, the training of occupational therapy technicians, the community based workers was on rehabilitation focusing mainly on the health sector (Rule et al., 2006); something that was not in line with the objectives that it needed to achieve equalization of opportunities, integration for people with disabilities and community development (ILO, UNESCO, WHO 2004). The community based workers were employed subsequent to training and rehabilitation services were made available to a number of disadvantaged communities in both rural and urban areas of South Africa. This was done in an attempt to increase human resources for rehabilitation in these areas. However Musanze district in Rwanda, unlike areas in other developing countries, does not have community or outreach services for people presenting with disabilities. Of particular mention was stroke survivors who are seen for rehabilitation as either inpatients or outpatients (Urimubenshi & Rhoda, 2011).

2.4 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF PEOPLE WITH DISABILITY

It was mentioned earlier that the prevalence of disability of South Africa is 5% of the population, the majority of whom are blacks, followed by whites, coloureds and Indians (Statistics SA: Census, 2001). They present with various forms of disability, the majority of which are visual and physical followed by hearing, emotional, intellectual and communication disability respectively (Statistics SA: Census, 2001).
Females with disabilities were slightly more than males in the black and white population groups. The same applies to Gauteng, the province where the study took place where the number of females who presented with disabilities was slightly higher than males (Statistics SA: Census, 2001). The census revealed that the prevalence of disability increases with age. The level of education was another area where people with disabilities especially blacks were seen to be more affected than their non-disabled counterparts. Poverty and exclusion from educational opportunities seems to be a possible explanation to no education and low levels of education amongst people with disabilities of different age groups. The low level of education among people with disabilities was one of the factors that is contributing towards their fewer opportunities of employment when compared to the non-disabled population, and that is also responsible for poverty and the low socio-economic status in people with disabilities (Statistics SA: Census, 2001).

2.5 ACCESSIBILITY OF SERVICES

According to the National Council on Disability of South Africa (2009) problems with accessing health care are accounted for by various factors; physical barriers, provider misinformation, lack of appropriate provider training, limited medical facility accessibility, lack of equipment used by people with diverse disability, and inadequate transport. Accessibility of services for people with disabilities was also a concern in Nigeria, a developing country like South Africa (Amusat, 2009).

2.5.1 Transport

The Integrated National Disability Strategy of South Africa (1997) recommends a flexible and accessible public transport system which should help enhance the livelihood of people with disabilities by enabling them to access services such as shops, recreational places and schools and not only community health centres. However, South Africa is not achieving
much in terms of transport for people with disabilities; it is still not flexible and accessible. This lack of appropriate transport for people with physical disabilities is a long-standing phenomenon which has been highlighted by various authors in the past decades. Unfortunately, it poses challenges to mobility within communities including accessing health care services by people with physical disabilities. Transport problems are seen to interfere with attendance of and follow-up rehabilitation sessions not only in community health centres but in hospitals. It is costly to pay transport fees to every session including follow-up and as a result follow-up visits are not honoured. People would opt to stay home instead, irrespective of whether the follow-up visit was in the hospital or primary health centres, due to transport challenges (Kahonde, Mlenzana & Rhoda, 2010; Urimubenshi & Rhoda, 2011).

Transport and physical access to rehabilitation services at community centres in Cape Town were challenges encountered by people with physical disability. Overcrowding and failure to stop for people with disabilities by taxis and buses make access to this form of public transport problematic. People with disabilities in this part of South Africa hired transport from neighbours at a fee as an alternative and a special form of transport that delivers them to healthcare facilities. This is normally higher than the fee charged by taxis and buses and has financial implications for people with disabilities who rely solely on disability grants for their livelihood (Kahonde, Mlenzana & Rhoda, 2010).

Distance to the health facilities for rehabilitation services was another reason that made transport a need since these were far from where people with disabilities lived and forced them to use transport to reach the facilities, which not all people with disabilities could afford (Urimubenshi & Rhoda, 2011). According to Elrod and De Jong (2008), rehabilitation services are essential and need to be accessible to people with disabilities if they are to reap the benefits linked with rehabilitation such as attainment of functional independence which can potentially liberate a person with disability.
2.6 ENVIRONMENTAL BARRIERS TO REHABILITATION

Design practitioners, landscape architects, city transportation planners, developers and contractors are deemed to be important players in creating built environments to alleviate disabilities. They are, however, advised to involve people with mobility disabilities when drawing buildings plans so as to construct buildings that facilitate mobility (Gray, Gould & Bickenbach, 2003). The built environment poses a challenge to people with disabilities; this includes public health facilities, private clinics and doctors’ surgeries as well as health fitness centres (Jones & Tamari, 1997; Rivano-Fisher, 2004).

Barriers identified as affecting people with disability are provider misinformation, lack of appropriate provider training, limited health facility accessibility, lack of examination equipment appropriate for people with diverse disabilities and inadequate transport. Barriers in the physical environment encountered by people with disabilities are narrow doors, lack of ramps and small spaces dedicated for rehabilitation, toilet with no wall bars, limited space and no hand rails in the toilet and lack of appropriate transport for people with disabilities. This makes accessibility to healthcare services for people with disability a challenge (Ager & Pepper, 2005; Department of Health, South Africa, 2008; Kahonde, et al., 2010; National Council on Disability, 2009; Rimmer et al. 2008; Rivano-Fisher, 2004). Morrison, George and Mosqueda (2008) report that people with disability wish to have certain aspects included in the physical environment of primary health care facilities. These include among others disability parking, wide automatic/automated doors, large rooms, high-low tables, in order to reduce barriers to access to primary health care facilities.

Pan et al. (2006) report a limited number of primary healthcare centres and number of staff delivering the rehabilitation services as factors that influence utilisation of these services at community level in China. The lack of rehabilitation therapists and disproportional
distribution thereof were seen to limit access needs for rehabilitation in Nigeria by Amusat (2009). Soshanguve and Winterveldt have 10 primary healthcare centres which render rehabilitation care for people with disabilities in these two townships for a population of over a million. It is therefore clear that overcrowding exists in these centres and that puts a great strain on the staff employed to render services in these communities.

The opinions and experiences of other service recipients about the choice of health care is influenced by the opinions and experiences of others. Users are able to delay getting treatment until they hear of a provider with a good reputation. This is usually realized if the centre has a full complement of rehabilitation providers, accessible premises and enough rehabilitation space. Furthermore, users would not use the services if they perceive providers do not have enough time to attend to them, expertise and effective intervention (Ager & Pepper, 2005; Mukhalo, 2009).

It is also observed that the perceptions of community members in Indonesia affected their decision of which health facilities to use. Their view was hospital services render better quality services than primary healthcare centres which are perceived to be suitable to cure only minor ailments such as the common cold and they therefore preferred using hospital services rather than primary health care centre services (Lee et al., 2011; Triratnawati, 2006).

There were, however, health facilities and other buildings which had some facilities in the built environment such as ramps including hand rails, accessible parking space, parking areas close to entrances, which encouraged use by people with disabilities and therefore made them accessible to people with disabilities (Kahonde, et al., 2010; Rivano-Fisher, 2004).
2.7 AWARENESS ABOUT COMMUNITY BASED REHABILITATION SERVICES WITHIN COMMUNITIES

Community based rehabilitation has several benefits but awareness of such benefits to people with disability is lacking and needs to increase, as this may assist people with disability to develop a sense of identity as people with disabilities (Peat, 1997). People with disabilities not only lack awareness about the benefit of community based rehabilitation but also lack of awareness about the available rehabilitation services, particularly those which are rendered within primary health centres. This was observed in Seoul by Lee et al. (2011) who recommend that health professionals should actively promote and educate people with disabilities and potential users about rehabilitation services rendered in primary health centres and the community in order to increase awareness.

The lack of awareness about rehabilitation services based in primary health centres seems to contribute to greater use of hospital services by community members including people with disabilities. This lack of awareness is caused by lack of promotion, preference of rehabilitation centres as opposed to primary health centres by people with disabilities, and fixed ideas or prejudices about rehabilitation services at primary health centres (Lee et al., 2011).

This lack of awareness about community based rehabilitation services is seen to be amongst the reasons for low utilisation of these services by caregivers and their loved ones with disabilities (Salojee et al., 2007).

2.8 CHALLENGES FACED BY COUNTRIES REGARDING COMMUNITY BASED REHABILITATION

There are challenges which several countries experience regarding community based rehabilitation. Cheausuwantavee (2005) notes the following in Thailand: lack of community
concern on disabilities, financial support, skills and knowledge on rehabilitation, continuity and evaluation system, limitation of transportation and service delivery, low self-empowerment and psychological weakness of people with disabilities, and poverty.

China’s community participation in community based programmes is not easily achieved particularly if these programmes are initiated by ordinary people at grass-roots level. Programmes flourish only when they are initiated and managed by high ranking officials. Moreover disability and community based rehabilitation does not feature on China’s national agenda for programmes that feature at community level (Purves, 2000).

The understanding of disability in South Africa’s situation is limited; there is no understanding of the outcomes of community based rehabilitation and rehabilitation in practice is not recognised as an enabling process. Training of mid-level workers is inappropriate if they are to effectively work with disability related matters. Training of occupational therapy technicians focuses on the health of people with disabilities instead of equalization of opportunities and social integration. This falls away from the intent of community based rehabilitation which should promote poverty alleviation, community participation, economic empowerment, and the development and survival of people with disabilities as a strategy within community development. The profile of community based rehabilitation should be raised in South Africa (Rule et al., 2006).
CHAPTER III
RESEARCH DESIGN AND METHODOLOGY

The chapter discusses the methodology used in data collection and data analysis including measures taken to ensure validity and reliability.

3.1 STUDY DESIGN

A retrospective quantitative descriptive design was used to gather information in the study. Numeric and quantifiable data was used. The variables were not manipulated by the researcher but were studied as they existed and conclusions were presented without making unfounded statements (Leedy & Omrod, 2005).

3.2 SETTING FOR THE STUDY

The study setting was the rehabilitation departments (Physiotherapy, Speech and Audiology, Occupational Therapy and Human Nutrition) of Dr George Mukhari Hospital in Gauteng Province. Dr George Mukhari is a 1500-bed referral hospital located in Ga-Rankuwa 32 km north of Pretoria. It is the only tertiary hospital situated close to Soshanguve (20 – 30 km) and Winterveldt (40 km). There are eight (8) clinics in Soshanguve Township and two (2) clinics in Winterveldt, which offer rehabilitation services.

The Soshanguve and Winterveldt communities have primary health facilities that offer rehabilitation services for people with disabilities. The five main clinics in Soshanguve township which offer rehabilitation services are; clinic III, clinic II, Boikhutsong clinic, Maria Rantho clinic, KT Motubatse clinic and an additional three, Block X clinic, Block JJ and Block TT which are outreach clinics. Winterveldt on the other hand has Kgabo clinic as the main clinic for rehabilitation services and Dube clinic as an outreach clinic. The services in Kgabo clinic in Winterveldt are rendered daily except on Thursday by twelve (12)
rehabilitation personnel: community rehabilitation workers (3), speech therapist (1), occupational therapist (1), occupational therapy assistants (3), occupational therapy technician (1), podiatrist (1), social worker (1) and physiotherapist (1)). Dube clinic rehabilitation services are offered by an occupational therapist (1), occupational therapy assistant (1), physiotherapist (1), podiatrist (1) and a social worker all from Kgabo clinic on Fridays only. The services in Soshanguve Township are rendered on specific days of the week in five different clinics by a team of rehabilitation personnel. The outreach clinics with few rehabilitation personnel who come from the main clinics are Block JJ clinic and Block X clinic. Clinic III and clinic II have seven rehabilitation personnel: physiotherapist (1), occupational therapist (1), occupational therapy assistants (2), podiatrist (1), speech therapist and audiologist (1) and social worker (1). Boikhutsong clinic has 6 rehabilitation personnel: physiotherapist (1), occupational therapist (1), occupational therapy assistants (2), podiatrist (1) and social worker (1). KT Motubatse has 6 rehabilitation personnel: physiotherapist (1), occupational therapist (1), occupational therapy assistants (1), audiologist (1) and social worker (1), psychologist (1). Maria Rantho clinic has five rehabilitation personnel: physiotherapist (1), occupational therapist (1), occupational therapy assistants (1), podiatrist (1), social worker (1). Block TT clinic has 6 rehabilitation personnel: physiotherapist (1), occupational therapist (1), occupational therapy assistants (1), podiatrist (1), audiologist (1) and social worker (1). Furthermore, the teams in Soshanguve Township dedicate a week in a month to do home visits and in that week rehabilitation services are not rendered at the primary health centres.

The estimated number of people residing in Soshanguve is 612000 and of Winterveldt is 191511 according to Census South Africa of 2001 and both populations are still growing.
3.3 STUDY POPULATION

The study population comprised all patients with disabilities who are able to communicate and comprehend, and caregivers of paediatric patients with disabilities who reside in Soshanguve and Winterveldt townships and were attending rehabilitation sessions in the Physiotherapy, Speech Therapy and Audiology, Occupational Therapy and Human Nutrition departments of Dr George Mukhari Hospital in 2011. An average number of 193 patients were treated by the rehabilitation providers at Dr George Mukhari Hospital from June 2010 to October 2011, the majority of whom reside in Winterveldt and Soshanguve.

3.4 SAMPLE SIZE

An estimated sample size was calculated using Epi-Info 3.5, power of 90% at the confidence level of 95% and 70 participants were drawn from all rehabilitation departments i.e. Physiotherapy, Occupational and Speech Therapy and Audiology and Human Nutrition departments of Dr George Mukhari Hospital. The sample size was increased by 10% of 193 to 89 to allow for spoilt questionnaires.

3.5 SAMPLING PROCEDURE

A convenience sampling procedure was used to select the participants of the study into each of the four departments that formed a stratum. The number of participants depended on the number of patients who were seen in each department per month. The Physiotherapy Department saw 104 patients therefore 48 participants were selected, Occupational Therapy 31 patients and therefore 14 participants were selected, Speech Therapy Department 50 patients and therefore 23 participants were selected and then Human Nutrition department saw 8 patients per month and therefore 4 participants were selected into the study.
3.5.1 Inclusion criteria

The participants of the study were patients with disabilities who were able to communicate, comprehend and who could read and caregivers of paediatric patients with disabilities who resided in Soshanguve and Winterveldt, and were attending rehabilitation sessions in Physiotherapy, Speech and Audiology, Occupational Therapy and Human Nutrition departments of Dr George Mukhari Hospital.

3.5.2 Exclusion criteria

The study excluded all patients with disabilities who did not reside in Soshanguve and Winterveldt, and were attending rehabilitation sessions in Physiotherapy, Speech and Audiology, Occupational Therapy and Human Nutrition departments of Dr George Mukhari Hospital.

3.6 DATA COLLECTION

3.6.1 Data collection instrument

A self-constructed structured questionnaire with closed and open ended questions was used to collect data in the study. The questionnaire comprised three sections. Section A included questions about the socio-demographic information; Section B comprised questions on the awareness about rehabilitation services in the community health centres. Section C was on the attitudes of patients towards the rehabilitation services rendered in the community clinics for patients with disabilities who have used the services before in the clinics and are now using Dr George Mukhari Hospital rehabilitation services. Section D was on the environmental barriers in the clinics which render rehabilitation services. The questionnaire was translated into Setswana, the language commonly used in the Soshanguve and Winterveldt communities.
A checklist was used to collect information regarding accessibility of the clinics where rehabilitation services were rendered in the Soshanguve and Winterveldt communities.

### 3.6.2 Data collection methods

#### 3.6.2.1 Recruitment

Participants were recruited from the outpatient section of Physiotherapy, Occupational Therapy, Speech Therapy and Audiology and Human Nutrition departments at Dr George Mukhari Hospital as patients with disabilities and caregivers for children with disabilities who came for rehabilitation in the above-mentioned departments. The patients with disabilities and the caregivers of children with disability were informed of their right to participate or not. Patients with disabilities and caregivers of children with disabilities who were interested, volunteered and consented to participate in the study were recruited as participants in the study on the day of consultation.

A copy of the proposal, a permission letter from the rehabilitation manager, a clearance certificate from the Medunsa Research Ethics and Clearance Committee (MREC) were submitted to the head of rehabilitation at the clinic. An appointment with the head of rehabilitation was secured. The study and the objectives thereof were explained and the head of rehabilitation who volunteered to participate in the study agreed to be contacted at the time of data collection.

#### 3.6.2.2 Data collection process

Data was collected in the months of June to October 2011. The researcher was called to a concerned department on the day for a patient or a caregiver for a child with disability who came for consultation and was residing in either Soshanguve or Winterveldt communities. An explanation about the study and its objectives was given by the researcher in addition to
giving or reading the information leaflet to patients. Patients with disabilities and caregivers of children with disabilities who were recruited into the study and were willing and volunteered to participate in the study on the day of consultation were taken to a separate place/room for privacy. They were given consent forms to complete and the consent forms were placed by the participants inside a box marked for this purpose. Participants who were able to read and write were given the questionnaire to complete on their own. Participants who could not read and write but who could comprehend and speak were asked questions by the researcher who then completed the questionnaire on their behalf. The completed questionnaires were placed inside a separate box provided. The data was collected on the day of the appointment with the respective department and at a point where participants were waiting to receive treatment or after treatment.

The data collection took place on Mondays and Thursdays for caregivers of children with disabilities since the clinic was open on these days. The data collection for adult patients with disabilities was done on Wednesdays, Thursdays and Fridays since their appointments were on those days.

The data collection using the checklist was done at the following clinics within the Soshanguve and Winterveldt communities respectively: Clinic III, Clinic II, Maria Rantho, KT Motubatse and Boikhutsong. The heads of rehabilitation at the clinics who gave consent to participate in the study completed the checklist and the researcher took measurements for the size of the area designated for rehabilitation using a tape measure and noted the width and the length of the rehabilitation area.

The researcher observed during data collection that there was an overlap in the services that patients with disabilities received; some of the patients with disabilities received a combination of rehabilitation services not only one service.
3.6.2.3 Pre-testing

The checklist and the questionnaire were pre-tested in order to increase their content validity. Clinicians who have experience and expertise in the field of rehabilitation were given the checklist and the questionnaire for pre-testing and the following questions were added and corrected from the findings of the pre-testing. According to Demaio, Willimack and Ingold (2006) if there is insufficient evidence about how well a question performs, it must be subjected to some form of questionnaire pre-test.

3.6.2.4 Piloting the instrument

A pilot study was conducted on five patients who consulted at Dr George Mukhari Hospital for rehabilitation services and who met the inclusion criteria but who were not made part of the study ultimately. The checklist was piloted at Phedisong 4 clinic in Ga-Rankuwa, Gauteng Province, one of the clinics which renders rehabilitation services and falls within the demarcations of Gauteng Province and shares the same criteria as clinics in the study (patients with disability). Piloting of the questionnaire and the checklist was done and changes were effected according to recommended changes.

3.7 DATA CAPTURING AND ANALYSIS

3.7.1 Data capturing

Data was captured in an Excel spreadsheet and presented in the forms of graphs, charts and frequencies.

3.7.2 Data analysis

Data was cleaned and coded before an analysis was conducted. Captured data was imported to Statistical Package for the Social Sciences (SPSS) version 20.0 for analysis.
Descriptive statistics was used to summarize the responses. Measures of central tendency (mean, median and mode) frequency and percentages were calculated.

For categorical data the frequency of responses to each question and percentage of the total sample was calculated.

A Chi-squared test was used to examine relations between categorical data (two or more sets of responses) to test if they are independent of each other.

3.8 RELIABILITY AND VALIDITY

All participants were asked the same questions in the same manner and for close-ended questions all participants were required to choose among the same alternative answers. For open-ended questions, the participants’ responses formed themes.

Internal and external validity was maintained using a questionnaire as it is able to reduce the Hawthorne effect. For face validity a questionnaire was used and recording was done according to the participants’ responses without altering what was said or chosen.

All the participants answered the same questionnaire which has precisely the same number of questions. The checklist was completed by the heads of the rehabilitation section in the clinics since they are knowledgeable about the rehabilitation service facility.

3.9 BIAS

Pre-testing was done to help identify questionnaire problems and was undertaken to determine clarity of questions, their relevance, completeness, consistency and the time required to complete the questions.

Bias could occur when explanations are given to participants during the data collection and this was minimized by translating the questionnaire into Setswana. Questions were read
exactly the way they were structured to avoid researcher bias and this was done for participants who could not read and write.

3.10 ETHICAL CONSIDERATIONS

Ethical approval to conduct the study was obtained from the Medunsa Research and Ethics Committee (MREC) of the University of Limpopo, Medunsa Campus. Permission to conduct the study was sought from the chief executive officer of Dr George Mukhari Hospital, the manager of the Gauteng North Rehabilitation Services and heads of the following departments: Physiotherapy, Occupational Therapy and Speech and Audiology before the study was conducted.

Other ethical considerations that were observed in the study were informed consent from participants. The choice to participate in the study by a participant was based on sufficient information provided by the researcher and not coercion. Participation in the study was voluntary and participants had a right to withdraw from the study at any time. The participants’ written informed consent was obtained after they volunteered to be part of the study. The confidentiality of the participants was assured by informing them that they would not be identified in any published work that emanated from the study. The anonymity of participants was ensured in that the questionnaires and consent did not demand that the participants’ names or their identity be revealed in the study.
CHAPTER IV
RESULTS

4.1 INTRODUCTION

The chapter presents and describes quantitative research findings of the data collected in the study. It comprises four sections: the socio-demographic characteristics of people with disabilities of the study sample (N=89), awareness about availability of rehabilitation services in the community healthcare centres, perceptions of people with disability towards the community health centres and the environmental barriers affecting access to rehabilitation within healthcare centres.

4.2 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF PEOPLE WITH DISABILITIES

Table 4.1: Demographic profile of participants, % in rows

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequencies</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N=89</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>( \mu =2.93 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>( \sigma =2.22 )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 – 10 years</td>
<td>45</td>
<td>50.60</td>
</tr>
<tr>
<td>21 – 30 years</td>
<td>10</td>
<td>11.20</td>
</tr>
<tr>
<td>31 – 40 years</td>
<td>11</td>
<td>12.40</td>
</tr>
<tr>
<td>41 – 50 years</td>
<td>6</td>
<td>6.70</td>
</tr>
<tr>
<td>&gt;50 years</td>
<td>17</td>
<td>19.10</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>50</td>
<td>56.20</td>
</tr>
<tr>
<td>Female</td>
<td>39</td>
<td>43.80</td>
</tr>
<tr>
<td><strong>Disability grant</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>42</td>
<td>47.20</td>
</tr>
<tr>
<td>No</td>
<td>47</td>
<td>52.80</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n = 44)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not married</td>
<td>25</td>
<td>56.81</td>
</tr>
<tr>
<td>Married</td>
<td>19</td>
<td>43.18</td>
</tr>
<tr>
<td><strong>Educational status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=44)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No school</td>
<td>5</td>
<td>11.36</td>
</tr>
<tr>
<td>Primary school</td>
<td>14</td>
<td>31.81</td>
</tr>
<tr>
<td>Secondary school</td>
<td>17</td>
<td>38.63</td>
</tr>
</tbody>
</table>
Table 4.1 shows that half of the participants (50.6%) were under 10 years of age, more males (56.2%) than females (43.8%) and 52.8% of the participants did not receive disability grants. Most of the participants presented with hemiplegia (44.9%) and cerebral palsy (36.9%). Eighty five percent (85%) of the participants were from Soshanguve and 15% were from Winterveldt community and most of participants (67.40%) used taxis, followed by those who used hired cars (19.10%) and then those who used their own cars (13.50%) to travel to the hospital. Most of the participants (67.4%) paid less than R50 for transport. Of the 44 adult participants, 43.18% were married and 56.72% were unmarried. The level of education ranged from 43.17% with no schooling or primary school to 56.8% with secondary school or tertiary level. Of the 34 adult participants, 83.25% were unemployed.
The figure 4.1 shows that most of the participants (44.9%) presented with hemiplegia and cerebral palsy (40.4%) and 14.6 with spinal conditions.

Table 4.2: Gender versus disability (% in rows)

<table>
<thead>
<tr>
<th>Disabilities</th>
<th>Gender</th>
<th>( \bar{X} )</th>
<th>P values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male n(%)</td>
<td>Female n (%)</td>
<td></td>
</tr>
<tr>
<td>Hemi (n=40)</td>
<td>25(62.50)</td>
<td>15(37.50)</td>
<td>( \bar{X} = 5.897 )</td>
</tr>
<tr>
<td>CP (n = 36)</td>
<td>21 (58.33)</td>
<td>15(41.66)</td>
<td>P = 0.207</td>
</tr>
<tr>
<td>Spinal (n = 13)</td>
<td>4(30.76)</td>
<td>9(69.23)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>50(56.18)</td>
<td>39(43.82)</td>
<td></td>
</tr>
</tbody>
</table>

The table 4.2 shows that 25 (62.5%) males compared to 37.50% females presented with hemiplegia; 58.33% males compared to 41.66% females presented with cerebral palsy (CP) and 9 (69.23%) females compared to 30.76% males presented with spinal conditions. These
results show no significant differences in disability distribution according to gender (p = 0.207).

Table 4.3: Disability versus type of transport used (% in rows)

<table>
<thead>
<tr>
<th>Disabilities</th>
<th>Transport</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Taxi n(%)</td>
<td>Hired car n(%)</td>
<td>Own car n (%)</td>
<td></td>
</tr>
<tr>
<td>Hemi (n=40)</td>
<td>25(62.50)</td>
<td>10(25.00)</td>
<td>5(12.50)</td>
<td></td>
</tr>
<tr>
<td>CP (n = 36)</td>
<td>32(88.88)</td>
<td>0(0.00)</td>
<td>4(11.11)</td>
<td></td>
</tr>
<tr>
<td>Spinal (n = 13)</td>
<td>5(38.46)</td>
<td>5(38.46)</td>
<td>3(23.07)</td>
<td></td>
</tr>
</tbody>
</table>

The table 4.3 shows that the majority of participants (n = 62; 70%) used taxis (combi) to the hospital, irrespective of the type of disability. Most CPs (88.88%) and hemiplegic patients (62.5%) and 38.46% of spinal patients used taxis (combi), 25% of Hemiplegics and 38.46% spinal patients used hired cars, and 23% of spinal patients and 11% of CP and 12.5% of hemiplegics use their own transport.
Table 4.4: Rehabilitation departments visited by the participants

<table>
<thead>
<tr>
<th>Disabilities</th>
<th>Occupational therapy only n(%)</th>
<th>Physiotherapy only n(%)</th>
<th>Speech therapy only n(%)</th>
<th>Combination of departments. N(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemi (n=40)</td>
<td>8(20.0)</td>
<td>18(45.0)</td>
<td>6(15.0)</td>
<td>8(20.0)</td>
</tr>
<tr>
<td>CP (n = 36)</td>
<td>4(11.11)</td>
<td>13(36.11)</td>
<td>2(5.55)</td>
<td>17(47.22)</td>
</tr>
<tr>
<td>Spinal(n = 13)</td>
<td>1(7.69)</td>
<td>9(69.23)</td>
<td>0(0.00)</td>
<td>3(2.30)</td>
</tr>
<tr>
<td>Total</td>
<td>13(14.6)</td>
<td>40(45.0)</td>
<td>8(9.0)</td>
<td>12(13.5)</td>
</tr>
</tbody>
</table>

Table 4.4 shows that 45% of the participants attended physiotherapy, 14.6% attended occupational therapy, 13.5% a combination of departments, and the least speech therapy (9.0%). Most hemiplegics and spinal patients attended physiotherapy (45% and 69.23% respectively); 47.2% of CPs attended a combination of departments.

Figure 4.2: Frequency of visits to rehabilitation services
Figure 4.2 indicates that 65.2% of participants attended rehabilitation services once a month followed by 23.6% of those who attended rehabilitation more than 3 times a month and the least were those who attended 3 times a month (2.2%).

Table 4.5: Disability grant versus type of transport used (% in rows)

<table>
<thead>
<tr>
<th>Disability grant</th>
<th>Transport</th>
<th>P-values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Taxi n (%)</td>
<td>Hired car n (%)</td>
</tr>
<tr>
<td>Has disability grant (n = 47)</td>
<td>31(65.95)</td>
<td>9(19.14)</td>
</tr>
<tr>
<td>No disability grant (n = 42)</td>
<td>29(69.04)</td>
<td>8(19.04)</td>
</tr>
<tr>
<td>Total</td>
<td>60(67.4)</td>
<td>17(19.1)</td>
</tr>
</tbody>
</table>

Table 4.5 shows that a total of 60 (67.4%) of participants used taxis to travel to the hospital irrespective of whether they received a disability grant or not. There was no significant difference between the type of transport used and whether one has a disability grant or not (P=0.195).
4.3 AWARENESS ABOUT AVAILABILITY OF REHABILITATION SERVICES IN THE COMMUNITY

![Awareness about the availability of rehabilitation services](image)

Figure 4.3: Awareness about availability of rehabilitation services

Figure 4.3 shows that 78% of the participants were not aware that there were rehabilitation services within their communities whilst 22% were aware of these services. Of those who are aware (n = 20) 16 (80%) had used the services before and 4 (20%) did not use the services.
Table 4.6: Reasons for not using rehabilitation services in the community (% in columns)

<table>
<thead>
<tr>
<th>Reason</th>
<th>N</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient equipment</td>
<td>16</td>
<td>2</td>
<td>(10.00)</td>
</tr>
<tr>
<td>Not enough staff</td>
<td>16</td>
<td>2</td>
<td>(10.00)</td>
</tr>
<tr>
<td>Services not rendered daily</td>
<td>16</td>
<td>1</td>
<td>(5.00)</td>
</tr>
<tr>
<td>Referred to Dr George Mukhari Hospital</td>
<td>16</td>
<td>7</td>
<td>(35.00)</td>
</tr>
<tr>
<td>Combination of reasons</td>
<td>16</td>
<td>5</td>
<td>(25.00)</td>
</tr>
<tr>
<td>Mixed clinic and hospital services</td>
<td>16</td>
<td>2</td>
<td>(10.00)</td>
</tr>
<tr>
<td>Clinic is not accessible</td>
<td>16</td>
<td>1</td>
<td>(5.00)</td>
</tr>
</tbody>
</table>

Table 4.6 shows that of 80% of the participants who discontinued using rehabilitation services in the community clinics, 35% were referred to Dr George Mukhari Hospital by the centres and 25% had a combination of reasons and an average of 10% reported that the clinics did not have sufficient equipment, not enough staff and some were mixing clinic and hospital services.

Table 4.7: Reasons for seeking rehabilitation services in Dr George Mukhari Hospital (% in rows)

<table>
<thead>
<tr>
<th>Reasons</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was admitted to hospital and referred internally</td>
<td>78</td>
<td>(87.60)</td>
</tr>
<tr>
<td>Services are better</td>
<td>2</td>
<td>(2.22)</td>
</tr>
<tr>
<td>Have sufficient equipment</td>
<td>2</td>
<td>(2.22)</td>
</tr>
<tr>
<td>Combination of reasons</td>
<td>7</td>
<td>(7.90)</td>
</tr>
</tbody>
</table>
Table 4.7 shows that 87.60% of participants were referred internally to rehabilitation departments in Dr George Mukhari Hospital, 7.9% had a combination of reasons and 2.2% reported that services were better and there was sufficient equipment at the hospital.

### 4.4 PERCEPTIONS ABOUT REHABILITATION SERVICES IN COMMUNITY

Table 4.8: Self-reported perceptions about clinic rehabilitation activities (n=16; % in rows)

<table>
<thead>
<tr>
<th>Statements</th>
<th>Agree n (%)</th>
<th>Neutral n (%)</th>
<th>Disagree n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic has sufficient staff</td>
<td>4(25.0)</td>
<td>2(12.5)</td>
<td>10(62.5)</td>
</tr>
<tr>
<td>Clinic has sufficient equipment</td>
<td>3(18.8)</td>
<td>3(18.8)</td>
<td>10(62.5)</td>
</tr>
<tr>
<td>Services are rendered daily</td>
<td>1(6.3)</td>
<td>1(6.3)</td>
<td>14(87.5)</td>
</tr>
<tr>
<td>Clinic provides assistive devices</td>
<td>6(37.5)</td>
<td>0</td>
<td>10(62.5)</td>
</tr>
<tr>
<td>Patient involved in decision making</td>
<td>9(56.3)</td>
<td>2(12.5)</td>
<td>5(31.3)</td>
</tr>
<tr>
<td>Family involved in decision making</td>
<td>6(37.5)</td>
<td>2(12.5)</td>
<td>8(50.0)</td>
</tr>
<tr>
<td>Rehab services help me to play an active part of my community</td>
<td>7(43.8)</td>
<td>1(6.3)</td>
<td>8(50.0)</td>
</tr>
<tr>
<td>Community participates in rehabilitation activities</td>
<td>5(31.3)</td>
<td>1(6.3)</td>
<td>10(62.5)</td>
</tr>
</tbody>
</table>

Table 4.8 shows that of those participants (n=16) who reported that they have been to the clinic, 62.5% perceive that there is insufficient staffing, insufficient equipment and insufficient assistive devices in the clinics. 87.5% of participants also report that rehabilitation services are not rendered daily in the clinics. Most participants (56.3%) agreed
that they are involved in decision making about their rehabilitation, but not their family (50.0%) and community (62.5%).

4.5 ENVIRONMENTAL BARRIERS AFFECTING ACCESS TO PRIMARY HEALTH CENTRES

Table 4.9: Accessibility of the clinics

<table>
<thead>
<tr>
<th>Variables</th>
<th>Clinic</th>
<th>Soshangwe clinics n=8 clinics</th>
<th>Winterveldt clinics n=2 clinics</th>
<th>Accessibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance to clinic from drop off point</td>
<td>Near the clinic</td>
<td>6 (75.0)</td>
<td>2 (100.00)</td>
<td>Accessible</td>
</tr>
<tr>
<td></td>
<td>Far from the clinic</td>
<td>2 (25.0)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Toilet with wall bars</td>
<td>Has</td>
<td>2 (25.0)</td>
<td>0</td>
<td>Not accessible</td>
</tr>
<tr>
<td></td>
<td>Does not have</td>
<td>6 (75.0)</td>
<td>2 (100)</td>
<td></td>
</tr>
<tr>
<td>Toilet flush control</td>
<td>Has</td>
<td>1 (13.5)</td>
<td>0</td>
<td>Not accessible</td>
</tr>
<tr>
<td></td>
<td>Does not have</td>
<td>7 (87.5)</td>
<td>2 (100)</td>
<td></td>
</tr>
<tr>
<td>Ramps</td>
<td>Has</td>
<td>7 (87.5)</td>
<td>0</td>
<td>Accessible</td>
</tr>
<tr>
<td></td>
<td>Does not have</td>
<td>1 (13.5)</td>
<td>2 (100)</td>
<td></td>
</tr>
<tr>
<td>Ramps with hand rails</td>
<td>Has</td>
<td>2 (25.0)</td>
<td>0</td>
<td>Not accessible</td>
</tr>
<tr>
<td></td>
<td>Does not have</td>
<td>6 (75.0)</td>
<td>2 (100)</td>
<td></td>
</tr>
<tr>
<td>Loading zone for people with disabilities</td>
<td>Has</td>
<td>5 (62.5)</td>
<td>2 (100)</td>
<td>Accessible</td>
</tr>
<tr>
<td></td>
<td>Does not have</td>
<td>3 (37.5)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Loading zone next to accessible entrance</td>
<td>Has</td>
<td>5 (62.5)</td>
<td>1 (50.0)</td>
<td>Accessible</td>
</tr>
<tr>
<td></td>
<td>Does not have</td>
<td>3 (37.5)</td>
<td>1 (50.0)</td>
<td></td>
</tr>
<tr>
<td>Parking bay for people with disabilities</td>
<td>Has</td>
<td>4 (50.0)</td>
<td>2 (100)</td>
<td>Accessible</td>
</tr>
<tr>
<td></td>
<td>Does not have</td>
<td>4 (50.0)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Parking bay sign posted for people with disabilities</td>
<td>Has</td>
<td>2 (25.0)</td>
<td>2 (100)</td>
<td>Not accessible</td>
</tr>
<tr>
<td></td>
<td>Does not have</td>
<td>6 (75.0)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Door frame size allowing entrance to the building</td>
<td>Has</td>
<td>6 (75.0)</td>
<td>2 (100)</td>
<td>Accessible</td>
</tr>
<tr>
<td></td>
<td>Does not have</td>
<td>2 (25.0)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Automatic doors</td>
<td>Has</td>
<td>0</td>
<td>0</td>
<td>Not accessible</td>
</tr>
</tbody>
</table>
Table 4.9 shows that of the 13 aspects used to determine accessibility, 54% of clinics were accessible in terms of distance to clinic from drop off point (80%); presence of ramps (87%); loading zone for people with disabilities (70%) and has rehabilitation personnel (90%). Forty six percent (46%) of clinics were not accessible in terms of access to toilet, lack of hand rails, and small space for rehabilitation.
CHAPTER V:
DISCUSSION

5.1 INTRODUCTION

This chapter discusses the research findings which aimed at determining factors that influenced the utilisation of community based rehabilitation services by people with disabilities in the Soshanguve and Winterveldt communities, South Africa. This chapter also includes a conclusion and recommendations. The discussion is based on the results that address the objectives of the study.

5.1.1 The socio-demographic characteristics of participants

The results of this study show that of the 89 participants, 50% were children under 10 years of age and more than two thirds of participants (85%) were from Soshanguve Township. This township has eight clinics which render rehabilitation services daily as compared to Winterveldt with only two clinics and 91511 residents (Census 2001). Soshanguve has 612000 residents and only 8 clinics to cater for the healthcare services for this community. Rehabilitation staff are shared among clinics, therefore, it is possible that rehabilitation staff in these clinics are overwhelmed by the number of patients to whom they render services on a daily basis. However, it is a concern that patients from this township would opt to pay large sums of money, some up to R200 for transport for 1 hospital visit ±35km away to seek similar services that are already available in their local clinics. Islam and Aktar (2011) report that there is a relationship between the distribution of the population and the supply of health care facilities which implies that the number of health care facilities and staffing within a community should match the size of that particular community’s population which, regrettably, is not the case in Soshanguve and Winterveldt. It is for this reason that most patients prefer to seek rehabilitation in bigger healthcare centres such as a hospital.
The results of the study show participants presented with a variety of disabilities and over three quarters of the participants presented with chronic neurological disorders such as hemiplegia and cerebral palsy. The results also show that most of the participants (56%) are males compared to 44% females. Similarly, several studies show that males are more prone to physical disability than females, especially hemiplegia at the rate of 2:1 in Sub-Saharan Africa (Masika & Lutala, 2011; Nordholm & Lundgren-Lindquist, 1999; Walker et al., 1999). Even among children, more boys than girls (58.3% and 41.66% respectively) under 10 years of age have cerebral palsy (CP) in this study. Ogunlesi et al. (2008) found similar results when they profiled children attending the paediatric clinic in Nigeria, further affirming that males are more affected than females. The findings of this study are contrary to South Africa’s census of 1996 and that of 2001 where it was revealed that there were more females with disabilities than males. However, the community survey of 2007 revealed that there was an equal number of males and females with disabilities nationally and in Gauteng Province. Perhaps these differences were because the sample size for this study was relatively small and considered only one hospital and two communities, whereas the census and surveys look at larger sample sizes and multiple populations. These results also highlight the need to design rehabilitation interventions that address the risk factors associated with disability according to specific gender.

Further observed in this study is that two thirds of the participants (67%) use public transport to access rehabilitation services in the hospital. There are variations in transport costs incurred by participants; participants who use taxis (combi) spend less than R50.00 as compared to those who use their cars and those who hire transport which costs up to R200 per trip to the hospital. Given the fact that more than half (52%) of participants do not receive a disability grant, transport cost can put a financial strain on breadwinners, especially when they are forced to hire private cars because public transport is not standardized to cater for the
needs of the disabled in this country. In a study conducted in Cape Town by Kahonde et al. (2010) it was reported that people with disabilities are forced to hire private transport from neighbours and the community as an alternative to the problems that they experience with the normally running public transport such as failure of buses and taxis to stop for them and overcrowding in these forms of transport as well. The fact that public transport does not cater for the disabled as revealed by Kahonde et al. 2010 further affirms the need for the disabled to use their local clinics for rehabilitation, but regrettably, that is not endorsed by the department of transport and the municipality.

The study results show that the majority of participants are unemployed and rely on disability grants and pension while those who do not receive a disability grant rely on family for financial support. It would be beneficial for them to use healthcare centres that are closer to them for rehabilitation, than commute to hospitals that are far away. Though taxis are a cheaper means of transport for these patients, the challenge is accessibility, and discrimination. South African taxis and buses are not equipped with features to load and offload disabled people and because of this, they are not willing to stop and load people with disabilities compared to the general population (Kahonde, et al., 2010). According to Rule, Lorenzo and Wolmarans (2010) people with disabilities are sometimes charged double fees in the taxi because their assistive devices such as wheelchairs need additional space. This further puts a strain on the wallet of the disabled people, who also need special care from hired caregivers, especially children and some severely disabled adults, further affirming the need for these patients to minimize cost by seeking rehabilitation in the local clinics.

Furthermore, Venter et al. (2002) report that taxis in South Africa provide better access to people with disabilities than buses, although this excludes access for assistive devices such as wheelchairs. The problem of transport access for the disabled is not only unique to South Africa; rural India and Sri Lanka have reported similar problems of inaccessibility of public
transport for people with disability (Ratnala & Vardhani, 2008). In contrast, countries like Mozambique, Malawi and rural India have reported better access to public transport because they have policies that ensure that public and private transport have seats reserved for passengers with disability and may commute free (Venter et al., 2002). It is disturbing that there are no policies in South Africa that compel public transport to be accessible to people with disability and/or exempt disabled passenger from paying for public transport including that provided by minibus taxis. There is therefore a need for the government to act and support disabled people by reinforcing policies that favour the disabled in terms of transport access and exemption from paying for public transport irrespective of where they are going. It is indeed a fact that the participants cannot afford the cost incurred for transport, because the majority depend on a disability grant of maximum R1200 per month. In addition, some, for example all children and some adults, need a caregiver to assist with other needs and who may have to be paid from the very social grant income they receive. Therefore, it would be to their benefit to utilize the rehabilitation available in their own community.

In summary, it is a fact that patients discharged from hospitals after a few weeks or months of rehabilitation may still present with residual disabilities and hospitals cannot serve their long term rehabilitation needs (Barnes & Radermacher, 2001). It is therefore important for these patients to continue their rehabilitation within their communities to reduce the cost of transport to health institutions that are far from them. Soshanguve and Winterveldt communities have primary health centres that do provide rehabilitation services, but the study shows that some patients seek services from a hospital that is situated far from their communities, despite the existence of similar services in clinics within their communities. Also, seeing that more males than females are disabled it is important for the clinics to develop activities that are gender specific. Personal experience shows that most male patients were unhappy with activities they are taught by the rehabilitation team in the clinics, e.g.
baking and knitting, citing that those activities are for women and they therefore perceive rehabilitators as trying to look down upon them.

5.1.2 Awareness about rehabilitation services

The study results reveal that the majority (77.5%) of the participants were not aware that rehabilitation services were available at the clinics within their communities. However, this lack of awareness of rehabilitation services for people with disability is not unique to these communities in South Africa. Rimmer, Wang and Smith (2008) and Monk and Wee (2008) report similar findings in the USA and in rural Kenya where most people with disabilities were not aware of services available within their community healthcare centres, and as a result did not use them. One of the roles of healthcare workers (rehabilitation team) is to empower communities with knowledge about what services they render within their clinics. However, it looks as if this is not happening and as a result disabled people seek rehabilitation in hospitals that are far from them. Again, this lack of awareness of services for people with disability is not only unique to people with disabilities. Monk and Wee (2008) made a survey in the general population in Western Kenya to determine the awareness and availability of rehabilitation services within communities and found that only 36% were aware that rehabilitation services exist within the community healthcare centres. It is therefore essential that rehabilitators increase awareness about their services so that they are utilized maximally within communities.

Lack of awareness about rehabilitation services was mentioned as the reason for low utilisation of available rehabilitation services for children with disabilities in Orange Farm, an informal settlement in South Africa. Besides lack of awareness, caregivers of children with disabilities stated other reasons for non-utilisation of rehabilitation services such as lack of money for transport, difficulties in accessing transport, no improvement in the child despite
therapy and lack of awareness that the child could benefit from therapy (Salojee et al., 2007).

It is also the responsibility of therapists to make caregivers aware of the functional outcomes of their children and design home activities that will be continued in their homes.

This lack of awareness by both disabled people and the general population indicates that a large number of people who need help travel a long distance to hospitals to seek for help they could easily access within their community setting. It is therefore the duty of a community rehabilitation team to raise awareness about the services they render so that people who need these services can access them.

The study results also showed that 22% of participants who were aware on the availability of rehabilitation services within their community opted not to use them. Some of the patients who have used these rehabilitation services within their community opted to be treated in the hospitals for reasons such as inaccessibility of clinics, lack of staffing, referral to Dr. George Mukhari hospital, services which are not rendered daily, insufficient equipment and so on. In other words, their awareness did not influence their decision to use these services within the community. Similarly, Lee et al. (2011) also find that people with disabilities in China prefer to use hospitals and larger rehabilitation centres for rehabilitation and do not know about the availability of community based rehabilitation services at the primary health centres within their communities. The caregivers and people with disabilities in the study by Lee et al. (2011) prefer to use the hospital for rehabilitation services over those services rendered within the community’s primary health centres, a practice that is similar to that of participants in the current study, including the ones who were accompanied by caregivers and family members who sought these services at the hospital.

Several factors, such as staffing, space, no referral and attitude could have a significant impact on one’s decision of whether to use the community clinics/centres or not. The results
in this study show that among the reasons for not utilising community services are that patients who have been admitted to Dr George Mukhari Hospital have never been referred to the community healthcare centres but have been given a follow-up appointment at the same hospital. It is also possible that health professionals involved in rehabilitation at Dr George Mukhari Hospital are not aware of the scope of rehabilitation services which are rendered in clinics in the community or that there are problems with the referral system between the different levels of care. “The referral process does not simply entail transferring a patient from a lower to a higher level of care, nor does it end when a patient is discharged from a referring hospital. An effective referral system requires good communication and coordination between levels of care and support from higher to lower levels to help manage patients at the lowest level of care possible” (Hensher, Price & Adomakoh, 2006:1233).

According to the Gauteng Department of Health (2008), when a patient who has been receiving rehabilitation at a tertiary institution no longer requires management at this level, the patient is referred to the next appropriate level of service and it is the responsibility of the rehabilitation team to plan and organise the rehabilitation aspects of the transfer. This means that patients who are discharged from hospital are supposed to be down-referred, but at times that is not done and instead, patients are given a follow-up appointment to the hospital and not to the community clinic. Another possible explanation is that patients receive all services at the hospital and follow-up can be done on the same day in different departments that offer rehabilitation services, which does not apply to a clinic because some do not have the full complement of a rehabilitation team and even at a clinic where there are services, the clinic is required to share therapists, further limiting the accessibility of therapists. Lee et al. (2011) suggest additional reasons for lack of awareness about community based rehabilitation services. These are: lack of promotion of community based rehabilitation services, preference
by patients to use rehabilitation centres rather than primary health care centres and prejudices about rehabilitation services at primary health centres by people in general.

These results show that there is a gap in communication between hospital and clinic staff and this leads to hospital staff continuing to carry patient load which they could download to clinics. One cannot, however, ignore the fact that some patients prefer hospital to clinic services, where they can exercise their rights to choose the treatment centre of their choice, as stipulated in the Batho-Pele Charter on a patient’s rights. In this case, it explains why the 22.5% who were aware of the availability of these services in the community, chose to use the hospital instead of clinic services.

5.1.3 Perceptions of people with disability regarding rehabilitation services

The results of this study show that most of the participants reported that there was insufficient staffing in the clinics. The majority of the participants reported that services were not rendered daily. This was also found by Al-Oraibi et al. (2011) in Jordan, where participants of the reported limited occupational and physiotherapy services in the community. This was further confirmed by the findings of the checklist, where this study found that most rehabilitation staff were allocated to more than one clinic at which to work, making them render services on specific days at each clinic. Staff shortage and limited rehabilitation services were also reported in Jordan by Al-Oraibi et al. (2011). In this study shortage of staff could lead to staff being overworked, as they are required to commute from one clinic to another far away. In this instance, patients who seek treatment on the day when the rehabilitation team is working elsewhere will be met with a challenge as they will be forced to return to their homes without being seen by the therapist. This can therefore influence patients to return to the hospital for treatment, as they perceive there are insufficient rehabilitation services being rendered at clinics.
The results of the study show that more than two thirds of the participants reported that the rehabilitation clinics do not provide assistive devices. Bingham and Beatty (2003) in the USA find that a third of the participants with disability who have been receiving rehabilitation services and need an assistive device have not received one every time it was needed. A disability survey conducted in Nigeria in 2005 reveals that only a third of people with disability have assistive devices (Smith, 2011). There is a lack of assistive devices such as wheelchairs, walking aids and buggy for children for people with disability which may have an impact on their quality of life.

The results of the study show that half of the participants indicated that their family members are involved in the decision making process in the rehabilitation of their loved ones. This was contrary to the findings of Kahonde et al. (2010) in Cape Town where it has been found that the family was more involved in the rehabilitation of their loved ones with disability and just above half of the participants in the study reported to have been involved in the decision making process of the rehabilitation in the study, similar to the findings of Kahonde et al. (2010). The involvement of people with disabilities and family in the rehabilitation excludes participation of the community since more than two thirds of the participants report that the community is not involved in rehabilitation activities at the clinics. The involvement of people with disability, their families and the community should be more encouraged in rehabilitation as this may in turn encourage them to take ownership of the services at community level.

5.1.4 The environmental barriers affecting access to rehabilitation areas of primary health centres

The results of the study show that there were ten primary health clinics collectively which offered services to people in Soshanguve and Winterveldt. Also, staffing was found to be a
problem, because most clinics share one rehabilitation staff member, who is working on certain days in one clinic and on other days in another clinic, further making clinics inaccessible to patients and overloaded on the days when rehabilitation is accessible. People with disability have special needs, and require individual attention and at times, maximal assistance, therefore, there is a need for more rehabilitation staff to be trained and employed so that they can deliver quality service to all patients with special needs (Morrison et al., 2008).

The built environment rendered 46% of clinics inaccessible to people with disabilities in the following aspects: All clinics did not have an automated door and raised toilet seats, making it difficult for patients to enter the clinic premises and even more difficult to relieve themselves, especially if they use devices like callipers. Only one of the ten clinics had an extended toilet lever flush control and two had toilets with no wall bars for support whilst using the facility. This makes it extremely difficult for patients to use these facilities and as a result, some may end up soiling their clothes whilst trying to adjust themselves and access the toilet. Even when they eventually sit on the toilet, it is extremely difficult to stand up when there are no wall bars and, in addition, the seat is low. Patients have no choice but to ask for help from passers-by, which impairs their dignity and makes them feel helpless. The Batho-Pele Charter states that patients have a right to be treated with dignity, but this instance of the inaccessibility of clinic toilets infringes these rights. These findings are similar to those of Kahonde et al. (2010) in Cape Town health centres where disabled patients report inhibitors in the built environment such as toilets with no wall bars, limited space and no hand rails. Dr George Mukhari Hospital rehabilitation areas are different; toilets are accessible and there is enough space for wheelchair access as well.

Parking was also reported as a problem where only four of 10 clinics has a parking bay demarcated for people with disability and of these four clinics with demarcated parking, two
have a parking bay sign posted for people with disabilities. Even in these reserved parking spaces, there are challenges which emanate from the general population who illegally park in these spaces while clinic management has no mechanism in place to prohibit members of the public from parking in these designated parking spaces. The township clinics’ inaccessibility to disabled patients is not only unique in South Africa. De Silva (2010) also finds that primary health centres and their sub-centres in rural India do not have a disabled-friendly infrastructure. However, the settings where rehabilitation services were rendered which were studied regarding accessibility differed from those in the current study. Rimmer et al. (2008) focus on the accessibility of fitness facilities and health clubs in the USA. They report that the built environment is not accessible and this fact limits people with mobility and visual disabilities from accessing physical activity programmes presented within those settings.

The results of this study also show that 54% of clinics have some aspects of the built environment that make them accessible to people with disabilities. The majority of clinics (8/10) are located close to public transport drop-off points, which makes it easy for the patients to access the clinics without walking for a long distance and a lengthy time. The entrances to most clinics have ramps and a loading zone that is located next to an accessible entrance. In contrast, findings from a study in Cape Town where some of the rehabilitation centres considered accessible to people with disabilities have been built with clients in mind were compared to the clinics in the current study which could not be regarded as accessible and show that some aspects of the built environment are regarded as allowing people with disability access (Kahonde et al., 2010).

In summary, accessibility of clinics to people with disability is a serious problem, which can influence whether or not people use the rehabilitation services at that clinic. In other words, awareness alone must not be the only aspect to be considered when looking at reasons why
one does not use the clinics for rehabilitation. Accessibility of the built environment also plays an equally important role in decision-making of whether to use the clinics or not.

5.2 CONCLUSION

The objectives of the study were achieved. The findings indicate that the majority of the participants in the study were not aware of the availability of rehabilitation services in their communities. The lack of awareness about the available rehabilitation services, the presence of barriers in the built environment at the clinics, the perception that there is insufficient equipment, assistive devices, staff rendering rehabilitation services at the clinic and the limited involvement in decision making regarding rehabilitation of people with disability, family and the community within the two communities are the main factors that may be affecting the utilisation of community based rehabilitation services by people with disabilities in Soshanguve and Winterveldt communities.

5.3 LIMITATIONS OF THE STUDY

- The study focused only on people with disability who were from Winterveldt and Soshanguve. Those with disability from other communities were not part of the study and therefore the study might have missed the views of those who were excluded.

- The study focused on patients and caregivers of children with disabilities only and valuable data could have been collected from rehabilitation service providers from both the hospital and clinics within the two communities.

- Regarding the environmental barriers, the study focused on the built environment only. It could have explored a wider scope of barriers, like attitudinal and social barriers.
The study did not explore how participants who were aware of the rehabilitation services in the community got the information about the services.

5.4 RECOMMENDATIONS

- The health professionals involved in rehabilitation within primary health care centres in the community should raise the awareness of people with disabilities, their families and the community on the availability of rehabilitation services. This can be done in schools, churches, clinics, during community meetings and media (local radio stations and local newspapers).

- Rehabilitation professionals involved in Dr George Mukhari Hospital should assist in raising awareness by creating a link between the hospital and primary health care centres in the community and by referring patients in need of rehabilitation to clinics offering rehabilitation services closer to where they reside.

- Environmental barriers identified such as lack of ramps and rails, absence of wall bars, toilets without flush control, door frames not allowing access, lack of parking bay for people with disability in the primary health care centres should be addressed to ensure access for people with disabilities.

- Primary health care centre managers should consider filling more posts of rehabilitation professionals in the clinics within the community to increase the number of personnel to attend to people with disability who consult at this level of care.

- The rehabilitation professionals should consider increasing the number of working days from some of the days in the week to daily so that people who need rehabilitation or are referred to the clinics are able to find them in all the working days of the week in the clinics.
Primary health care centre managers should ensure that future centres that are built for rehabilitation are physical accessibility (all have ramps and rails, wall bars, toilets with flush control, door frames allowing access, parking bay) to people with disabilities.
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54


APPENDIX A

QUESTIONNAIRE

Thank you for taking your time to answer the questions contained in this questionnaire. Agreeing to answer questions indicates that you are giving consent to participate in the study as explained to you.

Please read the questions below and mark with an X in the box, fill in what is missing and specify where necessary. Skip questions that are not applicable to you.

SECTION A

SOCIO-DEMOGRAPHIC INFORMATION

Please tick with an X or fill in where applicable. (Please answer all questions)

1. Age in years ________________________________

2. Gender
   - Male
   - Female

3. Type of disability
   - Hemiplegic
   - CP
   - Paraplegia
   - Other (Please specify) ______________________

4. Year of disability ________________________________

5. Do you receive a disability grant?
   - Yes
   - No

6. Marital status
   - Single
   - Married
   - Co-habitation
   - Divorced
   - Other (specify) __________________________

7. Residential area
   - Soshanguve
   - Winterveldt

8. Educational status
   - Primary school
   - High school
   - Tertiary education
   - Other (please specify) ______________________

9. Occupation
   - Unemployed
   - Employed
   - Other (please specify) ______________________

10. Which type of transport do you use to get to the hospital?
   - Bus
   - Taxi
   - Private hired
   - Private owned

11. How much is the transport cost per trip? Please specify ______________________

   60
12. Who pays for the transport?
   - Self
   - Spouse
   - Relatives
   - Friends
   - Siblings

SECTION B

AWARENESS ABOUT REHABILITATION SERVICES

Please tick with an X or fill in where applicable.

13. The department where you attend rehabilitation services. You may choose more than one department.
   - Occupational therapy
   - Physiotherapy
   - Speech and audiology therapy
   - Human nutrition

14. In which year did you start rehabilitation in the department/s selected above?
   - Please specify __________________________

15. How often do you attend your rehabilitation sessions in the hospital?
   - Once a week
   - Once a month
   - Twice a month
   - Thrice a month
   - Other (please specify) __________________________

16. Why are you attending rehabilitation in this hospital?
   - I was referred to the hospital
   - It is closer to where I stay
   - It has all the equipment I need
   - The staff is friendly
   - The staff is available daily
   - The services are better
   - Other (please specify) __________________________

17. Which clinic is closer to you?
   - Kgabo clinic
   - KT Motubatse clinic
   - Maria Rantho clinic
   - Clinic II
   - Clinic III
   - Other (specify) __________________________

18. Are you aware that the local clinics in your area provide rehabilitation services?
   - Yes
   - No

19. If yes, why are you not attending rehabilitation in your local clinic?
   - Treatment is not adequate
   - The treatment space is not enough
   - Equipment is not enough
   - The staff is not enough
   - The services are not available daily
   - Other (specify) __________________________

20. Have you ever attended rehabilitation in your local clinic before?
   - Yes
   - No
SECTION C

PERCEPTIONS TOWARDS REHABILITATION SERVICES

A scale of options ranging from Agree to Disagree is given to statements that ask you to state how you feel about rehabilitation services in your local clinic. Please tick with an X an option that is applicable to you.

21. The rehabilitation clinic in my community has sufficient staff to render the services.
   
   Agree  □  Neutral □  Disagree □

22. The rehabilitation clinic in my community has sufficient rehabilitation equipment.

   Agree  □  Neutral □  Disagree □

23. The rehabilitation services in my community are rendered daily.

   Agree  □  Neutral □  Disagree □

24. The rehabilitation clinic provides assistive devices to people with disability.

   Agree  □  Neutral □  Disagree □

25. I am involved in decision making in my rehabilitation.

   Agree  □  Neutral □  Disagree □

26. My family is involved in decision making in my rehabilitation.

   Agree  □  Neutral □  Disagree □

27. The rehabilitation services helped me to be an active part of my community.

   Agree  □  Neutral □  Disagree □

28. The community participate in the rehabilitation activities.

   Agree  □  Neutral □  Disagree □

SECTION D

ENVIRONMENTAL BARRIERS IN CLINICS WHICH RENDER REHABILITATION SERVICES.

Please tick with an X where applicable.

30. The clinic that renders rehabilitation services in my community has ramps.
   
   • Yes  □  No □

31. The clinic that renders rehabilitation services in my community has ramps with rails.
   
   • Yes  □  No □

32. The toilet in the clinic that renders rehabilitation services has wall bars

   • Yes  □  No □

33. The toilet in the clinic that renders rehabilitation services is spacious to allow wheelchair access.

   • Yes  □  No □

34. The door frame size in the clinic that renders rehabilitation services is big enough to allow a wheelchair.

   • Yes  □  No □

35. The space allocated for rehabilitation in the clinic is big enough.

   • Yes  □  No □

THANK YOU FOR YOUR TIME!
APPENDIX B

LETLAKALA LA DIPOTSO A

Ke leboga nako ya gago e o e tsayang g o araba dipotso tse di leng mo letlakaleng le. Go dumela go araba dipotso tse go raya gore o dumela go isaya karolo ya porojeke ya Patlisiso e o e tlhaloseditsweng.
Ke kopa o buise dipotso tse di latelang mme o tshwaye kgotsa o tlatse mo go tlhokeang. Tlola dipotso tse di seng maleba mo go wena.

KAROLO A

TSA LEAGO LE KATLAAPELO (SOCIO-DEMOGRAPHIC)

Ke kopa o tshwaye ka sefapaano mo lepokising o be o tlatse mo go tlhokeang. Ke kopa o arabe dipotso tsothle.

1. Dingwaga
   - Monna
   - Mosadi

2. Bong
   - Hemiplegia
   - CP
   - Paraplegia
   - Tse dingwe (ka kopo tlhagisa)

3. Mofuta wa bogole
   - Hemiplegia
   - CP
   - Paraplegia
   - Tse dingwe (ka kopo tlhagisa)

4. Ngwaga o bogole bo simolotseng

5. A o amogela madi a Bogole?
   - Ee
   - Nyaya

6. Boemo ba lenyalo
   - Ga ke a nyalwa/nyala
   - Ke nyetswe/nyetse
   - Ke nnisana le mongwe
   - Ke tlhadile
   - Tse dingwe (ka kopo tlhagisa)

7. Bodulo
   - Soshanguve
   - Winterveldt

8. Boemo jwa tsa thuto
   - Sekolo potlana
   - Sekolo segolo
   - Thuto ya kwa godimo
   - Tse dingwe (ka kopo tlhagisa)

9. Tsia tiro
   - Ga ke dire
   - Ke a dira
   - Tse dingwe (ka kopo tlhagisa)

10. O dirisa teranseporoto ya mofuta mang fa o ya sepetlele?
    - Bese
    - Tekesi
    - Koloi e e hirilweng
    - Koloi ya ka
11. O dirisa bokae go duela teranseporoto ge o tla sepetlele?

Ka kopo tlhagisa

12. Ke mang a duelang madi a teranseporoto?

- Nna
- Mogatse
- Ba losika
- Ditsala
- Bana ba etsho

KAROLO B

PATLHALATSO YA DITIRELO TSA PUSELETSO (REHABILITATION SERVICES)

Ke kopa o kgethe kgotsa o tlatse se se leng maleba mo go wena.

13. Deparetemente e o amogelang tirelo ya puseletso ko go yona.
- Occupational therapy
- Physiotherapy
- Speech and Audiology therapy
- Human Nutrition

14. O simolotse go amogela tirelo ya puseletso ka ngwaga ofe ko dideparetementeng/deparetementeng tse/e o di/e tlhophileng kwa potsong e e kwa godimo?
- Ka kopo tlhagisa

15. O amogela tirelo ya puseletso ga kae ko sepetlele?
- Gangwe mo kgweding
- Gabedi mo kgweding
- Gararo mo kgweding
- Ka kopo tlhagisa

16. Go reng o amogela tirelo ya puseletso mo sepetlele?
- Ke rometswe ko sepetlele
- Sepetlele se gaufi le ko ke dulang teng
- Sepetlele se na le didiriswa tse ke di tlhokang
- Badiri ba botsalano
- Badiri ba teng letsatsi lengwe le lengwe
- Ditirelo di botoka
- E nngwe (Ka kopo tlhagisa )

17. Kliniki e e gaufi le wena ke efe?
- Kgabo clinic
- KT Motubatse clinic
- Maria Rantho clinic
- Clinic II
- Clinic III
- E nngwe (tlhagisa)

18. A o a itse gore dikliniki tse di mo motseng wa gago di abelana ka ditirelo tsa puseletso?
- Ee
- Nyaa

19. Ge karabo ya gago e le Ee, goreng o sa amogele tirelo ya puseletso mo kliniking ya motse wa gago?
- Kalafi ga e a lekana
- Lefelo bodirelo le kalafi e abelwang mo go lona le lennye
- Didiriswa tsa tirelo ya puseletso ga di a lekanela
- Palo ya badiri ke e nnyane
- Tirelo ya puseletso ga e abiwe letsatsi lengwe le lengwe
- E nngwe (Ka kopo tlhagisa )
20. A o kile wa amogela tirelo ya puseletso mo kliniking ya motse wa gago?
   - Ee
   - Nyaa

KAROLO C

TEBO (ATTITUDES) YA GAGO MABAPI LE TIRELO YA PUSELETSO

O neiwe seele se o ka kgethäng gotswa mo go sona; Ke a Dumela, Ke mo bogareng kgotsa Ke a Gana mo ditatementeng tse di go kopang go thagisa tebo ya gaga mabapi le ditirelo tsa puseletso tse di newang ke kliniki ya motse wa gago.

Ke kopa o kgethe e e leng maleba mo go wena.

21. Kliniki ya tirelo ya puseletso mo motseng wa me e na le badiiri ba ha lekaneng go abelana ka ditirelo.
   Ke a dumela  Ke mo bogareng  Ke a gana

22. Kliniki ya tirelo ya puseletso mo motseng wa me e na le didiriswa tse di lekanetseng tsa tirelo ya puseletso.
   Ke a dumela  Ke mo bogareng  Ke a gana

23. Ditirelo tsa puseletso mo motseng wa me di ahiwa letatsi lengwe le lengwe.
   Ke a dumela  Ke mo bogareng  Ke a gana

24. Kliniki ya tirelo ya puseletso mo motseng wa me e abo didiriswa tsa thuuso go batho ba ba nang le bogole.
   Ke a dumela  Ke mo bogareng  Ke a gana

25. Ke tsaya karolo mo ditshweotso tse di tsewang ka tirelo ya puseletso ya me.
   Ke a dumela  Ke mo bogareng  Ke a gana

26. Ba lelapa la me ba tsaya karolo mo go tseyeng ditshweotso mo tirelong ya puseletso ya me.
   Ke a dumela  Ke mo bogareng  Ke a gana

27. Ditirelo tsa puseletso di nthusitse go mma karolo e e matlhagathaga ya motse wa me.
   Ke a dumela  Ke mo bogareng  Ke a gana

28. Batho mo motse ba tsaya karolo mo diakitibiting tsa tirelo ya puseletso.
   Ke a dumela  Ke mo bogareng  Ke a gana

KAROLO D

DIKGORELETSI TSE DI BONWANG MO KLINIKING E E ABELENANG KA DITIRELO TSA PUSELETSO.

Ke kopa o kgethe se se leng maleba mo go wena.

30. Kliniki e e abang ditirelo tsa puseletso mo motseng wa me e na le dirempe.
    - Ee
    - Nyaa

31. Kliniki e e abang ditirelo tsa puseletso mo motseng wa me e na le dirempe tse di nang le ditshipi tsa go ithega.
    - Ee
    - Nyaa

32. Ntlwana ya boithusetso mo kliniking e e abang ditirelo tsa puseletso mo motseng wa me e na le ditshipi tsa go ithega mo lebotaneng.
    - Ee
    - Nyaa

33. Nltwana ya boithusetso mo kliniking e e abang ditirelo tsa puseletso mo motseng wa me e bulegile go letlelela setulo sa maotwana (wheelchair) go tsena.
    - Ee
    - Nyaa

34. Bogolo ba selekanyi sa lobati (door frame) mo kliniking e e abang ditirelo tsa puseletso se segolo go letlelela setulo sa maotwana (wheelchair) go tsena.
    - Ee
    - Nyaa
35. Bogolo ba lefelo le tirelo ya puseletso e abelwang mo go lona mo kliniking bo lekanetse.
   - Ee
   - Nyaa

KE A LEOGELA!
APPENDIX C

CHECK LIST

Thank you for taking your time in answering the questions on this check list. Your response in answering the questions is an indication that you are consenting to participating in the research project which has been explained to you.

Kindly read the following questions and indicate with a cross [X] and fill in where applicable.

36. The name of the community based rehabilitation clinic
   Staffing

37. Rehabilitation personnel and number of employed professionals
   Yes number of staff
   • Physiotherapists
   • Occupational Therapists
   • Speech, Language and Pathology Therapists
   • Human Nutritionists/Dieticians
   • Social Workers
   • Psychologists
   Other (Please specify) _________________________________

Physical setting

38. Clinic located on public transport route
   • Yes
   • No

39. The rehabilitation area size ______________________ square/m$^2$ (to be measured).

40. The space is used by the following disciplines: you may choose more than one discipline.
   • Physiotherapists
   • Occupational Therapists
   • Speech, Language and Pathology Therapists
   • Human Nutritionists/Dieticians
   • Social Workers
   • Psychologists
   • Other (Please specify) _________________________________

41. Entrance accessibility
   Ramps at entrances
   • Yes
   • No

42. Ramps with hand rails
   • Yes
   • No

43. A passenger loading zone for patients with disability
   • Yes
   • No

44. A passenger loading zone for patients with disability next to an accessible entrance
   • Yes
   • No

45. Parking bay demarcated for people with disability
   • Yes
   • No

46. Parking bay sign posted for people with disability
   • Yes
• No
47. Door frame sizes big enough to allow a wheelchair access
  • Yes
  • No
48. Automatic door
  • Yes
  • No
50. Toilets have wall bars
  • Yes
  • No
51. Extended toilet lever-flush controls
  • Yes
  • No
52. Raised toilet seat
  • Yes
  • No
53. Days of rendering services
    Rehabilitation services are offered on the following days: You may tick more than one.
    • Mondays
    • Tuesdays
    • Wednesdays
    • Thursdays
    • Fridays

Conditions seen for rehabilitation in the clinic
54. The following conditions are seen for rehabilitation in the clinic. Please tick what is appropriate to your clinic; you may tick more than one.
  • Hemiplegia
  • Paraplegia
  • Cerebral palsy
  • Other, please specify __________________________________________________________

THANK YOU
APPENDIX D

UNIVERSITY OF LIMPOPO (Medunsa Campus) ENGLISH CONSENT FORM

Statement concerning participation in a research project.

Name of study
Factors influencing the utilization of community based rehabilitation services by people with disability in Soshanguve and Winterveldt, Gauteng Province.

I have heard and read the information on the aims and objectives the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I understand that participation in this study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular treatment that holds for my condition neither will it influence the care that I receive from my regular doctor.

I know that this study has been approved by the Medunsa Campus Research and Ethics (MCREC), University of Limpopo (Medunsa Campus). I am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this study.

............................................................  .........................................................
Name of patient/volunteer  Signature of patient or guardian.

........................................  ...............................................  ........................................
Place  Date  Witness

Statement by the Researcher
I provided verbal and written information regarding this study.
I agree to answer any future questions concerning the study as best as I am able.
I will adhere to the approved protocol.

F.M.Kotsokoane

........................................  ...............................................  ........................................  ...............  ........................................
Name of Researcher  Signature  Date  Place
APPENDIX E

UNIVERSITY OF LIMPOPO (Medunsa Campus) FOROMO YA SETSWANA YA GO DUMELA

Seteitemente se, se ka ga go tsaya karolo mo porojeke ya Patlisiso.

Leina la patlisiso

Mabaka a a tshwaetsang tiriso ya tirelo ya leago ya puseletso kwa Soshanguve le Winterveldt mo poroferenseng ya Gauteng.
Ke buisitse tshedimosetso ebile ke utlwile maithlumo le maikemisetsa a patlisiso e e tshitshintsweng mme ke filwe tšhono ya go botsa dipotso le go fiwa nako e e lekaneng ya go akanya gape ka nthla e. Maithlumo le ma ikemisetso a patlisiso e a tlhalogangye ga tsaya karolo.

Ke tlhaloganya gore go tsaya karolo mo patlisisong e be boithaopo le gore nako ikgogela morago mo go yona ka nako nngwe le nngwe kwa ntle ga go neela mabaka. Se ga se kitla se nna le seabe sepe mo kalafong ya me ya go le gale ya bolwetsi jo ke nang le jona e bile ga se kitla se nna le tlhololetso epe mo tlhokomeleng e ke e amogelang mo ngakeng ya me ya go le gale.

Ke a itse gore patlisiso e, e rebotswe ke Patlisiso le Molao wa Maitsholo tsa Khampase ya Medunsa (MCREC), Yunibesithi ya Limpopo (Khampase ya Medunsa). Ke itse ka botlalo gore dipholo tsa patlisiso di tla dirisetse ga lecha ka saentifiki e bile di ka nna nang le jona e e e amogelang mo ngakeng ya me ya go le gale.

Ke a itse gore patlisisong e, e rebotswe ke Patlisiso le Molao wa Maitsholo tsa Khampase ya Medunsa (MCREC), Yunibesithi ya Limpopo (Khampase ya Medunsa). Ke itse ka botlalo gore dipholo tsa patlisiso di tla dirisetse ga lecha ka saentifiki e bile di ka nna nang le jona e e e amogelang mo ngakeng ya me ya go le gale.

Fano ke neela tumelelo ya go tsaya karolo mo patlisisong e.

............................................................  ............................................................

Leina ka molwetse/moithaopi  Tshaeno ya molwetse/motlamedi.

.................................................  .................................................  .................................................

Lefelo.  Letlha.  Paki

_________________________________________

Seteitemente ka Mmatlisisi
Ke tlametse tshedimosetso ka molomo le e kwadilweng malebana le patlisiso e.
Ke dumela go araba dipotso dingwe le dingwe mo nakong e e tlang tse di amanang le patlisiso ka moo nka kgonang ka teng.
Ke tla tshegetsa porotokolo e e rebotsweng.

F.M. Kotsokoane

.................................................  .................................................  .................................................

Leina la Mmatlisisi  Tshaeno Letlha  Lefelo
APPENDIX F

PARTICIPANT INFORMATION LEAFLET

Title of study: Factors influencing the utilization of community based rehabilitation services by people with disability in Soshanguve and Winterveldt, Gauteng Province.

INTRODUCTION
I invite you to volunteer for a research study. This information sheet is to help you decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, please ask the researcher. You should not agree to take part unless you are completely happy about the study.

PURPOSE OF THE STUDY
There are community based rehabilitation services within the community of Soshanguve and Winterveldt which are nearer the patient’s homes and some patients use similar services in Dr George Mukhari hospital which is located more than 30km away from the two communities. It appears that the rehabilitation services are underutilized. Therefore, this study will determine factors influencing the utilization of community based rehabilitation services by people with disability in Soshanguve and Winterveldt, Gauteng Province.

THE OBJECTIVES OF THE STUDY
The study intends:

- To determine the socio-demographic characteristics of people with physical disability who are not utilizing rehabilitation services at their own community healthcare centres (age, gender, type of disability, geographic area, source of financial income, mode and cost of transport).
- To determine whether people with disability are aware of availability of rehabilitation services in their own community healthcare centres.
- To determine the attitude of people with disability regarding rehabilitation services at their community health centres.
- To identify environmental barriers affecting access to rehabilitation areas of primary healthcare centres.

WHAT DOES THIS STUDY INVOLVE?
If you decide to take part, you will be one of the participants in Winterveldt or Soshanguve in the study. The study will use a questionnaire that will be read to each participant, the researcher will assist the participants to fill the questionnaire. This will take about 20 minutes of your time.

ETHICAL APPROVAL
This research study protocol was submitted to the Medunsa Research and Ethics Committee (MREC) for approval.

YOUR RIGHTS AS A PARTICIPANT
Your participation in this study is entirely VOLUNTARY and you can refuse to participate or stop at any time without stating any reason.

CONFIDENTIALITY
All information obtained during this study is strictly CONFIDENTIAL. Your name will not appear on any of the forms used to record information. Data that will be reported will not include any information which identifies you as a participant in this study.

For any further information, contact person:

Frida Mafuri Kotsokoane (MPH first year student)
Department of Public Health (University of Limpopo, Medunsa Campus).
APPENDIX G

LETLAKALA LA TSHEDIMOSETSO LA MOTSAYA KAROLO

Leina la patlisiso: Mabaka a a tshwaetsang tiriso ya tirelo ya leago ya puseletso kwa Soshanguve le Winterveldt mo poroferenseng ya Gauteng.

MATSENO

Ke go laletsa go ithaopa go tsaya karolo mo projekeng ya patlisiso. Letlakala le la tshedimosetso le tl go thuna go tsaya tsweetso ya gore a o eletsa go tsaya karolo mo patlisisong e. Pele o ka tsaya karolo, o tshwanetse go tšhaloganya ka botlalo se patlisiso e leng ka ga sona. Ga o na le dipotso tše ka gongwe di sa tšhageleleŋ mo letlakaleng le la tshedimosetso, ka kopo botsisa mommatlisisi. Ga o a tshwanela go dumela go tsaya karolo mo patlisisong fa o sa itumelel ga bokgakala ba karolo ya patlisiso e.

MAIKAELELO A POROJEKE

Go na le tirelo ya leago ya puseletso kwa metseng ya Soshanguve le Winterveldt tše di leng gaufi le magae a balwetse mme balwetse ba tšhopha go dirisa ditirelo tše di tšhwanang le tsona kwa sepetlelieng sa Dr. George Mukhari hospital se se leng bokgakala ba dikoloritse tše fetang some a mararo (30km) go tswa mo go tsona. Go lebeqa ekete tiriso ya ditirelo tše tsaya karolo mo puseletso di kwa tlase. Ke ka moo projek e eletsa go tšhwanisa Mabaka a a tshwaetsang tiriso ya tirelo ya leago ya puseletso kwa Soshanguve le Winterveldt mo poroferenseng ya Gauteng.

MOREROTHEO WA POROJEKE

Projek e e ikeletsetso go:
- Go batalisa tsa leago le katlaapelo ya batho ba ba nang le bogole b aba sa dirising ditirelo tsa puseletso kwa disentareng tsa pholo kwa metseng ya bona (dingwaga, bong, mofuta wa bogole, lefelo kago, motswedi wa tsabo madi, mofuta wa teranseporot le madi a a lefiwang)
- Go batalisa gore a batho b aba nang le bogole ba a itse ka ditirelo tsa puseletso tše di leng teng kwa disentareng tsa pholo kwa metseng ya bona.
- Go batalisa tebello ya maikutlo a batho b aba nang le bogole go ditirelo tsa puseletso tše di leng teng kwa disentareng tsa pholo kwa metseng ya bona.
- Go batalisa dikgoreletsi mo loaong tše di tšhwaetsang go tsena mo mafelong a ditirelo tsa puseletso tše di leng teng kwa disentareng tsa pholo kwa metseng ya bona.

POROJEKE E MABAPI LE ENG?

Ga o tsaya tshweetso ya go ba karolo ya patlisiso e, o tšla baa o mongwe wa ba tsaya karolo mo Winterveldt kgotsa Soshanguve mo projekeng. Projek e e tše dirisa letlakala patlisiso e e tše tladiwang ke wena metsotso-karolo. E tše go tsaya metsotso e e le se a mabedi a nako ya gago.

TETLA YA TSA MAITSHOLO

Tetla go dira patlisiso e, e rebotswe ke komiti ya Patlisiso le Molao wa Maitsholo tše Khampase ya Medunsa (MREC), Yunibesithi ya Limpopo (Khampase ya Medunsa). This research study protocol was submitted to the Medunsa Research and Ethics Committee (MREC) for approval.

TSHWANELO YA GAGO JAAKA MOTSAYA KAROLO

Go tsaya karolo gag agog mo projekeng e key a BOITHAPOPO e biele o na le go ka go gana go tsaya karolo kgotsa go emisa nako nangwe le nngwe kwa ntle le go ga lebaka.

KHUPAMARAMA

Tshedimoso yotlhe e e amogetsweng mo projekeng ke KHUPAMARAMA. Leina le gago le ka se tšhagelele mo ditorieng dipe tše di dirisingwang go kgobokanya tshedimoso. Melaetsa e e tše bong e begiwa e ka se akaretse tshedimosetso e e go supang jaaka metsotso karolo mo projekeng.

Fa o batla tshedimosetso e e gaisang fa founela motho yo o latelang:
- Frida Mafuri Kotsoane (moithuti wa MPH wa ngwaga wa bobedi) 0824575063/0713650186
- Lefapha la Phoło ya Phatlhalatso (Yunibesiti of Limpopo, khampase ya Medunsa).
APPENDIX H

University of Limpopo (Medunsa Campus)
Department of public health
P.O. BOX 215
MEDUNSA
0204

The Principal
Medunsa Research and Ethics Committee
University of Limpopo (Medunsa Campus)

Dear Sir/Madam

Request to conduct a research study in Dr George Mukhari with involvement of patients and Soshanguve and Winterveldt rehabilitation clinics.

Title of study: Factors influencing the utilization of community based rehabilitation services by people with disability in Soshanguve and Winterveldt, Gauteng Province.

I, the researcher, am a 2nd year Master of Public Health student undertaking a research project for a post graduate research module. I therefore request ethical approval to conduct my research study in Soshanguve and Winterveldt rehabilitation clinics and Dr George Mukhari hospital with involvement of patients.

The objectives of the study are:

- To determine the socio-demographic characteristics of people with physical disability who are not utilizing rehabilitation services at their own community healthcare centres. (age, gender, type of disability, geographic area, source of financial income, mode and cost of transport)
- To determine whether people with disability are aware of availability of rehabilitation services in their own community healthcare centres.
- To determine the attitude of people with disability regarding rehabilitation services at their community health centres.
- To identify environmental barriers affecting access to rehabilitation areas of primary healthcare centres.

A participant information leaflet has been attached in order to reflect the nature of the study.

Hope that the request will be positively considered.

Yours faithfully

_______________________
Ms Frida Mafuri Kotsokoane
APPENDIX I

University of Limpopo (Medunsa Campus)
Department of Public Health
P O BOX 215
MEDUNSA
0204

The Manager
Gauteng North Rehabilitation Services
PRETORIA
0001

Dear Sir/Madam

Request to conduct a research study in Soshanguve and Winterveldt rehabilitation clinics

Title of study: Factors influencing the utilization of community based rehabilitation services by people with disability in Soshanguve and Winterveldt, Gauteng Province.

I, the researcher, am a 2nd year Master of Public Health student undertaking a research project for a post graduate research module. I therefore request ethical approval to conduct my research study in Soshanguve and Winterveldt rehabilitation clinics.

The objectives of the study are:

- To determine the socio-demographic characteristics of people with physical disability who are not utilizing rehabilitation services at their own community healthcare centres (age, gender, type of disability, geographic area, source of financial income, mode and cost of transport)
- To determine whether people with disability are aware of availability of rehabilitation services in their own community healthcare centres.
- To determine the attitude of people with disability regarding rehabilitation services at their community health centres.
- To identify environmental barriers affecting access to rehabilitation areas of primary healthcare centres.

A participant information leaflet has been attached in order to reflect the nature of the study.

Hope that the request will be positively considered.

Yours faithfully

_______________________
Ms Frida Mafuri Kotsokoane
Dear Sir/Madam

Request to conduct a research study in Dr. George Mukhari hospital with involvement of patients

**Title of study:** Factors influencing the utilization of community based rehabilitation services by people with disability in Soshanguve and Winterveldt, Gauteng Province.

I, the researcher, am a 2nd year Master of public health student undertaking a research project for a post graduate research module. I therefore request ethical approval to conduct my research study in your hospital in the departments of Physiotherapy, Occupational Therapy, Human Nutrition and Speech Language and Pathology with the involvement of patients.

The objectives of the study are:

- To determine the socio-demographic characteristics of people with physical disability who are not utilizing rehabilitation services at their own community healthcare centres (age, gender, type of disability, geographic area, source of financial income, mode and cost of transport)
- To determine whether people with disability are aware of availability of rehabilitation services in their own community healthcare centres.
- To determine the attitude of people with disability regarding rehabilitation services at their community health centres.
- To identify environmental barriers affecting access to rehabilitation areas of primary healthcare centres.

A participant information leaflet has been attached in order to reflect the nature of the study.

Hope that the request will be positively considered.

Yours faithfully

____________________
Ms Frida Mafuri Kotsokoane
Dear Sir/Madam

Request to conduct a research study in Dr. George Mukhari with involvement of patients in your department

Title of study: Factors influencing the utilization of community based rehabilitation services by people with disability in Soshanguve and Winterveldt, Gauteng Province.

I, the researcher, am a 2nd year Master of Public Health student undertaking a research project for a post graduate research module. I therefore request permission to conduct my research study in your department with involvement of patients.

The objectives of the study are:

To determine the socio-demographic characteristics of people with physical disability who are not utilizing rehabilitation services at their own community healthcare centres (age, gender, type of disability, geographic area, source of financial income, mode and cost of transport).
To determine whether people with disability are aware of availability of rehabilitation services in their own community healthcare centres.
To determine the attitude of people with disability regarding rehabilitation services at their community health centres.
To identify environmental barriers affecting access to rehabilitation areas of primary healthcare centres.
A participant information leaflet has been attached in order to reflect the nature of the study.

Hope that the request will be positively considered.

Yours faithfully

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Ms Frida Mafuri Kotsokoane
MEDUNSA RESEARCH & ETHICS COMMITTEE

CLEARANCE CERTIFICATE

MEETING: 01/2011
PROJECT NUMBER: MRECH/07/2011: PG
PROJECT:
Title: Factors influencing the utilization of community based rehabilitation services by people with disability in Soshanguve and Winterveldt, Gauteng Province
Researcher: Ms FM Kotsokoane
Supervisor: Dr L Skela
Co-supervisor: Dr H Hoever
Department: Physiotherapy
School: Health Care Sciences
Degree: MPH

DECISION OF THE COMMITTEE:
MREC approved the project.
DATE: 10 February 2011

Note:
1) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
2) The budget for the research will be considered separately from the protocol. PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.
TSHWANE METSWEDING REGION RESEARCH ETHICS COMMITTEE

CLEARANCE CERTIFICATE

Meeting: 02/2011

PROJECT NUMBER: TMREC 2011/08

PROJECT:

Title: Factors influencing the utilization of community based rehabilitation services by people with disability in Soshanguve and Winterveldt, Gauteng Province

Researcher: Ms FM Kotsikoane
Supervisor: Dr L Skaal
Co-supervisor: Dr H Heever
Department: Physiotherapy (University of Limpopo)
Degree: MPH

DECISION OF THE COMMITTEE

Approved

Date: 22 March 2011

Dr K.E. Letebele-Hartell
Chairperson Tshwane Metsweding Research Ethics Committee
Tshwane Metsweding Region

Mr. M Pitsi
Director: District Health Services Support
Tshwane Metsweding Region

NOTE: Resubmission of the protocol by researcher(s) is required if there is departure from the protocol procedure as approved by the committee.
ALL CORRESPONDANCE TO INCLUDE PROTOCOL NUMBER
To: Ms. Frida Mafuri Kotsokoane  
Department of Public Health  
P.O. Box 215  
University of Limpopo  
MEDUNSA  
0204

Date: 10 March 2011

RE: PERMISSION TO CONDUCT RESEARCH.

The Dr. George Mukhari Hospital hereby grants you permission to conduct research on "Factors influencing the utilization of community based rehabilitation services by people with disability in Soshanguve and Winterveldt, Gauteng Province."

We note that you have already obtained ethical Clearance from the Human Research Ethics Committee.

This permission is granted subject to the following conditions:

☐ That the Hospital incurs no cost in the course of your research.

☐ That access to the staff and patients at the Dr George Mukhari Hospital will not interrupt the daily provision of services.

☐ That prior to conducting the research you will liaise with the supervisors of the relevant sections to introduce yourself (with this letter) and to make arrangements with them in a manner that is convenient to the sections.

Yours sincerely

[Signature]

DR. P. SHEMBE
DIRECTOR: CLINICAL SERVICES