FRAMEWORK AND STRATEGY FOR DISABILITY AND REHABILITATION SERVICES IN SOUTH AFRICA

2015 - 2020

A long and healthy life for all South Africans
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FOREWORD BY THE MINISTER

The transformation of the South African health system towards universal coverage is a critical step in overcoming the deep inequities in our society, including for people with disabilities. The health system has a crucial role to play in reducing the number of people who sustain impairments, improving access to healthcare for people with disabilities, and supporting all to live long and healthy lives. Rehabilitation is an important component in the continuum of care and is essential to a good quality of life and increased life expectancy. A transforming health service, including Primary Health Care Re-engineering, makes this the perfect moment to reconfigure rehabilitation as an integral part of health services across all programmes, within a system that provides services as close as possible to where people live and work.

Disability has far-reaching effects on the health and socio-economic status of households and communities, and people with disability continue to be disproportionately represented among the extremely poor. As South Africa works towards reducing inequality and eliminating absolute poverty, rehabilitation has a crucial role to play in translating health gains made by mainstream clinical services into people’s capacity to live socially and economically productive lives, thus interrupting the vicious cycle of poverty and ill-health.

This Framework and Strategy for Disability and Rehabilitation Services in South Africa 2015 was compiled in consultation with people with disabilities; the Task Team on Disability, professional rehabilitation service providers, academics, and other key stakeholders in the field. It offers a framework for rehabilitation services within all levels of care and reflects our commitment to an increasingly equitable and inclusive society, which will ensure “a long and healthy life for all South Africans”.

DR A MOTSOALEDI, MP
MINISTER OF HEALTH
This document signals the Department of Health’s full commitment to addressing the health concerns of people with disability. While much of the prevention of disability rests in the social determinants of health, much is still required from the health sector in terms of prevention as well as rehabilitation and access to health services. This Framework and Strategy on Disability and Rehabilitation proposes disability and rehabilitation services at all levels of care; from home to tertiary services. The role that individuals with disabilities and their families play is recognised and valued paying due respect to the dictum “nothing about us without us”.

South Africa embraces the human rights culture outlined in the UN Convention on the Rights of Persons with Disabilities that was ratified in 2007. In line with this we commit to a package of services for all affected by disability. Measures will be taken so that services are available at the closest point to where people live and work. We also commit to provide services in the shortest possible time. Article 26 of the UN Convention on the Rights of Persons with Disabilities enjoins us to organise, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, and through this document we translate these ideals into concrete achievable strategies.

DR J PHAAHLA, MP
DEPUTY MINISTER OF HEALTH
Given government’s commitment to equity and non-discrimination, including for people with disabilities, the Honourable Minister of Health, Dr Aaron Motsoaledi appointed a Task Team to develop a Framework and Strategy for Disability and Rehabilitation in 2013. This Team represented a wide range of stakeholders, including Disabled People’s Organizations, academics, professional organisations, provincial representatives, private sector and other government departments. On behalf of the Department I would like to express my gratitude to all the members of the Task Team for producing the first draft of this Policy Framework and Strategy.

Dr Pamela McLaren from Disability Action Research Team and Ms Fiorenza Monticelli from the Health Systems Trust were responsible for synthesising inputs from consulted contributors in an earlier version. Ms Jeanette Hunter, Deputy Director-General, Primary Health Care in the National Department of Health led its completion and was assisted by Professor Melvyn Freeman and his team in the Non-Communicable Diseases Chief Directorate. I am confident that this document will put the Department on the right course to improve health services to persons with disabilities. Our goal is to achieve equal access to health care services as well as to provide specified rehabilitation services where and when required. We will endeavour to implement this framework and strategy to ensure that services for persons with disabilities are available at all levels of health care.

MS MP MOTSOSO
DIRECTOR-GENERAL: HEALTH

ACKNOWLEDGMENTS BY THE DIRECTOR-GENERAL
1. INTRODUCTION

This Policy Framework and Strategy for Disability and Rehabilitation services in South Africa outlines comprehensive and integrated disability and rehabilitation services within the broader health and developmental context to facilitate improved access at all levels of health care.

With improved treatment people live longer, and with this a higher number of people experience chronic conditions/illness and disability. This places a larger burden on households and fiscal finances, facilities and human resources in the country.

Some programmes within the health sector can prevent the onset of impairment, however many interventions required for the prevention of disability lie outside its mandate, within the broader society, with other government departments and are part of the social determinants of health. The emphasis in this document is on health interventions with rehabilitation cutting across the promotive, preventive, curative, rehabilitative and palliative continuum of care. Rehabilitation services make the vital, practical link between medical treatment and the translation of a person’s restored capacity into a productive and health-promoting social and economic life. Rehabilitation should start as early as possible, be as decentralised as possible, and requires a defined referral pathway, extending from community to tertiary and specialised rehabilitation levels. Referral pathways for persons with disabilities and those at risk must be in place to create access to appropriate care by the best qualified service providers, in the right place and at the right time. It is critical that referral pathways are aligned to departmental policy on referrals, clinical guidelines and protocols.

2. CONTEXT

The prevalence of disability in South Africa is contentious in part because stakeholders are not agreeing on a definition of disability. Present definitions are applied in terms of different legislation and contexts, and focus primarily on impairment without necessarily addressing the contexts in which barriers limit participation. A major limitation in determining true levels of disability in South Africa is that disability prevalence surveys are usually based on reported disability, often by a proxy informant, which may overestimate or underestimate the prevalence.

According to a Statistics South Africa Report (StatsSA) based on Census 2011 data, the national disability prevalence rate is 7.5% in South Africa. Disability is more prevalent among females than males (8.3% and 6.5% respectively). It must be noted however, that this prevalence rate excludes children under the age of 5 and people with psychosocial and certain neurological disabilities.

The prevalence of a specific type of disability shows that 11% of people 5 years and older had seeing difficulties, 4.2% had cognitive difficulties (remembering/concentrating), 3.6% had hearing difficulties, and around 2% had communication, self-care and walking difficulties.

Provinces with the highest reported disability were Free State and Northern Cape (both 11.0%). Reported disability figures for the remaining provinces, in descending order, are North West (10.0%), Eastern Cape (9.6%), KwaZulu-Natal (8.4%), Mpumalanga (7.0%), Limpopo (6.9%), Western Cape (5.4%) and Gauteng (5.3%).

The overall prevalence of childhood disability has been studied among smaller target populations in South Africa over the past 30 years, but recent data is scant. Moreover estimates of child disability prevalence are not directly comparable as studies use different definitions of disability and methods of data collection.

With regards to older persons, according to StatsSA, South Africa’s population over 60 years is 7.8% and the proportion of people with disabilities in the 60 to 69 year age group is 14.5%, rising to 34.7% in the over70 year group. Population ageing is associated with impaired functioning and mobility limitations, i.e. impaired vision, glaucoma, diabetic retinopathy, hearing loss, and impaired mobility due to strokes, falls, bone and joint conditions. The prevalence of Alzheimer’s and Parkinson’s disease and dementia in the South African population is not known.

Decreased childhood mortality in South Africa has had the unintended and unfortunate consequence of increased childhood disability, as is evidenced by the number of children presenting with developmental delays and cerebral palsy Chhagan and Kauchaliadvocate for combining improved child survival with optimal development into a single outcome measure of “disability-free survival”.


The role of disability in entrenching and exacerbating the cycle of ill-health and poverty is often inadequately understood in health service planning.

Figure 1 illustrates the cycle in which poverty increases the risk of ill-health, while simultaneously restricting access to appropriate and affordable healthcare. Poor health outcomes frequently include residual functional impairments, which result in loss of productive capacity, increased care and cost burdens on households, and create additional barriers to healthcare access.

**Figure 1: Cycle of poverty, ill-health and disability**


In South Africa, poor people, and particularly those living in rural areas, frequently have the least access to quality healthcare, including rehabilitation services. Poor health outcomes have a regressive effect, both increasing the incidence and complexity of healthcare needs in the affected person, and creating additional barriers to accessing healthcare, such as an inability to use public transport or a need for personal assistance when seeking healthcare.

As increasing numbers of people from high-risk groups (e.g. high-risk babies and people with HIV) survive due to medical and social interventions, the number of people with disabilities increases. Ironically, a saved life does not automatically become a productive or healthy life in the long term.

Many risk factors and common conditions may lead to disability. These include health related risk factors (pre-natal, perinatal and postnatal risk factors, various communicable and non-communicable diseases, ototoxic drugs), environmental risk factors (food insecurity and under-nutrition, iron-deficiency anaemia (IDA), Micronutrient deficiencies (e.g. vitamin A deficiency (VAD), poverty, violence, injury, motor vehicle crashes, neglect, child abuse and child sexual abuse).

Challenges experienced in implementing rehabilitation services in South Africa are related to a variety of factors. These include:
• A medical model resulting in poor access to a comprehensive disability and rehabilitation service especially to persons in rural and disadvantaged areas.

• The implementation of disability and rehabilitation services as a vertical programme with little or no scope for integration with priority health programmes, such as Non-Communicable Diseases, Maternal Child and Women’s Health (MCWH), as well as HIV and AIDS.

• Inadequate follow-up due to a lack of clarity on referral pathways as well as poor availability of services. This problem is aggravated by the fact that there are inadequate rehabilitation units available in district hospitals and only two specialised rehabilitation centres in the country. There is also poor communication and coordination between service levels.

• Inaccessible and unaffordable transport. Families of people with disabilities incur significant costs for public transport and car hire in order to access health care. Studies have been conducted in the Eastern Cape¹ and Mpumalanga² relating to “out-of-pocket” expenditure when accessing health care.

• Poor inter-sectoral collaboration.

• Inaccessibility of health services with regard to facility infrastructure¹, signage and information in an appropriate medium including sign language and Braille. In addition, therapy is often not done in the client’s first language.

• Inadequate provision of appropriate assistive devices/technology and accessories. Assistive devices ranging from walking aids to Augmentative and Alternative Communication devices should be available to clients based on their needs. Some devices such as the white cane have traditionally been issued only by the NGO sector.

• The lack of awareness, knowledge and training among healthcare providers regarding the challenges, needs and rights of persons with disabilities results in poor care and disempowerment. Negative attitudes towards children and adults with disability obstruct their participation in health and rehabilitation services. Rehabilitation professionals are often not “culture-sensitive” and do not respect the value systems and beliefs of their clients, which may delay early identification and intervention.³

• The paucity of appropriate rehabilitation indicators in the national and provincial data sets impairs the quality and type of service, as there is no proof of effective service delivery which could be used to motivate for resources. There is little research linked to the outcomes of rehabilitation services at secondary, tertiary and specialised levels, and none at PHC level.

• The ideal core rehabilitation team usually does not exist. This should comprise of a physiotherapist, occupational therapist, speech therapist, audiologist, medical orthotist and prosthetist, and related mid-level health workers. The support team should include a social worker, dietician, orientation and mobility instructor, podiatrist, optometrist and psychologist. There is an inequitable distribution and high vacancy rate of service providers at the different levels of care especially rehabilitation staff at primary level.

In addition to the need to fill posts, the Department of Health has adopted a policy on contracting of professional health workers that currently work only in the private sector - as the vast majority of health workers, including rehabilitation workers, presently service only a relatively small percentage of the population. This policy will permit the proportion of rehabilitation professionals to population ratios in the public sector to decrease progressively.
Importantly persons with disabilities have specific health needs which require special attention. These include:

- reproductive health services,
- oral health,
- spinal care,
- medication and consumables,
- adequate sun protection,
- bladder and bowel management including incontinence products,
- prevention, management and control of communicable and non-communicable diseases, and
- surgical interventions.

Ideally both health and rehabilitation services should be accessible at single points of care.

The above challenges as well as the specific health care needs of persons with disabilities illustrate the need for a comprehensive strategy for the provision of disability and rehabilitation services across the life course at all levels of the health system, extending from the community to specialised centres.
3. LEGISLATIVE AND POLICY FRAMEWORK

The following key legislative and policy instruments guide the content of this Framework and Strategy.

3.1. Key International Instruments
   i. The Convention on the Rights of the Child (CRC) provides for children with disabilities to enjoy all the same rights as other children, including the right to health.
   ii. The UN Convention on the Rights of Persons with disability (CRPD) was signed and ratified by the South African government in 2007 and its provisions reflect the obligations of the State. The CRPD is an international human rights treaty aimed at protecting the rights and dignity of people with disabilities. Central principles include respect, non-discrimination, full and effective participation and inclusion in society, equality of opportunity and accessibility. The ratification of the CRPD requires the State to review a range of national policies and legislation across sectors to ensure compliance.

   The CRPD contains specific provisions for health, habilitation and rehabilitation, but equally applicable are articles relating to personal mobility, living independently and being included in the community, as well as many cross-cutting articles.

3.2. National Instruments
   i. The Constitution of South Africa Act (108 of 1996) provides that everyone is equal before the law and has equal protection and benefit of the law. It prohibits discrimination on a number of grounds, including disability.
   ii. National Development Plan envisages a country which by 2030 has eliminated poverty and has reduced inequality. The NDP 2030 acknowledges that many persons with disability are not able to develop to their full potential due to a range of barriers, resulting in their often being viewed as unproductive and a burden and proposes changes to redress this.
   iii. Promotion of Equality and Prevention of Unfair Discrimination Act (4 of 2000) gives effect to section 9 of the Constitution, to prevent and prohibit unfair discrimination and harassment; to promote equality and eliminate unfair discrimination; and to prevent and prohibit hate speech. It mandates the removal of barriers and taking positive steps to ensure that people with disabilities are able to enjoy full and equal participation and access to opportunities.
   iv. National Health Act (61 of 2003) provides for the provision of quality health services to the population of South Africa. The Act also provides for the establishment of the National Health Council, which is a structure responsible for making health policy in the country. It further gives the Minister of Health the authority to make regulations on any health matter, including regulations on rehabilitation and assistive devices.
   v. Mental Health Care Act (17 of 2002) provides a framework for the provision of mental health care services in South Africa. Among other things it enables the establishment of observation services for 72 hours in non-mental health facilities. It further provides a framework for the designation of mental health facilities and establishment of mental health review boards.
   vi. Other sector instruments such as Road Accident Fund Act (56 of 1996), Social Assistance Act (13 of 2004), Road Accident Fund Amendment Act (19 of 2005) and Children’s Act (38 of 2005) promote and protect the rights of persons with disability within different sectors.
4. POLICY FRAMEWORK AND STRATEGY ON DISABILITY AND REHABILITATION

4.1. Vision
Accessible, affordable, appropriate and quality disability and rehabilitation services throughout the life course.

4.2. Mission
The provision of integrated, comprehensive, appropriate disability and rehabilitation services through effective and equitable resource allocation and inter-sectoral collaboration.

4.3. Values
1.1.1 Ensuring appropriate disability and rehabilitation services through the participation and inclusion of persons with disability, based on the principles of community based rehabilitation and using a disability-inclusive developmental approach and evidence-based practice.

1.1.2 Ensuring quality services through the adoption of norms and standards within the public health sector that are aimed at promotion, preventive, curative, rehabilitative and palliative care measures using the principle of continuum of care across the lifespan.

1.1.3 Ensuring accessibility to disability and rehabilitation services through an integrated approach (cutting across all health programmes throughout the continuum of care to implement PHC-R) and the integration of rehabilitation services by the rehabilitation professional groups.

1.1.4 Ensuring affordable services through evidence-based rehabilitation interventions and provision of rehabilitation services at all levels of health care, especially providing services as close as possible to where children and adults with disability and those at risk live, thus reducing “out-of-pocket” expenditure and the burden on the district hospital.

4.4. Goals
4.4.1 Integrate comprehensive disability and rehabilitation services including within priority health programmes from primary to tertiary and specialised health care levels as guided by the document on Integrated Disability Management and Rehabilitation Pathways of Care.

4.4.2 Develop an appropriate, effective and efficient referral system between all levels of care including the expansion of services to improve access to rehabilitation units and specialised rehabilitation centres.

4.4.3 Foster inter-sectoral collaboration to address social determinants.

4.4.4 Implement accessibility standards for infra-structure, communication, signage and information.

4.4.5 Increase awareness and knowledge of health care workers to change their attitudes toward children and adults with disabilities and their families.

4.4.6 Improve monitoring and evaluation of disability and rehabilitation services.

4.4.7 Improve Human Resources for disability and rehabilitation services.

4.4.8 Improve access to appropriate assistive/technology and accessories.

5. APPROACH

Disability and rehabilitation services within South Africa’s health sector will span across an individual’s life course, be comprehensively provided at all levels of the health system and be grounded within the philosophy of community based rehabilitation (CBR).

This strategy focuses on the mandate of the health sector but fully subscribes to the CBR philosophy. CBR is a co-ordinated approach across multiple sectors to realise the inclusion of and equal opportunities for persons with disabilities. CBR recognises that co-ordinated action is required from role-players in health, social development, education, public works, human settlements, transport and other sectors, if independent functioning is to be realised.

The CBR Matrix (Figure 2) offers a map of the five core components of this overarching strategy, that is, health, education, livelihoods, social life and empowerment, and their key elements.
The following is a summary of the services that will be provided at each level of care:

**5.1 Home/Community Setting**

The goal of rehabilitation at all levels of care is to give the client the tools to live an independent life to his/her potential. The role of rehabilitation at home/community level covers the following areas:

i. Engagement with all key stakeholders and community leadership such as traditional leaders and civic leaders. The stakeholders collectively identify community resources for the benefit of all community members, including people with disabilities.

ii. Participating in community mapping and referrals – rehabilitation contributes in community mapping and the development of a referral structure in the community.

iii. Advocacy for people with disabilities and other vulnerable groups in the community; children and adults with HIV; children in conflict with the law; older persons and children out of school.

iv. Screening, assessing and treating people with different impairments; physical, emotional, speech, hearing, communication and visual impairments. Orientation and mobility services should be part of the service package offered at this level.

v. Utilise community rehabilitation workers and peer support counsellors within homes and communities wherever possible.

vi. Conducting home visits to clients in their homes by therapists for specific interventions and follow up visits by midlevel health workers.

vii. Conducting health promotion and prevention of disability campaigns in collaboration with other stakeholders.

viii. Training of community health workers on disability issues to empower them to detect disability early and to refer appropriately.

ix. Providing screening and referral for vocational rehabilitation.

x. Lobbying for the opportunity for people with disabilities to participate in decision making and planning of intervention programmes.

xi. Facilitating access to Sign Language interpretation services, and peer counselling and support.
xii. Providing input and support into programmes offered at day care centres and other residential facilities for children and adults with disabilities and other vulnerable groups in the community.

xiii. Providing assessment, treatment and follow up at other non health facilities in the community such as residential care facilities, half way houses, stimulation centres, and protective employment workshops. Other services that should be available at these facilities include stimulation, assessment, management, support and orthotic and prosthetic services.

Irrespective of where the service is offered the client remains at the centre of all services.

5.2 School Setting

5.2.1 Screening as set out in the Integrated School Health Programme:
• Vision
• Hearing
• Speech and language
• Physical (gross and fine motor)

5.2.2 Integrating with the school health outreach services by including therapists to do assessment for seating and other high level interventions, including modelling for seating in the classroom.

5.2.3 Making referrals to specialized hospital based rehabilitation services.

5.3 Primary Health Care Facilities (clinics, community health centres)

Some of the services offered at home/community level will also be offered at this level. Orientation and mobility services should be part of the service package offered at this level.

5.3.1 Screening, assessing and treating people with different impairments - physical, emotional, speech, hearing, communication and visual.

5.3.2 Conducting home visits in collaboration with the Ward Based Primary Health Care Outreach Teams (WBPHCOT) to clients by therapists for specific interventions and follow up visits by midlevel health workers.

5.3.3 Conducting integrated health promotion and prevention of disability campaigns in collaboration with all stakeholders.

5.3.4 Training of community health workers on disability issues to empower them to do early detection of disability and referral to the right place.

5.3.5 Providing screening and referral for vocational rehabilitation.

5.3.6 Lobbying for an opportunity for people with disabilities to participate in decision making and planning of intervention programmes, as well as access to training as community health workers and similar cadres.

5.3.7 Facilitating access to Sign Language interpretation services, and peer counselling and support.

5.3.8 Providing input and support into programmes offered at day care centres and other residential facilities for people with disabilities and other vulnerable groups in the community.

5.3.9 Providing assessment, treatment and follow up at other non health facilities in the community such as residential care facilities, half way houses, stimulation centres, and protective employment workshops. Other services that should be available at these facilities include stimulation, assessment, management, support and orthotic and prosthetic services.

5.3.10 Providing wheelchair repair services at selected clinics and community health centres.

5.3.11 Assessing for and issuing minor assistive devices such as crutches and walking aids.

5.3.12 Providing early childhood intervention for general childhood health conditions.

5.3.13 Providing early hearing detection and intervention in post natal and well baby clinics.

5.4 Hospital Based Services

Rehabilitation services in hospitals will cover the following areas:

a) Assessment of patients.
b) Management of patients.
c) Treatment in a multi-disciplinary team.
d) Referral up and down.
e) Vocational rehabilitation and referral to specialized VR centres where necessary.
f) Early hearing detection and intervention and upward referral for diagnostic procedures at other specialised services.
The above rehabilitation services in hospital will be in line with medical services prescribed by regulation for different categories of hospitals. Regulation No. R. 185 prescribe general and specialised services that should be rendered at different levels and the rehabilitation service should be structured so as to respond adequately to this.

5.4.1 District Hospitals

A district hospital must:
   a) serve a defined population within a health district and support primary health care;
   b) provide a district hospital package of care on a 24 hour basis;
   c) have general practitioners and clinical nurse practitioners primary health services;
   d) provide services that include in-patient, ambulatory health services as well as emergency health services; and
   e) where practical, provide training for health care service providers.

A district hospital receives rehabilitation outreach and support from general specialists based at regional hospitals.

A district hospital may only provide the following services:
   a) Paediatric health services
   b) Obstetrics and gynaecology
   c) Internal medicine
   d) General surgery
   e) Family physician

Rehabilitation - A multi-disciplinary rehabilitation team must be available at district hospital level to provide general rehabilitation that includes assessment and clinical interventions based on the client’s condition. At this level the rehabilitation team is also able to prescribe and issue a wide range of assistive devices.

5.4.2 Regional Hospitals

A regional hospital must, on a 24 hour basis, provide:
   a) health services in the fields of Internal Medicine, Paediatrics, Obstetrics and Gynaecology, and General surgery;
   b) health services in at least one of the following specialties;
      i. Orthopaedic surgery
      ii. Psychiatry
      iii. Anaesthetics
      iv. Diagnostic radiology
   c) trauma and emergency services;
   d) short term ventilation in a critical service;
   e) services to a defined regional drainage population, limited to provincial boundaries and receives referrals from several district hospitals; and
   f) where practical, provide training for health care service providers.

Rehabilitation - A multi-disciplinary team must be available at regional hospital level to provide all aspects of rehabilitation. The rehabilitation team at this level is able to provide specialist services to major disabling conditions such as spinal injury and stroke. The team at this level is able to assess for and prescribe and issue assistive devices.
5.4.3 Tertiary Hospitals

A tertiary hospital -
   a) provide specialist level services provided by regional hospitals;
   b) provide subspecialties of specialties referred to in paragraph (a)
   c) provide intensive care service under the supervision of a specialist or specialist intensivist;
   d) may provide training for health care service providers;
   e) receives referrals from regional hospitals not limited to provincial boundaries; and
   f) has between 400 and 800 beds.

Rehabilitation - A multi-disciplinary team is available at the tertiary level of care to provide specialist rehabilitation to a wide range of clients. Some of the specialist services rendered at this level will include theatre and ICU physiotherapy, as well as services rendered at the regional level. The team is also able to assess for and prescribe and issue assistive devices.

5.4.4 Central Hospitals

A central hospital -
   a) must provide tertiary hospital services and central referral services and may provide national referral;
   b) must provide training of health care providers;
   c) must conduct research;
   d) receives patients referred to it from more than one province;
   e) must be attached to a medical school as the main teaching platform; and
   f) must have a maximum of 1200 beds.

Central referral services are provided in highly specialised units, require unique, highly skilled and scarce personnel and at a small number of sites nationwide.

National referral services refer to super-specialised national referral units and represents extremely specialised and expensive services (e.g. heart and lung transplant, bone marrow transplant, liver transplant, cochlear implants).

Rehabilitation - A multi-disciplinary team is available at this level to provide specialist rehabilitation services required. Clients at this level are admitted for short periods of time so the rehabilitation team needs to be responsive to the needs of the clients at short notice. Personnel at this level should have the requisite specialist skills in order to provide an optimum service. Due to the short admission period at this level a referral to lower levels for assistive devices may be preferable.

5.4.5 Specialised Hospitals

A specialised hospital -
   a) provides specialised health services like psychiatric services, tuberculosis services, infectious diseases and rehabilitation services; and
   b) has a maximum of 600 beds.

Rehabilitation – A specialised rehabilitation hospital caters for clients with severe disabling conditions and requires the services of rehabilitation personnel with specialist skills. There should be at least one specialised rehabilitation hospital in each province. The multi-disciplinary team at this level is able to assess for and prescribe and issue assistive devices. Clients at this level undergo intensive rehabilitation to regain as many functional abilities and skills as possible to be able to go back and integrate into communities.
## STRATEGIC PLAN 2015 - 2020

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<td><strong>GOAL 1:</strong> Integrate comprehensive disability and rehabilitation services within priority health programmes (including Maternal and Child Health, District Health Services, HIV/AIDS, TB, Health Promotion, Nutrition, Tertiary Services, Mental Health and Substance Abuse and Human Resources) from primary to tertiary and specialised health care levels.</td>
<td>Operational plans of respective priority programmes reflect disability and rehabilitation services</td>
<td>50% of priority programmes reflect disability and rehabilitation services in operational plans</td>
<td>2016/2017</td>
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<td>1. Integrate disability and rehabilitation services in the operational plans of respective priority programmes at National level</td>
<td>Operational plans of respective priority programmes reflect disability and rehabilitation services</td>
<td>100% of priority programmes reflect disability and rehabilitation services in operational plans</td>
<td>2019/2020</td>
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<td><strong>GOAL 2:</strong> Develop an appropriate, effective and efficient referral system between all levels of care including the expansion of services to improve access to rehabilitation units and specialised rehabilitation centres.</td>
<td>Disability and rehabilitation service norms on including HR, infra-structure and equipment</td>
<td>Draft 1 of Disability and rehabilitation service norms on including HR, infra-structure and equipment developed</td>
<td>March 2016</td>
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<td>1. Develop disability and rehabilitation service norms on HR, infra-structure and equipment</td>
<td>Disability and rehabilitation service norms on including HR, infra-structure and equipment developed</td>
<td>Final draft 2 of Disability and rehabilitation service norms on including HR, infra-structure and equipment developed</td>
<td>March 2017</td>
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<td>2. Develop a National Referral Guideline for Disability and Rehabilitation Services</td>
<td>National Referral Guideline for Disability and Rehabilitation Services is developed</td>
<td>National Referral Guideline for Disability and Rehabilitation Services is developed</td>
<td>September 2016</td>
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<td>3. Facilitate the compilation of Provincial Directories of Disability and Rehabilitation Services</td>
<td>Compilation of provincial Directories of Disability and Rehabilitation Services facilitated</td>
<td>50% of provinces compiled directories</td>
<td>March 2017</td>
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<tr>
<td><strong>GOAL 3:</strong> Foster inter-sectoral collaboration to address social determinants.</td>
<td>Inter-sectoral Disability and Rehabilitation for Health Steering Committee established</td>
<td>Inter-sectoral Disability and Rehabilitation for Health Steering Committee established</td>
<td>December 2015</td>
</tr>
<tr>
<td>1. Establish an Inter-sectoral Disability and Rehabilitation for Health Steering Committee to be housed within the National Health Commission</td>
<td>Inter-sectoral Disability and Rehabilitation for Health Steering Committee established</td>
<td>Inter-sectoral Disability and Rehabilitation for Health Steering Committee established</td>
<td>December 2015</td>
</tr>
<tr>
<td><strong>GOAL 4:</strong> Implement accessibility standards for infra-structure, communication, signage and information.</td>
<td>Existing accessibility standards for public sector facilities reviewed and aligned</td>
<td>Existing accessibility standards for public sector facilities reviewed and aligned</td>
<td>March 2016</td>
</tr>
<tr>
<td>1. Review and align existing accessibility standards for public sector facilities</td>
<td>Existing accessibility standards for public sector facilities reviewed and aligned</td>
<td>Existing accessibility standards for public sector facilities reviewed and aligned</td>
<td>March 2016</td>
</tr>
<tr>
<td>2. Transcribe key IEC material into accessible modes of communication</td>
<td>Key IEC material transcribed into accessible modes of communication</td>
<td>Key IEC material transcribed into accessible modes of communication</td>
<td>September 2017</td>
</tr>
<tr>
<td><strong>GOAL 5:</strong> Increase awareness, knowledge and attitudes of health care workers around disability.</td>
<td>Conducting of sensitisation workshops for health workers in all provinces</td>
<td>Conducting of sensitisation workshops for health workers commissioned in 5 provinces</td>
<td>March 2017</td>
</tr>
<tr>
<td>1. Conduct sensitisation workshops for health workers in all provinces</td>
<td>Conducting of sensitisation workshops for health workers in all provinces commissioned</td>
<td>Conducting of sensitisation workshops for health workers commissioned in remaining 4 provinces</td>
<td>March 2018</td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
</tr>
<tr>
<td>3. Audit facility based complaints registers to identify disability related complaints</td>
<td>Facility based complaints registers audited to identify disability related complaints</td>
<td>5 Health facilities audited in 10 NHI District</td>
<td>December 2016</td>
</tr>
</tbody>
</table>

**GOAL 6: Improve monitoring and evaluation of disability and rehabilitation services.**

<table>
<thead>
<tr>
<th>1. Develop and implement a monitoring and evaluation framework</th>
<th>Monitoring and evaluation framework developed and implemented</th>
<th>Monitoring and evaluation framework developed and implemented</th>
<th>December 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monitoring and evaluation framework implemented in full</td>
<td>Monitoring and evaluation framework implemented in full</td>
<td>March 2020</td>
</tr>
</tbody>
</table>

**GOAL 7: Improve Human Resources for disability and rehabilitation services.**

<table>
<thead>
<tr>
<th>1. Develop and implement a human resources plan</th>
<th>A human resources plan developed and implemented</th>
<th>A human resources plan developed and implemented</th>
<th>December 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A human resources plan implemented in 10 NHI Districts</td>
<td>A human resources plan implemented in 10 NHI Districts</td>
<td>December 2017</td>
</tr>
<tr>
<td></td>
<td>A human resources plan implemented in 26 districts</td>
<td>A human resources plan implemented in 26 districts</td>
<td>December 2018</td>
</tr>
<tr>
<td></td>
<td>A human resources plan implemented in all districts</td>
<td>A human resources plan implemented in all districts</td>
<td>December 2020</td>
</tr>
</tbody>
</table>

**GOAL 8: Improve access to appropriate assistive/technology and accessories.**

<table>
<thead>
<tr>
<th>1. Provide appropriate assistive/technology and accessories</th>
<th>Appropriate assistive/technology and accessories provided</th>
<th>Guideline on Provision of Assistive Devices and accessories revised</th>
<th>March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Revised Guideline on Assistive devices and accessories implemented in 10 NHI sites</td>
<td>Revised Guideline on Assistive devices and accessories implemented in 10 NHI sites</td>
<td>March 2018</td>
</tr>
<tr>
<td></td>
<td>Revised Guideline on Assistive devices and accessories implemented in 26 districts sites</td>
<td>Revised Guideline on Assistive devices and accessories implemented in 26 districts sites</td>
<td>March 2019</td>
</tr>
<tr>
<td></td>
<td>Revised Guideline on Assistive devices and accessories implemented in all districts</td>
<td>Revised Guideline on Assistive devices and accessories implemented in all districts</td>
<td>March 2020</td>
</tr>
</tbody>
</table>
### Appendix A: GLOSSARY

<table>
<thead>
<tr>
<th>Core professional rehabilitation service providers</th>
<th>Description of the roles</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Audiologist (Audio)</strong></td>
<td>Evaluating and determining the range, nature and degree of people’s hearing function in relation to their auditory efficiency and communication needs, including observation, the use of electro-acoustic instrumentation, and assessing receptive and expressive speech and language pathologies associated with hearing impairment. The planning, conducting or directing of or participating in the habilitation and/or rehabilitation of people with hearing pathologies, including the fitting and use of hearing aids, auditory training, speech reading, signing systems, speech conservation, speech and language acquisition, counselling and guidance related to the hearing impairment and to hearing conservation programmes.</td>
</tr>
<tr>
<td><strong>Medical Orthotist and Prosthetist (MOP)</strong></td>
<td>The profession of Medical Orthotics and Prosthetics includes the design and/or production of appliances intended to restore function or compensate limitations in the musculoskeletal system. This includes the design and/or production of appliances intended to replace, in whole or in part, amputated or deformed limbs, to restore or improve function. A Medical Orthotist and Prosthetist works directly with patients in the specialised field of orthopaedic rehabilitation in co-operation with other members of the MDT, by assessing, measuring, designing, manufacturing, maintaining and fitting orthoses and prostheses to assist with the rehabilitation of physically impaired patients.</td>
</tr>
<tr>
<td><strong>Occupational Therapist (OT)</strong></td>
<td>Occupational Therapy is a skilled treatment that helps individuals achieve independence in all facets of their lives. It gives people the skills necessary for independent and satisfying lives. Occupational Therapists work across the lifespan with newborns, young children, people with disabilities, the elderly, and with anyone who has a permanent or temporary impairment in their physical or mental functioning. Occupational Therapists help with rehabilitation of neuropsychological deficits, including memory and attention, as well as motor function, sensory function, and interpersonal skills.</td>
</tr>
<tr>
<td><strong>Physiotherapist (PT)</strong></td>
<td>A Physiotherapist assesses, treats and manages a wide variety of illnesses and injuries, including ailments from the fields of orthopaedics, neurology, respiratory and thoracic, cardiovascular, obstetrics, sports medicine, paediatrics, geriatrics, intensive care units and general rehabilitation.</td>
</tr>
<tr>
<td><strong>Speech-Language Therapist (SLT)</strong></td>
<td>A Speech-Language Therapist optimises an individual’s ability to communicate and swallow, thereby enhancing the quality of life. Speech-Language Therapists provide services across the lifespan to all age groups from neonates to the geriatric population, to individuals, families and groups from diverse linguistic and cultural backgrounds. The professional functions in Speech-Language Therapy include clinical/educational services (diagnosis, assessment, planning and treatment), prevention, advocacy, education and administration.</td>
</tr>
</tbody>
</table>

Source: HPCSA Regulations; 2015.
Refers to equitable access for people with disabilities to all services, products and facilities on an equal basis with others. This includes access to the built environment, transportation, information and communication technologies (ICT), live assistance, and all other systems and facilities offered to the public.

Describe inability/difficulty in performing an activity in the manner of or within the range considered normal for all individuals of a similar group. The use of assistive devices may remove limitations on certain activities, in specific areas/domains. Lack of interest in meal preparation and poor self-care and grooming when clinically depressed are also examples of activity limitations.

Describes any item or piece of equipment acquired commercially, modified or customised that is used to increase, maintain or help a person to perform a task or activity.

Assistive technology includes assistive devices (ADs) (such as mobility devices, orthotics, prosthetics) through to communication devices (hearing aids, as well as augmentative and alternative communication) , and medical products (all medical and surgical supplies that are consumables) excluding medication. Medical products include catheters, condoms, linen-savers, tape, wound-management materials (e.g. ointment and dressings) and Senokot tablets, required by an individual on a monthly basis to support independent living, a healthy lifestyle and maintenance of outcome level achieved prior to discharge from hospital.

Is an approach stating that biological, psychological (thoughts, emotions and behaviours) and social (socio-economic, socio-environmental and cultural) factors all play a significant role in human function.

Is someone with visual acuity of less than 3/60 (0.05) or corresponding visual field loss in the better eye with best possible correction (walk-about vision). Total blindness occurs when a person is unable to detect the direction of light, to identify shapes or forms, or has no vision at all.

Are individualised, non-linear and combine service elements unique to a specific patient that may cut across levels of care and sectors. They address clinical recovery and facilitate personal recovery.

CBR is a strategy within general community development for the rehabilitation, equalisation of opportunities and social inclusion of people with disabilities.

Is defined as inclusive of languages, display of text, Braille, textile communication, large-print and accessible multimedia, as well as written, audio, plain-language, human-reader and augmentative and alternative modes, means and formats of communication, including accessible ICT.

Refers to impairment in the ability to receive, send, process and comprehend concepts or verbal, nonverbal and graphic symbol systems. A communication disorder may be evident in the process of speech, voice, language and/or hearing.

Speech disorder: impairment in the articulation of speech sounds, fluency and/or voice. Language disorder refers to impaired comprehension and or use of spoken, written or manual modalities. Voice disorder is the abnormal production and/or absence of vocal quality, pitch, loudness, resonance and/or duration.

Describes an additional health condition that an individual may experience, which is independent and unrelated to the primary health condition.

Represent the background to an individual’s life and include environmental factors (i.e. age, gender, race, educational background, experiences, personality, character style, lifestyle, upbringing and coping styles).

Deafness is the disability associated with hearing impairment and may be mild, moderate, severe or profound (total). Hearing impairment is a loss of function in the auditory system that interferes with the reception and comprehension of a speech-sound signal and other meaningful environmental signals (considered to be in the better ear after maximum corrections at 1KHz, 2KHz and 4KHz for people under 15 years >30dB and older than 15 years >40dB). Hearing loss is caused by anything that prevents sound from travelling from the outer ear to the inner ear. It may be congenital (e.g. congenital hearing loss, foetal rubella) or acquired from infections (e.g. oitis media), medication or loud noises. The hearing loss may be Conductive – pathology of middle or outer ear; Sensori-neural – pathology of the inner ear; Mixed – pathology of the inner, middle or outer ear; Retro cochlear or neural hearing loss – pathology of the central auditory system.

Deaf-blindness is a unique sensory disability of combined loss of hearing and vision that significantly affects communication, socialisation, orientation and mobility, access to information and daily living.

Is defined as including those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (CRPD). The term disability serves as an umbrella term for impairments, activity limitations or participation restrictions, taking into account environmental factors that interact with all these constructs. The International Classification of Functioning, Disability and Health is used as a reference in defining the terminology.

Includes and involves everyone, particularly those who are subject to marginalisation and discrimination. Because people with disabilities and their families (especially those living in rural areas or urban informal settlements) often do not benefit from development initiatives, disability-inclusive development is a way of ensuring that they can participate effectively in development processes and policies. Indeed, including the rights of disabled people in the development agenda is a means of achieving equality for people with disabilities.
<table>
<thead>
<tr>
<th>Disease prevention</th>
<th>Includes interventions that not only prevent the occurrence of a disease, such as risk factor reduction, but also arrest its progress and reduce its consequences once established.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysphagia</td>
<td>Is a disturbance in the active transport of food or liquid from the mouth to the stomach, and is potentially life-threatening.</td>
</tr>
<tr>
<td>Early Childhood Development (ECD)ző</td>
<td>Is an umbrella term that applies to the processes by which children from the point of gestation for the first 1000 days to at least nine years, grow and thrive, physically, mentally, emotionally, spiritually, morally and socially.</td>
</tr>
<tr>
<td>Early Childhood Intervention Programmes (ECI)¹⁰</td>
<td>Are designed to support young children who are at risk of developmental delay (prevention), or who have been identified as having developmental delays or disabilities (treatment). The aim of ECI is to intervene as soon as possible to address problems that emerge early in life and early in the development of a problem. ECI comprises a range of services and supports to ensure and enhance children’s personal development and resilience, strengthen family competencies, and promote the social inclusion of families and children.</td>
</tr>
<tr>
<td>Early Hearing Detection and Intervention (EHDI)</td>
<td>Aims to ensure hearing screening by the age of one month, diagnosis of hearing impairment by the age of three months and intervention services (optimal amplification as well as family-based early communication intervention) by the age of six months. Infants who receive early intervention within the first six to nine months of life show significantly better outcomes in speech and language of development – potentially even comparable to their normal hearing peers.</td>
</tr>
<tr>
<td>Functioning (ICF)</td>
<td>Is an umbrella term used to describe body functions, body structures, activities and participation. It denotes the positive aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors).</td>
</tr>
<tr>
<td>Health promotion</td>
<td>Includes actions and advocacy to address the full range of potentially modifiable determinants of health, including actions that allow people to adopt and maintain healthy lives and those that create conditions and environments that support health.</td>
</tr>
<tr>
<td>Intellectual disability</td>
<td>Is present in an individual when both cognitive functions and the ability to function in society are impaired. Adaptive functions may be impaired in communication, self-care, home living, social/interpersonal skills, functional academic skills, work and leisure. Occurs before the age of 18 years.</td>
</tr>
<tr>
<td>International Classification of Functioning, Disability and Health ((ICF)</td>
<td>Is a WHO classification that provides a standard language and conceptual framework for the description of health and health-related states of functioning associated with the experience of health conditions.</td>
</tr>
<tr>
<td>Impairment</td>
<td>Is a loss or abnormality in body structure or physiological function, including mental function. It may be temporary or permanent; progressive, regressive or static; intermittent or continuous. The deviation from the norm may be slight to severe and may fluctuate over time. The presence of impairment necessarily implies a cause. However the cause may not be sufficient to explain the resulting impairment. It may be part of, or an expression of a health condition, but does not necessarily indicate that a disease is present or that the individual should be regarded as sick. A primary impairment may result in further impairments.</td>
</tr>
<tr>
<td>Participation</td>
<td>Is a person’s involvement in a life situation. It represents the societal perspective of functioning.</td>
</tr>
<tr>
<td>Participation restrictions (ICF)</td>
<td>Denote the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors), i.e. the problems an individual experiences in their life situations (social roles). For example, a participation restriction refers to the challenges a child with juvenile arthritis would experience as a learner in the absence of appropriate assistive technology and/or the necessary reasonable accommodation.</td>
</tr>
<tr>
<td>Perinatal period</td>
<td>Is the period during pregnancy (antenatal/prenatal), labour, and up to one year after birth (postnatal).</td>
</tr>
<tr>
<td>Personal recovery²¹</td>
<td>Is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of illness.</td>
</tr>
<tr>
<td>Primary level services</td>
<td>Is the first level of contact for individuals seeking healthcare.</td>
</tr>
<tr>
<td>Prevention</td>
<td>Means measures aimed at preventing the onset of mental, physical and sensory impairments (primary prevention) or at preventing impairment, when it has occurred, from having negative physical, psychological and social consequences (secondary prevention).</td>
</tr>
<tr>
<td>Psychosocial rehabilitation</td>
<td>Refers to mental healthcare services that bring together approaches from the rehabilitation and the mental health fields, combining pharmacological treatment and skills training, as well as psychological and social support to clients and families, in order to improve their lives and functioning capacities.</td>
</tr>
<tr>
<td>Reasonable accommodation (CRPD)</td>
<td>Refers to necessary and appropriate modification and adjustments where needed in a particular case, to ensure that people with disability receive all human rights and fundamental freedoms on an equal basis with others.</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>The term rehabilitation is a goal-directed process to reduce the impact of disability and facilitate full participation in society by enabling people with disability (PwD) to reach optimum mental, physical, sensory and/or social functional levels at various times in their lifespan. The rehabilitation process has levels or stages with specific outcomes for participation throughout the lifespan.</td>
</tr>
<tr>
<td>Secondary Care</td>
<td>Is specialist care that is typically rendered in a hospital setting following a referral from a primary or community health facility.</td>
</tr>
</tbody>
</table>
Include the social and economic environment, the physical environment and the person’s individual characteristics and behaviours (i.e. the “causes of the causes” of ill-health).

Programmes designed to restore or develop the capabilities of people with disabilities to secure, retain and advance in suitable employment, e.g. job training, job counselling and job placement services.

REFERENCES

7. Dementia SA. Dementia, the invisible disability. What are we up against? The DG Murray Trust Hands-on Learning Brief 73 2014, Dec; Cape Town: 1-3