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Perceptions on transitioning from impairment- based to occupation-based practice in public healthcare within KwaZulu-Natal Phana Lucy Gumede Student no: 217039651 Submitted in fulfilment of the requirements for the degree of Master's in Occupational Therapy in the School of Health Sciences, University of KwaZulu-Natal October 2023 DECLARATION I, Ms Phana Lucy Gumede, student number 217039651, declare as follows: 1. The research reported in this thesis, except where otherwise indicated, is my original research. It is my original work, both in concept and execution and apart from the normal guidance from my supervisor, I have had no other assistance in writing this dissertation. 2. The work described in this thesis has not been previously submitted to the University of KwaZulu-Natal or other tertiary institutions for purposes of obtaining an academic qualification, whether by myself or any other party. 3. Where contributions of others were used, they were acknowledged in the writing and the reference section, and where direct quotations were used, in text and were placed in quotation marks and referenced accordingly. 4. The researcher chose the topic, reviewed available literature on the topic and compiled the research proposal with guidance from the supervisors. Gatekeeper, ethical approval and participant consent were received before the commencement of data collection. 5. This work was completed under the guidance of my supervisors at the University of KwaZulu- Natal, College of Health Sciences, Discipline of Occupational Therapy. Signed by: Phana Lucy Gumede Signature: Date: 23 October 2023 i DEDICATION I dedicate this research to God and my ancestors, my answered prayers and guidance. To my family and friends, thank you. To my supervisors, thank you for your patience and knowledge. To the profession, my lovely clients, it's a pleasure to serve and to learn. Finally, I dedicate this research to art for keeping me sober-minded. ii ACKNOWLEDGEMENTS I want to acknowledge and show my appreciation and gratitude to the following individuals for assisting in bringing this study to life. • My supervisors, thank you. • My Family. • The participants, the Department of Health, the University of KwaZulu-Natal and the different facility managers/ Chief Executive Officers (CEOs). iii LIST OF FIGURES: Figure 1: Interactions between the ICF (World Health Organisation, 2007) .... 10 Figure 2: Map of the iLembe district with available full-time rehabilitation personnel...............32 Figure 3: Interactions between the ICF (World Health Organisation, 2007) ....34 Figure 4: Number of special schools in the iLembe district...43 Figure 5: Barriers towards OBP implementation...61 Figure 6: Interrelatedness of OBP and IBP during different stages of illness and rehabilitation services...64 iv LIST OF TABLES Table 1: Trustworthiness...34 Table 2: Demographic characteristics: semi-structured interview participants (n= 13)..............36 Table 3: Demographic characteristics: focus group participants (n= 4)...............................38 Table 4: Themes and sub-themes...39 Table 5: Number of rehabilitation personnel in each facility (year 2022: August- December)........43 Table 6: Number of rehabilitation personnel in each facility (year 2023: January- May)..............43 v OPERATIONAL DEFINITIONS Impairment-based practice: focuses on reducing impairments in the person's body structure and function (Tomori et al., 2015). International Classification of Functioning, Disability and Health: A framework used to understand and describe functioning, disability, and an individual's level of functioning, considering their health conditions, environment, and personal factors (World Health Organization, 2007). Occupation-based practice: a multifaceted practice targeting impairment reduction, adaptation, accommodation, skill acquisition, social reconstruction, or health and well-being, used to address an issue in occupational performance or engagement (Polatajko& Davis, 2012) Occupational therapy: a client-centred health profession that focuses on improving well-being and health through occupation. The main goal of occupational therapy is to enable people to participate in everyday life activities. Occupational rehabilitation personnel achieve this goal by working with people and communities to improve their independence to engage in activities that are meaningful to them or by adapting the occupation or the environment to support their occupational engagement better (World Federation of Occupational Therapy, 2023). Physiotherapy: focuses on the biomedical science of movement and helps people restore, maintain, and improve physical skills, motion, and overall health by treating underlying physical issues (South Vancouver Physiotherapy Clinic., 2022) Primary healthcare: "is an essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country's health system, of which it is the central function and focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first elements of a continuing health care process" (World health Organisation, 1978). vi Rural setting: An area with a lower population density and size than urban centres and lengthier travel times to reach hospitals compared to trusts in urban areas (Nuffield Trust, 2023) Semi-rural: partly rural; between rural and urban; somewhat but not wholly characteristic of rural areas (Collins, 2022). Speech-language pathology: is the assessment and diagnosis of communication and/ or swallowing disorders and the identification of retained abilities to offer advice and support to prevent, maintain, or improve communication and swallowing (Enderby & Emerson, 1996). The Framework and Strategy for Disability and Rehabilitation services: is a framework which was developed in 2015-2020 to ensure the inclusion of people with disabilities and strengthen access to rehabilitation services in all aspects of community life (Ilifa Labantwana, 2016). The Social model of disability: This model is about how society disables people with impairments and how treatment must be directed at societal change rather than just individual impairment. The model aims to remove unnecessary barriers which limit people with disabilities from engaging in society (Shakespeare, 2006) vii ABBREVIATIONS ADL: Activities of daily living CSO: Community Service Officer DOH: Department of Health HPCSA: Health Professions Council of South Africa HSSREC: Humanities and Social Sciences Research Ethics Committee IADL: Instrumental activities of daily living IBP: Impairment-based practice ICF: The International Classification of Functioning, Disability and Health KZN: KwaZulu-Natal NOPS: Number of permanent staff NOSCSO: Number of community service officers OBP: Occupation-based practice OT: Occupational therapist PHC: Primary Health Care Physio: Physiotherapist POPIA: Protection of Personal Information Act SMoD: Social model of disability UCT: University of Cape Town UFS: University of Free State UKZN: University of KwaZulu-Natal UP: University of Pretoria UWC: University of Western Cape viii PREAMBLE This thesis follows a master's by manuscript research format from the College of Health Sciences at the University of KwaZulu-Natal, Westville Campus, South Africa. It consists of an introductory chapter (Chapter One), which comprises the background, problem statement, research question, aims, objectives, significance of the study, literature review, theoretical framework and methodology. It also consists of Chapter Two, the manuscript that includes the journal article, followed by Chapter Three, which outlines the study's conclusions, implications, limitations and recommendations. The research thesis used the American Psychological Association referencing style as per the guidelines of the University of KwaZulu-Natal. The manuscript used a

different referencing style (Vancouver referencing style) as per the requirements of the South African Journal of Occupational Therapy. Additionally, each chapter has its own reference list. There are some repetitions in the thesis due to the methodology being repeated in Chapters one and two. ix

ABSTRACT Introduction: Impairment-based practice is the more traditional approach to providing rehabilitation services to clients, with occupational-based practice not being widely accepted. The study explored the rehabilitation personnel's perceptions on transitioning from impairment-based to occupation-based practice in the public healthcare sector. The study further explored rehabilitation personnel's challenges with occupation-based practice and the implementation of holistic rehabilitation services to improve training, clinical experience, and health promotion/ education. The study was conducted in the rural and semi-rural communities of the iLembe district, KwaZulu-Natal (KZN), South Africa. Methods: A qualitative research design was utilised to understand the rehabilitation personnel's perceptions. Purposive sampling was used to select seventeen participants (occupational therapists, speech therapists and physiotherapists) who were employed within the district's public sector. The data collection methods utilised were semi-structured interviews, a focus group and community mapping. There were thirteen participants in the semi-structured interviews and four participants in the focus group. Community mapping was completed to identify contextual factors affecting the implementation of rehabilitation services. Data were analysed using deductive thematic analysis. The research questions, aims and objectives guided by the ICF framework, assisted the researcher to analyse the participants' perceptions of IBP and OBP concerning the components of health. Furthermore, Braun and Clark's six- step data analysis techniques guided the write up process of the study's key findings using sub-themes and themes. Findings: Three main themes emerged from the study, namely, Attitudes towards IBP, Reflections on OBP, and Way forward. Participants outlined different factors that influence their practice choice and the implications of using IBP as an approach in therapy. IBP was identified as diagnosis-focused, with factors such as acute settings, the dominance of the medical model, high turnover rates, limited staff and lack of insight on OBP from other health practitioners promoting IBP implementation. Barriers towards OBP implementation noted were community-specific, facility- specific and client specific factors. Despite all the barriers identified, rehabilitation personnel noted facilitators for OBP implementation. The facilitators included an initial assessment that assesses all the client's components of health, planning, intentionality, time, and knowledge. Factors such as interdisciplinary practice, a collaboration between the rehabilitation personnel and clients, improved access to rehabilitation services, and facilities to carry over OBP in the community were also found to facilitate OBP implementation. When implemented correctly, OBP was highlighted to have positive outcomes, such as improved client independence in activity participation and overall health. However, the rehabilitation personnel noted that when choosing an assessment and intervention approach, it is essential to consider the client's body functions and structures, activity, participation, environment and personal needs. Thus, different approaches can be used to implement client-specific assessment and intervention. Conclusion: Despite the different factors influencing the rehabilitation personnel's x practice choice, the study concluded that there is a need to utilise more OBP approaches due to OBP's health outcomes and ability to address all the components of health when implemented optimally. Implications and recommendations were identified for the Department of Health, rehabilitation personnel, community stakeholders, Department of Higher Education and Training (Health Sciences) and further research to improve the implementation of rehabilitation services within public healthcare in the iLembe district. Keywords: Occupation-based practice, impairment-based practice, social model of disability, The international classification of functioning, disability, and health. xi TABLE OF CONTENTS

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CHAPTER ONE: INTRODUCTION 1.1. Context of the study Since the 1990s, advocates for the social model of disability have widely held that impairment and disability work together and that the individual challenges of disability should not be ignored (Hogan, 2019). This led to a movement away from the medical model towards a more holistic healthcare model, representing a greater need to understand the range of interventions that could be offered and their differences, such as impairment-based practice (IBP) and occupation-based practice (OBP). Tomori et al. (2015) and Psillas & Stav (2021) found that OBP can increase a client's prognosis more than IBP. Despite rehabilitation goals often focusing on improving clients' participation in their premorbid roles and activity performance, South African research has found that rehabilitation personnel have a limited understanding and experience with OBP (Hess-April et al., 2017). Rehabilitation personnel's perceptions/ understanding of IBP and OBP is vital to the type of intervention they offer their clients. Rehabilitation personnel who used

impairment-based treatment were usually influenced by previous training, clinical experience and lack of creative, grading, and analysing skills in activities, which are crucial components of OBP (Daud et al., 2016). Further implying a need to explore the perceptions of rehabilitation personnel on IBP and OBP to improve the understanding of occupation-based interventions and improve undergraduate training, and the quality of holistic rehabilitation services offered to clients. According to Daud et al. (2016), clients and rehabilitation personnel incur challenges when implementing OBP. These challenges include having limited human and physical resources in the South African public healthcare sector. Additionally, factors such as, most facilities being medical model- oriented (focus on curing disease and not function), a lack of space to conduct OBP, high client caseloads (limited staff members), limited access to client's context (for context and client-specific intervention), and a lack of time (patients discharged before completion of rehabilitation) to implement rehabilitation services, serve as barriers towards OBP (Daud et al., 2016). By exploring rehabilitation personnel's perceptions of OBP, we gained insight into factors hindering its implementation within the iLembe district. This study allowed for exploring the different barriers towards OBP as reported by rehabilitation personnel from their experience working within the iLembe district, with different clients and their effect on OBP implementation. Although the theory of OBP is taught at an undergraduate level, it is understood at a more postgraduate and abstract level. As a result of this occupation-based practice implementation is more complex, especially in the acute intervention phases (Psillas & Stav, 2021). Occupation-based practice is a dynamic approach focusing on impairment reduction, accommodation, adaptation, social reconstruction, skill acquisition, health, and well-being to address occupational performance and engagement (Polatajko & Davis, 2012). According to Tomori et al. (2015), OBP has three main components: assessment, treatment, and goals. Assessment includes occupational interviewing and observation of clients engaging in occupations in their natural or simulated contexts and environment. The treatment uses occupations in the client's natural or simulated contexts and environment to improve the client's independence and ability to engage in meaningful activities. Goals focus on facilitating engagement in occupation and participation in everyday life within the community rather than only reducing the client's physical impairments. Thus, to implement OBP rehabilitation personnel must understand the three components of OBP. Rehabilitation personnel must also understand the difference between IBP and OBP to provide their clients with quality healthcare services within a holistic model. The social model of disability was formed to counteract the medical model and societal barriers towards people with disabilities. The proponents of the social model of disability state that impairment and disability interact (Hogan, 2019); thus, impairment and disability affect the individual's ability to participate in life physically, emotionally, socially, psychologically, spiritually, economically, and culturally. Wolf et al. (2015) stated that occupational therapy is too focused on ADL performance, thus limiting other meaningful occupations and factors in the individual's life that make their life holistic. This focus on one component further emphasises the need to acknowledge impairment and other components of the individual's life and health. Using the individuals meaningful activities, for example, play in paediatric practice, improves the clients' motivation to engage in sessions and, subsequently, their function (Nordström et al., 2023). Although there is limited literature on occupational-based practice in physiotherapy and speech therapy, Nagayama et al. (2017) found that impairment-based approaches yield less quality-of-life results than occupation-based approaches. This study aimed to understand the rehabilitation personnel's perceptions (occupational therapists, physiotherapists, and speech therapists) on moving from IBP to OBP e within the public healthcare sector. The study also explored their perceptions of IBP and OBP in semi-rural and rural settings within the iLembe district. Additionally, this study explored rehabilitation personnel's challenges with OBP and implementing holistic rehabilitation services to improve training, clinical experience, and health promotion/ education. 1.2. Problem Statement Impairment-based practice is the more traditional approach to rehabilitating clients, with occupational- based practice not being widely accepted. Anecdotally, within the iLembe district, there are various challenges to implementing occupational-based practice. These include decreased human and physical resources, lack of infrastructure, lack of knowledge, and rehabilitation personnel's contextual and personal barriers. This research study aimed to explore the perceptions of rehabilitation personnel around implementing OBP and IBP within the iLembe district and to identify the different personal and contextual barriers to effectively implementing OBP within the district. Furthermore, the study aimed to decrease the gap in the literature on OBP among the different rehabilitation personnel to improve understanding of OBP and the different factors that could promote its implementation within the iLembe district. The increased insight could assist in developing strategies to facilitate more widespread adoption of holistic interventions within public healthcare. 1.3. Research questions, aims and objectives 1.3.1. Research Questions • What are the perceptions of rehabilitation personnel (occupational therapists, physiotherapists, and speech therapists) related to impairment-based and occupation-based practice? • What are the perceptions of rehabilitation personnel in the iLembe district (within public healthcare) concerning transitioning from impairment-based practice to occupational-based practice? • What are the rehabilitation personnel's perceptions of the barriers (environmental, physical, and psychological) of occupational-based practice in public healthcare, specifically the iLembe district? • What is required to effectively implement occupational-based practice in the public healthcare facilities within the iLembe district? 1.3.2. Aim • To explore perceptions of rehabilitation personnel within the iLembe district on occupational-based practice and impairment-based practice • To explore the perceptions of rehabilitation personnel within the iLembe district regarding transitioning from impairment-based practice to occupational-based practice • To explore the different personal and contextual barriers to effectively implementing occupational- based practice within the iLembe district. • To identify the critical components required to effectively implement the occupational-based practice in public healthcare facilities within a South African context, specifically the iLembe district 1.3.3. Objectives • To determine the rehabilitation personnel's preferred choice between occupational-based practice and impairment-based practice and their reasoning. • To explore the benefits of occupational-based practice and formulate a holistic definition of occupation-based practice. • To explore rehabilitation personnel's perceptions regarding relevant motivators that would drive transitioning from impairment-based practice to occupational-based practice. • To identify the barriers to occupational-based practice (personal and contextual) in public healthcare as perceived by rehabilitation personnel in the iLembe district. 1.4. Significance of the study: There are currently limited studies on rehabilitation personnel's perceptions of occupational-based practice and impairment-based practice within public healthcare and the barriers to the optimal implementation of occupational-based practice. This study will assist in identifying the challenges that rehabilitation personnel encounter with OBP implementation. Additionally, the findings can provide evidence to improve training associated with occupational-based practice and health promotion related to occupation-based and impairment-based practice in the public healthcare sector. Further, the study may improve rehabilitation personnel's understanding on what it entails to move away from impairment-based practice to OBP within public healthcare and how to implement OBP in semi-rural and rural settings. It will also assist in identifying the gaps in knowledge about occupational-based practice within public healthcare, thus bridge this gap through disseminating the study findings to the Department of Health and Rehabilitation personnel. The study will improve the literature about OBP e and the implementation of OBP in public healthcare within the context of South Africa. Additionally, service delivery will be improved through rehabilitation personnel gaining insight on policies that guide intervention and possible changes to intervention approaches that facilitate the use of OBP can be made. 1.5. Overview of literature 1.5.1. Introduction This section explores literature relevant to this research's aims and objectives, including literature on IBP and OBP. Additionally, it explores the literature relevant to this study, such as literature surrounding perceptions of rehabilitation personnel on transitioning from IBP to OBP. It further explores the barriers to implementing OBP, the critical factors required to implement occupational-based practice effectively, and the framework guiding the study. The review aims to highlight the gaps in the literature around the study by discussing IBP, OBP, and the social model of disability within the implementation of rehabilitation services. Additionally, it explores the different frameworks, policies and strategies towards implementing rehabilitation services in public healthcare. These frameworks, policies and strategies include the Alma-Ata, universal health coverage, the national framework and strategy for disability and rehabilitation services, the social model of disability, and the International Classification of Functioning of Disability and Health (ICF). 1.5.2. Context of rehabilitation services in South Africa Narain and Mathye (2023) reported limited awareness of rehabilitation services in the South African context, especially in rural Black communities; reporting that this was attributable to the country's historical past. South Africa's apartheid history led to Black communities regarding rehabilitation services to be only for wealthy White communities, thus decreasing insight into such services. Literature found limited involvement of persons with disabilities in healthcare policy-making processes (Chichaya et al., 2019; Narain & Mathye, 2023). Chichaya et al. (2019) further explained that due to the limited involvement of persons with disabilities in the policy-making process, policies for people with disabilities are medical model-oriented. Limited engagement and incorporation of people with disabilities also influenced the decreased awareness of the value of rehabilitation services by policymakers. Further, limited efforts to promote rehabilitation services result in poor knowledge and awareness among illiterate persons and other healthcare practitioners (Narain & Mathye, 2023). Semi-rural and rural communities, such as the iLembe district, with factors like high levels of unemployment, poverty, illiteracy, and poor roads and infrastructure (ILembe District Municipality KZN, 2023), have restrictions on access to healthcare services. The previously noted factors are linked to inaccessibility because it is expensive to travel to healthcare facilities, especially for people with disabilities, who sometimes must pay twice the amount for transportation (Chichaya et al., 2019). 1.5.3. The social model of disability The social model of disability focuses on the disabling nature of society on people with disabilities through directing treatment at societal change (Shakespeare, 2006). The model aims to remove unnecessary barriers which limit people with disabilities from engaging in society rather than the individual's impairment (World Health Organization, 2007). The social model of disability states that managing problems with participation requires social action and the collective responsibility of everyone in the community to enable the necessary environmental changes to allow people with disabilities to engage in all areas of social engagement (World Health Organisation, 2007). Shakespeare (2006) outlined three benefits of the social model of disability; firstly, the model assists in identifying social barriers leading to social exclusion and oppression. Secondly, the model assists in improving persons with disabilities psychological factors, for example, self-esteem, through the use of terminology such as "people with disabilities" instead of "disabled people". The use of such terminology to redefine disability as the restrictions caused by inequitable social and structural support for people with disabilities within the community. However, the model is seen to present with a disadvantage, as it may neglect that the impairment impacts people with disabilities' ability to engage in daily activities and not just their societal barriers (Oliver, 2013). This model has offered a basis for understanding contextual factors influencing health, which are predominantly neglected in South African healthcare facilities. It also highlighted the need to utilise holistic approaches and frameworks when implementing rehabilitation services and, indirectly, the importance of acknowledging body structures and functions as one of the components of health within the study. 1.5.4. Policies and legislations within the implementation of rehabilitation services The World Health Organisation identified various physical and attitudinal barriers towards participation, and access to critical healthcare services in different communities, which led to national legislative changes

to strengthen the rights of people with disabilities (Mji et al., 2013). The guiding policies in South Africa are the National Rehabilitation Policy (NRP) of South Africa, the UN Convention for the Rights of Persons with Disabilities and the World Health Organisation (2007) Community-Based Rehabilitation (CBR) Guidelines (Mji et al., 2013). The International Classification of Functioning of Disability and Health , according to the World Health Organization (2007), describes different components of health and health-related components of well-being from the perspective of the body, the individual and society in five components, namely, body functions and structures, activities, participation, environmental and personal factors. The ICF requires diverse stages of analysis and intervention (Shakespeare, 2006) as it provides a multi-perspective approach to the classification of functioning and disability as an interactive and evolutionary process (World Health Organization, 2007). The Alma-Ata highlights a strong need for community-based healthcare services and community participation and empowerment (Perry, 2018). This highlights the need to consider the community factors affecting rehabilitation services at a primary healthcare level. The need for community-based primary healthcare is further emphasised by the universal health coverage which aims to improve access to high-quality healthcare, including rehabilitation services in communities that are socially or geographically disadvantaged (Sacks et al., 2020). The framework and strategy for disability and rehabilitation services (FSDR) was developed from 2015 to 2020 to strengthen inclusion and access to rehabilitation services within South Africa, with a focus on rehabilitation and the interface between rehabilitation, CBR and primary healthcare (Kout et al., 2022). However, there is limited literature on the evaluation of public health rehabilitation services in implementing the guiding policies and legislation in South Africa (Mji et al., 2013). 1.5.5. Impairment-based practice in the implementation of rehabilitation services According to Best et al. (2008), a change in impairment may be reflected in a measurable change in activity; for example, when speech therapists use IBP, they do so in the belief that changes in speech and language will affect the person's communication and everyday life activities. Contrarily, Teixeira et al. (2011) found that impairment-based interventions had a low impact, at best, on improving the performance of specific functional tasks in individuals with, for example, knee osteoarthritis and limited studies report how IBP impact performance in functional tasks. IBP is used in speech therapy to help clients speak better through information-processing models and therapy, and target reading and writing abilities (Worrall & Bennet, 2001). Additionally, IBP tablet- based platforms were found to be effective in language and cognitive therapy for individuals with aphasia (Des Roches et al., 2015). Further, Wenke et al. (2018) found that intensive impairment-based hybrid intervention models in acute aphasia recovery could improve information processing models and therapy by targeting reading and writing abilities. However, there were limited findings on IBP's impact on the ability to communicate with others in social environments (Wenke et al., 2018). Within physiotherapy, Narain and Mathye (2023) found that most physiotherapists are medical model oriented, they focus intensively on impairment-based treatments and use impairment-based outcome measures when implementing rehabilitation services. The use of increased IBP approaches was accredited to most healthcare facilities in South Africa being medical model oriented (Inglis et al., 2008). These medical model oriented healthcare facilities in South Africa also result in most occupational therapy assessments and interventions focusing on body structures and function (Aas & Bonsaksen, 2022; Alotaibi et al., 2009; Di Tommaso et al., 2019). O'Donoghue et al. (2021) found that some rehabilitation personnel believe IBP is a more practical approach for acute rehabilitation. Rehabilitation personnel felt resource constraints such as lack of time for planning, limited funds, and equipment led to the use of impairment-based approaches when implementing rehabilitation services (Hess-April et al., 2017). Although rehabilitation personnel perceived IBP as a practical approach, it was found to focus only on the impact of disease or other health conditions, and sometimes neglected other factors such as activity, participation, and environmental and personal factors that influence the person's health and quality of life (World Health Organization, 2007). In support of this, focusing only on the body functions and structures also hinders rehabilitation personnel from holistically understanding the client's needs to provide optimal and holistic healthcare services (Heymani et al., 2020). 1.5.6. Occupation-based practice in the implementation of rehabilitation services According to Hess-April et al. (2017), OBP is focused on the client's needs, goals, values and interests, and it's a partnership between the client and rehabilitation personnel. OBP comprises an assessment including occupational interviewing and skilled observation of the person in the most natural context possible. After the assessment, there is intervention, which uses occupation in the most natural context possible, with goals focused on facilitating engagement in occupation and participation in society rather than solely on reducing impairments in the person's body structure and function (Tomori et al., 2015). Occupation-based interventions such as highly structured and simulated activities are client-specific and depending on the client's needs (Finestack & Satterlund, 2018). These simulated activities help generalise object names in speech therapy as they are client-directed, where intervention goals are embedded in routine, planned, or client-initiated activities (Botts et al., 2012). Physiotherapists focus on impairment-based approaches that result in cumulative effects in the rehabilitation process (Inglis et al., 2008). Thus, there is a need for physiotherapy to focus more on participation to meet the client's needs (Narain & Mathye, 2023). Occupational therapists perceived OBP to have more potential to improve general health (Tomori et al., 2015). Although OBP was perceived to have more health outcomes, Wolf et al. (2015) found a decreased focus on occupation in the acute phases of rehabilitation. Thus, identifying a need to address activity and participation in the early stages of occupational therapy intervention. Acute phases of intervention along with other factors such as, limited availability of resources and medical model dominance (Hess-April et al., 2017) were regarded as barriers to OBP implementation. OBP was seen as more difficult in a medical-oriented facility, and OBP implementation was complex as pragmatic factors and contextual forces exerted strong influences (Estes& Pierce, 2012). Due to a lack of experience and skills in implementing OBP, some recent graduates choose impairment-based techniques over OBP (Di Tommaso et al., 2019). However, even though there are numerous barriers towards OBP implementation; rehabilitation personnel valued OBP (Aas & Bonsaksen, 2022) and perceived it as more motivating, understandable, valuable, and easily generalised to clients' everyday lives (Estes & Pierce, 2012). Literature states that using OBP improves function in areas of occupation, specifically after stroke (Wolf et al., 2015). Further, confidence in implementing OBP was found to be an essential factor for its implementation (Di Tommaso et al., 2019). 1.6. Theoretical Frameworks The World Health Organisation has focused on activities and participation in developing the International Classification of Functioning, Disability and Health (ICF) to promote optimal health and social engagement (Lotter et al., 2020). The ICF describes and organises data on functioning and disability. This framework, which was approved in 2001, views an individual's level of functioning as a dynamic interaction between their health conditions, environment, and personal factors (World Health Organization, 2007). The ICF aims to provide a scientific basis for health and health-related states, determinants, outcomes, health status and functioning. It also aims to create a common language to describe health and health-related states to improve communication between individuals, such as healthcare practitioners, researchers, policymakers and community members, to allow for data comparison across different healthcare settings and to establish a systematic health information coding system (The Centers for Disease Control and Prevention, 2022). The ICF was used to guide the formulation of data collection tools in exploring the rehabilitation personnel's perceptions and how these perceptions affect their practice choices when implementing rehabilitation services. The framework comprises two parts, namely Functioning and Disability, which include the components of health, such as body functions and structures, activities, and participation; and contextual factors, including environmental and personal factors (World Health Organisation, 2007). Literature notes that the ICF has numerous benefits, it provides a holistic view of the client, assesses complexities of functioning, provides an understanding of function and disability, and provides a common language (Kostanjsek, 2011). However, the framework has complicated terminology and is subjective, which serves as a disadvantage to its effective implementation (Kostanjsek, 2011). Figure 1: Interactions between the ICF (World health Organisation, 2007) During the data collection process, the ICF framework was used in community mapping to study the environmental, physical, and psychological factors influencing occupational-based practice implementation in the iLembe district's public healthcare sector. Additionally, it assisted in establishing a common language when conceptualising questions for the focus group and semi-structured interviews. The framework guided the data analysis process to highlight how contextual and personal factors influence rehabilitation personnel practice choices within the district. This framework has a biopsychosocial perspective, which was used when creating the data collection tools. This biopsychosocial perspective assisted in understanding the participants' perspectives on occupational- based practice and how physical, psychological, and social factors influence it (The Centers for Disease Control and Prevention, 2022). The research questions were used as the framework during the data analysis process guided by the ICF framework. This allowed the researcher to identify perceptions relevant to the study's aims and objectives. 1.7. Methodology This section outlines the methodology used in this study, which includes the research design, study setting, study population, sampling and recruitment, data collection methods, pilot study, data management and data analysis. It also highlights the ethical considerations which guided the study. 1.7.1. Research Design A qualitative research design was utilised to understand the rehabilitation personnel's perceptions. This research design allowed for an increased understanding of the rehabilitation personnel's experiences, social context, and views (Fossey et al., 2002). The data was collected through semi-structured interviews, a focus group and community mapping. The data from the semi-structured interviews were used to gain participants' in-depth opinions on their experiences and a detailed explanation of their perceptions. The data gathered from the focus group was used to explore the collective perspective regarding the study aims and objectives (Gibbs, 2012). Community mapping allowed for the identification of community resources such as knowledge and infrastructure. 1.7.2. Study setting This research study was conducted in the iLembe district, within rural and semi-rural communities. The iLembe district has an area of 3269 km2, with its primary economic sector being agriculture. It is located on the east coast of KwaZulu-Natal. It comprises four municipalities: KwaDukuza, Maphumulo, Ndwedwe, and Mandeni. A large area within the district presents with limited access to healthcare services, water, electricity, and other essential services. A quarter of the population lives in traditional and informal settlements, with 50% of the roads being in good condition, 22% being medium, 20% being poor, and about 8% in bad condition (ILembe District Municipality KZN, 2023). The district has an estimated population of 630 464 people (iLembe District Municipality KZN, 2023). It has three hospitals and two primary healthcare centres with multidisciplinary and rehabilitation services, all of which are medical model-oriented. Rehabilitation personnel who work in the public healthcare sector in the district were targeted as research participants. 1.7.3. Sampling and recruitment 1.7.3.1. Sampling: The participants consisted of rehabilitation personnel (speech therapists, occupational therapists and physiotherapists) in the iLembe district public healthcare sector with more than six months of experience working in South African public healthcare. Sampling techniques and recruitment of sample: Purposive sampling was utilised to recruit research participants for the study. Participants were recruited from the district's public healthcare institutions (four facilities) and consisted of rehabilitation personnel familiar with occupation-based and impairment-based practices, namely occupational therapists, physiotherapists, and speech therapists. They were recruited through emailing and calling the chief executive officers (CEOs) of the different facilities (to seek consent), explaining the nature of the research study and inviting the rehabilitation personnel to engage in the

study. Sample Size: The participants were recruited from rehabilitation personnel working in the iLembe district within the following areas; KwaDukuza (ten participants), Maphumulo (two participants), Ndwedwe (three participants), and Mandeni (two participants). The sample comprised five occupational therapists, nine physiotherapists, and three speech therapists who met the inclusion criteria, allowing maximum variation sampling and representing the rehabilitation team. Inclusion criteria: - Participants could speak and understand English or isiZulu, the local language in the community. - Participants, including policymakers, were rehabilitation personnel (occupational therapists, physiotherapists, and speech therapists) in the iLembe District. - Participants worked in the iLembe district public healthcare sector. - Participants had more than six months of experience working in the South African public healthcare sector. - All the participants were rehabilitation personnel who graduated (for their profession) from a South African institution and were registered with HPCSA. Exclusion criteria: - Rehabilitation personnel from the private health care sector. - Rehabilitation personnel with less than six months experience in the South African public healthcare sector. - Rehabilitation personnel who were not working in the iLembe district. - Health professionals who were not rehabilitation personnel. - Rehabilitation personnel who did not graduate in South Africa. 1.7.3.2. Recruitment Following ethical approval from the Humanities and Social Sciences Research Ethics Committee of UKZN, the Department of Health district office of the iLembe district and the different hospital CEOs. Research participants were recruited over two months by contacting the CEOs and acquiring data on the names of the different rehabilitation personnel employed in the iLembe district and the number of rehabilitation personnel employed in each hospital or primary healthcare institution. The rehabilitation personnel who met the inclusion criteria were invited to participate in the study telephonically. The study was explained to them, and all their questions were answered before signing the consent forms to promote informed consent. 1.7.4. Pilot study The pilot study was used to analyse the feasibility of the semi-structured interviews before performing the main study (In, 2017). It was conducted within the eThekwini and uMgungundlovu districts with two occupational therapists employed in the public healthcare sector. It assisted in making necessary changes and adjusting the research tools to improve the study's rigour by minimising any uncertainty on how to implement the semi-structured interviews. Moreover, this improved the research study's credibility. 1.7.5. Data collection The primary data collection tools used were semi-structured interviews , a focus group and community mapping. The semi-structured interviews took place face-to-face, and the focus group took place over the Zoom platform. The semi-structured interviews (Annexure 7) were used to understand the rehabilitation personnel's perspectives regarding the research questions. The focus group (Annexure 8) was used to understand their perspectives when with other rehabilitation personnel from other disciplines in a group setting. Community mapping (Annexure 9) was used to identify the infrastructure and resources in the community, such as available special schools and sheltered workshops. All the participants were given informed consent (Annexure 5) before the focus group and semi-structured interviews so that they understood the nature of the research study. The participants only heard the questions when the semi-structured interviews and focus group took place to prevent the participants from having planned answers because this would have restricted engagement and responses during the data collection process. 1.7.5.1. Semi-structured interviews: Creswell (2018) states that semi-structured interviews allow participants to give in-depth opinions on their experiences; thus, allowing them to give a detailed explanation of their perceptions. The semi- structured interviews comprised of eight open-ended questions. They were conducted in different venues (Sundumbili CHC, Mphumulo Hospital, Ndwedwe CHC, and General Justice Gizenga Mpanza Regional Hospital). The interviews were aimed at community service officers and permanent rehabilitation staff members. The questions from the semi-structured interviews and the focus group aimed to explore the perspectives of the people responsible for policies, frameworks, and approaches utilised within the different departments regarding occupation-based and impairment-based practice. Moreover, the questions explored the perceived/reported challenges for occupational-based practice in the iLembe district. The semi-structured interview questions were developed utilising literature on OBP, IBP, the ICF and social model. The data from the face-to-face semi-structured interviews were recorded using a recording device and transcribed. The researcher conducted the semi-structured interviews for 15 minutes to one hour. They were conducted in English which is a language that all the participants preferred and could converse in. Different venues were utilised, depending on where the participant worked to prevent any inconvenience. 1.7.5.2. Focus groups: Smithson (2000) states that focus groups provide many different forms of interaction which allowed the researcher to identify contradictions between participants in different and similar disciplines. The focus group was used to define occupational-based practice in neutral language and improve the insight into the positive and negative factors of occupational-based practice and impairment-based practice in the iLembe district. It allowed for a circular conversation and the participants to learn from each other. Which also allowed participants to share their opinions, knowledge, and insights on the topic, and for them to receive feedback from other participants. It also allowed the participants to improve their insight into occupational-based and impairment-based practices and the different factors influencing the practices. The focus group targeted the Heads of Department, Acting Directors, and Chiefs of the different departments of rehabilitation personnel in the district. It was conducted on the Zoom platform, with one Acting Head of Department, Assistant Director, Chief and one grade one practitioner. The data from the focus group was recorded through Zoom and was transcribed. The researcher conducted the focus group for one and a half hours. 1.7.5.3 Community mapping Community mapping is the drawing, moulding, writing or expressing of an aspect of community knowledge, infrastructure, and experiences (Amsden & VanWynsberghe, 2005). In this study community mapping was used to understand the contextual factors the iLembe district influencing rehabilitation personnel's practice choices, such as available healthcare facilities with rehabilitation personnel and facilities, such as special schools and sheltered workshops. The data for community mapping was obtained through interacting with community members and healthcare practitioners in the district. 1.7.6. Data analysis The data were initially analysed using a deductive thematic analysis, using the research questions, aims, and objectives guided by the ICF. The data was transcribed verbatim from the audio recordings and analysed by the researcher. The supervisors provided critique on the data analysis process and the initial codes, categories and sub-themes to ensure that there was no bias nor was there any data excluded. Method for data analysis: The study's research questions were used during the initial process of deductive thematic analysis. Thereafter, Braun and Clark's (Peel, 2020) six-step data analysis were used to create codes using the transcripts from the data collection process. The transcripts were analysed with the guidance from the supervisors. This was done through the process of familiarisation, by transcribing verbatim from the audio recordings and analysing the different and similar views of the rehabilitation personnel. After coding, similar codes were grouped to generate categories which were grouped to create sub-themes and themes. This was done through observing the link between the participant's contextual and personal experiences and how these influenced their perceptions and preferred practice choice within implementing rehabilitation services. After these sub-themes and themes were reviewed, the final themes were defined and named, which were used to write up the findings. 1.7.7. Data management: The semi-structured interviews and focus group were recorded (audio), transcribed and saved on the researcher's password protected laptop. All the transcripts from the semi-structured interviews and focus groups were backed up on the researcher's password-protected laptop to ensure anonymity and confidentiality. Only the researcher and the supervisors had access to the research data; after five years, all the written information from the research data collection process will be shredded and the digital data deleted from the researcher's laptop and the hard drive. Data from the community mapping process was transcribed and stored on the researcher's password-protected laptop and will also be deleted after five years. 1.7.8. Trustworthiness 1.7.8.1. Credibility: The researcher used data triangulation to ensure credibility through different data collection methods, such as semi-structured interviews, a focus group and community mapping to engage with the research participants during the data collection process. The different data collection tools allowed the researcher to better understand the participant's perceptions and what influences these perceptions (e.g., their demographics, experiences, and educational background). The researcher engaged with different community members and stakeholders to increase the understanding of the context during the community mapping process. Different themes were used to describe the research findings to increase the study's credibility. The researcher made sure that all the participants met the research inclusion criteria. Additionally, the researcher did not give the participants the questions for the semi-structured interviews or the focus group before data collection to ensure that other individuals outside of the study did not influence the their answers to ensure honesty. Furthermore, the participants were given the same questions and time to respond. The researcher used literature to guide data collection and framing of research findings. Additionally, literature and supervisor guidance were used to guide the researcher and member checks (Birth et al., 2016) were conducted before data collection face to face and/or through the Zoom platform. 1.7.8.2. Transferability: The researcher ensured that the study has transferability through clearly describing the context and environment of the study setting using a thick description. Community mapping was used to describe the iLembe district to allow for data transferability in communities with a similar context and environment. A clear description of the resources within the district and the contextual barriers to occupational-based practice within the district were explored in the study. The semi-structured interviews and focus group consisted of open-ended questions supporting the research questions, and a consistent style of data collection was ensured. Transferability was further ensured through purposive sampling and a pilot study was conducted to prepare for the data collection process. 1.7.8.3. Dependability: Dependability was ensured by creating a process to collect the data for the study and ensuring that all the stages of the data collection were completed as planned. The researcher was supervised during the data collection and analysis processes including, when interpreting and reporting findings. Additionally, an audit trail was conducted to ensure that all the research processes were conducted. The researcher ran a pilot study to ascertain the feasibility of the main study and prepare for the data collection in the main study. Further, an in-depth methodological description regarding the different data collection tools utilised and the different tools' aims was given. 1.7.8.4. Confirmability: The researcher's supervisors evaluated all the stages of the research process to increase the study's confirmability and ensure that the researcher was not biased. The participants were asked the same questions and given an equal amount of time to answer to ensure consistency. To reduce researcher bias, the researcher used three data collection methods: semi-structured interviews, focus groups and community mapping. A clear description of the limitations of the research study and their potential effects was outlined. Furthermore, direct quotes and thick descriptions of the participant's perceptions were used to write up the findings. An audit trail using field notes, audio files and electronic data files was used to report research findings to ensure the accuracy of findings by organising them thematically. Additionally, the researcher used reflective appraisal and self-examination to increase the study's veracity. 1.7.9. Ethical considerations The research study followed the guidelines for the Protection of Personal Information Act 4 of 2013, which restricts the disclosure of personal and confidential information (de Stadler & Esselaar, 2015). The act regulates the processing of personal information by the researcher to allow for transparency and the promotion of participant rights. The researcher ensured that participants' private and personal information was protected by storing the information from the data collection process on a password- protected laptop and drive that only the researcher and the researcher's supervisors can access. Storing the data in a password

protected laptop and drive prevented the inappropriate disclosure of information that could infringe the rights of the participants. Ethical clearance was attained from the University of KwaZulu-Natal (UKZN), HSSREC, the iLembe district department of health head office, the KwaZulu-Natal provincial department of health, and the CEOs of the different facilities before the start of data collection. 1.7.9.1. Informed consent: The researcher ensured that the individuals who met the inclusion criteria received all the information about the study to decide whether or not to participate. The research procedure was explained to the individuals, and any concerns or questions were answered and addressed. They were also informed about their rights, e.g., their right to withdraw from the study if they needed to. 1.7.9.2. Privacy and Confidentiality: The participants' rights to privacy and confidentiality were conserved by the researcher holding the semi-structured interviews and focus group in a private area. The data collected from the semi- structured interviews and the focus group were stored on a password-protected laptop and drive that only the researcher and supervisors could access. Pseudonyms were used to protect the participants' identities during data collection and display to allow for anonymity. 1.7.9.3. Non-maleficence The researcher ensured that the participants were not harmed because of the study and that the study did not pose any risks to the participants. The researcher responded and provided reassurance if any participant became concerned or asked questions about the study. Participants were given time to gain clarity during the semi-structured interviews and focus group. 1.7.9.4. Beneficence: The research study improved the participant's understanding of the different practices, e.g., impairment- based practice and occupation-based practice, in a South African semi-rural and rural public healthcare context. It improved their understanding of occupational-based practice and what influences its implementation in the public healthcare sector. Further, it allowed the participants to understand the views of individuals in other disciplines on occupational-based practice and impairment-based practice to improve insight and allow for improved knowledge. Rehabilitation personnel were made aware of the available infrastructure and resources available in the community that they can use to implement occupational-based rehabilitation and the barriers limiting the implementation of rehab services. 1.8. Outline of the thesis Chapter One of this thesis includes the introduction and background of the study, research questions, aims and objectives, problem statement, the overall literature review and methodology of the study. Chapter Two of this thesis includes the details of the journal that the manuscript will be submitted to, the South African Journal of Occupational Therapy. It includes the manuscript of the research article that will be submitted to the South African Journal of Occupational Therapy. It includes an abstract, introduction, research methods and design, findings, discussion, implications of study, recommendations and conclusion. Chapter Three of this thesis is the synthesis of the study, which includes the summary of findings, the outcomes of the objectives, recommendations and conclusions of the study.

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World Health Organization. Regional Office for Europe. World Health Organization. (2007). International Classification of Functioning, Disability, and Health: Children & Youth Version: ICF-CY. World Health Organization. Worrall, L., & Bennet, S. (2001). Evidence-based practice: Barriers and facilitators for speech-language pathologists. Journal of Medical Speech-Language Pathology., 9(2), XI–VI. Chapter Two: Manuscript Perceptions on transitioning from impairment-based to occupation-based practice in public healthcare within KwaZulu-Natal 26 2.1. Description of the Journal The South African Journal of Occupational Therapy (SAJOT) is the leading publication for research into occupational therapy in Africa. The Journal is the official Journal of the Occupational Therapy Association of South Africa and is accredited by the South African Department of Higher Education and Training (DHET). SAJOT publishes three issues of the Journal per year (in April, August and December). 2.2. Manuscript This manuscript was formatted according to the South African Journal of Occupational Therapy (SAJOT) guidelines for authors. The abstract and content of the article meet the journal guidelines. The abstract comprises 200 words, and the article's content contains 7263 words without the reference list. A Vancouver referencing style was used as per the journal guidelines. 2.3. Status of Publication The manuscript has been submitted for review by the South African Journal of Occupational Therapy. 2.4. Rationale for Journal Choice: SAJOT was chosen to allow for data dissemination to the South African population by improving the article's accessibility to rehabilitation personnel in the country. SAJOT caters to a broad audience in different sectors, including primary healthcare, vocational rehabilitation and community-based therapy. Furthermore, an Occupational Therapy specific journal will allow healthcare professionals in different fields, such as physical rehabilitation, paediatrics, and mental health, to access the article. Further adding to the literature on OBP includes other members of the rehabilitation team and not just occupational therapists to improve occupational therapists' knowledge on what are perceptions of OBP from other rehabilitation personnel such as speech therapists and physiotherapists. Perceptions on transitioning from impairment-based to occupation-based practice in public healthcare within KwaZulu-Natal Abstract: Introduction: Holistic healthcare service delivery requires rehabilitation personnel to consider all the components of health that influence the client's quality of life. However, there is limited literature on approaches to implementing rehabilitation services within South African public healthcare. This study explored rehabilitation personnel's use of occupation-based (OBP), impairment-based practice (IBP) and the barriers and facilitators associated with their practice choice. Methods: A qualitative research design was conducted through semi-structured interviews (13 participants), a focus group (4 participants) and community mapping. Purposive sampling was utilised to select participants in the iLembe district, KwaZulu-Natal (KZN), South Africa. Data was analysed using deductive thematic analysis. Findings: Three themes emerged from the study; Attitudes towards impairment-based practice, Reflections on OBP, and The way forward. The need to focus on all the components of health rather than just the disease and the benefits of using the OBP approach were highlighted. Additionally, different factors required to implement holistic rehabilitation services and the barriers to OBP were identified. Conclusion: Although the study identified OBP benefits, various barriers associated with its implementation were identified. Rehabilitation personnel, community stakeholders, and clients must work together to improve OBP implementation in public healthcare by combating the barriers identified in the study. Keywords: Occupation-based practice, impairment-based practice, rehabilitation personnel, International Classification of Functioning, Disability and Health (ICF), social model of disability. Background Impairment-based practice (IBP) was reported as the dominant paradigm within medical-oriented healthcare facilities in South Africa, focusing on body structures and function1. The dominance of the medical model, which defines health as the absence of disease, results in a limited focus on external components influencing the client's participation, in contrast with the World Health Organisation's (WHO) definition of health2. This appears at odds with the WHO's definition of health as not just the absence of disease but a complete state of physical, mental and social well-being2. Holistic healthcare interventions require more than focusing predominantly on the impairments. Healthcare providers must consider other factors, such as contextual factors and activity participation, especially when implementing rehabilitation services3. The WHO has been promoting this agenda, as seen in their shift from the International Classification of Functioning, Disability, and Health (ICF) in 1980 to 20012. The paradigmatic shift entailed changing terminology and service focus from a "consequences of disease" classification to a "components of health" classification in 2001 2. These components of health represented a move toward including components that consider an individual's holistic health. The ICF is a multifaceted classification providing a theoretical base for implementing healthcare services, specifically rehabilitation services. There are two parts of the ICF, namely Functioning and Disability, which includes body functions and structures, activities, participation, and contextual factors, including environmental and personal factors 2. The framework highlights participation limitations within roles and activities, which are influenced by physical and social factors while emphasising the importance of activities and participation in health and quality of life. The initial shift towards the inclusion of activities and participation in the ICF resulted in a need for a subsequent shift towards focusing more on occupation-based practice (OBP) to facilitate improved quality of life and health. OBP includes activities and participation, which are often unaddressed during the implementation of rehabilitation services 4. Hali & Visagie 5 noted that the ICF is not optimally utilised in clinical rehabilitation practice in South Africa. Additionally, efforts to view clients from a holistic perspective are primarily outside of the medical model 6. These contentions are influenced contextually as South Africa has increased unemployment and poverty rates, negatively impacting access to healthcare services, especially in poor communities 3. Personal resource restrictions create a need for more client-specific and context-specific healthcare. The iLembe community comprises 89.2% isiZulu-speaking Africans, 3.4% White, 6.9% Asian, and 0.8% Coloured populations 7. A quarter of the population lives in traditional and informal settlements; 50% of the roads are in good condition, and 50% in fair and poor conditions 7. The South African public healthcare sector caters to 80% of the country's population; however, numerous barriers exist to accessing rehabilitation services 8. These barriers include a lack of human resources, budget constraints, transportation limitations, a focus on the medical model, high turnover rates in acute hospitals, poor compliance, communication challenges and a breakdown in referral pathways 9,10. Anecdotally, therapists have highlighted the challenges above as the critical reasons for the decreased use of OBP in South Africa. There is limited research regarding therapists' experiences in implementing OBP 11. Thus, there is a need to explore rehabilitation personnel's experiences with implementing IBP and OBP, and the different factors affecting their practice choice within public healthcare in South Africa. Understanding their views and beliefs will assist in understanding the rationale for their practice choice when implementing rehabilitation services within the district. The need for holistic healthcare requires exploring the factors influencing rehabilitation personnel's practice choice. The study will explore the factors influencing rehabilitation personnel's practice choices when implementing rehabilitation services in public healthcare. Local conditions influence contextual factors linked to clients' access to rehabilitation services and personnel practice choices within the district. This study explores the personal and contextual barriers and facilitators promoting effective OBP implementation. Method Study design An explorative qualitative research design was used to understand the rehabilitation personnel's perceptions regarding IBP and OBP, and the rationale behind their practice choice. This research approach supported exploring rehabilitation personnel's experiences, social context, and views 12 through semi-structured interviews, a focus group, and community mapping. These data collection methods allowed the researcher to capture and understand the participant's in-depth perceptions and feelings through careful and focused analysis. Study population, sampling and recruitment strategy Participants were recruited over two months by contacting the facility managers and acquiring the names of the individuals employed in the district's hospitals and primary healthcare institutions, as seen in Figure 2. Purposive sampling was utilised to recruit individuals working in the district for maximum variation. The study population comprised of rehabilitation personnel working in the iLembe district's public healthcare sector with more than six months work experience in the South African public healthcare sector and registered with the Health Professions Council of South Africa (HPCSA). The individuals who met the inclusion criteria described above were invited to participate in the study telephonically. Participants provided informed consent prior to data collection. The sample comprised five occupational therapists (OT), nine physiotherapists (PT), three speech therapists (ST), and three of which were key informants including one assistant director, chief physiotherapist and occupational therapy deputy head of department. Figure 2: Map of the iLembe district with available full-time rehabilitation personnel. Key: CHC- Community Healthcare Centre Data collection The data collection tools were semi-structured interviews, a focus group and community mapping. The focus group was aimed at critical key informants. The semi-structured interviews targeted community service officers and grade one practitioners to explore the primary factors influencing their practice choice. The ICF's biopsychosocial perspective guided the compilation of the questions used for the semi-structured interviews and the focus group to understand the participants' perceptions of the different practice choices and which contextual factors influence them. Semi-structured interviews: Semi-structured interviews allow participants to give in-depth opinions on their experiences and report a detailed explanation of their perceptions 13,14. The semi-structured interviews comprised of eight open-ended questions that explored the perspectives of the people responsible for implementing rehabilitation services. Further, exploring their perception on IBP and OBP, and OBP facilitators and barriers. The data from the face-to-face and zoom semi-structured interviews which ranged from 15 minutes to 1 hour, were recorded using an audio-recording device and manually transcribed. The interviews were conducted in English, a language both the participants and the researcher were comfortable with and could effectively communicate in. Different venues within KwaDukuza, Maphumulo, Ndwedwe, and Mandeni were utilised, depending on where the participant was employed. Focus groups: Focus groups provide many different forms of interaction 14, allowing the researcher to identify contradictions between participants. The focus group assisted in defining OBP in a neutral language and improved insight into positive and negative factors contributing to OBP and IBP implementation in the district. It was conducted for one and a half hours on the Zoom platform, with key informants: an Acting Head of Department, Assistant Director (AD), Chief and grade one practitioner. These key informants are involved in the development of policies, permanent staff employment, the training of community service officers (CSO) and make decisions concerning rehabilitation services at a district level. The data were recorded using Zoom and manually transcribed. The focus group allowed participants to share their opinions, knowledge, and insights on the topic, and to receive feedback from other participants. The researcher conducted the focus group in English, which all the participants reported they were to comfortable to converse in. Community mapping:

Community mapping was used to understand the contextual influences of OBP within the iLembe district, such as available healthcare facilities with and without rehabilitation personnel, and facilities, such as special schools and sheltered workshops. Data for community mapping was obtained through interacting with community members and healthcare practioners in the district. Pilot study: The pilot study was conducted to test the semi-structured interview's viability, and the necessary changes were made in the questions and questioning method before data collection. Two rehabilitation personnel from different settings within the public healthcare sector participated in the pilot. This assisted in amending the questions and prompts for the semi-structured interviews to improve clarity and elicit sufficient information depth. It also allowed the researcher to become familiar with implementing data collection method before the main study. Data Analysis Data were analysed using deductive thematic analysis guided by the ICF framework, which allowed the researcher to analyse the participants' perceptions of IBP and OBP concerning the components of health, as seen in Figure 3 15. Furthermore, Braun and Clark's six-step data analysis techniques 16 guided the write up process of the study's key findings using sub-themes and themes. Initially, the researcher engaged in a process of familiarisation with the data, which was done through transcribing verbatim from the audio recordings and analysing the transcripts with guidance from the supervisors using thematic coding. After coding, similar concepts and findings were grouped to formulate sub-themes and themes. These sub-themes and themes were generated and reviewed, and then the final themes were defined and named, aand used to write up the data findings. Figure 3: Interactions between the ICF 2 Trustworthiness The researcher used various strategies to ensure the trustworthiness of the study, as seen in Table 1 below: Table 1: Trustworthiness Criterion Strategy employed Applicability Credibility Peer briefing • The researcher's supervisors guided and reviewed the data collection and analysis processes. Member checks17 • Semi-structured interviews and focus group consisted of open-ended questions supporting research questions, done face to face and Zoom. Triangulation • • • Multiple data collection methods were used, (semi-structured interviews, community mapping and a focus group). Participants were given the same questions and an equal amount of time to answer questions. A pilot study was used to prepare for the data collection. Transferability Providing a description thick • Direct quotes and thick descriptions of the participant's perceptions were used to write up the findings. Purposive sampling All the participants met the inclusion criteria. • Could speak and understand English or isiZulu, • Worked in the iLembe district public health care with more than six months experience, • Registered with HPCSA. Dependability An audit trail • Field notes, audio files and electronic data files were used to report findings truthfully and accurately. Confirmability Sceptical peer review • Researcher's supervisors evaluated data collection and analysis. Reflexivity • Self-examination • Ensuring that the researcher's subjectivity did not influence the findings. Ethical considerations The study followed the Protection of Personal Information Act 4 of 2013 guidelines restricting disclosure of personal and confidential information 18. The purpose of the study, and voluntary participation and confidentiality were emphasised, meaning participants' information was confidential, and withdrawal from the study could occur at any point in the study. Informed consent was obtained from the participants before data collection. All the participants were assigned pseudonyms to ensure anonymity. Ethical clearance was received from the Human and Social Sciences Research Ethics Committee of the University of KZN and the KZN Department of Health (DOH). Gatekeeper permission was obtained from the iLembe District Office. After completing this research study, the findings will be sent to the participants, the facility managers and DOH to influence rehabilitation service implementation and awareness. The findings of the study will be disseminated through this journal article. Findings Demographics: Seventeen participants took part in this study in total. There were thirteen participants in the semi- structured interviews; three speech therapists, three occupational therapists and seven physiotherapists as seen in Table 2. The focus group comprised four participants, represented in Table 3. Tables 2 and 3 illustrate the participant's experience and different factors influencing their practice choice and view of rehabilitation services within the district. Table 2 below illustrates that the semi- structured interviews comprised 76,92 % community service officers, 23,08% permanent staff, only one postgraduate. Table 2 and 3 demonstrate there are 17,65% of the participants are isiZulu speakers and 82,35% non-isiZulu speakers. Table 3 shows that 50% of the participants had postgraduate degrees. Table 2: Demographic characteristics: semi-structured interview participants (n= 13) Occupational-therapists Physiotherapists Speech- therapists Total Age 20-29 3 5 3 11 30-39 0 2 0 2 Race/ Ethnicity Black/ African 0 1 1 2 Indian 1 3 0 4 White/ Caucasian 2 3 2 7 Gender Gender/ Female 3 6 3 12 Identity Male 0 1 0 1 Facility Sundumbili CHC 1 1 0 2 Ndwedwe CHC 0 2 1 3 uMpumulo Hospital 0 2 0 2 uNtunjambili Hospital 0 0 0 0 General Justice Gizenga Mpanza Regional Hospital (GJGMRH) 2 2 2 6 University University of Pretoria (UP) 1 3 1 5 University of Kwa-Zulu Natal (UKZN) 1 3 0 4 University of Western Cape 0 1 0 1 University of Witwatersrand 0 0 2 2 University of Free State 1 0 0 1 Qualification Bachelors 3 6 3 12 Masters 0 1 0 1 Years of < 1 3 5 2 10 experience 1-6 0 2 1 3 Level of the post-occupied CSO 3 5 2 10 Permanent 0 2 1 3 Courses done on different approaches to rehabilitation No courses done on different approaches to rehabilitation service implementation. Table 3: Demographic characteristics: focus group participants (n= 4) Occupational- therapists Physiotherapists Total Age 20-29 0 0 0 30-39 2 1 3 40-49 0 0 0 50-59 0 1 1 Race/ Ethnicity Black/ African 0 1 1 Indian 1 2 3 Gender/ Gender Female 0 0 3 Identity Male 1 0 1 Facility GJGMRH 2 2 4 College University &/or UKZN 2 2 2 UP 1 (Post graduate diploma) 0 1 Regent Business School 0 1 (MBA) 1 Qualification Bachelors 1 1 2 Masters 1 1 2 Postgraduate diploma 1 0 1 Years of 1-6 1 0 1 experience 6-10 1 0 1 10-20 0 1 1 >20 years 0 1 1 Level of post Permanent Grade on 1 0 1 occupied Chief 0 1 1 Acting head of department 1 0 1 AD 0 1 1 Three themes emerged from the data analysis, as illustrated in Table 4 below. Theme 1 related to attitudes towards IBP while highlighting how public healthcare is geared towards treating body structures and functions and the different factors promoting IBP. Theme 2 explored reflections on OBP and factors influencing its implementation and Theme 3 discusses participants' positionalities in moving towards more OBP-oriented rehabilitation approaches. Table 4: Themes and sub-themes Theme Sub-themes Attitudes towards IBP • • Diagnosis Focused Contextual influences Reflections on OBP • • • • Prerequisites for implementation, Barriers to implementation, Facilitators of OBP, Outcomes Way forward • • "We can't shy away from the impairment", "You aren't just treating a condition." Theme 1: Attitudes towards IBP Participants highlighted an increased need to understand how the client's diagnosis impacts their client's body functions and structures, as seen in IBP. IBP was described as focusing solely on the impairment experienced by the client and the main reason for referrals from other healthcare practitioners. Participants outlined different factors influencing their practice choice and the implications of using IBP. Two sub-themes were identified: Diagnosis Focused and Contextual influences. Diagnosis Focused IBP was seen to only focus on body functions and structures, neglecting other components of the ICF, namely, activities and participation and environmental and personal factors. They reported that this limits understanding of other factors influencing the client's health, including restrictions in participation, activity limitations and contextual factors. Participants from different facilities and professions noted that IBP does not allow for a holistic view of the client's needs to offer optimal rehabilitation intervention. "Sometimes you can be solely focused on one aspect... if somebody... had a physical injury you focus so much on the physical injury that you tend to overlook their psych aspects" (Participant 9, occupational-therapist CSO, semi-structured interview) Contextual influences Most participants highlighted an increased need to understand how the client's impairment impacts their client's body functions and structures, as seen in IBP. Furthermore, IBP was described as focusing solely on the client's impairment and the reason for referrals from other healthcare practitioners. "What we find difficult when we go into the ward, we can't get straight in there and always start functional rehab because sometimes patients are very sick ... when we doing our undergrad, we always focusing on function ... and that's ... fine function and activity-based treatment. But sometimes it doesn't always work in the first... maybe two sessions in a ... patient that's really ... unwell, and it's not there yet." (Participant 1, occupational-therapist, focus group) "They just refer a patient for the impairment; they never refer a patient because the patient can't dress ... I think doctors are more trained for more impairment based" (Participant 2, occupational-therapist CSO, semi-structured interview) Participants reported a dominance of the medical model within healthcare facilities and amongst other healthcare practitioners who expect them to implement IBP rather than OBP. Further, noting a limited understanding of OBP among other healthcare professionals, high turnover rates, and limited staff are some of the reasons for focusing on body functions and structures as it is perceived as the faster practice choice. "This facility is quite acute, so patients come and go... quickly, so you tend to prioritise your rehab towards the patient, especially if they're inpatient or outpatient, and then you tend to focus a lot more on... what the impairment is what the condition is? How can you treat it" (Participant 9, occupational-therapist CSO, semi-structured interview) "You sort out... the major issues... the cause of a problem and... it gets the patient through the system faster so it's less taxing on resources ... resources are usually... limited, understaffed there's loads of patients" (Participant 3, physiotherapist CSO, semi-structured interview) Some participants in the semi-structured interviews reported they felt their roles as physiotherapists were more IBP-oriented to improve body functions and structures, while OBP was the domain of occupational therapists to improve participation using activities. This perception was held by half of the permanent physiotherapy staff who engaged in the study, the CSOs were observed to have a deeper understanding of the ICF framework and holistic interventions. "I think with physio we want to get you to your highest level functioning as early as possible... we deal with the impairment itself" (Participant 7, physiotherapist, semi-structured interview) "The ICF method it targets everything the patient's impairment. What they can do? What they cannot do? Activities they used to do? And how it impact their activities?... their environment and personal factors" (Participant 4, speech-therapist CSO, semi-structured interview) Theme 2: Reflections on OBP Many participants displayed uncertainty when defining OBP and required verbal prompting to report their perceptions of the practice. When they could articulate their understanding of the practice, they regarded OBP as a more holistic approach considering all the "components of health". Some participants who utilised OBP needed to be made aware of the practice name. They highlighted that OBP was client- specific and yielded more activity participation and performance outcomes when utilised correctly. Participants also highlighted factors influencing OBP implementation in the district, resulting in the following sub-themes; Prerequisites for implementation, Barriers to implementation, Facilitators of OBP, and Outcomes. Prerequisites for implementation OBP required an initial assessment that allowed participants to gain insight into the client's personal and environmental activity limitations and facilitators. The insight into the client's life allowed participants to work towards improving health and quality of life. Participants noted that OBP must be implemented correctly to yield results and improve participation, which requires intense planning, intentionality, time, and knowledge. "If you do a good subjective and you ask them what job you do ... what are your hobbies... you will always think of ways to incorporate your exercises" (Participant 11, physiotherapist CSO, semi-structured interview) "We have the whole knowledge of occupational science and everything that contributes... to how I do occupation-based treatment. My skills are not always the best" (Participant 2, occupational-therapist CSO, semi-structured interview). Barriers to implementation Participants identified barriers to OBP implementation in the district's public healthcare, namely; contextual barriers, such as, community-specific and facility-specific; and personal factors, such as, client-specific factors. The district was observed to be predominantly made up of hills, valleys and gravel roads outside the central towns. Participants noted that most clients are unemployed and poverty-stricken, leading to an inability to afford transportation fees, resulting in non-compliance with rehabilitation services. The

district has six public healthcare facilities (five hospitals and two CHCs) with rehabilitation services, with the rehabilitation personnel being primarily CSOs. There are 34 clinics in the district, but not all have outreach programmes, limiting access to rehabilitation services. Participants noted a communication barrier as the community members in the district were predominantly isiZulu speaking. Therefore, being unable to speak and understand isiZulu was a limitation towards implementing OBP. Thus, it is difficult to understand the clients leading to difficulties in obtaining subjective information on their activity, participation and contextual needs. "Language barrier... your different languages trying to explain how to do a certain thing in a certain way but at the same time, cultures, people have different ways of doing different occupations" (Participant 10, occupational-therapist CSO, semi-structured interview) Some participants in the focus group reported a lack of facilities outside DOH to carry over OBP, including sheltered workshops and schools catering to individuals with different disabilities. Available schools catering to children with disabilities within the district are represented in Figure 4. No schools catered to children with only physical disabilities, hearing, visual, and multiple impairments. Moreover, there were no remedial and prevocational schools in the district. The lack of these facilities was believed to be a societal constraint negatively impacting quality of life and carryover of OBP into the community. "Children with disabilities that ... have physical disabilities, but have good cognitive function, are not being included in mainstream schools, because those schools do not cater for children with disabilities" (Participant 1, occupational-therapist, focus group) Number of special schools in the district 3.5 3 2.5 2 1.5 1 0.5 0 Number of special schools in the district Figure 4: Number of special schools in the iLembe district Participants identified human resources as a contextual limitation towards implementing OBP as it requires intense planning and intentionality. It was difficult due to the human resource constraints, specifically permanent staff, as noted in Table 5 and 6. Most participants working in the district were CSOs. They reported having limited experience and skills, which restricted client-specific OBP, which requires intentionality and planning. Table 5: Number of rehabilitation personnel in each facility (year 2022: August- December) Facility 1 Facility 2 Facility 3 Facility 4 Facility 5 Speech NOPS 0 0 0 0 1 therapists NOCSO 0 0 1 1 1 Occupational NOPS 0 0 0 0 2 therapists NOCSO 0 0 1 1 2 Physiotherapists NOPS 1 1 0 1 10 NOCSO 0 1 2 1 3 Table 6: Number of rehabilitation personnel in each facility (year 2023: January- May) Facility 1 Facility 2 Facility 3 Facility 4 Facility 5 Speech therapists NOPS 0 0 0 0 1 NOCSO 1 0 1 1 0 Occupational therapists NOPS 1 0 0 0 2 NOCSO 0 1 1 0 2 Physiotherapists NOPS 1 1 0 1 9 NOCSO 1 1 1 1 1 KEY: NOPS: Number of permanent staff NOCSO: Number of community service officers Participants noted that limited human resources as seen in Table 5 and 6, and high facility turnover rates in acute settings led to shorter rehabilitation sessions. "We don't have permanent staff ... if you just have comserves as well that's working, it's hard to do an MDT... most of the comserve's as well they ... learning still" (Participant 6, physiotherapist, semi-structured interview) "I definitely think that the knowledge needs to be improved so that they have a good understanding of what's occupation-based, a good understanding about impairment based and when it's best to use which on... In acute hospital, you have such a short time, so you end up having to treat... the impairment... might not have the time frame to do all the occupations ... it's easier to just treat the impairment" (Participant 10, occupational-therapist CSO, Semi- structured interview) Participants perceived OBP to require more time for planning and implementation, which was difficult to conduct in a fast-paced environment that required more straightforward approaches to counteract the time constraints. "It's difficult to give... intense occupation-based therapy which takes planning which takes a lot of intentionality to put the patient's needs first if you're seeing a lot of patients by yourself" (Participant 5, speech therapist CSO, semi-structured interview) "...For doctors to... understand... rehab and the role of rehab and not just... being so focused on discharge" (Participant 1, speech-therapist, semi-structured interview) Numerous environmental barriers within the facilities were reported, including limited space, equipment, and infrastructure, as activity participation could not be simulated within the facilities to improve performance. "Physical resources... we don't have space to store the equipment ... it's a barrier as well and general understanding of what therapy is what therapy does for you" (Participant 6, physiotherapist, semi-structured interview) Participants identified client-specific barriers to OBP implementation, including poor support systems, unemployment, and poverty, limiting compliance and carryover of OBP at home. "People don't have a family structure... the family abandons them or they just around people who don't really know them, so it's hard to... bring their occupation into therapy" (Participant 1, speech therapist, semi-structured interview) "Financially, a lot of patients cannot get to the hospital ...transport fees are... expensive" (Participant 3, physiotherapist CSO, semi-structured interview). Facilitators of OBP Numerous environmental facilitators for OBP were identified. Participants reported needing a complete rehabilitation team, an excellent subjective assessment, MDT combined sessions, and working with the client and family to set therapy goals. One participants mentioned that standard operating procedures (SOPs) are required to improve access to rehabilitation services through the correct referral pathways and set a standard level for the rehabilitation services to be implemented. "If somebody transfers out, gets another post or resigns and tires... the post gets frozen... your patient load is increasing, and your staffing load is decreasing" (Participant 2, physiotherapist, focus group)." "When you see a patient, you have to assess... set some goals where you want to go with this patient. So your goals should come from what... the client wants to achieve... So I'll be working out every... session... with the patient will be directed in terms of... making this patient being able to integrate into the work environment." (Participant 3, occupational-therapist, focus group) "Having joint sessions where the OT, physio and... speech therapist worked together on one patient with the family member to get the optimal goals or outcomes" (Participant 5, speech- therapist CSO, semi-structured interview) "The SOP's and... DOH policies...it's not specifically for a certain condition, but it is how the patient can access the service...the pathway the patient needs to follow up to access the service, and in terms of referral pathways" ((Participant 2, physiotherapist, focus group)) Special schools and sheltered employment opportunities were noted as key factors required to facilitate OBP carryover in the community. Persons with disabilities were noted to have decreased opportunities to engage in activity performance and participation within the community, which are vital to improving quality of life and health outcomes. "A program whereby these the skills that I acquire from the centre they can get some kind of... employment, or it can be... where they can start doing their own things maybe that will also give those disabled patients... some kind of purpose and have a meaningful life" (Participant 3, occupational-therapist, focus group). Outcomes OBP was viewed as a holistic approach, facilitating activity participation and improved independence. OBP allowed participants to understand the different components of the client's health, such as functioning and disability, contextual factors, the limitations towards activity performance and participation to work with the client towards returning to the highest level of independence possible. Additionally, allowing for carryover at home as clients could incorporate techniques learnt in therapy. "Occupation-based is a more holistic approach, according to me, on how we can look at how getting the people back into society ... looking at what they can do... what must they do every day in their life to be able to be as independent as possible" (Participant 2, occupational- therapist CSO, semi-structured interview) "Patients... do recover mostly to a high level of functioning, returning to a high level of functioning... to a life that they used to live before so patients are more satisfied and then also... the quality of life... Today I had a patient that has low back pain; so she also said she doesn't have time to do all these extensive exercises because she is a mom of four kids, so she's... busy doing house chores all the time, so I taught her how to do her core exercises while doing dishes for instance" (Participant 3, physiotherapist CSO, semi-structured interview) "It's more functional based than just looking at just one joint or one impairment... it's looking at the person as a whole" (Participant 11, physiotherapist CSO, semi-structured interview) Theme 3: Way forward Most participants had decreased insight into the social model of disability (SMoD). Once the definition of SMoD was given to them, they identified the model to have similar principles with OBP, namely, the focus on participation in activities and not just the limiting impairment. Participants reported that OBP allowed for compensation for lost function and contextual adjustments if body functions and structures could not be improved. One participant highlighted that therapy should not be viewed as linear or binary. However, we should consider the different factors influencing the client, such as changes in body structures and functions, capacity to participate in activities, environmental facilitators and barriers, and personal factors. Participants reported that IBP and OBP could be used together depending on the client's needs. Most participants highlighted the need to transition towards OBP to address all the components of health as it is neglected in biomedical healthcare settings. These perceptions resulted in two sub-themes, "We can't shy away from the impairment" and "You are not just treating a condition". "We can't shy away from the impairment." Participants acknowledged that the client's body structure and function form part of the components of health. They reported a need to remediate the body structure and functions in acute stages of rehabilitation, if possible, through using different approaches and activities to improve participation in meaningful activities in different environments. "...You can use both interchangeably because... we can't shy away from the impairment. We still need to try to find ways to improve the impairment as well as trying to find ways to help the patient to do whatever they used to do" (Participant 4, speech-therapist CSO, semi- structured interview). "You aren't just treating a condition." Even though the client cannot be isolated from their impairment, participants highlighted that the impairment cannot be treated without addressing the client as an active member of society. Due to the medical model dominance in the public healthcare settings in the district, participants reported a need to move towards more OBP. OBP allows participants to understand the client and the different factors influencing their health, such as their body structures and functions, environment, activities and participation. "Occupational based would... be the better one because... if people are really wanting to do a specific task then if that if you start early... they are able to achieve that quicker" (Participant 11, physiotherapist CSO, semi-structured interview) "Occupation based... it's more functional... and allowing the patient to use those strategies in real life... it's more holistic" (Participant 1, speech-therapist, semi-structured interview) "I... think that focusing on occupation rather than impairment, focusing on getting these people out there, getting them to see that my disability doesn't stop me from doing these things" (Participant 2, occupational-therapist CSO, semi-structured interview) Discussion The study identified IBP as a non-holistic approach focusing on addressing body functions and structures, which concurs with the finding by Tomori et al. 9. This focus on impairment was found to sometimes neglect the other components of health, such as activity participation, and environmental and personal factors, which are critical when providing rehabilitation services. Even though IBP was viewed to focus on one component of health, it was still widely utilised in the district's public healthcare sector due to different factors such as stage of illness and rehabilitation, limited human resources, limited insight on OBP and physical resources geared towards body functions and structures in the healthcare facilities. Despite the increased use of IBP approach, participants perceived OBP as a more holistic approach. It is perceived to consider all the components of health, including activity performance, participation, contextual factors, and how their presenting impairment, disability, and body functions interrelate to impact client health needs. The participants in this study suggested that OBP is multifaceted and aimed at improving health and well-being through activity participation, and easily generalised to client's lives 19. OBP implementation was perceived to have improved quality of life and overall health outcomes, correlating with findings by Tomori et al. 9 and Aas & Bonsaksen 20 who found OBP has more potential to improve general health and emotional well-being. If body functions and structures cannot be improved, OBP was identified to improve quality of life by compensating for lost function by addressing contextual factors. Furthermore, it

was viewed to allow participants to view clients as occupational beings, not just their impairment 10. Although OBP was viewed as a holistic approach, there are numerous barriers impeding its implementation within the district. Contextual factors, namely, socio-demographic variables such as language, high unemployment, transport limitations, and crime rates which contradict findings by Aas & Bonsaksen's 20, who found that these factors did not impact OBP access and implementation. Additionally, language barriers were found to cause difficulty in rehabilitation personnel's understanding of their clients' activities, participation, and contextual needs. Language barriers resulted in a decreased understanding of their client's contextual and personal factors, and rehabilitation goals. The previously mentioned barrier further limits the client's insight into rehabilitation services and OBP, along with other contextual factors such as poverty and transportation limitations leading to non- compliance, which reinforces findings by Narain & Mathye 21. Narain & Mathye 21 further, assert limited awareness of rehabilitation services in rural South African communities. The iLembe community is predominantly a Black community, and this was linked to the decreased awareness of rehabilitation services within the district, which was perceived to be a barrier to OBP implementation, as these services are perceived to be for wealthy White communities 21. Limited awareness of OBP negatively impacts clients' personal factors, such as motivation to engage in activity- based approaches such as OBP, further impacting their function and participation within their context. Contextual factors within the district, such as the decreased number of special schools and sheltered workshops, were perceived to decrease compliance and carryover of OBP into the community. Furthermore, emphasising a need for more of these facilities to carry over OBP within the community outside of DOH, which was not seen in other literature relating to OBP. Contextual factors within the healthcare facilities, such as limited facilities offering rehabilitation services, limited rehabilitation personnel employed in the district's public healthcare sector and limited physical resources also served as barriers. The previously mentioned barriers led to limited time to explore activity performance and identify barriers to activity participation within the client's context. Additionally, this study highlighted the need for rehabilitation personnel to advocate and bring awareness for community stakeholders to conduct environmental changes in the district's healthcare facilities to promote activity performance and participation, which reinforces the findings by Scaffa & Reitz 22. KZN DOH financial constraints influenced the lack of availability of physical resources for OBP implementation 23. These facility-specific barriers concur with a study by Hall & Visagie 5, which identified the dominance of the medical model, decreased human resources, high turnover rates, and limited time as factors that led to IBP being the primary practice choice. The previously mentioned barriers concur with multiple studies 24–27, highlighting the limited availability of resources, participants' lack of experience and skills, and medical model dominance hinder OBP implementation. OBP was considered difficult to implement in a medical-model-based facility as pragmatic and contextual factors exerted opposing influences 22,27. Due to a lack of experience and skills in implementing OBP, some recent graduates choose IBP over OBP 27. CSOs found OBP inherently complex, requiring skills, time and complicated techniques to implement. They felt they needed more time to plan and experience implementing OBP 24,25,27, leading to them implementing more IBP. Even though they viewed OBP to be holistic and client-specific, some permanent physiotherapists considered OBP to be an approach for occupational therapists and IBP as more aligned with physiotherapy, which is in keeping with findings from Narain & Mathye 21 and Inglis et al. 28 . The perception that OBP is the core of the occupational therapy profession is one reason why OBP is not used by other rehabilitation personnel 21. CSOs considered OBP as a practice all rehabilitation personnel should utilise as it encompasses all the components of health, including physiotherapists CSOs. Similarly, Narain & Mathye 21 stated that physiotherapy must focus more on participation to meet the client's needs. Contrary to findings by Wolf et al. 29 and O'Donoghue et al. 25 this study found that decreased family involvement was a barrier towards implementing OBP in terms of facilitating carryover and home- based OBP. Wolf et al. 29 found that family involvement was perceived not to impact OBP implementation. In contrast, O'Donoghue et al. 25found that family members increased involvement resulted in the family feeling obligated to help the clients in their activity participation, becoming over-involved and taking over the client's responsibilities and decision-making. Unemployment and poverty were found to limit access to healthcare services and continuous OBP, as seen by Chichaya et al. 30 as accessing healthcare services is expensive for people with disabilities. Further, limiting continuous and practical OBP which is critical to producing activity and participation outcomes. The study identified key factors to promote OBP implementation within the district. The need to improve the client-therapist ratio by employing permanent staff from each discipline to form a complete rehabilitation team in each healthcare facility was identified. More permanent staff would improve human resources to deliver rehabilitation services and access to supervision and mentorship for community service officers 31, thus improving OBP implementation. More staffing will promote inter- professional practice and collaboration with clients and their families to set therapy goals. Standard operating procedures (SOPs) focusing on improving access to rehabilitation services and awareness of the available rehabilitation services are required to implement OBP and access rehabilitation services. CSOs spoke highly of OBP, indicating they valued the approach, which concurs with the literature 20,22. However, their decreased skills, experience and knowledge resulted in decreased confidence to implement OBP, which is essential in OBP implementation. Furthermore, it highlights the need for undergraduate health science programmes in South Africa to better prepare newly graduated rehabilitation personnel's theoretical knowledge and skills in considering all the components of health and implementing the OBP approaches11. Facilities such as special schools and sheltered employment or employment opportunities are needed in the district to carry over OBP to improve activity participation and quality of life. When transitioning towards more OBP approaches, it is vital to acknowledge that the clients' impairment is a part of their health. Following the findings by Oliver 32, the study highlighted the importance of recognising the relationship between the client's impairment and other components of health. Neglecting body functions and structures, as seen in SMoD, creates a gap in understanding the holistic client and health 32, thus, the importance of choosing a practice choice according to the client's needs. Different approaches can be utilised depending on the client's needs. Additionally, rehabilitation service implementation needs to be tackled collaboratively, with the understanding that the components of health are influenced by a dynamic system 22,32,33. Activity participation is often unaddressed 4; therefore, the study found that rehabilitation personnel must adopt more OBP approaches when implementing rehabilitation services. Implications and recommendations This study has implications for rehabilitation service implementation in the iLembe district public healthcare sector. OBP was perceived to have more quality of life and health outcomes, which leads to implications for practice. There is a need to transition from the medical model with approaches only focusing on body structures and functions into approaches that consider all the components of health, such as the OBP. Even though there are barriers towards OBP implementation, rehabilitation personnel can still promote its implementation through inter-professional practice, continuous professional development and health promotion. Furthermore, there are implications for undergraduate programmes to equip undergraduates with the skills to implement OBP within under-resourced facilities. It is suggested that DOH involves people with disabilities when formulating policies and addressing public healthcare concerns regarding disability. Rehabilitation personnel, other healthcare practitioners and policymakers are advised to gain insight into the components of health when formulating policies and implementing OBP. Additionally, to counteract human and physical resource barriers, DOH is advised to improve the budget towards rehabilitation services to promote the implementation of holistic, client-specific interventions. Non-holistic approaches may lead to further complications and unnecessary use of state resources (Revolving door syndrome). Moreover, it is suggested that DOH funds training for rehabilitation personnel, and encourage rehabilitation personnel's' continuous professional development to improve their knowledge of OBP implementation to conduct holistic, subjective, environmental assessments of client-specific healthcare needs. Future studies exploring OBP in physiotherapy and speech therapy and other healthcare practitioners are required to improve insight into the effect of OBP within these disciplines. Rehabilitation personnel are advised to improve awareness of rehabilitation services, their role in holistic healthcare and the importance of OBP through health promotion programmes. Furthermore, rehabilitation personnel and community stakeholders must problem-solve ways to counteract barriers to access to rehabilitation services, e.g. outreach services. Community stakeholders are advised to establish sheltered workshops and more schools catering to the needs of persons with disabilities to improve clients' community engagement, activity participation and quality of life. The undergraduate curriculum should focus more on community-based rehabilitation, inter- professional practice and education, and encourage learning the skills required to implement OBP in public healthcare. Limitations The study explores the perspectives of rehabilitation personnel within public healthcare in semi-rural and rural communities in one district; therefore, contextual factors cannot be generalised to other populations. Furthermore, most participants were community service officers who still needed to establish their professional identity. The dominant medical model influenced their practice choices in their workplace. The study is focused on the perspective of rehabilitation personnel; this includes physiotherapists and speech and occupational therapists. The study did not consider the perceptions of other healthcare practitioners vital in providing holistic healthcare services. Conclusion OBP was found to improve the components of health, level of independence and carryover into the community. Even though OBP was perceived to have more health outcomes, IBP dominates the district's public healthcare facilities. IBP's dominance is accredited to factors such as the dominance of the medical model, acute phases of illness, high hospital turnovers, limited staff, skills, experience and insight into OBP and the belief that OBP is restricted for occupational therapists. Other client-specific and community-specific factors also served as barriers to OBP implementation. The limited resources within the district's public healthcare system require rehabilitation personnel to problem-solve sustainable and innovative ways to improve OBP implementation. This requires the district stakeholders to work together and use the available resources to improve OBP and holistic healthcare implementation, considering all the components of health. The study emphasised the need for continuous learning and skills development to equip CSOs with the necessary skills to make them confident to implement OBP. Additionally, collaboration between stakeholders in the community was reinforced to improve awareness and access to OBP. Stakeholders are advised to find ways to bridge the gaps in human and physical resources required to implement OBP, including advocating for funds towards OBP implementation. Insight building amongst healthcare practitioners about OBP is required to decrease the misinformed perceptions associated with OBP. The study emphasised collaboration between DOH, healthcare practitioners and people with disabilities to formulate policies improving awareness, access and OBP implementation.
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STRENGTHS AND LIMITATIONS OF QUALITATIVE AND QUANTITATIVE RESEARCH METHODS. European journal of education studies 2017; doi: 10.5281/zenodo.887089. Chapter Three Synthesis 3.1. Introduction: an overview of the chapter and the study This chapter concludes the study by summarising the study's main findings according to the research questions, aims, and objectives. Additionally, it will highlight the study's significance and contribution to literature and public healthcare by answering the research questions. The findings will be positioned contextually within South Africa and in more depth than in the manuscript, with its limited word count, while illustrating aspects of the ICF. Finally, the researcher will report the study's limitations, recommendations, and implications. Chapter One highlighted a need to explore the perceptions of rehabilitation personnel on the different practice choices and approaches to rehabilitation services. Moreover, there are limited studies on occupation-based practice in physiotherapy and speech therapy; thus, exploring OBP in the mentioned profession is necessary. With the movement from the medical model towards a more holistic healthcare model that considers all the components of health, there has been a need to explore approaches to implement rehabilitation services. Thus, the study explored rehabilitation personnel's perceptions of impairment-based and occupation-based practice in semi-rural and rural settings in the iLembe district. Additionally, this study aimed to understand the rehabilitation personnel's perceptions (occupational therapists, physiotherapists, and speech therapists) on transitioning from impairment-based to a more occupation-based practice within public healthcare. Although literature associates improved quality-of- life results for clients while using an OBP approach to rehabilitation (Nagayama et al., 2017), this practice was found to have numerous barriers towards its implementation. This study explored rehabilitation personnel's perceptions of barriers towards occupation-based practice implementation. Furthermore, the study identified the benefits of OBP, and factors required to effectively implement OBP within the public healthcare facilities within the iLembe district. 3.2. Summary of key findings: Implementing rehabilitation services requires intentionality and consideration of all the components of health, as seen in the study. This study contributes to future rehabilitation services and OBP implementation within the semi-rural and rural communities in KwaZulu-Natal, South Africa, by providing insight into OBP and IBP among rehabilitation personnel such as physiotherapists and speech and occupational therapists currently implement OBP and IBP. It also indicates barriers to OBP implementation in public healthcare, specifically in the iLembe district, that need to be addressed to facilitate better OBP implementation. Moreover, it contributes towards counteracting the barriers towards OBP and rehabilitation services implementation in public healthcare through identifying the recommendations for undergraduate training, DOH, healthcare practitioners and community stakeholders. The study identified factors required to implement OBP within the iLembe district public healthcare facilities effectively. The research questions, aims, and objectives were used to highlight the key findings, as seen below. 3.2.1. Perceptions of rehabilitation personnel on occupational based practice and impairment-based practice The study indicated that rehabilitation personnel in the iLembe district perceived impairment-based practice (IBP) as a non-holistic approach, focusing on diagnostic factors such as body structures and functions. However, the findings indicate that the rehabilitation personnel in the iLembe public healthcare widely utilise IBP. Rehabilitation personnel attributed this increased use of IBP to factors such as the dominance of the medical model, decreased human resources, acute settings, and limited time to conduct assessment and treatment sessions. Furthermore, the findings indicated a decreased awareness of OBP and how to optimally implement the practice, which led to a focus on IBP. This focus on IBP sometimes results in only focusing on one component of the components of health, namely, body structures and functions, and other components such as activity, participation, and environmental and personal factors needing to be addressed. When implementing rehabilitation services, rehabilitation personnel need to consider the interrelatedness of the different components of health, such as body functions, activities, participation, environmental factors, and personal factors. Considering the client's impairment in isolation reveals the gap in using IBP when implementing holistic rehabilitation services. Similarly, Heymani et al. (2020) found that the above are critical components of health, and consideration thereof is essential for implementing holistic rehabilitation services. The study highlights that rehabilitation personnel report that clients have different personal and contextual needs. It also indicates that their disability or impairment affects them differently depending on their context, personal factors, and activity and participation needs. Thus, holistic and client-specific interventions are needed to meet each client's healthcare needs. Rehabilitation personnel in the district defined OBP as a holistic and client-specific practice once they understood the concept. Moreover, they valued OBP as they believed it considered all the different components of health, allowing them to implement client-specific rehabilitation services. Rehabilitation personnel associated OBP with more positive functional outcomes, improved quality of life and health when implemented optimally, with collaboration between the clients, their families and the multi-disciplinary team as equal drivers of the rehabilitation process. OBP acknowledges how the impairment impacts activity performance and participation, the contextual influences such as environmental inhibitors and facilitators of participation, and the personal factors affecting their components of health. However, participants identified that more knowledge and resources are needed towards its implementation. Even though all the rehabilitation personnel perceived OBP as a more holistic practice, the study found that some physiotherapists post community service regarded IBP as part of their profession. Physiotherapists post community service viewed OBP as occupational therapy specific, which correlates with a study by Inglis et al. (2008) which stated that physiotherapists are more interested in the impairment-based approaches. Additionally, Narain and Mathye's (2023) study indicated a need for physiotherapy to focus more on activity performance and participation to meet client-specific needs, which concurs with this study findings. The study findings identified other factors, such as space, equipment, and infrastructure, influencing the rehabilitation personnel's practice choice. 3.2.2. Barriers to effectively implementing occupational-based practice within the iLembe district. Rehabilitation personnel identified clients' personal and contextual factors influencing their practice choice when implementing rehabilitation services, which mainly served as barriers to using OBP, as seen in Figure 5. Most of the rehabilitation personnel employed in the district's public healthcare sector were community service officers (CSOs). The CSOs had limited skills, experience, and knowledge; they felt they could not optimally implement OBP because they needed permanent staff within their facilities to guide them. This lack of skills and experience negatively impacted their confidence to implement OBP effectively, which led to them utilising more IBP approaches. Likewise, Di Tommaso et al. (2019) state that some recent South African graduates chose IBP over OBP due to a lack of experience and skills in implementing OBP. Moreover, the study findings found other factors hindering OBP implementation, such as limited human resources, which results in more focus on body functions and structures, and shorter assessment and intervention sessions due to higher patient-therapist ratios. A study by Hess-April et al. (2017) found that a lack of time for planning resulted in rehabilitation personnel implementing more IBP approaches than OBP, as perceived by the rehabilitation personnel in this study. Decreased human resources and incomplete rehabilitation teams were found to restrict accessibility to OBP and rehabilitation services in the iLembe public healthcare sector. Limited accessibility to rehabilitation services, namely, OBP, was also influenced by the lack of awareness on rehabilitation services and OBP within the different facilities and in the iLembe community, which concurs with the findings by Narai and Mathye (2023). Contextual factors within the healthcare facilities, such as limited space, equipment, and infrastructure, which were influenced by medical model-oriented settings, were found to limit OBP implementation. These medical model-oriented facilities

lacked contextual factors to simulate clients' activity participation to conduct OBP assessment and intervention sessions to improve activity performance (Hess-April et al., 2017). The previously mentioned factors lead to OBP being perceived as challenging to implement in the district, which concurs with findings by Estes & Pierce (2012), who stated that the medical model exerts strong contextual influences towards IBP. As seen in a study by Estes & Pierce (2012), this focus on the medical model and a limited understanding of OBP amongst other healthcare practitioners negatively impacts the focus of referrals. The barriers within the healthcare facilities result in clients only being referred for their diagnostic factors, body functions and structures rather than their holistic healthcare needs. When conducting the subjective assessments, non-isiZulu speaking rehabilitation personnel identified language and communication as barriers. The inability of clients and rehabilitation personnel to fully converse and communicate results in a lack of occupation consciousness and cultural sensitivity, as seen in Figure 5, as rehabilitation personnel cannot understand their client's activity and participation needs. Furthermore, language is fundamental for client specific OBP, which correlates with findings by De Klerk et al. (2016), who states that language in South Africa is one of the barriers towards OBP implementation. OBP was perceived to require increased communication and understanding from the client, family, and rehabilitation personnel to be implemented optimally. Personal factors and client- specific barriers, as illustrated in Figure 5, including socio-demographic factors, such as poor support systems, unemployment, and poverty, were also viewed as barriers to OBP. The previously mentioned factors were viewed to lead to non-compliance, as clients could not attend sessions due to a lack of caregivers to take them to sessions and the inability to afford transport fees. These client-specific barriers are exacerbated by facility-specific barriers such as limited staff and time constraints, as clients have limited access to community-based rehabilitation and home-based OBP sessions. Aas & Bonsaksen (2022) offer a contrary view, stating that socio-demographic variables do not impact OBP implementation. Community-specific barriers to OBP and rehabilitation services in the district include a lack of facilities outside the Department of Health in the community to carry over occupation-based practice, such as sheltered workshops and schools catering for children with disabilities. These facilities are necessary to ensure clients can implement their skills learnt in OBP sessions in areas such as work and schools, leading to decreased quality of life and OBP carryover into the community. Most of the above-noted barriers were attributed to the dominance of the IBP, the focus on body functions and structures and the neglect of OBP within the iLembe public healthcare sector. This results in rehabilitation personnel utilising more IBP than OBP when implementing rehabilitation services, which could negatively affect the client's health and quality of life as focusing solely on the impairment neglects the other critical components of health (World Health Organization, 2007). These barriers add to the literature on the barriers of OBP, but how do rehabilitation personnel move forward and counteract these barriers? Figure 5: Barriers towards OBP implementation 3.2.3. Key components required to effectively implement occupational-based practice in public healthcare facilities within a South African context. Rehabilitation personnel noted different motivators that would drive transitioning into OBP and allow for its effective implementation within public healthcare. These factors include insight into OBP, critical thinking, and knowledge to conduct client-specific assessments and interventions. Additionally, a complete rehabilitation team and permanent staff were required in each facility to improve accessibility and implementation of OBP approaches and rehabilitation services in the iLembe public healthcare sector. The study indicated that optimal OBP implementation requires collaboration between rehabilitation personnel, the client, the client's family, other healthcare practitioners and community stakeholders. This collaboration was perceived to assist in problem-solving to counteract the barriers towards OBP and rehabilitation services, such as access to rehabilitation services and limited facilities to carry over OBP in the community. Some participants felt that improved opportunities to engage in activity performance and participation within the community for persons with disabilities are required to improve OBP carryover into the community, the client's quality of life and health outcomes. This study found that collaboration at a facility level was required to assist in formulating standard operating procedures (SOPs) specific to the iLembe district. SOPs to improve access to rehabilitation services through the correct referral pathways and health promotion on the available rehabilitation services were noted to be required to counteract OBP contextual barriers and effectively implement OBP. OBP implementation in the iLembe district was found to require physical resources such as space, equipment, and infrastructure. These physical resources were noted to be a necessity to simulate activities and conduct OBP interventions within the public healthcare facilities in the district due to most of the facilities being medical model oriented, as found by Di Tommaso et al. (2019), Aas & Bonsaksen (2022), and Alotaibi et al. (2009). Moreover, as previously highlighted, the inability to communicate effectively leads to a lack of cultural sensitivity and occupation consciousness, as rehabilitation personnel need to understand their clients to gain insight into their activity, participation, and contextual and personal factors. Consequently, rehabilitation personnel must learn verbal and non- verbal techniques to communicate with clients to implement OBP optimally. The study findings indicated that confidence, critical thinking, skill, and knowledge are required to implement OBP effectively. Additionally, time and planning, which are dependent on human resources, are required for client specific OBP. Community facilities such as sheltered workshops and special schools were perceived as facilitators of OBP carryover into the community and community engagement, consequently improving the client's quality of life. The rehabilitation personnel in the district noted multiple motivators and prerequisites for OBP. Most of the motivators such as human and physical resources, were limited by KZN DOH's financial constraints and the lack of insight on the importance of OBP and rehabilitation services. Critical thinking is required for rehabilitation personnel to counteract the barriers and find ways to work with community multi-stakeholders to source physical resources, and to build insight at a district and provisional level on the benefits of OBP and the prerequisites for its implementation. 3.2.4. Perceptions of rehabilitation personnel within the iLembe district regarding transitioning from impairment-based practice to occupational-based practice The study aimed to identify rehabilitation personnel's preferred practice choice and their reasoning. Most participants highlighted a need for more OBP approaches when implementing rehabilitation and moving away from ideologies associated with the medical model. These medical ideologies were seen to work against OBP implementation. Even though there needs to be a more significant transition towards OBP, it is important to acknowledge that the practice choice used during assessment and intervention depends on the client's needs. OBP approaches were perceived to consider all the components of health when providing holistic treatment. OBP is perceived to produce more results in client independence, and all the components of health, including performance and participation in meaningful activities. OBP assists in rehabilitating clients back to active community members when implemented correctly. Additionally, OBP considers that the components of health are interrelated and acknowledges that body functions and structure do not influence the client's health in isolation. Contextual limitations also impact activity performance and participation along with body structures and functions, thus the importance of OBP in holistic rehabilitation services. Factors such as the perception of OBP being client-specific and incorporating all the components of health are motivators to transition towards more OBP approaches. With most of the participants acknowledging the need to transition towards OBP, some physiotherapists felt their scope of treatment required them to use IBP and that OBP was for occupational therapists as they viewed activity and participation or OBP approaches to be the core or essence of the occupational therapy profession supporting the findings by Hess-April et al. (2017). Despite the rehabilitation personnel acknowledging the need for a shift towards more OBP approaches when implementing rehabilitation services, they acknowledged the importance of IBP. By acknowledging the importance of not neglecting impairment, rehabilitation personnel are able to consider all the components of health and have a holistic view of the client. As seen in the social model of disability, neglecting impairment results in a lack of holistic healthcare as the impairment impacts the persons with disabilities everyday life (Oliver, 2013). They noted that IBP is crucial in acute stages of rehabilitation to remediate body functions and structures until the client is stable enough to engage in OBP. When a client is not ready to engage in activity and participation in the initial stages of rehabilitation services, there is a need to remediate body function and structures first before initiating OBP. It is essential to remember that the client's rehabilitation needs cannot be treated without addressing all the components of health, namely, activity, participation, and environmental and personal factors. The client needs to be treated as an individual and an active member of society. Thus, the previously mentioned components must be addressed when they are stable and ready for functional rehabilitation. Figure 6 demonstrates the relationship between stages of illness and stages of rehabilitation services, indicating the use of both IBP and OBP in conjunction. Figure 6 illustrates that in the initial stages of rehabilitation and illness, the predominant practice is IBP, as the client cannot engage more actively in activity participation and that as the illness stabilises, the focus is redirected towards OBP. It is also important to note that rehabilitation services do not occur in a linear process, and it is not merely a progression; the different components of health can change at any point, directly impacting the practice choice implemented during intervention sessions. Figure 6: Interrelatedness of OBP and IBP during different stages of illness and rehabilitation services 3.3. Limitations of the study Limitations include that the study explores the perspectives of rehabilitation personnel within only the public healthcare sector; therefore, contextual factors cannot be generalised to the private sector. The study was conducted in one district and with four healthcare facilities in the district. Therefore, if more healthcare facilities in different districts participated in the study, more perceptions would be explored and a greater variety of findings. As most of the participants were CSOs their lack of experience may have influenced their perceptions, limiting the study's findings. The focus group was over the Zoom platform, so the researcher could not observe non-verbal communication. This study did not consider the perceptions of other healthcare practitioners vital in providing holistic healthcare services, such as doctors, nurses, social workers, psychologists etc., due to the focus of the study being on the primary individuals/rehabilitation personnel implementing OBP in the field/ healthcare facilities. 3.4. Recommendations and implications 3.4.1. Recommendations for the Department of Health (DOH): It is suggested that DOH creates posts for permanent rehabilitation personnel in all the rehabilitation disciplines in the iLembe district to improve the client-therapist ratio and to promote the implementation of holistic, culturally sensitive, and client-specific OBP interventions. DOH is encouraged to fund training to promote continuous professional development to improve the rehabilitation personnel's knowledge and skills on OBP implementation and other rehabilitation practices. Continuous professional development amongst health practitioners on OBP and the roles of different rehabilitation personnel is required to improve insight and accessibility to rehabilitation services and improve referral pathways. DOH should work with community stakeholders to find ways to improve access to public healthcare in the district and counteract barriers such as transportation limitations. Improved funding for physical resources is advised to improve OBP implementation in the district's public healthcare and counteract the lack of physical resources in the healthcare facilities. Health education within the iLembe community is suggested to promote the transition from medical model-oriented facilities towards a more holistic framework, such as the ICF and OBP, to improve health and quality of life. 3.4.2. Recommendations for rehabilitation personnel: Rehabilitation personnel should consider attending courses or training to gain more insight on how to implement OBP, and holistic rehabilitation services. Rehabilitation personnel are encouraged to coordinate health promotion and education within the iLembe district to increase awareness on OBP, its uses, and its benefits in the iLembe community and how to access these services. Community-based rehabilitation is encouraged to improve access to OBP and context-specific interventions. Moreover,

rehabilitation personnel are encouraged to advocate for their clients so they do not get discharged without a discharge and continuum of care plan, on how they will continue rehabilitation services outside the hospital. This will assist in counteracting premature discharges, which may lead to more complications in the client's health, resulting in the revolving door syndrome. 3.4.3. Recommendations for community stakeholders: Consultation and collaboration between community stakeholders, the Department of Social Services, the Department of Labour, the Sector Education and Training Authority and the Department of Education are encouraged to establish sheltered workshops and special schools to improve community engagement, activity participation and improve the quality of life for people with disabilities. Community members need to be involved in planning and implementing these facilities so they can take ownership and sustain them. Resources such as shuttles transporting healthcare clients from their homes to healthcare facilities are required to enable access to healthcare services. 3.4.4. Recommendations for further research: Further research should investigate other healthcare practitioners' perceptions of occupation-based practice and rehabilitation services to understand the gaps in insight to allow for targeted health promotion to decrease these gaps. Action-based research to improve healthcare users' and practitioners' knowledge of occupation-based practice, how to implement OBP and available rehabilitation services. Studies surrounding occupation-based practice implementation in physiotherapy and speech therapy are recommended to improve insight into the effect of OBP within these professions. 3.4.5. Recommendations for the Department of Higher Education and Training (Health Sciences) Inter-professional education is encouraged for healthcare practitioners during their undergraduate to understand the different roles and scopes of the different members of the healthcare team to improve insight into the referral system and accessibility to rehabilitation services. The undergraduate program for rehabilitation personnel in South Africa is recommended to equip them with enough knowledge to implement OBP and engage in community-based rehabilitation at an earlier stage of the programme. More case studies with OBP implementation during fieldwork or practice-based learning are encouraged so that healthcare professionals can gain practical examples of how OBP to improve their professional reasoning for OBP when practising as independent practitioners. 3.4.6. Implications This study has implications for rehabilitation personnel, DOH, community stakeholders, the Department of Higher Education and Training (Health Sciences), and further research. Rehabilitation personnel need to improve their skills and knowledge and find new context specific strategies to implement OBP within the iLembe district to counteract the financial constraints using the available resources within the community. Rehabilitation services should transition towards more OBP approaches due to its quality of life and health outcomes without neglecting body functions and structures. Although, there needs to be a transition towards more OBP approaches, rehabilitation personnel are required to choose the practice choice based on the client's contextual and personnel needs. There is a need to transition from the medical model towards more holistic models and frameworks within the DOH facilities within the iLembe district. The study highlights implications for inter-professional practice, continuous professional development and health promotion within the district's DOH facilities to improve OBP implementation. Furthermore, there are implications for the Department of Higher Education and Training (Health Sciences) the Department of Higher Education and Training (Health Sciences) undergraduate programmes to have a stronger OBP presence to equip undergraduates with the skills, knowledge and experience to implement OBP within under-resourced facilities. 3.5. Conclusion This study emphasises a need to transition towards a more OBP approach, which acknowledges impairment and the interrelatedness of the components of health in the ICF framework when implementing rehabilitation services. Even though there are numerous community-specific, facility- specific, and client-specific barriers towards OBP, rehabilitation personnel noted different OBP facilitators. Human and physical resources were noted as some of the critical facilitators required to implement OBP and holistic rehabilitation services optimally. Continuous professional development is required to improve insight into OBP. Additionally, undergraduate programmes should focus on skills building on how to implement OBP and other approaches that focus on all the components of health in the undergraduate programme to improve CSO confidence, skills, and knowledge on how to implement OBP. The study reinforces inter-professional practice and collaboration between rehabilitation personnel, clients, and stakeholders within the iLembe community to implement holistic rehabilitation services and OBP optimally.
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ANNEXURES Annexure 1: UKZN Ethical Approval Annexure 2: KZN DOH Ethical Approval Annexure 3: Gatekeeper Request Letter (District office) Annexure 4: Gatekeeper Approval Letter (District office) Annexure 5: Consent letter Annexure 6: Demographic questionnaire Annexure 7: Semi-structured interview questions Annexure 8: focus group questions Annexure 9: Community mapping form Annexure 10: Ethics Certificate Annexure 11: Timeline Annexure 12: Budget Annexure 13: Reflexive Statement Annexure 1: UKZN Ethical Approval Annexure 2: KZN DOH Ethical Approval Annexure 3: Gatekeeper Request Letter (District office) Annexure 4: Gatekeeper Approval Letter (District office) Annexure 5: CONSENT CONSENT I ____________________(Name) have been informed about the study Perceptions on transitioning from impairment-based to Occupation-based practice in public healthcare within KwaZulu-Natal by Phana Lucy Gumede. I understand the purpose and procedures of the study. I have been given an opportunity to answer questions about the study and have had answers to my satisfaction. I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to. I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures. If I have any further questions/concerns or queries related to the study, I understand that I may contact the researcher at cell number: 0627115489 or email address: phanagumede03@gmail.com. If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact: HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION Research Office, Westville Campus Govan Mbeki Building Private Bag X 54001 Durban 4000 KwaZulu-Natal, SOUTH AFRICA Tel: 27 31 2604557 - Fax: 27 31 2604609 Email: HSSREC@ukzn.ac.za Additional consent, where applicable I hereby provide consent to: Audio-record my interview / focus group discussion Video-record my interview / focus group discussion Use of my photographs for research purposes ____________________ Signature of Participant YES / NO YES / NO YES / NO ____________________ Date ____________________ Signature of Witness ____________________ Date (Where applicable) ____________________ Signature of Translator (Where applicable) ____________________ Date Annexure 6: Demographics Form Full name: Age: Race/Ethnicity: Gender/Gender Identity: Marital status: Facility currently working at: Occupation: First Generation Status (Has either of your parents/guardian earned a degree, in a college or university), if yes please specify the type of degree: Socio-economic status: Qualifications/Education: Institution where qualifications were obtained: Level of post occupied/ Experience in public healthcare (months or years): Any courses done on the different approaches to rehabilitation (number, names and focus of course) Annexure 7: Semi-structured interview questions 1. Tell me about what you think about impairment-based practice? Prompts: general about impairment, can you please give an example, do you think that impairment caters for holistic treatment, where do you think impairment-based practice works best (paeds, adults, context) So following from that do you think…. 2. Now let's talk about what you think of the counter practice occupation-based practice …. Prompts: goals of occupational based practice, can you please give an example, do you think that occupational based practice caters for holistic treatment, where do you think occupational- based practice works best (paeds, adults, context),I 3. Now I would like you to think of the benefits of each practice. Can you tell me about the benefits that you can think about? Prompts: benefits of occupational-based practice, benefits of impairment-based practice, what are the benefits have you seen in your current setting, carry-over, time, 4. Taking what you just mentioned what are your thoughts on which practice you think has more treatment outcome? Prompts: how did it meet the client's needs, which one leads to more improvement in function, as well as your thoughts based on this specific context 5. Do you know the social model? … How would you could you explain it…. Which practice has similar characteristics to the social model of disability/ approach shares similar ? The social model of disability talks about how society disables people with impairments and how treatment must be directed at societal change rather than just individual impairment. The model aims to remove unnecessary barriers which limit people with disabilities from engaging in society. Prompts: principles/ characteristics with the social model of disability? application 6. Tell me about your thoughts about transitioning from impairment-based practice to occupation- based practice in when providing rehabilitation services? Prompts: within this community or facility, resources, 7. I'm interested in knowing some of the personal and contextual barriers to occupational-based practice? Tell me a story about one of the barriers? Prompts: personal, university AND contextual within this facility: policy, institutional; ideological. Knowledge, skills, time 8. Now let's talk about some of the different factors that promote occupational-based practice? Prompts: within this community? contextual and personal 9. In the future how do you think we can better implement occupational based practice? Prompts: what do we need to improve contextually within this community, what are some of personal factors needed? MDT? Annexure 8: FOCUS GROUP Focus group questions: 1. Can you tell me about your experience working in rehab Prompts: Any experience with models within your profession, within this district, at this hospital level What are some of the models you have used. Ok let's list them Now can we sort them into so called IBP or OBP NB: Think about polls, asking for opinions, asking if anyone disagrees Be an agent provocateur say you don't understand or have another understanding 2. I'm interested in learning your thoughts on impairment-based practice? Prompts: How many of you think that you'll understand impairment-based practice What is your general understanding of the practice, What are some of the benefits of the practice in your profession, What are some of the disadvantages of the practice in your profession, What are some of the core principles of this practice what prompts you to use this practice during rehab Definition: Impairment-based practice: focuses on reducing impairments in the person's body structure and function 3. Now can you tell me about your thoughts on occupation-based practice? Prompts: How many of you think that you'll understand occupation-based practice What is your general understanding of the practice, What are some of the benefits of the practice in your profession, What are some of the disadvantages of the practice in your profession, What are some of the core principles of this practice what prompts you to use this practice during rehab Definition: Occupation-based practice is a multifaceted practice targeting impairment reduction, adaptation, accommodation, skill acquisition, social reconstruction, or health and well-being, singly or in combination, to address an issue in occupational performance or engagement 4. I'm interested in knowing some of the personal and contextual barriers to occupational-based practice within your different departments? Prompts: Personal (what role does language play? Does the undergraduate curriculum play a role in therapist's ability to implement OBP, what is the role of cultural sensitivity?) Contextual: what are the institutional barriers? Does therapist ideological play a role in the implementation of OBP? How do the other healthcare providers (nurses, psychologists and doctors etc.) affect the implementation of OBP? How does Knowledge, experience and skills affect the implementation of OBP? Time… why is it a barrier for OBP if you only see the patient/ client once Resources… why can't we implement OBP due to limited resources? 5. Can you tell me about your understanding of the social model of disability? Prompts: which practice do you feel goes in line with the social model of disability what are the similar principles that the model shares with the two practices The social model of disability talks about how society disables people with impairments and how treatment must be directed at societal change rather than just individual impairment. The model aims to remove unnecessary barriers which limit people with disabilities from engaging in society 6. Can you tell me about the policies and legislations that y'all have in place that guide rehabilitation services within the district Prompts: Are the policies similar or different across disciplines Annexure 9: Community mapping of Community Infrastructure: Report on the availability, access, quality, and quantity of the following: 1. Resources within the public healthcare facilities that allow for the implementation of Occupational-based practice using South African specific activities within the public healthcare facilities, e.g., ADL room with basins and showers to cater for both clients in low and medium socio-economic statuses? 2. Limitations within the public healthcare facilities that hinder the implementation of occupational-based practice due to difficultly simulating client specific contexts and physical environments. 3. Availability of public transport, distance to taxi ranks; number of shops and malls next to the public healthcare facilities in the iLembe district to allow for implementation of IADL activities and community integration. 4. Availability of context specific (for both the South African context and the iLembe Community) leisure activities available in the public healthcare facilities 5. Availability of recreational and religious facilities in the community and their level of accessibility to persons with disabilities. 6. Availability of resources for vocational rehabilitation for the vocational needs for clients and their level of work within the public healthcare facilities in the iLembe community 7. The distance between the different public healthcare facilities and the communities that they serve within the iLembe district 8. The distance between special schools and the communities they cater to within the iLembe district. 9. Other basic community resources found in the iLembe district that promotes occupational- based practice implementation in the

iLembe district. Human & Materials Resources: Report on the availability, access, quality, and quantity of the following: 1. Safety within the iLembe district and its effect on occupational-based practice 2. Human resources available to implement occupational-based practice within the public healthcare facilities in the iLembe district. 3. Caregivers/ CCG's that work within the iLembe district and in the different sub-communities within the district 4. Which communities benefit from the community outreach programmes and the structural and human resource limitations in implementing occupation-based practice within the iLembe district. Annexure 10: Ethics Certificates Annexure 11: Timeline Date Research Process August - - - Submit to ethics board- HSSREC. Obtain consent from department of health district office (iLembe). Consent from research participants November- February - Data collection February- March - Data analysis April - Manuscript draft 1 15 April - Full thesis draft 1 03 May - Manuscript draft 2 08 May - Chapter 3 draft 2 31 May - Manuscript draft 3 06 June - Chapter 3 draft 3 15 June - Manuscript draft 4 18 June - Chapter 3 draft 4 20 June - Chapter 1 31 July - Chapter 3 draft 5 11 August - Manuscript draft 5 09 September - Complete thesis draft 2 27 September o Final complete thesis Annexure 12: Budget Budget Task Budget Printing of consent forms R50 Data Collection process including travelling to the community and providing refreshments for pilot study and main study R1000 (transport fee) R2400 (refreshments for the pilot study and the main study) Research Project final submission (printing costs for demographic forms and consent forms) R350 TOTAL R3800 Annexure 13: Reflexive statement In this reflexive statement, I address how my positionality affected the research process, my challenges and how the study affected me as a person and as a healthcare practitioner. During my community service year, I attended a course for children with cerebral palsy. The course facilitator, who was a physiotherapist mentioned how in order to implement service user-specific intervention we have to look at only their activities and not their body functions and structures, which contradicted what I learnt in my undergraduate programme. This prompted a lot of questions regarding holistic service user-specific rehabilitation interventions. This prompted to study the different practices (IBP and OBP), then I studied the social model of disability, which linked to the facilitators perceptions but there I had a lot of questions because I felt that as much as the service user is not their health condition or impairment, but it's a component of them. This resulted in so many questions that I could only answer through conducting more research, thus, this study was born. I then spoke to my main supervisor who guided me with formulating a concept paper. After I had my concept paper, I got my second supervisor, they both guided me through getting my ethical approval and permission from the relevant stakeholder. When I got permission I started data collection, data analysis and thesis writing, through their guidance. I had some road blocks along the way as this was the first time I head embarked on a research study by myself and not as a group, and my first time conducting qualitative research. I had to not look at myself as an occupational therapist but as a Researcher, I had to remove my perceptions and positionality from the study to truly understand the participants perceptions, which I had to remind myself every time before an interview and focus group. I had some issues with multi-tasking the study and working full- time, and changing provinces in the process but I had to problem-solve to conduct my data collection. I had to familiarise myself with data coding and thesis writing, by my supervisors were very understanding and guided me through the process. My data analysis took longer than I had expected, which demotivated me for some time but I had questions and I had to finish the study to answer them. I had a beautiful experience understanding other people's perception of rehabilitation services and its implementation. This study has led to my personal and professional growth. Even though I've had hiccups along the way, I feel that this thesis has prepared me for my PhD and has changed how I see my clients, and rehabilitation service implementation. 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88

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