Integration of Rehabilitation in Primary Care Level in Eswatini

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Presentation Outline

- Country context
- Levels of health care delivery system in Eswatini
- How rehabilitation is integrated into primary care level
- Examples of rehabilitation services integration into primary care level
- Successes and Challenges of the integration
- Opportunities for improvement
Country Context

17,364 sq km - landlocked
Population – 1,080,000
Life expectancy – 57.2 yrs
(55.1 yrs M: 59.3 yrs F)
High HIV prevalence – 27%
but 50% decline in incidence, MDR TB and rising NCDs
There are **327 facilities** organized in 5 levels:

- **Level 5**
  - 3 Ref Hosp. – MDRTB, Psych, MGH (highly specialized care)

- **Level 4**
  - 2 Mission Hosp. + 4 Govt Hosp. (basic specialized care)

- **Level 3**
  - 5 Health Centres (Rural) (general medical care)

- **Level 2**
  - 304 Clinics (NGOs, Govt, Private) (preventative services)

- **Level 1**
  - >4,000 RHMs + NGO CHWs (promotive, preventative, rehabilitative)
Rehabilitation Activities in the country

Tertiary Care Level (National and Regional Referral Hospitals)
- Physiotherapy, Occupational therapy, Speech and language therapy, Audiology

Secondary Care Level (Health Centres)
- Outreach visits from main hospitals

Primary Care Level
- RHM programme
- School health programme
- Community NGOs (Cheshire Homes, Hope House,
How Rehabilitation is integrated into Primary Care Level

**Policy** – Essential Health Care Package 2010 and 2012 includes disability screening and basic interventions at level 1 (community) and level 2 (community clinics)

- **School Health** - screening vision and hearing, nutrition, childhood growth and development, immunization, disability and referral of pupils
- **Outreach services** – from bigger hospitals to health centres – speech therapy, physio, OT – education on prevention of disability, screening, self-care
- **Community clinics** – diagnose, refer and continued care
- **Community services** - Package of services for CHWs (Rural Health Motivators) includes – care for stroke, debilitating illness – link with clinic for medication and supplies
Rural Health Motivators (RHMs) – since 1976
Role of Rural Health Motivators

• Recognize disabilities e.g. suspected blindness, deafness, physical, mental and refer to appropriate care level
• Assist relatives to manage disabilities caused by stroke, injury and others causes
• Advise communities on available resources, e.g. wheelchairs, walking aids, cataract surgery
• Provide first aid and teach safety and home nursing skills for minor illnesses
• Encourage Self-Care for clients with HIV/AIDS, TB, stroke
Training Manual for RHMs

Module 4: Family Health and welfare – MNCH and welfare, growth monitoring, ageing and elderly

Module 7: HIV/AIDS, TB, HBC

Module 8: NCDs and complications

Module 9: Community Mental Health and substance abuse

Module 12: Community Based Rehabilitation, Eye Care and prevention of blindness, Dental Care, School health, Prevention and Care of Epilepsy
Module 12: Role of RHM in preventing disability

- Educate on preventive measures;
- Participate in case finding for referral to appropriate resources;
- Educate the family and members of the community about programmes, treatment and the importance of inclusion of the disabled persons in everyday life;
- Counsel the disabled person and his family;
- Work with community rehabilitation extension workers, and follow up programmes which have been planned in rehabilitation institutions in central areas;
- Refer persons with a suspected disability to a clinic or hospital
Why Rehabilitation integration at Primary Care level

• Increasing demand - Upsurge of debilitating diseases – HIV/AIDS, TB, NCDs (DM complications and amputations, Strokes, Depression, Substance abuse), injuries

• Centralized services (hospitals and health centres)

• Inadequate numbers of rehabilitation cadres to cope with demand

• Opportunities exist – NCD Pen Decentralization, Govt Paramedics and EMS
Successes and Challenges

**Successes**
- DPM – DSW, Disability Unit
- Rehabilitation included in EHCP 2016
- Reforms of RHMP to CHP to improve coordination
- CHWs expansion beyond RHMs, e.g. Parish Nurses, NGOs
- School Health Teams (multidisciplinary)
- M&E Framework exist and 59% RHMs are reporting
- Availability of assistive technology – Referral Medical Scheme - hearing aids, cochlear implants, artificial limbs

**Challenges**
- Poor coordination of CHW community activities and often disease focused
- Rehabilitation services frequently overshadowed by primary illness – not reported clearly
- CHWs still not reporting through a similar format, except RHM Programme – under reporting of some rehabilitation activities
- No impact studies done and benefits of integration of rehabilitation not known
- Only 17% households visited by RHMs in 2018
- Assistive technology not well planned – workshops poorly funded
Thank you....Siyabonga....

Rural Health Motivators

Interventions for Club Foot