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User Satisfaction with Primary Health Care Rehabilitation Services in a South African Metropolitan District

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Abstract

Rehabilitation services are critical to improve health outcomes, particularly at community level within primary healthcare settings. As groups with an interest in the health system, rehabilitation service users' and caregivers' involvement in various aspects of health system strengthening is important for healthcare planning and evaluation. This study aimed to explore rehabilitation service users' perceptions of the rehabilitation services and their effect on their functioning in the Johannesburg Metropolitan District. A qualitative study was conducted using purposive sampling of participants attending rehabilitation at nine provincially funded clinics. Semi-structured interviews were conducted, and data were analysed using reflexive thematic analysis. The findings revealed the theme of *happy with rehabilitation services* and five associated categories, namely (1) service provider actions, (2) service organisation, (3) service user actions, (4) service access, and (5) service outcomes. The participants expressed overall satisfaction with their experiences of rehabilitation services, highlighting the importance of effective communication, patient-centred care, strong therapeutic relationships, and active patient engagement to achieve positive outcomes. This study provides the evidence for maintaining and extending rehabilitation at the PHC level in support of the health policy changes proposed for South Africa.

Keywords

patient experience, audiology, occupational therapy, physiotherapy, speech therapy

Introduction

Rehabilitation services are an essential component of healthcare systems worldwide, particularly within primary healthcare (PHC).[1] The potential for improved health outcomes at community level is most promising in PHC.[2] The integration of rehabilitation services into PHC has gained considerable attention as a means to strengthen access to care and enhance patient outcomes.[3] The World Health Assembly endorsed the resolution to strengthen rehabilitation within health systems, and the endorsement has been recognised by many countries for expanding and integrating these services in health systems as part of universal health coverage.[4] With the move in South Africa to universal health care funded by a National Health Insurance, PHC has been highlighted as well as the inclusion of rehabilitation services at the PHC level.[5]

The transition to universal health care has emphasised the need for empirical evidence and understanding of rehabilitation integration into PHC in South Africa. How service users perceive rehabilitation services in this context is crucial to appropriately target services to satisfy their needs[6] in providing access to the full range of accessible, affordable health services.[7] However research considering

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the insights from service users and their families, as key interest groups in this process, to improve service planning, delivery, and evaluation, is limited. Creating empowering opportunities for individuals and communities is at the core of integrated healthcare services.[8]

A service user approach should be used to tailor PHC rehabilitation services to the unique needs and expectations of individual service users within their respective contexts, making services effective. This approach aligns with the main objective of PHC to include user voices in patient-centred interventions. User satisfaction, a vital measure in today's consumer-oriented healthcare markets, may provide patient and family feedback, with useful insights to guide healthcare improvements.[9] Moreover, satisfied service users tend to comply with prescribed interventions, resulting in improved health outcomes, and are more likely to advocate for the service among their peers.[10]

When measuring patient experience of rehabilitation services, satisfaction with the health care system, the level of engagement in the service and the quality of relationships between rehabilitation professionals and service users as well as outcomes need to be considered.[11] Studies exploring satisfaction with rehabilitation services in South Africa have not comprehensively covered these aspects at the PHC level and are mostly limited to a single age or diagnostic group and do not report on outcomes. Factors affecting patient experience with rehabilitation reported in the studies include stereotypes and cultural values related to the aetiology of disability such as the belief that disability is imposed by outside entities such as ancestors due to wrongdoing. Discrimination against persons with disabilities and lack of finances affect their ability to use public transport to access rehabilitation services impacting continuity of care, have been reported to influence satisfaction with the service.[12]

Over seventy percent of people with disabilities access rehabilitation in the public health sector in South Africa. They are frequently more economically disadvantaged with financial constraints which do allow them to subscribe to health insurance[13] and private healthcare. Although the public health sector provides free health care to children under six years, those over 60 years and those receiving social grants and pensions, overcrowding, staff shortages, long waiting times of up to eight hours, negative staff attitudes and lack of resources and complex referral pathways affect service user experiences.[14–16] South Africa is a multicultural society as evidenced by the 12 official languages legislated in the country. Patients as service users receiving rehabilitation, represent various ethnic and cultural groups with service providers having divergent beliefs about health care and home languages, necessitating that the service providers be culturally competent[17,18]

In this study, we explored a comprehensive service user perspective of PHC rehabilitation services within a South African metropolitan district. The study encompassed factors influencing service user satisfaction, including healthcare provider and user behaviour, the service organisation, accessibility, affordability, and the extent to which services achieve desired health outcomes. Delving into these aspects can inform rehabilitation service planning and evaluation, ultimately contributing to accessible, and quality patient-centred services being integrated into PHC.[9,19–24]

Methods

Study Setting

The study was conducted in the Johannesburg Metropolitan District, which comprises 81 PHC clinics and community health centres (CHCs) distributed across seven regions. Due to financial constraints within the health service only nine of the provincially funded PHC clinics and CHCs offer rehabilitation services that include physiotherapy, occupational therapy, speech-language therapy, and audiology.[25] Some of these services are provided at the CHCs and clinics daily while others are only available a few days in the week, fortnightly or once a month. The clinics and CHCs are situated in low socioeconomic, overcrowded urban suburbs of the Metro where taxis are the most affordable form of transport. Contrary to the WHO recommendations as supported by research in SA, this means that services are not available within the 5 km distance radius, and 3 min travel time from a patients home.[26,27]

Study Design

A descriptive qualitative study was conducted to explore the experiences of rehabilitation services among service users.

Participant Recruitment

Purposive sampling was used to select 38 participants from nine clinics and CHCs that offer rehabilitation services. Potential participants were identified by clinicians at the clinics, and recruited into the study by research assistants trained to conduct the interviews. The sample included service users of occupational therapy, physiotherapy, speech-language therapy, and audiology services who had attended at least three rehabilitation sessions at the time of the interview. Both adults and caregivers of children receiving rehabilitation and attending these services, were included in the study. Participants were recruited when they arrived at the clinic to attend their scheduled rehabilitation appointments over the data collection period. Caregivers were invited to participate if the service users were children or had communication impairments.

Data Collection

Semi-structured interviews with open ended questions were used to collect data due to the variable education level of service users at the clinics and CHCs. In South Africa this may range from no formal education with many individuals

not achieving secondary school qualifications. Research assistants who were rehabilitation professionals were trained by the first author to conduct the interviews. which were conducted at the nine clinics.

The semi-structured interviews were audio-recorded and conducted in English using a specially designed interview guide that collected demographic information, such as age, gender, type of disability, clinic attended, and frequency of rehabilitation attendance, to gain a comprehensive understanding of the participants. Twelve open ended questions about daily activities, mobility, employment, and schooling required participants to describe satisfaction with the services, their access to the services, their role in the rehabilitation process and the outcomes achieved by indicating their engagement in activities and daily life before they started receiving rehabilitation and after receiving rehabilitation at the clinic.

Ethical Considerations

Ethics approval was obtained from the Human Research Ethics Committee (Medical) of the Faculty of Health Sciences at the University of the Witwatersrand (M190466). Permission to conduct the study was also obtained from the Gauteng Department of Health. Participants provided signed informed consent for the interviews and audio recording.

Data Analysis

Demographic data were analysed descriptively. Audio-recorded data were transcribed verbatim and analysed using NVivo v.11. Confidentiality was maintained by assigning unique codes to each participant to ensure protection of personal data. The transcriptions of the service users' responses to open ended questions were reviewed by two of the researchers. These responses were analysed to rate the overall perceived effectiveness of the rehabilitation services they received at the clinic to identify the percentage of patients who were highly satisfied, moderately satisfied or minimally satisfied.[28]

The six steps in reflexive thematic analysis, using experimental analysis, following the approach of Braun and Clarke, was used.[29] LM and a colleague experienced in qualitative research coded the data inductively, allowing categories and themes to emerge from the participants' own words.[29] Extracts from the data were included to support the main theme, ensuring the interpretation remained directly tied to the participants' words.[30]

Results

A total of 38 participants, 21 adults and 17 caregivers of children attending rehabilitation services, were included in the study. Caregivers represented children, all below the age of seven, in the interviews. The highest presenting impairment in both adults (100%) and children (64.7%) was related to neuromusculoskeletal and movement functions. Most participants attended rehabilitation services once a month. See Table 1 for detailed demographic information.

A substantial proportion of adult (85.7%) and child (70.6%) participants perceived the rehabilitation services they received at the PHC facilities as satisfactory and as having a positive impact. (Table 2). The factors influencing these perceptions are discussed in the central theme.

Central Theme: Happy with Rehabilitation Services—'My Journey is Very, Very Happy. I'm Happy'

This study explored the perceptions of service users attending rehabilitation services in the Johannesburg Metropolitan District. Notably, most respondents expressed satisfaction with rehabilitation services, complimenting the effectiveness and timeliness of services, as well as the compassion and professionalism of staff generating a central theme reflecting the overall satisfaction with the rehabilitation services they receive in the Johannesburg Metropolitan District. This theme: happy with rehabilitation services— 'My journey is very, very happy. I'm happy'—encapsulated the positive experiences and perceived effect of the services on the participants' wellbeing. The central theme had five associated categories: service provider actions, organisation of service, service user actions, service access, and service outcomes (Figure 1).

Category 1: Service Provider Actions

Perceptions of service provider actions by the participants emphasised the positive impact of the interaction with the rehabilitation personnel and the quality of care they provided. This included the way the rehabilitation personnel made the service users feel, the client-centred care provided to service users, good interpersonal relationships (IPRs) between service users and rehabilitation personnel, constructive clinical actions of the rehabilitation personnel, and their strong work ethic. The participants expressed that the rehabilitation personnel gave them confidence and were invested equally in their progress, as two participants explained:

> I saw the actions; I saw everything, the reaction to care for us, for everybody in community … I found people who can help me, and they helped me to get life … I'm happy … they sat down with me and … show me to get life. (Male, 64 yrs.)

> They make me more confident about myself, and I can manage on my own. (Male, 54 yrs.)

Service users commented that they felt respected, listened to, and supported, which they associated with feeling like being part of a family and understood by the rehabilitation personnel. The participants highlighted the partnership and collaborative nature of the user-provider relationship. As seen in the following comments, the service users consistently described

Table 1. Personal Factors of Rehabilitation Service Users in PHC Facilities in the Johannesburg Metropolitan District (n = 38).

Variable	Description	Adults (n = 21) n (%)	Children represented by caregivers (n = 17) n (%)
Sex	Male	9 (42.86)	12 (70.59)
	Female	11 (52.38)	5 (29.41)
	Other	1 (4.76)	0 (0.00)
Age at assessment (years)	< 3	N/A	4 (23.53)
	3–7	N/A	13 (76.47)
	11–20	1 (4.76)	0
	21–40	6 (28.57)	N/A
	41–60	10 (47.62)	N/A
	61–70	4 (19.05)	N/A
Occupation status	Unemployed	9 (42.86)	N/A
	Employed	7 (33.33)	N/A
	Retired	5 (23.81)	N/A
Social grant	Yes	8 (38.10)	10 (58.82)
	No	13 (61.90)	7 (41.18)
Impairments	Neuromusculoskeletal and movement-related functions	21 (100.00)	11 (64.71)
	Voice and speech functions	0 (0.00)	1 (5.88)
	Sensory functions and pain	0 (0.00)	2 (11.76)
	Mental functions	0 (0.00)	3 (17.65)
Referral source (level of care)	Quaternary	0 (0.00)	1 (5.88)
	Tertiary	7 (33.33)	9 (52.95)
	Secondary	4 (19.05)	1 (5.88)
	Primary/clinic	8 (38.10)	4 (23.53)
	Other	2 (9.52)	2 (11.76)
Rehabilitation attendance	Weekly (1x a week)	1 (4.76))	1 (5.88)
	Monthly (1x a month)	20 (95.24)	16 (94.12)

Table 2. Overall Satisfaction with Rehabilitation Services (n = 38).

	Adults (n = 21)		Children represented by caregivers (n = 17)	
Category	N	%	N	%
Highly satisfied	18	85.71	12	70.58
Moderately satisfied	3	14.28	5	29.41
Minimally satisfied	0	0.00	0	0.00
Missing	3	0.00	0	0.00

the rehabilitation personnel as empathetic in their approach, indicating person-centredness in rehabilitation service delivery.

> I'm satisfied with it … when I need to come for appointment, you inform me, I inform you … for me sometimes it's like a big family … you become one big family. (Caregiver, representing a male child, 4yrs)

> My overall impression is … they treat us [as if] they were in our shoes. (Male, 37yrs)

One participant perceived the rehabilitation personnel at the clinic as more caring because they issued a walking stick, which the referring tertiary hospital did not do:

> You know at [name of hospital] they didn't even give me that walking stick … I only came here for six or seven months … then they give me that walking stick … I felt that they [therapists at clinic] were very more caring. (Female, 67)

The participants appreciated the positive and effective IPRs between themselves and the rehabilitation personnel and the encouragement from the personnel throughout their rehabilitation journey. Furthermore, the rehabilitation personnel inform service users about rehabilitation interventions. The following comments represented participants' experiences:

> I got such good services from them… African people [caregiver referring to her own culture] they come to me they say what does she [therapist from another culture] understand about my culture? But when they leave there, they can truly say thank you. (Caregiver, representing a male child, 4yrs)

> They try to reach out to you as much as they can so that you get informed. (Female, 41)

Good work ethic, professionalism, and comprehensive knowledge were evident among the rehabilitation personnel, as shown in the following comments:

> Like they're professional actually. (Male, 37yrs)

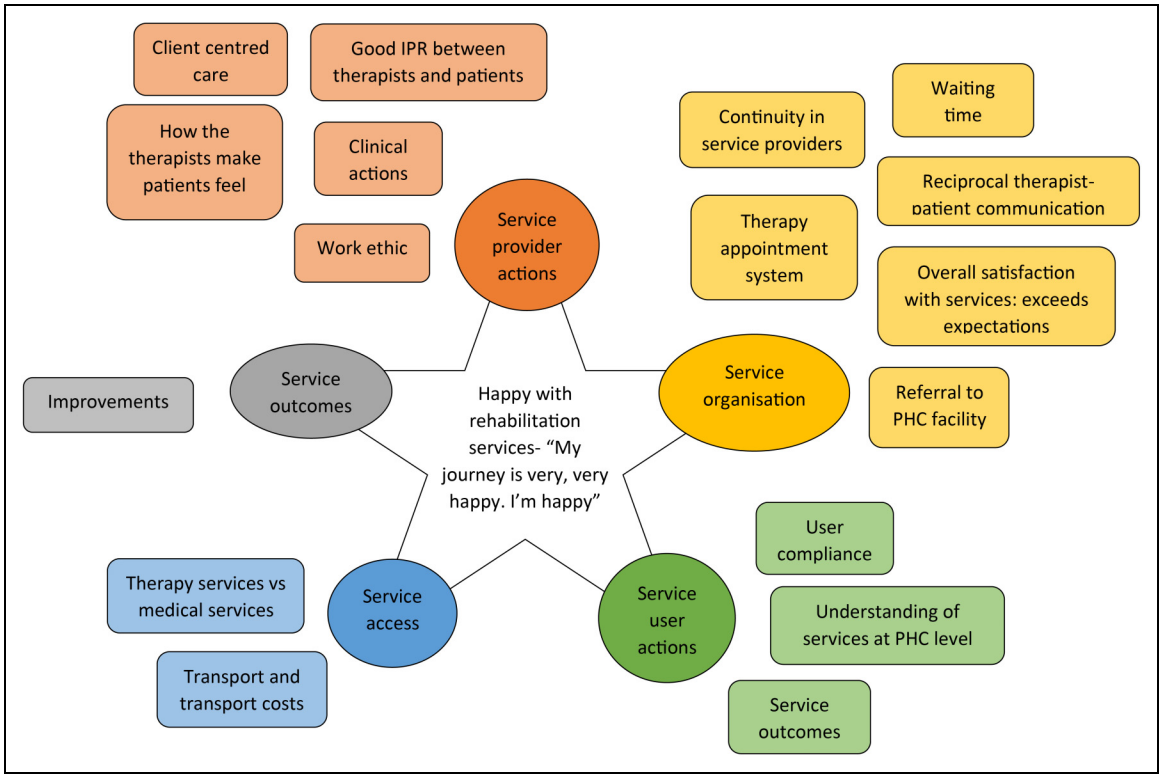


Figure 1. Schematic representation of the thematic analysis of interviews with rehabilitation service users.

> Therapists know what they are doing, not doing guesswork. (Female, 55yrs)

Category 2: Service Organisation

In terms of the organisation of the rehabilitation services most service users perceived that referral pathways between services, appointment systems, and short waiting times contributed to their positive experience and satisfaction with the service. Participants indicated that therapists scheduled appointments for them to attend all of their rehabilitation services on the same day to save money on transportation, and that the appointment system prioritised those with more severe disabilities, resulting in shorter waiting times for therapy. This was stated:

> I just walk and then she saw me with the crutches … I gave her a letter that they refer me … she put me under appointment and … said … "I will give you the next appointment". (Female, 45 yrs.)

> When you go somewhere they want to leave you for 30 min go and drink tea and do what they want to do … but here, when they book you for nine, make sure that you're there … they will help you nicely … without any complaints… I do see them [rehabilitation services on] the same day … it's very helpful (Caregiver, representing a male child, 4yrs.)

Category 3: Service User Actions

Participants perceived it was their own responsibility to be compliant with their prescribed home programme and therapy appointments. They mentioned the importance of their actions contributing to the positive outcomes of rehabilitation and how they willingly sacrifice their personal needs to attend therapy sessions, as seen in the following comments:

> I did everything that they told me to do, like not to let him watch TV a lot. (Caregiver, representing a male child, 3yrs)

> I didn't eat if I come here … just because I know what I'm here for … I dedicate myself … and I want to be better. I want to do what I have to do. (Male, 37)

Category 4: Service Access

Participants said they used public transport, specifically taxis. Nearby residents walked to the clinic/CHC. The expense of a single visit using public transport to access various rehabilitation services in one day influenced service accessibility. Although participants used rehabilitation services at PHC clinics and CHCs, they collected their medication from tertiary hospitals. They described it as follows:

> .. because we are using public transport to come to the clinic …, it's better for me and it saves me a lot of money. (Caregiver, representing a male child, 4yrs.)

> I don't get medication from you guys [referring to the PHC facility] … I am only coming here for the audiologist and then for the physio … I go to [name of tertiary hospital] … I have 3 or 4 appointments a week at [name of tertiary hospital]. (Female, 55)

Category 5: Service Outcomes

The participants reported noticeable improvements in their functional performance and activity participation from attending rehabilitation services, as shown in the following comment:

> I couldn't walk. I couldn't do anything for myself … they take step-by-step showing me love and then give me exercises … now I'm doing it and … I'm standing myself. I don't have a pain anymore … I'm not crippled anymore … I'm working … I'm fine. (Male, 37)

Discussion

This study aimed to comprehensively explore the perceptions of rehabilitation service users in the nine clinics/CHCs offering rehabilitation services in the Johannesburg Metropolitan District. Overall, participants had positive perceptions of the rehabilitation services and expressed high satisfaction, describing their journey as 'very happy'. This reflects the findings from other studies on rehabilitation services offered in urban hospital-based settings in South Africa.[14,16,31] Positive perceptions of rehabilitation services provided at a PHC level were reported for all variables researched including the actions of rehabilitation professionals, streamlined services, improved accessibility, the patients' own active involvement in the process, and notable functional improvements. This differs somewhat from a study which only considered children with cerebral palsy and their caregivers in rural areas, who were dissatisfied with the quality of access to PHC services.[15] It would appear that the context and availability of rehabilitation services in urban areas may be more satisfactory.

In terms of the service provider actions the attentive care provided by rehabilitation personnel significantly contributed to positive perceptions among rehabilitation service users. Addressing participants as equals in the rehabilitation journey rather than just as patients receiving the service made them feel respected and valued. This user-centred approach translated into their opinions being considered when addressing their care needs, resulting in a sense of empowerment and active involvement in their rehabilitation process. Moreover, the participants valued the effective communication established with rehabilitation personnel, ensuring not only their active involvement but also fostering a sense of being genuinely cared for and supported[9] particularly in view of the stigma often experienced by disabled individuals in South Africa.[18] Thus, continuous and meaningful interactions between healthcare providers and service users should be emphasised in delivering integrated PHC rehabilitation services to ensure satisfaction and engagement in rehabilitation services.[32] This aligns with the National Core Standards for Health Establishments in South Africa,[33] which emphasises the rights of patients must be upheld, including access to needed care and respectful, informed, and dignified attention from healthcare professionals.[23] Building strong IPRs and trust between service providers and users are important for successful rehabilitation interventions, with trust between service providers and users essential in fostering collaborative user-provider interactions in the health care context.[34] Surprisingly, this study did not uncover concerns related to service continuity, where rehabilitation service users consistently see the same healthcare professional.[35] Participants highlighted frequent interactions with different rehabilitation personnel, yet they still perceived they received consistent, high-quality care. Previous research suggests that continuity of services is important.[16] However, the findings of this study suggest that issues with service fragmentation can be overcome by effective communication, keeping patients informed. Rehabilitation outcomes are attainable even when multiple therapists are involved in a service users' care, if a consistent and high standard of care is upheld. This finding is contrary to a previous study where clinical skills were found to be inadequate.[16]

Attentive listening is important for effective therapeutic relationships in rehabilitation. Allocating ample time for attentive listening was identified as a prerequisite for service satisfaction and leads to reduced stress, increased engagement, and overall well-adjustment.[9] The emotional impact of how rehabilitation providers made service users feel throughout the rehabilitation process was found to significantly influence the overall service user experience. Additionally, providing rehabilitation service users with access to relevant information and explaining treatment options further enhanced the overall patient experience.[23,32]

Cultural competence, which allowed rehabilitation personnel to connect with and respect people from other cultures, had a positive influence on IPRs. Within this context, encouraging patient agency and providing culturally competent services is supported by Majumdar et al,[36] and highlighted effective therapeutic relationships between rehabilitation personnel and service users in the current study even though the cultures and home languages of the personnel providing the service and patients who were receiving the service differed.[18] Cultural competence that respects diverse values, languages, and beliefs about health and disease is particularly important in South Africa,[37] where service providers may rely on translators to assist with communicating effectively with patients.[18]

When considering the service organisation the profound impact of patient-centred care on the health outcomes and

agency of service users was evident. Service users trust that PHC rehabilitation services will meet their expectations in terms of organised service delivery with set appointments, duration of treatment sessions and reduced waiting times, which have been a reported cause for service user dissatisfaction in other South African studies.[14,16] Trust extends beyond the physical safety conditions of the environment and includes organisation of the service to foster the belief that healthcare providers are competent in their knowledge and skills to deliver the care needed, instilling confidence in vulnerable clients that they are in capable hands.[23] Kloppers et al indicate the importance of enhanced confidence in rehabilitation services through emotional support and encouragement, fostering a sense of hope and courage for the future,[32] making patients more likely to actively engage in their rehabilitation journey as demonstrated in the current study. These findings were in contrast to other studies where service users reported dissatisfaction with the rehabilitation professionals' knowledge and skill for some conditions.[16] The dissatisfaction may be due to many PHC rehabilitation services being provided by novice therapists completing a year of compulsory community service directly after graduating,[38] whereas the clinics and CHCs in this study had permanent post community service posts, where services were delivered by more experienced therapists who may be more skilled in addressing different conditions.[39]

Active service user behaviour or engagement not only correlates with the factors discussed above, but with better rehabilitation outcomes, and facilitates more service user control, reciprocal sharing of emotional responses, and increased exchange of information.[23] Participants in the study displayed a strong sense of agency and active engagement in their rehabilitation journey, with dedication and commitment to following instructions and completing home programmes, even sacrificing personal needs to attend rehabilitation sessions, and taking full responsibility for their progress. Active service user engagement appears to have been supported by the effective communication with rehabilitation personnel resulting in treatment compliance and positive service user perceptions. Patients as service users who have poor communication with healthcare providers are more likely to struggle with treatment compliance since they are likely to lack understanding of the relevance of the rehabilitation programme.[40]

In view of the socioeconomic status of the service users attending the clinics/CHC participants highlighted their appreciation of the service providers understanding of their financial constraints in accessing the clinics/CHCs. The convenience of multiple rehabilitation appointments on the same day as was organised within the clinic/CHCs, reduced transportation costs and minimised disruptions to their daily lives.[19] Addressing the challenges posed by transportation barriers is crucial as high levels of unemployment make frequent visits to clinics financially burdensome. Public transport minibus drivers may discriminate people with disabilities, refusing them access to the vehicle or charging extra for assistive device transport.[41] The relatively new and accessible Rea Vaya bus service in the Johannesburg Metropolitan where the study was conducted is more affordable, however it only has stops at three of the nine clinics, still limiting access using this method of public transport.[42] Implementing service delivery models closer to patients' homes, such as community-based services and task shifting to community-based rehabilitation workers, may significantly improve accessibility and affordability.[24]

Participants were satisfied with the outcomes of their rehabilitation and it is important to note that participants' positive outlook and high satisfaction may have been influenced by the functional improvements they were experiencing at the time of the interviews.[37] The positive improvements in functional performance and activity participation validated the effectiveness of the rehabilitation interventions provided in the clinics and CHCs.[11] This finding is supported by another South African study on children with cerebral palsy receiving PHC rehabilitation services, where satisfaction with services was related to definitive functional outcomes achieved.[15]

Ensuring that the perspectives of service users shape decisions regarding rehabilitation service delivery can result in services that are more tailored and responsive to individual needs.[37] Future research should examine the extent of service delivery reach and coverage, particularly considering the positive outcomes for those receiving services.

Limitations

A limitation of this study was that the data were gathered from individuals already receiving rehabilitation services who spoke English, and who may have perceived services in a positive way resulting in them reporting high satisfaction. The use of rehabilitation professionals in conducting the interviews may have also influenced participants in reporting their negative perceptions. Future research should include the experiences of those who are lost to follow-up and those who were referred but do not access the service, to gain a more comprehensive understanding of factors influencing satisfaction and service discontinuation. Although at least five participants were recruited in each clinic the data from nine clinics and the small sample cannot be generalised to other PHC rehabilitation services. Additionally, further investigation into other areas related to user experiences, such as barriers to access and affordability, would provide valuable insights.

Conclusion

The study provides evidence for the importance of retaining rehabilitation services at a PHC level in urban contexts in South Africa. It highlights the first contact status of PHC, and the need for continuity of rehabilitation services which are more accessible to service users who require longer term interventions at a lower cost, based on rehabilitation

service users' overall satisfaction and the positive impact of services received. The findings indicate a comprehensive view of rehabilitation services including the importance of rehabilitation personnel behaviour in people-centred care, cultural competence, and strong IPRs. Participants perceived the service organisation within the clinics provided adequate, experienced rehabilitation personnel with expertise and participants felt empowered to actively participate in their own or their child's healthcare decisions which resulted in positive service user behaviours in engaging and complying with the rehabilitation programme. The services were structured to accommodate access particularly in view of financial constraints and outcomes achieved were perceived in a positive light ultimately enhancing service user satisfaction.

Recommendations

1. **Prioritise patient-centred care, cultural competence, and communication skills:** Rehabilitation service providers in PHC should ensure that rehabilitation services are centred on service users' needs, preferences, and values, culturally competent services that respect diverse values, language, and beliefs about health and disease and establishing effective therapeutic relationships, including attentive listening.
2. **Service organisation:** ensure adequate rehabilitation service provision with the required skill and expertise is available in the clinics and CHCs by ensuring senior posts are available at this level of care for service provision and oversight of community service cadres.
3. **Empower patients**: allow patients to actively participate in their treatment decisions to facilitate control and sense of agency for compliance and engagement in their rehabilitation journey.
4. **Improve service accessibility:** Address barriers to access by implementing service delivery models that bring rehabilitation services closer to patients' homes, such as community-based services and task shifting to community-based rehabilitation workers trained to provide rehabilitation services.
5. **Monitor patient outcomes:** Regularly assess and monitor patient outcomes from the patients' perspective to gauge the effectiveness of rehabilitation interventions and inform improvements in rehabilitation service delivery in PHC.
6. **Future research** should include individuals who have discontinued rehabilitation services to understand the factors influencing the discontinuation and identify areas for intervention. In a multicultural society such as that in South Africa, key actions or behaviour of service providers in demonstrating cultural sensitivity should also be considered. Evidence generated will assist rehabilitation professionals in advocating for rehabilitation services to be prioritized at the PHC level in view of new legislation and policies supporting universal health coverage in South Africa.

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Authors' Contributions

LM conceptualised and designed the study, collected data, carried out the initial and secondary analysis, and drafted, reviewed, and revised the manuscript. HM and FA coordinated and supervised the study, including conceptualisation, and critically reviewed the manuscript for important intellectual content. All authors approved the final manuscript submitted and agreed to be accountable for all aspects of the work.

Data Availability

The data that support the findings of this study are available from the corresponding author, LM, upon reasonable request.

Disclaimer

The authors hereby declare that the views expressed in the submitted article are their own and not an official position of the University of the Witwatersrand.

Ethical Approval

Ethics approval was obtained from the Human Research Ethics Committee (Medical) of the Faculty of Health Sciences at the University of the Witwatersrand (M190466). Permission to conduct the study was also obtained from the Gauteng Department of Health.

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Statement of Human and Animal Rights

All procedures in this study were conducted in accordance with the Human Research Ethics Committee (Medical) of the Faculty of Health Sciences at the University of the Witwatersrand (M190466) approved protocols.

Statement of Informed Consent

Written informed consent was obtained from the participant(s) for their anonymised information to be published in this article.

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References

1. Gimigliano F, Negrini S. The world health organization "rehabilitation 2030: a call for action". *Eur J Phys Rehabil Med*. 2017;53(2):155-68.
2. Sherry K. Essential considerations for equitable, accessible and poverty-reducing health care in South Africa. *South African Heal Rev 2014/2015 [Internet]*. 2015;2014(1):89-99. Available from: http://www.rhap.org.za/wp-content/uploads/2015/10/Disability-and-rehabilitation-Essential-considerations-for-equitableaccessible-and-poverty-reducing-health-care-in-South-Africa.pdf
3. World Health Organization. *Rehabilitation in Health Systems: Guide for Action [Internet]*. Geneva: World Health Organization; 2019. Available from: https://www.who.int/rehabilitation/en/
4. World Health Organization. *Landmark resolution on strengthening rehabilitation in health systems [Internet]*. Departmental news Geneva; 2023. Available from: https://www.who.int/news/item/27-05-2023-landmark-resolution-on-strengthening-rehabilitation-in-health-systems
5. Conradie T, Charumbira M, Bezuidenhout M, Leong T, Louw Q. Rehabilitation and primary care treatment guidelines, South Africa. *Bull World Health Organ*. 2022;100(11):689-98.
6. Samudre S, Shidhaye R, Ahuja S, et al. Service user involvement for mental health system strengthening in India: a qualitative study. *BMC Psychiatry [Internet]*. 2016;16(1):1-11. Available from: http://dx.doi.org/10.1186/s12888-016-0981-8
7. World Health Organization. Preparations for the high-level meeting of the united nations general assembly on health-related issues. *World Heal Organ*. 2019;2023(April):5.
8. World Health Organization, United Nations Children's Fund. *Operational Framework for Primary Health Care: Transforming Vision into Action [Internet]*. Vol. 2009. Geneva: World Health Organization; 2020:1-106. Available from: https://apps.who.int/iris/handle/10665/337641
9. Karaca A, Durna Z. Patient satisfaction with the quality of nursing care. *Nurs Open*. 2019;6(2):535-45.
10. Buchanan J, Dawkins P, Lindo JLM. Satisfaction with nursing care in the emergency department of an urban hospital in the developing world: a pilot study. *Int Emerg Nurs*. 2015;23(3):218-24.
11. McMurray J, McNeil H, Lafortune C, Black S, Prorok J, Stolee P. Measuring patients' experience of rehabilitation services across the care continuum. Part I: a systematic review of the literature. *Arch Phys Med Rehabil [Internet]*. 2016;97(1):104-20. Available from: http://dx.doi.org/10.1016/j.apmr.2015.08.407
12. Maart S, Eide AH, Jelsma J, Loeb ME, Toni MK. Environmental barriers experienced by urban and rural disabled people in South Africa. *Disabil Soc*. 2007;22(4):357-69.
13. Gordon T, Booysen F, Mbonigaba J. Socio-economic inequalities in the multiple dimensions of access to healthcare: the case of South Africa. *BMC Public Health*. 2020;20(1):1-13.
14. Mlenzana NB, Eide AH, Frantz JM. Perceptions and satisfaction of caregivers regarding rehabilitation services from selected rehabilitation centres in the Western Cape. *African J Disabil*. 2018;7:415. https://doi.org/10.4102/ajod.v7i0.415
15. Ngubane M, Chetty V. Caregiver satisfaction with a multidisciplinary community-based rehabilitation programme for children with cerebral palsy in South Africa. *South African Fam Pract [Internet]*. 2017;59(1):35-40. Available from: http://dx.doi.org/10.1080/20786190.2016.1254929
16. Kumurenzi A, Goliath C, Mji G, et al. Experiences of patients and service providers with out-patient rehabilitation services in a rehabilitation centre in the Western Cape province. *African J Disabil*. 2015;4(1):1-7.
17. Matthews M, Van Wyk J. Towards a culturally competent health professional: a South African case study. *BMC Med Educ*. 2018;18(1):1-11.
18. Wegner L, Rhoda A. The influence of cultural beliefs on the utilisation of rehabilitation services in a rural South African context: therapists' perspective. *African J Disabil*. 2015;4(1):1-8.
19. Ameh S, Klipstein-Grobusch K, Ambruoso D, et al. Quality of integrated chronic disease care in rural South Africa: user and provider perspectives. *Health Policy Plan [Internet]*. 2017 Sep 1;32(2):257-66. Available from: https://academic.oup.com/heapol/article-lookup/doi/10.1093/heapol/czw118
20. Sjömar J, Ottesen H, Banik G, et al. Exploring caregivers' experiences of kangaroo mother care in Bangladesh: a descriptive qualitative study. *PLoS One*. 2023;18(1 January):1-16.
21. Steihaug S, Lippestad J-WW, Werner A. Between ideals and reality in home-based rehabilitation. *Scand J Prim Health Care [Internet]*. 2016 Jan 2;34(1):46-54. Available from: http://www.tandfonline.com/doi/full/10.3109/02813432.2015.1132888
22. Tsai PC, Yip PK, Tai JJ, Lou MF. Needs of family caregivers of stroke patients: a longitudinal study of caregivers' perspectives. *Patient Prefer Adherence*. 2015;9:449-57. http://dx.doi.org/10.2147/PPA.S77713
23. McMurray J, McNeil H, Lafortune C, Black S, Prorok J, Stolee P. Measuring patients' experience of rehabilitation services across the care continuum. Part II: key dimensions. *Arch Phys Med Rehabil [Internet]*. 2016;97(1):104-20. Available from: http://dx.doi.org/10.1016/j.apmr.2015.08.408
24. Bickenbach J, Cieza A, Kleinitz P, Marks E, Mills J-A. Access to rehabilitation in primary health care: an ongoing challenge. World Health Organization; 2018. Available from: https://apps.who.int/iris/handle/10665/325522
25. City of Johannesburg. Health [Internet]. 2018. Available from: https://www.joburg.org.za/services_/JoburgCares/Pages/Health.aspx
26. McLaren ZM, Ardington C, Leibbrandt M. Distance decay and persistent health care disparities in South Africa. *BMC Health Serv Res [Internet]*. 2014 Dec 4 [cited 2018 Apr

30];14(1):541. Available from: http://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-014-0541-1
27. Lalla-Edward ST, Mosam A, Hove J, et al. Essential health services delivery in South Africa during COVID-19: community and healthcare worker perspectives. *Front Public Heal*. 2022;10:992481. https://doi.org/10.3389/fpubh.2022.992481
28. Zhao T, Kwok JKF. Evaluating Community Based Rehabilitation : Guidelines for Accountable Practice [Internet]. 1999 [cited 2019 Feb 15]. Available from: http://unipd-centrodirittiumani.it/public/docs/34011_planning.pdf
29. Braun V, Clarke V. Toward good practice in thematic analysis: avoiding common problems and be(com)ing a knowing researcher. *Int J Transgender Heal [Internet]*. 2023;24(1):1-6. Available from: https://doi.org/10.1080/26895269.2022.2129597
30. Nowell LS, Norris JM, White DE, Moules NJ. Thematic analysis: striving to meet the trustworthiness criteria. *Int J Qual Methods [Internet]*. 2017;16(1):1-13.
31. Verusia C, Tanuja D, Simira M, et al. Satisfaction and adherence of patients with amputations to physiotherapy service at public hospitals in Kwazulu-Natal, South Africa. *Afr Health Sci*. 2015;15(2):450-56.
32. Kloppers M, Pretorius B, Vlok ED. Clients' subjective experience of their participation in rehabilitation at an out-patient community rehabilitation center. *South African J Occup Ther [Internet]*. 2016;46(1):59-63. Available from: http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S2310-38332016000100012&lang=pt
33. National Department of Health. 2011. National Core Standards for Health Establishments in South Africa.
34. AlRuthia Y, Alwhaibi M, Almalag H, et al. The relationship between trust in primary healthcare providers among patients with diabetes and levels of depression and anxiety. *PLoS One [Internet]*. 2020;15(9). Available from: https://doi.org/10.1371/journal.pone.0239035
35. Liu C, Wu Y, Chi X. Relationship preferences and experience of primary care patients in continuity of care : a case study in Beijing, China. *BMC Health Serv Res*. 2017;17(1):585. https://doi.org/10.1186/s12913-017-2536-1
36. Majumdar B, Browne G, Roberts J, Carpio B. Effects of cultural sensitivity training on health care provider attitudes and patient outcomes. *J Nurs Scholarsh*. 2004;36(2):161-6.
37. Bresick GF, Sayed A-R, Grange C le, Bhagwan S, Manga N, Hellenberg D. Western cape primary care assessment tool (PCAT) study: measuring primary care organisation and performance in the western cape province, South Africa (2013). *African J Prim Heal Care Fam Med [Internet]*. 2016 May 19;8(1):12. Available from: https://phcfm.org/index.php/phcfm/article/view/1057/1593
38. Ned L, Cloete L, Mji G. The experiences and challenges faced by rehabilitation community service therapists within the South African primary healthcare health system. *African J Disabil [Internet]*. 2017;6(1):a311-a311. Available from: http://0-search.ebscohost.com.innopac.wits.ac.za/login.aspx?direct=true&db=lhh&AN=20183215752&site=ehost-live&scope=site
39. van Stormbroek K, Buchanan H. Novice occupational therapists: navigating complex practice contexts in South Africa. *Aust Occup Ther J*. 2019;66(4):469-81.
40. Kelly G, Mrengqwa L, Geffen L. They don't care about us": older people's experiences of primary healthcare in Cape Town, South Africa. *BMC Geriatr*. 2019;19(98):1-14. https://doi.org/10.1186/s12877-019-1116-0
41. Grut L, Mji G, Braathen SH, Ingstad B. Accessing community health services: challenges faced by poor people with disabilities in a rural community in South Africa. *African J Disabil*. 2012;1(1):1-7.
42. City of Johannesburg. Rea Vaya Bus Services [Internet]. Available from: reavaya@joburg.org.za