

STANDARDISATION OF PROVISION OF ASSISTIVE DEVICES IN SOUTH AFRICA:

A GUIDELINE FOR USE IN THE PUBLIC SECTOR:

CONTENTS:

MINISTERS FORWARD	03
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SECTION 1

Introduction	04
1. Significance of Assistive Devices for people with disabilities	04
2. The Epidemiology of disability in South Africa	04

SECTION 2

1. Budget for Assistive Devices	07
2. Assessment, Prescription and Ordering of Assistive Devices	09
3. Issuing of Assistive Devices	09
4. Repairs, Replacement and recycling of Assistive Devices	10
5. Payment for Assistive Devices and Accessories	11
6. Free Assistive Devices	11
7. Record-keeping of Assistive Devices	12
8. Training in the use of Assistive Devices	12
9. Stocks of Assistive Devices and Accessories	12
10. Custom-made and Self-made Assistive Devices	14
11. Motorized Wheelchairs	13
12. Alternative and Augmentative Communication (AAC)	13
13. Personal Assistance	13
14. Inclusions in Tenders for Assistive Devices	13

ACKNOWLEDGEMENTS	16
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APPENDIX A

Acronyms	17
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FORWARD

It gives me great pleasure to present the national guideline on the standardisation of provision of Assistive Devices in South Africa.

As government we have a commitment to improve the quality of life of people with disabilities in this country. We are fully aware that people with disabilities are amongst the poorest and the most vulnerable groups in society. They are often denied access to education and training, which in turn results in lack of skills that are necessary for employment.

An assistive device opens doors to learning, employment and social participation. There is always a possibility of viewing people with disabilities as a homogeneous group, all requiring the same type of intervention and the same type of device. The reality is that people with disabilities are as diverse as society itself, each with their own unique contributions and requirements.

It is my firm belief that this document will provide the policy framework, which will ensure that the provision of assistive devices is equitable and appropriate. The document will also place an obligation on service users to ensure that the devices are properly cared for. It is our contention that even those that are known to break down easily can last longer if properly cared for. We are positive that no matter how big the challenge of providing services to our people seem, at the end we will make a difference.

I want to take this opportunity and salute all those who were involved in the process of developing this document, both from government and civil society organizations. A special word of thanks goes to the Technical Committee members who worked so tirelessly to make this dream a reality. To all of you I say well done.

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SECTION 1:

Introduction

For people with disabilities, an assistive device promotes a normal lifestyle, improves their quality of life and enhances the prospects of employment, education and participation. Simultaneously, it reduces the cost of care and dependency. Devices reduce the extent of hospitalisation, as well as the demand of hospitalisation, and therefore liberate scarce resources for other uses.

Even more important are the political and moral benefits: the general availability of devices has been proven to promote the dignity of people with disabilities and transform attitudes towards them.

This guideline puts forward proposals that will have a direct, practical benefit for people with disabilities with due consideration to cost implications to the state.

1. SIGNIFICANCE OF ASSISTIVE DEVICES FOR PEOPLE WITH DISSABILITIES

Assistive Devices (A.Ds) are key mechanisms by which disabled people can participate as equal citizens within society. The World Programme of Action (WPA) concerning disabled persons (UN, 1982) outlines three areas of importance, viz prevention of disability, rehabilitation and equalisation of opportunities that needs to be addressed. Included in rehabilitation is the provision of measures intended to compensate for a loss of function or functional limitation- one of these being through technical appliances. It is also recognized that a precondition for the equalisation of opportunities is the provision of support services to disabled people.

Assistive Devices should include those that:

- Promote the independence of a disabled person;
- Contribute to disabled people functioning in society;
- Facilitate communication for disabled people; and
- Improve the quality of life of disabled people.

An Assistive Device is both impairment- specific and person specific.

2. THE EPIDEMIOLOGY OF DISSABILITY IN SOUTH AFRICA

In order to estimate the number of disabled people requiring assistive devices, it is necessary to examine the epidemiology of disability. This is a difficult task because baseline data on disability prevalence is not readily available. Prevalence studies on disability in South Africa have used different definitions of disability, which makes comparison of disability rates problematic.

Most of the prevalence studies on overall disability in South Africa have used a two-staged methodology for self – (or proxy) reported disability and confirmed medically diagnosed impairment. The disability survey by the Department Health (DoH) (1999) was a one-stage study for self- and / or proxy reported disability.

A further complication is that results related to reported disability need to be carefully interpreted. For example, reported motor disability may only be an indication of a subjective manifestation of difficulty with body functions.

In order to estimate the prevalence of need for assistive devices, an attempt has been made to combine estimates from the available disability prevalence studies for three impairment/ disability types:

- Visual (blind and visually impaired people)
- Communication (speech, voice, language disorders, hearing disorders and deafness)
- Motor (movement, mobility, locomotor)

It is important to clarify and emphasise that the overall crude rates only provide a rough indication of the need for specific Assistive Devices. In order to determine the exact prevalence of need for Assistive Devices, specific studies should be performed.

Crude prevalence rates are given where age/sex- specific adjusted rates are not available .The non-availability of adjusted rates makes the comparison of prevalence rates in different areas or from different studies difficult. This is further compounded by the variation in the prevalence of different disabilities according to age and sex.

The national disability study (DOH 1999) gave an overall crude prevalence rate of 2 % for reported movement disability 1.7% for reported moving around disability and 1.8% for reported activities of daily living disability.

COMPOSITE TABLE: CRUDE PREVAILENCE RATES FOR VISUAL COMMUNICATION AND MOTOR IMPAIRMENT IN SOUTH AFRICA.

		CONFIRMED IMPAIRMENT	TYPE OF DISSABILITY	REPORT ED DISSABILITY
<i>Visual</i>	VISUAL IMPAIRMENT	1.4 (Sancb,1999)	Seeing disability	1.7 (Doh, 1999)
	BLINDNESS	0.644 (Sancb, 1999)		
	PARTIALLY SIGHTED	0.76 (Sancb, 1999)		
<u>COMMUNICATION</u> (SPEECH-VOICE-LANGUAGE)	MODERATE	4.0-6.0 (CAAC, 1996)	COMMUNICATION DISABILITY	0.8 (Doh, 1999)
	SEVERE	0.8-1.0 (Caac, 1996)		
<u>COMMUNICATION</u> (HEARING)	Mild- hard of hearing	6.0 (Deafsa,1999)	Hearing disability	1.0 (Doh, 1999)
	Moderate-extremely hard of hearing	3.0 Deafsa, 1999		
	Severe profoundly deaf	1.0 (deafsa,1999)		
<i>Motor</i>	Locomotor	7.6(Mclaren, 1987) 2.6 (cornielje, 1991)	Movement disability	2.0 (Doh,1999)
	Walking difficulty	0.9 (cornielje)	Moving around disability	1.7 (Doh, 1999)
	Inability to walk	0.2 (cornielje)		

TABLE 1: CRUDE PREVAILENCE RATES: VISUAL, COMMUNICATION, MOTOR

In conclusion, this section has outlined the need for Assistive Devices in South Africa. Existing literature was reviewed in terms of available prevalence rates, which could be used to assess the extent of the need for Assistive Devices for visual, communication and motor impairment. Only very rough estimates can be made using the available data. Specific studies are required to refine the data and obtain age-adjusted prevalence rates, which can be used to indicate the cost implications of the provisioning of Assistive Devices in South Africa.

SECTION 2:

PRINCIPLES REGARDING ASSISTIVE TECHNOLOGY:

The unavailability of A.Ds causes a high degree of dependency or even total dependency. It might also lead to the waste of time and money by training institutions because the acquired skills by professionals are not practiced and applied and the client relapses into dependency again. In most cases these A.Ds enable persons to enter the labour market. The devices are therefore essential for independent living, education and participation in social life.

The devices are principles for the provisioning of the necessary assistive devices by the public sector:

1. BUDGETS FOR ASSISTIVE DEVICES

- A budget allocation applicable to all categories of A.Ds should be promoted at provincial and regional/district level. Budgets should be based on local needs and should also provide for any backlog that may have accumulated in each province. Input should be obtained from relevant rehabilitation providers regarding decision making and planning for budgets and tendering for A.Ds. Professionals directly involved in issuing A.Ds should be involved in the budgeting, tender and procurement processes.
- The actual (realistic) need for A.Ds, taking into account the effect of replacement, repair and maintenance of A.Ds, must be budgeted for.
- A budget to supply a specified number of A.Ds for short-term loan and rental purposes must be available.

- A standardized record system of ADs that are prescribed, issued, repaired replaced and recycled must be kept to facilitate budgeting. The date on which a client receives an AD, and the expected date of replacement, should be logged in, in detail.
- Accessories for ADs and non-tender wheelchair accessories and items (e.g. gloves, commodes etc) should be budgeted for at relevant levels.
- **SPECIAL FUNDS OR DONATIONS FOR ADS:**
- The recipient authority should establish a committee of relevant rehabilitation and personnel, both administrative and clinical, to manage the funds/donated A.Ds.
- A.Ds accepted, as donations should at least adhere to international and or SABS endurance standards where possible, and are appropriate for the South African environment.
- Home made ADS and materials for these items must be obtainable via supplies budget at all levels of the health system.
- Adequate provision must be made for larger quantities of items that need regular replacement (high wear and tear items).

2. ASSESSMENT, PRESCRIPTION AND ORDERING OF ASSISTIVE DEVICES:

- There shall be no discrimination against clients on the grounds of disability, age, gender, social conditions, financial situation, disease, medical condition, or any other basis in the assessment for issuing an AD.
- Assessment and prescription for A.Ds shall only be done by appropriately trained rehabilitation providers. Once the selection has been finalized, the same professional or assistant should issue the device and provide the necessary training.
- Prescription forms for an AD shall not have to be co-signed by a medical practitioner or medical superintendent. The prescription should be co-signed by individual department heads who are more readily available and knowledgeable.
- Prescriptions should not be altered by any person/s (e.g. Administration Clerk) responsible for ordering or administration of A.Ds.
- Only speech therapists may evaluate, Assess, diagnose and treat patients with feeding and/or swallowing problems.
- Assistive Devices for hearing impairments should be prescribed, fitted and issued by audiologists, hearing aid acousticians, audiometricians or any other appropriately registered category only.
- Newly trained graduates should be specifically trained in the issuing of Ads after the commencement of employment.
- Newly Developed Assistive Devices are to be considered for addition to the Government Tender.

3. ISSUING OF ASSISTIVE DEVICES:

- The client should be issued with the required AD by the institution/ organisation discharging the client to his home (i.e. the facility providing rehabilitation to his client) or the referral facility doing the rehabilitation. The AD should be issued immediately when prescribed or, at the latest, on discharge.
- All persons with a disability where the sensory functions are affected (e.g. paraplegic/quadruplegic) shall be discharged from hospital with the basic assistive technology requirements (viz. An appropriate wheelchair, wheelchair cushion and mattress).
- Instant access to Assistive Devices for infants, children and adults with feeding and swallowing difficulties, e.g. cleft palate, stroke and cerebral palsy, should be guaranteed.

- First Time issue of ADs should only be done by the appropriately trained rehabilitation provider who prescribed the item or appointed substitute.
- Establishments other than health facilities should be allowed to issue Ads subject to prior arrangements with the health authority (Private Public Partnership or contracting out of services).
- Alterations of ADs should only be done by an appropriately trained provider. A standardized contract should be drawn up and signed by the client before or on issuing of the AD, stipulating that the AD will be returned to the issuing institution if no longer required and that it remains the property of the state provider.
- A limited number of A.Ds for loan or rent purposes shall be made available at all health facilities for persons with disabilities. If the particular facility cannot provide this service, it should be contracted out or a PPP can be established.

4. REPAIRS, REPLACEMENTS AND RECYCLING OF ASSISTIVE DEVICES:

- High wear and tear items should preferably be replaced by trained rehabilitation providers (or other staff members). However, where appropriate, clients should be trained to replace such items.
- Specialists repairs, e.g. for Braille watches, should be made available to users.
- Repairs under warranty should be dealt with according to principles.
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- The establishment should ensure that repairs are done by qualified/ trained persons.
- Records of repairs should be kept to facilitate budgeting and control repairs.
- The manufacturer or supplier should indicate the expected lifespan of an AD.
- There should be no limits on the replacement of an AD unless it is not needed anymore, or there is evidence of poor maintenance or abuse.
- If possible replacement should be done by the issuing establishment, as a condemning report will be required if a device cannot be used any longer.
- Repairs should be done on a “ fix while you wait” basis or at least within three days.
- High-cost Ads requiring replacement should be evaluated for recycling.
- In the case of the AD being re-issued to another client, the AD should be fully serviced and supplied with new parts, where deemed necessary, by a trained technician before issuing. These repairs should be paid for by the facility who owns the AD.

- Repairs to A.Ds should be included in the tender (service tender). This will enable provinces to operate within a dedicated repairs budget.
- Devices that are not utilised shall be returned by the client for recycling.
- The facility that owns the device should take responsibility for making repair arrangements. Where possible, this arrangement should ensure that the closest establishment to the client assist with repairs.
- A.Ds should be replaced only for the following reasons (accompanied by proof wherever possible):
All clients should be re-assessed every two years and A.Ds replaced if necessary where the clients condition deteriorates/ changes to the extent that replacements necessary.
- Where the lifespan of Ads and accessories has been completed.
- Recycled items may need replacement sooner than new items and therefore record keeping is essential. The original worn-out item should accompany the request for replacement. The relevant staff member should take possession of the worn out item to prevent repetitive submission of the same item for replacement. Such items should then be destroyed. When clients apply for the replacement of stolen items they should provide an appropriate South African Police service case number. A.D s will be replaced free of charge while still under warranty IF the malfunction is not the result of negligence or abuse on the part of the client. Subsequent issue of A.Ds as a result of wear and tear or breakage could be by a different provider if the user presents the old AD with the relevant specifications, e.g. sizes, numbers, etc.

5. PAYMENT FOR ASSISTIVE DEVICES AND ACCESSORIES:

- Payment for assistive devices should be done according to a Uniform Patient Free System (UPFS).
- The same will apply to accessories and maintenance.
- Refunding should be done if the item is returned and can be re-utilised. A.Ds will only be recovered justify the administrative burden.
- Cross-border payment arrangements shall be put into place.

6. FREE ASSISTIVE DEVICES:

Assistive Devices should be part of the service package offered free of charge to qualifying members e.g. children under six and disabled people qualifying for free health care.

7. RECORD KEEPING FOR ASSISTIVE DEVICES:

- A record of all applications for A.Ds should be kept with the client's particulars (age, name, address, file number, type, specifications of A.D and patient classification).
- The serial number or an appropriate description(including for example colour, size, type) and expected lifespan of the AD should be recorded on issue.Items with a short lifespan of the AD should be recorded on issue.Items wit a short life span or inexpensive items need not meet this requirement.
- In the case of long term A,Ds, the name of the place where the AD was issued should be indicated on the AD if possible.
- Records should be kept of repairs/ maintenance and AD replacement.

8. TRAINING IN THE USE OF ASSISTIVE DEVICES:

- Training/ rehabilitation should be done by an appropriately trained rehabilitation provider. This is necessary to ensure that the client gets the full benefit of the device and that he or she knows how to maintain the device, as well as when and where to take it for repairs.
- The training/ rehabilitation regarding the AD usage should be inclusive in the payment for the device.
- Rehabilitation should start immediately and discharge should not be delayed unnecessarily. This will ensure a cost effective service.

9. STOCKS OF ASSISTIVE DEVICES AND ACCESSORIES.

- For bulk buying care should be taken that adequate numbers of different sizes of A.D.s and the relevant spare parts are purchased.
- In the case of prescription glasses, at least two options for frames should be available for men, woman and children. Ready made glasses (low cost glasses), in the ranges most often prescribed, should be stocked at all times.
- Stocks should be kept at various levels of care services.
- Suitable storage security and stock control should be maintained.
- Essential accessories shall bee obtainable and/or available at every level of service delivery.

10. CUSTOM- MADE AND SELF MADE ASSISTIVE DEVICES

- Self-made devices should be the device of choice where appropriate.
- Undergraduate training curricula for rehabilitation personal shall include training in the making and customizing of certain A.Ds.
- Clients are to be assisted to produce home made devices out of appropriate materials.

11. MOTORIZED WHEELCHAIRS

A motorized wheelchair is an essential mobility device for a person who has quadriplegia/tetraplegia. Since it is an expensive device, certain criteria should be adhered to before the device is issued. The following factors shall be considered before issuing:

- Resources available
- Permanent disability
- All limbs affected
- Uninterrupted electricity at home to maintain the product
- Proper training to utilise the AD correctly and the resources to maintain it correctly
- Environmental accessibility
- Sufficiently motivated user
- Preference to be given to people who are employed or in educational institutions, or have the potential to be employed / educated

12. AUGUMENTATIVE AND ALTERNATIVE COMMUNICATION

Augmentative and Alternative Communication (AAC) is used to assist with severe communication disorders in children and adults, and consists of:

- Dedicated computer systems
- Software for non-dedicated computers
- Computer access devices, including specially designed keyboards and voice recognition systems.
- Other peripherals that provide adapted access to computers
- Computer output devices adapted for monitors and printers
- Computer operated environmental control units for appliances
- Software programmes specific to AAC systems
- Switching devices

Please note: AAC should only be available at tertiary level of health care.

13. PERSONAL ASSISTANCE:

Personal assistants, such as those for the blind, people with locomotor disability, and the deaf (sign language interpreters), shall be made available by institutions to assist the public to access health services.

14. INCLUSIONS IN TENDERS FOR ASSISTIVE DEVICES

- The guarantee period should start after the device has been issued to the client, not when the hospital receives the devices.
- Wherever possible, service tenders should stipulate that suppliers include the prescribed device or assistive device package, (e.g. hearing aid, ear mould, starter pack of batteries), as well as after issue maintenance and repair, if applicable, as part of transaction.
- International tenders shall be encouraged if they insure a more affordable product, e.g. intra-ocular lenses.
- Specifications for children's wheelchairs should stipulate a 20-inch rear wheel. Set specifications should be developed.

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The Department of Health wishes to acknowledge all individuals and organisations, in the development of this guideline. The following organisations, in their capacity as members of the technical committee, played a very significant role in the development of this document:

- National Council for persons with physical disabilities in South Africa
- National council for the blind
- Deaf Federation of South Africa
- Disability Action Research Team
- Disabled People of South Africa
- Department of Health, Limpopo Province.

Acronyms

ADs	Assistive devices
AAC	Augmentative and Alternative Communication
CI	Cochlear Implantation
DART	Disability Action Research Team
DEAFSA	Deaf Federation of South Africa
DoH	Department of Health
DPSA	Disabled People South Africa
ENT	Ear, Nose and Throat
HPCSA	Health Professions Council of South Africa
NGO	Non-governmental organisation
OT	Occupational therapist
PHRC	Provincial Health Restructuring Committee
PPP	Public Private Partnership
PT	Physiotherapist
RAF	Road Accident Fund
SABS	South African Bureau of Standards
SANCB	South African National Council for the Blind
SAPS	South African Police Service
SLI	Sign Language Interpreter
STA	Speech Therapist and Audiologist
TCAD	Technical Committee on assistive Devices
UN	United Nations
WHO	World Health Organisations
WCA	Workman's Compensation Act
WPA	World Programme of Action