Facilitating improvement and change in services for children with Cerebral Palsy in low resourced, rural hospitals without increasing costs

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BACKGROUND

In rural, low resourced hospitals serving large communities in South Africa and Lesotho, children attending Cerebral Palsy (CP) Clinics typically are invited to attend once a month for 10 months of the year. Often due to transport difficulties or poor weather, children may not even be able to attend once a month. There are often many children to see at each CP clinic and only a small team of therapists to see them (often one or two therapists – usually Physiotherapists or Occupational Therapists – on very rare occasions a Speech and Language therapist may be available. Children with CP thus typically receive 36 minutes of therapy monthly which translates to an average of 4 hours of therapy annually. Passive movements are the ministry of therapy and by their own admissions, many rehabilitation teams therapists at hospitals feel that they lack the necessary skills to treat children with cerebral palsy and advise and support caregivers accordingly. Sessions rarely include dialogue with caregivers or individual goal-directed therapy programmes. Often – standardised home programmes are given to children and caregivers.

AIM

To establish whether therapy time could be increased and a more comprehensive service offered to children with cerebral palsy and their families using the existing resources at rural hospitals, and taking into account that children with cerebral palsy are only a portion of the client caseload seen at hospitals.

METHODS

Over a two year period, teams of 3 – 4 specialist therapists spent five days at rural hospitals annually. Three outreach programmes included:

- training of local therapists – through workshops and a form of clinical supervision where specialist therapists worked together with local therapists in treating children on their own caseload using a structured, problem solving approach that could be adapted to the wider caseload.
- working with children in groups – matching common goals in children attending the CP clinic such that therapists could spend more time working on specific goals and facilitate caregiver interaction, whilst at the same time ensuring more children could be seen.
- goal-setting – the importance of good assessment and goal setting and how this helps to guide practice in busy settings. An important part of the programme.
- practical management – this is particularly important in rural caseloads where children are rarely seen and where socio-economic situations dictate on home versus hospital versus caregiver visits. These visits – these are particularly important in follow-up of older children and young adults with cerebral palsy where much of the therapy is devoted to independence, due to lack of equipment and resources.
- short intensive therapy blocks – these are advocated for more complex cases or children with significant anterior deviations. With CP there are many different variable factors – this is deemed a luxury in third world settings due to difficulties faced on both the part of the caregivers and their children (transport, costs, etc) as well as staff (lack of manpower and resources).
- career-to-career training – where caregivers of children with CP are trained to run workshops for other caregivers with CP, and CP and basic principles related to the condition.
- practical management – this programme included practical guidelines on minimising movement of resources and our experience of rural settings.
- client management systems – client management systems are often poorly based and difficult to track and record. Part of our programme is to set up and supply simple basic database clients (Hospital link database software and as these need to be easily applicable to any operating system).

Direct observation, a review of patient records and clinic statistics as well as self-completed questionnaires and focus groups with therapists and caregivers were used to measure outcomes.

RESULTS

Twenty-eight outreach visits to 14 rural primary health facilities in South Africa and Lesotho tracking 70 therapists and 751 children were conducted. On average, therapy contact time as well as the number of new children accessing the services doubled. Therapeutic blocks were introduced in 4 hospitals. Structural home visits are now part of the service at 9 hospitals, whilst 4 hospitals have electronic databases. Goal setting and individual therapy plans are offered at 5 hospitals and a career-to-career training programme is active at 80% of the sites. The majority of therapists (80%) felt more competent and confident.

CONCLUSIONS

Through a short focused outreach programme by a team of therapists experienced in working in rural settings, it is possible to improve quality of therapy services and care for children with CP in resource-constrained rural areas without increasing resources or costs.

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