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A Coordinated Collaborative Response to Rehabilitation Needs of Persons with Disabilities

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Abstract

The full integration of persons with disabilities cannot be achieved by one sector because of the complexity of disability issues. Rehabilitation is one strategy that aims for the full integration of persons with disabilities in communities calling for integrated and collaborative inter professional and intersect oral approaches towards achieving this goal. This paper proposes an inclusive participatory process of a coordinated collaborative response to the rehabilitation needs of persons with disabilities as a model of best practice which is currently being piloted in a specific rural community in South Africa. Through this participatory process, the model demonstrates how the UNCRPD, CBR and ICF can be used and contextualised within a new inclusive development model in responding to both the cultural and contextual demands in communities, whilst also building the capacity of stakeholders who will be involved in participating in the implementation of this coordinated collaborative response to the needs of persons with disabilities in this specific area. At the core of this proposed model is the art of reclaiming the human dignity of persons with disability and facilitating empowerment through such collaborative spaces where persons with disabilities from the beginning form part of the discussions in the various stages of this proposed model and given the spaces to respond and inform the development of solutions that will have an impact in their lives. This state of the art innovative rehabilitation model of best practice is proposing the integration of the translation of the rights of persons with disabilities as well as the current rehabilitation theories and policies into the actual lived community experiences of persons with disabilities. The outcomes of this model are the principles of empowerment, inclusivity, collaboration and a socially responsive model of best practice that speaks and addresses directly and appropriately to the needs of persons with disabilities at community levels. We perceive that this model is the practical example where the expression coined by persons with disabilities- "nothing about us without us" is being practically implemented at ground level.

Keywords: Rehabilitation; Disabilities; Stakeholders; Human Dignity

Introduction

In 2011, the Theology Faculty, the Centre for Rehabilitation Studies (CRS) from the Medicine and Health Science Faculty (MHSF) and Psychology Department of Stellenbosch University (SU) collaborated and hosted a conference with the theme- Disability, Theology and Human Dignity. This was a fist for SU as the first international interfaculty conference. The 3rd day of this conference was held at the campus of the National Institute for the Deaf in Worcester with the goal of meeting with a group of persons with disabilities (PWDs) in Worcester. The rationale for this was to get an understanding from persons with disabilities from Worcester what are their needs and services as the MHSF at the time was busy developing a rural clinical school (hereby referred to as Ukwanda: Centre for Rural Health) in Worcester and was preparing to place medical and rehabilitation (Occupational Therapy, Speech therapy, Human Nutrition and Physiotherapy) students in the rural clinical school in Worcester. From this conference in Worcester, a 2 page list of needs (See a detailed list of needs in Appendix 1) was then developed and handed over to clinical facilitators of the above mentioned group of students that were going to be placed in the Ukwanda: Centre for Rural health in the following year.

In response to this 2 page list of needs of PWDs, an internal process was being developed within the CRS and the Ukwanda: Centre for Rural Health of SU to further discuss the issues of disability and human dignity within a broader university strategy. The Hope project, which is Stellenbosch University's institutional response to issues of poverty and vulnerability in Africa chimes closely to some of the 2011 conference recommendations and the needs that had been specified by persons with disabilities (PWDs) in Worcester. Subsequent to this, the CRS started planning on how to ensure that clinical facilitators that are placing students in Worcester with the goal of responding to the needs of PWDs in that area are using the list to guide them in placement of students.

The CRS as a postgraduate study Centre that facilitates the development of models of best practice in responding to the needs of PWDs started designing a rehabilitation research response to the needs of PWDs in Worcester. To further respond to the two page list of the needs expressed by PWDs in Worcester the CRS drew in key

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stakeholders from Ukwanda Centre for Rural Health with the goal of fostering collaboration and developing a combined engagement and response to needs of PWDs in Worcester. The CRS then took the two pages of the needs and aligned them with the CBR matrix. The next step was to see how needs are also aligned to the 5 articles that underpin access to health and rehabilitation services in the UNCRPD. We also wanted to see if environmental barriers and personal factors further hindered access to services for PWDs. The rationale was to start developing a coordinated collaborative rehabilitation response to these needs expressed by this group.

a. Lately debates that have directed and driven the rehabilitation theory and scope of practice had centred around three international instruments: The International Classification of Functioning, Disability and Health (ICF) [1];

b. The Community Based Rehabilitation strategy (CBR) with its matrix and 4 Pillars (health, Education, Livelihood, Social and Empowerment) [2]; and

c. The United Nations Convention for Persons with Disabilities (UNCRPD) [3].

In addition to ratifying the UNCRPD, South Africa has developed some of the most progressive rights-based policies concerning disability and rehabilitation in the world. At national level, strategic policies include the Integrated National Disability Strategy, the National Rehabilitation Policy, the Education White Paper 6; the Disability Framework for local government 2009-2014 and at provincial level in the Western Cape, there is the WCED Disability Strategy.

Recently the National Department of Health had tasked a selected few of rehabilitation academics, Provincial rehabilitation managers and CEOs of disabled people organizations to develop a rehabilitation strategy and respond to the needs of disabled people in South Africa. At the core of these discussions is, how to domesticate (how to make these instruments relevant for the contextual issues of South Africa) the UNCRPD, the CBR guidelines and the ICF with the hope that these three instruments will assist in the development of a contextual relevant framework for rehabilitation in SA. The piloting of the UNCRPD, the CBR guidelines and the ICF as part of a response by the Ukwanda: Centre for Rural Health to the rehabilitation needs of persons with disabilities in Worcester could assist in strengthening links of Stellenbosch University with international organizations such as the WHO and the UN while also practically responding to the Health Department of South Africa's need to domesticate the three instruments.

The Journey of Rehabilitation

Rehabilitation has long lacked a unifying conceptual framework [4]. The discourse was also subject to the changing theoretical and socio-political understandings surrounding disability. The World Report on Disability [5] reports on how historically, the term rehabilitation has circled around describing a range of responses to impairment, from interventions to improve body function to more comprehensive measures designed to promote inclusion. Rehabilitation services used to focus within a medical model approach where services were institutionally based and very individualistic in its nature of therapy rendered [6]. Within a medical model, the bodies of persons with disability were viewed as incomplete and needing to be fixed by those who were presumed to have the expertise and knowledge. Over the years, the social model brought a new paradigm shift in the construction of disability whereby a distinction was made between impairment and a disability [6]. Many scholars have highlighted that disability is not only about pathology and health but also about exclusion and discrimination imposed on individuals with impairment [7]. This is not negating the medical needs but there is a need to acknowledge disability as a political and human rights issue.

Recently, the World Report on Disability [5] positioned Disability as a complex multidimensional experience that poses several challenges for implementation of rehabilitation services. South Africa is one of the African countries that had ratified the United Nations Convention on the Rights of Persons with Disability (UNCRPD) Preamble [3] which acknowledges that disability is "an evolving concept" but also stresses that "disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others".

This view of disability as an interaction implies that "disability" is not an attribute of the person. Because disability is a social construct, as society continues to evolve with regards to its terminology and how it defines certain aspects- disability definitions will continue to evolve too. People with disabilities face various physical, social and attitudinal barriers to participation in their communities and access to vital services pertinent to their day to day needs [5]. These barriers have led to the development of national and international legislature to respond to the needs of persons with disabilities while also protecting and strengthening their rights as equal members of society.

The current guiding policies in South Africa are the National Rehabilitation Policy (NRP) of South Africa [8] the UN Convention on the Rights of Persons with Disabilities (UNCRPD) [3], International Classification of Functioning, Disability and Health (ICF) [1] and the Community Based Rehabilitation (CBR) Guidelines [2]. All of these policies and guidelines set out the objectives for effective and accountable rehabilitation services that include the full participation of people with disabilities in the planning, implementation, monitoring and evaluation of services.

The NRP aims to facilitate the rights for every citizen to have access to health and rehabilitation services to bring about equalisation of opportunities and enhancement of human rights [8]. However, Mji et al [9] bring to attention that there are still gaps in the implementation of this policy with no empirical evidence suggesting such implementation that is aligned with its objectives. Alternatively, the ICF provides a standard language and conceptual basis for measuring and defining disability. This framework makes awareness to both impairment and impact on activity limitation and participation restriction with cognisance to both the personal and environmental factors which can be both barriers and facilitators [1]. The question is how rehabilitation professionals are exposed to these critical elements of the ICF to be able to respond to issues of activity limitation and participation restriction (see Figure 1 for the ICF framework).

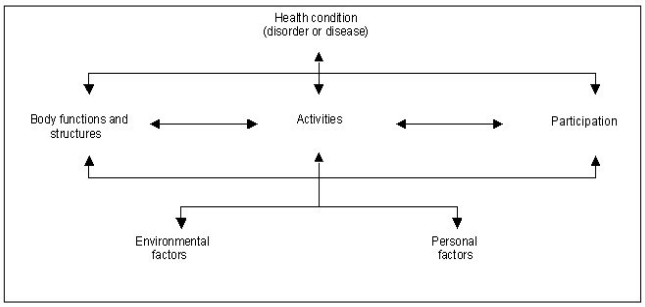

Figure 1: International Classification of Health, Functioning and Disability (ICF) [1].

This exposure to the ICF could assist rehabilitation professionals; firstly, to move away from a biomedical view of disability which could neglect the functional and contextual factors and secondarily, to adopt a holistic view of health and health care to which participation and functionality are key focus areas as indicators of health [10]. This perception of the ICF really brings a new inclusive understanding about impairment and disability whereby there is less categorising of one group against the other and more of checking indicators for impairment and disability.

Clearly the ICF does provide a framework that can be used for all rehabilitation aspects. However, people with disabilities have also needs related to human rights issues whereby the ICF actually falls short and does not cover this aspect of rights. Whereas the UNCRPD which aims to ensure respect and protection of all rights of persons with disabilities [3] completes the triad of viewing disability. Articles 9 (Accessibility), 19 (living independently and being included in the community), 20(Personal mobility), 25(Health) and 26 (Habilitation and Rehabilitation) of the UNCRPD provide clear guidelines of responding to the rehabilitation needs of persons with disabilities (See Table 1 below for the 5 selected articles on rehabilitation).

To be able to critically analyse and actionalise these policies at a practical level, rehabilitation professionals do need to be capacitated fully. One strategy for providing and delivering effective rehabilitation services is the CBR [2] as it takes an inclusive development approach to working with persons with disabilities [11]. It proposes five key components namely; health, education, livelihood, social and empowerment (See Figure 2 below for the CBR matrix) that should be incorporated to enhance the quality of life of persons with disabilities and their families with a strong focus on empowerment through the facilitation of the inclusion and participation of persons with disabilities, their families and community in all development and decision making processes. It also showcases very well the cross sectoral approach to disability and rehabilitation highlighting

Table 1: Selected Articles on rehabilitation from UN Convention for the Rights of Persons with Disabilities.

Article No.	Topic Area
9	Accessibility
19	Living independently and being included in the community
20	Personal mobility
25	Health
26	Habilitation and rehabilitation

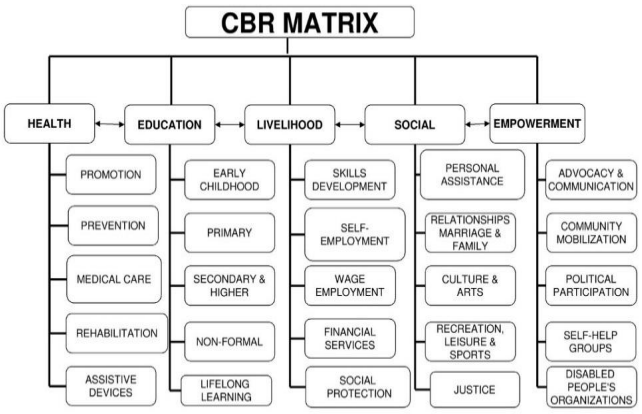

Figure 2: The CBR Matrix (WHO, 2010).

disability as everyone's responsibility and fitting in across these components hence the need to come together and be coordinated.

In critically analysing these four policies, it is clear to see how the principles of these policies coincide with each other and are all contained in the objectives and the goals of the NRP [9]. Many persons with disabilities ascribe to the social model of disability which points to the need for their equitable participation of persons with disabilities at community level. This participation includes access to health and rehabilitation services. But, Mji et al [9] point that many of the health and rehabilitation services still function within the medical model. This implies then that this progressive NRP which includes the latest thinking around equalisation of opportunities for persons with disabilities lacked a suitable environment for its implementation. Hence it has been unsuccessful.

Madden, Hartley, Mpofu and Baguwemu [12] state clearly how these three frameworks relate to each other which- when implemented effectively can better support the implementation of the NRP. While very different in form, the CBR, UNCRPD and the ICF are based on a common and coherent view of disability and the rights of persons with disabilities. They seek to enable disability rights as human rights to equal participation, health and wellbeing with CBR being an all-inclusive approach to translate these rights into actual lived community experience. It is grounded in the convention, influenced by it and aiming to contribute to its implementation. While the ICF, in line with the UNCRPD, has a broad scope across all domains of functioning in daily life and requires an accounting for environmental factors that influence functioning. The ICF is further consistent with the principles of both the convention and the CBR Guidelines.

The participation of disabled people and their families in processes and programmes planned to improve their lives (nothing about us without us) is one of the critical issues that these two international frameworks (UNCRPD and CBR) point to. These policies, when effectively implemented could pave way for effective rehabilitation services that include persons with disabilities and their families in all key mainstream developments. This paper suggests a participatory process of a coordinated collaborative response to the rehabilitation needs of persons with disabilities in Worcester as a model of best practice. It demonstrates how in collaboration with persons with

disabilities, the UNCRPD, CBR and ICF can be used within a new inclusive development model in order to improve its effectiveness as well as its appropriateness in responding to the cultural and contextual demands in Worcester, a rural area in the Western Cape Province.

Pilot Site

The town Worcester is situated in the Breede Valley Municipal area. The Breede Valley includes the towns Rawsonville, Worcester, De Doorns and Touwsriver as well as the farming areas and small settlements. The population estimate for 2015 is 179 451, with half of that staying in the town Worcester [13].

Worcester is generally regarded as a centre where people with disabilities have flourished, mainly because the Institute for the Blind and the National Institute for the Deaf (NID) were established in 1881. Many of their blind or deaf clients have disabilities other than loss of vision or hearing. The level of the services rendered is fairly sophisticated, and they have well established international links. A Dutch charity funds the Deaf Net secretariat in Worcester, and it networks with the Deaf in more than 40 countries across the African continent.

There are services for other types of disabilities too, and the department of Education manages 5 special schools in Worcester.

The Centre for Rehabilitation Studies at the FMHS

The Centre for Rehabilitation Studies (CRS) based at the Faculty of Medicine and Health Sciences (FMHS) at Stellenbosch University is a committed, co-ordinating and directive institution that aims at excellence in addressing the current need for advanced interdisciplinary studies, research and service in the disability- and rehabilitation-related fields. This is achieved by education and training of all health professionals from a variety of disciplines and areas of specializations, to have the necessary clinical decision-making, managerial, educational and research knowledge, skills and socio-political attitudes, to assume positions of consultancy and leadership within the Disability management and Rehabilitation related fields of study. The Centre's mission is underpinned by the principles of the comprehensive primary health care approach and community-based rehabilitation (CBR) philosophy and will be realized by working in collaboration with the disability and service sectors.

The CRS had been mandated by the Dean for community to start working together with the rehabilitation related program that were already placed in Worcester within a research paradigm and capacity building (CRS a postgraduate entity). The University of Stellenbosch established a campus in Worcester in 2011. It has a hostel for 40 students, and an academic building. The Faculty of Medicine and Health Sciences (FMHS) was the initiator and is the main user through its Centre for Rural Health: Ukwanda. The school is a Hub in Worcester with five surrounding towns used as spokes.

The conference of theology, human dignity and disability: a space for understanding the needs of persons with disabilities in Worcester

The challenge for the CRS was how to integrate the needs of persons with disabilities that have been identified to the clinical scope of practice of the rehabilitation related programmes and students that were based in the Ukwanda: Centre for Rural Health and to also ensure that during this process disabled people are capacitated with the goal of facilitating inclusive development for persons with disabilities within the Worcester area. The conference on Theology, disability and Human dignity with the third day presented in Worcester exploring needs of persons with disabilities in that area gave the CRS an impetus to start developing a model of best practice that will respond to the needs of persons with disabilities in Worcester. From this conference a two- page list of needs of persons with disabilities was given to the student's clinical convenors of rehabilitation programmes to ensure that they align the placement of students with the list of needs of PWDs in Worcester. From this meeting, a 2 page list of needs was then developed. Some of these expressed needs that were listed included:

- Clarifying the correct terminology to be used for persons with disabilities including disabilities related to Early Childhood Development;
- Inclusion of aspects of disability in curriculum on all levels that is targeting the undergraduate theoretical curriculum including research strategies to put theory into practice. For example research could include a needs assessment and issues related to mobility, access and transport as well as the development of a database for information on disability related issues;
- Sharing resources with provincial departments to join hands in achieving their priorities.
- Partnering with DPOs and communities for capacity building and empowerment and to sensitise and engage with communities on disability issues, equal opportunities for persons with disabilities.

Participation of students within Ukwanda: Centre for Rural Health and Worcester community

Senior undergraduate students from 5 programmes from the FMHS spend time at the Ukwanda: Centre for Rural Health: Medicine; Occupational Therapy; Physiotherapy; Human Nutrition; Speech-, Language- and Hearing therapy. The first two spend a full final year in the centre. There is a strong focus on inter professional education. Many students spend time with people with disabilities, or patients in need of rehabilitation. These patients are seen in the hospitals, clinics, mobile clinics, special schools and the venues of the NPO's. The educational value of home visits was assessed as very valuable to students. This takes place mainly in one suburb of Worcester, Avian Park, where a student learning centre was established. In discussions with the CRS, the clinical facilitators and students showed that this work is quite extensive, and is making a significant contribution to these people and the NPO's.

Methodology

Initially, this work was taken as a single case study in Worcester linking up with persons with disabilities and investigated what their needs are. This was informed by the case study methodology. Case study design is particularly suited with the intention to gain an in-depth understanding into how a situation comes about or a process unfolds over time [14]. The Pilot site is an area considered

as the HUB for disability with well-established disability institutions such as the NID, Institute for the Blind and DEAFNET with international footprints. Various other stakeholders are also involved in continuously addressing the needs of persons with disabilities. However the list expressed by persons with disabilities highlights a case for exploration of a collaborative and coordinated response to these expressed needs. In this regard, this tradition of qualitative inquiry is deemed appropriate to use Worcester as a case while situating each stakeholder in its historical, political, economic, as well as socio-cultural contexts demanding multiple data sources [15, 14].

With this design of the methodology, Participatory Action Research (PAR) was further chosen as a methodology and a process that is constantly going back and forth in further developing a best model of practice for responding to the disability and rehabilitation needs of persons with disabilities in this area. Given the focus of this project, making the research subordinate to inclusive development was ethically imperative. This development needed to be for but also by persons with disabilities hence it started by listening to persons with disabilities with regard to what their needs are. This is supported by Willms [16] who defined a broader interpretation of research as a process of re-experiencing and reconstructing personal and social realities. PAR in its approach, is a cyclical movement from the way things are to the way things could be [17], through engaging in interactions and relationship building with each other [18]. PAR in this project therefore allows participants to be involved in decision-making whereby communities lead the inquiry process and create their solutions for social change.

Mertens [18] further states that the intent is to capacitate people to participate in decisions that affect their lives. The research process can thus help marginalised and deprived people to gain self-confidence and pride in their ability to contribute towards their communities and to generate knowledge for training of students and to better respond to the needs of PWDs. Within this coordinated response all participants meet in workshops. In these workshops some training will be done, but also the main business has been for stakeholders to come together to align their services with the needs, report back on progress, and identify gaps for capacity building and research and to plan together on a way forward. All participants then contribute in processes of reflection and problem-solving, ultimately drawing up a way forward for responding to the needs. So it is a process of facilitating both participation as contribution and also participation as empowerment and resulting to shared-learning.

The objectives of the proposed model

The objectives that were outlined for the coordinated collaborative rehabilitation response to needs expressed by persons with disability in Worcester were to:

- Consult with key stakeholders within the Medical and Health Science Faculty and the Worcester Disability Sector to verify the needs identified previously.
- Validate the needs through action research with the different stakeholders using the CBR matrix
- Consultation with stakeholders on the model on how to address the needs.
- Capacitate staff, students and persons with disabilities through postgraduate programmes, short courses and workshops.
- Implementation of the model by the Rural Clinical School of Stellenbosch University.

Sampling stakeholders for collaboration

For the sustainability and the ensuring of an appropriate response to the needs expressed, the model has to be inclusive of persons with disabilities in all phases. The key role players should dialogue and pull out names of key disabled person in the community, all DPOs existing in the community and invite them to the different stages of dialogue and planning. This is a combination of both convenience and purposive sampling [19]. All the disability sector role players and disabled people who were present when developing the list of needs will be invited as they were part of the first step that led to this need of a coordinated response. These people will highlight other relevant role players within the disability sector who could further be invited to contribute to the process.

Purposive sampling [19] will be used to draw in other critical stakeholders in the community from the service providers aligning these service providers with the list of needs. Bearing in mind that disability is complex with multiple factors that are to be addressed by different sectors- this sampling approach is deemed appropriate for the selection of stakeholders.

The coordinated collaborative response

There is a need for service providers to be aware of what the needs of persons with disabilities are and start engaging with persons with disabilities, families and disabled peoples organisations in a coordinated manner to debate and develop ways of addressing these needs aiming at improving both service delivery and community development as well as capacity building to better support developments. Fefoame, Walungembe and Mpofu [20] in their writings on building partnerships and alliances in CBR explore the significance of partnerships at different levels calling for full coordinated involvement of all levels of society. They further assert that successful partnerships between a wide range of stakeholders at community level is a strategy for disability inclusive development and better enable active participation and empowerment. The complex world in which rehabilitation functions has undermined relationships and partnerships compounded by factors such as; no implementation of policies that are (in themselves) fragmented, lack of structure (and infrastructure) and leadership and/or coordination of rehabilitation services that are responsive to contextual demands, and lastly very limited rehabilitation services and infrastructure offered generally within the South African context as well as the limited understanding of fellow health/rehabilitation professionals [20, 21]. The other question that is blighting the rehabilitation machinery has been how to link and align services with training and research so that they actually fit a population oriented agenda? These questions require dialogue to happen at all levels in order for integration of interventions of all relevant role players to happen, for services to be interlinked and for rehabilitation professionals to learn to collaborate more.

Using the process of Participatory Action Research, the proposed model is about developing best models of practice that ask for new perspectives while also drawing on what already exists in the

community as assets to build on, promotes inter-professional and inter-sectoral dialogue and strategies that will make things happen – within a unified framework. The objectives of this model will be implemented in 6 phases using the following steps will be used to implement the plan for the coordinated rehabilitation response to the needs of persons with disability within the URCS.

Phase 1: A workshop to discuss critical components of the research process and what will be included in the research proposal for initial funding: In this phase, a workshop will be conducted for all the key role players within the Medicine and Health sciences faculty as well as the Disability sector in Worcester. The aims of the workshop will be to- firstly introduce these key stakeholders to each other. Secondarily, discuss the process of developing a research proposal to source funding for the development of steps to respond to the needs of persons with disabilities from Worcester. Thirdly, share the list of needs of persons with disabilities with all the role players with the aim to further improve the list. Lastly, share briefly the three instruments that have been driving rehabilitation theory and scope of practice i.e. ICF; b. CBR and UNCRPD and identify training needs about the use of the instruments from the different stakeholder's i.e. disabled people, clinical coordinators, clinical facilitators and students. This first phase is about creating structures and starting to build relationships and partners. Organisational structure is an essential tool for change [22].

Phase 2: Validation of needs and identification of role players who will participate in responding to needs of persons with disabilities within the URCS: This second phase will focus on re-linking with the clinical coordinators for the rehabilitation professionals that have students based at the URCS to check how much of the two pages needs expressed by persons with disability in Worcester is being covered through the current student service learning activities, which aspects are not covered and what are other issues they are covering for persons with disabilities in Worcester that are not included in the 2 page list.

After this process, a second workshop will be conducted to connect with the disability reference groups that are working together with URCS with the aim of further validating and improving the needs expressed by persons with disability and gaining an understanding of how they further suggest the needs to be addressed. In this workshop, key stakeholders that could play a role in the development of a coordinated collaborative rehabilitation response to needs expressed by persons with disability coordinated in Worcester will be identified. Consolidation will therefore be done with the structures that will drive the response i.e. Disability and rehabilitation reference group in the URCS, students that will drive the research as well as drawing time lines for the activities of the response.

Phase 3: The implementation of the response: The structure for the response to the needs of persons with disabilities in Worcester will be implemented in the following process:

a) **The use of the CBR matrix in coordinating action research activities:**

As explained in the introduction the CBR matrix has 5 pillars: health, Education, Livelihood, Social and Empowerment. An integrated team of masters' students (each working with one pillar) will work with students from the rehabilitation professions, NGOs and DPOs in the area in responding to the five pillars of the CBR Matrix as a response to the needs of persons with disability in Worcester using action research. A PhD student will pull the five pillars together to bring out a coordinated response and start suggesting a model for a sustainable response to the needs of disabled people in Worcester.

b) **Capacity building of stakeholders:**

Workshops will be conducted with clinical coordinators, clinical facilitators, students and disabled people to assist them with the understanding of the three instruments that have been driving rehabilitation theory and scope of practice i.e. (a) ICF; (b) CBR and (c) UNCRPD. A short course will further be developed to address the training needs of other academic and clinical facilitators beyond the rural clinical school (other departments with SU and in other Universities).

Phase 4: Establishment of a resource Centre (depending on availability of funds):

The starting point would be that the Centre offers academic services to support on long term basis the disabled community to develop as independent equal citizens with research capacity building going hand in hand. An inventory of already available resources for persons with disability in Worcester would be developed.

It will also serve as an information Centre to assist both the students based in the URCS and Worcester community with information that will assist them to have a better understanding of the needs of disabled people in Worcester. Subjects for short courses identified by the stakeholders during the workshop: Project management, lobbying and advocacy, change management, communication skills, management skills will be packaged and offered.

c) **Writing skills and publications:**

Lastly, workshops will be conducted for clinical facilitators for both those that are registered for master's programme and those that are not to ensure that there is documentation of the process. There is an already existing part-time senior lecturer at the CRS with writing and publication skills who already have assisted clinicians to publish their work.

Phase 5: Development of a funding model for the rehabilitation coordinated response: There is a need to continue searching for further funding to support the response of the collaborative response within URCS to the needs of persons with disabilities in Worcester. The model implementers intend to make generation of third income to be a priority for the sustainability of the project.

Phase 6: Monitoring and evaluation: A template for monitoring and evaluation of the implementation process of developing a rehabilitation response to needs expressed by persons with disability in Worcester will be developed and used to log-in the progress made.

At the core of this model is the whole notion of the working together of rehabilitation professionals, persons with disabilities and the community in the creation of inclusive spaces for all to develop [23] and that addressing disability is not one man's business. Additionally the community should not be starting from a clean slate, rather key to the full integration of persons with disabilities is the building on

existing low lying fruits at community and build that for change to occur. This might mean drawing knowledge's from parents of persons with disabilities and disabled persons themselves as they have lived experience of how to cope with disability issues at community level. This opens a space for professions, especially those that teach new rehabilitation graduates to learn from these experiences and adjust accordingly their curriculum. All rehabilitation professionals, when going to any community should first understand (and then) work with the existing resources, knowledge and skills in that community.

Conclusion

It is recommended that communities implement and adapt this proposed model in their contexts and start facilitating a new kind of leadership and a culture in all levels, where the very leaders are the people with disability themselves. This will assist in the development of inclusive communities for all people as citizens of society and embrace humanity for change to occur. The power of networking and meaningful partnerships between service providers, the disability sector, disabled people and their families as a good strategy to facilitate equitable participation for persons with disabilities cannot be underestimated. There is a dire need to learn to work together to breakdown the complexities that have been (for a long time) undermining rehabilitation. Working together and creating solutions together has the potential to lead change and transform rehabilitation through a participatory methodology that will in turn give birth to reflective practitioners and empowered persons with disability. This model demonstrates an example of what is perceived as a practical implementation of the expression which was coined by persons with disabilities- "Nothing about us without us" at a ground level. It also demonstrates how stakeholders including persons with disabilities as the leaders can take existing models, critically analyse these in relation to their own contexts, adjust and design their own implementation solutions to ensure that the needs and rights of persons with disabilities are fully addressed and realised. Therefore, this state of the art innovative rehabilitation model of best practice is proposing the integration of the translation of the rights of persons with disabilities as well as the current rehabilitation theories and policies into the actual lived community experiences of persons with disabilities. At the core of this proposed model is the art of reclaiming the human dignity of persons with disabilities and facilitating empowerment through such collaborative spaces where persons with disabilities from the beginning are given the spaces to respond and inform the development of solutions that will have an impact in their lives. The efficacy of this model in transforming communities of persons with disabilities and reclaiming their dignity will be monitored and feedback will be disseminated in the next publications which will focus on the outcomes of this model.

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