

Community-based peer supporters for persons with disabilities:

experiences from two training programmes

Authors

Gillian Saloojeeⁱ
Maryke Bezuidenhoutⁱⁱ

Peer supporters assist caregivers to understand and care for those with disabilities in helpful ways. They help to transform a sense of hopelessness, isolation and guilt into pride, acceptance and increased self-confidence.

This chapter describes the development and implementation of peer-supporter training programmes by two non-profit organisations. Malamulele Onward has trained and currently funds parents of children with cerebral palsy (CP) at 18 sites nationally, while eight adults with spinal cord injuries (SCIs) formed the Manguzi-based Siletha lthemba, following their training as peer supporters.

The impact of both programmes has demonstrated their value. Malamulele Onward has assisted caregivers to understand CP, and helped them learn how to care for their children in helpful ways and how to transform a sense of hopelessness, isolation and guilt into pride, acceptance and increased self-confidence. Clients with newly acquired SCIs experienced easier inclusion and integration back into family and community settings. Their ongoing telephonic contact with SCI peer supporters prevented unnecessary out-of-pocket expenses and created an early warning system for avoidable secondary complications. Challenges encountered

during training and implementation included content development and ensuring that training materials were appropriate for people with low literacy levels; integration of peer supporters into existing rehabilitation services; travel; and sustainability of a peer-support service.

The lived experience of a SCI or of caring for a child with a complex disability combined with in-depth training and ongoing mentoring gives peer supporters credibility, and their advice and information are more likely to be believed and acted upon. What takes therapists years to achieve with clients in terms of behaviour and lifestyle changes can be achieved by a peer supporter in one session. Peer supporters offer a way of filling the gaps in the current inequity of access to rehabilitation for persons with disabilities. If integrated into traditional rehabilitation services and with a sustainable funding model, improved outcomes are possible for adults and children with disabilities in terms of social inclusion and prevention of secondary complications.

i Independent physiotherapist, Johannesburg; formerly Malamulele Onward

ii Rehabilitation Department, Manguzi Hospital

Introduction

Despite an increase in number of graduates, access to rehabilitation professionals remains an international challenge, especially in rural and underserved areas.^{1,2} Current approaches to care appear unsustainable and unattainable for the most vulnerable.¹ Consequently, the majority of adults and children with disabilities have limited access to interventions that promote inclusion and participation and that prevent long-term sequelae of their disabilities.² This is even more true for adults and children with lifelong disabilities, such as those caused by cerebral palsy (CP) and spinal cord injuries (SCIs), living in low- and middle-income countries (LMICs). Despite the relatively low incidence of SCI and CP, the social and economic impact of these conditions is considerable.^{3,4}

Adults and children with long-term neurological disabilities rely extensively on informal caregivers such as family members for general assistance, transportation and regular emotional support.⁵ Centralised institution-based and profession-dominant services perpetuate out-of-pocket expenditure, negatively affecting service uptake and retention in care.⁵ For children with severe disabilities as a result of CP, physically caring for a child who needs total assistance in all daily activities generally falls on the family and it is usually mothers who are the primary caregivers, a role and responsibility they are often unprepared for. Caregiver strain, stress, fatigue, depression, and ultimately a reduced quality of life, are well-described in the literature.⁶

Community-based rehabilitation (CBR) has long been advocated as a comprehensive strategy for general community development and to facilitate services at community level. It provides rehabilitation, reduces poverty, and equalises opportunities and social inclusion for all persons with disabilities.² Both CBR and peer supporters form part of South Africa's Framework and Strategy for Disability and Rehabilitation.⁷ CBR is currently implemented in over 90 LMICs, and although it has been shown to have a modest beneficial effect, in reality, few persons with disabilities are believed to have access to even basic health and rehabilitation services.² Poor intersectoral collaboration and lack of integration of CBR into existing rehabilitation programmes, combined with the longstanding controversy regarding what CBR actually is, may help to explain why this strategy has not had the desired outcome in terms of access to rehabilitation.^{8,9}

Thus there remains a need for further innovation to close the gaps in the provision of rehabilitation services. Self-management, peer-delivered support, and integration of peer supporters into rehabilitation settings have emerged as promising complementary interventions to counter the limitations and lack of access to services encountered by children and adults with lifelong neurological conditions.¹⁰

The concept of peer supporters originated in the mental health field alongside community-based services for families.¹¹ Defined as persons with similar life experiences who also have a professional role, peer supporters are perceived as credible role models who instil hope and facilitate engagement in services.¹¹ People learn more and try harder when they learn from others who they perceive to be like themselves and managing similar circumstances.

Peer supporters have been proposed as a cost-effective complement to other professional-led programmes.¹² A variety of models of care exist, ranging from telephone-based support to institution and community-based individual and group approaches. Remuneration and lack of recognised training have led to questions around sustainability, scalability, and acceptance of the cadre by health professionals.

For persons with SCI, peer-supporter programmes have the potential to reduce bed stay, reduce costly readmissions,¹³ improve mental health and community participation,¹⁴ increase access to care through referrals and advocacy, address issues of compliancy, and appear acceptable to persons with disabilities and their caregivers at all levels of care.¹² Parent-to-parent peer support for parents of children with disabilities has been found to improve emotional and psychosocial well-being.¹⁵

This chapter describes the development and implementation of two peer-supporter programmes in South Africa, viz. the Malamulele Onward Carer-2-Carer Training Programme (MO C2CTP) for caregivers of children with CP, and the Manguzi-based SCI peer-support programme. After discussing key findings from these two programmes, the chapter concludes with recommendations regarding the integration of peer supporters into current rehabilitation services for persons with disabilities in South Africa.

Development of two peer-supporter programmes in South Africa

The Malamulele Onward peer-supporter programme

CP is the most common cause of motor disability in children. These motor disorders are often accompanied by “disturbances of sensation, perception, cognition, communication, behaviour, epilepsy, and by secondary musculo-skeletal problems”.¹⁶ This makes CP a complex condition placing a significant burden on families, the healthcare system and the general economy.⁴

In LMICs, the prevalence of CP is 2.6-3.4 per 1 000 live births.¹⁷ Extrapolating this to South Africa, it can be estimated that there are close to 59 000 children with CP. Unpublished research in a single rural setting by the first author found

that current rehabilitation services are reaching less than half these children.

Malamulele Onward (MO) is a non-profit organisation (NPO) founded in 2005 in response to the need for children in resource-constrained settings to access ongoing therapy. The C2CTP was designed by a multi-disciplinary team of MO therapists to meet the need for:

- Access to information on CP, using easily understood terminology.

- Understanding of the causes of CP and ways to reduce feelings of guilt and isolation.
- Practical skills and knowledge in order for parents to handle and position their children during everyday activities.
- Opportunities for parents to share their personal stories and struggles within a safe space.

The MO C2CTP comprises seven modules (Table 1).

Table 1: Content of the Malamulele Onward Carer-2-Carer training programme, 2019

Module	Content
1	Introduction to CP: What is it and how does it affect my child?
2	CP as a way of life: Looking after my child throughout the day
3	Getting active: Getting my child's body ready to move throughout the day
4	Eating and drinking: Making mealtimes safe and comfortable for my child
5	Communication: My child and I understanding each other
6	Cerebral visual impairment: Understanding where and what my child can see
7	Play: Unlocking my child's potential

Each module involves a two-hour workshop presented by a peer supporter, who is a family member (usually a mother or grandmother) of a child with CP who has been trained as a parent facilitator. Training programmes for caregivers of children have been advocated as an intervention in LMICs,¹⁸ but the MO C2CTP is the first programme to completely task-shift the training role from healthcare workers to caregivers.

The C2CTP was developed and refined over a period of seven years. The parent facilitators were major contributors to the final product through their feedback and their experiences in running the programme. Training a parent facilitator to be able to run the full training programme of seven modules takes 240 hours, and this is usually spread over three two-week blocks. One of the parent facilitators is now a master trainer, able to train new parent facilitators with minimal input from a therapist. There are currently 27 parent facilitators working at 18 sites in five provinces and Lesotho. All parent facilitators receive supervision and mentoring through on-site visits and telephone support, in addition to support from local rehabilitation therapists.

Subsequent observations from regular site visits revealed the additional role that parent facilitators were playing in monthly hospital-based CP clinics. Consequently, parent facilitators received further training on how to work with parents and children in groups and how to lead discussions on topics covered in the C2CTP. Their role was further expanded to include home visits to children no longer

attending therapy and families that were struggling. Hence the term 'parent-led' services has been adopted to reflect the role they are playing at community level in supporting children with CP and their families.

Between 2014 and 2019, a total of 1 211 children and their families were reached through the C2CTP.

The Manguzi SCI peer-supporter programme

Ten adult wheelchair users known to the Manguzi Rehabilitation Department attended a five-day peer group training run by Afrique Rehabilitation and Research Consultants (ARRC), a Cape Town-based non-profit company. These 10 adults, including males and females, with varying reasons for their SCIs, and varying educational backgrounds, were selected based on their level of community participation, their capacity to volunteer, and the level of interest shown in the programme. Two wheelchair users were already working at Manguzi Hospital as wheelchair technicians through a service-level agreement between Disabled People South Africa (DPSA) and the KwaZulu-Natal Department of Health.

The peer-supporter training included input on disability rights; bladder and bowel care; skin care; sexuality; relationships; healthy lifestyle and exercise; transfers; assistive devices; and communication. The content of the peer-supporter training manual was developed over six years by a team led by Jacques Lloyd, himself a person with an SCI. The material was piloted in Uganda and

further refined during training courses in Tanzania and Mozambique, and is constantly updated. The manual uses examples appropriate to low-resource settings and emphasises group dialogue. This encourages participants to share and explore contextually relevant problems, challenges and solutions with a skilled facilitator. At the end of the five-day training course, SCI peer supporters are equipped to identify the challenges and secondary

complications persons with SCI encounter and refer them to the appropriate health, rehabilitation and social service departments.

Currently two of the trained peer supporters play a dual role as both wheelchair repairers and peer supporters at Manguzi Hospital, while a further four have been integrated into the rehabilitation service (Table 2).

Table 2: Role and function of SCI peer supporters at Manguzi Hospital, 2019

Setting	Role and function
Acute care/ward setting	<ul style="list-style-type: none"> • Initiate contact, befriend peers. • Offer counselling; answer tough questions, give hope/outline a future. • Demonstrate basic mobility/activities of daily living (ADL). • Accompany rehabilitation staff on pre-discharge home environment assessments. • Provide coaching on wheelchair maintenance and repairs. • Introduce new clients to the peer-support network.
Outpatient/clinic setting	<ul style="list-style-type: none"> • Identify new clients and onward referral. • Provide ongoing mentoring. • Provide role modelling and health education/advice. • Maintain own database of wheelchair users; keep in telephonic contact with members in the network; provide the link between the community and health services. • Provide wheelchair maintenance and repair services. • Provide coaching on wheelchair skills, mobility and ADL skills and goal setting under direct supervision from rehabilitation professionals. • Organise wheelchair repair/peer-support outreach clinics. • Provide new healthcare professionals with disability sensitisation training, wheelchair skills training, and training on topics including bowel and bladder care.
Community setting	<ul style="list-style-type: none"> • Engage with community structures such as traditional authorities, municipal counsellors, NGOs, taxi associations, churches, etc. • Provide advocacy and awareness raising.
Home	<ul style="list-style-type: none"> • Do home visits and provide mentoring and psychosocial support, including acting as an intermediary with family or community. • Provide practical advice on adaptations within the home setting. • Provide coaching on wheelchair and general mobility skills, including ADL activities.

The Manguzi SCI peer supporters formed their own NPO, Siletha lthemba, which has over 40 active users on its client list. Therapists and peer supporters work collaboratively, and have triaged clients to ensure that those requiring regular and intensive face-to-face support receive this, whereas clients at lower risk for secondary complications receive telephonic follow up.

Key findings

Key findings related to training and development of the two peer-supporter programmes are presented under two themes, namely: (1) the impact of the programmes to date; and (2) challenges encountered in programme training and implementation.

Impact of the two peer-supporter programmes

Impact of the MO C2CTP

A qualitative study was undertaken to evaluate the impact of the MO C2CTP. This comprised two components, viz. self-completed questionnaires, and focus groups. All caregivers attending the parent-led C2C workshops during the first three years of the programme completed an open-ended questionnaire at the end of each workshop. Focus groups at five rural sites where the programme was well established were facilitated by the master trainer. Criteria for choosing participants was that they had to have attended all five workshops and be comfortable expressing themselves.

A lay translator translated data from 470 questionnaires into English. The focus group discussions were recorded on a tablet after written informed consent was obtained from participants. A total of 41 caregivers (mothers, grandmothers and one father), participated in the focus groups. The

recordings were transcribed and translated into English by a lay translator.

The qualitative data were organised into four predetermined themes based on the identified goals of the programme, viz.

caregiver information and understanding; caregiver mental health; caregiving practices and behaviour; and caregiver empowerment. Deductive analysis was used to organise and analyse the data according to these predetermined themes (Table 3).¹⁹

Table 3: Themes, sub-themes and categories from qualitative analysis of MO CTCTP data, 2019

Theme	Sub-themes	Category	Example
Caregiver information and understanding	Caregiver understanding of the child with CP	Understanding of CP	"I believed that a child with CP doesn't live very long, so I didn't accept my child."
		Understanding of the child	"I now know that my child doesn't like meat, because of listening to him."
		The future	"We are thankful because after learning we see the future."
Caregiver mental health	Negative feelings	Feelings of isolation	"I like to hear other parents tell stories about their children, this made me understand that I am not alone."
		Feelings of guilt and self-blame	"As a parent to a child with CP, I feel I can accept this because it is not my fault."
		Confusion and hopelessness	"Before the workshop I was confused about my child and hopeless."
	Positive feelings	Hopefulness	"I am really feeling counselled because my hope was lost but now I feel proud of my child."
		Confidence and self-esteem	"I feel open to talk to my neighbour about my child's condition."
Caregiving practices and behaviours	Practical skills	Communication skills	"We could not cope well, especially with communication, but since coming here for the workshop we understand that he uses his eyes."
		Positioning	"My child could not sit straight, she was bent all the time. Coming here helped me a lot to learn from the workshop on how to position my child and how to use a cut-out cup."
		Feeding	"The workshops helped in that I know how to position my child for eating, also how to help him to learn to chew."
	Relationship with child	Progress and improvement	"Because I have been taught how to work with my child at home, there is progress with my child and I am happy."
		Expectations of child	"Even with housework I let her try and help, I learned from the workshop to give her a chance."
		Love and acceptance	"We were taught to love them and not take them as a burden."

Theme	Sub-themes	Category	Example
Caregiver empowerment	Relationships	Family	“When carrying my child on my back people will ask me silly questions because they don’t understand, but the workshops have played an important role in the relationships within my family.”
		Other parents	“I can tell others that their child is not sick.”
		Community	“Now I can stand in front of people and tell them what causes CP.”
	Participation	Going to church	“Now I am proud to push him to church.”
		Play	“But now everybody loves him and they play freely with him after I shared with them what CP is.”

As a result of attending the parent-led workshops, many caregivers described feelings of hopefulness, a deeper understanding of CP and of their own child, and greater understanding of how to care for their child. Evidence of increased self-esteem and self-confidence was also apparent: “At first it was difficult with my neighbours not knowing what to say to them, but now thanks to the workshops it is better.”

Qualitative evaluation of the C2CTP demonstrated that the programme went beyond helping parents to understand their child’s condition, to facilitating acceptance and helping parents to stop blaming themselves. Caregivers felt empowered and ready to explain CP to family members and neighbours, were equipped with basic skills, and displayed a sense of control. This has to be liberating for parents in rural settings where ignorance and negative attitudes towards disability abound.

Impact of the SCI peer-support programme

Impact of the SCI peer supporters has not been formally evaluated yet. Rehabilitation professionals at Manguzi Hospital reflected on the early use of SCI peer supporters across settings, from acute through to chronic care. In their opinion, input from SCI peer supporters has positively influenced clients’ coping skills; allowed them to raise and discuss questions not usually asked of health professionals; improved engagement with rehabilitation goals; and promoted an overall positive outlook. They observed how peer supporters assisted family members to prepare for the client’s return home and how their involvement has added legitimacy to advice and facilitated frank discussions. Younger therapists and doctors commented on how their personal attitudes around disability and ability had changed and been shaped through the peer supporters’ involvement in practical orientation events for new health professional staff. It was observed that the number of wheelchair and buggy users attending the local annual sports day had quadrupled over the past four years, and that the number of wheelchair users seen on any given day on the main

streets of Manguzi had increased, which is perhaps further evidence of the role that the peer supporters have played in promoting inclusion, re-integration and participation.

The extensive network built by the SCI peer supporters has strengthened communication between persons with SCIs, the therapists and the health system in the Manguzi area. Clients readily contact the peer supporters telephonically to voice challenges ranging from broken assistive devices to medical symptoms and psychosocial issues. Pertinent problems are relayed without delay to therapists who advise the peer supporters on further actions. This system has provided an effective early identification warning system and/or averted and minimised secondary complications. The system’s effectiveness was highlighted during the COVID-19 lockdown and numerous service-delivery protests.

Challenges encountered in training and implementation of the peer-supporter programmes

Content development: An initial challenge was deciding on the core content of the training modules for the MO C2CTP. Cerebral palsy is a complex condition and it was important to decide what information was pertinent and how to convey it in a clear and simple manner. Analogies were made using unconventional examples relevant to a non-medical rural audience. The therapist-trainers had to learn to let go of precise medical explanations and allow for minor inaccuracies in order to achieve the bigger goal of understanding concepts and the impact of the disability. Content development was less of a challenge when training the SCI peer supporters as it had been adapted for low-literacy settings through earlier field testing.

Training: Coming from a diverse variety of rural areas, speaking different languages, and with varying literacy levels and understanding of English as a common language, impacted significantly on the pace of training in the first group of 20 parent facilitators in the MO CTCTP. It became necessary to extend the training from three weeks (as

originally intended) to five weeks. A variety of teaching methods helped facilitate the participants' understanding and retention of the content. The use of clear visual cues, plenty of appropriate photographs and a standardised layout in the manual helped decrease the literacy demands of the training material. Therapists grappled with finding the right words to describe concepts as well as appropriate images for the display materials, and it was here that the parent facilitators made a valuable contribution, e.g. in suggesting how concepts could be explained more simply, what words to use, and what practical exercises worked best. Translations presented another hurdle as there were terms for which there was no translation in local languages. Professional translators were employed once the material had been revised, and the parent facilitators reviewed the translated material to ensure comprehensibility and understandability.

Language, literacy levels and translation posed a similar challenge in the SCI peer-support training. Considerable logistics were involved in accommodating 12 wheelchair users at a central venue in a deep rural area. The initial five-day training provided a basic knowledge base, but ongoing training, mentorship and support are required to enable new peer supporters to manage complex social scenarios and varying levels of function, acuteness, and types of SCIs.

Mentoring and supervision: Mentorship and ongoing training are critical to the sustainability, quality, relevance and success of the programmes. Peer supporters need to be able to self-organise, work independently, prioritise, and submit simple reports. Low literacy levels need to be accommodated when designing, monitoring and evaluating systems. These are all skills that need to be taught and that cannot be assumed.

Integration into existing formal rehabilitation settings:

Given peer supporters' lived experience of disability and/or their experience of parenting a child with disability, plus their in-depth training, it is not surprising that some therapists may feel threatened. This is especially true for younger therapists who have not yet established their professional identity, or in settings where rehabilitation professionals are accustomed to being the experts. If rehabilitation professionals are not comfortable with role-release, with the concept of 'non-professionals' being experts, and if there is no 'buy-in' from the rehabilitation team, then peer supporters will be underutilised.

The experience with the SCI peer supporters at Manguzi was that trust between therapists and the peer supporters grew through mutual respect for one another's complementary roles and expertise, and the improved outcomes obtained when working together in challenging situations. Open lines of communication between therapists and peer supporters reduced out-of-pocket expenditure, e.g. clients making unnecessary trips to the hospital, and

also served as an early warning system, allowing prevention, early identification and intervention for secondary complications. Through consistent leadership from the rehabilitation management team and enthusiastic support from the peer supporters themselves, junior therapists were given a safe space to learn: "The peer supporters reduce so much anxiety and stress, particularly around the socio-economic and cultural contexts and because they already have a rapport with the clients. I know I can rely on them, and in so many instances they can simply take the lead. It's such a great partnership and our community services would be sunk without them" (community service physiotherapist, Manguzi Hospital).

Scalability and sustainability: By far the biggest challenge in implementing a peer-supporter programme is that no precedent exists for formal and funded integration into existing rehabilitation services. Currently all peer supporters are volunteers or donor funded. Apart from training and mentoring costs, expenses include stipends, data, airtime and travel.

Travel: Getting around the community to do home visits is a challenge in rural areas where peer supporters rely on public transport. Not only is public transport inaccessible to wheelchair users, but drivers often charge additional rates for wheelchairs. The Manguzi area is comprised mostly of deep beach sand, making it difficult for even the fittest and most skilled wheelchair users to propel themselves more than three kilometres (the maximum distance achieved in a contest!). Furthermore, taxis to remote areas are infrequent, and transport between areas is unavailable.

Key lessons

- Current rehabilitation services within the South African public sector are fragmented, centralised, and rely on a high turnover of junior staff, affecting quality of care and sustainability of community-based services.^a Training of mid-level rehabilitation workers has stalled because of regulatory, training-institution, professional-preference, and budgetary challenges.^a Years of austerity measures have resulted in stagnating numbers of rehabilitation staff in the public sector between 2012 and 2016.

Against this background, peer supporters are a beacon of hope. Experience from both the localised Manguzi SCI programme and the more national MO C2CTP has demonstrated the value of peer supporters in addressing some of the inequities in rehabilitation, particularly in resource-constrained settings where access to quality and consistent rehabilitation is lacking.

a Cole J. Situational and gap analysis of rehabilitation and the human resource need and supply of health therapists in South Africa. Social Trends Development Services: An unpublished report prepared for the South African Committee of Health Sciences Deans, 2012.

- Caregivers of children with CP and persons with SCIs voice concern about therapists' knowledge of living with a disability, and the ability of therapists to impart practical and subjectively relevant advice.¹² Peer supporters are viewed as legitimate sources of information, having 'lived through a similar situation', therefore having more credibility. Consequently, advice and information from a peer supporter is more likely to be believed and acted upon. Often, what takes therapists years to achieve in terms of behaviour and lifestyle changes can be achieved by a peer supporter in one session.
- Newly qualified rehabilitation therapists are ill-equipped to deal with the complexities and realities of lifelong disabilities such as CP and SCI. Undergraduate syllabi struggle to ensure that students learn the necessary skills in managing SCI and CP clients in low-resource settings.⁹ In addition, disability is a cross-cutting issue, yet it is often taught from a discipline-specific perspective. Partnering with an experienced peer supporter fast tracks the learning of newly qualified therapists in a way that no undergraduate training is able to achieve.
- The challenges encountered in developing the content and training materials for peer supporters highlights that this process should not be undertaken lightly. Success can only be achieved when rehabilitation professionals and peer supporters work together closely, listen to each other, and learn from one another.
- In order to assist their peers, peer supporters require in-depth knowledge of the nature of the disability (viz. CP or SCI), beyond the information that they themselves received as clients. They need to be able to answer questions that they may not have personal experience of. There is a risk that when questioned by their clients, peer supporters may offer personal explanations, which could be misleading or factually incorrect. An open and respectful relationship between peer supporters and the professionals supporting them helps to minimise this risk. For a peer-supporter programme to be effective, investment in ongoing peer-supporter training cannot be underestimated.
- Peer supporters should not be viewed as replacements for rehabilitation professionals and mid-level workers as their input is restricted to a specific disability. However, for complex conditions such as CP and SCI, the experience of the MO C2C parent facilitators and the Manguzi SCI peer supporters provides clear evidence of their value to existing services. Their roles are based on legitimacy and first-hand experience that cannot be substituted by other cadres.
- Peer supporters not only act as motivators and role models, but also facilitate access to the healthcare system, navigation of the system, and retention in care. At community level they provide significant support to clients and caregivers in negotiating the numerous barriers to social participation and inclusion.

Recommendations

Transform peer-supporter NPOs into micro-enterprises:

Funding is required if there is to be long-term sustainability of peer-supporter programmes. In the absence of any regulatory authority for peer supporters, it is highly unlikely that posts will be created in the government sector. Current peer supporters are funded by NPOs, which are themselves donor dependent. A more sustainable solution could include transforming these NPOs into micro-enterprises that sell their services to government departments. This requires an attitudinal shift from healthcare providers in recognising peer supporters as non-traditional experts, the complementary role they play in optimising rehabilitation services, and a willingness to pay for their services. For this model to be successful, peer supporters require skills and training in how to run an NPO as a micro-enterprise.

Professionalise peer-supporter training: Apart from the recently developed Higher Certification in Disability Practice at the University of Cape Town, no other accredited or recognised training exists for mid-level disability workers or peer supporters. Registration of an occupation-based qualification with the Quality Council for Trades and Occupations (QCTO) would not only make peer supporters more employable, but would also guarantee the quality and standard of training.

Find transport solutions for peer supporters: Apart from the fact that public transport is inaccessible to SCI peer supporters, relying on public transport to get around the community is not an option for rural community-based peer supporters. Unlike community health workers who are assigned to a number of households in one geographical area where it is generally possible to reach all clients by foot, clients with SCI and CP are spread across a district. Hence creative transport solutions need to be found if peer supporters are to work independently. One option for parent facilitators is motorbikes, using the Riders for Health motorcycle model.^b

In the case of SCI peer supporters, the ideal transport solution would be an adapted 4 x 4 vehicle. However, cost-wise this is unrealistic, hence the importance of SCI peer supporters being integrated into the rehabilitation service and the appropriate allocation of adapted vehicles to the rehabilitation department.

b <https://ridersintl.org>

Integrate peer supporters into rehabilitation services:

Change-management workshops may be required to assist with the integration of non-traditional health workers into rehabilitation services, and to facilitate attitudinal change among professionals.²⁰

Include peer supporters in undergraduate training programmes:

The participation of persons with disabilities and parents of children with disabilities in undergraduate training programmes for all health professionals, combined with meaningful interaction with well-functioning peer-supporter programmes, will expose undergraduates to the lived experiences of clients they will encounter as newly qualified therapists. Learning to listen to and learn from non-traditional experts will surely assist in ensuring that future rehabilitation services are more inclusive, effective and relevant.

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