Issue 01/06/2020

HPCSA
Health Professions Council of South Africa

Speech Language & Hearing Professions NEWS

Newsletter for Speech Language and Hearing Profession (SLH) Board

Contents

CHAIRPERSON'S NOTE

The Professional Board for Speech, Language and Hearing has continued to carry out our mandate as our term of office comes to closure. The year started off with a review of our strategic plan and the development of our annual performance plan. In keeping with our objective to improve the legal framework for the profession the following guidelines were reviewed: Ethical Rules of Conduct for Practitioners registered under the Health Professions Act; Regulations relating to the curricula and professional examinations in hearing aid acoustics; Rules of conduct pertaining specifically to the speech, language therapy technicians; Rules of conduct pertaining specifically to the audiology technicians and the Regulations defining the scope of the professions of speech therapy and audiology. The Guidelines on Language and Culture which aim to meet the professions' specific needs in providing services in a multi-lingual and multi-cultural society were published. An annual stakeholder engagement meeting with the broader representations (Universities, Professional Associations, Provincial Coordinators, and National Department of Health) was held on the 16th of July 2019. The meeting focused on implementation of the published guidelines on EDHI, minimum standards for hearing screening in schools, guidelines for audiological management of patients on treatment that include ototoxic medications. The Chairperson of the Board attended the Rehabilitation 2030 conference hosted by WHO in Geneva. The Chairperson also represented the Board at the National Rehabilitation Forum, HWSETA stakeholder engagement session on skills development and the NDoH Human Resources in Health (HRH) Indaba. The SLH Board also ensured that the professions' voice was heard through its submissions on the draft NDoH HRH strategy as it relates to the SLH profession and the NHI policy document. Three members of the Board presented at the first HPCSA conference. Board members also participated in the first Interboard collaboration on an Assisted Devices Task Team. Within its mandate to guide, develop and regulate education and training of the professions the Board ensured adherence to the evaluation cycle for 2019/2020, reviewed the curricula of various institutions, assessed clinical hours of final year students, conducted a training session of evaluators and developed a bank of case studies for the professional board exams. We look forward to finalising all outstanding tasks and handing over to the next board.

Dr Sadna Balton
Chairperson of Speech Language and Hearing Professions Board

SPEECH-LANGUAGE AND HEARING PROFESSIONS' CONSIDERATIONS AROUND NATIONAL HEALTH INSURANCE: NEED FOR PARADIGM SHIFT?

By Prof. Katijah Khoza-Shangase

The Speech-Language and Hearing (SLH) Professions Board of the Health Professions Council of South Africa (HPCSA) is intimate with the reality that SLH services within the South African context have to be provided paying careful cognisance to the contextual realities that impact both access to and efficacy of their clinical services. It is these contextual realities, that negatively influence the provision of SLH services within this context, that the Board hopes will be partly resolved by the National Health Insurance (NHI).

There are key realities that impact SLH services provision in the South African context. Firstly, the lack of appropriate SLH skills as well as the unfavourable professional-to-patient ratios lead to serious demand: capacity challenges where a large number of patients requiring SLH services do not have access to these services. These demand: capacity challenges are exacerbated by the obvious incongruence between supply and demand, with approximately 1 out of 15 SLH professionals working in the public sector that services over 70% of the South African population – with the rest being in the private sector.

Secondly, SLH services provision is impacted by healthcare sector infrastructural constraints – where access to healthcare services is severely compromised by limited well-functioning public health facilities. This has been and continues to be negatively influenced by health spending budget cuts – with spending on SLH being low on the priority list. The infrastructural constraints extend to general lack of resources for the size of the population requiring SLH services, with the public sector being oversubscribed for the population it serves and the professional: patient ratios. The private health sector, which services approximately 20% of the population, only provides clinical care to fewer than 1 in 5 South Africans that were members of medical aids in 2018 (StatsSA, 2018).

Thirdly, SLH service provision within the South African context has to contend with challenges of translating knowledge and policies into practice for various reasons; including linguistic and cultural diversity quandaries. Fourthly, our professions face additional challenges with provision of SLH services, such as lack of a government mandate for a number of clinical programmes, e.g. Universal Newborn Hearing Screening in audiology; high burden of disease (where SLH conditions are not high on the government's healthcare priorities); poor social determinants of health that have serious implications for SLH services seeking behaviours and SLH services intervention adherence; the lagging behind in the utilisation of tele-practice with its inherent challenges including connectivity issues and ethical challenges linked to it; linguistic and cultural diversity challenges which include SLH professionals versus our patients incongruence, lack of linguistically and culturally diverse clinical resources, epistemological positioning of the training and clinical service provision being westernised, etc.; lack of enforceable mandate for language and culture in healthcare (which has significant implications for our professions); as well as lack of seamless and systematic collaboration between health and other sectors (e.g. education, social development, industrial sector, etc.) – which is key in SLH for continuity of care as well as for enhanced success of our patients. All these challenges call for the South African SLH professions to deliberate on our role and its success or lack thereof within the South African context. These challenges raise serious concerns about the South African SLH professions' ability to provide universal SLH services coverage. Deliberations around the National Health Insurance (NHI) have to therefore take these contextual challenges into consideration.

The former South African Health Minister, Hon. A. Motsoaledi (2012), pronounced "...a long and healthy life" as a motto guiding the

ministry's health strategy for the country during his tenure. This motto is supported by a key motivation for the National Health Insurance plan reflected in the White Paper on the NHI (National Health Insurance for South Africa, 2017), that stresses that NHI is justified for the country because South Africa believes that access to healthcare is a human right. The NHI has been argued to represent a homogeneous approach, which may be sufficient to achieve universal access to high quality of care – however quality improvement across both the public and private sectors is essential for it to succeed.

NHI is based on principles of right to access healthcare found in the Bill of Rights, Section 27 of the Constitution of the Republic of South Africa, 1996 (Republic of South Africa 1996); social solidarity which relies on cross-subsidisation between the young and old, rich and poor as well as the healthy and the sick; equity; healthcare as a public good and not a commodity of trade; affordability which implies reasonable cost as well as sustainability within the country's resources; efficiency with regards to value for money; effectiveness, which means that expected outcomes are obtained and that acceptable standards of quality exist; and lastly, appropriateness to the context and various levels of care (National Health Insurance for South Africa, 2017).

The White Paper on NHI (National Health Insurance for South Africa, 2017), which is the precursor to the subsequent NHI Bill (2019), asserts that *"...good health is an essential value of the social and economic life of humans and is an indispensable prerequisite".* NHI aims to achieve a healthier nation, where people will live longer and suffer less illness. This aim correlates very well with the goals of SLH services, positioned under rehabilitation – with preventive care as ideal. NHI also aims to prevent illness and to ensure that patients receive treatment at an early stage of illness to prevent complications. This, again, is consistent with the goals of any early detection and early intervention for patients with SLH needs. Furthermore, NHI aims to have family health teams in all neighbourhoods providing preventive health services and home-based care; which are strategies that improve access to healthcare services; and would, for SLH services, be contextually relevant and responsive. Lastly, NHI will encourage the expansion of primary healthcare services, which is a model of healthcare that the South African Government has adopted.

The South African hospital sector is historically divided into old divisions and new developments, and distinct divisions still exist between public and private health sectors; with the public health sector servicing the majority of the South African citizens (over 70%) who are not privately funded. The NHI is a proposal of a harmonised approach to healthcare where South African citizens can access health services in both public and private sector at the cost of the national health insurance – irrespective of their socio-economic status. This therefore indicates the South African government's intention to achieve universal health coverage and access to high quality of care (South African Health Review -SAHR, 2017). All this must ensue in the context of South Africa trying to attend to the long term goal of tackling the social determinants of health. Addressing social determinants of health in South Africa has been acknowledged as a long journey where "...the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness" (WHO Commission on the Social Determinants of Health, 2008) are enhanced.

The SLH Board believes that this approach should also carefully consider risk versus benefit of any initiative adopted to address a health challenge within this resource constrained context. This purports deliberation on risk/benefit (potential harm/positive effects-efficacy) of all SLH clinical initiatives (e.g. ECI, EHDI) interventions/programmes the country adopts for contextual relevance, contextual responsiveness, and contextual responsibility/accountability; with exploration of interventions/programmes that are systematic, comprehensive, have a strategic plan behind them; and involve SLH professionals in their development and monitoring (e.g. involvement from policy to implementation and monitoring).

The World Health Organisation's Director-General, Dr Tedros Adhanom Ghebreyesus, asserts that all roads lead to universal health coverage, highlighting that this is the goal, but not the means (Ghebreyesus, 2017). This author acknowledges that countries adopt different

paths (whether public or private services purchasing), but he also emphasises that countries "will need to know where they stand on universal health coverage, benchmarked against others". Furthermore, he stresses that universal health coverage (UHC) is not an end in itself, but allows realisation of the other health-related Sustainable Development Goals (SDGs). Jointly with the World Bank, the World Health Organisation (WHO) has furnished guidance on tracking progress towards UHC in the form of the UHC service coverage index (Hogan et al., 2018; World Health Organisation, 2017) which can be of benefit to the SLH professions in terms of tracking access to our services.

NHI aims to achieve a healthier nation, where people will live longer and suffer less illness – with prevention of illness being key. This speaks directly to SLH professions' cradle to grave assessment and intervention services, with a key emphasis on prevention. This calls for heightened emphasis on this scope of our practice to ensure that our clinical services are aligned to the health priorities of this country. For example, in audiology, strategic planning of preventive audiology around National Department of Health (NDoH) health priority programmes such as EHDI, occupational noise induced hearing loss (ONIHL) – hearing conservation programmes (HCPs), Ototoxicity Management, Vestibular Management, becomes key.

NHI asserts that citizens must receive treatment at an early stage of illness to prevent complications – again this directly speaks to all SLH professions' early intervention goals. Furthermore, NHI aims to have family health teams in all neighbourhoods. Sufficient evidence exists that proves improved efficacy of SLH interventions when family-centred and/or home-based. Within the South African context, this has the added benefit of ensuring that clinical services provided become culturally and linguistically relevant and contextually responsive. Lastly, NHI will encourage the expansion of primary health care services – which are more easily accessible to communities; especially the currently neglected rural communities. This has obvious benefits for expansion of SLH services provision; with deliberations around task-shifting and the use of tele-practice to ensure protection of the public.

These deliberations around NHI and SLH highlight a need for paradigm shifting in SLH in order to be in line with NHI goals. SLH services in South Africa should be responsive to the context; be in line with national healthcare priorities; and be linked to NDoH programmes. Furthermore, SLH services should take the following factors into consideration: burden of disease, cost-effectiveness of interventions aimed at preventing disease and reducing the burden of disease, human and institutional resources at the level closest to the affected communities; · PHC (UHC – NHI) to ensure high reach, health needs, etc.

South Africa is nowhere close to achieving UHC. Although NHI plans continue, the date for its final implementation has not been pronounced; with public inputs on the Bill still being processed. The SLH Board supports NHI, and has provided inputs on the Bill. Below are some of the inputs by the SLH Board (2019) to the NHI Bill:

- Overall: There is a very strong medical bias to the NHI Bill with near silence on rehabilitation. No clarity has been provided on informed consent and patient confidentiality within the systems established for patient records and data capturing and management systems. The Office of Health Standards Compliance (OHSC) must ensure that its tools are relevant to rehabilitation. The NHI needs to look at how accreditation of service providers will link up with systems within the HPCSA e.g. registration, CPD compliance and good standing of clinicians. We question why the HR strategy is only being looked at in Phase three. Lastly, as a principle, there should be a commitment to fill vacant posts in the public health sector before contracting with private service providers.
- Both the NHI and the amendments to the Medical Schemes Act are complex, and will have far reaching implications to all the health professions. So, HPCSA should have an expert committee to give input on behalf of all 12 Professional Boards, including SLH Board.
- There should be very strong monitoring and evaluation instruments or systems in the new dispensation of both the NHI and the Medical Schemes Act that will specifically measure the improved access to health services for all including people with disabilities. If the impact is not measured, we as a Board and other stakeholders will not know if there is a positive impact on access to healthcare, and rehabilitation in particular, and resultant better outcomes citizens.
- The Bill tends to focus on a bio-medical approach and limited, if any, detail on prevention and rehabilitation services are outlined, hence in its current form, the Bill is silent on wellness and health promotion.
- The NHI Board should also include a social and behavioural change communication expert to promote health and wellbeing in order to ensure that people remain healthy and promote early health seeking behaviours.
- Part 8 46(1) of the Bill states that the Health Minister in consultation with the Minister of Finance will determine budget allocation to the fund on a yearly basis. This is worrying in that sources of income to the fund are not clearly mentioned. It is only reported that allocation to the fund will depend on donations and return on investment made by the fund page 54 (3) {b and c} of the Bill. It is, therefore, recommended that specifics and clarity be made regarding sources of income to the fund.
- It is recommended that the question of beneficiaries versus migrants be clearly addressed in the Act itself.
- The Bill advocates for the establishment of highly centralised National Health Insurance Fund. Considering the magnitude of the scheme, number of entities and institutions to be serviced at a time, number of people and practitioners to be serviced and to be served, the SLH Board recommended that the envisaged Act make provision for the establishment of Province-based (NHI)fund scheme offices to co-ordinate the work of the Scheme. These offices should have devolved and delegated powers to, among others, service staff, practitioners and service providers. In that way, monitoring and evaluation of the scheme can be managed better.
- In the Bill, the Board is assuming that "comprehensive coverage" includes rehabilitation services - including therapy sessions. It is not specified in the Bill if there will be a cap on this – as there is with traditional medical aids.

Acknowledgements:

Portions of this manuscript are part of a chapter titled Confronting Realities to Early Hearing Detection in South Africa in the upcoming book Khoza-Shangase K & Kanji A (submitted 2019). Early Identification and Intervention in Audiology: An African Perspective. (Eds) Wits Press.

SLH Board's inputs to the NHI Bill are included in summary form in this manuscript.

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HUMAN RESOURCE MATTERS WITHIN THE PROFESSIONS

Rehabilitation encompasses a complete package of care that includes health promotion, prevention, rehabilitation and palliative care at all levels of service delivery (i.e. primary, district, and tertiary levels of care) for continuity of care and service; which is aligned to the Batho Pele principles and Patient's Rights Charter. There is a need for Person-Centred Care with systemic support for inter-professional practice and inter-sectoral collaboration. With regards to inter-sectoral collaboration the Board specifically wishes to raise the issue of speech language therapy and audiology services for the school aged-children, which requires collaboration with the Department of Basic Education.

In South Africa, practitioners were historically trained in both Speech-Language Therapy and Audiology, and offered clinical services in both. This has changed with Speech-Language Therapy having a separate scope of practice to that of Audiology, which has implications for HR planning. The new graduates who are qualifying as either Speech-Language Therapists or Audiologists are not currently adequately accommodated within the post structure in the public sector. Regarding the clinical training platform offered by the Department of Health for audiology and speech language therapy, HR needs to accommodate clinical training students at all levels of care across the continuum of care.

Some of the issues the SLH Board has raised in its input to Government HR strategy include lack of senior posts in public health to attract skilled and highly qualified practitioners. Lack of recognition of advanced skills and qualifications hinders recruitment and retention of staff, and results in a leadership vacuum, as well as affecting staff morale and quality of services offered, as there is little or no opportunity for career progression. Currently over 60% of posts are at entry level and are filled by community service clinicians working in isolation. The lack of a retention strategy around community service clinicians and continuation of such posts impacts on continuity of care and sustainability of services where these services have been established. The current insufficient number of posts and the freezing of existing posts has led to a high number of graduates remaining unemployed following community service. Staff opportunity for further development (e.g. CPD, Postgraduate studies and research) which would directly lead to improved service, is not always supported financially or with workload adjustments. The inability to conduct research limits the production of contextually relevant evidence for appropriate clinical care and strategic planning. The lack of accurate data on human resources in both the private and public sectors hinders HR planning and projection of staff, including clinicians and mid-level workers, required at the appropriate levels of care. The Department of Health must take a position on whether there will be mid-level workers within these professions.

There is a need to develop staffing norms for rehabilitation, based on evidence and need, at a national and provincial level by appropriately skilled people. This important task should not devolve to clinicians as this is outside their scope. Electronic health records and research data would contribute to understanding community and population needs for rehabilitation and the development of a responsive HR plan. Profession specific administrative and support staff (including interpreters) are important to alleviate the burden of the already stretched clinical staff and would lead to improved opportunity to deliver quality care. An HR model should be flexible to accommodate largely female dominated professions and make provision for maternity leave replacements, and sessional appointments.

MONITORING AND EVALUATING OF TRAINING COURSES AND PRESENTERS

As part of the mandate of the Health Professions Council of South Africa, as set out in the Health Professions Act of 1974, which is:

To serve and protect the public in matters involving the rendering of health services by persons practising a health profession (par.(j) added by s.3 of Act 29/2007); and to uphold and maintain professional and ethical standards within the health professions (par(m) added by s.3 of Act 29/2007).

The Professional Board for Speech, Language and Hearing wishes to draw practitioners attention to the requirement that all course material should be evidence based. In addition, treatment will be based on evidence as to its efficacy and will cause no harm to the patient.

The Professional Board has received a number of concerns regarding treatment of patients with dysphagia through Vitalstim Therapy.

The following are some of the concerns that Professional Board is exploring:

1. Evidence for use in very young infants and across the age spectrum, as well as its diagnostic and therapeutic efficacy is not conclusive;
2. There is no evidence that the Vitalstim electrical stimulator followed all safety procedures for use on the public;
3. Vitalstim therapy equipment purchase had been made a prerequisite for attending the training offered.

In light of the above, the Board wishes to alert the Profession that the Board had commissioned an investigation on the use of Vitalstim Therapy .

SOUTH AFRICAN SIGN LANGUAGE CELEBRATION

On 12 March 2019, the National Institute for the Deaf (NID) in partnership with the Culture, Religion and Language Rights Commission supported by the UNESCO Information for All Programme (IFAP), hosted the 'National Celebration of SA Sign Language as the 12th recommended language in South Africa'. In July 2017 the recommendation was made by Parliament's constitutional review committee for official status to be given to South African Sign Language (SASL) as the country's 12th official language. The news was welcomed by deaf people and persons with hearing loss across the country as it has been a struggle for many years to get SASL recognised as an official language. It is seen as a historical event in South Africa and with successful implementation, deaf people and persons with hearing loss will be able to access society on equal level with hearing people - thus the reason for a celebratory occasion.

The event included participants who are role players and stakeholders including and representing all organisations related to people with hearing disabilities. Special guests of honour were Minister of Department of Higher Education and Training, Naledi Pandor and Deputy Minister of Department of Sport and Recreation, Gert Oosthuizen. The department has indicated that they will support and join hands with NID and UNESCO regarding the celebration of this particular milestone and the way forward for SASL to be recognised as 12th official language. This occasion also supports NID's goal to serve the broader community of South Africa by creating Deaf awareness and promoting the use of SASL in communities.

Practitioners to practise within the scope of practice of their professions

The current SLH Board has been approached by practitioners to recognise qualifications and training that lies outside of the SLH professions' scopes of practice. The most recent requests concerns hippotherapy as a therapy medium, lactation to be included within feeding management of the infant, and Speech Therapists to include suctioning of tracheostomy and ventilator dependent patients in their scope of practice. It is the Board's opinion that Speech Therapists and Audiologists should, wherever possible, function within a multidisciplinary team who practise within their own scopes of practice. The nurses forms an integral part of patient management in a hospital and clinic environment and should work with the speech therapist instead of the speech therapist performing a task which lies outside of their scope of practice.

Practice Guidelines and Ethical Rules

The SLH Professional Board has documented the following guidelines during its' 2015-2020 term. Practitioners are encouraged to read and implement these guideline in their practice

These guidelines may be found by clicking on the links provided. Please see links below:

1. **Guidelines for Early Hearing Detection and Intervention (EHDI).**
   https://www.hpcsa.co.za/Uploads/SLH/Guidelines%20for%20Early_Hearing_Detection_and_Intervention_(EHDI)_2018.pdf

2. **Guidelines for audiological management of patients on treatment that includes ototoxic medications.**
   https://www.hpcsa.co.za/Uploads/SLH/Guidelines%20for%20Audiological%20Management%20of%20Patients%20on%20Treatment%20that%20includes%20Ototoxic%20Medications.pdf

3. **Minimum standard for the Hearing Screening in Schools.**
   https://www.hpcsa.co.za/Uploads/SLH/Minimum%20Standards%20for%20the%20Hearing%20Screening%20in%20Schools.pdf

4. **Guidelines of practice in a culturally and linguistically diverse South Africa**
   https://www.hpcsa.co.za/Uploads/SLH/Guidelines%20for%20practice%20in%20a%20culturally%20and%20linguistically%20divers---.pdf

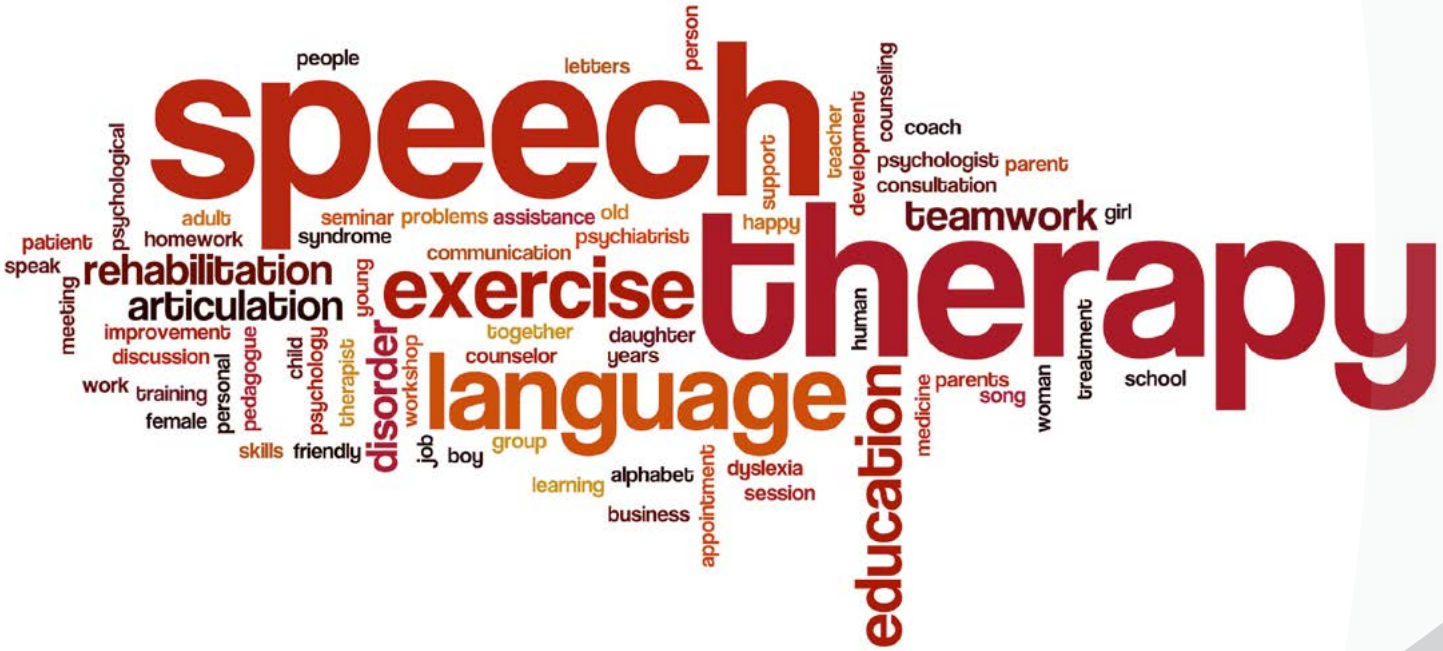
Reminders to practitioners

by Jane Elizabeth Herbert

Practitioners practising in the Speech, Language and Hearing professions in South Africa are reminded

1. To check that they are registered by their Board
2. To update their address and/or other personal details
3. To ensure that they are CPD compliant

Regarding CPD compliance, practitioners are encouraged to be accountable for their own continued development by checking that courses that they attend are relevant, evidence based, and within the SLH profession scopes of practice. This also applies to CPD providers. CPD points cannot be approved for a course, workshop, or training that is not based on reliable research evidence, is not harmful, and does not fall under the scope of practice of the SLH profession.



GENERAL INFORMATIONS

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