Socio-political
Context of CBR
Developments in South Africa

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Introduction

In Apartheid South Africa, the focus of health care delivery and rehabilitation services in particular was primarily geared to the needs of the "white" minority. It also followed a biomedical model not only in the development of its health services but in the training of its personnel as well. This medically oriented paradigm concentrated almost exclusively on university-based training of therapeutic professionals and had a strong Eurocentric focus.

As a result South Africa has not been able to develop a comprehensive national rehabilitation policy, let alone implement such a policy. This does not mean that rehabilitation programmes do not exist. Indeed, there is now a strong movement towards the development of regional and national rehabilitation policy, but until recently, the country's socio-political divisions prevented various participants from joining the ranks. Rehabilitation has yet to be viewed as a serious issue on the political agenda.

Previous difficulties concerning the adoption of a rehabilitation policy in South Africa should be seen in the context of power struggles among the various participants. These are closely related to the political history of Apartheid and the swift developments on the political front since the early 1990s. The situation has been affected
dramatically as the disability movement moves towards achieving new disability rights and equalisation of opportunities. South Africa is finally seriously discussing the development of a rehabilitation policy and the expectation is that South Africa will be able to design systems and structures for the delivery of effective, appropriate, accessible, affordable and equitable services (Government Gazette March 1996).

Every society or social system is inherently predisposed to changes. Social life occurs in the context of two kinds of forces – restraining forces and driving forces – in a quasi stationary balance. Disturbances in this balance, if followed by changes in the structure of the system, result in social change (Ogburn 1960; Ferrinho 1971).

When a social system changes it is natural to expect that the health status of a population would reflect this change. After all, the social system is a determinant of health status (Riley 1994). This process is explained by the concept of health transition, which is defined as the change in the health profile of a population associated with socio-economic development. It involves a shift towards a relatively higher proportion of non-communicable diseases even if the actual mortality rates of these diseases are declining. Concepts associated with the health transition are demographic, epidemiological, and risk transitions. The demographic
transition reflects the influence of evolving patterns of vital statistics (birth and death rates) on population size and distribution (Notestein 1945). Grounded in the demographic transition is the concept of epidemiological transition (Omran 1971). This refers to the changes in patterns of health and disease in relation to social factors. As countries evolve through higher levels of development and social conditions improve, there is a transition to increased survival into older ages, with a relatively greater proportion of morbidity, disability, and mortality from non-communicable diseases (Verbrugge 1984).

Risk transition refers to the changing pattern of disease determinants that accompany social development. Such determinants range from traditional environmental exposures (such as bacterial water contamination) to exposure associated with agricultural development, industrialisation and urbanisation (see chapter XYZ).

South Africa is undergoing a demographic transition along the lines of the contemporary delayed model (see below), which is characteristic of many middle-income countries. In these countries, the change in health status has not been accompanied by the expected high rate of decline in mortality and fertility. Significantly, changes in health status are driven by investments in health care and in technology, but high levels of morbidity associated with infectious and
parasitic disease persist; the rise of degenerative diseases is apparent; there is an increasingly high proportion of mortality and morbidity associated with lifestyle (such as smoking, alcohol abuse, violence, traffic accidents); and the rising life expectancy of people beyond the age of 50 together with high levels of fertility, becomes a crucial factor in population growth. This demographic transition results in an increased incidence and prevalence of disabling conditions and subsequently influences the ability to provide essential rehabilitation services.

The South African socio-political history has greatly influenced the development of several community based rehabilitation (CBR) pilot programmes. Similarly, it set the scene for specific training for CBR personnel, notably the training programme at the Institute of Urban Primary Health Care (IUPHC) in Alexandra, a slum north of Johannesburg.

This chapter examines socio-political influences on the development of CBR in South Africa. It uses the experiences of the CBR training programme at the IUPHC to illustrate some of the most relevant issues. Finally, it makes some recommendations regarding the future of CBR in South Africa.

**About Professional Preservation**

South African rehabilitation services have basically followed Western models of bio-medical intervention. The three
therapeutic professions (physiotherapy, occupational therapy and speech and hearing therapy) have played an active role in this process. As professionals, they have restricted their rehabilitation skills primarily to institution-based therapeutic intervention, focusing more on alleviating functional inabilities than on integrating the person with a disability (PWD) into society. Their scope has largely been dictated by the high-technology medical establishment which accommodated the needs of the "white" minority. Therapy has developed into sophisticated and predominantly acute care services responding to the medical demand. Ninety-eight percent of all state-subsidised physiotherapy services are rendered at - and limited to - secondary and tertiary institutions (Smit 1990). Physiotherapy is primarily found in privately owned practice, mainly in middle-class urban areas, and it is both high quality and highly specialised. However, it is unlikely to contribute to any significant improvement in the health and welfare of the majority "black" population and as such not a meaningful answer to the marked demographic transition.

The relationship between the number of therapists and the population is more favourable in South Africa than in any other African country (Anti-Apartheid Movement undated), yet in spite of the claim made by therapists that they fulfil a key role in the rehabilitation of PWDs, the real needs of such persons are hardly being recognised, let alone being met.
And the problem is not that there are not enough therapists to cover the population in need of rehabilitation services. As long as so many newly qualified therapists open private practices serving the privileged elite, these certainly very relevant professionals have failed to act as responsible bodies.

Statistics on professional registration with the South African Medical and Dental Council (SAMDC) reveal, since the early eighties, a dramatic decline of physiotherapists working in the public sector. In 1988, 2,784 physiotherapists were registered with the SAMDC, only 27% working in the public sector ("black", "coloured", Indian and "white" institutions). This figure was significantly higher in 1983 (63%) and declined even further to 20 percent in 1990 (Smit 1990). These figures were confirmed by an official of the Department of National Health and Population Development who has stated that the private sector in which 80% of physiotherapists work, serves approximately 20% of the wealthy, usually "white" population (Mostert 1994).

To a large extent, universities are responsible for this situation. This is illustrated very well by a lecturer of the University of the Witwatersrand in Johannesburg: "With one notable exception, all universities are at present training physiotherapy students in high-technology academic hospitals,
and their graduates are most competent to practice their profession in these areas both in South Africa and abroad" (Wallner 1992, p 2). No mention is made of the role of physiotherapists in the rehabilitation of the majority of PWDs who live in rural and semi-urban areas. No mention is made of the necessity of informing physiotherapy students and students of allied health disciplines about alternative, possibly more appropriate, strategies of treating disease, disorders, and disabilities within the specifically African context.

Occupational therapists have, to a certain degree, received more training in the area of integration of PWDs into society. However, they have also been confined into Eurocentrism while criticizing the regulations that do not allow them to come out of their institutions. As with physiotherapists, only exceptionally bold and committed people have bypassed the bureaucratic and ideological barriers to become involved in the activities of professional action groups such as the recently disbanded Rural Disability Action Group (RURACT) and the Progressive Primary Health Care network (PPHC).

Probably the most obvious shortcoming of physical therapists has been their failure to acknowledge the individual person who happened to have a disability as an inextricable part of his or her family and community. Arkles (1995) observed this painful shortcoming when visiting a leading Johannesburg hospital for injured mine workers. Noting the excellent
medical care provided she asked, "What happens to these men after being discharged?" The reply from a variety of staff members was, "We don't know". This answer implies that the institution-based therapist is out of touch with the reality of daily life experienced by individuals with disabilities as soon as the hospitalisation ends and necessity compels their clients to go to their shacks in the townships or their huts in the mountains or semi-deserts of South Africa. This leads to situations whereby, for example, people with spinal cord injuries reportedly have been discharged with wheelchairs that they could never use in the steep mountains of Lesotho or the barren sandy grounds of Kuruman. This, in turn, means that the efforts of the few dedicated hospital-based therapists fade away as soon as the person leaves the hospital.

Contact between therapists and patients at homes is usually non-existent. Much competent care and rehabilitation is thus wasted when therapists do not pay attention to the broader needs of PWDs, their families, and community-at-large.

Another illustration of the inefficiency of the rehabilitation system during Apartheid was the predicament of wheelchair-bound people who needed to visit their hospital regularly for follow-up and check-ups. Their hospital was not always the closest one: health care services were segregated on the basis of race and colour. In practice, its resultant harm was evident among "black" paraplegic wheelchair drivers travelling
long distances to hospitals, while passing other "white" or private hospitals. The people themselves with disabilities often had to pay their own travelling expenses from meagre disability grants.

Even harder to understand were the hospital authorities and therapists who (silently) accepted, and thus maintained, this status quo. If they had voiced their outrage about the waste of funds spent on this inefficiency, the quality of life for many people with disabilities, and their relatives, could have been greatly improved.

Conventional training of rehabilitation professionals in South Africa is the responsibility of the medical faculties of seven public universities. While this training equips professionals to deal primarily with an individual's impairments and loss of function, a number of CBR programmes in South Africa focus on the social aspects and consequences of disability. CBR is viewed by PWDs and increasingly by health planners and rehabilitation professionals as a more appropriate rehabilitation approach, based on its goal of empowering people and encouraging subsequent social action.

Since it recognizes rehabilitation as an integral part of a broader community development approach, CBR is a sharp contrast to the medically oriented approach of conventional rehabilitation programmes (Cornielje & Ferrinho, 1993). This
community development approach is particularly important to a transitional society where, until recently, there was a marked absence of democracy and where poverty, the most handicapping of all social problems, is a growing obstacle to an improved life situation for rising numbers of PWDs.

"Hostile" Disability Activists

The national disability movement, Disabled People South Africa (DPSA) which is the leading organization of PWDs has, time and time again, raised its voice against the ambiguous role of rehabilitation professionals, and even more specifically against the role of the conventional charity/welfare movement in the empowerment of PWDs. Conferences on disability issues often end up with conflict among the participants: defensive professionals on one side, outspoken PWDs on the other.

At the same time an increasing number of professionals (mostly therapists) have joined PWDs in their struggle for emancipation. The Rural Disability Action Group (RURACT), an organization affiliated to DPSA, but now superfluous since other democratic structures are in place, was the catalyzing organization facilitating mutual co-operation between professionals and PWDs. Until it disbanded, therapists and PWDs were able to work together, through RURACT, towards the promotion of CBR for rural areas. While this mutual action in itself has had a great impact, the ability of interested parties to bridge the gap between these two groups and form a
coalition in the struggle for appropriate and equitable services has probably been more important. The increased interest of local South African professionals in CBR is certainly a result of the activities of the Rural Disability Action Group.

**CBR training: more then the acquisition of clinical skills**

The coinciding emergence of the disability rights and CBR movements in South Africa is a significant development in the Southern African region. More then in any other Southern African country has rehabilitation in South Africa been promoted as a basic human right of all inhabitants; rich or poor; urban or rural; "white" or "black".

Various CBR models have emerged in several parts - both rural and urban - in the region. One of the models, an urban CBR pilot programme, was developed at the Institute of Urban Primary Health Care (IUPHC) in Alexandra.

In 1990, the IUPHC decided to develop a training course to introduce and prepare a new type of rehabilitation personnel, the Community Rehabilitation Facilitator (CRF) as part of the emerging CBR programme. The institute developed this programme in view of the immense human resource deficit, not only in Alexandra but also in other areas in South Africa. Similar programmes, though with a less explicit social action component, have emerged in other parts of the country.
At the IUPHC, CBR training is a one-year education and instruction programme in which empowerment and social integration of PWDs form the underlying philosophies of the training. Students are selected by a selection panel on basis of educational background and motivation. The training methodology is based on the ideas of Knowles and Freire (Knowles 1980; Freire 1982). Imperative for this training programme, based on humanist and radical views, is a significant focus on developing human resources, the CRFs, in this instance. Such a strong concern with the empowerment of CRFs has been pursued in the conviction that only through their personal empowerment, could appropriate CBR programmes be initiated and developed (Cornielje and Ferrinho 1995).

Besides clinical skills, a very important element of training includes the advancement of knowledge and skills in the area of community development.

The IUPHC training centre believes that disability can no longer be seen as a specific anatomical impairment for which there is a rather simple therapeutic solution. Nor can rehabilitation be defined by finding a therapeutic solution outside the community context. As a result of this philosophy, the training places considerable focus on developing students' attitudes towards rehabilitation. This occurs to such an extent that they see rehabilitation as part of social development.
The training methods encourage active participation by the students in the learning process. Various methods are used, such as role play, problem-solving exercises, group discussions, and experiential learning. Participatory methods are used to optimally address the transfer of skills in the areas of problem-solving and critical thinking (see chapter XYZ). Both these skills are essential for the CRF, who often works independently and as such needs to be able to do new things, to think about local realities and to cope with change in the community.

The first weeks of the course focus on building trust among the participants and enhancing interpersonal skills. Acknowledging the risk of being too abstract and/or theoretical, everyday examples of the difficulties faced by PWDs form the background and framework of the training. This means that both the teaching methods and the course content have to be selected carefully and adapted or re-focused to fit the defined course objectives. For example, the daily struggle by people with a visual disability was made evident when students were blindfolded and asked to construct an animal using Lego blocks while receiving only verbal instructions from their partner. Not only is blindness experienced, but teamwork and problem-solving skills are also fostered, not to mention the trust which such an activity forges.
The training topics focus on specific knowledge about community development and relate to the field of sociology. They include such issues as accountability and community analysis, as well as the concepts of power, community involvement and participation, and primary health care. Also covered are the politics of health care, economics of health care and the impact of the social, ecological and cultural environment on PWDs.

All these issues are discussed in global and local contexts. The course developers were of the opinion that a good understanding of local developmental issues would emerge if the students could appreciate the more global developmental issues. This in effect would help them to critically view, for example, their own limited role in national, regional and local power-politics, while learning to appreciate the need for collective self-reliance and development.

An element of the training strongly related to community development is insight into ones' own attitudes and those of others. Negative attitudes towards PWDs is one of these. Just as important, cross-cultural communication and management styles form the direct basis of the challenge faced by the course leaders and students. A great deal has been learned about the prejudices even educators have, which are often based on Western value systems.
The different disability-aggravating circumstances - such as the prevalence of specific disabilities - that justify different developments of CBR programmes receives adequate attention during training. However, to effectively accommodate students from a variety of different programmes, a curriculum with a certain number of core modules considering the major disabilities plus a number of optional modules has been developed. Besides, the impact of an intervention strategy is considered in both the planning of services and curriculum development. For example, it is debatable whether an intensive module on post-polio paralysis should be included in a CBR training programme because this condition often requires more institutional forms of rehabilitation following to surgery. Yet, CRFs need to know when it is appropriate to refer, encourage PWDs to use secondary and tertiary facilities.

Also addressed are culturally determined factors (such as the extended family, role of religion, attitudes towards time and respect) in community development and health care that influence the management environment in day-to-day relations. In this process of mutual learning, insights are acquired into the dynamics of culture and as such generating a basis for appropriate rehabilitation interventions.

By appealing for solidarity among students, particularly in conflict situations, an attempt is made to reinforce positive attitudes towards communal organization, a typically African
cultural strength in the process of community development. Appreciating one's own cultural values is one of the acknowledged cornerstones in empowerment and of much importance in the process of community development. The value of having cross-cultural communication skills and a knowledge of African cultures are too often neglected, while these should in fact form the foundation of any community development programme.

One influence on the enhancement of cultural awareness is the socio-political context. Considering this issue in a training programme like the rehabilitation course is of utmost importance. During Apartheid, several students were active in liberation movements. This influenced some of the ethical issues that have been addressed. Some participants have felt that they could never provide their services for their political opponents, a topic that has needed careful facilitation indeed. The educators' own Western value system, with a solid belief in medical neutrality, could easily have become an obstacle if the socio-political context (i.e. close family members of the learners were killed) in which these attitudes had developed, was not acknowledged right from the start.

**CBR: Palliation or Liberation?**

Students from different locations attend the IUPHC training programme and develop, during and after training, CBR
programmes in their own communities. Recent evidence shows that CBR programmes facilitated by these students can thrive under very different institutional and community circumstances, taking into consideration the specific needs of PWDs in their specific community (Cornielje, Fernandes and Ferrinho 1994).

The different CBR programmes have succeeded in:
* developing services for and with PWDs in areas where formerly none (or few) existed;
* increasing awareness among the community at large and specifically among health personnel about the needs of PWDs;
* acknowledging that social rehabilitation is a critical area to be addressed by the CBR movement.

In addition, most programmes deploying CRFs have allowed them to take on an empowering role. There is persuasive evidence that support structures determine, to a large degree, the ability of CRFs to fulfill the role for which they prepared at the IUPHC.

The main difficulties and problems encountered and reported during the early phase of programme development relate to:
* the lack of consensus among policy makers and professional therapists regarding what is to be the accepted CBR paradigm;
* the subsequent role of the CRF; and
* the individual performance of CRFs.

The role as change agent that some CRFs fulfill has resulted in significant progress towards empowering of PWDs. There is a general awareness and acknowledgement among health care managers that the CRFs' most important role should be in the area of social rehabilitation since the needs and demands of PWDs are greatest in this area. However, not all CRFs are allowed by their management to take on such a role. This is partly due to the failure on the part of the training institute to sensitize health care managers to the unconventional roles of CRFs. Consequently, in such programmes, a depreciation of the programme's impact was noticed. The lack of a common vision at the supervisory and management levels of the programmes as to what CBR should be appears to correlate with a declining and poor individual performance of the CRF.

On the basis of a recent study (Cornielje, Fernandes and Ferrinho 1994), it seems appropriate to conclude that in most instances there is a common perception by managers, CRFs and clients about what is feasible within the constraints of existing resources. Individual, home-based rehabilitation is very satisfying for clients and CRFs, but has the disadvantage of evolving into individual palliative interventions. Besides, there is the risk of turning into expensive programmes. Most
rehabilitation efforts should be channelled through disability rights movements, self help groups, support groups, income generating projects and other projects in the social area of rehabilitation. These projects appear to guarantee appropriate and sustainable interventions for large groups of PWDs, resulting in more truly emancipation of these people. A significant proportion of the CRFs' time should be spent in supporting the development of these community structures.

Towards a national policy
"You cannot develop by act of Parliament" (Bas de Gaay Fortman 1984)

The risk of copying Western systems of rehabilitation persist, particularly in South Africa where excellent forms of rehabilitation have been available for prolonged periods, be it only to the minority of the country's population. Analysis of the history and experiences of both the IUPHC training programme and the actual CBR programmes set up by CRFs provide a basis for the further "maturation" of policy proposals.

Many resources, provided mainly by local and international non-governmental organizations, have been applied in the development of local rehabilitation programmes. As a result, several interesting models of rehabilitation have emerged in South Africa in spite of its years of isolation from the rest of the world. The experiences of these, often small-scale, local projects, initiated by individuals with and without
disabilities, are worthy of further evaluation and could be used for developing a long-overdue rehabilitation policy.

The regional authorities should use these guidelines as a framework to develop systems and structures for the development and delivery of rehabilitation. The interests of PWDs seem best served if the ultimate responsibility for rehabilitation policy and planning is the responsibility of the national government. As such, national policy should, at least, state firm and binding guidelines that guarantee an appropriate, accessible, affordable, and equitable rehabilitation programme. However, regions should be allowed to develop, on the basis of already existing experiences, their own contextualized rehabilitation programmes in view of the differing geography, infrastructure, and/or culture. This requires, at least during the implementation process, flexibility and a focus on participatory decision-making. Community support should form the basis for policy, planning, and subsequent implementation of rehabilitation programmes.

The scaling-up of the small-scale, bottom-up programmes requires vision and tact: there is a great risk of losing the essence of these specific programmes, community participation. Access to rehabilitation for all will subsequently result in a rise in the costs of rehabilitation. Therefore, the acceptance of whatever rehabilitation system, be it institutional-based
or community-based, should be viewed in terms of macro-economic efficiency. This, in turn, will mean that with limited funding available, the South African government would have only one option: to allow, on the basis of minimum but socially acceptable levels, the development of essential regional and local rehabilitation programmes.

Those who choose to receive sophisticated high-technology rehabilitation, provided for in private practices and private hospitals, could insure themselves or pay individually. This development could mean that the accusation "CBR is for the poor" finally would become a reality!

During 1995, DPSA and RURACT were asked to send one delegate each to the Restructuring Development Programme (RDP) of the Government of National Unity. Disability issues seem to have at last been placed on the political agenda. A major breakthrough is the role given to PWDs and concerned professionals: at the highest level of decision-making, they will contribute towards rehabilitation for all in South Africa. It is hoped that the conventional participants, such as universities, will not be ignored completely, but that they will have a role in which they will learn to use their knowledge and skills not only to help those who are wealthy but also for the sake of the thousands of poor "black" PWDs in South Africa.
Major efforts towards the advancement of CBR should be placed on the development and support of community-based structures. The IUPHC experience shows that the concerns for social change and health transition are best addressed by a community development methodology that guarantees collective problem-solving of rehabilitation issues and joint implementation of rehabilitation plans. This can be done by supporting institutions, including rehabilitation services and voluntary associations in the community, within a common ecological framework.

This methodology supplies the framework to develop CBR as a social movement. The current social and political changes, following the euphoria of the political transition in 1994, present an opportunity to establish a realistic national policy and provide essential rehabilitation for the majority of people with disabilities. The various CBR models signify a need for strengthening the community components. This can only be achieved by organizing communities around their felt needs, fostering and consolidating democracy as an essential characteristic for the long-term success of CBR.
REFERENCES


