20 *Community-based rehabilitation: new challenges*

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Introduction

Community-based rehabilitation (CBR) has been piloted in different parts of rural and urban South Africa since the 1980s. This chapter reports on the implementation of CBR within two contexts in South Africa – in Pietermaritzburg by the CBR Education and Training for Empowerment (CREATE) programme and in Mpumalanga, a CBR partnership programme between Disabled People South Africa (DPSA) and the provincial Department of Health.

The chapter explores:

- Different ways of implementing CBR as a strategy for community development, including rehabilitation, equalisation of opportunities and social integration;
- Two approaches to development of grassroots workers, namely community rehabilitation facilitators (CRFs) and CBR consultants;
- The challenges facing CBR based on the use of mid-level workers and the challenges faced in developing the CBR programme in Mpumalanga, as well as the framework used and the implementation of the CBR partnership programme.

The chapter provides an initial section on the background to CBR, followed by the two case studies. Specific issues highlighted are: the importance of intersectoral collaboration; the nature of grassroots workers; the nature of partnership between Disabled People South Africa (DPSA) and government departments; integration with other formal development and rehabilitation programmes; and the need for monitoring and evaluation of programmes.

CBR developments

In the late 1980s, a number of disabled people and therapists in South Africa became interested in finding an alternative to traditional or conventional rehabilitation services. Traditional rehabilitation services were provided in hospitals, mostly in urban areas, and focused on the deficits of the person with a disability. This medical-model approach to rehabilitation, failed to meet the needs of many disabled South Africans in terms of availability, and appropriateness. As Werner writes:

> conventional rehabilitation tries to change or normalise disabled persons to fit into society as it exists, rather than trying to change society so that it accepts and accommodates to a wider range of human differences. (Werner, 1993, p. viii)

CBR was an alternative that brought the issues of the participation of disabled people, community development and social integration to the fore. Internationally, CBR projects had been initiated in various countries by the early 1980s. In South Africa, three pilot training programmes were set up for CBR workers in the early 1990s. One training project was started in Khayelitsha, Cape Town, at SACLA clinic, another at Tintswalo Hospital, Acornhoek, under the auspices of the University of Witwatersrand, and the third at the Alexandra Health Centre in Alexandra township, Johannesburg.

International context

CBR has been implemented in many different ways throughout the world. The World Health Organization (WHO) published a manual to train local supervisors and family members of disabled people to become involved with CBR (Helander, et al., 1989). The WHO model of CBR has placed a strong emphasis on medical rehabilitation. The International Labour Organisation (ILO) has placed more emphasis on vocational rehabilitation and community integration. In 1994, the ILO, the United Nations Education, Scientific and Cultural Organisation (UNESCO) and WHO came together and drew up a joint position paper on CBR based on their similarities of approach. Their joint paper defines CBR as:

> a strategy within community development for the rehabilitation, equalisation of opportunities and social integration of people with disabilities. It is achieved through the combined efforts of people with disabilities, their families, and communities and the appropriate health, education, vocational and social services. (ILO, UNESCO, WHO, 1994, p. 1)

This definition of CBR, now widely accepted in South Africa, advocates a broader concept of rehabilitation, wider than purely medical rehabilitation. By incorporating social integration, the equalisation of opportunities and community development into the definition of CBR, the three UN organisations indicate an approach to CBR that is more in line with the social model of disability. In addition, the participation of disabled people and their families is seen as an integral part of CBR, rather than an optional extra, as often happens in conventional rehabilitation.

In spite of the support for this definition of CBR, Disabled Peoples International (2003) argue that CBR is still medically oriented in some regions and, in some cases, disabled people's ideas and concerns are not given equal weight to those of professionals. Lang (1999) concurs and indicates that many CBR projects are managed without much input from disabled people or local people. Miles

(1996) points out that in a number of cases there has been a divide between CBR programmes and disabled people's organisations (DPOs) and that some CBR workers have dismissed the value of working with the disability rights movement.

According to Miles (1996), the goal of CBR programmes should be to empower disabled people to control their own lives and play a key role in services for themselves. An international review of CBR in 2003 indicated that there has indeed been a marked shift in emphasis in CBR programmes towards the empowerment of disabled people (WHO, 2003). The definition of CBR has been reviewed to shift the focus to the equalisation of opportunities, poverty reduction and social inclusion of disabled people (WHO, 2003). The question of ownership of CBR programmes by disabled people's organisations (DPOs) has received more attention and is receiving more serious deliberation. The promotion of disabled people's rights is seen together with the promotion of their responsibilities to contribute maximally. The dissemination of information as a resource has been highlighted. The concept of interdependence of the different stakeholders and DPOs to achieve the goals of CBR programmes is gaining more recognition, though more research that focuses on the nature of local resources and participation in CBR programmes is needed (Finkelflugel, 2004). With the shift from focusing on individual need to seeing disability as a universal right and part of community development, research is beginning to show how CBR is making a difference in significant ways. More people have started to participate and gain access to resources. Coleridge (2004) encourages us to keep faith and hope alive.

Internationally, there is a range of options in terms of personnel to carry out and run CBR programmes. A number of CBR projects use the WHO model in which local supervisors (who may or may not be volunteers) work with family members of the person with a disability (Jaffer & Jaffer, 1994; Valdez & Mitchell, 1999). A number of other projects use volunteers who are given several weeks of training and become grassroots CBR workers (Thorburn, 1994). In some countries, including South Africa, mid-level rehabilitation workers may be employed in CBR programmes. There are also likely to be managers of CBR programmes who may come from a variety of professional or other backgrounds. Depending on the project, some personnel may be disabled people or family members of disabled people.

Case study 1: implementing CBR through mid-level workers in South Africa

One of the pilot CBR training programmes in South Africa was set up in 1990 at Alexandra Health Centre by the Institute of Urban Primary Health-Care (IUPHC). The IUPHC training programme trained mid-level CBR workers, known as community rehabilitation facilitators (CRFs), in community development as well as social and physical rehabilitation, for two years. The CBR projects that developed around the country using CRFs thus represent a model of CBR that

uses mid-level CBR workers who are employed to provide services that include community development, physical rehabilitation, social integration and the equalisation of opportunities.

The CBR training, started at Alexandra, was then continued in Pietermaritzburg by CBR Education and Training for Empowerment (CREATE). The training consists of modules that integrate skills in community development and aspects of physiotherapy, occupational therapy, speech therapy and social work. This multi-skilling of CRFs has played a crucial role in offering an integrated service to disabled people and their communities. CRFs are encouraged to bring disability issues into any development projects in their areas and to work with disabled people to overcome negative attitudes and other barriers to inclusion. The CBR training programme enables CRFs to work individually with children or adults with disabilities to improve their ability to function independently. CRFs are also taught to set up and work with support groups, and to work with disabled people's organisations if they exist.

Since 1990, approximately a quarter of all trained CRFs have been disabled people or family members of disabled people. Although the IUPHC and subsequently CREATE have recommended that students selected for the course should have experience of disability, many of the organisations that send students to the course do not adhere to this recommendation. In CBR projects where the CRF is disabled, we have noticed that there is greater commitment from the CRF to the project. Disabled CRFs also often have greater empathy with their clients. Greater ownership of the CBR project by disabled people is also possible when a local disabled person is chosen and trained as a CRF. In the Drakensberg area of KwaZulu-Natal, all the CRFs are disabled and the CBR programme has been monitored by a local organisation that includes disabled people. Three of the CRFs worked for several years as volunteers before becoming employed to do CBR. This is quite remarkable, given the usually high turnover of volunteers in CBR projects (Crishna, 1999).

Since the mid- to late-1990s, CRFs have been able to register with the Occupational Therapy Board of the Health Professions Council of South Africa. This has enabled CRFs to be employed in posts as therapy assistants within the Department of Health. However, this also means that the Occupational Therapy Board has to accredit the CBR training, and when the policies of the Occupational Therapy Board change, this affects the CBR training. Currently, the CBR course run by CREATE in Pietermaritzburg is accredited until the end of 2006. At this point, the changing policy of the Occupational Therapy Board dictates that, if it is to be accredited, CREATE will have to train occupational therapy technicians rather than CRFs. Eighty per cent of the course will need to be concerned with occupational therapy knowledge and skills while only 10 per cent of the course will be allowed to focus on community development, and another 10 per cent

will focus on skills from physiotherapy and speech therapy. In essence, the very nature of the CBR course would have to change. This illustrates the danger that can befall CBR and CBR training if it becomes too focused on one sector (in this case, health). As the ILO, UNESCO, WHO (1994) definition suggests, CBR should at least be involved with health, education, welfare and labour sectors.

The model of CBR based on the employment of mid-level CBR workers (CRFs and community rehabilitation workers) has meant that communities and disabled people receive services broader than therapy alone. Another achievement of this model has been that over 100 disadvantaged urban and rural communities now receive rehabilitation and disability services through the employment of CRFs and community rehabilitation workers (the latter trained in Bushbuckridge). Many of these disadvantaged communities now have active DPOs or support groups where none existed previously. In these communities, the CRFs work with the support groups or DPOs, although, as in other international CBR programmes, there may not be full ownership and participation by disabled people. Two examples follow to illustrate what CBR can be like if implemented with the help of CRFs.

One of the concerns of CBR is the equalisation of opportunities for disabled people. In a small town and rural area in KwaZulu-Natal, the CRF decided to tackle the difficulties that disabled people experienced with public transport. In particular, it wanted wheelchair users to have equal access to taxis. At that time the local taxi association had a practice of charging double fares for wheelchair users. The CRF ran a disability awareness workshop with the taxi owners. The taxi owners then requested that similar workshops be run for the taxi drivers. The CRF, together with her supervisor, ran these workshops. The result of these workshops was a change in attitude by the taxi association, and consequently, they stopped the practice of charging double for wheelchair users. In addition, at the time of Yellow Ribbon Day, the taxi association made nine taxis available free of charge to transport disabled people from the rural areas to an event in Pietermaritzburg. The intervention of the CRF with regard to public transport in this area has had an impact on the equalisation of various opportunities for disabled people. Not only do disabled people now have equal access to public transport, they also now have easier access to health care, potential employment and other services offered in the town.

The ILO, UNESCO, WHO definition of CBR (1994) states that CBR is part of community development. Community development encompasses many activities that may uplift a community. A CRF working in a peri-urban area near Durban has been involved in a water and sanitation project in his community. The *nkosi* (chief) of the area approached the CRF and requested his involvement in a project to bring running water and sanitation to the homesteads of this area. The CRF participated in the meeting between the *nkosi* and the local eThekwini municipality and was able to advise the municipality of what adaptations would

need to be made to meet the needs of disabled people. At the request of the municipality, the CRF was then involved in a project to map all the homesteads of disabled people where adaptations would need to be made to the planned water and sanitation system. Now, those disabled people who have needed it, have had toilets installed with ramps and the water tanks are supplied with taps and a locking mechanism that are at a suitable height for wheelchair users.

The involvement of a CRF in this water and sanitation project is a good illustration of what can be achieved when CBR is implemented in a comprehensive way. Community development no longer only benefits nondisabled people; disabled people are also beneficiaries of any development. In this example, CBR is so much more than rehabilitation or therapy at a community level. Yet in the current set-up, CRFs are the only employed grouping that would provide such services. As illustrated in this case study, CBR should not be restricted to rehabilitation or therapy, as it can reach so many more people through the emphasis on community development.

Where there is a focus on the removal of barriers experienced by disabled people in a CBR project, social action may result. One CBR student studying at CREATE formed a CBR committee in his community to oversee and guide the implementation of CBR. The committee was made up of disabled people, the CRFs, a youth representative and representatives from local non-government organisations. The local councillor was invited to join the committee, but he did not attend any of the meetings. One of the first priorities identified by the CBR committee was the removal of barriers to community participation experienced by disabled people. The barriers the committee identified included a lack of sign-language interpreters at community services, negative attitudes of community members and the councillor, and physical barriers such as steps. The committee decided that it would be appropriate to hold a march of disabled people who would present a memorandum of their demands to the local councillor. The march would make disabled people visible in the community and hopefully this would help to change attitudes. The march took place on a Saturday between the community hall and the local taxi rank. Representatives of the municipality did not arrive, but the memorandum was read out to all those present. Community members and taxi drivers listened as disabled people and some of their family members spoke to the gathering about their experiences of disability and the barriers they encounter in that community. The memorandum was later delivered to the municipality. This event not only served to make the community aware of disability, it also encouraged and empowered disabled people to speak for themselves.

Social integration of disabled people is another key component of CBR, as defined by ILO, UNESCO, WHO (1994) and WHO (2003). Social integration can happen in a number of ways and CRFs have approached this aspect of their work from an

individual and family level, as well as from a community level. One CRF working with a disabled person in a wheelchair in Gauteng recognised that the disabled man was socially isolated and found that one of the causes of this isolation was that there was no ramp at his front door. The CRF discussed the need for a ramp with the man's family. On her next visit, the CRF found that the family had built a ramp at the front door and they had improved access at the gate. The disabled man was not at home, as he had gone to visit his friends!

Another CRF approached social integration from a different angle. She had heard that at a local church disabled people were being made to sit behind the door of the church during services because they were 'sinners'. A disabled person herself, she approached the priest and discussed the rights of disabled people. Although it was difficult to change the priest's ideas, her intervention meant disabled people were then allowed to join the rest of the congregation in the main section of the church. In the same area, at another church, the priest himself was disabled. Many members of this congregation were refusing to take communion from this priest because of his disability. Again the CRF was involved in raising awareness of disability, this time with members of the congregation. The outcome of this work was that the congregation became more accepting of their priest.

These examples illustrate that CBR is certainly more than a health concern, although in South Africa it is generally the Department of Health in different provinces or health-related non-government organisations that have taken CBR on board. Most CRFs incorporate aspects of social services (such as helping disabled people access disability grants) in their work, as well as health-related activities and sometimes working with education authorities.

This intersectoral nature of CBR is also illustrated in the work of one CRF employed at a special school in KwaZulu-Natal. The 2001 Education Department's White Paper 6: *Building an Inclusive Education and Training System* (EWP6), sets out government's strategy for making the education system responsive to and inclusive of learners who experience barriers to learning (which includes disabled learners). One part of the strategy is to identify and include youth and children who are out of school. The national Department of Education piloted a study of the implementation of EWP6 and inclusive education. One of the research sites of this pilot study was a special school that already employed a CRF. The CRF became involved with the pilot project, specifically with identifying and locating youth and children who were out of school. She managed to find a number of these children and youth in the area, and through the pilot project, some of these learners were placed at schools. The national Department of Education commended this research site as being the most effective of all the sites of the pilot project in finding out-of-school youth and children. In addition to this work, the CRF is also involved in activities with staff from the district Department of Health. She works with therapists to bring rehabilitation to children in a local

day-care centre for severely disabled children. This CRF has also worked with a group of disabled adults who started an income-generating project. If the CRF was to restrict her work to one sector only, for example education, her service to the community would be incomplete and would probably not meet the needs of disabled people in the area.

This case study illustrates that CBR is multifaceted and cannot be reduced purely to rehabilitation. The equalisation of opportunities and social integration of disabled people are equally important aspects of CBR and are promoted by CRFs. Although not all CRFs are involved in projects and activities such as those mentioned above, the studies illustrate what is possible when a CRF is included in the implementation of CBR.

Case study 2: the Mpumalanga CBR Disability Support Programme

Most debates about CBR have contributed little to the empowerment of disabled adults and parents of disabled children, and this is a matter of great concern. Since 1998, the Mpumalanga Department of Health has had a formal service partnership with two provincial DPOs for the delivery of CBR, of which one is an agreement with DPSA Mpumalanga for the implementation of community-based disability-support services.[1]

The majority of the disabled children and adults living in Mpumalanga Province live in conditions of abject poverty and isolation. Rehabilitation professionals have found it very difficult to provide effective rehabilitation services, including community support services, due to the wide gap between professionals and disabled people. This gap is due to low literacy and empowerment levels among people with disabilities and cultural and language barriers. At the same time, however, DPOs strive to give their membership the greatest possible measure of social and economic participation and independence, irrespective of the nature and origin of their impairment.

In 1994, the Mpumalanga Department of Health's rehabilitation services were limited to 4 out of 27 provincial hospitals. These services reached about 500 people per annum out of a total of 3.1 million people in the province. However, there were numerous CBR activities through the efforts of DPOs in the province. All of these activities were community-initiated. Thus, the challenge for the Rehabilitation Programme of the Mpumalanga Provincial Department of Health was how to build on what was already there. Services in the province needed to be developed to make them accessible to everyone, but the challenge lay in how to develop these services. It was recognised that there was a need to develop a plan of action involving all stakeholders.

The process of developing a model

Certain principles underpinned the framework used to develop CBR as an appropriate model of service provision in Mpumalanga. The process took two years of negotiation (1996–1997) to reach agreement on the model for implementation.

The first component focused on the need to establish meaningful and equal partnerships between all stakeholders. Regular meetings created a space for debate and dialogue so as to reach consensus and mutual understanding about the definitions of disability and the meaning of CBR, as well as to build trust within the partnership. It was important to develop an understanding of disability as a human rights and development issue, and link that with rehabilitation services. In this way, the partnership was achieved.

The process also enabled a review of current practice and an appreciation of the strengths of the model and aspects that should be changed. Arising from this was a common understanding of service delivery, and a package of required services was developed. The CBR Disability Support Service was designed to provide disabled people with the tools of self-empowerment. The programme's long-term objective is to facilitate social re-integration, development and poverty alleviation of and for disabled people, which corresponds to the key outputs of the Provincial Rehabilitation Programme of the Mpumalanga Department of Health. Addressing disability issues requires the active participation of disabled people themselves. It was imperative that the outcomes of interventions should be empowerment-orientated. The programme was initially piloted in 1998, with DPSA as the service provider.

Principles for service delivery

Implementation followed principles identified by the stakeholders. Disabled people would participate equally in decision-making and not just as passive recipients of services. Services would be based on needs identified by people with disabilities themselves. Family involvement formed a key aspect of the rehabilitation process. As such, partnerships between the client, their family and rehabilitation personnel formed the basis of rehabilitation service delivery. Peer support is seen as a central part of the rehabilitation programme and the development of peer counselling services receives priority. Rehabilitation services should be provided as close to home as possible.

Implementation

The implementation takes place through disabled people contracted by DPSA to render the following services at community level: the identification of disabled people; the provision of information about their rights and available services

to disabled people; peer support and counselling as well as family counselling; raising awareness on disability rights in order to reduce discriminatory attitudes; and referring disabled people to relevant health, rehabilitation, education, social and employment services.

The CBR consultants sign an annual performance agreement with, and are accountable to, DPSA through their community-based organisations or self-help groups. They are paid on an hourly rate based on performance. Initial training focuses on disability rights, government service-delivery mechanisms and systems, basic counselling and communication skills and advocacy and awareness. Follow-up training is needs based. The pilot project was implemented in Ehlanzeni District, then known as the lowveld region, as rehabilitation services in general were under-developed in the rest of the province. DPSA's administrative capacity at the time was also weak. The results of the pilot were overwhelming, with over 400 people with disabilities accessing the service in a six-month period. In 1999, CBR, implemented in partnership with disabled people, became part of formal rehabilitation service delivery, but was still only implemented in the lowveld region to ensure sustainability. The project was extended to all 17 municipalities on 1 November 2000.

Some successes to date

The programme provides support to DPOs, while identification and referral of adults and children with impairments to relevant services increased. Dissemination of information relating to disability was made a priority, and disabled consultants were trained in peer counselling as well as facilitating access to assistive devices in order to enhance social rehabilitation and integration.

- Thirty-one unemployed activists with different disabilities were contracted as CBR consultants. They have been trained by DPSA Mpumalanga to render a service in all 17 municipalities in Mpumalanga.
- More than 35 000 people with disabilities and their families were reached between 1997 and 2004. They have been provided with information about their rights and disability services. People with disabilities have been referred to different social services and as a result disabled people have had access to assistive devices such as wheelchairs and hearing aids (many for the first time). Also, children are going to school and are receiving formal rehabilitation services for the first time;
- A wide network including district education authorities, welfare authorities, paralegal advice centres, non-government organisations and the South African Human Rights Commission has been established with the aim of improving access to opportunities for people with disabilities.
- People with disabilities now have access to peer support and information whilst still in hospital immediately after the onset of disability – this directly impacts on the success of formal rehabilitation services

- Community-based organisations of disabled people are experiencing a tremendous growth as a result of the increased advocacy within communities.
- People with disabilities are accessing appropriate HIV/AIDS information for the first time.

More specifically, from 2003 to 2004, the successes of the Mpumalanga CBR Disability Support Programme include:

- 12 061 new clients with disabilities were identified and received information on services and available opportunities for people with disabilities.
- 29 unemployed disabled activists with different disabilities, including parents of disabled children, were contracted as CBR consultants for the implementation of services. Economically, this has liberated them from abject poverty, as they all earn between R 1 500–R 2500 per month.
- A total of 9192 clients were referred to therapy and orthotic prosthetic services provided at public hospitals, community health centres and clinics, and to local schools and special schools via the education district office, pension officers and social workers, and home affairs officials.
- An estimated 53 children with disabilities that were outside the education system as a result of the programme have accessed education for the first time.
- An estimated 882 people with disabilities accessed assistive devices that enabled them to move around more freely, leave their homes, participate in community activities, look for jobs, and communicate more easily.
- Nine new self-help groups of disabled people have been established as a direct result of the CBR Project.
- Three CBR consultants and a provincial administrator accessed permanent employment through their involvement with the project.

To date, the programme has had a direct impact on the quality of life of people with disabilities, and contributes significantly to the accessibility of services, especially in rural areas. It costs only R125 per individual, per annum to access the service.

The programme forms a vital component in maximising the impact of community service therapists, as it ensures sustainability and continuity of services within an identified community-based knowledge system.

The CBR project has significantly contributed to the expansion of formal rehabilitation services. There are a total of 120 rehabilitation professionals working in the province with formal rehabilitation services in 24 of the 27 provincial hospitals, and monthly outreach rehabilitation to 154 clinics and community health centres and to 109 pension pay points.

Key lessons learnt from the Mpumalanga programme

The programme managers and stakeholders have identified various issues arising from reflecting on and monitoring the programme on a continuous basis.

Partnership

One of the key challenges was to understand and work out answers to the question, 'what does an equal partnership with disabled people really mean?' It is crucial to understand that building partnerships is an ongoing process, not a once-off activity, we have to keep on committing ourselves to this as people come and go. This might sound obvious today with the benefit of all the knowledge developed and accumulated over the past seven years. Yet it is my firm belief that it is as difficult today, if not more so, as it was nine years ago, to really commit ourselves to meaningful and equal partnerships that are devoid of suspicion, paternalism, pretence, anger and rubber-stamping.

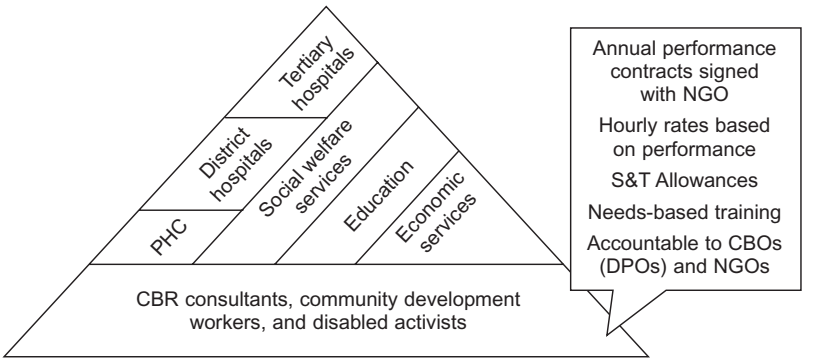
Professionals and DPOs in Mpumalanga had to learn by listening to one another. A fundamental principle underlying our partnership is the principle of consensus building – it is a relationship of give-and-take between the different stakeholders involved. The *Integrated National Disability Strategy* (ODP, 1997) provided indicators of successful partnerships, noting that they require the full participation of DPOs and parents' organisations, and the recognition that DPOs play a key role in CBR.

There was a need to recognise that rehabilitation is a means to an end, and not an end in itself. Therefore, there is a critical need for rehabilitation personnel to link with other disability services and programmes (for example, around education, social services, employment, housing, transport, etc.).

There was a need to distinguish between different levels of service and to identify a clear role for each – namely, CBR, outreach services (understood to comprise services rendered by professionals based at centres outside the community, for example, hospitals and clinics), and hospital-based services.

It is recognised that there is currently a gap in terms of specialised services for people with disabilities. CBR provides the framework and philosophy of the rehabilitation package. We have learned together the importance of localising the model – to start small and learn together in partnership. Expansion then follows rapidly.

Figure 20.1: CBR partnership programme: an implementation model



Intersectoral collaboration

For the CBR programme to be successful, it has to have formal links with the Departments of Education, Social Services, Health, Labour and Housing as shown in Figure 20.1. It also needs to have formal links with programmes focusing on economic empowerment of people with disabilities. In reality, effective interdepartmental co-operation and planning of service delivery at provincial, district and community level is minimal and is a major challenge in the implementation of the programme. Over the years, some intersectoral collaboration has been achieved at a community level, although this is happening on an ad hoc basis and not within formalised systems. One of the reasons for this could be the lack of an intersectoral policy framework and therefore no intersectoral budgeting for activities of this nature.

Disability-specific focus

Sometimes people ask why there is a need for services to specifically focus on disabled people. Disability is a complex multi-faceted issue. There are numerous opportunities for disabled people, but few people are able to access them as a result of attitudinal, physical and communication barriers. There is a need to facilitate the process whereby disabled people can access resources and services to which they are entitled. This programme helps to bring people up to the 'starting line', as previously they have been disadvantaged, and so they are starting at a level that is below that of other people. There is a need to create opportunities for disabled people to be providers of services, not always being only recipients of services. Lastly, CBR consultants become disability resource persons, and this contributes to community development in the areas where they work. Access to enabling services for disabled people opens up participation opportunities for people with disabilities to contribute meaningfully to community development processes.

Integration

One of the factors contributing to the success of the CBR programme is that it has been integrated into the formal rehabilitation programme of the Mpumalanga provincial Department of Health. The CBR disability support programme is integrated into the rehabilitation referral network, thus enabling identified people with disabilities to access appropriate formal rehabilitation services. However, it is important to localise the model as well as to harness resources in the community. The overall co-ordinator of rehabilitation services has an excellent grasp of how to work with the political structures and different levels of government.

The role of the Office on the Status of Disabled People

This case study would not be complete without giving recognition to the important role of the Office on the Status of Disabled People (OSDP) in the Office of the provincial Premier. The OSDP has been a major force in promoting a perspective of disability as a human right and development issue as well as bringing together stakeholders.

Being able to use the OSDP as a sounding board and support structure, as well as being part of broader disability equity processes through the OSDP, enabled the rehabilitation programme to develop a broad vision and context within which to work, adapt, negotiate and advocate for more enabling and sustainable rehabilitation services and partnerships. It has therefore also served as a tool to reassure us in challenging times and to give us the energy to remain focused and persevere.

'Nothing about us without us'

In concluding this case study, the joy and fulfilment of working with children and adults with disabilities lies in the slogan of DPSA and Disabled Children's Action Group: 'Nothing about us without us'. Seeing people who previously were downtrodden, depressed and unable to assert themselves suddenly have the courage and skills to challenge bad practices in government services and non-government institutions should not threaten us. Rather, it should give us courage to go on, as we are achieving the ultimate aim of CBR – empowering people to take control over their own lives.

The Mpumalanga CBR programme has shown that real partnerships with communities are essential for sustainable socio-economic development. Also that affirmation of disabled people contributes to them playing active and leading roles in society.

Priority challenges for the way forward for CBR in South Africa

The work in Mpumalanga and KwaZulu-Natal illustrates the value of CBR together with the need for consensus-building on the future of CBR within the South African context. The liveliness of the debates amongst the three authors in the writing of this chapter was evidence of what is needed on a larger scale. The key challenges faced by stakeholders and practitioners in implementing CBR in South Africa have been debated in an attempt to identify priorities for the way forward (Philpott, 2004).

There is a need to broaden our understanding of disability. A broader understanding must recognise rehabilitation as an enabling process to promote poverty alleviation, community participation, economic empowerment and development, and survival of people with disabilities. Is the concept of independent living relevant in a South African, or indeed any social context? Conflict between the different stakeholders involved in CBR needs to be channelled constructively into developing new knowledge related to effective strategies for implementation, and the training of future service providers. The *Integrated National Disability Strategy* (ODP, 1997) and *National Rehabilitation Policy* (DoH, 2000) need to develop implementation mechanisms that could contribute to growing a common understanding of CBR as a strategy in community development to alleviate poverty. In this way, sustainability of CBR initiatives would be fostered.

In a number of situations the implementers of CBR programmes have to account for their work in terms of health-related activities, rather than considering the broad outcomes of CBR, including equalisation of opportunities and social inclusion. For this reason, a challenge facing South Africa is to gain a broader understanding of the outcomes of CBR. A key challenge lies in the principle of recognising rehabilitation as a means to an end and not as an end in itself. As a strategy within community development, CBR could contribute to the service delivery agendas of different government departments such as primary health care, inclusive education, social development and poverty alleviation. There is a need for the development of an interdepartmental policy framework for CBR with clear mandates and role clarification for different stakeholders. The plan would include a budgeting framework that would allow for contributions from all stakeholders. It is important that CBR programmes build alliances and facilitate collaboration among a wide range of stakeholders.

The challenge facing people involved in CBR is to bring the issue of CBR to the provincial and local levels of government and to encourage support and resources from the various government departments that could be involved. There is a need for strong formal partnerships (an underlying principle of CBR) between DPOs and professionals employed by government or non-government organisations. This challenge extends to those involved in CBR to form closer ties with DPOs. Cornielje (1993) and Miles (1996) write about urban based CBR projects in Alexandra township in Johannesburg and Amaoti informal settlement in KwaZulu-Natal

that have been closely linked with DPOs. Another challenge lies in recognising the role that DPOs play in the implementation of CBR. In a number of cases the formation of community-based DPOs are the result of CBR projects that empower and motivate disabled people to come together. However, it is necessary that the contribution these initiatives make to the outcomes of CBR be formally recognised. The challenge, therefore, lies in including DPOs in the accountability chain and governance of CBR programmes. At a district and provincial level CBR will benefit from close partnerships with DPSA and other DPOs. If CBR projects become accountable to disability organisations and not only to the employer, this will enable CBR to be implemented with and not for disabled people. In situations where disabled people become CRFs or CBR consultants, the disability sector has a direct stake in CBR.

The need to develop an accredited training for mid-level workers in order that they can be registered and employed in South Africa remains a contentious issue. With the impending change in the accreditation of mid-level CBR training by the Occupational Therapy Board of the Health Professions Council of South Africa, it is important to evaluate what skills personnel working in CBR need. The proposed change in course outline is likely to produce Occupational Therapy Technicians who have a health bias and who do not have in-depth community development understanding and skills. Personnel trained on such a course are likely to focus on rehabilitation, with less consideration for equal opportunities and social integration.

Increased collaboration between professional therapists, mid-level workers, CBR consultants and stakeholder sectors has yet to be achieved throughout the different provinces. Institutions of higher education involved in training health-care professionals and social workers bear responsibility for ensuring that these challenges are addressed in the curriculum. The challenge is to locate the training of CRFs within a community development framework. The Department of Public Service and Administration and the Department of Provincial and Local Government are in the process of training community development worker cadres through a learnership programme which will implement community development programmes. The challenge for existing CBR programmes is where and how the interface with these programmes will happen.

There is ample evidence of the urgency to raise the profile of CBR in South Africa. This can be achieved by increasing awareness of the value of CBR at national, provincial, district and local government levels, but requires documentation and publishing of CBR programmes in South Africa. Many stakeholders and donor agencies have voiced concern related to the lack of published documentation and research in South Africa. Such publications could present evidence of the value and impact of CBR in particular communities. It seems the time has come to revive networks such as the Rural Action Group on Disability, which was very active

prior to the 1994 democratic elections in South Africa. Such a structure is needed to advocate and lobby nationally, provincially and at local government level for changed attitudes towards, and a better understanding of, CBR.

Delegates involved in international consultations on CBR need to give feedback to the grassroots structures such as DPOs and community development and health forums, higher education institutions and centres. To establish a system to continually monitor and evaluate CBR and the training of practitioners and grassroots workers at different levels of governance, is to ensure continuity along the continuum of service delivery. Linked to such a structure is the need to establish funding channels. The revival of CBR networks and gatherings to discuss the value and impact of CBR in South Africa would provide a means to co-ordinate information on CBR, together with the benefits of identifying a CBR research agenda.

The two case studies in Mpumalanga and KwaZulu-Natal demonstrate the challenges involved in ensuring these projects are sustainable, as well as showing the urgency of integrating different approaches into policies, alongside rigorous monitoring and evaluation. The two approaches complement each other to provide the means to disseminate information and the means for early intervention with sustained follow-up and development. The vision of equal opportunities, poverty reduction and social inclusion of disabled people and their families can then become a reality!

Note

1 This case study is adapted from a paper presented by Milani Wolmarans, Rehabilitation Programme Manager in the Department of Health, Mpumalanga, at the CBR workshop held at Valley Trust, 28 June 2004.

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