How Cultural Diversity Impacts on Service Delivery in Rehabilitation in Sisonke District, of KwaZulu-Natal by Sibusisiwe Consolate Felicity

Key Message

To raise awareness and understanding on how cultural differences impacts on rehabilitation services in Sisonke district

Everyone has a right to equal access to quality rehabilitation services regardless of their race, ethnicity, gender, disability, age, etc. However there is inequitable provision of rehabilitation services to clients due to different cultural backgrounds of clients and therapists. This document will be discussing how the following cultural differences can limit equitable provision of rehabilitation services in Sisonke district through:

- Language
- attitudes
- beliefs
- age

According to Batho Pele principles (South Africa Health service delivery model), clients should be provided with the best services using all available resources. It also emphasizes the importance of asking our clients what they want and finding out how we can best meet their needs. As service providers it is our responsibility to inform our clients on the aims and objectives of Batho Pele principles.

In Sisonke district the blacks form the majority group and the Coloureds, Indians and Whites form the minority racial group. Although Xhosa speaking and Zulu speaking people are from the same racial group, they are of different ethnic groups.

In Sisonke district the predominant languages spoken are isi-Zulu and isi-Xhosa. Language barriers still have a negative impact on rehabilitation services as the therapists are not able to effectively communicate with clients. This results in difficulties in:

- promoting meaningful relationships with clients.
- obtaining the clients needs and consents
- raising awareness
- assessment and screening

• the reviewing their intervention programmes and to be able to stress the importance of therapeutic intervention.

It also results in therapists and clients limited ability to expresses their needs regarding the level of services rendered. This then generally compromises the quality of rehabilitation services and hence the need for interpreters to bridge the communication gap effectively.

The use of interpreters:

- does not promote effective communication as they are not exposed to medical terminology and therefore the value of information is lost.
- increase time spent with one client.
- does not encourage confidentiality as interpreters currently used are not trained professional.

Understanding the racial groups of the community that therapists serve. This will lead to effective interaction and therapeutic intervention as most therapists do not speak and understand isi-Zulu and is-Xhosa.

The attitudes of therapist towards the understanding of clients with disabilities should not be biased thereby preventing discrimination of clients. If therapists have inadequate understanding of dealing with clients with E.g. a therapist that does not have knowledge on how to interact with a client using the wheelchair, one that is blind or deaf cannot provide quality services to these clients. This leads to decreased access to rehabilitation services.

The attitudes of therapists who are not sensitive to the environment of their clients also have an impact on provision of rehabilitation services. Since most clients are from rural areas and are affected by poverty, they may have to walk long distances to access services. Most clients may therefore not afford to buy toiletries. To deal with this some therapists end up using gloves when treating clients which is extremely insulting as it suggests that clients have germs or infectious diseases. Clients will therefore perceive service rendered as of poor quality.

The attitudes of therapists based on the medical model, results in therapists seeing the disability instead of a client with the disability thereby emphasizing that therapists knows the needs of clients without consulting them. Therapists mainly rely on referral to know the need of clients without asking them. Clients end up feeling disrespected and discriminated. E.g. a therapist once told the client that he does no need a motorized wheelchair since he is able to use his hands before assessing the clients needs.

Therapists do not understand the beliefs of clients resulting to clients refraining from therapeutic intervention. Clients believe in traditional healing i.e. a mother of child with spastic cerebral palsy who has developed contractures while she was seeking alternative treatment. Others may believe that God will heal them and therefore do not continue with treatment regime. This understanding of the belief of the clients will help therapists to handle the issues sensitively thereby improve service delivery.

Therapists need to understand the effect of age difference when dealing with older clients as they are younger therapists. Especially when dealing with issues that those clients do not discuss with younger people i.e. reproductive health and sexuality. Discussing these issues may end up with client refusing intervention. This may result in secondary complications and management difficulties).

The community module, which raises awareness to cultural diversity, was introduced by Universities in South Africa to prepare students to become rehabilitation therapists.

In 2003 the department of Health introduced rehabilitation community service programme to facilitate access to rehabilitation service delivery between health facilities and the community. These strategies are crucial for effective rehabilitation service delivery. According to Rehabilitation Cultural Diversity Initiative (RCDI) it is the responsibility of rehabilitation service providers to promote opportunities to enhance equal access and quality services for individuals who are culturally diverse As therapists therefore we need to understand cultural diversity as crucial tool to deliver effective rehabilitation services. The social model looks at the individual holistically (physical, social, spiritual and psychosocial). Understanding of clients holistically will enhance ability of therapists to accept the clients and thereby improved the quality of service delivery.

Community Based Rehabilitation as a vehicle of empowerment for people with disabilities in accessing equitable Health Care by Mncedisi Christian Lodwyk Mdunyelwa

The Executive Summary:

The point of departure of this document is twofold:

Firstly, it explains why CBR can be used as tool to facilitate equitable and quality health care for PWDs and

Secondly, it proposes the development of CBR policies.

CBR increases participation of PWDs and their families in the development and provision of health care services. It encourages a process of self development of PWDs.

CBR as a tool for service delivery require substantial changes in conventional rehabilitation systems. These include:

* technology;

*service delivery systems;

*decentralization of decision-making;

*community involvement with emphasis to DPOs;

* inter-intrasectoral collaboration.

The PWDs can meaningfully contribute to the transformation and implementation of service through capacity-building. This include:

* planning, implementation and monitoring skills;

* peer support and counseling skills;

* communication skills.

The CBR views disabled people and their families as the best resource to handle the daily training and care for the disabled people. Its programme seeks to integrate the interventions of all relevant stakeholders. It further promotes the full representation and empowerment of PWDs.

On this basis, policies and implementation strategies need to be developed in the province of KwaZulu-Natal.

Actual Article

The role of Community Based Rehabilitation (CBR) in facilitating equitable health care for persons with disabilities (PWDs)

The South African Constitution (Act no. 108 of 1996) guarantees the right to quality health care for all. Further, government legislation and policies such as: the Promotion of Equality and Prevention of Unfair Discrimination Act, (2000); the white paper on an Integrated National Disability Strategy, (1997); the Rehabilitation Policy guidelines, (2000) emphasize the need to include issues of disability in health service development and provision. However, the lack of strategies to facilitate access to quality health care for PWDs results in their exclusion. This document explores why CBR can be a facilitating tool in accessing quality health care by PWDs .It also proposes that CBR policies are developed.

Promoting CBR increases participation of PWDs and their families in provision of health care services. The Involvement of PWDs in health care service delivery is a necessary component as it would encourage a process of their self-development. This would include local micro management through disabled people structures resulting in political decision-making and decentralization of control of resources.

Using CBR as a tool for service delivery will require a number of substantial changes in conventional rehabilitation systems. This among other things includes:

* technology, so that it would be better suited to the sociocultural, educational and health realities of the province of KwaZulu-Natal ;

* service delivery systems so that eventually all PWDs could at least access essential services and opportunities ;

* decentralization of decision-making ;

* community involvement with emphasis to disabled people's organizations ;

* inter - intrasectoral strategies and protocols developed.

The outreach approach by rehabilitation professionals only benefits those people who are able to access the Health institutions. The KwaZulu-Natal Blind and Deaf Society indicate that: less than 10% of blind and Deaf people are receiving rehabilitation in the Province. Whereas there is an estimated number of 120,000 blind people in the province according to Statistics South Africa, only 60 Deaf-blind persons have been identified in the period of two years since this organization started CBR.

Transforming health care implies moving away from the established professional focused systems to people oriented ones.

CBR implementation cannot be possible without the radical change in the training of personnel. It also requires the mobilization of untapped resources most importantly PWDs and their families. This would also require that CBR structures are developed and properly resourced.

CBR as a tool of service implementation ensures equitable access to quality health care. The government departments need:

* to improve communication strategies with the consumers of service;

* to use Disabled People's Organizations (DPOs) and community rehabilitation workers ; * to effect quality service ;

* to strengthen the capacity of service providers on diversity management.

Access to equitable health services and quality care can be realized through collaborative efforts. When disabled people, their families and the health professionals collaborate they are able to provide needed services in a non-institutional setting. Currently, the collaboration between the KZN Department of Health and Disabled

People South Africa (DPSA); Magaye Visually Impaired People's Association; KZN Blind and Deaf Society clearly demonstrates the impact of intersectoral collaboration. In the 2004 – 5 financial year there was an increase of disabled people accessing other government basic services as a result of such CBR collaborative efforts.

Ensuring meaningful contribution and service delivery transformation by PWDs in CBR service implementation requires capacity-building. The following areas are critical in building the capacity of PWDs :

* organizational management skills;

* peer support mechanisms;

* effective CBR advocacy and implementation skills;

* disability information dissemination strategies;

* planning, implementation and monitoring skills.

This collaborative impact is revealed through the changes which occurred before the new dispensation where services for PWDs were very limited.

After 1996, the government realized the value of PWDs in quality service delivery. It started supporting them in various forms (including providing them with financial and skills support). The majority of PWDs identified never accessed services before. In fact after the year 2000, the budgets for appropriate assistive devices increased.

The participation of PWDs in health and rehabilitation service delivery has shown strength of effectiveness and value in integrated intervention.

Since the government has started to collaborate with DPOs, the number of people accessing services increased. Between 2004 and 2006, 60 blind people received basic orientation and mobility and independence training from the government for the first time in history.

In conclusion, I believe CBR should be supported at all levels of society and policies be developed for the enhancement of better service delivery in the province of KwaZulu-Natal. As reflected above CBR approach views PWDs and their family members as the best resource to handle both the daily training and care for the disabled people. It seeks the integration of interventions of all relevant sectors. It aims at the full representation and empowerment of PWDs. It also promotes interventions in the general systems of society and facilitates the inclusion and the self actualizations of disabled people.