

CURRENT STATUS OF CBR IN AFRICA: A REVIEW

Geert Vanneste

ABSTRACT

Despite the growth in the number of community based rehabilitation (CBR) programmes in Africa, services for people with disabilities in most regions of Africa are still limited to what people can do for themselves, or what can be provided by specialised centres such as residential homes, schools, or sheltered workshops. Most of the 'formal' CBR programmes implemented till now are products of foreign policy and interest, with inputs of foreign manpower and money, and not the result of the inventiveness, creativity and hard work of the local people themselves. This chapter reviews the status of community based rehabilitation in Africa, detailing the types of programmes in the governmental and non-governmental sectors, and discusses the problems related to the implementation of CBR programmes in the continent. The author goes on to critically analyse issues related to planning of programmes, selection and training of staff, monitoring and evaluation, community involvement, information sharing, role of specialists, use and misuse of funds, sustainability and the role of disabled persons. The advantages and disadvantages of CBR in Africa, in comparison with institutional programmes, are also discussed.

Most “CBR programmes “ implemented till now in Africa have not resulted from the inventiveness, creativity and hard work of the local people themselves. They are products of foreign policy and interest, with inputs of foreign manpower and money. Writing an article on CBR in Africa is a risky endeavour for another two reasons. “Africa” is 57 different countries, 350 million population, thousands of tribes and peoples, with cultural, geographical, political and organisational differences. An article on “Community “ based rehabilitation in Africa really needs to find some common ground in this particular type of service towards persons with disabilities (PWDs); yet people with field experience may have met quite different situations from those described here.

There is also a wide diversity of meanings currently attached to the term “CBR”. The reason is that “CBR” is not just a concept or a working definition, but also an ideology, assuming that community members are willing and able to mobilise local resources and to provide appropriate services to their disabled people. The debate is very much about how far local people can do this by themselves. We therefore have to first agree on a ‘working definition’ of CBR for this article. Most users of the term “CBR” might agree with the following one: “CBR programmes improve, facilitate, stimulate and/or provide services to people with disabilities and their families and caretakers; within the locations of their families and communities; through local, full time or part time, paid or volunteer, community rehabilitation workers; who are being trained, followed up and managed within a certain organisational set-up”.

When we speak about CBR, we think first about programmes, projects or organisations working with PWDs in their communities. Yet it would be wrong to start without mentioning the other type of CBR, which happens day by day in every corner of Africa, namely, the efforts of several million

parents and family members who live with a moderately or severely disabled person, coping with the situation, doing whatever they can, in living conditions which often make any special attention very difficult. Their efforts, and those of PWDs themselves, should form the basis of any “effective” CBR programmes, projects and organisations. CBR should facilitate, strengthen and improve existing family and community efforts.

TYPICAL PROBLEMS OF POST-COLONIAL SUB-SAHARAN AFRICA

Community based services for disabled people in Africa naturally face all the problems inherent in the particular community they are situated in. Major decisions on health and on education are made mostly by urban elite, seldom representing the interests or wishes of the masses with whom they are hardly in touch. Official government services are extremely weak, because of nepotism, corruption and therefore also a chronic lack of funds. People like to believe that low salaries are the main reason for the dysfunctioning of their official structures. NGO and church organisations, who should offer an alternative or complement the government services, are also mostly in the hands of the same elite, who have achieved their positions by surviving within corrupt systems. Very few find the moral strength to end these habits once they get into better-paid jobs in NGO or church systems.

The main obstacles to bringing about a change in this situation and thus in what is usually called “development” in Africa are the difficulties people encounter in making proper and efficient use of private as well as other (project) money, and a lack of tradition in formal management. Law and order, police, and government revenue collection seem to be just a pretext behind which the “real reality” functions as a parallel world. Nobody seems to be willing or able to do something about these informal organisational structures, because of the practical consequences that may ensue, particularly the corruption at all levels which such a change in mentality and in administration would undoubtedly reveal. This situation ensures that personal and family obligations take precedence over civic spirit and legal duties. High unemployment and large families add even more pressure. These problems will probably persist in future decades, jeopardising the capacity building of strong local CBR projects and organisations, which could have strengthened the existing rehabilitation efforts within the families.

CBR IN AFRICA

It is hard to discover the number of CBR programmes in Africa. Some estimate the number of self proclaimed “CBR programmes” in Sub-Saharan Africa, exclusive of south Africa, to be around 200-220. Some are full fledged programmes, working with full time paid staff, of whom most are local community rehabilitation workers (CRWs) or supervisory staff, working at the homes of people with various disabilities. Most programmes however, work only part-time in the communities, while operating out of a centre, a hospital, or other social services, and they encompass only some CBR components such as outreach work, clinics, parent guidance, referrals etc. They seldom work with all age groups. There are almost as many “types” of CBR programmes as there are programmes. However, most CBR programmes are financed by overseas agencies, hence they plan their programmes to fit the donors’ requirements.

TYPES OF CBR PROGRAMMES IN AFRICA

CBR programmes using mainly existing government structures

In several African countries, governments have set up large or small scale CBR programmes, often with financial support from international organisations and local NGOs. With a manager at the ministry level, and existing government employees as supervisors, local community rehabilitation committees are formed to facilitate the work of local volunteers. These volunteers receive a short training of about two to six weeks' duration, and are then asked to provide services to all types of PWDs, basically by making use of the WHO manual "Training in the Communities for People with Disabilities" Some programmes make use of locally available technical staff (physiotherapists etc.) and other resources (hospitals, etc.), whereas others do not.

This WHO model of CBR has been in many respects more of a normative demand, rather than a pragmatic concept. It is of course quite ambitious to try to provide services to a minority group (i.e. disabled people) by the use of existing government structures which everyone agrees are unable to provide even the more vital services to the majority of people, such as primary schooling and basic health care. One reason for relying on existing structures is the hope of decreasing the cost of the programme. In practice, this hope has seldom been justified. Using government services that are full of counter-productive traditions usually absorbs a lot of money that in a new and independent structure could more directly be used for service provision. Such programmes are as a whole often more expensive than the NGO-CBR programmes.

While NGO-CBR programmes usually pay their CBR worker, the WHO model programmes try to work with "volunteers". Yet, despite this they often manage to acquire some expensive four-wheel drive cars, each costing yearly more than the cost of paying proper salaries for 15 or more CBR workers. There are other specific problems with the WHO model. While local "rehabilitation committees" have an important role within the "system", they seldom function at all ("we don't know what to do"; "we have no money"), and good CBR work demands more motivation and qualification than most "volunteer" workers have. It also requires a higher level of rehabilitation skills than most volunteers are willing to acquire and practise without additional incentives and/or full employment. As each volunteer works with only very few PWDs, by the time they get skilled and experienced they already have families and need to earn a living in order to survive.

The NGO type of CBR programmes

These programmes, which are mostly financed by an international NGO, and often carrying its name, emphasise direct service delivery to PWDs, by the use of the NGO's own salaried employees, who are trained and monitored by the programme. Such programmes are usually very expensive, while their quality is often not much better than those using the WHO model described above. However, some NGO-CBR programmes have been quite successful. In the following section, an attempt is made to describe what makes this difference.

Objectives, priorities and planning within a CBR Programme

Programmes often lack clear objectives, and therefore also lack "planning". Their "priorities" are often not geared towards what the community needs most. One of the reasons is that they are

donor driven: “we have to do what we are able to get money for”. Another reason is a lack of proper “vision” on disability. Many of the people they serve are indeed “impaired”, as individuals, but they are not disabled in the communities where they are living. A clear illustration of this “lack of vision on disability” in disability programmes is seen in the many special schools and sheltered workshops for physically disabled people which have been set up all over Africa. Very often one finds people with disabilities in these schools playing basket ball or some other sport, equipped with different types of orthopaedic aids, while some others may be mildly disabled. Since most of these children come from rural areas, the question is why they could not join the regular schools in their villages, once they had been made mobile. The answer is that the quality of schools for disabled people is much better than the regular schools, and as every thing is provided for them, it also means that their poor families have one mouth less to feed. However, would it not be better to spend the millions of dollars spent by these schools every year, to provide mobility aids to the remote unreached disabled children, or on surgery for almost half of the blind population in Africa? This brings up another question. Do these schools or workshops serve the children or do the children serve the institutions? This illustration shows that a wrong “vision” on disability often leads to choosing the “wrong priorities”, unnecessary activity and waste of resources.

In Africa, 95% of disability is poverty related. The social environment for most PWDs is poor, with few chances for education or change. This means also that the objectives of “community based” programmes should be realistic, realising that they will need to be achieved in the midst of poor living conditions, which are at the same time poor conditions for rehabilitation. Therefore, given the vast number of PWDs who are still not reached today, the objectives of rehabilitation should be limited to essential services: to restore abilities or to reduce disabling effects, only to the extent however, that their dysfunctioning is of limiting influence on the integral development of the person (in case of children), and provide opportunities to lead a “meaningful” life in their own community (in case of young people and adults). If not all people can be served, priority should be given to “easy” before “difficult”, “young” before “old”, “near” before “far”. In other words, “cost effective rehabilitation is all about “prognosis”, not about “diagnosis”.

Objectives of rehabilitation also need to be “objective” and “operationalisable” into clear planning, focusing on clear targets (e.g. ability to walk independently), strategies (e.g. 1. surgery; 2. prosthesis; 3. follow-up at home by...etc.) and methods (referral to hospital x on April 16., parallel bars at home etc).

Selection of CBR Field staff

Most programmes start with the “wrong” staff, through lack of experience in using proper selection criteria. As always, the job of the CRW should first of all be a social promotion of the selected person. In rural areas, this means that anyone having a higher educational level than primary school plus some post-primary schooling, will quickly be frustrated in a job working at the homes of poor people, with lots of displacements, in often poor weather conditions. In urban areas however, the educational level of CRWs can and should, be a little higher. Candidates should also be aware of, accept and be able to perform this physically very demanding job. They should also not expect “promotion”, in fact the chances of promotion are almost zero. Many believe that most of the aspects of CBR fieldwork in Africa are better done by women.

Some CBR programmes in Africa experimented by initially selecting 4 candidates for each position of a CRW. These candidates first receive a short training in how to conduct a survey and how to evaluate it; the best two candidates are then chosen and trained in CBR work with one category of PWDs. After this theoretical and practical training, the best of them will get the job, while the other person will receive a compensation for the time spent, and may one day still be of use to the programme.

Training of CBR Staff

A lot of training is often provided to people high up in the organisational structure, who are mostly office - bound, while very few skills are filtered down to the level where the rehabilitation is supposed to take place, which is the home and neighbourhood of the PWDs.

In some curricula of training sessions for CBR staff in Africa, the emphasis is often on “training in CBR concepts, how to motivate the community, how to promote positive attitudes, how to talk to community leaders” etc. Yet this “community” aspect of CBR, however important, does not automatically lead to rehabilitation. It can be an empowering factor, and a necessary condition for “integration” and respect of human rights of PWDs. However people tend to forget that rehabilitation is largely the result of services provided to disabled people. It involves therapy, stimulation and skills training, resulting in changes in how people live and function and also changes in how disabled people interact with their family and community, as a result of the skills training they receive. This goes far beyond the curricula of some of the CBR field workers’ training sessions.

Daily management of CBR fieldwork

Lack of formal management is a problem in most CBR programmes. Community based rehabilitation needs community based management! Such formal day-to-day management in the field is unlikely to be done by directors of national programmes, working at the ministry level in the capital of the country, or by NGO directors or supervisors often with advanced degrees, for whom it is hardly attractive to visit the homes of poor people. Even most “supervisors” spend up to 80% of their time at the office. It is not rare to find that a CBR worker, who was supposed to perform a total of 50 visits to a certain family over a period of one year, in reality only entered their house 3 or 4 times. Even a good salary cannot be a substitute for formal management, monitoring and encouragement.

Evaluation

Evaluation in general and case management in particular are very weak in most CBR programmes. Unclear objectives are part of the reason. If we do not know where we are going, how do we know that we have arrived? The most efficient way of evaluation is therefore to install proper “case management”, which includes setting clear aims and objectives for each PWD, pointing out a clear strategy, the actions to be undertaken, organising regular case review and evaluation of the services to each individual.

Community Involvement

Some programmes do not involve the community at all, while others are over-taxing the communities. In the prevailing conditions in many African countries, involving the communities,

however nice it might sound, is often an obstacle towards progress of the programme and a burden on the shoulders of those who focus on “direct results”. On the other hand, local culture and involving local structures is of course a “condition” towards “real” progress of the community! You do not get your car to the other side of the road by taking a taxi! Some would say....unless you get everyone into the taxi, and pull the car!?

Other programmes, which almost completely rely on existing resources, might indeed be over-taxing the communities. It is precisely the “lack of community”, i.e. the breakdown of traditional structures, that contributes to the multitude of problems facing African countries. So it is unlikely that these weakly constructed communities could organise appropriate services for their PWDs.

Knowing that rehabilitation for PWDs is seldom a priority issue in Africa, it is unrealistic to expect countries to invest scarce resources in solving problems of the weakest amongst them, rather than investing in health (vaccinations, basic health services), survival (prevention against AIDS, malaria etc.) and education (primary school education, basic training, etc.) of the “stronger” people who are considered more likely to repay such investment.

Theoretically and ideally, rehabilitation for disabled people is a matter of human rights, for which all people are responsible. Yet practically, in Africa, it is a humanitarian, welfare target. Given the very gloomy socio-economic circumstances, it is sometimes a luxury.

The role of specialists: physiotherapists, occupation therapists, educators etc.

Most local CRWs have few skills to offer on their own. CBR programmes have been placing a lot of trust by just providing CRWs with a training, after which they are being “supervised”, but often by people who possess barely more technical know-how than the CRWs themselves. Evaluations have shown that some CRWs may in this case obtain some good results in the field of functional rehabilitation for adult PWDs, but have rather poor results in early intervention in general, developmental stimulation in particular, as well as in treatment of patients with arthritis and stroke. This is particularly significant, given the epidemiological transition in the African region towards more childhood and old age disability.

Programmes therefore should stress the importance of greater direct involvement of specialist personnel (physiotherapists, occupation therapists, special teachers etc.) in the whole process of case management, from the training of CRWs, to advising them on the individual programmes at PWDs homes, to setting clear targets and strategies, till the stage of evaluation. Such a day-to-day involvement by specialist staff in the field is increasingly considered a pre-requisite for a cost-effective CBR programmes(Figure 1).

Figure 1

Use and misuse of funds

The systematic misuse of funds is of course not a problem exclusive to the CBR field! The main cause for the misuse is the unprofessional way in which some donor agencies operate. Some of their representatives come to Africa for a few days, meet with some “very nice” people in whom they put all their trust, and start sending vast sums of money. As a rule, organisations which do not

have their own experienced representatives in Africa will see more than half their funds being misused. Even having local representatives is not always a solution: many of them are inexperienced, often naïve, do not spend time enough in the projects to really see what is happening, or do not have the knowledge or expertise to do so. Organisations using local African representatives will often find that the latter, because of different types of pressure on them, are part of the corruption in projects.

Rehabilitation services are care not cure

Long term sustainability of programmes is therefore very important. Programmes which are set up for just two to three years may cause a lot of frustration. They may create hope in the lives of disabled people, but once the project disappears, the often poor family may have to cope with the changed attitudes and expectations from the disabled member, which they cannot fulfil without external assistance.

Sharing experiences

As most CBR programmes in Africa are highly dependent on external donors, there is a tendency towards secrecy and guarding of resources, so that little collaboration or mutual learning takes place between programmes. Each proceeds by trial and error, repeating others' mistakes.

Programmes by disabled people for disabled people

There is no doubt that disabled people have a lot to offer to each other, and to any disability programme. In many African countries, disabled people with different disabilities or of one disability group have gathered in meetings, have formed pressure groups, have started their own projects, and some have become full fledged organisations. Some of these initiatives are very meaningful, representing disabled people from different levels of the society. Others however, seem to have an even more patronising effect on disabled people than other programmes. Many of these initiatives failed once they were taken over by disabled people, who had other goals, rather than the fight for better living conditions and for the human rights of their fellow disabled people. Here also, input of foreign money has done a lot of damage.

Is it all that gloomy?

This paper indeed did not say a lot that was positive. Despite the many problems, much has been achieved in some places, often by people who would not even know what "CBR" stands for. They may have been creative simply in organising some practical ways of solving day-to-day problems of PWDs and their families, by bringing together mothers of disabled children; by organising small neighbourhood day care centres (a community does not stop in front of a wall!); by explaining both the special needs and the "ordinariness" of these kids to schoolteachers; by collecting some money to pay for surgery etc. Such small initiatives however are often jeopardised once foreign money is brought in, which usually leads to a change of leadership style and consequently to a change of objectives.

It would be unfair not to mention here that there are CBR programmes, of the WHO or NGO style, which have been providing good services for some time by using, as far as possible, local

human, material and financial resources. Many of them are still continuing today, though they are dependent on one or two dynamic people who know the art of writing straight on curved lines.

SUMMARY

Advantages of CBR, compared to the institutional approach, as experienced in Africa

- a. In time, and in theory, all the disabled people in a community can be reached, and their basic needs met.
- b. “Tailor-made” rehabilitation programmes can be established, based on the individual’s capacities and needs, and focused directly on integration into the family/community.
- c. “Disability” is not a stable situation. Disabled children become disabled adults, with greatly different vulnerabilities and needs. CBR can evolve and adapt to such fluid situations, while the rehabilitation centre will often only be able to “take a photo”: i.e. deal with one set of problems at one point in the life of the disabled person.
- d. Family members can witness and participate in the progress of a disabled relative, thus enhancing their faith in that person’s abilities and potential, and challenging their own prejudices.
- e. CBR services, apart from carrying out their core work in rehabilitation, can also contribute towards the prevention of impairments and disabilities, through activities such as primary health care, vaccinations, nutrition and hygiene, etc.
- f. CBR programmes can trace many disabled people who would never be found by institutions, and, through referral, can make the work of other existing specialised services more effective.
- g. Early detection also allows early intervention which is very important given the increase of childhood disability in Africa.
- h. CBR is cost-effective (if well managed!).

Problems of CBR, compared to the centralised approach, as experienced in Africa

- a. The poor living conditions of most people with disabilities are also poor conditions for rehabilitation. The objectives of individual CBR programmes therefore have to be very realistic, focusing on essential needs.
- b. Community and home-based services by community rehabilitation workers can sometimes be rather routine and boring, for the worker, client and family alike; they may be less challenging than training or education in a centre.
- c. Poor families’ priorities may be at the level of survival needs, rather than solving problems of a disabled member. Further, the disability of one family member is not always problematic for other family members; so it is sometimes very hard to enlist their active collaboration.
- d. The organisation and management of CBR is complex and difficult, in a continent where people either have no tradition of formal management and handling funds, or where traditions were severely weakened during the experience of colonialism.

- e. The usual educational level of the CRWs has been rather low. Better-educated workers do not like to go into the field, and may find it hard to communicate well with disabled people who are often uneducated or undereducated. Front line CBR is a low profile job, which gives no social status to people with higher education.

These factors influence the kind, level and quality of the services which can be provided at the ground level by a CBR programme.

CONCLUSION

Despite the number of CBR programmes, services for PWDs in most regions of Africa are still limited to what people can do for themselves, or what can be provided by specialised centres such as residential homes, schools, sheltered workshops etc., along with a little “casual”, unplanned school integration.

By far the most widespread positive resources are those that already exist in the hearts and minds of African mothers, sisters, grandparents, neighbours, and disabled persons themselves. If CBR is to have an impact on hundreds of thousands, rather than on merely hundreds, then programmes must study, value, enlist and enhance these vital existing community resources. No plan should be approved unless some “multiplication factors” are built in, whereby a small input of knowledge and skills can bring into play a much larger amount of latent energy.

Geert Vanneste
CCBRT, Headquarters Training Unit
P.O. Box 23.310, Dar es salaam, Tanzania