Western(ised) Personnel from the Practice of Rehabilitation Projects versus Local Cultures

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Introduction

This paper discusses *Western(ised) personnel from the practice of Rehabilitation Projects versus Indigenous/Local Culture*. The issue is narrowed down to *the role of Western(ised) personnel versus local personnel in rehabilitation projects*. In the author's opinion *development co-operation* in rehabilitation is first of all about *manpower development* or, in other words, *development of human capital*. The *aim* is not to build institutions, to set up an outreach system, to provide sewing machines for an income generation project, to send wheelchairs, or to make pre-fabricated prostheses available. All this might help to (re)gain abilities but living with a disability is, first of all – and like anything else in life – a learning and training process.

When discussing people as *human capital* people are seen as individuals with abilities and potentials, expectations and aspirations. People are not seen as instruments that can be used to reach goals that are not part of their own life. This applies of course to people with and without disabilities. What people do, what they want to do and what they want to learn is related to their expectations of life and their perceived role in their own family and community. The starting point of this paper is personnel as the service providers but our frame of reference is always the client: the person with a disability who seeks assistance. The client is part of the local culture. The rehabilitation worker might be or might not be part of this local culture. Both situations create opportunities and threats. At this point it is good to realise that there is no unambiguous definition or description of any local culture. People within one community most likely share some values and morals but will differ on others. Also communities are often stratified along family lines or traditional roles. A rehabilitation worker and a client from the same community might have the same understanding of the cause of the disability, the need for assistance

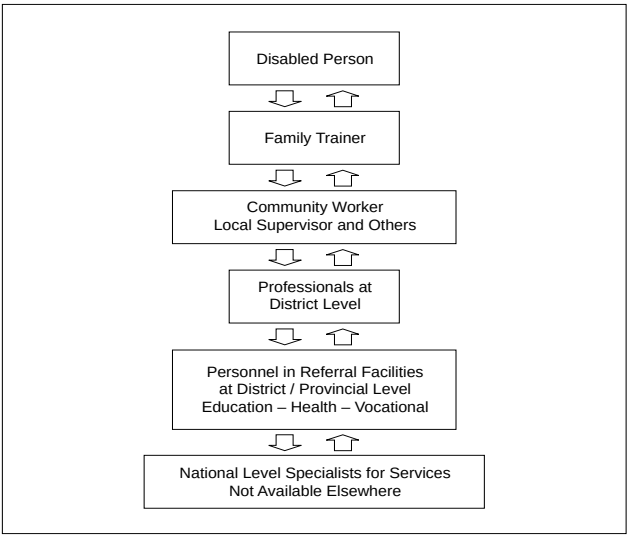
and the perspectives but it is also quite possible that they hold different views.

Before working out a *S*trengths, *W*eaknesses, *O*pportunities and *T*hreats (SWOT) analysis of Western(ised) and local personnel the different cadres in the rehabilitation process are outlined. The author's experience is with education and rehabilitation projects in Zimbabwe, Malawi and, of course, the Netherlands. Examples will be mainly from these countries. It is assumed that the readers have a basic understanding of the Community-Based Rehabilitation (CBR) model. In this paper the CBR model will not be explicitly discussed but will be part of the discussion on the role of rehabilitation workers. Instead of sticking to a label like CBR the phrase *rehabilitation process* is used here to indicate that it is a dynamic notion, not limited to one type of service provision.

People Involved in the Rehabilitation Process

The rehabiltation process cannot be described as a therapeutic intervention of a trainer and a person with a disability. Such an approach is far too simple. The rehabilitation process is a learning process which involves a complete client system (including the family and community) and a professional system. A large part of this learning process happens when the client is engaged in daily situations and happens without the intervention of professionals. Direct client-trainer intervention might be needed to start a new phase in the learning process or to correct the learning process. Guiding the people who are part of this learning process or changing the living environment are in most cases far more effective than direct intervention. Helander (1993) distinguishes six levels in the CBR delivery system (table 1). This model can help in discussing the role of (professional) rehabilitation workers.

Table 1: CBR Delivery System (Helander 1993)



In this article the focus is on the *Professionals at District Level*, *Personnel in Referral Centres* and the *National Level Specialists*. The Community Worker (CW) or Local Supervisor (LS) is, by definition, a member of the community. She/he might be chosen by the community, assigned by community leaders or approached by programme co-ordinators. Often these CWs are already involved in other health or education programmes (e.g. as Village Community Workers, Red Cross volunteers or pre-school teachers), are part of an organisation and easy to contact. Although these CWs sometimes get some kind of incentives (soap, food, clothes) or a part-time salary for their community work they are considered volunteers and non-professionals.

Professionals at District Level

The professional at district level is a formally trained professional. He or she might be a nurse, a social worker or a teacher with a few months additional training or a rehabilitation assistant or officer with at least twelve months' training. The need and the role of this cadre has been questioned and appears to fit into public service structures with great difficulty. These professionals may have different professional backgrounds, e.g. in medical rehabilitation, vocational rehabilitation, special education or

social work. In practice it will be the aims and objectives of the programme, rather than the needs of people with disabilities, that determine what type of education is required.

In Zimbabwe the Ministry of Health started a *rehabilitation technicians training school*. Initially the rehabilitation technicians were seen as an affordable answer to the needs of the many people with disabilities. It was also presented as a short-term solution because in the long run enough physiotherapists and occupational therapists would be trained to attend to people with disabilities. By now this school has more than 200 graduates, a few dozen coming from other African countries. Most of them are working in district hospitals and are involved with community rehabilitation projects. It is important to note that these rehabilitation technicians do have a specific role in the practice of decentralisation of health (including rehabilitation) services in Zimbabwe. This, originally temporary, cadre has become an essential part of the health system (Hanekom 1983; Finkenflügel 1991; Mpala 1998).

McLaren (1986) proposes a four-tiered rehabilitation delivery system for rural health services in KwaZulu, South Africa. At the rural level paraprofessional workers (rehabilitation therapists), recruited from their own area, work under the supervision of professional therapists. Also from South Africa is a study by Dolan et al. (1995) on the training of Community Rehabilitation Workers who, after a two-year training, are entirely community based and will use the district hospital as a referral centre and resource base.

Cornielje and Ferrinho (1995) and Deetlefs (1995) described the training and practical experiences of Community Rehabilitation Facilitators (CRFs). In this two-year training programme rehabilitation is approached as part of community development. Training focuses on the enhancement of knowledge and skills in community development and contrasts with medically orientated training. In Malawi, MAP (Malawi Against Polio) trains MAP-assistants for their outreach rehabilitation services (Chipofya 1993). Other countries have set up different training paths; sometimes one-offs, sometimes on a regular basis.

Personnel in Referral Facilities at District/Provincial Level

In the WHO-CBR model professionals in referral centres at district/provincial levels are working in the fields of education, health or vocational training. These professionals train professionals at district level and will provide diagnostic and rehabilitation services for people with disabilities referred to them. CBR-programmes are often run by professionals like nurses, physiotherapists, occupational therapists, social

workers, and vocational trainers. All these professionals have, on the basis of their own background, developed a broader view of rehabilitation through experience and study. Some have been able to attend additional training in CBR; for example the CBR training course of the Institute of Child Health in Britain (Guthrie 1986). There is probably no professional education that is perfectly suitable as a basis for becoming a CBR-trainer. (Most likely there is also no professional training in the field of education, health, or vocational training that is a contra-indication to becoming a CBR-trainer.)

Mendis, a physiotherapist by training and involved in CBR for two decades, commented on the role of the physiotherapist in primary health care in developing countries. She argued that there is a "need to reconceptualise our role in rehabilitation along the lines of the new approaches so that we are capable of guiding primary health workers, the community, the family and the disabled in the total rehabilitation process" (Mendis 1982: 34). The question *what makes somebody a good trainer* is not easy to answer. McAllister (1989) writes about her personal experiences as a physiotherapist working in Zimbabwe. She appeared to be impressed by what is, and can be, achieved but points out that expatriate therapists encounter many frustrations and limitations in their work as it involves many administrative duties. She continues, "Initially, it is essential to stand back, observe and learn about the people" (McAllister 1989: 7). I'm sure this is a quality that applies to every professional in CBR. It has been outlined already that it is not only medically trained professionals that get involved in CBR. Zhoya (1986) presents a personal view of the one year Certificate Course in Rehabilitation at the school of Social Work.

National Level Specialists for Services Not Available Elsewhere

Specialists at national level are qualified in the training of clients with rare conditions or are seen as extremely skilled in the intervention with clients with specific disabilities. Their role is to function as a referral centre and to collect and disseminate knowledge about the training of these clients. Also at national level we find training schools for professional rehabilitation workers. These training schools can be part of a university or polytechnic and are often linked to a hospital, rehabilitation centre or a special school.

Local and Western(ised) personnel can work at all professional levels. Some donor-organisations have made it a policy to support people at grassroots-level and send trainers to work directly with the people in the community. Other donor-organisations support the training and

back-up of local personnel and station their trainers at provincial and national levels.

Before proceeding to an analysis of strengths, weaknesses, opportunities and threats as regards the different professionals it is important to realise that local personnel in rehabilitation often hold a double position. They are familiar with more traditional beliefs about disability and know the social context of families and communities and the roles of the people. Their education is modelled upon the same lines as in Europe. They are very often even trained by Western(ised) personnel, either by having had their education abroad (United Kingdom, Canada, the former Soviet Union, Germany etc.) or being taught at home by expatriates from Europe or North America. Local personnel is trained with Western concepts of health, disability, equity and citizenship. From the author's experience in Zimbabwe it is noted that most trainees use both reference frames and try to make them supplemental to each other. This has also been described by Barbee (1986), who talks about a dialectic tension between traditional beliefs and acquired beliefs.

Analysis of Strengths, Weaknesses, Opportunities and Threats (SWOT) of Western(ised) and Local Personnel in Rehabilitation Projects

The *s*trengths, *w*eaknesses, *o*pportunities and *t*hreats (SWOT) can be visualised using a simple quadrant.

Table 2: SWOT-Quadrant

Strengths	Weaknesses
Opportunities	Threats

Each quarter can be completed for both Western(ised) and local personnel and the results can be used for discussion and analysis. Strengths create opportunities and weaknesses hold threats. A step further, it can be argued that *strengths* can also imply threats (e.g. a highly skilled professional who excludes others from treating some clients) and that weaknesses can become opportunities (e.g. ignorance, unprejudiced

observations and study can lead to unknown and unusual but successful interventions). A SWOT analysis can be most helpful to reflect on our roles and to make pitfalls visible. Western(ised) rehabilitation workers might easily consider themselves as highly skilled rehabilitation workers with a big rucksack of practical experience and scientifically-based knowledge. Although this paper is not the right forum to discuss this supposedly scientifically-based knowledge it is useful to point out that recent studies in Europe and North America teach us that there is hardly any scientific basis for the interventions in physiotherapy, occupational therapy and speech therapy. This leaves us with a lot of practical experience gained in Western hospitals, institutions and private practices. As for those trained in Europe, community work is not part of the training and nor is teaching and coaching. In this SWOT analysis it should be discussed what our skills are worth in the context of a developing country. It might seem obvious that a physiotherapist specialised in problems of the mandibular joint might be of great value in industrialised countries but will not be considered a priority in developing countries (although there are also people with mandibular joint problems). But what about a physiotherapist or special teacher with no specialist skills? Is he any better than a local rehabilitation worker with the same skills or can he even learn from local rehabilitation workers with specialists skills? If so, what is he doing in a developing country? In the workshop on *Local Concepts and Beliefs about Disability in Different Cultures* in Bonn (May 1998) the participants came up with a lot of suggestions. These suggestions are summarised in the following two quadrants.

Table 3: Western(ised) Personnel

1. Strengths	**2. Weaknesses**
– full professional education including post-graduate courses – broad clinical experience – access to professional organisations / networks – access to foreign donor funds – good understanding of scientific approaches to health issues	– professional education aimed at people living in industrialised countries – lack of community experience – not familiar with local organisations / networks – no access to local resources – limited understanding of traditional beliefs and community-oriented systems of health care
3. Opportunities	**4. Threats**
– increase knowledge about impairments, disabilities and training programmes – share clinical experiences – involve professional and donor organisations in the development of rehabilitation services in the host country – offer a different understanding of disability to decrease stigma in some types of disabilities	– offering supply-generated rehabilitation services – offering culture-alien rehabilitation services – medicalising or educationalising disability issues – shift of responsibility from community to professional services – create dependency on western type of health care

Table 4: Local Personnel

1. Strengths	**2. Weaknesses**
– education based on local needs / circumstances – ample community experience – familiar with local organisations / networks – access to local resources – understanding of traditional beliefs and community-oriented systems of health care	– poor access to post-graduate courses – limited affiliation with (national and international) professional organisations – limited access to international resources
3. Opportunities	**4. Threats**
– offer needs-generated rehabilitation services – involve local political health, education and other organisations – to deal with dialectic tension between traditional and acquired beliefs (to get the best out of the two approaches)	– knowledge and skills stagnate or deteriorate – none or poor testing of quality of work by – colleagues – no financial resources to back up intervention and gain credibility – adopting western concepts to increase status – presenting local knowledge as inferior to western-based knowledge

The participants pointed out that disability and handicap are tightly linked with local beliefs and local living circumstances. The applicability of standard Western interventions and solutions is limited. Locally trained personnel will more easily understand these local beliefs and will adapt their interventions to the local circumstances. Local personnel is also not part of

the supposedly rich, four-wheel driven services provided by foreign NGOs and expatriates and are so less troubled by demands from people with a disability for relief, money or compensation. The SWOT-analysis reveals a lot of differences between Western(ised) and local personnel but by listing these, and by enlarging the differences, it looks as if both are being made into caricatures. One can easily argue that some local personnel is highly qualified and has a leading role in international organisations and with international NGOs. It can also be argued that knowledge about local culture and traditional beliefs has been collected by (Western) anthropologists and is being integrated by Western(ised) personnel in rehabilitation programmes. Despite all this, the SWOT quadrants are helpful and will give us tools to overcome the difficulties; the weaknesses and threats.

Are There Ways to Overcome These Difficulties?

On the basis of the SWOT-analysis it is as legitimate to answer the above question with *yes* as it is to say *no*. For the local rehabilitation worker the challenge appears to be how to integrate traditional beliefs about disability and knowledge about society with the Western perception of these. If she/he is not able or willing to accept the ideas of her/his (Western) teachers and (international) colleagues she/he will bring professional isolation upon her or himself. The Western, scientific approach to health issues is the dominant approach in this epoch. On the basis of this approach people involved in rehabilitation set their priorities for clinical work and research and allocate funds.

We now see a co-operation between Western, scientific, health care workers and some traditional health workers, e.g. traditional healers and traditional birth attendants. This co-operation is based on the presence and availability of traditional healers and birth attendants and their role in community health. Such co-operation programmes are not known to exist in rehabilitation, most likely because *disability* has not been recognised as a bounded, well defined and separate issue. Traditional handling of people with disabilities is scarcely documented and/or often not accessible to Western, and even local, rehabilitation personnel.

For the Western(ised) rehabilitation worker the question is to what extent he/she is able to adapt to local circumstances and to the local needs. Overcoming the difficulties is not the same as eradicating the differences. It might not even be realistic or wise to strive to overcome the differences. A better strategy for the Western(ised) personnel is to recog-

nise and admit the differences and work out how she/he can handle these differences and how these can be integrated. The differences between Western(ised) and local personnel in the practice of rehabilitation are most visible in the direct intervention between the person with a disability and the trainer or in the interaction between a trainee rehabilitation worker and a Western(ised) teacher. In the author's opinion we should not aim at changing beliefs and attitudes related to disability. What needs to be done is to present a different framework – alongside their own frame of thinking – and to show that disability is not irreversible and that the person with a disability is able to learn. The author's experience is that children might be seen as victims of disability but are not held responsible for the cause. Caregiver and child were accessible for training and the family would try to resolve the *why-issue* separately from it. On the other hand some people who had had a stroke were not motivated to have training because they believed they were responsible for the stroke themselves and their first priority was to resolve the family matters that caused the stroke. This point of view might sometimes feel inhuman. It is hard to see people who could benefit from rehabilitation but are not accessible to us suffer. And it is difficult not to solve daily and short-term problems because rehabilitation workers have committed themselves to training and coaching and expect results in the longer term.

A local counterpart is indispensable for every Western(ised) rehabilitation worker. If it is not possible to work with a colleague then one should team up with somebody who knows the local situation and the people. The first priority of Western(ised) rehabilitation personnel is to train, coach and support local rehabilitation personnel. Too often Western(ised) rehabilitation workers work intensively with people with a disability for a period of two or three years in a remote area, district or referral hospital and realise by the end of their contract that the only way to carry on with the work is to bring in another Western(ised) rehabilitation worker. This might be quite acceptable if people at other levels (i.e. community and district level) have been trained and if it is embedded in manpower development planning that plans for deployment of local personnel in a reasonable period.

Rehabilitation is not a matter of life or death. It is acknowledged that early intervention gives better results but there is no excuse for a Western(ised) rehabilitation worker if she/he does not involve a local colleague, counterpart, nurse, teacher, volunteer or family member. This all means that the intervention of the Western(ised) rehabilitation worker should not aim at the person with a disability but at the people who are involved in the training of this person with a disability. The person with

a disability discusses her/his problems with a local rehabilitation worker. They share the same frame of thinking or at least they are able to create a basis of understanding. The indigenous/local rehabilitation worker is the key person when it comes to linking traditional views with the Western approach. And if we want to understand the local colleague we should try to be open-minded. Ignorance and questions work better than explaining how the world should be. One of the best ways to learn about traditional beliefs and traditional handling of people with disabilities is to start discussions with trainee rehabilitation workers. They have been introduced to a Western scientific approach to disability but also still have their roots in their own community. In Zimbabwe the students were very willing to discuss our and their views on the causes of disability. For example: a virus as the causal agent for polio was acceptable but not that one child contracts polio and another child in the same village, using the same water and sanitation facilities, doesn't. (There is always a danger that people who become educated and start earning money turn their back on their own background, regarding this as backward and simple. This is not typical for developing countries but it disqualifies these people from being a key person acting as intermediary between the local community and Western approaches.)

As a teacher the author found it difficult that students started using status symbols like a white jacket and stethoscope. Symbols that most of us Western(ised) personnel have abandoned in non-clinical settings. But maybe we should give them the same credit as we have advocated for people with disabilities and their communities. If this is within their frame of thinking it is to be approved and tested by others within the same frame of thinking.

In a chapter with the title *to overcome difficulties* it is tempting to end with do's and don'ts. But with regard to this subject *the ten golden rules* should be avoided. Maybe except one: *development co-operation is a continuous learning process and we should try to keep this process going.*

Without pretending to be complete the paper, including the input of the participants of the workshop, can be summarised in a few lines.

- There is not one concept of rehabilitation, nor is there a blueprint. Realise that any concept is a product of a culture that encompasses much more than rehabilitation or disability issues.
- Make sure any intervention is within the frame of thinking of the other. Work together with local personnel who share or understand the traditional beliefs of the people with disabilities.
- Training and education are more sustainable than direct intervention.
- Ignorance and questions are better tools than persuasive force.

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