Community-Based Rehabilitation for Human Development in Sub-Saharan Africa

18

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Human development supports are about enabling people to lifelong, healthy, and creative lives to advance other goals which they value (UNDP, 2011). Concerning disability, supports may need to counteract the effects of social disadvantage from community barriers to participate in activities typical of others. The *World Disability Report of 2011* estimates that there are now over 1 billion people with disabilities in the world (World Health Organization, 2011). This translates to 15% of the world population, and, of this number, 110–190 million experience very significant difficulties. With a population close to a billion, at least 15 million people living in sub-Saharan Africa (SSA) have significant disability. The report further notes that 80% of people with disabilities live in low-income countries, mostly in Africa and Southeast Asia. People with disabilities face marginalization from mainstream society due to stigma-laden beliefs about their right to full citizenship and their ability to make meaningful contributions to decisions that affect their lives (Chan & Chiu, 2007; Minkowitz, 2006; Mpofu, Chronister, Johnson, & Denham, 2012).

A large proportion of people with disabilities in sub-Saharan Africa (SSA) live in chronic poverty and often are excluded from community development activities such as literacy programs. Moreover, they are at elavated risk for exclusion from nonformal education and income generation schemes (Dutch Coalition on Disability and Development, 2006; Groce et al., 2011; Thomas, 2011; Makuwira, 2013). A universally endorsed vision for the social inclusion for people with disabilities is contained in various disability rights statements, such as Article 19 of the United Nations (UN, 2006) Convention on the Rights of Persons with Disabilities (UNCRPD), which provides for equal opportunity to participate in the affairs of the community to persons with disabilities. The obstacles to participation and the challenges of daily living experienced by people with disabilities also affect their families,

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acquaintances, and friends through the process of courtesy stigma (Whyte and Muyinda, 2002; Mitra, 2005). This dynamic occurs when families that have a member with disability experience social exclusion due to their association with the family member with disability (Bwana & Kyohere, 2002). Article 32 of the UNCRPD provides for international development organizations to include people with disabilities in their processes and programs in order to improve their quality of life. People with disabilities should be accorded their educational, social, cultural, religious, economic, and political rights in order to unlock their potential and be able to participate fully in communities.

Disability Social Inclusion as Child Development Support

Children living with disabilities are among the most socially excluded persons in Africa (UNICEF, 2012).; This occurs largely due to their status as dependent minors and also to limited legal and social protections for them (Ndawi, 2002). For example, about 90% of children with disabilities do not go to school in many low-income countries (United Nations Educational, Scientific and Cultural Organization: UNICEF, 2005a, b), and many SSA countries lack enforceable legal instruments for the equalization of opportunities for children with disabilities (Ndawi, 2002; Mutepfa, Mpofu, & Chataika, 2007). This is despite the fact that the United Nations Educational, Scientific, and Cultural Organization (UNESCO) (2005a) considers inclusive education as a child development and rehabilitation strategy "to address the learning needs of all children, youth and adults with a specific focus on those who are vulnerable to marginalization and exclusion" (p. 1). Community–based rehabilitation (CBR) holds the key to opening up the world of opportunities for children with disabilities in sub-Saharan Africa through social inclusion, which in turn supports human development. For instance, a South African study reported disability social inclusion of children in playing structured indigenous Zulu games to reinforce their social skills and cognitive skills (Roux, Burnett, & Hollander, 2008). In another study, 50% of Ugandan children in an inclusive program achieved improved physical and mental health (UNESCO, 2001). Mpofu (2003) reported that school social inclusion with disability inclusive leadership roles enhanced social acceptance and participation of Zimbabwean early adolescents with physical disabilities. Furthermore, Wanderi, Mwisukha, and Bukhala (2009) observed that inclusion of persons with disabilities in physical education and sports, which are adapted to suit their physical ability to attain total physical fitness, enhances their cognitive, psychomotor, and affective development.

With disability social inclusion, children with disabilities are fully integrated into their communities, including participation in establishing and maintaining reciprocal relationships with others as well in employment. Involvement in the community also comes with the access and use of community resources: recreation, leisure, church, and volunteer service opportunities. The United Nations Development Program (UNDP, 2011) asserts that social inclusion should be a core human development strategy, aimed at the equalization of opportunity for all and regardless of social attributes. Full community inclusion is a developmental right of children with disabilities (United Nations, 2007).

According to the ecological model of human development (see Bronfenbrenner, 1994; Bronfenbrenner & Morris, 2006), children are nested within families, and families are nested within their communities. Children and families participate in intersecting social circles, in which they imbue as well as enact social attitudes with their relatives, friends, and peers. The quality of relationships within the social circles influences the child's self-concept and ongoing socialization into typical community activities over the developmental period (Bronfenbrenner, 1994; Levers, 2012). Actual peer social acceptance of Zimbabwean adolescents with disabilities was similar to that of same gender teenagers from the social networks in which the teenagers with disabilities were involved (Mpofu, 1999). This socio-ecological network implies numerous and

complex reciprocal relationships for supporting the development of children to their potential. Development supports could be at the individual, family, and community levels. At each of these levels, the same development support needs can be addressed differently, resulting in the same desired ultimate goal, which is to equip children, regardless of disability, to participate meaningfully in their communities.

In the SSA context, the levels at which families are involved in disability social inclusion support for a child member with disability vary according to their residence (rural vs urban), type of disability in their family member, socioeconomic status (SES), and the parent (or guardian) relationship (Whyte & Muyinda, 2002; Mutepfa et al., 2007). Overall, children with developmental disabilities would have lower community participation access than typical others, as family members tend to monitor their movements relatively more closely than they would to other typical children. Children with disability in rural SSA are relatively more integrated into their communities than those in the cities. This is because others in the rural village community are mostly kin, with culturally expected parenting responsibility over all children in their community, regardless of disability status. However, children with a severe disability who reside in a rural district would also be at risk for significantly lower community participation than for typically developing other children; this is due to the lack of access to resources needed to treat associated medical conditions that require ongoing monitoring or for social participation in the broader society beyond their own village (Devlieger, 1998; Whyte & Muyinda, 2002; Mpofu, 2004). Families with more material resources have affordances to provide greater access to and participation in the community for the child with disability than for less advantaged others. Parents with a disability may be more aware of disability supports for child development than others without a history of disability (Whyte & Muyinda, 2002).

The notion of inclusive communities entails structures and procedures that facilitate the inclusion of people with disabilities, rather than expecting people with disabilities to change to fit in with existing arrangements (ILO, UNESCO, WHO, 2004). "Community" is a multilevel construct that is inclusive of schools, support groups, local administrative units, and other social affiliations (Geiser & Boersma, 2013). In the SSA context, social inclusiveness is likely to involve CBR initiatives that address the following interconnected aspects: poverty, human rights, community participation, empowerment, and sustainability of community development action (ILO et al., 2004). Every community engages in some form of community action for its own development. When properly conceived, community action offers one of the best ways to optimize a community's resources (people, technology, natural resources, and supplies) in the service of its members' health and well-being.

Community-Based Rehabilitation as a Human Development Framework

Community-based rehabilitation (CBR) is the strategy endorsed by the World Health Organization for general community development for the rehabilitation, poverty reduction, equalization of opportunities, and social inclusion of all PWDs (World Health Organization, 2010a). It is a strategy which targets social inclusion across five broad areas of participation: health, education, livelihood, social, and empowerment (See Fig. 18.1).

These are typical life domains in which people seek to overcome activity limitations and participation restrictions, thus improving their lifestyle. CBR is defined as "a strategy for rehabilitation, equalization of opportunities, poverty reduction and social inclusion of people with disabilities" (ILO et al., 2004, p. 2). Within this framework, the major objectives of CBR are:

1. To ensure that people with disabilities are able to maximize their physical and mental abilities, to gain access to regular services and opportunities, and to become active contributors to the community and society at large

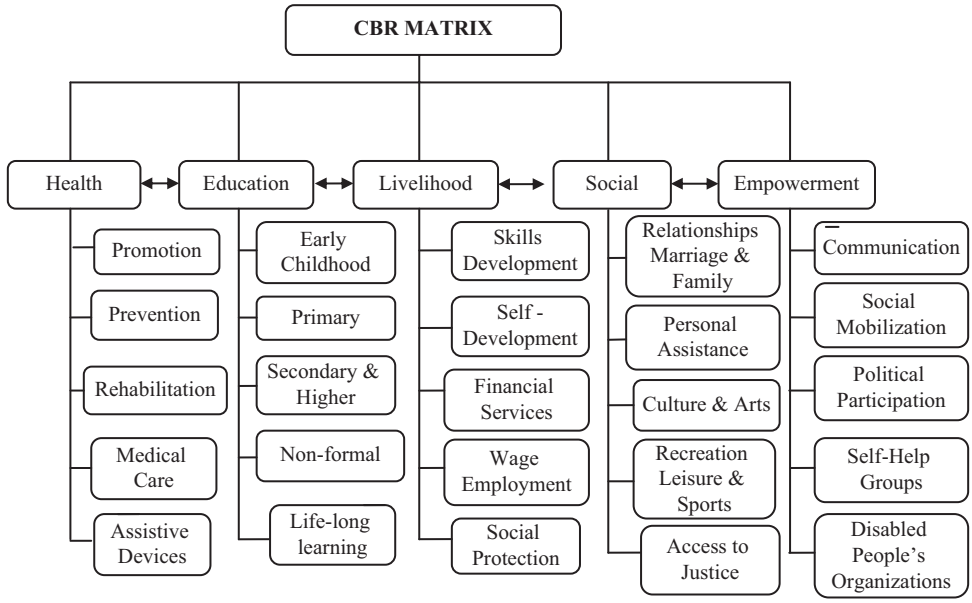

Fig. 18.1 CBR Matrix. Source: World Health Organization (2010b, p. 25)

2. To activate communities to promote and protect the human rights of people with disabilities through changes within the community, for example, by removing barriers to participation

The CBR strategy's strength lies in the promotion of collaboration among community leaders, people with disabilities, their families, and other concerned citizens in providing equal opportunities for all people with disabilities and their organizations. It promotes multi-sectoral collaboration, to support community needs and activities, as well as collaboration among all groups that can contribute to meeting its goals. A well-planned CBR can have a positive impact on the various aspects of quality of life by increasing self-esteem, empowerment and influence, self-reliance, and social inclusion.

CBR can be distinguished from community rehabilitation (CR). CBR seeks to achieve rehabilitation outcomes for people with disabilities though context-sensitive interventions and support systems with full participation of the community and for full community inclusion (Umeasiegbu, Mpofu, & Mpofu, 2013). CR is about the delivery of rehabilitation services to community settings, and not necessarily with the community. For example, a home care nursing service would be a CR option, whereas interventions to make social service facilities accessible to people with disabilities would be a CBR activity.

Over the years, the push has intensified to include disability as a part of the global development policy agenda, especially with CBR as a relevant community response (Albert, Dube, & Riis-Hansen, 2005; Kett, Lang, & Trani, 2009). CBR promotes human development through a humane approach to health and well-being, while encouraging full educational, social, cultural, religious, economic, and political participation of those with disadvantage (Anderson, 2004; ILO et al., 2004). CBR, as used for social inclusion, seeks to address major human development barriers such as poverty reduction, universal primary education, major public health problems, gender equity, and environmental sustainability (Dutch Coalition on Disability and Development, 2006). The link between disability and poverty is robust (Mitra, 2004, 2005), and the majority of people with disabilities live in material poverty (Coleridge, 2007). Because poverty typically leads to increased disability, and disability in turn

may lead to increased poverty, this issue has strong implications across the life span. However, conditions associated with poverty can be mitigated by full community inclusion of people with disabilities, through the vehicle of CBR. By removing the barriers to development for people with disabilities, as well as to their access to and use of social services, CBR helps to reduce poverty and improves the lives of everyone in the community (Heinicke-Motsch, 2013). As a human development strategy, CBR enables access to social capital that enhances community interdependence resourcing across the life span. For example, the United Nations (1998) has recommended that the following components be included in a CBR program: (1) creating a positive attitude toward people with disabilities; (2) provision of functional rehabilitation services; (3) provision of education and training opportunities; (4) creation of micro and macro income-generation opportunities; (5) provision of care facilities; (6) prevention of the causes of disabilities; and (7) management, monitoring, and evaluation. These are qualities of social programs designed to support human development across the life span.

The World Bank's "Global Partnership for Disability and Development" encourages developing countries' governments and international cooperation agencies to integrate people with disabilities into their poverty eradication efforts. Fewer opportunities to attain access to education and employment serve to relegate people with disabilities into deeper poverty, which in turn increases the risk of disability (Hartley, Finkenflugel, Kuipers, & Thomas, 2009). In order to break this vicious cycle of the "poverty-disability trap," specific action is needed that is geared toward including people with disabilities in every area of society and in every development activity (Coleridge, 2007; Mitra, Posarac, & Vick, 2011).

Illustrative Programs

Various methods from the CBR model are used for development in SSA: (a) Community Rehabilitation Village (CRV), (b) Family-Based Rehabilitation Program (FRP), (c) Community Integrated Program (CIP), (d) Neighbourhood Day Centre (NDC), and (e) Outreach Mobile Team (OMT). The CRV is a system in which the whole village or community is involved in the rehabilitation process. The FRP involves some outreach support from outside the village or community. The CIP is a variation of the CRV, whereby people with disabilities and the rest of the community are collectively involved in a joint project, for example, a communal garden to ensure village food security and storage. Finally, the NDC brings together people with different disabilities, and sometimes carers, to a common location within the community to work, counsel each other, gossip, and rejoice (see Musoke & Geiser, 2013). An important aspect of these programs is that they are not residential; thus participants return to their respective families and are not isolated from the community. The OMT is a rehabilitation outreach program, whereby specialist staff members from a nearby institution such as a hospital or a school visit individual homes, day centers, or clinics; these staff members are similar to itinerant community health care providers. It is important to note that these approaches are not mutually exclusive; CRV and CIP can operate simultaneously, likewise so can CIP and FRP, and all of these models can be used with OMT coordination. The possible models or combinations that are designed entirely depends upon the people involved using the "participatory" approach and the circumstances of each situation.

Influences on the Design and Implementation of CBR for Development

The use of CRB is interpreted and implemented in a variety of ways globally, and this is paralleled throughout SSA (Cornielje & Bogopane-Zulu, 2008). CBR activities may range from giving personal assistance to those needing appliances, such as crutches or hearing aids, to political lobbying for inclusive education or other forms of human rights that people with disabilities deserve (Asindua, 2002).

Influences on the design and implementation of CBR programs for development in the SSA context include the mission and values of the sponsors of the specific programs. For instance, in some cases CBR programs are initiated and led by NGOs that are supported by international partners. In other cases, the lead agency may be a government ministry. The CBR programs scenario in Zimbabwe is a case in point. In that country, CBR may be delivered either by the Ministry of Social Welfare and Development or by the Ministry of Health (Ndawi, 2002; Mpofu et al., 2007). In Malawi, the government established the Ministry of Persons with Disabilities and the Elderly, which leads the CBR for the development agenda (Makuwira, 2013). In large measure, CBR for development programs across SSA typically is funded and managed by donor or multilateral agencies, rather than a part of standard policies for social inclusion by the national and local governments. With few exceptions, CBR for development programs, supported by the national governments, often reflect the choices and priorities of government policy or decision-makers, with variable input by people with disabilities or their organizations.

Scope of CBR for Human Development

Historically, CBR was associated with the health sector, because many programs started within that sector and used primary health care workers as the liaisons with people with disabilities and their families (Rifkin & Kangere, 2002; World Health Organisation, 2003). Ministries or Departments of Health established rehabilitation services units, mostly hospital based and some with community outreach (Mpofu et al., 2007). Subsequently, CBR was adopted for community outreach work with marginalized groups, including people with disabilities.

Currently, CBR is based firmly within a community development framework (Heinicke-Motsch, 2013). Constraints to CBR, as a human development tool in the sub-Saharan African context, include its limited scope of design, lack of sufficient human and material resources, and lack of enough focus on sustainable community action planning. As an example of a design limitation, CBR programs in SSA have tended to be disability-group specific rather than inclusive (such as projects specifically directed at people with intellectual, physical, sensory impairments, or age groups [e.g., children, elderly people] (Makuwira, 2012). Also, organizations can be identified that offer a specific type of assistance or specific rehabilitation (e.g., medical, vocational, educational). Organizations have their own backgrounds and missions and are often part of, or related to, ministries or NGOs with a specific interest in certain aspects of disabilities. In some cases, the selection of people with disabilities to be included in a CBR project is apparently done according to the criteria set by stakeholders external to the community and not by the people with disabilities themselves (Fefoame, 2013), which take away from the long-term sustainability of such externally driven programs. The Mpumalanga (South Africa) and Busia (Uganda) CBR programs are notable exceptions.

With the Mpumalanga CBR, Disabled People of South Africa (DPSA) works in liaison with the Department of Health as CBR consultants. These consultants are all people with disabilities, and they provide peer counseling and access to government-provided services through information sharing and referral to these services such as rehabilitation and assistive devices (Rule, Lorenzo, & Wolmarans, 2006). The CBR consultants who are people with disabilities provide a positive role model to others. They also provide context-sensitive disability social inclusion support peer counseling, and referrals are provided at the home of the person with a disability. The Busia CBR engages paraprofessional CBR providers to deliver community supports in the local villages, and using tricycle transportation services, the paraprofessionals offer access to other resources outside of the local community.

Manpower resource limitations also hinder the success of some CBR programs across the SSA region. As an example, a comparative study on rehabilitation service access and use across seven SSA countries reported differences in

scope and quality of services by the availability of trained personnel to deliver the services (Mpofu et al., 2007). Countries with higher levels of personnel preparation and resourcing (i.e., South Africa and Botswana) had superior scope for delivering rehabilitation services in the community than comparison peer countries (e.g., Cameroon, Zambia, Zimbabwe). In another study, CBR programs in Ghana and Guyana were less successful, compared to those in South Africa, due to having lower human resource support (WHO and SHIA, 2002). Poverty or material scarcity at the community level also might influence the success of CBR for development, but not in an absolute sense. Poorer communities might be able to customize their CBR services, prioritizing actionable plans and accessible materials.

Country approaches to implementing CBR vary a great deal, but they have some elements in common that contribute to the sustainability of their CBR programs. These include (1) national level support through policies, coordination, and resource allocation; (2) multi-sectoral collaboration, including collaboration with DPOs, NGOs, and government sectors; (3) recognition of the need for CBR programs to be based on a human rights approach; (4) the willingness of the community to respond to the needs of their members with disabilities; (5) integration of CBR within government, with allocation of adequate resources, (6) the presence of motivated community workers; and (7) availability of resources and support, from outside the community (ILO et al., 2004; Cornielje, Majisi, & Locoro, 2013). Most CBR programs do not operate in an environment where all these preconditions are fulfilled. To address these important elements of CBR, action is needed at national, intermediate/district, and local levels in order to ensure that people with disabilities, their families, and communities benefit from CBR programs for improved lifestyle. This entails ongoing reviewing of strategies by all stakeholders to increase commitment and collaboration among all sectors and levels of government and civil society to optimize outcomes from CBR as a human development instrument.

Multilevel Analysis of Partner Organizations

Three levels of analysis and intervention are relevant to understand the resourcing of CBR in sub-Saharan Africa for sustainability: inter-organizational, intraorganizational, and social-psychological. At the **inter**organizational level, there is a need to appreciate the fact that there are many players at the ground level (government-supported programs, programs by international multilateral agencies, and local not-for-profit organizations) (Fefoame, 2013). CBR for sustainable human development supports, in the SSA region, would need to assess and promote coalitions that support social inclusiveness of community action programs for disability. Careful attention, which has been hitherto paid to the organizations themselves, now needs to be paid to the processes as well (including organizational and community policies). Such processes have evolved in ways that can nourish and sustain these coalitions, with a view toward strengthening those policies and processes that translate into actual social inclusion outcomes for people with disabilities, their families, and communities. At the **intra**organizational level, each CBR partner should self-audit to understand how its *structural* behavior supports or impedes disability-inclusive human development for people with disabilities, their families, and communities. For instance, while poverty and lack of access to basic services are two of the many major obstacles to community social inclusion by people with disabilities, not many agencies explicitly connect their objectives of CBR to the mainstream development policies (Heinicke-Motsch, 2013). At the **social-psychological** level, the behavior, attitudes, and dispositions of organizational members and other community residents may support or impede disability social inclusion. Often, strategies may need to be engaged to minimize the negative or unwanted effects on human developmental potential from misaligned inter- and intraorganization disability support priorities.

Allied Services

CBR programs in SSA have been resilient in responding flexibly to local sociocultural demands and building on existing community traditions, structures, and networks such as the extended family system and local development committees (Fefoame, 2013). However, the community-based nature of CBR does not mean that all services are provided by the community itself. While it is currently estimated that 70–80% of rehabilitation needs can be met within the local community, the fact is that some people still need referrals to specialized services at a higher level for the provision of prostheses or other appliances such as customized wheelchairs. Less than 5% of people with disabilities in low-income countries have access to formal or structured rehabilitation services (Makuwira, 2013), which underscore the importance of CBR as a tool for human development in low-resource settings like sub-Saharan Africa. Exemplary CBR for human development programs in SSA tends to have referral networks through which various needs can be addressed by utilizing local resources, people, low-cost materials, and adequate financing (Whyte & Muyinda, 2002).

The Futures of CBR for Human Development in SSA

For CBR to thrive as a human development strategy in the SSA context, strategies must be in place to increase the knowledge base about disability-related rights and their enforcement by state government entities (Lansdown, 2002; Makuwira, 2012). This may require some level of development education to governmental and local authority social service providers for them to fully appreciate that disability rights are human rights (Hicks, 2004; Makuwira, 2013). As some studies have shown (see Kandyomunda, Dube, Kangere, & Gebretensay, 2002; WHO & SHIA, 2002; Cornielje et al., 2013), the promotion of empowerment is the key to self-development, and it requires that local community people be a part of development programs' decision-making processes and, more importantly, in controlling resources for community participation (Kandyomunda et al., 2002; Ingstad & Grut, 2007). Part of this process is to provide people with the resources, opportunities, knowledge, and skill needed to increase their capacity to determine their own future. These abilities are important for the full community inclusion of people with disability or disadvantage, taking into account culture relevance (Hartley et al., 2009). Similarly, empowerment of people with disabilities in SSA for development, inclusive of their families, entails involving people with disabilities in activities to increase control of their lives and to contribute to important decisions that affect their destiny (Anderson, 2004) or supporting people with disabilities to find solutions to their own problems and to access available resources themselves (Asindua, 2002).

Far too often, CBR for development programs in SSA is sporadic and disorganized (Ndawi, 2002; Fefoame, 2013); then there are those actions which are foisted upon the community by outside agencies (public, private, and multilateral). Neither sporadic, community-driven actions nor well-organized ones that are foisted from outside would yield positive and sustainable human development. By paying attention to the locality of CBR programming and its grounding to support community action, human development outcomes for children in SSA, for example, would be tremendously enhanced. These positive outcomes are likely when CBR for development programs attempt to build on activities that currently are occurring in the community. This way, community ownership—an indispensable attribute to sustainable human development —is secured.

Summary and Conclusion

CBR is an inclusive human development framework and widely adopted in the SSA context. As a tool for human development, CBR addresses the support needs of vulnerable populations, like people with disabilities. In the SSA context, influences on the scope and function of CBR for human development include the mission and val-

ues of the partner organizations are aligned to the needs of the partner communities. Moreover, the success and sustainability of CBR as a human development resource for those with disability in the SSA region would depend on the extent to which the design and implementation of related activities are informed by people with disabilities themselves. A number of grassroots-level CBR endeavors are successful in SSA and model what could be achieved with CBR as a human development framework in other low-resource settings. National and international CBR partner agencies would be better able to support people with disabilities in their developmental needs in partnership with the people with disabilities, their families, and communities. CBR for development models with evidence of success in other SSA national or international settings, could be adapted for replication and use in other similar contexts with historical disadvantage.

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