

CHAPTER 5

Professionals’ Participation in CBR Programmes

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SUMMARY

This chapter examines the role of professionals in the development and sustainability of CBR programmes in Africa. It considers what is meant by ‘a professional’ and whether CBR workers should be, or would want to be, considered a separate profession. It looks at how some professional groups have participated in the development of CBR programmes and considers what lessons can be learned from these experiences. It uses research concerning the relationship between parents and professionals and considers these frameworks as a way of clarifying the relationships between the stakeholders of CBR programmes. In conclusion, it suggests that if positive contributions are to be made by professionals to the lives of disabled people, there is a need for a ‘new professionalism’. This new professionalism will require courage and determination on behalf of existing professionals and it will need to be embraced at a contextual and local level, if it is to be meaningfully interpreted in the Ugandan context.

INTRODUCTION

What is the definition of ‘a professional’?

Perhaps, as you read this, you would like to reflect on what you consider are the essential ingredients of a professional, and whether you consider

yourself to be one, or not? What are the good things about professionals? What things are not so good? To what extent do you fulfill these criteria? Which of the people you work with, are professional and what makes them different from the others? What do you have in common with these different groups? Could you aspire to change yourself and your activities, to match those of the people you admire the most? Do you want to be considered a professional at all? If so, why? If not, why not?

The responses to the above questions reflect the definition adopted for a professional, which according to the Oxford English Dictionary, is a person who follows an occupation or 'calling', together with other people who have the same 'calling'. It assumes a similar educational experience with jointly maintained standards and involves using this knowledge and skills to earn a living.

Using these criteria to examine the professional status of CBR workers, I think we would all agree that they have a common occupation or calling, and most use their knowledge and skills to earn their living, some of course, are volunteers. But do CBR workers have a similar educational experience with jointly maintained standards? Perhaps the more important question we need to ask here is, is it desirable for CBR workers to have a similar educational experience with jointly maintained standards, or is their diversity and flexibility their strongest ingredient?

Another question we might like to consider is: **if CBR became a profession in its own right who would benefit most? the CBR professional or the people with disabilities?** For most of the present century it has been considered 'honorable' to be a professional. Traditionally, professionals work hard, serve other people, can be depended upon for their good judgment and can be turned to, for help, in times of trouble. Many CBR programmes were and still are, started by established professional groups such as therapists, doctors, and teachers. Many CBR programmes are run by professionals and controlled by professionals. **BUT IS THIS A GOOD THING?**

As we all know, it creates many problems. Professionals are often ‘placed on pedestals’ and this has fostered a kind of elitism, which has created a barrier for them in terms of participation with other groups. Professionals are inclined to take over, talk too much, listen too little, and know best. Traditionally, professionals work hard, serve other people, can be depended upon for their good judgment and can be turned to, for help in times of trouble.

Chambers (1997) helps us examine the relative status of the different professions. Many insights can be gained from reading his work. I am going to draw upon from two of his books, both, with a clear message in their titles. One is called ‘Challenging the professionals’ (Chambers 1993) and the other, ‘Whose reality counts?’ (Chambers 1997). These books make very stimulating reading and are strongly recommended by the authors. Both publications examine the activities of professionals and their relative status.

Chambers (1997) argues that professionals need to be challenged, particularly ‘high status professionals’, who tend to be concerned with ‘things’, or with ‘people as things’. These professionals specialise, they rely on precise measurements and their groups are dominated by men. They like things to be ‘standardised’, ‘controlled’ and ‘predictable’. For example, a consultant specialist may know everything about a certain part of the body; lets say ‘the eye’. This part of the body is looked at as a ‘thing’ not a person or part of a person, and operations, research and treatment are often carried out in isolation from the thoughts and feelings of the person who owns the eye. The daily problems and realities that a malfunction of this organ might cause, are often ignored. Chambers (a man himself) says this professional is most likely to be a man and he is most likely, to be a powerful man.

On the other hand, ‘low status professionals’ are usually concerned with ‘people as people’. They tend to work in environments, which are diverse, complex, dynamic and uncontrollable. They are generalists, they look at things holistically, they include nurses, teachers and therapists. Chamber’s (1997) says they are more likely to be a woman.

Given these different ranks of professionals, let us examine whom they participate with and how they participate.

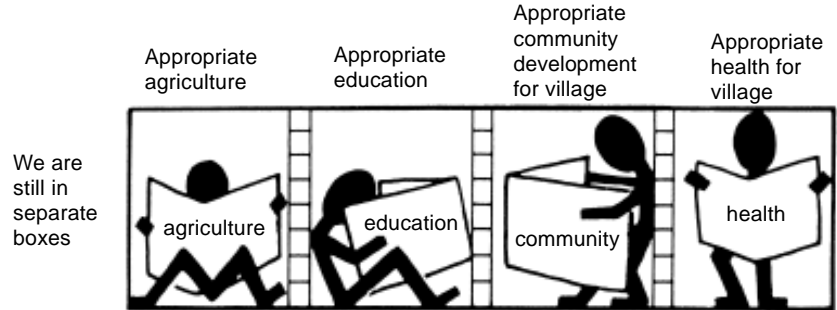
Professionals all have their own organisations and can be seen to fraternise with their own groups, creating their own culture, education, society and rules. But one of the biggest barriers to their participation with other groups is, that KNOWLEDGE IS POWER. For example, if I know how to make canes for blind people, and you know about how to teach braille, as long as we don't teach each other to do the thing we know how to do, we will both keep our jobs. Thus, multi-sectorial teams are created with teachers, technicians and medical doctors etc. as essential members. However, it is important to realise that teams are competitive; the members seek to identify their differences to keep their status and often their jobs (e.g. 'you know how to make canes, I know how to read braille, our jobs are clearly defined, we are both needed').

Most certainly, 'Knowledge is power' and this reality CAN have a destructive impact. However, a more positive and constructive vision can be reflected if the phrase is completed as follows: KNOWLEDGE IS POWER BUT SHARING KNOWLEDGE IS PROGRESS TO A MORE EQUITABLE AND SUSTAINABLE WORLD. Rifkin and Pridmore (2001) in their publication on 'Partners in Planning' illustrate the possibilities which open up by taking this more positive approach.

The illustration from 'Helping health workers learn' (Werner and Bower 1982), gives us a visualisation of the barriers between the different professional groups. I think we would all agree that these barriers exist but need to be broken down. Are we still in separate boxes? UNISE boxes, USDC boxes, ADD boxes, CICH boxes? Education boxes? Health boxes, Physiotherapy boxes? Doctor's boxes? UK boxes? Uganda boxes? Do we want to break down the barriers between our professional boxes? Or, do we want to create more professional boxes? If we do want to break down these boxes, what do we have to do? How can it be done? How can we break down the barriers that exist between us and get to know each other, work together? Perhaps, CBR programmes offer a unique opportunity to do just that? Most disciplines become more

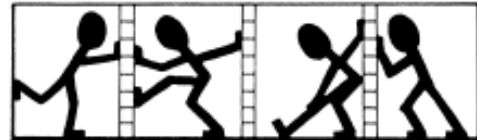
Illustration 1

THE DISCIPLINES THAT NEED TO WORK TOGETHER FOR HEALTH



Where do we go from here?

Break down the walls



Get to know each other



Work together



Courtesy: 'Helping health workers learn', Hesperian Foundation.

successful the more they specialise; however, in the development of effective CBR, EVERYONE is needed for a programme to be effective. No, one agency or profession can succeed alone, it is essential that ways be found to break down the barriers.

So far, I have only been talking about the barriers between the different professions and the organisations that those professionals create, but I am not forgetting the other important stakeholders in the CBR vision; the people with disabilities themselves, their parents, families and communities in which they live.

Goulet (1997), says that partnerships, whether with other professionals or with other stakeholders, are created when two or more people or organisations plan and implement projects and activities together, with the intentions of achieving agreed outputs. Implicit in this definition is, 'a sharing of power, resources and information in the context of cooperation based on common goals and values'. Since it is known that achievements through partnerships are greater than the sum of the parts working alone, a partnership is of mutual benefit.

As the Masai proverb puts it, 'One head cannot contain all wisdom'.

In CBR work, a very important partnership is often formed between the professional and the parent of a disabled child. Let us look at the research relating to this relationship and see if any lessons can be learnt from this.

Community work often relies heavily on training parents, and it is salutary to remember that when professionals ask parents to carry out certain tasks, parents are not paid, but professionals are, parents are on duty 24 hours a day, professionals have more reasonable working hours. Parents are often isolated, professionals have a network of colleagues, parents look at the whole child and professionals tend to look at one aspect. These different ground rules make partnerships difficult. There is an assumption that parents will be able and responsible, but in practice this is determined by time, energy, resources and attitude (Coleridge 1993) (O'Toole 1991).

The literature indicates that there are different partnership models and I will examine them very briefly.

The **Expert model** as described by Cunningham and Davis (1985) is often associated with rehabilitation in institutional settings and has the following dimensions:

- Professionals are experts, have knowledge and skills;
- Professionals aim to promote a child's functional status;
- Perceptions of users largely rejected;
- Users mainly passive recipients;
- Comply with treatment and advice;
- De-skills parents and disabled people;
- Creates dependency;
- Reduces personal efficacy;
- Creates feelings of inadequacy;
- Unique knowledge and skills of parents and disabled people ignored.

The **Transplant model** described by Mittler and McConachie (1986), has the following dimensions:

- Trains parents to promote functional status.
- Users of service are regarded as a resource for expanding the coverage.
- Parents are co-educators, co-therapists.
- Professional is the instructor.
- Transplant technical knowledge to parents.
- Ensures consistency of approach.
- Sustainable, after parent leaves.

- Two-way dialogue.
- Assumes all parents are willing and able.
- Ignores differences between families.
- Lack of recognition for parents' existing strengths.
- Professionals still in control.
- Parents can become dependent.

The **Partnership/negotiating model** described by Cunningham and Davis (1985) has the following dimensions:

- Recognises parents' expertise and ultimate knowledge
- Recognises diverse needs of different families
- Active participation in decision making
- Professional supports the parents and family
- Professional enhances the use of existing resources and coping strategies
- Assumes parents and professional will reach agreement

The **Eclectic model** described by Dale (1996), is perhaps the most desirable solution where the 3 models are used at different times, in response to need. i.e. sometimes parents need the expert model.

Interestingly, these structures have many similarities with the structures used to describe levels of participation (Werner and Bower 1982).

1. Expert prescription dis-empowerment
2. Expert recommendation 'opinion asked'
3. Expert suggestions 'participation'
4. Consultant support 'involvement'
5. Enabling support 'empowerment'

These models can be applied to the different possibilities open to professionals, who wish to participate in the development of CBR programmes. For example, professionals have the choice of starting CBR programmes, of teaching CBR students, of conducting research, using any, or even all of these models. What they have to decide is, which one should they use and how much of each?

Examining key aspects of the legislative service system can also serve to give us guidance about how services should develop and subsequently, what role professionals should/could play in this. The UN Standard Rules (UN 1994), give a clear mandate for professionals to participate with all stakeholders, not just parents. They say, “*every individual has a right to participate*” but, how often does this happen? Are professionals trained in how to do this? Is participation an objective of programmes from the very beginning? Or, even at the end? How many professionals working with people with disabilities are aware of the UN rules? How seriously do they take them on board and apply them to their practice in training, in research, in curriculum development? What changes have been made to the training of professionals, so that they have the necessary attitudes and skills to participate with other stakeholders? Indeed, have the skills they require, been identified at all?

The UN rules also say that persons with disabilities have a right to remain within their local communities and should receive the support they need, within existing local structures. This is of course the philosophy underpinning the development of CBR services, but is providing professional services at community level something that professionals strive for enough? Do they set up their services in remote rural communities? Or, do they tend to prefer the city life? Do they spend enough of their time, sharing their knowledge and skills with community workers, to enable them to function more effectively at community level? If the answer to these questions is no, then we need to ask, WHY NOT?

Helander (1993), says that it is hard to think of a better way of blocking the development of services for disabled people in developing countries, or of a more effective instrument to make governments delay in the

setting up of services, than insisting that there should be no change in duration of professional training and no change in the curricula. Adoption of unnecessarily high standards of training and narrowness of specialisation considerably increases the price of providing training and subsequent rehabilitation.

O'Toole and McConkey (1995), attribute the lack of progress to adopting professional roles which are inappropriate for that society (i.e. imported from other cultures). 'Modernisation image' fosters the illusion that western skills, knowledge and attitudes should be diffused to developing countries. I think we probably all agree with Coleridge (1993) who says, "*professionals need to change...*" But this does not mean that they should become passive and de-skilled. Quite the contrary: acting, as a resource actually requires a higher degree of skill than treating someone who is merely an object in the process. But it does require a different attitude and different training. The questions we must address therefore are, how are we going to change the attitude of professionals?

HOW ARE WE GOING TO CHANGE THE TRAINING?

Chambers (1997) also suggests that there is a need for a new professionalism, that professionals have to learn not to dominate, that dominant superior behaviour damages participation, that professionals need to learn to facilitate, to engage in participatory rather than didactic teaching, to function effectively in communities rather than institutions, to teach through experience, to 'learn by doing', to develop participatory action orientated research, to stop rushing about and take time to listen.

So how can we carry forward these ideas in CBR practice? Some suggestions might include:

1. Engage with CBR programmes so that services develop in communities.
2. Establish what community services providers; disabled people and their families need to know.
3. Give up exclusive rights to their knowledge about impairments.

4. Share the knowledge and information they have, with all participants.
5. Act as facilitator.
6. Act as reinforcer.

Finally, and perhaps most important of all, professionals need to change their attitudes, they need something I am going to call 'HUMRESH'.

1. **Humility**, to be humble about their so called achievements.
2. **Respect** and learn from others.
3. **Sharing** their knowledge and skills willingly.

In the Ugandan context, the attributes described can be highlighted by three Ugandan terms, which seem to summarise what is required of a professional in CBR. The first is *Mwalimu*, the second is *okuyiyayiya* and the third is *Muntu mulamu*.

Mwalimu means teacher, leader, and the one who shows the way. One such teacher was Mwalimu Julius Nyere, the former president of Tanzania. Professionals in CBR need to show the way, to be facilitators, to share knowledge and help others discover things for themselves.

Muntu Mulamu. Translates literally into 'person alive', but its meaning relates to one who does not cheat, is not proud, not quarrelsome, shares and is down-to-earth and helpful. This is what the new professional should be. They should be 'persons alive'.

The third term *Okuyiyayiya* is very interesting. This term became popular when Amin was President of Uganda. Essential commodities were scarce, so one had to be creative in order to survive. This creativeness required using what one had at hand to replace or get a commodity, like using honey in porridge; washing clothes with pawpaw leaves. The new CBR professional needs to have this skill of *okuyiyayiya*, to be creative, to be innovative, to persevere in solving problems.

We need to consider nurturing the skills we wish to find in professionals during their training. We need to ask, do our training schools give

physiotherapists, doctors, teachers and economists, the skills to be creative, adaptable and work with the community? Do we train them to be facilitators or bosses?

A few weeks ago, we were reviewing curricula for nurses, clinical officers, midwives and health assistants with the view of including CBR. The curricula we use are very much facility-based and community health and practice is often cosmetic. One issue of concern of people with disabilities and parents of children with disabilities was the rude, uncaring and crude manner in which people with disabilities (PWDs) were treated by health workers. In a recent meeting with District Directors of Health Services, it was noted that rude health workers reduced accessibility to services.

The challenge however, is how do you 'train' a person to be a *muntu mulamu*- a living person? Where does it fit in the curriculum? Should it be placed under ethics? Can it be learnt from his mentor? Does a large salary buy politeness and empathy? Or does it have the opposite effect?

On the issue of diluting the profession, are we watering down our noble professions when we train a community worker to teach a mother how to care for her baby? Or are we effectively providing information to those who need it? Professionals, especially rehabilitation professionals, are very few and the need is so big. We need to consider if there is a way that CBR can utilise more professionals, such as nurses, health assistants or community health workers and how can they be taught to identify people who require direct intervention from the more specialist rehabilitation worker. We also need to consider the role, which could be played by the indigenous professionals. Can CBR programmes capitalise on their existence? How can they do this? Do the local communities recognise their usefulness? How can they participate and make their contribution towards better lives for disabled people and their families?

Then, there are the power struggles. Are CBR professionals willing to leave decision making to the community? Are they prepared to involve and work with the indigenous professionals? Where will their next meal come from, when they are no longer needed? My experience is that the

service users continue to be ‘them’ and service providers ‘us’, or vice versa. How can this wall between the groups really break? Who will break down these walls when the professionals have fought so hard to build up their credibility, their standards and their professional status? Perhaps one possible solution lies with the inclusion of PWDs within the professionals’ ranks; perhaps it is only PWDs who can lead the way towards breaking down these walls and bridging the gap.

CBR professionals with formal training in CBR also need to be creative-*okuyiyayiya*. When reporting back to their station after training, many wish to deliver the complete package of CBR exactly as they were taught. This is often not possible because CBR is contextually defined and activities may need to be fed into the existing programmes or job descriptions, at the same time as networks are built with communities, professionals and organisations to fill the gaps.

A Parting Thought

‘There is very little difference in people. But that little difference makes a big difference. The little difference is attitude. The big difference is whether it is positive or negative’.

W. Clemens Stone

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