Community-Based Rehabilitation: Opportunities and Challenges

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Presentation Outline

- Genesis, evolution and critique of Community-Based Rehabilitation
- The Social Model of Disability
- Implications for professional practice
CBR - Rationale and Key Characteristics

- 1970s – no real service provision for disabled people in developing
  - Largely urban-based
  - Emulated western health care model
  - Not cost effective
  - Mismatch of demographics
    - 80/20 principle
    - Less than 2% received any provision
CBR – Rationale and Key Characteristics II

- WHO approach (1970s)
  - Basic rehabilitation services can be provided at local level;
  - Key role of the family
  - Establish a working partnership between local communities, disabled people, their families, governments and professionals trained in rehabilitation
  - Specialist services can be provided at regional and national level
Community- Based Rehabilitation
Evolution I

- **1970s**
  - Concept was very new, but was medically orientated
  - Einer Helander
  - Strong medical model influence
  - “top-down” power relations
  - No effective involvement by disabled people

- **1980s/1990s**
  - Shift of emphasis – away from medical towards empowerment and community development
  - Increasing influence of social model
  - Consensual power relations.
Community- Based Rehabilitation Evolution II

- **2000 onwards**
  - CBR perceived in terms of human rights
  - Increasing influence & involvement of disabled people,
  - “Bottom-up” power relations
  - Rights-based approaches to development
Community- Based Rehabilitation Critique I

- Until very recently, the involvement of disabled people has been tokenistic
  - Rhetoric of participation – (donor requirements)
- Professional dominance
  - Hierarchal power relations
- Unproblematised conception of community and family involvement
  - Assumed to by homogeneous and harmonious
  - Families may be too poor/over-burdened to play active role (disability-poverty nexus)
Community-Based Rehabilitation Critique II

“Some professionals see CBR as just another way of reaching the disabled, and continue to define their needs. They come with pre-fabricated lists of handicaps and functions that people should be able to do. They know what is good for the handicapped and cannot accept that CBR should start from the other side; the people themselves define their needs and tell what they need and the professionals are challenged to adapt themselves to their needs and situation”.

(Wolffers, I. and Finkenfügel, H. 1993:10).
Community- Based Rehabilitation Critique III

- Based on western philosophy

“The concepts of ‘self-fulfilment’, attaining one’s ‘maximum potential’, being ‘normalised’, and ‘integrated into society’ are part of a Western package of ideals and philosophy. ... The value-inequality of human-beings, by reason of birth, caste, skin pigmentation, economic and social status, is a fundamental tenet throughout Asia, whereas the educated Westerner tends to cherish an ideal of value-equality, while being highly competitive, individualistic and intolerant of under-achievement” (Miles, M. 1981:7).
Community- Based Rehabilitation
Critique IV

- Scaling-up for national service provision
  - Many pilot projects
- Lack of resources for training and personnel
- Multi-sectorial collaboration remains difficult
Social Model of Disability I

Key Characteristics

- Developed during the 1970s
- Focuses upon the manner in which society systematically discriminates against and oppresses disabled people
- Emphasis on politics, empowerment, human rights deficits, social inclusion and choice
- Crucial distinction between Impairment and Disability
The Union of the Physically Impaired Against Segregation, 1976

“**Impairment** (is) lacking part of or all of a limb, or having a defective limb, organism or mechanism of the body;

**Disability** (is) the disadvantage or restriction of activity caused by contemporary organisation which takes no or little account of people who have physical impairments and thus excludes them from the mainstream of social activities.”
Social Model of Disability I
Marxist Variant (Oliver 1990)

- Binary distinction between disabled people and able-bodied people
- Historically, disabled people have been the passive recipients of charity
- Disability results from the systematic oppression and discrimination of those with impairments
- “oppression” is the cohesive factor that united all disabled people in their fight for disability rights
“Oppression is a phenomenon of power in which relations between people and between groups are experienced in terms of domination and subordination, superiority and control. Those with power control; those without power lack control. Power presupposes political, economic and social hierarchies, structured relations of groups of people, and a system or regime of power. This system, the existing power structure, encompasses the thousand of ways some groups and individuals impose control over others.”

(Charlton, J. Nothing About Us Without Us, 1998:30)
Social Model of Disability III

Critique

- Social model has raised the political profile of disability
- Has provided the foundation for the rise of the disability movement
- Has become the ideological hegemony for policy-making and service provision in western liberal democracies
Social Model of Disability IV
Critique

- Disabled people are perceived as a homogeneous entity, united by oppression
  - However, they are heterogeneous
- “The body” remains unproblematised
  - Disability has nothing to do with the body
  - Feminist and postmodern disability scholars dispute this
Social Model of Disability V

Critique

- Western model
  - May now be appropriate in developing countries
  - Decisions in many African and Asian countries made by the family

- Leads an adversarial politics (them v. us)
  - May be the most effective strategy for sustainable change
  - Oppression can be unwitting
  - More education
Implications for Professional Practice I

The Context

- Social model of disability has the ideological hegemony
- Greater “user involvement” in policy-making & service provision
  - Greater emphasis of a minimalist role for the state
- Policy networks and partnerships
Increasingly politicised environment in the disability sector

The recognition of the heterogeneous nature of impairment will inevitably result in service delivery becoming more complex

There has to be greater dialogue between the disability movement and service providers
Implications for Professional Practice III

- Role of the able-bodied professional should be that of a facilitator
- To be “on tap – not on top”