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OPINION PIECE

A population approach to occupational therapy

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ABSTRACT

Structural and chronic poverty, adverse incorporation, a decline in employment opportunities and the neglect of rural development needs have combined to further destabilise the lives of people who have inhabited the margins of South African society for decades. While many adults struggle to cope with the demands of daily living, children are not thriving or coping well academically. People who receive some form of social grant are relatively better off than many of their neighbours, but in a communitarian society this regular income is shared with the whole household. A community-based rehabilitation approach with a strong occupational perspective could be used to mobilise rural residents (all ages, including disabled people, their households and neighbours) to self-help action, leading to better health, wellbeing and fruitful life course development. This would require conscientisation, effective teamwork and long term commitment from services and the community alike to an evolving process of development across many different sectors. The possibility poses an opportunity for occupational therapists that catch this vision to adopt a population approach to change, and to simultaneously promote people-centred development through occupation.

Key words: Poverty, life course development, community based rehabilitation, population occupational therapy

INTRODUCTION

"Undoubtedly most disabled people living in poverty want to be self-reliant so that they can reach their aspirations and care for their households. Their ability to do this is thwarted by many different factors. Still, every small change and shift towards meeting peoples' hope for the future can be counted as a step forward. The dimensions of chronic poverty are so widespread and their relief at present so limited that it is imperative to use every possible means of support to effect change"[1:165].

The profession of occupational therapy has not yet fully acknowledged the need for a theoretical and practical position regarding service from a population perspective (i.e. beyond individual and small group therapy). The Alma Ata declaration challenged all health workers to give more attention to a state of well-being as the outcome of health service interventions, and not only to the absence of disease or infirmity[2]. Wilcock[3] claims a primary link between health and occupation, and describes occupation as one of life's fundamental mechanisms for achieving and maintaining health. Part of her definition of health asserts that health promotion, from an occupational perspective, should enable and enhance peoples' capacity to strive towards realising their potential, while promoting social integration and cohesion.

Traditionally services have tended to focus on an individual's ill health, rather than on prevention, and the promotion of well-being through enabling occupation for large numbers of people. Creative ideas about how to practise occupational therapy have coupled services to disabled people with community development principles[4]. However, generally the focus in South Africa has been slow to shift from a therapeutic to a broader perspective. If the profession were to commit to understanding the impact of what people do every day on their health and well being[5], a population approach would be needed. Viewed by some as a legitimate domain for professional development, and linked to a pervasive problem of occupational injustice i.e. the denial of equitable opportunities and resources for people to engage in meaningful occupations[6], this form of service was backed by limited practice experience when first proposed. Some supportive ideas and experiences of doing population occupational therapy have been published (for example various authors in Kronenberg, Aldago & Pollard[7]; Watson & Swartz[8]). These therapists were motivated by professional concerns for members of the general public whose rights to occupational engagement are compromised for various reasons. Increased awareness and exposure to the restrictive realities which many people face, and the accumulation of practical experience[9], including student education, community service, and research are helping a population practice approach to develop.

The opportunity to be a researcher in a rural community of the Alfred Nzo district of the Eastern Cape Province for the past six years (2007-2012)[10] made it possible for me to learn about the realities of lives that have been exposed to numerous changes, most of them adverse. The impact of these influences continues to this day. In South Africa rurality is often associated with poverty, and defined by RuDASA[11] as human settlements where more than 50% of people live at least 5 kilometres from a tarred road, more than 25% of residents rely on rivers, streams, dams or water tanks for their water, and have limited choice or access to services. Based on this experience, the paper draws attention to realities experienced by marginalised communities and explores the possibility of enabling occupation and of promoting health through community-based rehabilitation. It concludes by bringing these different elements together in a proposed approach to population occupational therapy.

POVERTY AND RURALITY

Structural poverty

Most of the many ways of describing poverty focus on the monetary and personal consequences of living without access to the financial and material resources required to sustain a reasonable life. In order to understand the lived experience of poverty and the multi-dimensional impact which it has on peoples' occupations, a broader perspective than this is needed. The structural poverty approach argues that a quantitative analysis of asset endowments does not consider how livelihoods are shaped and mediated by the broader political and social contexts within which they are pursued[12,13]. Understanding structural poverty requires an engagement with the complexities of culture, and with how people construct their identity, interpret their agency and think and feel about being poor.

Graaff describes structural poverty as "the situation of people whose advancement is blocked by patterns of power and discrimination in society"[14:69]. This perspective, linking poverty to power, suggests that some shift in favour of poor people is necessary if equilibrium is to be achieved[15]. Inequality undermines society and its institutions by disrupting social cohesion and vesting control and authority with a few[16]. Inequality creates uneven opportunities and access to privileges and resources. However, the politics of power i.e. the processes through which groups of people develop ideas and make decisions can also be used for the general good. The Universal Declaration of Human Rights[17] sets out basic guidelines for recognising, creating and equalising power, and provides a framework that acknowledges the achievement of human rights as a global responsibility. Powerlessness is epitomised by the chronically poor person who has no voice or little choice and whose focus is on where the next meal is going to come from. The poorest collectives of people in South Africa are found in rural areas, and it is here that structural poverty has its greatest impact. The longer people stay poor the greater the risk that their situation will become chronic.

Chronic Poverty

Chronic poverty is a state of severe deprivation which is experienced for extended periods or throughout life. The condition exists not only in the present generation, but may extend into the future as intergenerational poverty[18]. The International Fund for Agricultural Development (IFAD) compared poverty dynamics in different countries based on each one's poverty line and population statistics. Surveys conducted between 1993 and 2004 showed that South Africa's national chronic poverty rate was 51.4%[19]. During the same period only 5.3% of this population exited a state of poverty and 32.5 % became poor. In contrast, countries like Uganda and Vietnam showed considerable growth and poverty exits (e.g. Vietnam 39.3% exits, i.e. people were no longer poor) between the two survey years. However, cross country comparability in this study was weak because of different poverty line values.

The Eastern Cape district of Alfred Nzo is one of the poorest in the country. In its Umzimvubu municipality 72.1% of the economically active population do not generate an income[20]. Poor rural people, who had few and inferior educational opportunities during the apartheid years, have become poorer since democracy because of increasing difficulties in entering the labour market due to the demand for skilled labour, increased productivity, and downsising[21,22]. Agricultural activity in Unzimvubu is sporadic, depending on climate, soil (which is often poor), and ploughing for crop preparation. The latter is also hampered by a lack of suitable animals to do the work or funds to pay for mechanised ploughing. In this area therefore "rural poverty remains stubbornly resistant to quick fix solutions or rapid reduction"[23:163].

Adverse Incorporation

The colonial and apartheid policies which disrupted the Xhosa peoples' way of life, including the loss of land, forced removals and the mass recruitment of labour for industry and the mines, seriously interfered with family ties, community and cultural life. Many people who live in the Alfred Nzo district today exist on the margins of society. The impression that Mount Frere creates is that of a large, extremely busy commercial centre. The N2 highway runs through its centre, lined on each side by a range of shops and other enterprises. The town is the only convenient business hub that is relatively accessible for outlying communities (village shops have all but disappeared because they are unable to compete with the multi-national stores in town). Rural residents are therefore included in these enterprises, but on inequitable or invidious terms[24]. The

same disadvantageous relationship between supplier and client or between services and users is repeated in other situations. This is seen in the provision of educational, health and social services e.g. if somebody is referred from a community clinic to hospital (situated in one of the two towns or even Mhtatha), they must pay for their own transport.

The Umzimvubu municipality (which forms approximately 1/3 of the Alfred Nzo district) records that 74.1 % of the population are under the age of 35 years, and 42.5% of the population are under the age of 14 years[20]. In 2007 83.3% of the people of Umzimvubu between the ages of 5 and 24 years were attending some educational institution[25].The local authority and members of the community are aware that this service is currently not satisfactory (e.g. on pay day teachers are often absent; school results are very poor), but despite concerns no changes are evident. There are many primary schools, some high schools and only one post matriculation college (in Mount Ayliff, approximately 50 km from Mount Frere). There are no school or town libraries, and there is no power supply in some rural areas adjacent to these towns, so internet connectivity is out of their range. The Department of Education's White Paper 526 recognises the importance of early learning and of development opportunities for young children (birth to 9 years) but does not provide for the pre-school years (See *Figure 1*). Children in this group may meet in private homes or crèches, and a few receive input from Non-Governmental Organizations. The Human Resources Development Review found that good educational intentions do not appear to be having the desired outcome; that school results for literacy and numeracy are very poor and that "15% of the children at Grade 3 level (9 years of age) could neither read nor calculate at the most basic level"[27:187].

Figure 1: No toys? Beetles will do

The last example of adverse incorporation that is significant to this discussion is the position of disabled people in the community. The disability grant is a valuable resource for those who get and keep it. It makes a difference to households (in a communitarian society), which rely on its provision, small as this is. A range of problems are associated with the allocation and retention system, all of which have serious repercussions for recipients. The discontinuation of a grant, at times for administrative rather than service reasons (e.g. withdrawal of a grant held by a person with known schizophrenia because of irregular clinic attendance) reflects the imbalance between provider and recipient. A grant can create dependency, but withdrawal might undermine the human initiative that uses it to support diverse needs.

Is poverty declining in rural areas?

Are things improving for rural people? In the area where our projects were situated most households now have pit toilets, and piped water is usually available two or three days a week from a communal tap. However, despite available power lines (since 2010) the electricity has not been connected. The condition of the dirt roads is very poor and worsened by heavy seasonable rain. Most people live in huts, made from handmade mud bricks created entirely from their own labour, but since 2012 RDP[a] houses have started to appear. These have been allocated according to special need. Residents lack local economic activity and dependence on income from outside sources makes their position insecure. Most people rely on remittances sent by householders who are employed in distant cities, and/or on one of the Social Grants allocated to eligible people. This leaves the community economically unstable and vulnerable and it appears that their situation is getting worse, despite some improvements since 1994. The majority of householders are struggling to meet their needs, and suffering from a range of relational, health, material and security problems. The kind of problems dealt with by the local Imbizo (tribal council) relate to family violence, to gangs of youth accused of petty theft, the illegal smuggling of marijuana (dagga) and increasingly, the use of dangerous substances brought in from the cities. Health related issues are a source of constant worry. In 2008 an HIV/Aids prevalence of 9% was reported for the Alfred Nzo district[28]. Recent research in South Africa has identified the dynamic between three interlinked changes: rising unemployment; reduced marital rates and increased single adult child-care; and increased migration of young women due to poor rural living conditions. These are all seen as possible risks for HIV infection[29].

Are things improving? This should be considered within an historic perspective: underdeveloped areas "were selected by the apartheid regime precisely because they could not sustain economic growth"[23:157], forcing adults to migrate to towns and cities. Most of the problems described above stem from this source but many current trends do not favour development either e.g. extensive soil erosion, no cattle to plough the land with, a lack of basic handiness, and poorly educated, unskilled youth who don't want to stay in the villages. With these problems in mind the next section turns to a theory of human development and proposes an occupational point of view for thinking about the common-place and extra-ordinary things that people do.

LIFE COURSE DEVELOPMENT (LCD) AND OCCUPATIONAL JUSTICE (OJ)

Chronic poverty inevitably narrows the type and range of occupations that people can engage with, which means that the likelihood of individuals developing their potential is limited, with varied consequences. The threats to continuous development are explored here from the perspective of the theory of life course development. This will be followed by some reflections about the possible meaning of occupational justice in a context such as has been described above.

Life Course Development (LCD)

Human development can be understood as more than a process of change through ages and stages[30], and conceptualised as an interweaving of many different transitions across the life course, or "a sequence of socially defined events and roles that the individual enacts over time"[31:22]. Developmental researchers working from the 1960's onwards considered that the available theories of socialisation did not adequately provide the sort of information that they required to study the adult life span. They believed that more theorising about the significance of role histories, early choices and social forces was needed. The Life Course Development approach, which emerged from this quest, recognised that ontogenetic change takes many different directions which are associated with gains and losses, growth and decline, and are not necessarily age related. For example, in the Eastern Cape area known to me, wives and husbands are living together, which was not so in the past when most men were working away from home; and now, instead of their own children (who are in the cities), they are raising grandchildren.

Elder and Glen[32] and other theorists recognised the significance of the influence of societal change, as well as historical location, the timing of lives, linked or interdependent lives and human agency as shaping individuals within their particular context. The LCD theory[33] (which is still evolving, backed by ongoing research) therefore acknowledges the impact of context, process and meaning on human development and family life. The family is perceived as a micro social group within a macro social context—a "collection of individuals with shared history who interact within ever-changing social contexts and across ever increasing time and space"[34:294].

[a]RDP: Reconstruction and Development Programme

This reflects the intersection of social and historical factors with personal biography and development, providing the context for close relationships and social change.

There are parallels here between LCD theory and the Eastern Cape community both in their micro and macro context, despite the differences in circumstances, the problems created by poverty and rurality, and the interpretation of 'family' and 'household.' The communitarian creation of Xhosa (African) society forms the foundation of personal and social life and creates a bridge to the broader society. Within this context development occurs, but much depends on the people who are part of it and the roles which they fulfil, the materials, tools and expertise available, the events, challenges, decisions and responsibilities assigned or assumed by them, and the economic cycles and social and cultural ideologies that are played out in the present, and that shape the future. What is the impact of chronic poverty on the lives of people who lack opportunity to do, be and become, and who lose hope in the future?

Occupational justice

Many people who live in isolated and/or deep rural places have little access to the occupations that they either need to do to promote their development and livelihoods, or that they want to do out of personal interest and ability (see *Figure 2*). Worse still is the fact that their repertoire of possible roles, tasks and activities is fairly limited due to a lack of exposure, opportunity and resources. An occupational therapy view of the prospects for chronically poor village people who live in such places evokes disquiet both for their present and future wellbeing. While empathy stems from a sense of humanity, it also springs from the professional conviction that social and occupational justice[35] can restore the opportunity for people to find meaning and purpose in and through their doing, being, belonging and becoming[36], in accordance with their potential and circumstances. Any proposed change should not be imposed; in order to be successful it must evolve from shared exploration in a manner fitting to the community and their customs. If occupational justice is to be claimed for people who live in deep rural contexts, social change that incorporates inclusion and participation of the whole community would first need to occur. A practice that is occupation-based, developmentally intended, structured to meet immediate needs, but sufficiently adaptable to accommodate challenges and changes, and adapted for people at all stages of the life-course, could be developed according to the principles of community based rehabilitation (CBR). This should not be attempted without the support and cooperation of service providers and community stakeholders at all levels.

Figure 2: Collecting fuel during school time

In the next section CBR is introduced as a strategy for addressing the issues which the article has outlined, not just for disabled people and their householders, but also for other people who are most at risk.

A POPULATION APPROACH TO OCCUPATIONAL THERAPY

The link made between CBR and a population approach to occupational therapy will be explored by using the example of research undertaken in the Eastern Cape between 2010 and 2012, followed by ways of combining CBR and occupational therapy for community development.

People informing Policy: Power and Progress, PP: P&P[10]

One of the things that we learnt from a project conducted in 17 rural villages (2007 to 2009)[10] explore the dynamic relationship between poverty, disability and occupation was that many residents did not know what their rights were, or how to access services. The researchers, being reluctant to leave without giving something back to the community, launched the PP: P&P project. Our purpose was to enable residents of a selected village to understand their needs and rights with respect to education, health and social development services, to access these and to solve problems. The project had three parts. One canvassed service users (i.e. the villagers) perspectives on disability inclusive service delivery[37], while the second collected information from education, health and social development service providers on the implementation of disability policy[38]. Community members reported that service delivery was hampered by poor infrastructure e.g. the access roads, and showed a limited appreciated of many of the rights related to disabled people's needs. Interviews with service providers indicated that all staff needed in-depth training about disability concepts and policies. The third and largest component of the project adopted a participatory action research approach and, keeping the CBR Matrix[40] in mind set about planning six workshops to explore dimensions of the meaning of disability inclusion and the practicalities of community involvement and social change.[41]

The community nominated an advisory group of local residents and together with them a programme of six workshops was launched with the purpose of achieving policy literacy related to the three service domains. The local Imbizo assisted the project by encouraging all villagers' to attend, and community health workers alerted disabled people of all ages to the opportunity. The workshops were voluntary and well attended (± 40 people at each one), but very few service providers came, this despite regular invitations and our previous contact with them. Each workshop had a theme e.g. what is policy; how can the community help to make education accessible for disabled children? Work-related issues and the role of the Department of Labour. The structure allowed time for sharing information, discussion and questions, and participants got into heated discussions on some of the topics. They seemed to welcome an opportunity to do something different while learning together. Set tasks in-between workshops provided participants with personal experiences and a deeper understanding of the different topics, e.g. visit and interview a disabled person and somebody close to them about their experience of living in your village, and report back at the next workshop.

The final evaluation of the policy literacy project was done at the end of 2012. Data are in the process of analysis, but impressions are that while the community have benefited from the opportunity to engage with the researchers and one another about services, rights, and responsibilities (public and providers), many serious gaps remain, particularly related to service delivery. Building on experience accrued from the two projects conducted in the same area, it would seem feasible to consider the introduction of a more intensive CBR project, one that addresses the communities' most pressing needs for training and subsistence.

Community- based Rehabilitation (CBR)

The community-based rehabilitation approach developed in response to the need to reach people with disabilities at the community level, provide them with rehabilitation and promote their rights (WHO: 2003)[39]. It was strongly linked to health services, and spread internationally in low and medium income countries. A reinterpretation of CBR (ILO, UNESCO & WHO)[40], has helped to create a broader strategy to meet the need for disability integration and general community development. One of the objectives of the 2010 WHO Community-based Rehabilitation Guidelines (seven booklets cover all aspects of CBR) is: "To promote CBR as a strategy for community-based inclusive development, to assist

in the mainstreaming of disability in development initiatives, and in particular, to reduce poverty"[40:10].

This is clearly not a therapeutic strategy, but it claims disabled people's place as part of the community, and emphasises the need to address hardship. CBR has become a strategy relevant to community development and to national plans for poverty reduction[42]. Community participation in CBR is appreciated as a necessary and useful development strategy, creating opportunities for previously and/or currently disadvantaged people to overcome their financial and personal difficulties. The standard rules for the equalisation of opportunities for disabled people together with service departments' specific policies can be used to lay the foundations for both specific community improvements.

The CBR Matrix provides the framework for this, bringing five parallel public services together, each supported by five components or elements and a set of practical principles[43]. Special emphasis is given to empowerment throughout. Initiating a CBR programme requires cooperation from all the relevant authorities, community structures and disabled peoples' organizations and the backing of community members. The implementation must be in a true participatory community development style, backed by local government. Guidelines for building a CBR programme include linking the project to relevant policies, some of which have associated funding, e.g. poverty reduction strategies; municipal allocations. Recruiting a percentage of available income from service providers equal to the population census percentage of disabled people is another way of capturing funding. All of this might not appear to be an occupational therapy undertaking, and as indicated would not occur without cooperation from many sectors. In principle however CBR is a good match for realising the occupational goal of a dynamic, developing society, while simultaneously accommodating the special needs of different individuals and groups. It can thus provide opportunities for all people to develop their potential, and become self-supporting and contributing members of society[44].

Occupation for all: a population approach

The Person-Environment-Occupation (PEO) model[45] emphasises the interaction and interdependence between its three components. It was developed for use with individuals as a therapeutic tool but the principles might just as well be applied to make a community diagnosis and to plan a subsequent intervention, if 'person' is replaced with 'community'. It is possible to do this due to the transactional nature of the components, creating an opportunity to interpret the impact each could have on the others. This might also help to provide some insight into why and how an adverse environment undermines community occupational performance, growth and development (as outlined in this article), and how it problems might be overcome.

Empowerment of a community could be viewed as a combination of a PEO diagnostic and planning perspective with a CBR implementation model, which would provide a structured milieu within which the local government services and the community's capacity might be developed. Choices about where to focus would depend on local circumstances and available resources. The World Bank Local and Community Driven Development (LCDD) approach has been improved and implemented internationally[46]. It vests control with community groups and representative local governments, as does CBR, but also provides clear guidelines for implementation, control and evaluation, and for evidence of success[47]. A practical approach would be to combine a PEO perspective (of individuals, within their community context) with CBR principles, and to apply these to an identified and agreed local service, by following the World Bank expert guidelines. More detail along similar lines is available.

The purpose of this article was to make some important links for the reader, and to challenge occupational therapists to think about the role and scope of our practice, particularly with respect to the large numbers of vulnerable people in our country, and about how we might serve them. Health, wellbeing and doing, being and becoming is our service link to the community, one which we have not yet fully interpreted.

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BOOK REVIEW

Title: Brain development - Milestones and learning

Author: Melodie de Jager

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This book is aimed at new parents or caregivers and it provides general information on various aspects such as pregnancy, birth, childhood development and milestones. It is written in an easy-to-understand-language and there are interesting snippets of information throughout the book. These relate to specific questions parents might have, relevant facts, research, advice for parents or explanations of specific medical terminology. The focus of the book is on the 'reflex brain', the 'thinking brain' and the 'feeling brain' and on how stimulation helps with the 'wiring' of the baby's brain as well as the role parents can play in this process. The book is divided into 3 parts: part one focuses on the development of the baby's