The Provision of Speech, Language and Hearing Services in a Rural District of South Africa

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ABSTRACT

In this paper the delivery of a speech, language and hearing therapy (SLHT) service in a rural area is discussed. In the light of the need to relate the delivery of this service to principles of primary health care (PHC) and community based rehabilitation (CBR), a brief theoretical background is given. Obstacles to service delivery are then presented, followed by a description of some attempts to implement principles of PHC and CBR. The author concludes that many challenges need to be faced in providing SLHT services that will benefit the majority of the population of South Africa.

OPSOMMING

In hierdie artikel word die dienslewering van die spraak-taal-en gehoorterapeut in 'n plattelandse gebied bespreek. In 'n poging om die behoefte aan hierdie dienslewering in verband te bring met die beginsels van primêre gesondheidsorg en gemeenskap gebaseerde rehabilitasie, word 'n kort teoretiese oorsig verskaf. Probleme tydens die instelling van 'n diens word uitgelig. Hierna word die rol van 'n spraak-taal-en gehoorterapeut in 'n plattelandse gebied ondersoek, beide binne die rehabilitasie en die primêre gesondheidsorg-span. Die gevolgtrekking wat gemaak word is dat alhoewel die spraak-taal-en gehoorterapeut 'n belangrike rol het om te vervul in die platteland, hierdie rol gesien moet word in die lig van die gemeenskap se behoeftes. Dit is egter 'n groot uitdaging vir spraak-taal-en gehoorterapeute om 'n diens te lewer wat tot voordeel van die meerderheid populasies in Suid-Afrika sal strek.

The profession of speech, language and hearing therapy (SLHT) is under pressure in South Africa to provide services to the majority of the population within a situation of transition. According to Aron (1991) the linguistic, cultural and socio-economic changes in the country will affect the nature, demand and delivery of our professional service. SLHT services within the public sector are delivered mainly through the health sector under the public service. Therefore an examination of theoretical principles of health and rehabilitation policy is necessary in order to formulate how SLHT can rise to meet these demands. It is nonetheless insufficient to scrutinise the level of policy alone, since it is clear that practical realities dictate the way in which policy decisions can or cannot be carried out. Newell (1989, p.80) in his discussion of district health systems stated that:

> although building blocks of a health service may be designed so that their general goals and form are consistent with a national standard, their expression in the field is not always the same. No countries are homogeneous; differences in structure, wealth, geography, disease pictures, and beliefs may influence how health services are delivered. Ideally, this tier conforms to a national standard, and reflects accepted rules of accountability as viewed from the capital, but within each block there should be unique qualities as viewed from the bottom.

The "block" that he identifies is the district. This paper can be seen as an attempt to take a view "from the bottom" that is the district level, at the implementation of SLHT services.

It is with this in mind that the present paper is aimed at locating the practical experience of SLHT in a rural district in South Africa within current demands for change and in the light of theoretical principles. This paper will begin with a discussion of some of the obstacles to providing an SLHT service in the rural district. This will be followed by a description of several projects which have been implemented in attempts to address these problems. The discussion of these projects will include an examination of the significance of each project with respect to the principles of primary health care (PHC) and community based rehabilitation (CBR). In addition there is a need to clarify the principles of both PHC and CBR, which provide the guiding principles for the delivery of an SLHT service in the Mhala district of Gazankulu. Before such a discussion can be meaningful, however, it is important to understand the physical and social background of the district and community under discussion.

By relating practical experience to theoretical principles, the author aims to promote discussion of the ways in which the present model of service delivery of SLHT can be made more relevant to the present needs of South Africa. It is clear that this is a major task and that the experience presented here is limited. Moreover the issues which are raised, are complex and deserve much more considered debate than can be presented here. Taking this into account, it is hoped that this paper can serve as a starting point for debate.

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DESCRIPTION OF THE MHALA DISTRICT, GAZANKULU AND ITS COMMUNITY

The Mhala district of Gazankulu is situated in the Lowveld area of the Eastern Transvaal. The population of this area experiences a high degree of poverty and unemployment. Despite the lack of documented studies, health authorities have concluded that there is a high degree of undernourishment in the area in both young and old (Infraplan, 1992). The community rates lack of water as its major health problem with poor attitudes of health workers and problems with sanitation coming next (NETHWORC, 1992). The population of Mhala is estimated at about 200 000 which is settled in 4 towns and 75 widely dispersed villages. The size of villages varies from 107 to 6 918 people (Infraplan, 1992). In addition to this population, there has been an influx of refugees to the district from Mozambique. This is estimated by local relief agencies as about 32 000 people (Sr. Agnes, 1992 personal communication[1]).

The proportion of the population with speech and hearing disorders is indicated by a survey conducted by the Occupational Therapy Department of the University of the Witwatersrand. This survey reveals a rate of 4.16 per thousand for speech disorders and 5.29 per thousand for hearing disorders in the Mhala district (Concha & Lorenzo, 1988). Health services in this district are provided by two hospitals (Tintswalo, 266 beds in the north and Matakwane, 178 beds in the south), two health centres, fourteen fixed clinics and one mobile clinic which serves ten visiting points on a fortnightly basis. There is in addition, considerable overlap with Mapulaneng district which is serviced by Mapulaneng Hospital, and patients from both districts are seen in both hospitals (Infraplan, 1992).

In 1987, rehabilitation services were implemented at Tintswalo Hospital. At present the rehabilitation unit consists of one physiotherapist and two physiotherapy assistants, one occupational therapist and three occupational therapy assistants and one speech, language and hearing (SLH) therapist and one SLH community worker. A training programme for community rehabilitation workers (CRWs) was initiated in 1991 by the occupational therapy department of the University of the Witwatersrand in consultation with the rehabilitation unit at Tintswalo. At present nine students are in training who will be based in the community from 1993 (Lorenzo, 1991).

PRINCIPLES OF PHC AND CBR

The PHC approach and health care was formulated at Alma-Ata in 1978 at a joint World Health Organisation (WHO) and United Nations Children's Fund (UNICEF) conference. This approach is based on a definition of health that goes beyond the mere absence of disease, but also involves a state of physical, social and mental well-being (McKenzie, A., 1989). Primary health care is defined as:

> essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (World Health Organisation (WHO) and United Nations Children's Fund (UNICEF), 1978, p.110).

The guiding principles of PHC are:

- equitable distribution of health care resources and adequate quality care for all
- a focus on preventive and promotive health services
- use of appropriate technology
- active community participation
- redressing of socio-economic equalities and use of a multi-sectoral approach

(McKenzie, A., & Mazibuko, 1989).

In addition to these broad principles, the PHC approach also identifies certain essential basic service components as follows:

- education concerning prevailing health problems and the methods of preventing and controlling them
- promotion of an adequate food supply and proper nutrition
- an adequate supply of safe water and basic sanitation
- maternal and child health care, including family planning
- immunisation against the major infectious diseases
- prevention and control of locally endemic diseases
- appropriate treatment of common diseases and injuries
- provision of essential drugs

(McKenzie, A., & Mazibuko, 1989).

The basic tenets of PHC have been adopted in South Africa as health policy. However Buch (1989) has noted that the reality of the health care system is far from achieving these goals. He has argued that gross inequity still exists within the system, as indicated by the relatively low health budget for the homelands. Preventive and promotive services are still not getting the priority they merit and community participation cannot be a reality in the absence of a broader political democracy. Thus the present reality for SLHT services in South Africa within the public sector is that we are operating within a PHC policy which is inadequately funded and poorly implemented. SLHT services will need to take into account both the principles underlying present policy and the obstacles preventing successful implementation.

At this point it is useful to consider the relationship between PHC and rehabilitation. The declaration of Alma-Ata states that PHC "addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly" (WHO & UNICEF, 1978, p.112). Thus it is accepted that rehabilitation is a component of primary health care. SLHT, as a component of rehabilitation services in general, can also be accommodated within the PHC model. While PHC may provide an overall framework for delivery of SLHT services, we need to examine its implementation in rehabilitation more specifically. McLaren (1989) has argued that rehabilitation should not be merely seen as the last resort when medical treatment has failed. It should be seen as part of a comprehensive overall health strategy in which disability prevention should be a priority of PHC. If this is the case then SLHT should be an integral part of PHC strategy, together with other rehabilitation disciplines. The strategy proposed by the WHO for disability prevention and rehabilitation is community based rehabilitation (CBR). This approach defines rehabilitation as follows:

> it includes all measures aimed at reducing the impact of disabling and handicapping conditions, and at enabling the disabled and the handicapped to achieve social integration. Rehabilitation aims not only at training disabled and handicapped persons to adapt to their environment, but also at intervening in their immediate environment and society as a whole, in order to facilitate their social integration. The disabled and handicapped themselves, their families and the communities they live in should be involved in the planning and implementation of services related to rehabilitation (WHO, 1981, p.39).

What is striking about this definition is its emphasis on the person with a disability within the social environment. Thus CBR

[1] Sr. Agnes, Acornhoek Catholic Mission.

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does not aim to develop the abilities of the person with a disability alone but also aims to change the society in which that individual lives so that the effects of disability can be minimised. CBR therefore, aims to deliver rehabilitation as defined above in a manner which builds on the resources of the community. Rehabilitation occurs in the community insofar as is possible with referral to hospital where appropriate (McLaren, 1989). In order to obtain community involvement, education of the community is seen as vital. Finally, it is acknowledged that the training of new levels of rehabilitation workers is necessary (McLaren, 1989). Given the theoretical background, how does this apply to the district under discussion and the practical implementation of a SLHT service? As discussed above there are obstacles to the provision of PHC services which must affect SLHT too. These obstacles will be discussed below. However, attempts have been made in the face of these obstacles to implement the principles of PHC and CBR. Examples of projects conducted by the SLHT service at Tintswalo will be presented with a critical discussion of how they succeeded or failed in implementing these principles.

OBSTACLES TO THE IMPLEMENTATION OF THE PRINCIPLES OF PHC AND CBR

1. **Inadequate infrastructure and poverty.** Poor telecommunications and roads affect the delivery of SLHT services. Community visits are time-consuming and arrangements have to be made well in advance in person or by letter. Support structures and services for the disabled are very limited. Thus, for example, the child with a mental handicap cannot be referred to an appropriate agency, but becomes the problem of the SLH therapist. As noted previously there is a high degree of poverty in the Mhala district. This means that clients for SLHT can not come in for regular therapy since they are unable to pay for transport costs. In addition, SLHT disorders can appear to be a trivial concern when one is struggling to survive. These issues relate to the PHC principle of redressing social inequality and a multisectoral approach (McKenzie, A., & Mazibuko, 1989). It will come as no surprise to the reader that there is much to be done in this regard.

2. **Training.** The training of the SLH therapist is not appropriate to the demands of the rural setting. Specific skills related to the remediation of SLH disorders cannot be used until the problems that prevent people from taking advantage of a SLHT service are addressed. Therapy might thus be provided for eg., the cerebral palsied (CP) child, but if the mother can not bring the child in on a regular basis then the service is ineffective. The therapist needs to develop skills in working with the community in order to find more appropriate ways of dealing with SLH disorders. The challenge lies in moving away from those clinical skills where s/he feels confident and secure, into the less certain waters of the community. The SLH therapist is trained to deal with sophisticated equipment but is not trained to work in the setting where this equipment is not available. The inadequate budget of rural hospitals has been discussed previously. This is experienced in SLHT in the absence of audiometric equipment. The SLH therapist will find that s/he has little experience of alternative and appropriate ways of testing hearing. In this instance, not only is training inappropriate, but also there is a lack of suitable appropriate technology.

3. **Community awareness.** There is a lack of awareness in the community about the service that we provide. Thus campaigns of awareness need to be conducted. The tension here is between raising awareness and developing the service in such a way that the increased demand can be dealt with. It is the impression of this author that this tension can be resolved to a certain degree by the manner in which awareness is raised. Werner and Bower (1982) have described two approaches to health education. The first is authoritarian and controlling and creates dependency and feelings of helplessness. The second is what they term "people-centred" learning. This helps people to become stronger and more self-reliant. If awareness campaigns for SLHT services are conducted in the first manner it is possible that the service might be overloaded, since people have not been encouraged to help themselves. They will depend on the service to do that for them. If the second approach is used it is possible that the service offered could be seen as one way to approach the problem once community efforts have failed.

4. **The balance between hospital and community.** There has been some difficulty in prioritising hospital and community services. How much time should be spent in the hospital and how much in the community? At present the rehabilitation service is between two models. Institution based rehabilitation, which occurs within a hospital setting is the old model (McLaren, 1989). It is obviously a valuable service and it is what the SLH therapist is employed at present to provide. However, as an attempt is made to implement CBR there is a necessity to be in the community more and more. Support for working in the community from head offices and the posts for community work are lacking.

DESCRIPTION OF PROJECTS ATTEMPTING TO IMPLEMENT PRINCIPLES OF PHC AND CBR

Despite the obstacles noted above, attempts have been made within the rehabilitation service at Tintswalo to implement the principles of PHC and CBR. Selected lessons from this for SLHT will now be discussed.

1. **Survey on stuttering.** It was noted that very few stutterers were being referred to Tintswalo Hospital for treatment (five cases in three years). This led to the consideration that either stuttering was not perceived as a problem, or that it did not in fact occur in this community on any significant scale. It was in order to test this possibility that a survey of attitudes, knowledge and beliefs about stuttering was done in the Acornhoek/Timbavati area (McKenzie, 1992). The community rehabilitation worker students planned and carried out the survey as part of their training. A hundred and thirteen community members were interviewed: fifty-two of these were primary school teachers. The respondents were selected by means of stratified random sampling. The results can be summarised as follows:

1. 91% of respondents knew what stuttering is
2. 93% of respondents knew at least one person who stutters
3. 86% of respondents believed that it is not infectious
4. 77% of respondents believed that stuttering causes problems for the individual
5. 87% of respondents believed that stuttering cannot be cured
6. 68% of respondents believed that stuttering cannot be prevented
7. 26% of respondents believed that stuttering is caused by rain falling on the child while still a baby
8. 42% believed that it is hereditary or "in the person's nature".

From the above, it is clear that stuttering is considered a problem in the community, but as long as people believe that it cannot be prevented or cured, there is no reason to consider referral for speech therapy. However, it does appear that stuttering could be a problem for the individual. This was confirmed in an awareness campaign arising from the survey. It

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became apparent that many children were being heavily penalised in schools because of their fluency problems. In certain cases children who were able to achieve scholastically, had stopped coming to school because they were not able to cope with the punishment or teasing.

The conclusion that can be drawn from the above is that the SLH therapist is likely to have little success with either recruiting or treating individuals who stutter. Even if stuttering therapy did take place the chance of success would be limited, given the prevailing beliefs and attitudes relating to stuttering. The definition of rehabilitation within CBR, emphasising the need to effect changes in the environment of the person with a disability is relevant here. The child who is penalised for fluency problems at school requires not only assistance with his/her speech but also an attempt to change the negative attitudes of the people around him/her.

The strategy for effecting changes in attitude is community education. This forms an integral part of CBR. Such education has been given to the teachers in report back sessions on the survey and in a subsequent workshop. Teachers have stated that this education was useful to them, since they had not understood the problem previously. They suggested that the focus should now be placed on the parents. It is envisaged that this will be the next phase of the awareness campaign. The above example gives validity to the prominent place that community education is given within CBR. This education should ideally be supplemented by appropriate and effective remediation of the fluency disorder.

2. **Workshop for disabled children.** Another feature of CBR is the involvement of families in the rehabilitation process, as discussed above. In 1989 a workshop for mothers of cerebral palsy (CP) and mentally handicapped (MH) children was run by the Rehabilitation Unit of Tintswalo Hospital (McKenzie, J & Concar, 1991). The motivation to run the workshop arose from visits to a clinic of Tintswalo Hospital. Since this clinic is 80 kilometres away from the hospital it was only possible to visit once a month. This resulted in lack of progress in the children and inadequate understanding of the mothers about the children's problems (McKenzie, J. & Concar, 1991).

The aim of the workshop was to provide a comprehensive educational programme addressing the mothers' and children's needs. Thus the physiotherapy department gave input on handling and positioning the child. The occupational therapy department educated the mothers about play, toy making and activities of daily living. The SLHT department focused on feeding and communication. Assessments of each child were done by all members of the team together and home programmes were given involving all therapies.

The programme did not only focus on rehabilitation techniques. There was health screening, and health education talks on nutrition and family planning were given. One of the most successful sessions was where mothers shared their feelings and experiences of having a disabled child. Mothers were fully involved in this programme at every stage which was a valuable experience, as they became much more confident in handling their children. However, as this workshop was held at some distance from the village where they lived, it was not possible to involve other family members sufficiently.

Another important feature of this workshop to be highlighted was the significance of working as a rehabilitation team. This enabled the therapists to assess the person with a disability as a whole rather than from the point of view of their own discipline. This aspect was developed through combined assessment, where problems in order of priority for the mother were emphasised rather than those relating to specific disciplines.

While the workshop itself was very successful according to parent and staff evaluations, the long term results are not satisfactory. The group continued to meet sporadically after that time but were unable to formulate any combined goals. There remained a great deal of dependency on the rehabilitation unit. Ultimately the project was discontinued. Possible reasons for this failure were discussed among rehabilitation staff. There was consensus that local community structures had been inadequately developed. The mothers continued to depend on the rehabilitation unit because there was little support for them in the community. The principle of CBR's building on local resources (McLaren, 1989) had not received due attention. In addition the rehabilitation effort had not been an integral part of the local PHC programme and thus support was also lacking from this quarter. It appeared that this lack of support could be attributed to inadequate development of local community structures.

One of the positive results of this effort was the selection for training as a CRW of one of the mothers of a disabled child in this group. She is at present trying to revive the group. It will be interesting to see whether she, as a community member and a mother of a disabled child with specialised training will be more successful in this project.

While this example and the previous one, look at approaches to already existing disability and ways of minimising its effects, the following example is concerned with prevention of disability as an integral part of the PHC approach.

3. **Hearing screening.** In the past, screening of hearing in creches and preschools has been conducted by the SLHT department. Problems in covering all the schools due to lack of human resources were experienced. Therefore it was decided that education of teachers about hearing loss should be undertaken, thereby encouraging appropriate referrals. Teachers in creches were given input on the causes of hearing loss, how to identify the child with a hearing loss and where to refer such a child. This programme, however, was also unsatisfactory, for the following reasons. The SLH team was acting in isolation from the PHC team. Thus the PHC team did not understand our goals and the follow up medical treatment was not always satisfactory. Referrals to the clinic were not always acted on by the parents because of lack of money and lack of community awareness of the problem. Furthermore teachers felt that they were not in a position to motivate the parents to attend the clinic because their own knowledge was scanty. It was therefore decided to incorporate hearing screening as part of a comprehensive programme of health screening in creches. The screening programme is a joint venture of the Health Services Development Unit of the University of the Witwatersrand and the rehabilitation unit and school health services of Tintswalo Hospital. Health sciences students (medical, occupational therapy and physiotherapy students) were given the task of screening under the supervision of a trained member of staff. In liaison with the senior hospital staff, it was agreed that referrals from such screening would be seen free of charge at the hospital and clinic. Creche teachers were consulted on how such a programme should be run. The clinic sister in the area where screening takes place was informed on that day and was given a list of those children who have been referred to the clinic.

To date, the programme has not been formally evaluated but it is intended that this will be done soon. Informally the response from teachers and nurses has been very positive. With respect to SLHT we have detected a marked improvement in the parents' response to referral, now that the first consultation is free of charge.

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Such a screening programme is aimed both at preventing hearing loss from occurring and at detecting hearing loss early so that appropriate intervention can be taken. Within the framework provided by McLaren (1989) it is clear that the SLHT service has been operating at the level of primary prevention in the programme by educating teachers. According to McLaren (1989) this entails preventing the occurrence of impairments, in this case hearing loss by education of key figures. The screening programme, however operates at the level of secondary prevention, where ear infections can be treated thereby preventing subsequent hearing impairment. It is clear that both levels need to be addressed. At present, screening only is being done and the education aspect needs to be incorporated into the programme. McLaren (1989) has argued that prevention should be included as a specific objective in PHC programmes. This screening programme is aimed at meeting this objective with what appears to be some degree of success.

CONCLUSION

The above discussion serves to illustrate the many challenges that the delivery of an SLHT service in a rural district poses. It is hoped that these will be taken up by the profession in a meaningful way so that the majority of the population of South Africa can be better served. Finally it needs to be noted that this cannot be achieved without the full participation of the community within the service. We must not fall into the trap of professional arrogance. As Kaseje (1991, p.2) has warned:

> doctors and "medical experts" are like roosters - they think the sun will not rise, that health will not happen if they do not crow. This attitude of medical arrogance needs to change and there must be more listening and trusting of the primary movers in PHC, that is the community.

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REFERENCES

Aron, M.E. (1991). Perspectives. *The South African Journal of Communication Disorders*, 38, 3-11.

Buch, E. (1989). Primary Health Care in South Africa. *Nursing RSA*, *4*(11), 34-36.

Concha, M. & Lorenzo, T. (1988). *The prevalence of disability in a rural area of South Africa.* Paper presented at the 2nd European Congress for Occupational Therapists, Portugal.

Infraplan (1992), Survey commissioned by Mhala Health Action Group.

Kaseje, D.C.O. (1991). *Community empowerment: The key to health for all.* Paper presented at Namibia National Primary Health Care Workshop.

Lorenzo, T. (1991). Strides in community rehabilitation worker training in a rural area in South Africa. *World Federation of Occupational Therapists Bulletin*, *2*(4), 2-5.

McKenzie, A. & Mazibuko, R. (1989). What is primary health care? *Nursing RSA*, *4*(11), 30.

McKenzie, J. & Concar, A. (1991). Report on a residential workshop for the mothers of cerebral palsy and mentally retarded children run by the rehabilitation unit of Tintswalo Hospital. *Communiphon*, *299*, 17-19.

McKenzie, J. (1992). Survey conducted on attitudes to stuttering in Acornhoek, Mhala district, Gazankulu. Unpublished.

McLaren, P. (1989). *Rehabilitation and primary health care.* Paper presented at Community Rehabilitation Meeting, Gazunkulu.

Newell, K. (1989). The way ahead for district health systems. *World Health Forum*, 80-87. Geneva: WHO.

NETHWORC Education Project (1992). *First community forum report.* Acornhoek.

WHO/UNICEF. (1978). *Primary health care: Report of the international conference on primary health care, Alma-Ata, USSR.* Geneva.

WHO. (1981). *Disability prevention and rehabilitation.* Technical Report Series 668. Geneva.

Werner, D. & Bower, B. (1982). *Helping health workers learn* (pp. 1.1-1.30). Palo Alto CA: Hesperian Foundation.

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