

# A COMMUNITY APPROACH TO PHYSIOTHERAPY

P J Wallner, BSc Physiotherapy  
Lecturer, Department of  
Physiotherapy, University of the  
Witwatersrand

A Stewart, BSc Physiotherapy,  
DPE, MSc Medicine  
Senior Lecturer, Department of  
Physiotherapy, University of the  
Witwatersrand

## Reasons for the introduction of a community component to the current physiotherapy curriculum:

A quick and selective survey of the South African community reveals:

- The population of South Africa in 1992 was 39,4 million<sup>1</sup>.
- Africans make up 76% of the population<sup>2</sup>.
- The Urban foundation estimates that by the year 2010 the total population will have increased by 55% and that between 1991 and 2010 a total of 14 million Africans will be added to the urban and metropolitan population<sup>2</sup>.
- Fifty percent of people in rural areas have an inadequate water supply and 75% have inadequate sanitation<sup>2</sup>.
- High levels of violence prevail. Researchers at the Centre for the Study of Health Policy cite a figure of approximately 15 000 murders annually or 42 per day, this being six times higher than the USA<sup>3</sup>.

In 1991, the Director General of the Department of National Health and Population Development, Coen Slabber estimated that the private sector catered for approximately 20% of the population through their membership of medical aid schemes. The remaining 80% relied on the public sector for their health care delivery<sup>4</sup>.

Research undertaken by Smith in 1991 revealed that only 20% of the physiotherapists registered with the South African Medical and Dental Council were employed in the public sector<sup>5</sup>.

The Minister of Health and Population Development announced in May 1991 that the philosophy of primary health care, which has been adopted in most developing countries decades ago, would be implemented in South Africa.

The Department of Physiotherapy recently examined their curriculum in order to ascertain whether it was training graduates to meet the needs of the entire population.

In the past, the training at the University placed a major emphasis on the development of a first world therapist. The private and export sector have been well catered for as can be seen by figures collected in 1992. An unpublished survey of graduates over the last 10 years revealed that 20% of our graduates have left the country. A further 10% have left the profession. Of the remaining 70% of the sample group, 74% are currently working in private practice<sup>6</sup>. These figures show that our graduates are not providing a service to the majority of the population at all. It would not be unreasonable to extrapolate this to most other training facilities in the country.

It was therefore felt that, because there was a changing emphasis in health care and our graduates are clearly not meeting the broad health needs of the country, changes needed to be made to the physiotherapy curriculum. Our graduates need to be trained to function effectively in the essentially transitional and developing South African situation. It was necessary to begin to expose our students to the reality of the communities from which their patients come such as:

- a depressed socio-economic environment
- insufficient transportation services
- violence as a daily experience
- discrimination on a very broad scale
- poor education.

In addition our students were not able to communicate in a common language which led to a breakdown in therapeutic communication.

The mission statement of the department of Physiotherapy reads as follows:

"The department strives towards developing the highest standards of academic and clinical excellence. We aim to produce responsible, innovative, critically thinking professionals committed to meeting the health needs of all the communities in South Africa, appropriately and cost effectively."

In order to achieve this goal, it was decided to include a community component into the four-year training. It is important to emphasise that this was taken with the express proviso that the standard of our training would not drop. On the contrary, this component, together with new teaching techniques, would allow for learning based on greater insight. Our aim was to expose all our students to alternative facilities of health care delivery as the only experience they had was in urban institutions such as the Johannesburg General and Baragwanath Hospitals, both tertiary training hospitals. Another important ob-

## ABSTRACT

This paper explores the reasons for the introduction of a community component to the current physiotherapy curriculum. The development of the community component of the course is outlined as are the student attitudes towards this development. The necessity for this trend to continue in the interests of meeting the rehabilitative needs of all the communities in South Africa is highlighted.

jective was to offer students who had very little experience of life outside the protected environment of predominantly white affluent areas, an exposure to the conditions in which the majority of their fellow citizens live.

## Development of the community component of the curriculum and student attitudes related to this development

In 1991, the community component of the course consisted of a two week period at one of three rural hospitals in the "self-governing state" of Gazankulu during the fourth year of study. Here the students were exposed to the problems which people face in rural areas and to examples of primary health care delivery systems. The students received very little preparation for the rural visit. The community syllabus was not sufficiently specific in its objectives to give the students an overall understanding of the South African context.

In 1992, the block was expanded to three weeks in response to a student evaluation expressing the wish to spend more time in the area (Fig 1). The evaluation consisted of a questionnaire in which the students were asked to rank their responses to questions on a scale of 1-5.

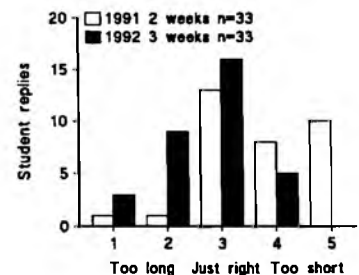


Fig 1: Student perception of time spent on rural block

In order to prepare the class more adequately for their rural block in fourth year, concepts such as Primary Health Care and Community Based Rehabilitation were introduced in 1992. The course evaluation revealed that the students did in fact feel more prepared for the block (Fig 2).

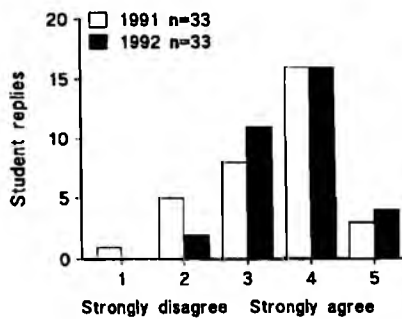


Fig 2: Felt well prepared for rural block

During the three week stay, the students were expected to offer a service to the hospital for 50% of the time. The remaining 50% was spent on the various outreach services and facilities. We felt that because students learn the most in a "hands on" situation and as the Gazankulu government funds the students stay, the service component to the hospital and surrounding community was vital.

As this was, unfortunately, the only clinical placement in which they worked together with physiotherapy assistants, the students perception of how they were able to work with auxiliary staff was surveyed. This shows that the students felt they worked better with the physiotherapy assistants in 1992 than in 1991 (Fig 3). This we attributed to a directed communication course which was introduced as well as the preparation and orientation that they received before they arrived at the rural hospital.

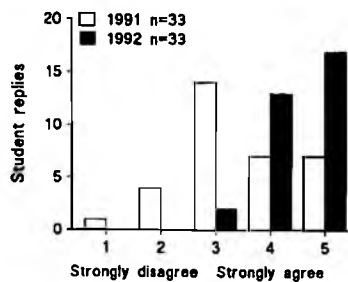


Fig 3: Was able to work well with physiotherapy assistants

Student responses have generally been very positive to this rural block experience. The sentiments expressed included:

- It was a very useful eye opener and a unique experience.
- I didn't know these facilities existed.
- I learned about coping with limited space and equipment.
- The best experience was the sleep over in the community. This gave me insight into the way people live. It was a very informative and worthwhile experience.
- I now appreciate all the things I take for granted.
- It is essential that all physiotherapy students get this kind of exposure.
- I noticed how many people need physiotherapy but are not getting it be-

cause they live too far away from the hospital or clinic.

- I was frustrated at working at a very slow pace.

In 1992 more students expressed an interest in returning to work in a rural area

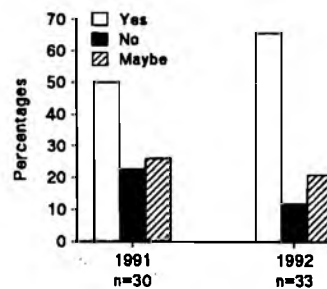


Fig 4: Would consider working in a rural area

than did the students in 1991 (Fig 4).

Until 1992, the community content emphasised rural environments. With the abolition of the pass laws, rapid urbanisation is occurring, with estimated numbers of informal settlers varying from 3,5-7 million in metropolitan areas<sup>2</sup>. An urban component was added to the course in 1993 in order to help dispel the misconception that community is synonymous with rural populations. In the urban community week, the students have a chance to explore disability issues and the concept of resource gathering and networking in an urban environment. During this week they participate in visits to facilities which offer services and opportunities to disabled people.

In the third year of study, all students spend four weeks in a community block. One week is spent at the Soweto clinics offering physiotherapy services. (This was introduced after surveying the numbers of patients who attend these clinics. Fig 5 represents attendances from January to September 1992).

The high attendances of people with neurological problems, mainly head injury and cerebral vascular accidents, prompted us to encourage the students to run classes for these patients and also to treat the other patients who attend these clinics. Three days are spent at ante and post natal facilities, one of which is in a high socio-economic suburb of Johannesburg. Six days are spent in chronic disease clinics at the

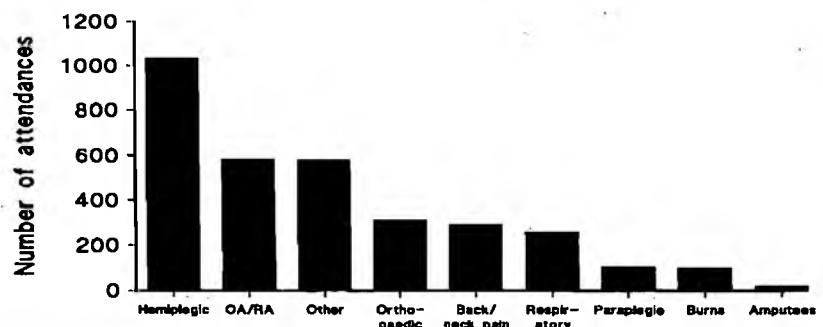


Fig 5: Attendances at Soweto Clinics

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Johannesburg General hospital. The last six days are spent giving exercise classes to the active and frail elderly in various communities around Johannesburg.

Throughout the four year training the students receive lectures on:

- Primary health care
- Community based rehabilitation
- Social welfare and benefits available in South Africa.
- Cultural beliefs and differences related to health care.
- Adult education
- Epidemiology
- Community analysis

Also included are:

- Workshops on communication
- A simulated disability exercise.
- A visit to the home of a disabled person.
- A twenty five hour course in an African language.

This particular course was introduced as the majority of our students are from white, English-speaking, privileged backgrounds and few are able to speak a black language<sup>2</sup>. As 76% of the population is African<sup>2</sup>, we feel it is essential that the students acquire these communication skills.

#### Problems encountered

The introduction of a community physiotherapy component to our curriculum is not without problems.

The rural hospitals, which we are able to utilise, are a six hour drive away and consequently the university input to these facilities is minimal, namely four brief visits annually. We rely as we do in all clinical placements on the existing clinical staff.

Our urban community component at the Soweto clinics is running reasonably well but not all the university teaching staff are sufficiently exposed to this approach to physiotherapy to ensure adequate carry over into the teaching environment, although all areas of clinical study now have community orientated objectives.

There is some resistance from students who feel that this component is not important even though it is an examinable course with the same weighting as other major subjects. This may be due to their perception that community work is not specialised enough. The fact that the communities in which they work in are foreign and alien

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to them may play some part in this resistance. Perhaps when we eventually start to train students from a wider cross-section of our community this resistance will be less evident.

#### Conclusion

In the three years since the development of a structured community course, the university has started to address some of the pressing issues which face our profession. It is evident from the ANC policy document on health, a major decision maker in the future, that all courses offered for health professionals need to be transformed, upgraded or modified so that they are appropriate to meet the needs of the entire population<sup>7</sup> and not only the financially privileged as is the case at present.

The ethical issue of the neglect of the rehabilitative needs of the majority of the population has eluded our profession up to now. This restructuring of the physiotherapy course at the University of the Witwatersrand may have the effect of our future graduates being able to play a more appropriate part in providing a service for the majority of the population.

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