REPORT

to

WORLD FEDERATION OF

OCCUPATIONAL THERAPISTS

Occupational Therapy Training Systems and Service Delivery in South Africa

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1. INTRODUCTION

'For South Africa, the time for painful reassessment has come. The country will have to face many difficult challenges and distressing problems in order to emerge from its current impasse. South Africa needs to learn a new way of being, thinking, acting and communicating; it will have to start all over again and restore its legitimacy'. **Pierre Mayer, Inspecteur General des Finances, France. 1987.**

1.1 SOUTH AFRICA - The Country, The People, The History, The Government

South Africa is a large country almost five times the size of the United Kingdom and as large as the combined areas of France, Italy, West Germany, The Netherlands and Belgium.

Its vegetation ranges from desert and semi-desert in the west, contrasting with mediterranean-type (evergreen shrubs and wild flowers) in the southern cape to bushveld (thornbush, very little grass) in the far north and east and temperate grassland in the central interior around Orange Free State, Southern Transvaal and the Eastern Cape.

The Republic of South Africa comprises:

4 Provinces

Natal
The Cape
Transvaal
Orange Free State

} 14 million mixed race population.

plus

6 Black Self-Governing States
(previously known as Homelands)

Lebowa
Gazankulu
Qwaqwa
Qwa Zulu
Kwa Ndebele
Ka Ngwane

} 5.3 million mainly black population

Since 1981 there have also existed 4 Black National States called:

Independent National States

Bophuthatswana
Venda
Ciskei
Transkei

} 4.7 million mainly black population

The governments of the Independent National States maintain close practical ties, and in some instances, economic ties with the Republic of South Africa.

Population figures are approximate and based on the 1985 census. 60% of the population is said to be living in rural areas with 80% living in what is termed as Third World conditions.

White - 5 million
Coloureds - 3 million with nearly 86% living in the Cape.
Indians - 800,000 nainly living in Natal Province.
Blacks - 15 million, of which two-thirds (10 million) live in Self-Governing States and Independent National States.

The greater part of the white population of the Republic is either English- or Afrikaans-speaking. Afrikaans derives from the Dutch and Flemish languages introduced by settlers in the 17th century. The major English settlement took place in 1820. English and Afrikaans are both official languages of the Republic

The coloureds are a people of mixed descent, with white, black, Malay and Khoisan ancestors. The Indian community is descended mainly from Indian labourers brought to South Africa to work on the Natal sugar plantations in the 19th century.

The black peoples are made up of four main linguistic groupings, the Nguni, the Sotho, the Venda, and Shangaan-Tsonga, with a number of sub-divisions in each group. The major Nguni languages are Zulu, Xhosa, Swazi and Ndebele; the major Sotho languages are Southern Sotho, North Sotho (Pedi) and Tswana. Each of these groups of black people have quite distinctive cultural identities including languages and social systems.

Recent history of South Africa shows massive changes in political and sociological emphasis since the founding of the Union of South Africa in 1910. There was an acceleration of policies of racial discrimination with the barring of black people from voting in the Transvaal, closely followed by the 1913 Natives Land Act and the Mines and Works Act which made legal the reservation of jobs for certain races. In 1925 Afrikaans became the second official language along with English and the mid-1930's saw removal of Black people from the common roll in the Cape Province. Coloured people were also removed from the voting roll but not until 1955.

The African National Congress (ANC) currently outlawed in South Africa originated in the early 1900's as did the first black university college, Fort Hare (1916).

The policy of 'separate development' - apatheid - gained in support through these years enabling an alliance of the National Party and the Afrikaner Party, to win the elections in 1948, using as their main platform the policy of apatheid.

The introduction of population registration (passes for blacks) and the Group Areas Act (segregating cities, towns and rural areas into black, white, and coloured areas) dated from the 1950's. The implementation of these policies were marked by resistance campaigns organised by black people and the African National Party, culminating in such well-known incidents as the 1960 Sharpville demonstration against pass laws and 1976 the Soweto riots and rioting in black schools throughout the country.

Recent years have seen a number of laws abolished, suspended or made more flexible. These include:

- abolition of passes for black people. These were replaced by identity documents for all population groups.
- suspension of forced removal of black people settled in white areas.
- recognition of Trade Unions for black workers.
- lifting of prohibition of mixed marriages and sexual relations between the races.
- opening up of some business districts to all population groups, both as traders and consumers.

Since 1985 South Africa has been in a state of emergency, initially in limited parts of the country but since 12th June 1986, covering the total country, with restrictions on foreign press coverage of events in South Africa.

The legal system is based on Roman Dutch Law mixed with 19th century English Law. English Law influences mainly that relating to company and mercantile law whilst Roman Dutch Law has particular influence in private law - (law of persons, property, succession, sale and lease).

The Constitution - The second constitution came into being in 1984 following an endorsement by a two-thirds majority of the white voters in 1983. This constitution provides for groups to share power on matters of common concern thus bringing for the first time coloured and Indian people into the legislature and executive branches of administration. Overall control however, in the terms of the constitution remains with the white population.

Legislative power is vested in a state president and a directly elected parliament consisting of three houses:-

The House of Assembly (for whites)
The House of Representatives (for coloureds)
The House of Delegates (for Indians)

Note: The World Federation Delegation were able to meet and talk with members of the House of Representatives and the House of Delegates in an informal, private home setting in Durban.

The Houses are equal in status, have concurrent terms and must be re-elected five yearly.

Executive authority is vested in the state president acting on advice from the Ministers Council (60 people) in consultation with the cabinet in the case of general affairs.

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.2 HEALTH AND EDUCATION

.2.1 EDUCATION

Since 1984 there have been five Ministries concerned with education:-

1. Ministry of National Education (General Affairs)

   covers overall policy (norms, standards for financing, syllabi, examinations, salaries, conditions of service and professional registration of all teachers)

2. Ministry of Education and Training for Black Education

   excludes the Independent National States of Bophuthatswana, Venda, Ciskei, Transkei.

} These two Ministries are part of the President's Central Cabinet.

3. Ministry for White Education - responsible to the House of Assembly.

4. Ministry for Indian Education - responsible to the House of Delegates

5. Ministry for Coloured Education - responsible to the House of Representatives.

Each of these last three Ministries has a Department of Education and Culture (DEC) which is responsible for all education at all levels for its race group which includes education for handicapped children and reform schools.

There are, therefore, three Departments of Education and Culture each responsible to its own Ministry.

TABLE I

	POPULATION GROUPS			
	BLACK	WHITE	INDIAN	COLOURED
Compulsory Education	Generally no	Yes	Yes	Policy only. Not in practice
Medium of Instruction	1st 4 yrs = black languages then = English	English or Afrikaans	English	English or Afrikaans
Predominent Medium	English	English and Afrikaans	English	Afrikaans
Compulsory languages as school subjects	English	← English and Afrikaans →		
Number of Universities by Predominent Race Group	5 Vista (day only) Fort Hare, Zululand, The North, Medunsa.	11	1 Durban-Westville	1 Western Cape
* No. of Teachers (1986) - primary and Secondary	104,542	67,847	10,878	30,415
* No. of Students (1986)				
Primary & Secondary	4,319,137	954,666	213,733	807,036
University & Colleges of Education	69,301	162,627	19,345	20,407
Technical Institutions	10,139	71,006	5,047	5,990
+ Cost per student 1983/4	R.234 (blacks in white areas) R.113-R.246 (in self-governing homelands)	R.1,654	R.1,088	R.569
++ Teacher/Pupil Ratios 1984	40.7 to 1	18.9 to 1	23 to 1	26 to 1

* RSA, Central Statistics Service 1987

\+ Survey of Race Relations in South Africa, South Africa Institute of Race Relations Johannesburg 1984 p.648

++ Survey of Race Relations in South Africa, South Africa Institute of Race Relations Johannesburg 1984 p.650

Table I gives a brief impression only of comparisons in the education system.. Detail must be followed up by reading references quoted.

The major limiting factor to increasing education of black people appears to be the shortage of qualified teachers. Efforts are being made to escalate this resource and is apparent by the increase in black teachers enrolling for qualifying courses. In 1981 the number enrolled was 436. By 1985 that number had increased to 7,300. There has been an enormous increase in schools for black students in recent years. It is stated this amounts to one school every 3 days.

To achieve parity in teacher pupil ratios, massive expenditure increases in all groups will be needed. The illiteracy of black people remains a major problem. The literacy rate amongst black people is said to be between 50% and 60% and among whites 98%. Rejection of the segregated education system by black students has, since 1976, caused political disruption of schools to the point that by the end of 1985 around 200,000 pupils were boycotting classes. Matriculation standards are said to be the same or at least similar between white and black schools. This point is widely debated.

In 1985 some 12,000 students eligible to write final examinations did not take them. Disruption by boycotts at Universities throughout 1986 and 1987 has seriously affected the chances of many occupational therapy students to meet the requirements for eligibility to sit final examinations. Hence, the attrition rate in occupational therapy programmes is very high.

'equality in education remains an objective rather than a reality'[3]

TABLE II

UNIVERSITY ENROLLMENT 1985					
	TOTAL	BLACKS	WHITES	COLOUREDS	INDIANS
Cape Town	11,205	320	9,483	1,133	269
Durban-Westville	6,337	140	159	153	5,885
Medunsa	1,226	1,043	170	2	11
Natal	10,056	953	7,519	208	1,376
Orange Free State	8,222	34	8,167	21	0
Pretoria	18,453	2	18,443	2	6
Stellenbosch	13,229	15	13,006	201	7
Western Cape	7,242	308	75	6,527	332
Witwatersand	15,869	924	13,782	222	941
Fort Hare	3,176	3,123	29	22	2
The North	5,370	5,357	6	4	3
Port Elizabeth	3,737	28	3,426	253	30
Potchefstroom	7,870	19	7,845	3	3
Rhodes	3,382	350	2,782	113	137
*UNISA	77,028	17,820	46,950	3,968	8,290
Vista (day only)	10,115	10,093	4	16	2
RAU	6,921	38	6,817	63	3
Zululand	2,318	2,305	7	3	3

* UNISA is a correspondence university. 60% of students are white.

Source: Central Statistical Service 1985.

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1.3 OCCUPATIONAL THERAPY

The practice of occupational therapy in South Africa covers a broad range of services, including highly-developed, specialised and traditional hospital-based practice and basic, generalised, rural community practice. Until recently, occupational therapists worked only in institutions; increasingly, they serve as members of health teams or welfare groups in the rural communities. Occupational therapy practice therefore reflects the same first-world and third-world dichotomy that characterises life in South Africa.

There are approximately 1000 occupational therapists registered by the South Africal Medical and Dental Council, the majority are in the Transvaal. More than 20% are between 25 and 35 years old. Non-white therapists number 47; not all are working.

Areas of practice are unequally represented by currently working therapists: 46% in pediatrics (including private practice) and 2% in geriatrics. There is a documented shortage of occupational therapists in all areas of practice, particularly psychiatry. This is a matter of concern to government health officials, and to the South African Occupational Therapy Association.

Administration of occupational therapy services may be at the central, regional, local (city) or private level. Thus, psychiatric and mental retardation services are in state facilities, general hospitals are under the jurisdiction of the regional services and facilities for the care of elderly people are locally administered. Prcposed changes in the health service under the new plan, will see all services administered by a Regional Health body.

Salaries for occupational therapists in the public sector are equal, regardless of type of facility. The incremental salary structure is on 4 levels: basic therapists, senior, chief occupational therapist and control therapist. Ten control positions exist at present. There is one post for Head Office control. A recent 12% salary increase has brought oocupational therapy salaries to a level that is generally on a par with other health professionals. Salaries for health service workers in the Independent States of Ciskei, Transkei, Bophuthatswana and Venda are entirely the responsibility of the governments of those republics and may bear no relation to salaries in the Republic of South Africa. However, the 6 self governing states are individually determined by their own internal administration and, as such, do not necessarily reflect the same salary increases or parity levels as the rest of South Africa. A location allowance is paid to South Africans working in a self-governing state who are not citizens of that state.

TRAINING

Occupational therapy education is provided on the bachelor's degree level (B OT, B Sc OT, or B Arb) in 8 universities. The earliest training centre was established in 1944 at the University of Witwatersrand; the most recently established centre is at the University of Western Cape. The first students from this school will complete their final training next year.

Enrollment at the training centres ranges from 29 students at Medunsa (Medical University of South Africa) to 105 students at the University of Pretoria. The total student enrollment is 575.

Geographically, seven educational programmes are located in major cities (Johannesburg, Pretoria, Durban , Cape Town, and Blomfontein); Medunsa is in one of the self governing states near Pretoria.

All the universities are theoretically open to all racial groups, however, the geographic placement of the university or the official language limits accessibility to certain groups of students. For example, the universities of Orange Free State, Pretoria and Stellenbosch are predominently white, with Afrikaans as the official language. The other universities use English as their medium. The University of Western Cape, although open to all races, is predominantly coloured. Likewise, the University of Durban/Westville, is predominantly Indian and the Medical University of South Africa (Medunsa) is predominantly black. The universities of Cape Town and Witwatersrand are totally non-racial.

Education standards, set by the Professional Board for Occupational Therapy must be met by all the training programmes and are reviewed every six years by the Professional Board, and 5 yearly by SAAOT. All medical and dental practitioners and supplementary personnel are equally registered with the Medical and Dental Council. External examiners are used by all the educational programmes as a further measure to maintain standards.

Post graduate courses, including Honours, Master of Science in Occupational Therapy or Master of Occupational Therapy are offered at all eight universities; a Ph D programme exists only at Witwatersrand. A Diploma in Advanced Occupational Therapy is also offered by the University of Witwatersrand.

The training schools have 6-12 faculty members, most of whom have both clinical and academic responsibilities. Nationally, only one faculty member currently holds a professorial appointment; all others are lecturers and senior lecturers.

The attrition rate in all schools is very high, partially attributed to academic failure, partially to lack of clearly defined career goals during the first two years. **(Appendix I)** Training of support staff is receiving increasing emphasis. A number of in-service training programmes are underway in hospitals. This move is supported by the Medical and Dental Council.

THE SOUTH AFRICAN ASSOCIATION OF OCCUPATIONAL THERAPISTS

The South African Association of Occupational Therapists (SAAOT) is a non-racial organisation maintaining and encouraging professional status and growth. It consists of a Council of Management representing five regional groups (Southern Transvaal, Northern Transvaal, Cape Province, Natal and Orange Free State). This Council is directed by an Executive Committee of five officers. The welfare, employment conditions, salaries, training standards and generally the status of the profession are the primary concern of the SAAOT. The Association, in collaboration with the Medical and Dental Council is further concerned with ensuring the quality of occupational therapy services to all peoples of South Africa irrespective of race, colour or creed.

The SAAOT officially adopted a Code of Ethics in the 1950s, and amended slightly in 1985 this sets forth that the therapist "shall at all times strive to give treatment of the highest level of professional skill, irrespective of race, colour, creed, nationality, politics and social status". **(Appendix C)**

Membership in the SAAOT is voluntary and open to all occupational therapy students and registered therapists. Total membership is 740.

The aims and objectives of the SAAOT are accomplished through standing committees. **(Appendix C)**

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2. THE DELEGATION AND ITS PURPOSE

2.1 THE DELEGATION

Members of the Delegation
(See WFOT Minutes of 1986 page 81)

The Delegation consisted of the following members:-

1 past delegate of WFOT	Mrs Barbara Neuhaus (USA)
1 present executive member of WFOT	Mrs Sue De Gilio (UK)
1 member of Scandanavian Council	Mrs Ulla Kroksmark (Sweden)
1 member from South Africa	Mrs Marj Concha (South Africa)

2.2 THE PURPOSE OF THE VISIT

The purpose of the visit to South Africa as approved by WFOT Council No 17, 1986 (see Minutes page 57) was to:

2.2.1 Review the training of Occupational Therapists

2.2.2 Discuss the role of SAAOT with regard to its members and the health care system

2.2.3 View the treatment offered to all the peoples of South Africa by its Occupational Therapists

2.2.4 Discuss with SAAOT the ways in which WFOT can provide assistance to SAAOT in the achievement of its goals.

These aims were interpreted by the delegation as viewing Occupational Therapy in the framework of apartheid and the effects that it has on the practice of Occupational Therapy.

2.3 THE DESIGN OF THE VISIT

2.3.1 A committee was constituted by SAAOT to plan the itinerary. This committee was chaired by Mrs Estelle Shipham a previous WFOT delegate. The committee took the following factors into account when planning the visit.

a) That although the basis of the visit is political, the emphasis should be on the practice of Occupational Therapy as per the aims listed in WFOT minutes 1986.

b) Some understanding of the complexities of the country should be gained by the delegation as the country is multi-racial and contains a combination of First and Third World characteristics.

c) Some understanding regarding a society in transition should be gained.

d) It was desirable to expose delegates to Occupational Therapy in a variety of settings - ie:

Rural and Urban
Hospital and Community
Acute and Chronic
Physical disability services and Psychiatric services

e) They should be given the opportunity to talk to a wide variety of people and to see the way in which they live.

f) They should also be given the opportunity to talk to Government officials regarding health services and policies.

These objectives were circulated to all members of SAAOT and to all Occupational Therapists registered with the South African Medical and Dental Council so that a representative opinion could be obtained from all Occupational Therapists in the country.

The itinerary was then planned according to the distances to be covered, the cost and time available. **(Appendix B)**

Additional suggestions from the delegation and included in the programme were meetings with:-

* The South African Society of Physiotherapists
* The South African Speech and Hearing Association
* The Black Sash Organisation
* The Afrikaaner Volkswag
* The National Medical and Dental Association

2.3.2 **Modus Operandi of Delegation**

The 4 members met for a day prior to the commencement of the tour to discuss recording, chairmanship and questions to be asked.

To do this certain premises were made and related to an objection. The action was detailed as well as the key points to look for in each situation (see 2.3.3). An offical spokesperson and recorder was appointed for each day, each person taking a turn. The delegation met each morning (at breakfast) prior to the commencement of the day to discuss the modus operandi for the day, and each evening to discuss the results of the day's activities and to record salient points.

Terms were used as follows to describe the racial slant of places visited:

Non-racial	Race did not feature at all in the description
Multi-racial	Available to all races but one race may receive preference as the service was originally developed for that race group.

2.3.3 **Objectives**

OBJECTIVE I Review of the function of Occupational Therapy schools

PREMISE Black and White education is not equal

ACTION View selection of Occupational Therapy schools

1. Medunsa
2. Durban Westville
3. Stellenbosch
4. Cape Town
5. Pretoria
6. University of Western Cape

KEY POINTS

1. Syllabus

   * Content — Multi cultural
   * Bias — Single ethnic
   * Standards — Falter-start programmes enabling /disqualifying factors

2. Accessibility

   * Availability
   * Recruitment — publicity; SAAOT function; school function
   * Criteria for admission
   * Clinical placements
   * Choices/restrictions
   * Number of students of other colour

3. Standards

   * Monitoring
   * Registration
   * Continuous assessment/evaluation
   * Teacher-student ratio

4. Further Education

   * Accessibility
   * Equality at all levels

5. Individual Needs of Students

   * How they view their opportunities
   * Bursaries/grants/loans
   * Teaching/training/research

6. Issues

   * Government restrictions on subsidies/grants
   * Resource allocation within Univsities
   * Decision making in resource allocation, policy development and government

OBJECTIVE II

PREMISE — View the practice offered to South African people by Occupational Therapists All people do not have equal opportunity for availability of occupational therapy.

ACTION — To visit a selection of practice areas.

KEY POINTS

1. Accessibility to Therapy and facilities available

   * Available for whom and where
   * Acceptance of referral/non-acceptance
   * Refusal of treatment by staff/patient
   * Referral to other services
   * Range of benefits
     - aids/appliannces
     - home adaptations
     - adaption
     - medical insurance
     - insurance
     - private health care
   * Choices/range of treatment
   * Ratios - patient/staff
     - urban/rural

2. Employment

   * Employment criteria
   * Range of benefits
     - salaries
     - uniforms
     - holidays
     - education
   * Job mobility, transfer between jobs, promotion, choices, specialisation
   * Student supervision
   * Private practice
     - extent
     - choice
     - charges

3. General Administration

   * Equal access to resources/policy determination
   * Involvement in decision making at all levels
   * Compliance

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3. DISCUSSIONS AND INFORMATION COLLECTION

3.1 SUMMARY OF MEETINGS WITH OFFICIALS

3.1.1 Meeting with the Minister of Health and Population Development Dr W van Niekerk - Saturday 25 July

This meeting was requested by the Minister. Prior to the meeting the delegation was asked to submit questions which were as follows:

a) 'We are aware that the State President has said that "Apartheid is dead in South Africa" yet we still see some evidence of this within the health care system. This means that there is some inequality of services within Occupational Therapy and therefore precious waste of limited manpower. Could the Minister give us some indication of the Government's plan to eliminate apartheid in health care and therefore to help the profession of Occupational Therapy to consolidate its resources and plan more easily for the patient's future.'

b) 'We note that Occupational Therapists work mainly within the hospitals and that patient turnover is quick. Therefore the Occupational Therapist does not have the opportunity for any really relevant contribution to patient care. Are there any plans to create community services, rehabilitation centres or both.'

In response to questions as stated above, the Minister indicated that:

a) In the case of employment that no discrimination exists, that therapists can be employed anywhere, and that therapists are governed by highly entrenched ethics (regulations) therefore cannot refuse treatment to a patient. On the other hand, patients had the right to exercise choice.

b) In addressing training the Minister indicated that if the SAMDC approved it, a new level of rehabilitation worker could come into existance. This proposal is due to be placed before the Director General of Health (from Occupational, Speech and Physio-therapists) shortly. The Minister made it clear that he did not see any change in the present standards of training of Occupational Therapists should other personnel be introduced.

c) The Minister stated that SAAOT should use the professional board to a greater extent than currently and that this was one of the avenues to push for change.

d) It was agreed that South African Occupational Therapists could learn from other countries and to promote this action, the Minister stated that he would finance some South African Occupational Therapists to visit countries to advise on and compare health care systems. A letter requesting written confirmation of this promise was sent from the delegation to the Minister.

e) The most positive outcome of the meeting was the high profile given to South African Occupational Therapy through meeting the Minister and his deputy, highlighting the awareness of Occupational Therapy and the concern expressed by WFOT.

OUTCOME FROM THE MEETING - as reported by SAAOT

1. The Minister has responded very promptly to a letter sent by SAAOT at the beginning of the year in which the SAAOT criticised the present health policies.

2. The Minister has also set the wheels in motion for 2 South African Occupational Therapists to visit overseas countries to look at the training of Rehabilitation Assistants as well as community services.

3.1.2 **Dr Retief - Secretary General for Health**

Two meetings were held with Dr Retief (21 and 31 July)

1st Meeting - 21 July

At the 1st Meeting the delegation was given an overview of the Health System. 12.7% of the population is said to be disabled. 40% of the health services are in the private sector.

2nd Meeting - 31 July

The following key points were discussed:-

a Role of the Universities in helping change the patterns of skill levels in training occupational therapists to be trainers and supervisors of lower levels.

b) The proactive rather than reactive role that Occupational Therapists should play and the vital role that the SAAOT has in the input to the Department of Health in this respect.

c) The way in which SAAOT could use the Professional Board of Occupational Therapy to bring about change and vice versa.

d) The desirability of an advisory Occupational Therapist at Central Government. This person could be seconded on a rotational basis.

3.1.3 **Dr Reeve Saunders - Deputy Director Hospital Services Cape Province**

Dr Reeve Saunders, an extremely dynamic person and a known anti-apartheid activist. Advised on the desirability of working for change from within the system rather than from without.

3.1.4 **Professor Philip Tobias**

Professor of Anatomy at Wits University and past WFOT expert advisor, Professor Tobias is a well known international expert in anthropology and an anti-apartheid

activist. Professor Tobias gave the background to the National Medical and Dental Association (NAMDA), Medical Education for South African Blacks (MESAB) and the Health Workers Association. He suggested that South African Occupational Therapy could be best served by remaining a member of WFOT.

3.1.5 **Professor C Rosendorff - Dean, Faculty of Medicine University of Witwatersrand**

Explained the problems that non racial institutions such as the University of the Witwatersrand have within the South African context. He also emphasised that the delegation should make a strong statement against apartheid. **(Appendix I)**

3.2 **SUMMARIES OF MEETINGS WITH PARTICULAR GROUPS**

3.2.1 **Representatives of the Speech and Hearing Association and Physiotherapy Society**

Speech and Hearing Therapists gave an overview of their Association and a creditable review of their attitudes to open access to all races.

Physiotherapists discussed the outcome of deliberations of the World Confederation of Physical Therapists regarding South Africa. Apparently there was not a quorum, therefore a decision could not be made, but it was recommended not to expel South Africa. The Physiotherapists did not believe that there was any discrimination by physiotherapists towards their patients.

The meeting was held to put into perspective the attitudes and actions of SAAOT in relation to the other health professions. In comparison it appears that SAAOT was doing much more than physiotherapy and as much as, if not more than Speech Therapy to bring about change and to eliminate apartheid from the practice of the profession.

3.2.2 **Meeting with Black Therapists, Soweto**

This meeting took place on 1 August 1988 in a therapist's home in Soweto. The therapists who attended the meeting wished to have the following points documented:-

* Apartheid is still thriving in South Africa and in the profession
* Until 1983 certain posts were reserved for whites, but although theoretically posts are now open, attitudinally they are still closed.
* Black therapists do not have access to all jobs, but white therapists can work anywhere.
* White therapists receive allowances to work in certain areas, but black therapists do not.
* Different occupational therapy resources exist for black and white therapists.
* When a fraction is given to a black therapist, it is less than that given to a white therapist.

* When black therapists come to a local SAAOT meeting, find it very difficult if only Afrikaans is spoken.
* At a SAAOT Conference some papers are delivered in Afrikaans only. A common language should be considered for SAAOT.
* Training of black therapists is inferior in Black universities.

The delegation followed these points through with SAAOT Executive. (See 3.3.2 and 3.3.3)

3.2.3 **Meetings with:**

The Black Sash
The South Africa Foundation
The Afrikaaner Volkswag
The FUNDA Centre
A Witchdoctor at Gazankulu
Occupational Therapy student groups

All of the above helped to provide the background and perspective of the Report.

3.3 SUMMARIES OF MEETINGS WITH THE EXECUTIVE BOARD, SAAOT

Three meetings took place, at the beginning, during and at the end of the visit.

3.3.1 Meeting 20 July 1987 - Johannesburg

This first meeting, lasting 2½ hours, was aimed at:

a) Providing information for the delegation in the form of an overview of occupational therapy training and practice in South Africa plus the role and functions of the SAAOT itself.

b) Agreeing the itinerary including alterations and additions by the delegation.

c) Advising the SAAOT of the objectives of the delegation, the system and approach they would be taking including the way the delegation would feedback to the SAAOT and when.

The system and approach taken by the delegation is outlined in 2.3. Suffice it to say that this first meeting was very much an information exchange in order to set correctly the agenda for the following three weeks. In addition to the meetings arranged by SAAOT

* The Foundation
* The South Africa Foundation
* Representatives of the House of Delegates
* Representatives of the House of Representatives
* University of Witwatersrand Medical Dean and Principal
* The FUNDA Centre

The delegation asked for the following to be added:

* The Black Sash Group
* The South African Society for Physiotherapy
* The South African Speech & Hearing Association
* The Afrikaaner Volkswag

3.3.2 **Meeting 28 July 1987 - Durban**

This was the first feedback the Executive had received. The following points were made and discussed at length. (see page 18)

THE ISSUE	THE DETAIL	THE DISCUSSION	THE POSSIBLE SOLUTIONS
1. The need to address coping strategies for therapists both in training and in practice.	The delegation observed a degree of passivity and compliance by therapists with the systems they must work under. This compliance revealed in several cases an underlying bitterness and a feeling of helplessness to influence changes.	The delegation suggested the SAAOT needed to address the need and the method whereby therapists could learn the coping strategies necessary to become Agents of Change.	* Training in the Management of Change * Increased cohesion and support from SAAOT. * Devising support systems - perhaps one or two Key Therapists designated in each area. (Set up via SAAOT Planning Committee).
2. The need to address the problems and difficulties for O.T.s working with other professionals not adopting the same non-racial stance as O.T.	O.T.s experience difficulties in some environments developing team approaches to treatment. To do so infers compliance and/or acceptance of the system.	Coping strategies need to be addressed.	* Support systems. * Training in managing change.
3. The need to consider involving students as an integral part of the professional body.	Encouragement for individuals to work together and support each other as a profession is enhanced in this environment. Equality of status was a concern particularly for non-white students. Being able to influence the professional body in respect of particular needs of student groups was another.	Considerable discussion ensued on how to integrate students into the SAAOT so that they could influence matters that concerned training and training issues in particular.	* Student representative on education committee. * Students form own local groups with an affiliation to the SAAOT and a representative voting right.

4. The need to institute ongoing information systems that will supply in particular, statistical information.	The delegation observed the apparent lack of statistical data that could be used as back-up evidence in particular for: a. Pressuring over inequalities in the service and training. b. Providing manpower detail for community services. c. Providing feedback to the SAAOT and O.T.s to enable efficiency and effectiveness in practice.	The SAAOT has been the prime mover in pushing Government for the development of a broad based approach to community rehabilitation services which are currently very limited in all areas. Whilst it is recognised that statistics have limitations, it was felt, never the less, that in the early stages of developing a new approach, some statistics could be helpful in setting the scene.	* Address the need to collect some statistical information as relates to efficiency, effectiveness and quality of service provision ongoing.
5. To consider the possibility of an occupational therapy advisor at Central Government level (Dept of National Health & Population Development) to advise on O.T. needs and developments.	The delegation noted that O.T.s have no way in policy making other than through advisory groups who may not neccessarily reflect particular issues or needs pertaining to O.T. This is the same for Speech & Physio-Therapy.	Discussion focused on the way this could be approached with the Director General of Health. Secondment and rotation were suggested. Rotation between the three professions was also considered.	* Secondment Rotation. * Need discussion with Director General.
6. Inadequacies in Primary and Secondary education may cause constraints for some individuals wishing to train in occupational therapy.	It seemed apparent to the delegation that limitations and inadequacies in early education could have a large part to play in people gaining access to O.T. training and in the current attrition rate in O.T. Schools.	The SAAOT has been concerned by the attrition rate.	There is an awareness that existing support programmes in education may need to be increased in order to ensure O.T.s can cope with the course.

THE ISSUE	THE DETAIL	THE DISCUSSION	THE POSSIBLE SOLUTIONS
7. A common language for SAAOT.	Black therapists advised the delegation that certain local SAAOT group meetings may be conducted partly in Afrikaans which effectively excluded participation by those not fluent in that language.	SAAOT view both English and Afrikaans as official languages for meetings and Congresses. The delegation made the point that only certain race groups are educated in both English and Afrikaans and therefore, non-Afrikaans speaking people are effectively excluded. Unlike Canada where two languages co-exist and complement each other, this is not so in South Africa. There is no automatic translation of material or speeches.	* That SAAOT consider english as official language for SAAOT. * That written material and Congress literature presented in Afrikaans be made available also in English.
8. SAAOT to advise the delegation of issues and results of discussions with black Therapists.	Black Therapists have had dialogue with SAAOT since 1985 on several issues which appear not to have been resolved according to the black therapist. These issues relate to: a. Salary and conditions of appointment in Independent States. b. Language. c. Level of training at Medunsa. d. Dissatisfaction with SAAOT efforts on behalf of black O.T.s.		SAAOT to inform delegation of details on 6 August 1987.

3.3.3 Meeting 6th August 1987 - University of Witwatersrand, Johannesburg

The final meeting provided the official feedback from the delegation, a forum of discussion and information exchange particularly in regard to support systems.

CHAIRPERSON: Mrs Soekie van Wyk, Immediate Past President of SAAOT.

SAAOT REPRESENTATIVES:

Ruth Watson	Hon. Life President
Robin Joubert	President
Dain van de Reyden	2nd Vice President
Stella Mountford	1st Alternate Delegate to WFOT
Rosemary Crouch	2nd Alternate Delegate to WFOT
Estelle Shipham	Chairman of the WFOT Organisation Committee
Pat de Witt	Secretary of WFOT Organising Committee.

The meeting covered two main parts:

i. Presentation of the delegation's findings

ii. Discussion on how WFOT could support the SAAOT.

The detail of Part (i) can be found in 4.1 and 4.2 Findings. Part (ii) is detailed in 4.3 Support Systems.

Discussion focused on the issues brought out in the second meeting 28th July and on the follow-up to the particular issue raised in relation to black therapists.

Summary of information on issues raised by black therapists.

In 1985 the SAAOT Executive received a letter from a group of black therapists expressing concern on the following issues:

* no parity in salaries structure.
* seven year service requirement before able to apply for advisor post.
* questionable equality of educational level between Medunsa and other Universities.
* questioning about opportunites in future for further studies at Medunsa.
* dissatisfaction with efforts of SAAOT on behalf of the black Occupational Therapists

SAAOT responded in writing and the Executive met with the Therapists. Misconceptions about SAAOT's role were ironed out. Many black therapists were not members but expected individual support without membership.

Action by SAAOT

1. The SAAOT issued a Statement of Intent that outlined SAAOT attitude to race groups.

2. SAAOT sent a letter to black therapists offering the SAAOT 2nd Vice President as a contact person, and offering assistance indicating willingness to act as a mediator when needed.

3. A document on occupational therapy was sent to Independent State Governments.

4. Language was looked at and it was agreed to attach summaries of articles written in Afrikaans.

5. Representations continuing to press for parity, were eventually successful. Parity was achieved in 1986.

Responses by Black Therapists

Some black therapists became members of SAAOT, otherwise, the SAAOT received no response.

In discussion, it became apparent to the delegation, that the dilemmas for black therapists are many. Even belonging to the SAAOT can be construed by some, particularly black people, as condoning apartheid. The SAAOT continues, however, to act on behalf of the therapists.

4. FINDINGS

4.1 OCCUPATIONAL THERAPY TRAINING SCHEMES

Training of occupational therapists presents a mixed picture. All Universities in terms of their policy are open to all races. However, whilst some Universities are definitely non-racial - eg Witwatersrand University and Cape Town University - some give preference to certain race groups (Medunsa University : blacks; West Cape : coloureds; Durban/Westville : Indians; Stellenbosch : whites) in order to boost the numbers of therapists of that race but other race groups are not totally excluded.

For some Universities (Pretoria, University of the Orange Free State) the combination of the language of instruction and Government regulations (The Group Areas Act) make it difficult to be a non-racial school. Some Universities - eg Witwatersrand - are defying the Group Areas Act and have opened their residences to all races. Other Universities - eg Pretoria - comply with the Act, thereby limiting accessibility for blacks, coloureds and Indians.

TABLE III ADMISSION POLICY

Training Schools for Occupational Therapists in South Africa 1987

UNIVERSITY	PROVINCE	ADMISSIONS POLICY	CURRENT STATUS
1. Cape Town	Cape	Merit only	students of all races.
2. Stellenbosch	Cape	Merit only	white and coloured students.
3. Western Cape	Cape	Merit but preference given to black, coloured and Indian.	black and coloured students.
4. Durban/Westville	Natal	Merit but preference given to Indian and Blacks.	students of all races.
5. Orange Free State	O.F.S.	Merit only.	white students.
6. Pretoria	Northern Transvaal	Merit only.	white students.
7. Witwatersrand	Northern Transvaal	Merit only.	students of all races.
8. Medical University of Southern Africa (Medunsa)	Independent State of Bophuthatswana	Merit but preference given to Blacks.	Black students.

The delegation viewed a selection of Schools and their attached training Hospitals (Medunsa, Durban/Westville, Cape Town, Stellenbosch) and had discussions with occupational therapy faculty members of these schools.

Active recruitment programmes were evident in all areas and SAAOT handles professional and education pubilcity through a Public Relations Officer.

Criteria for admission are in accordance with university policy with slight variations from one university to another eg some require mathematics, some do not. Clinical placements generally are limited to the teaching hospitals associated with the university, although students attend specialised areas such as Cerebral Palsy schools and employment retraining areas, wherever they might be located. The University of Witwatersrand has introduced an innovative rural clinical placement programme which has been operating for the past two years on a compulsory basis replacing electives. All students have open access to all clinical placement areas.

All courses have to meet W.F.O.T. minimum standards and are screened on a five yearly basis by two processes. The first is by the Medical and Dental Council and the second is by SAAOT. Content varies according to the particular university but there is a similarity throughout all programmes. Primary and secondary education in South Africa is not equal, therefore it is sometimes necessary for students to undertake an academic support programme in order to cope at the required academic level for occupational therapy training. Not all universities have this programme. This will usually extend the occupational therapy course by one year but enables access to occupational therapy training that may not be possible otherwise.

Some black therapists expressed strong feelings about their training at Medunsa being inferior to other occupational therapy training in South Africa. However, there is no evidence to suggest this is so. In order to maintain standards, apart from continuous evaluation, there is also a system of external examiners for the final year. In some universities eg Witwatersrand, there are external examiners for all four years. External examiners are appointed by the University Faculty Board. The attrition rate is high in all Schools and is a matter of grave concern to both the faculties and SAAOT. Reasons are being investigated and at this stage it is not clear if this is due to wrong career choices, academic requirements or examination failure.

All primary and secondary education is provided free by the State with parents providing books and uniforms. Tertiary education is not free. Universities have varying fee structures although there is a similarity between university charges. Bursaries are available to all students on application. There are a substantially greater number of bursaries for black students than for others.

There are no occupational therapy training facilities that substantially differ in quality and quantity. All of the schools we saw had good training facilities and resources.

* * * * *

4.2 OCCUPATIONAL THERAPY IN PRACTICE

Health services are made available in a variety of forms including those for all or only particular race groups, those for all or only particular disability groups. Health services include those provided wholly by the private sector, wholly through state contributions and those funded jointly by State and private agencies.

South Africa is not a social welfare state. It should be kept in mind that individuals are required to pay something towards their treatment and/or hospitalisation based on income, with a minimum income limit. Some people therefore, receive services without having to financially contribute.

TABLE IV

Examples of Health Services By Classifications

RACE GROUP	STATE FUNDING	DISABILITY GROUP	PRIVATE FUNDING	DISABILITY GROUP	LOCATION
NON-RACIAL (Integrated)	Lentegeur Hospital Groote Schuur Hosp	Psychiatric General/acute	League of Friends of the Blind St Giles Sports Club Workmens Accident and Rehabilitation Hospital Optima Training Centre Access Business College Independent Living Centre Saida Toy Library	Blind All Groups All Groups Blind All Groups All Groups Children	Cape Province Cape Province Durban Pretoria Pretoria Johannesburg Johannesburg
MULTI-RACIAL (all races but separate services)	Tygerberg Hospital Valkenberg Hospital Addington Hospital Johannesburg General Hospital (in-patients services segregated, out-patient services non-racial) Veskoopies Hospital	General/Acute Psychiatric General/Psychiatric Unit Psychiatric (black & white)			Cape Province Cape Province Durban Johannesburg Pretoria
MIXED RACES (Indian, Coloured, Black)	Hillbrow Hospital Baragwanath Hospital	General & Psychiatric Unit General & Psychiatric Unit			Johannesburg Soweto
SEPARATE RACES Black	Clarewood Hospital Echuhlengeni Hospital Elim Hospital	General Psychiatric General	SHAP (Self Help for Paraplegics) Medicos Centre	Paraplegics Children	Durban Durban Soweto Gazankulu } → In self-governing states Soshanguve }
SEPARATE RACES Coloured	Eros Cerebal Palsy School	Cerebral Palsy & Disabled Children			Cape Town
SEPARATE RACES Indian	R.H. Khan Hospital	General			Durban
SEPARATE RACES White	H.F. Verwoerd Hospital	General/Acute			Pretoria

Our starting point in relation to occupational therapy was whether people had equal access to occupational therapy and all occupational therapy facilities. The answer is NO. Whilst a number of services are non-racial (Groot Schuur), others are segregated such as at Falkenberg Psychiatric Hospital where there are separate occupational therapy services for black and white. In multi-racial hospitals where there are all races but separate services, occupational therapy is integrated (Tygerberg, Addington).

Some hospitals and therefore occupational therapy services are exclusively for black or whites. Some hospitals and therefore occupational therapy services include only black, coloured and Indian patients.

The majority of occupational therapists are white. All these therapists may work in all occupational therapy departments. A number of therapists are Indian and coloured. There are a few, about 30, black therapists. According to some black therapists with whom conversations were held, jobs in white hospitals would not be available to them. Occupational therapy jobs in self-governing states are designated for therapists who are citizens of that state but failing the availability of eligible candidates, these posts may be filled by other therapists from outside the state, on a seconded basis.

Some therapists are in private practice. Choice of client is the therapist's prerogative. Many private practices are multi-racial.

Legally, a therapist is not in a position to refuse a referral or refuse to treat a patient although a patient has the right to choose the therapist. This point was checked and clarified with the Minister of Health, Dr van Niekerk. Breaches of this regulation incur disciplinary measures. Occupational therapists are free to refer their patients to other members of the team even if those other team members work in segregated departments.

Facilities and equipment vary in quality and quantity. It appears that psychiatric occupational therapy facilities in general, and for black people in particular, are poor in comparison with occupational therapy facilities in hospitals dealing with physical disabilities (examples of poor facilities - Valkenberg, Weskoppies). Yet the most recently built (just completed 1987) psychiatric hospital for all races has what can only be described as superb occupational therapy facilities. There are a number of excellent specialised services in which occupational therapists are involved in both non-racial and segregated facilities - eg Access Business College, Tygerberg School for the Hard of Hearing, Optima Training Centre for the Blind and Hillbrow Hospital. Hi-tech equipment is available to all patients with physical disabilities - ie computers. This type of equipment is often not appropriate for rural areas but can be made available if appropriate.

There were no apparent discrepencies in activities and methods available for patients throughout the occupational therapy services. The ratio of staff to patients, however, varies greatly depending on whether the setting is physical disabilities or psychiatry. Low staff/patient ratios in psychiatry were widely evident and are a matter of concern to SAAOT. There was one marked example of concern, Weskoppies Hospital, Pretoria, where discrimination was evident on two counts. The ratio of white therapists to white patients was 10: 1000 in comparison to the ratio of one black therapist with 1000 black patients. The occupational therapy departments

were totally separate and the occupational therapy facilities for white patients were superior in quantity and quality to those provided for black patients. On the other hand the residential accommodation recently built and used for some, but not all, black patients was far superior to the accommodation for white patients. It is also fair to say that the poorest accommodation for white patients was still far superior to the poorest for black patients.

Whereas most occupational therapy posts are available to all therapists, there are some situations that have yet to be tested - eg H F Verwoerd Hospital and Johannesburg General Hospital, both of which have only white occupational therapy staff. To date, there are approximately 38 non-white occupational therapists known to be practising occupational therapy out of the total registered number of 1,100 (1987). Occupational therapists are not registered by the state or the SAAOT by race groups, thus figures by race group can only be estimated. The SAAOT extracted the information in Table V via the Occupational Therapy Training Schools.

TABLE V

NON-WHITE OCCUPATIONAL THERAPISTS KNOWN TO BE PRACTISING OCCUPATIONAL THERAPY AT AUGUST 1987

University Qualified At	Working In		
	Physical/General	Psychiatry	Paediatrics
Medunsa	9 (black)	8 (black)	4 (black)
Cape Town	2 (coloured)		2 (coloured)
Durban/Westville	3 (Indian)	2 (Indian)	1 (Indian)
Stellenbosch	1 (coloured)		2 (coloured)
Witwatersrand	1 (Indian)		1 (coloured) 1 (Indian)

At September 1986 parity of salaries was established for all occupational therapists regardless of where they were practising. There is a Location Allowance given to white occupational therapists who work in self-governing states. Occupational therapists who are citizens of a self-governing state and who are working in that state, do not receive this Location Allowance. There is a transport allowance for all occupational therapists who live more than 10km. from their place of work. Uniforms and shoe allowance is given to all occupational therapists.

Post-Graduate and inservice training is available to all therapists. At the same time as the introduction of parity in salaries, the length of time required to attain promotion was reduced from seven to three years. SAAOT was very active in pushing for this change. Although there are some promotional situations yet to be tested, there are good examples of non-white therapists achieving seniority. In one case a black therapist is the deputy director of a community medical service (in a self-governing state) which gives him, responsibility for a multi-disciplinary team and budgetary control for the service. All therapists have open access to specialisation, to transfer between jobs and student supervision.

There are a few therapists in private practice including at least one black therapist. Category of client and activity are the prerogative of the practitioner. Charges are controlled by the South Africa Medical and Dental Council.

Most health policy decision-making is centrally controlled by the Department of Health and occupational therapists have minimal input. This is common to all health professionals. In the Transvaal Province, the Head Office Occupational Therapist ensures equal distribution of resources throughout occupational therapy departments. It is a matter of concern for SAAOT that they do not have one particularly designated occupational therapist at Central Government level to specifically contribute to policy and decision-making systems.

* * * * *

4.3 SUPPORT SYSTEMS

Discussion on how SAAOT could help support the profession better and how WFOT could support SAAOT in the future, were focused around the main issues that had been raised at the SAAOT Executive/WFOT Delegation meetings of 28th July and 6th August.

These issues broadly covered:-

1. Coping strategies to enable therapists to influence change.

2. Integrating students into the SAAOT structure.

3. Devising information Systems for occupational therapy.

4. Promoting the concept of an Advisory Occupational Therapist to Central Government.

5. Reviewing inadequacies in early education and its influence on the accessibility to occupational therapy training and on the attrition rate.

6. Particular needs and concerns of black therapists

7. A common language for SAAOT

SAAOT felt WFOT could help them attain some success in addressing these issues by:

1. Following up the Minister of Health's proposal that an SAAOT Delegation funded by the South African Government be sent to view how other countries manage their racial problems (and occupational therapist in particular).

2. Showing support in writing of SAAOT's commitment to a community occupational therapy service approach and the need to view and learn from such approaches in other countries where it is well-established.

   It should be noted that the delegation, on behalf of WFOT, responded to 1 and 2 together in writing to the Minister of Health requesting he activate what he had indicated to us verbally. The Minister in October 1987 agreed in writing to send a delegation to other countries and to finance it. Preparations are now underway.

3. Encouraging an exchange of occupational therapists between countries and giving particular encouragement and support of those countries prepared to send occupational therapists to South Africa to advise and support occupational therapists in South Africa. This support and advice could perhaps be in the area of supplying contracts, information and maybe finance for Lecturers to assist in training therapists in coping strategies and providing assistance in setting up information systems to collect and interpret data.

4. Supporting the concept of an occupational therapy Advisor to Central Government through a letter of support written by the Executive of WFOT.

5. Encouraging greater communication between WFOT Countries using special interest groups, regionalisation, networking.

The Nordic Countries Representative on the delegation offered:

a. To invite a black therapist who is a member of SAAOT to Scandanavia to view occupational therapy services and to help strengthen the therapists professional approach by giving first-hand experience of the working of a professional association in another country.

b. To recognise a non-racial student union within the SAAOT (if it were set up) offering both finance and support.

The SAAOT agreed to investigate the issue of a common language for SAAOT and the issue relating to the influence of inadequacies in early educating on accessibility to occupational therapy training and the attrition rate.

The issues raised give a clear indication of the broad range of concerns of the profession and for the profession in South Africa. The SAAOT Executive are all practising occupational therapists who set time aside to voluntarily work on behalf of the profession. Financially the SAAOT is not able to support a paid secretariat or advisor or chairperson. Despite the wealth of occupational therapy expertise they all share between them, their need for support and advise from WFOT and member countries was very apparent. It was strongly felt that to heighten the awareness of the profession to its needs in a changing turbulent society, under many restrictions, probably needed outside intervention rather than an expectation that therapists within the system could work within it and still retain a clear vision of future needs and the influences needed to bring to bear in order to institute changes.

* * * * *

SUMMARY

In summary, a delegation from WFOT visited South Africa for the following purpose: 1) to review the training of occupational therapists; 2) To discuss the role of SAAOT with regard to its members and the health care system; 3) To view the treatment offered to all peoples of South Africa by its occupational therapists, and 4)To discuss with SAAOT the ways in which WFOT can provide assistance to SAAOT in the achievement of its goals.

The visit was designed to permit maximum exposure to the complexities of a multicultural and multiracial, 1st and 3rd world society in transition, and to view the contrasts between rural and urban, hospital and community, acute and chronic and physical and psychiatric settings. Also included were opportunities for discussions regarding health services and policies with people representing a wide variety of groups as well as with Government officials.

In order to maintain uniformity in its observations the delegation developed 2 sets of key points to be addressed in each school or practice setting. These points related to accessibility, availability and standards of education, employment or services. A special set of questions was developed for each Government or University official and for particular groups that had been selected for their political or cultural importance. Meetings were held with the SAAOT at the beginning, during and at the end of the visit, initially to exchange information and subsequently to report findings and provide recommendations.

The findings of the delegation were: 1) There is a mixed picture of integrated and separate (segregated) practice facilities; 2) The Occupational Therapy services are more non-racial than other departments in hospitals; 3) The quality of facilities and equipment varied: physical disabilities is generally good, while a marked difference exists between black and white psychiatric facilities; 4) There is an obvious shortage of occupational therapists that is detrimental to all patients. However, despite the circumstances the overall quality of treatment compared more than favourably with that experienced by the delegation in their own practice environment.

In training, the picture is equally mixed: some universities are non-racial, some are separate while others have language or geographic (location) criteria that make it difficult to be non-racial. The black therapists with whom the delegation met expressed strong feelings that their training was inferior; however, no evidence for this could be found. Finally, regarding SAAOT, the delegation found an active but compliant group who need to develop strategies for better use of the potential political power they possess and for becoming more active on the Professional Board of which they are members. Currently, they lack the statistical information needed to pressure the government. Students have not been incorporated into the professional group as early as needed. There was an effort made by officials to speak with the delegation and a number of them expressed readiness to work with SAAOT in promoting change.

Few signs of disciminiation by occupational therapists were found, although they are working within a system that still condones apartheid. It became increasingly clear that in spite of the political climate, South African occupational therapists ascribe to the same philosophy as their colleagues in other countries and that it is this philosophy that binds occupational therapists worldwide.

However, it must be noted that South African occupational therapists have been raised in an apartheid system and their application of this philosophy is based on their social structure. They will need factual exposure to other sytems and moral support in order to move toward change. Isolating South African colleagues at this time seems counterproductive and shortsighted. WFOT can play an important role in assisting SAAOT's efforts to bring about change by maintaining an open flow of communication with colleagues in other countries. Specifically, member countries can assist SAAOT to develop community occupational therapy as a way of providing better services to all the people of South Africa. Equally, member countries can offer support to South African therapists through exchange of information and study visits.

Ultimately, occupational therapy philosophy dictates responsibility to the individual patient. This should guide WFOT's future interaction with South African occupational therapists.

LIST OF TABLES AND REFERENCES

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Table I	Education
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Table III	Training Schools for Occupational Therapists in South Africa 1987
Table IV	Examples of Health Services by Classifications
Table V	Non White Occupational Therapists known to be practising Occupational Therapy at August 1987

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Southern Africa

Appendix A

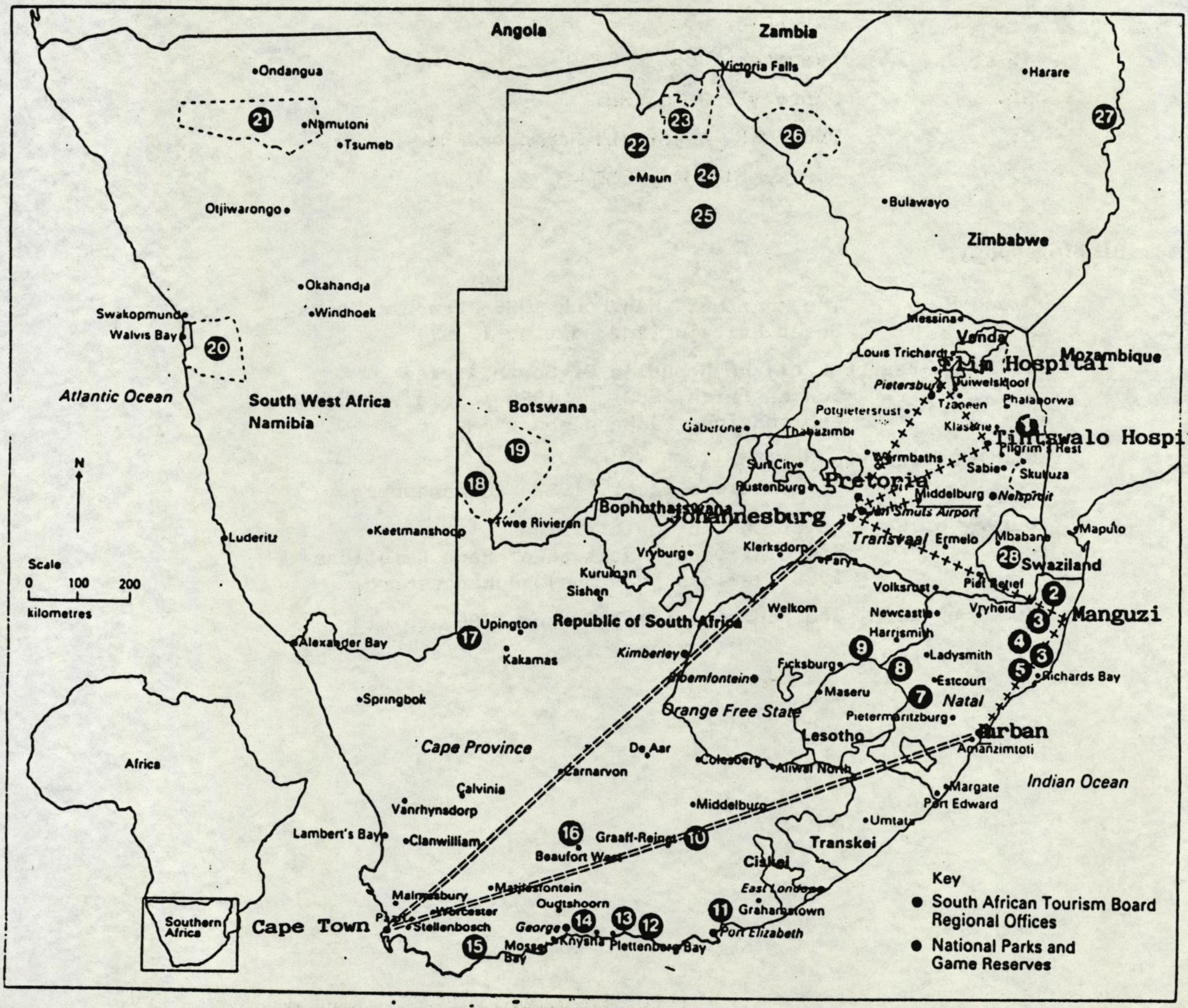
National Parks and Game Reserves

1. Kruger National Park
2. Ndumu Game Reserve
3. Mkuzi Game Reserve
4. Hluhluwe Game Reserve
5. Umfolozi Game Reserve
6. St Lucia Game Reserve
7. Giant's Castle Game Reserve
8. Royal Natal National Park
9. Golden Gate Highlands National Park
10. Mountain Zebra National Park
11. Addo Elephant National Park
12. Tsitsikamma Forest National Park
13. Tsitsikamma Coastal National Park
14. Wilderness Lakes
15. Bontebok National Park
16. Karoo National Park
17. Augrabies Falls National Park
18. Kalahari Gemsbok National Park
19. Gemsbok National Park
20. Namib Desert Park
21. Etosha National Park
22. Moremi Wildlife Reserve
23. Chobe National Park
24. Nxai Pan National Park
25. Makgadikgadi Pans Game Reserve
26. Hwange National Park
27. Inyanga National Park
28. Mlilwane National Park

TRAVEL DIRECTIONS BY DELEGATION

By Road +++++++

By Air ======



Appendix B

DELEGATION ITINERARY.

FRIDAY 17 JULY

Leave Heathrow 1800 - Flight 235

SATURDAY 18 JULY - JOHANNESBURG

am	Arrive Jan Smuts Airport
pm	Delegation Meeting
ppm	Informal Dinner with Organising Committee

SUNDAY 19 JULY - Johannesburg

All Day	Meeting of Delegation to organise visit plan and objectives
ppm	Informal Dinner with National Executive SAAOT

MONDAY 20 JULY - Johannesburg **Spokesperson: Sue De Gilio**

7.30	Review of day's plan
8.00	Meeting with SAAOT
am	Independent Living Centre
pm	Visit to SHAP (Self Help Association for Paraplegics) and Mr Friday Mavuso's home
ppm	1. Dinner with Southern Transvaal Regional Group 2. Evaluation of day by delegation

TUESDAY 21 JULY - Pretoria **Spokesperson: Ulla Kroksmark**

6.30	Review of day
7.30	Meeting with Dr Retief, Hon Pres SAAOT
am	Visit to Optima Medical Fitness for Work Lunch with Staff: University of Pretoria H F Verweord Hospital
pm	Access Business College for disabled people

Flight SA 345 for Cape Town
22.35 Arrive D F Malan Airport - Cape Town

WEDNESDAY 22 JULY - Cape Town **Spokesperson: Barbara Neuhaus**

am	Tygerberg OT Department Lunch with Prof Wasserman, Dean of Stellenbosch Medical School, Tygerberg
pm	University of Western Cape : Case presentations by students
ppm	Meeting with Cape Group of SAAOT, Conradie Hospital

THURSDAY 23 JULY - Cape Town **Spokesperson: Marj Concha**

am	Valkenberg OT Department
pm	Lunch with Dr Reeve Saunders, Cape Provincial Administration Meeting with Dr Reeve Saunders Groot Schuur OT Department Meeting with Heads of Training at University of Cape Town OT Department

Appendix B

FRIDAY 24 JULY - Cape Town **Spokesperson: Sue De Gilio**

am Eros Cerebral Palsy School
Lunch at Lentegeur Hospital
pm Lentegeur Hospital OT Department and Services
League of Friends of the Blind

SATURDAY 25 JULY - Cape Town **Spokesperson: Barbara Neuhaus**

am Meeting with Minister of Health and Population Developemnt - Dr van Niekerk
pm St Giles Sports Club

SUNDAY 26 JULY - Durban

8.15 D J Malan Airport - Fly to Durban
12.30 Arrive Louis Botha Airport
13.30 Leave for Manguzi

MONDAY 27 JULY - Kwazulu **Spokesperson: Ulla Kroksmark**

8.00 Drive to Manguzi
Visit Manguzi Community Projects
Stay Manguzi Hospital

TUESDAY 28 JULY - Durban **Spokesperson: Maria Concha**

7.30 Leave for Durban
pm Addington Hospital
ppm Social Reception with Batal Group of SAAOT including Heads of OT Departments and dignitaries
Stay in-home accommodation

WEDNESDAY 29 JULY - Durban **Spokesperson: Sue De Gilio**

am R H Khan General Hospital OT Department
Clarewood OT Department
Okuhlengeni Psyuchiatric Hospital OT Department
Traditional Indian lunch with OT students of Durban Westville University
pm Meeting with the Rector and Vice Rector of Durban Westville University
King Veorge V Hospital OT Department
ppm Flight SA 536 tyo Johannesburg

THURSDAY 30 JULY - Johannesburg **Spokesperson: Ulla Kroksmark**

M Hillbrow Hospital OT Department
Meeting with Prof Rosendoff - Dean, Wits Medical School
Lunch with Prof Tober - Vice Changellor, Wits University
pm SAODA Toy Library - TMI : Wits Perception and Learning Disabilities Clinic
Meeting with Mr von Schringding - Souty African Foundation

Appendix B

FRIDAY 31 JULY - Johannesburg and Pretoria

Spokesperson: Barbara Neuhaus

am	Baragwaneth Hospital OT Department
pm	Meeting with Afrikaaner Volkswag - Pretoria
	Meeting with official in the Department of Population Development to discuss community development projects
	Meeting with Dr Retief - Director General of Health
ppm	Dinner with Man to Man Division of South Africa Foundation

SATURDAY 1 AUGUST - Johannesburg **Spokesperson: Sue De Gilio**

am	Meeting with representatives from the Speech & Hearing Association and SA Physiotherapy Society
	Visit to Funda Educational Centre - Soweto
	Lunch with Manaeo Tsosane - Soweto

MONDAY 3 August - Gazankulu **Spokesperson Marj Concha**

am	Travel to Tintswalo Hospital - Gazaenkulu
	Tintswalo Hospital
	Presentation on research project on disabled in the community
pm	Visit to a Witch Doctor
	Travel to Magoebaskloof

TUESDAY 4 AUGUST - Gazankulu **Spokesperson: Sue De Gilio**

am	Travel to Elim Hospital
	Visit Elim Hospital
	Visit under 5s Clinic, OT Department and Community patients and Care Group programme
pm	Travel back to Pretoria

WEDNESDAY 5 AUGUST - Bophathutswana **Spokesperson: Ulla Kroksmark**

am	Visit Soshanguve and Medicos - Community project -
	Philadelphia High School for the Disabled
	Meet with Vice Principal of Medunsa, Prof Karlsson - Medical University of South Africa
	Lunch at Medunsa in Caladrius Room
pm	Ga-Rankuwa Hospital OT Department
	Meeting with Teaching Staff of the OT Department of Medunsa
	Cocktails with Northern Transvaal Group
ppm	Travel to Johannesburg

THURSDAY 6 AUGUST - Johannesburg **Spokesperson: Barbara Neuhaus**

am	Westkoppies Psychiatric Hospital
	OT Department - University of Witwatersrand
	Meeting with SAAOT
	Lunch in Wits OT Department with Wits students
pm	Writing report

FRIDAY 7 AUGUST - Johannesburg

8.00	Report writing
18.00	Leave for Jan Smuts Airport
20.00	Flight SA 234 for Heathrow

Appendix C

S.A.A.O.T.

AIMS AND OBJECTIVES

1. INTRODUCTION

Occupational Therapy as a Profession is an integral part of society. The Occupational Therapist helps the individual to achieve a meaningful existence in all aspects of daily life, viz: Personal management, work, leisure, community and social activities.

The South African Association of Occupational Therapists is a non-racial Organisation maintaining and encouraging professional status and growth.

The Association gives attention to the welfare and service conditions of Occupational Therapists and support staff, the standard of training, and is also concerned with ensuring the quality of Occupational Therapy services to all peoples irrespective of race, colour, creed, nationality, political standing or social status.

The Association strives to offer the best possible service to its members and clients.

It therefore has functions related to the following aims and objectives:-

2. AIMS

2.1 To provide a non-racial professional organisation for S.A. Therapists and support staff and to represent the interests of its members as individuals and as a group through:-

2.1.1. Regional Groups and Standing committees.

2.1.2 Representation to S.A. Medical and Dental Council, Allied bodies and Organisations, W.F.O.T., State and Local Government.

2.1.3 The provision of a forum for discussion and decision making about matters concerning the Profession.

2.1 ***To provide, develop and maintain an adequate and effective Occupational Therapy service to all persons in need by:***

2.2.1 Promoting and maintaining Professional and Ethical conduct.

2.2.2 Promoting and maintaining standards of training
- both undergraduate and postgraduate.

2.2.3 Motivating for the establishment of posts and new services.

2.2.4 Representation to relevant Government bodies concerning S.A.A.O.T. policy with regard to patient care and the role and contribution of the Occupational Therapist.

2.3 ***To maintain the standards of Occupational Therapy Practice by:***

2.3.1 Continually evaluating and updating training of Occupational Therapists and support staff.

2.3.2 Providing syllabi for use in training centres.

2.3.3 Providing guidelines for minimal clinical facilities.

2.3.4 Providing guidelines for establishment of private practice and a directory of private practitioners.

2.3.5 Providing opportunities for continuing education eg. congresses, workshops, study days and refresher courses.

2.3.6 Publishing journals and newsletters.

2.3.7 Encouraging and promoting research

2.3.8 Investigation and where necessary reporting Occupational Therapists for malpractice.

2.4 ***To promote the Profession through:***

2.4.1 Representation on professional bodies

2.4.2 Publication of policy and role statements.

2.4.3 Informing the general public about the role and scope of the profession.

2.4.4 Informing relevant Government bodies about role and scope of the profession.

2.4.5 Recruitment of students.

A
CODE OF ETHICS
FOR
SOUTH AFRICAN
OCCUPATIONAL THERAPISTS

Officially adopted by:

SOUTH AFRICAN ASSOCIATION
OF OCCUPATIONAL THERAPISTS

JULY 1985

A
CODE OF ETHICS
FOR
SOUTH AFRICAN
OCCUPATIONAL THERAPISTS

Professional ethics involves an appreciation of the basic principles for correct action.

This document is intended as a guide to the conduct that is appropriate to the professional situation in which the Occupational Therapist is involved.

The Therapist should possess the personal qualities of integrity, reliability, loyalty and sincerity of purpose in his professional relationships.

1. RESPONSIBILITY TO THE CLIENT
   a. In accepting a share of the responsibility for the physical and mental well-being of the patient, the Therapist shall at all times strive to give treatment of the highest level of professional skill, irrespective of race, colour, creed, nationality, politics or social status.
   b. The Therapist must respect information of a confidential nature regarding the patient and shall not divulge any information without the express permission of the patient, or in the case of a minor, his parent or guardian, or the next of kin or executor of the estate of a deceased patient.

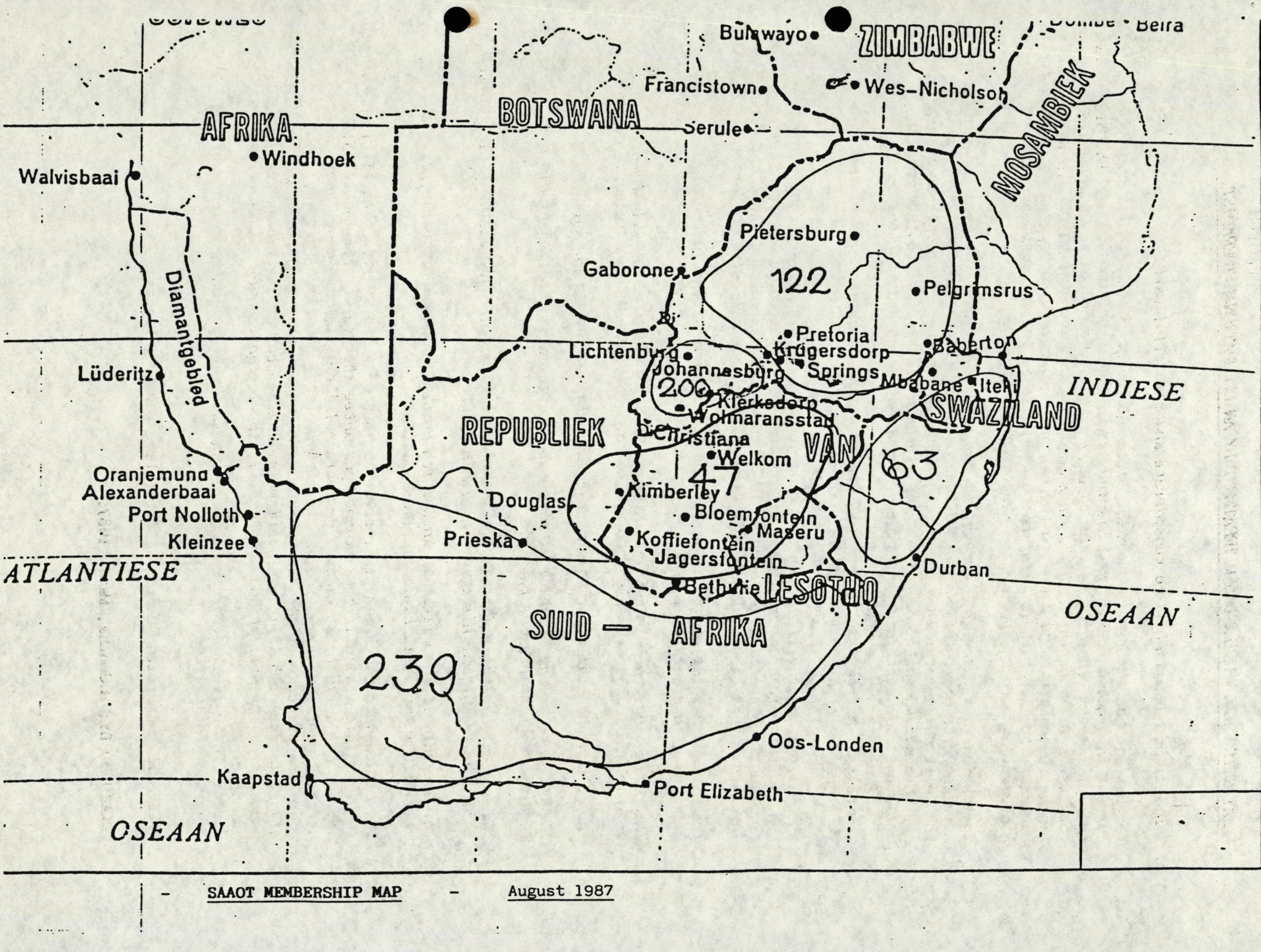
2. RESPONSIBILITY TO THE TEAM MEMBERS
   a. The Therapist shall co-operate fully in achieving the mutually established goals in consultation with the medical practitioner and other team members.
   b. The Therapist shall report regularly on the patient's progress for the information of team members and for possible legal purposes. (See 1b)
   c. The Therapist must show concern for, and loyalty to those practising the same or other professional skills, recognising that only by fostering mutual respect and understanding can the best service be rendered to the patient.

3. RESPONSIBILITY TO THE EMPLOYER
   The Therapist shall be loyal to the employing body and shall assist in the interpretation of its function within the community. A proper share of responsibility for the organisation and administration of the service to which he is appointed, must be accepted.

4. RESPONSIBILITY TO THE PROFESSION OF OCCUPATIONAL THERAPY
   The Therapist must recognise his responsibility in contributing to the growth and development of the Occupational Therapy profession through the exchange of information, the improvement of treatment and educational standards, as well as conditions of employment by supporting his professional organisation at the local, national and international levels.

5. RESPONSIBILITY TO THE COMMUNITY
   The Therapist shall provide information on and promote understanding of the functions and procedures of Occupational Therapy. It should at all times be recognised that in the eyes of the public, the attitude and philosophy presented, portrays the profession.

Appendix C



- SAAOT MEMBERSHIP MAP - August 1987

Appendix D

PATIENTS RIGHTS WHILE UNDER TREATMENT BY AN OCCUPATIONAL THERAPIST.

1. *The patient has a right to considerate and respectful care.*

2. *The patient has the right to obtain from his Occupational Therapist complete, current information regarding his functional status, treatment, and the prognosis thereof in terms that the patient can be reasonably expected to understand. In the case of a minor child this information must be made available, in terms that can be reasonably understood, to the parent or guardian. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person on his behalf.*

3. *The patient has the right to receive from his Occupational Therapist information necessary for him to give informed consent prior to the start of any treatment. When alternatives exist to the type of treatment being offered, these alternatives must be made known to the patient. It is the patients right to take part in decisions made concerning the type of treatment given and its length.*

4. *The patient has the right to refuse treatment and to be informed of the consequences of his action.*

5. *The patient has the right to every consideration of his privacy concerning his own medical care programme. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.*

6. *The patient has the right to expect that all communications and records pertaining to his case be treated as confidential.*

7. *The patient has the right to be informed of any research project which may involve him and has the right to refuse to participate in such research projects.*

8. *The patient has the right to expect reasonable continuity of care.*

9. *The patient has the right to examine and receive an explanation of his bill regardless of source of payment.*

10. *The patient has the right to request referral to another Occupational Therapist should he feel that his treatment is inadequate.*

11. *The patient has the right to know which hospital and departmental rules and regulations apply to his conduct as a patient.*

12. *The patient has the right to receive the best possible service that it is possible to give. This list of rights cannot guarantee the type of treatment that the patient has a right to expect. Occupational Therapists have many functions to perform involving prevention and treatment of the results of disease; the education of occupational therapy students and patients, and the conduct of clinical research. All these activities must be conducted with an overiding concern for the patient and, above all, the recognition of his dignity as a human being.*
Success in achieveing this recognition assures success in the defence of the rights of the patient..

REFERENCE: American Hospital Association - Bill of Rights.

COMPILED BY: M.Concha, March 1987.

GUIDE FOR OCCUPATIONAL THERAPISTS WITH RESPECT TO VICTIMS OF UNREST.

Introduction:

This document is drawn up with reference to the South African Association of Occupational Therapists Statement of Intent and the SAAOT Code of Ethics. SAAOT re-affirms these statements and further

1) *Re-affirms that all patients under the care of an Occupational Therapist shall receive the necessary treatment for physical and/or psychological problems regardless of religion, race, sex or nationality and regardless of the nature and cause of the problem. The first concern of the Occupational Therapist is towards the patient.*

2) *Re-affirms that all information concerning a patient is confidential and may only be divulged where instructed thereto by a Court of Law or where otherwise lawfully bound thereto. Divulging patient information is a breach of confidentiality for which action can be taken by the Professional Board.*

3) *Confirms that a law enforcement officer may not be allowed to interfere in the patient's treatment and medical needs.*

4) *Confirms that detailed records of patient's treatment must be kept. These records must be safeguarded against loss and should only be disclosed to a law enforcement officer in terms of a valid search warrant or subpoena or when required to by law. Occupational Therapy records should only be disclosed after the doctor in charge of the case and the Medical Superintendent of the hospital concerned have been consulted.*

5) *Confirms that if an Occupational Therapist's rights are affected by a search warrant (for instance, where the terms of the warrant require him/her to contravene the ethical duty of confidentiality) he/she is entitled to demand a copy of the search warrant. A search warrant is a document issued by a judge, magistrate or justice of the peace. A valid search warrant must clearly state what the officer entrusted with its execution is empowered to do, for instance, what premises he may search and what property, if found, is to be seized. Where a specific thing is to be searched for and seized it must be described in the warrant with sufficient precision. The Court will refuse to recognise as valid a warrant the terms of which are too wide or too general. It is important to remember that a police officer may without warrant search for and seize any article if the person concerned consents to the search and seizure or if the police officer, on reasonable grounds, believes that a search warrant would defeat the object of the search. Furthermore, under the Emergency Regulation made in terms of the Public Safety Act 1953, a member of a 'Force' may at any time without warrant search any person or premises and seize any object or article which may afford evidence of the commision or suspected commision of an offence. The test whether such material may afford such evidence is an objective one and is not simply dependent on the subjective belief of a member of the 'Force'.*

6) *Condemns any acts of violence, torture or humiliation perpetrated by any group or individual on either a group or individual.*

OCCUPATIONAL THERAPY TRAINING SCHOOLS IN SOUTH AFRICA

DATE SCHOOL STARTED	UNIVERSITY	UNDERGRADUATE	STUDENT NUMBERS Year	Students	Total	RACE	POSTGRADUATE Numbers	
1972	CAPE TOWN	BSc O.T.	1	25		NON-RACIAL	MSc O.T.	
			2	11		ENGLISH MEDIUM		
			3	21				
			4	19	76			
1983	WESTERN CAPE	B. O.T.	1	18		PREDOMINANTLY COLOURED		
			2	11		ENGLISH MEDIUM		
			3	9				
			4	-	38			
1960	STELLENBOSCH	B. O.T.	1	30		PREDOMINANTLY WHITE	M. O.T.	
			2	19		AFRIKAANS MEDIUM		
			3	18				
			4	16	83			
1976	ORANGE FREE STATE	B. ARB.	1	32		WHITE	M. ARB.	
			2	18		AFRIKAANS MEDIUM		
			3	17				
			4	22	89			
1981	DURBAN/WESTVILLE	B. O.T.	1	27		NON-RACIAL	M. O.T.	
			2	13		PREDOMINANTLY INDIAN		
			3	10				
			4	4	54	ENGLISH MEDIUM		
1944	WITWATERSRAND	BSc. O.T.	1	33		NON-RACIAL	MSc. O.T.	12
			2	29		ENGLISH MEDIUM	PhD	2
			3	24				
			4	16	101			
1952	PRETORIA	B. O.T.	1	37		WHITE	HONOURS	4
			2	34		AFRIKAANS MEDIUM	M. O.T.	2
			3	22				
			4	12	105			
1976	MEDUNSA	B. O.T.	1	15		PREDOMINANTLY BLACK	HONOURS	3
			2	5		ENGLISH MEDIUM	M. O.T.	2
			3	4				
			4	5	29			

Appendix G

Major city hospitals designated for all races

Pretoria News 1/8/87

PETER FABRICIUS Political Correspondent and JOSIAS CHARLE

MAJOR Pretoria hospitals such as H F Verwoerd, Eugene Marais, Jacaranda and the Little Company of Mary have been designated for use by all race groups — but most other "large" hospitals will remain for the use of whites only.

The Minister of National Health and Population Development, Dr Willie van Niekerk, announced the racial designations of the hospitals concerned in reply to a question in Parliament.

Pretoria-West, the Bond van Afrikaanse Moeders, the Zuid-Afrikaanse, the Andrew McColm Hospitals and the Daspoort Poli-Clinic have been desginated "own affairs" under the administration of the House of Assembly.

This means they are for the use of whites only.

Laudium Hospital has been designated "own affairs" for the administration: House of Delegates (Indians only).

All other hospitals will be designated "general affairs" or mixed, though this does not mean all the facilities will be mixed.

Where applicable, that is in hospitals accommodating all racial groups, various services will be used by all.

This include X-rays, operating theatres, catering services, radiation therapy, nuclear medicine, linen services, professional staff, orthopaedic workshops and transport services.

Dr van Niekerk pointed out in a different reply in Parliament that wards in "general affairs" hospitals would not be integrated.

Group examines SA therapy

The Star 21/7/87

By Janine Simon

A fact-finding delegation from the World Federation of Occupational Therapists, sent in response to pressure to expel the South African Association of Occupational Therapists (SAAOT), began work in Johannesburg yesterday.

SAAOT is a non-political, non-racial organisation representing 670 of the country's 1 000 registered occupational therapists.

If it is expelled, therapists from this country will find it practically impossible to travel overseas to work or study, and will be cut off from research.

The delegates — Professor Barbara Neuhaus (US), Mrs Ulla Kroksmark (Sweden), Ms Sue de Gilio (UK) and Professor Marge Concha, head of Occupational Therapy at the University of the Witwatersrand — arrived on Saturday.

Yesterday they met members of the SAAOT, then visited Johannesburg's Independent Living Centre in Soweto and the Self-Help for Paraplegics, Soweto (Shap) Centre.

The group plans to meet academics, the Black Sash, the Urban Foundation and the South Africa Foundation.

Senior officials from the Department of National Health and Population Development have asked to meet the group.

Blacks boosted

The Daily News July 29 1987.

FOUNDATION LAUNCHED TO HELP SMALL BUSINESSES

Financial Editor

SMALL black business has received a boost with the launch in Natal/KwaZulu of the Get-Ahead Foundation.

The privately-funded foundation, which already runs 13 offices in black townships around the country, officially opened Natal operations today.

The group initially hopes to establish offices at Empangeni and at either Lamontville or Claremont.

Founded by lawyer Don MacRobert and Soweto leader Dr Nthato Motlana to help black businessmen, the foundation's staff has grown from 13 to 40 in the past two years.

According to public relations officer Jenny Williams, Get-Ahead primarily enjoys sponsorship from overseas companies and governments. However there is a growing list of local firms — including several in Natal — becoming involved.

This is most welcome as the non-profit organisation has suffered from the disinvestment of many companies.

She says GetAhead operates on a far more informal basis than the Small Business Development Corporation, although it maintains close contact with the SBDC, Urban Foundation and other similar bodies.

It is primarily township-based, having support from blacks across the political spectrum. Its financing operations include "micro loans" — from R25 to about R400 — on which interest is 10 cents per week per R25 (repayable over two months).

Larger loans start from about R500 and are used by more formal businesses.

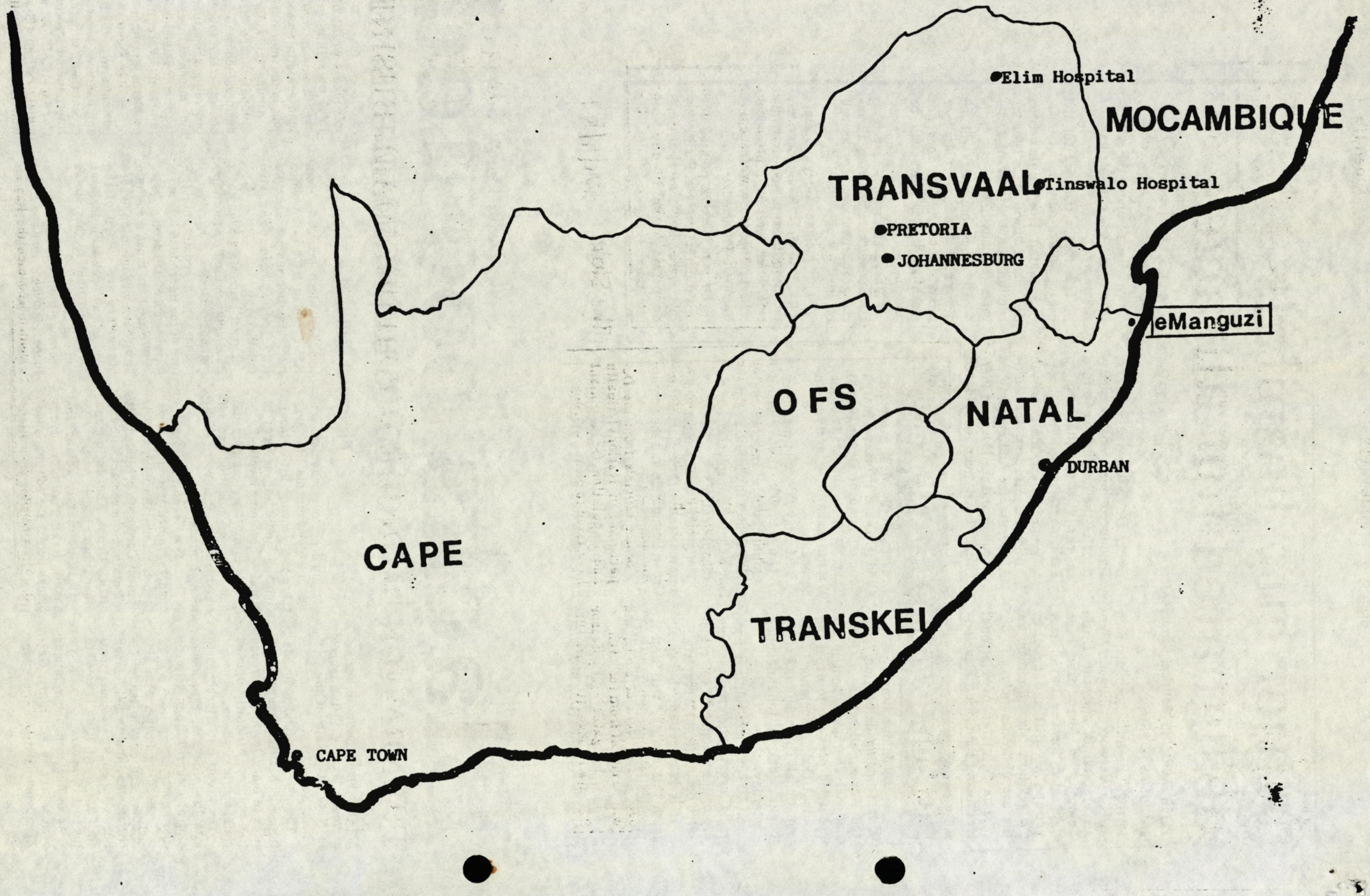
She says a remarkable feature of the micro loan scheme is the absence of bad debts.

"We are very much a community-based organisation where borrowers are aware of the need to pay back their loans as soon as possible so that others can use them."

Among the foundation's many success stories is that of a black woman who used the R25 loan to make a profit of more than R400 by selling green meilies over a few months. One small loan sometimes generates five jobs in the informal sector.

Among the activities of the foundation are "fronting" for businessmen who want to, but cannot, trade in central areas, providing shop space and running informal markets. Its legal team is involved in fighting red tape and overcoming licence problems and other restrictions.

Business mentoring is an important arm of the foundation — and has been boosted through a recent tie-up with the US-funded International Executive Service Corps (IESC) — a group of mainly retired US businessmen who advices small businessmen


Elim Hospital
MOCAMBIQUE
TRANSVAAL
Tinswalo Hospital
PRETORIA
JOHANNESBURG
eManguzi
OFS
NATAL
DURBAN
CAPE
TRANSKEI
CAPE TOWN