HOW COMMUNITY REHABILITATION WORKERS SEE THEIR WORK

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ABSTRACT: *This paper reports on research conducted by the Wits/Tintswalo Community Rehabilitation, Research and Education (CORRE) Programme amongst qualified community rehabilitation workers (CRWs). The aim was to understand how CRWs see their role, successes, supervision support received, problems encountered and possible solutions.*

Eighteen qualified CRWs completed a questionnaire, which contained a range of open-ended and semi-structured questions. The findings included their perceived role and successes in their work. They were satisfied with the supervision received from their therapy supervisors and support from their communities. The Department of Health did not support them as much as did their communities. The lack of government assistance for transport was their biggest problem: They were not always able to reach far away clients and spent a lot of time travelling to and from clients every day. They were also concerned that they were not registerable with the South African Medical and Dental Council (SAMDC).

These findings provided the Northern Province and the Community Based Rehabilitation (CBR) manager with information to improve CBR service delivery. A two year diploma course in therapy assistance (community) for CRWs, occupational and physiotherapy assistants has been started.

KEY WORDS: COMMUNITY REHABILITATION WORKERS (CRWS), COMMUNITY BASED REHABILITATION (CBR), WITS/TINTSWALO COMMUNITY REHABILITATION, RESEARCH AND EDUCATION PROGRAMME (CORRE)

Mr. Sichangwa passed away in 1999. We would like him to be the second author, as he played an important role in preparing for and collecting data for this research.

INTRODUCTION

Community rehabilitation workers (CRWs), trained in the Northern Province by the Wits-Tintswalo Community Rehabilitation, Research and Education (CORRE) programme, work in rural areas, mostly in this province, with people with disabilities (PWDs) and their communities. These areas are poverty-stricken with poor infrastructure, poor water and sanitation and the resultant health and disability risks. Here CRWs facilitate community based rehabilitation (CBR) as advocated by the World Health Organisation (WHO) since 1976. The benefit of having CRWs within the rehabilitation team has been established (Dolan et al, 1995, Petrick et al, 2001).

In the Northern Province CRWs are employed by their local hospitals on a specialised auxiliary service officer (SASO) post and receive regular supervision from the hospital therapists. A CBR manager, Mr. Kasenga Sichangwa, was appointed for a year in 1998.

This study was undertaken in 1998 to establish how the CRWs perceived their work, achievements and problems, in order to help the CBR manager and Northern Province manage the CBR service.

METHOD

At the beginning of 1998, a questionnaire was distributed to all 42 CRWs who had been trained by CORRE at that stage.

The questionnaires were compiled by the CBR manager in consultation with CRWs, supervising therapists, tutors of CRW students and a statistician. Two CRWs completed the initial version of the questionnaire as a pilot. The final version then included their suggestions. The questionnaire was in English and contained close-ended, open-ended, semi-opened and filter questions.

The close-ended questions established the respondents' sex, year of qualification, place where most working time was spent, number of clients seen a week, ability to deal with clients' conditions, means of travel and time spent to reach clients, the frequency and length of supervision visits and their supervisors' occupations.

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Open-ended questions established the reasons for becoming a CRW, the role of a CRW, who they were responsible to and suggested solutions for some of their problems.

Filter questions, with clarifying open-ended questions attached, established courses attended since qualifying, coverage of clients in the CRWs' area and support received from the Department of Health and their communities.

Semi-opened questions asked for the CRW's four most important achievements, five tasks done most often, five main work-related problems and five usual supervision activities.

RESULTS

Eighteen (43%) of the 42 questionnaire sent out were completed. Three of the respondents were male (17%) and 15 female (83%). Most of the respondents had qualified either in 1997 (n = 8) or in 1995 (n = 7), with only three (17%) having qualified in 1992.

In response to an open-ended question, all but one (n = 24 (96 %)) of the 25 reasons given for becoming CRWs involved a desire to help PWDs and their communities. One respondent became a CRW to have a better job (n = 1 (4 %)).

The CRWs' perceived roles can be seen in Table 1. They have a wide spectrum of roles, with the most commonly mentioned centering around individual home-based client rehabilitation, health education, disability awareness raising and working towards the integration of PWDs in society. Table 2 indicates the CRWs' most important achievements. This included successes in client rehabilitation and in starting and working with self-help/support groups for PWDs, integrating children with disabilities into ordinary schools and changing people's attitude towards disability. Table 3 shows the tasks done most frequently by a CRW, of which home visits, health education and support groups were mentioned most frequently.

All but one respondent spent most of their time working in the community (n = 17 (94 %)). Other places of work included clinics, day care centres and schools.

The CRWs saw from five to more than 15 different clients per week; seven (39 %) saw five to nine and 11 (61 %) saw more than 10 clients a week.

Ten of the respondents (56 %) reported being able to deal with all their clients' conditions, while eight (44 %) reported the opposite. The respondents indicated that they referred clients when necessary. Eleven (61 %) of the CRWs had attended courses since qualifying.

All CRWs (n = 18 (100 %)) walked to get to clients. Fifteen (83 %) also used taxis. Some used transport money donated by community members, lifts in a government or the client's vehicle or with anyone going in the required direction, a disability project vehicle or a bus. Walking was used most frequently (n = 14 (78 %)), while one of the respondents (6 %) used a disability project vehicle and two (11 %) used taxis most frequently. Ten CRWs (56 %) spent 1 - 2 hours a day travelling to and from clients, while six (33 %) spent 2 - 3 hours. Only one respondent (6 %) spent less than an

Table 1: The role of the CRW in the community (responses to an open-ended question)

ROLE	NR	%
To help/ rehabilitate/ treat/ give therapy/ render services to PWDs and their families at home	18	18,9
Health education to all people in the community and PWDs	9	9,5
Raise disability awareness/ educate people about disability issues and change attitudes e.g. of parents and of the community/ make sure people take PWDs into consideration/ see the value of PWDs in the community	9	9,5
Ensure full integration of PWDs in their communities and countrywide e.g. at schools/ not discriminated against in any community activity/ encourage socialising with PWDs and able-bodies people/ make chiefs, indunas etc. understand PWDs	7	7,4
Ensure that PWDs are aware of and fight for their human rights/ take a leading role in raising awareness to the government and the community, including service providers/ empower PWDs and parents of disabled children/ ensure that PWDs are taking part in making decisions on government policies/make PWDs understand that they are also people like everyone else	6	6,3
Make and receive referrals/ act as a link between hospital and community/ refer PWDs to hospital or specific institutions for further help	6	6,3
Form/start and facilitate groups e.g. care groups, groups for PWDs, support groups, self-help groups/help the community and PWDs form groups	6	6,3
Help community/ the poor/ PWDs start income generation projects by fundraising and teach them appropriate methods to suit their needs/ facilitate business skills	4	4,2
Identify PWDs	3	3,2
Make assistive devices/ appropriate paper technology (APT), involving the family	3	3,2
Attend meetings, e.g. rehab staff, community, PWDs	3	3,2
Help PWDs get disability grants	2	2,1
Follow up e.g. those not using medication or treatment	2	2,1
Make places accessible for PWDs	2	2,1
Counselling PWDs and their families	2	2,1
Promote independence of PWDs	2	2,1
Other	11	11,6
TOTAL	**95**	**100**

Table 2: The most important achievements of CRWs (responses to a semi-open question)

ACHIEVEMENT	NR	%
CLIENT SUCCESSES (n =24 (32 %)) Helped PWDs get disability grants	4	5,3
Some clients showed great improvement (e.g. in activities of daily living (ADL), personal care, mobility, speech and toileting)	3	4
Support to PWDs and reassurance where hope is lost/ able to handle them and help them to accept life	2	2,7
Facilitated a client with mental illness to start a spaza (tuck) shop himself	1	1,3
Epileptic children are now on medication	1	1,3
Some clients with cerebral palsy (CP) can now crawl and stand with support	1	1,3
One mentally retarded client now has head control	1	1,3
A client with CP and a hemiplegic are now walking	1	1,3
Helped amputees by referring them to hospital for artificial legs	1	1,3
Encouraging clients with mental illness to collect treatment from the hospital	1	1,3
Encouraging orthopaedic clients to wear surgical boots	1	1,3
Rehabilitated a boy with quadriplegic CP who was hidden away and wasn't able to do things for himself	1	1,3
Rehabilitated a hemiplegic	1	1,3
Helped a family that lived very unhiegenically to improve their hygiene, although they hated me at first	1	1,3
Using my interviewing skills, I helped the doctors diagnose a patient properly after a wrong history had been taken	1	1,3
Meet clients' needs	1	1,3
Helped a stroke client who was aggressive to cope well with the family members	1	1,3
Making some PWDs independent	1	1,3
OTHER SUCCESSES (n = 51 (68 %)) <u>Groups:</u> I've started a self-help/ support group of PWDs in my village/ started a support group for mothers of disabled children (now under Disabled Children's Action Group (DiCAG) and want to start a day care centre)/ Now we have Disabled People South Africa (DPSA) and DiCAG in our village/ written to DPSA to affiliate my support group of PWDs/ helped the community to make their garden project successful/ I facilitate an integrated self-help group: We have filled in forms and are waiting for funds/ started a support group for people with mental illness	11	14,7
Integrated disabled children in mainstream schools	8	10,7
Changed the attitudes most people had towards disability/ made people understand the importance of living with PWDs and treating them as equals/ PWDs are now considered at home and in the community/ awareness raising on disability within the community/ acceptance of PWDs and building their self esteem	8	10,7
Good relationship between us, client, families and community (e.g. chief, induna, civic, councillors)/ I have a good working and helping relationship with the community since they recognise that my work is helpful to them	5	6,7
Attitudes of teachers towards children with disabilities are improving/ a good relationship between schools and me regarding integration	3	4
Opened a day care centre for disabled children/ creche for both disabled and able-bodied children	3	4
The community is aware of the CRW's role and whenever they come across a PWD they now refer	2	2,7
Have integrated PWDs with other community members by buying them wheelchairs, thereby promoting their mobility	2	2,7
Good working relationships with other health professionals/ health workers are now aware of therapy since I work close to them and they refer	2	2,7
Teaching people health education and healthy diet	1	1,3
Helping the crËches to make APT toys and play grounds	1	1,3
Received a floating trophy and a certificate as the first CRW of the year under Riakona CBR	1	1,3
The community (chief, indunas, clinic committee) donated fences when the clinic was renovated	1	1,3
Screened pre-schools	1	1,3
Family members now include PWDs in ADL	1	1,3
Have relieved CP mothers from the pressure of having to carry their children on their backs by making CP chairs	1	1,3
TOTAL	**75**	**100**

hour travelling, while two (11 %) spent 3 - 4 hours a day.

Ten of the respondents (56 %) were unable to reach all the clients in their areas, while eight (44 %) were able to. The main reason for not being able to reach all clients was that some clients lived too far to reach on foot.

Most CRWs indicated being responsible to their clients (n = 10 (56 %)) or their community (n = 9 (50 %)). Others included their supervisors/ rehabilitation colleagues (n = 7 (39 %)), the PWDs' family members (n = 4 (22 %)) and the CBR manager, hospital management, their co-workers, the primary health care administrator and their employers (mentioned by one respondent (6 %) each).

Nine (50 %) of the respondents received three supervision visits in three months, three (17 %) received six visits, two (11 %) received two visits and one (6 %) received more than eight. Three of the respondents (17 %) did not answer this question. Most respondents (n = 14 (78 %)) had more than one supervisor: fourteen (78 %) had occupational therapists, eleven (61 %) had physiotherapists, eleven (61 %) had community speech and hearing workers and one (6 %) had a nurse. Supervision mostly lasted two hours or longer (n = 16 (88 %)). Table 4 lists the supervision activities. Most of these activities centered around client visits and related problem solving, but also included checking administrative work and a whole variety of other activities. Most respondents (n = 12 (67 %)) were satisfied with supervision as it was. Some suggested more training for supervisors, regular, punctual supervision and the need for good relationships between supervisors and CRWs.

Twelve respondents (67 %) felt unsupported by the Department of Health or were unsure, mainly because no transport assistance was given. Some felt that health workers and hospital management didn't know about CBR or the work of a CRW. Four (33 %) felt supported because of having salaries and being able to work together with other health workers.

Most respondents (n = 15 (83 %)) received good community support, while three (16,7 %) did not. Support was felt because the community helped the CRWs and often referred clients to them. Some CRWs indicated poor community support at times when there were political rallies, as any associations would be interpreted politically. Some community members also still lacked knowledge on CBR.

The CRWs main problems and suggested solutions can be seen in Table 5. The problems mainly centered around transport difficulties to reach clients and not being registered with the SAMDC.

DISCUSSION

Although the response rate was low, the sample was fairly representative, as CRWs from all three student intakes at that stage responded. There was only a slightly higher female: male ratio amongst the respondents (5:1) than the population of CRWs (3,2:1). Despite verbal explanations and information and informed consent sheets attached to the questionnaires, the researchers only discovered much later that some anxious/ dissatisfied individuals (anxious about what the research would be used for) did not complete the questionnaire. This may have put a positive bias on the results, as some people with more critical views did not participate. Possible anxieties about participation in the research should have been dealt with more thoroughly and reminders or follow-up questionnaires sent. A questionnaire in the respondents' mother tongue would possibly also have yielded a higher response rate.

The fact that the respondents overwhelmingly indicated their desire to help PWDs as a reason for becoming CRWs makes the CRWs highly suitable for their job and indicates that the correct candidates were selected for training. However, as there are very few employment opportunities in rural areas, the financial motivation may have been stronger than expressed in the questionnaire. CORRE advises that hospitals send students using a detailed selection process, involving the community, hospital management and therapy staff.

The CRWs' roles fitted their wide scope of practice, which is needed to meet the needs of the person with a disability holistically and provide a comprehensive service, as advocated by the National Rehabilitation Policy (2000). Such skills are covered during their two year training with CORRE.

CRWs formed links with various people and structures in the community and with health care workers. This helps to positively change people's attitudes towards disability and get them involved in rehabilitation.

Table 3: Tasks most frequently performed by a CRW (responses to a semi-open question)

TASKS	NR	%
Home visits to clients with a variety of disabilities for intervention/ therapy (e.g. assessment, exercises, language stimulation, feeding CP, orienting blind people, ADL, personal hygiene)	24	27,6
Health education on disability, causes and prevention to community (e.g. at clinics, crËches and schools), clients and their family members	11	12,6
Run/ organise support programmes with families of disabled members/ support or self help groups/ run groups for PWDs (including DPSA, DiCAG and CARE groups)	8	9,2
Administration (referrals, progress notes, letters for donations, diary, statistics, disability register, monthly programme)	7	8
Making assistive devices (often out of APT)	7	8
Meetings (e.g. rehabilitation/ staff/ community)	5	5,8
Disability awareness raising (e.g. that strange behaviour is caused by mental illness)	4	4,6
Low cost toy making	3	3,5
Counsel clients and families that have problems	3	3,5
Other	15	17,2
TOTAL	**87**	**100**

The CRWs were satisfied with their supervision and seemed to have a good relationship with their supervisors over all, which is very important in CBR (Vanneste, unpublished). An impressive range of activities was covered during supervision. Apart from three CRWs who did not indicate how often they were being supervised, the others received regular supervision, i.e. about once a month. Visits lasted from two (a bit short) to more than three hours a visit. Since this research has been conducted, the Northern Province CBR Management Manual (2001) has been developed, using wide consultation. It suggests at least one supervision visit a month for a whole day in the CRW's village. Reflecting the multi-disciplinary nature of CRW training, the CRW supervisors were from the three rehabilitation professions. Ideally, CRWs should have access to therapists from all three professions, here most had access to at least two. Supervising therapists are encouraged to contact the other rehabilitation disciplines for advice with CRWs' clients when needed.

Of the tasks that CRWs most frequently performed, by far the greatest

Table 4: Activities done during supervision (responses to a semi-open question)

ACTIVITY	NR	%
Administration		
Marking/ checking/ correcting all the CRW's administrative work (e.g. case reports of clients, progress notes, disability register, diary, stats, time line, year plan and supervision monitoring document)	16	19,8
Client visit related activities Home visits where supervisor and CRW work together/ assessing the client/ client visits where the supervisor watches what the CRW has taught the client and asks questions or helps the CRW and the client/ home visits to the areas that the CRW cannot reach on foot/ visit CRW's new clients, supervisor looking at case reports of new clients and helping where needed/ visit difficult clients/ supervisor and CRW support and teach each other skills to handle difficult cases	21	25,9
The supervisor helps the CRW with problems met in the community/ talks about any areas of the CRW's duty where the CRW has difficulties and gives advice/ advice on cases the CRW has difficulties with/ concentrate on the client's problems in discussion	8	9,9
Evaluate the session and correct each other's mistakes and help where necessary/ supervisor tells the CRW if she is doing some activities/ things incorrectly	6	7,4
Case presentation/ reading and explaining the case history	3	3,7
Looking at whether treatment and assistive devices for client are appropriate/ alter programme to suit the client and family where necessary	2	2,5
Plan for the future e.g. if the client needs a wheelchair and then take it further/ discuss if plan of action is correct according to the client's problem	2	2,5
Discuss the things the CRW has already made with the family	1	1,2
Strengthen efforts already made by CRW	1	1,2
Working together/ not only observing the CRW	1	1,2
Share ideas with the client before visiting them	1	1,2
Other supervision activities Sometimes making assistive devices	2	2,5
Running groups/ health education/ give education to prevent disability	2	2,5
Screening/ screening clients with ear infections	2	2,5
Supervisor provides information, such as the time tables for orthopaedic clinic	1	1,2
Review the work done through discussion	1	1,2
Support and encouragement	1	1,2
CRW gives supervisor a list of items that he'll need to be able to work in the community (e.g. urine bags)	1	1,2
Supervisor shows CRW the way forward to improve CRW's work	1	1,2
Give missing documents	1	1,2
Refer clients for assistive devices, further assessment and treatments	1	1,2
We share the problems we encounter in our work or with our clients	1	1,2
The supervisor and CRW use the supervision monitoring document	1	1,2
Short meeting before supervisor and CRW visit clients	1	1,2
CRW orientating the supervisor	1	1,2
CRW getting advice from the supervisor	1	1,2
Observation during workshops when different topics are addressed	1	1,2
TOTAL	**81**	**100**

emphasis was placed on home visits and interventions with individual clients. This was also emphasised during supervision visits, presumably as this is the area where therapists can best help CRWs. The CRWs also frequently ran health education sessions and facilitated support or self help groups. Although these activities form part of a CRW's scope of practice, they were not frequently done during supervision visits. Supervising therapists may possibly not feel confident in helping the CRWs in this area, as group techniques may not have been included in their own training (Petrick et al, 2001). Checking the CRWs' administration and client records formed a definite part of supervision, while the CRWs also put some emphasis on it as a frequently performed task. The elements that the supervisor asks to see during supervision are very important, as they indicate the value the supervisor attaches to them. Group activities need to be part of supervision, to help improve the CRW's group skills and make sure group activities do not fall away. The Northern Province CBR Management Manual (2001) now includes a check list for supervisors and CRWs to ensure that all the activities a CRW does are being supervised at some stage during the year. CORRE started running group and community development courses for supervisors in 2000.

The CRWs worked in the community (i.e. in the rural villages where they live and neighbouring villages). This practice is advocated by the World Health

Table 5: The problems CRWs face at work and suggested solutions (responses to semi-open and open-ended questions)

PROBLEM	NR	%	SOLUTION
Transport shortage/ no transport to and from villages/ not able to reach some communities/ using our own money to pay for transport to get to clients and not being refunded/ walking long distances to do follow ups on far clients/ my health is deteriorating from walking in the sun every day/ CRWs are not entitled to a subsidy car	20	28,2	Get strong support from others and work together (n = 2) A vehicle should be allocated to the CRWs at each hospital/ disability project (n = 3) Referral to big hospitals/ institutionalisation for PWDs without family members and with complicated disabilities, so they can be cared for. CRWs should get car subsidies or be able to claim back transport money/ transport allowance should be re-introduced (n = 4) Get ideas from other community workers (e.g. community developers) The CBR manager to negotiate with the Department of Health on the transport issue By participative workshops and collective decision making Need accommodation when visiting far away clients
Not being registered with the SAMDC, even though I'm working with clients/ fear of working with clients while not registered	10	14,1	Get strong support from others and work together The CBR manager and the director of CORRE should explain this problem to the SAMDC The CBR manager should explain this problem to the Minister of Health Register us so that we can have a word to our respective government By participative workshops and collective decision making
Low salary	3	4,2	The CBR manager should negotiate better salaries with the Department of Health
Not having a uniform	3	4,2	We NGO employed CRWs should rather be employed by the government
Some health personnel still don't understand what a CRW is/ other health workers not recognising us	2	2,8	CRWs should be allowed to work nation-wide regardless of the hospital under which they have trained
Parents/ caregivers not doing exercises/ carrying out my instructions during my absence	2	2,8	Having communication skills on counselling Annual refresher on home programmes
High expectations of handouts from clients and their families	2	2,8	
Too much paper work/ repetition of paper work	2	2,8	Collectively agree at workshops which paper work is really needed
Not getting stationary from hospital	2	2,8	We NGO employed CRWs should rather be employed by the government. If CBR manager can make regular visits to CRWs and supervisors to make sure if we get the right supervision, stationary, transport etc.
Don't have an office	2	2,8	Build 2 rooms per CRW
Other	23	32,4	
TOTAL	**71**	**100**	

Organisation (1994) to help ensure that a community based service is provided.

Although most saw more than 10 clients per week, some saw only 5 - 9 clients a week, i.e. one or two clients a day. Although CRWs also do group and community development activities and spend a considerable amount of time travelling on foot between clients, they should still be able to see more than 10 clients a week. The Northern Province CBR Management Manual (2001) suggests that CRWs do at least 4 group or client interventions a day. CRWs who do not manage this should problem-solve together with their supervisors to come up with a workable solution.

During their training, CRWs are taught the skills of problem solving with the client and family when dealing with clients (Concha, 1993). This is probably why so many CRWs felt that they were able to deal with all the different conditions with which their clients presented. When CRWs realised they needed help, they referred the client. Regular supervision and continuing education courses are necessary to upgrade CRWs' skills.

Overall the CRWs did not feel supported by the Department of Health. Although they had salaries, had access to some resources and were being recognised as health workers in some areas, CRWs felt strongly that they needed some form of transport assistance. The Department of Health also needs to understand CBR and the work of CRWs better and help make their work more known amongst other health workers.

CRWs received a lot of support from their communities, on the other hand. They had a good attitude towards the CRWs, were very helpful and referred new clients to the CRWs. This good relationship with their communities was evident in that CRWs felt accountable to their clients, the clients' families and communities. Working with their communities and obtaining support is essential for CRWs, as this will help them improve the lives of PWDs.

A lot of time was spent walking to and from clients, the CRWs' chief mode of transport. Receiving many referrals from the community for clients who are too far away to walk to and not being able to reach them constitutes a major problem for CRWs. They cannot afford taxi fares to get to these clients. Occasionally such a client would visit the CRW at the clinic, but many do not have the financial or physical means to do so.

CRWs would be able to reach more clients in their areas and further afield if they had a transport allowance/ access to a government vehicle/subsidy car. CRWs sometimes ask their supervisors to drive them to their far away clients during the supervision visits. Some CRWs suggested that one rehabilitation vehicle should be allocated for the CRWs at each hospital. The Department of Health should pay urgent attention to some form of transport assistance for CRWs.

Up until the end of 2000 all CRWs graduated with a CRW certificate issued by the Department of Occupational Therapy, University of the Witwatersrand. In response to CRWs' and therapy assistants' requests for a channel to be able to further their studies and to gain easier access to a therapy degree course, the physiotherapy and occupational therapy departments of the same university developed and recently started a two year diploma course for therapy assistants and CRWs, leading to a diploma in therapy assistance (community). Whereas therapy assistant students do the community development and CBR part of their training in their second year, CRWs follow an integrated course, with community development and CBR as part of their course throughout both years of training. CRWs are stationed in the community, whereas it is envisaged that the therapy assistant with the diploma would probably have a combination of hospital and community work.

RECOMMENDATIONS AND CONCLUSION

CRWs achieved many successes in the lives of their clients, with groups of PWDs and their care givers, and with disability awareness in their communities.

Most CRWs were supervised regularly by therapists. The supervising therapists of CRWs should, however, try and make sure they cover all aspects of the CRW's scope of practise during their supervision. They would benefit from attending courses on group and community development techniques. CORRE started running such courses in 2000.

The Department of Health and hospitals should provide some means of transport for their CRWs in order to enable them to reach clients that are too far to reach on foot and enable them to see more clients a day.

CRWs are now registerable with the HPCSA. A diploma course in therapy assistance (community) for CRWs, occupational and physiotherapy assistants has also been started.

REFERENCES

Concha ME. 1993 The introduction of a training programme for community rehabilitation workers - the Wits/Tintswalo model. South African Journal of Occupational Therapy 23:38-45

Department of Health. 2000 Rehabilitation for all. National Rehabilitation Policy: 8

Dolan C, Concha ME, Nyathi E. 1995 Community rehabilitation workers: Do they offer hope to disabled people in South Africa's rural areas? International Journal of Rehabilitation Research 18:187-200

Northern Province Task Team on Community Based Rehabilitation. 2001 Northern Province Community Based Rehabilitation Management Manual. Second revision. Unpublished

Petrick M, Sichangwa K, Collinson M and Pickford K. 2001 Supervision of qualified community rehabilitation workers. South African Journal of Physiotherapy 57:13 - 19

Vanneste G. Daily management of CBR fieldworkers and supervisors. Unpublished draft, CCBRT, Dar Es Salaam

World Health Organisation. 1994 Community - based rehabilitation and the health care referral services: A guide for programme managers, p83. World Health Organisation, Geneva