Training Community Rehabilitation Facilitators at the Alexandra Health Centre

Initial Findings from a Recent Evaluation

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This article describes the findings of an early evaluation of community based rehabilitation (CBR) training program. A new cadre of rehabilitation workers, Community Rehabilitation Facilitators (CRFs) are being trained at the Alexandra Health Centre and university clinic. Critical food for thought regarding the role of and need for such programmes is discussed, in the context of the findings of this earlier evaluation.

Background to CBR

The disabled population represents a group of people not only with neglected, but also with hidden and unacknowledged needs. These needs have recently been highlighted, but most of the rehabilitation models followed up to now have emphasized the role of professionals in a medical model. More appropriate models utilizing community based workers have been explored in rural and urban setting, but these are either not well received by professionals and academics, or they are viewed as appropriate only for the poor of this country.

The CBR Course at the Alex Health Centre

As an essential part of the CBR program, a two year training course was developed to train people as community rehabilitation facilitators (CRFs). CRFs are a new category of rehabilitation workers whose job it is to work with, and in the community to assist disabled people to overcome the difficulties they experience as a result of their handicap. As such, their job focuses mainly on assisting disabled people in overcoming the social consequences of their disability.

So far, there are two training programmes in South Africa training this category of rehabilitation facilitators, namely, one at Tintswalo Hospital in the north eastern Transvaal and one at the Alexandra Health Centre (AHC) north of Johannesburg.

The disabled population has neglected as well as hidden and unacknowledged needs. *Photo: Natasha Pincus*

The CBR course at the AHC is divided into two parts: Part one consists of a year of intensive training at the AHC; the second year is an internship spent in the student's own community. During the latter year, support is provided by the AHC with four seminars planned lasting one week each. A specific community development project is to be executed by each student. At least one seminar will emphasis the imparting of skills and knowledge to a lower category of Community Rehabilitation Workers (CRWs).

The course is a pilot project and the first of its kind in South Africa. The curriculum was drawn up and appropriate course objectives were developed utilizing the following:

1. Consultation with rehabilitative specialists;
2. Needs expressed by the community determined from a disability prevalence study conducted by the CRFs in the initial weeks of their training;
3. Six years of community development experience of the researcher.

Method of Evaluation

An initial evaluation of the CBR course was done during the first six months of 1992. It was decided to first evaluate the course objectives in terms of their appropriateness for different groups, including the students and other beneficiaries of the CBR service offered by the CRFs. This was important since the CBR program looks at social, political, environmental and cultural factors responsible for people' disabilities, and not only the medical background of disability. Traditional methods of evaluation involving professional rehabilitation workers would be inappropriate.

A danger exists in that professional values could soon be imposed in measuring non-professional input, hence the importance of community input. In a country such as South Africa, with well-established rehabilitation professions, there is a continuous quest for guaranteed standards with regard to job performance of rehabilitation professionals. This could result much later in resistance towards CBR as a philosophy and, consequently, also to community participation in evaluations of such programmes.

Supplementary vs. Complementary Role of CRFs

The evaluation of the objectives of the CBR course revealed interesting opinions regarding the role of CRFs. There is a general consensus that the CRFs can play an important role in the rehabilitation of disabled people. This role is seen as either complementary (suggesting the ability of the CRFs to work independently, without the support of a therapist), or supplementary (meaning that the CRF is part of a team of rehabilitation professionals, including therapists).

It is actually at this level that most disagreement existed between the different groups of people interviewed, including individuals in different professional groups. Questions were raised regarding the following issues:

- the supervision of CRFs
- their relatively independent role in remote areas
- their ability to solve problems on their own
- CRFs being facilitators of rehabilitation.

The last issue was particularly controversial. People on the outside with specialized areas of work, as well as lecturers, were much more of the opinion that the CRF was complementary to rehabilitation professionals. Where needed, they has to be able to work independently without too much supervision.

However, the CRFs themselves, as well as disabled people, indicated a much more supplementary role for the CRFs as part of a rehabilitation team, receiving regular supervision.

There is general concensus that CRFs can play a role in the rehabilitation of disabled people. *Photo: Natasha Pincus*

Clinical vs Developmental Skills

Among informants in general difference on these issues were less noticeable. However, individual opinions within the group of interviewed lecturers and experts regarding the importance of specific tasks showed fundamental differences. Definite differences existed as to the importance of clinical and practical skills of the CRFs. Some felt that this area was the most important area, which, as a topic, received least attention in the questionnaire (one wonders if they envisaged surrogate rehabilitation professionals). Other felt strongly that the strength of the CRFs was formed by the definite knowledge of community structures as well as the important role they could play in the area of intervening in the social consequences of disability. This social role, which in our opinion, is neglected in the training of rehabilitation professionals, could then also be explained as supplementary to traditional rehabilitation. Hence there appears to be an apparent contradiction with the generally accepted view amongst professionals

that CRFs should fulfill a complimentary function. However, we believe that it is more likely a reflection of the increasing limitations of traditional rehabilitation services in the sense that clinical rehabilitation is viewed in a vacuum, is removed from its psychological and political context.

The difference in opinion between the various interviewed groups of people concerning the role of the CRFs is important for the further planning of education and training of CRFs. Further research, particularly into this issue, should be done in the near future. The outcome should, ultimately, have serious consequences for the development of CBR services at a national level.

The drive for advocating and developing CBR services in South Africa should be seen against the background of the recognition of concerned individuals through the Rural Disability Action Group in the mid-80's. There were (and still are) severe shortages of rehabilitation personpower in remote rural and peri-urban areas. Apart from these shortages, there is the increasing awareness that rehabilitation professionals are inappropriately selected, trained and utilized. However, some caution with regard to new developments in rehabilitation is needed. It might be that CBR development will now deviate from the original motivation and that, ultimately, CBR becomes an integral part of rehabilitation services in general.

Conclusion

This early evaluation has raised a number of issues regarding the role of and training of CRFs. These have been outlined above. The time for more rhetoric has passed. What is required are open and vigorous evaluations of present CBR programmes in rural and peri-urban parts of the country. If we fail to unmask the myths about rehabilitation, South Africa will again end up with a service only for those who can afford to have a private therapist at home. On the other hand, those who advocate CBR as a service and philosophy for life will need to give evidence that it is affordable, cost-effective and of good quality. Only if criteria are met regarding affordability, efficiency and quality, can we expect CBR to be adopted as a national strategy and philosophy in the field of rehabilitation. Today, we at Alexandra don't have (as yet) such evidence.

It is up to us and others involved in the CBR movement to show evidence of success. This requires the development of performance indicators and criteria for evaluation. Old positions need to be reviewed, new directions need to be evolved. Above all, we have to continuously ask ourselves whether or not CBR is really meeting the needs of all disabled people in the country. If, and only if we receive a satisfactory answer to this question, further developments can and should take place.

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