Community Rehabilitation Workers

Marjorie Concha

Community based rehabilitation (CBR) and the training of Community Rehabilitation Workers (CRWs) has become the rallying call for many involved in rehabilitation and is seen as the solution to the provision of rehabilitation services, to a large extent. CBR is based on the Primary Health Care (PHC) concept of accessibility, affordability, equitability and availability. Traditionally, CBR includes all measures aimed at reducing the impact of disability and handicap and at enabling disabled people to achieve social integration. It includes not only the disabled individual but also the community and the environment in which he or she lives. In CBR the therapeutic interventions take place where the individual lives, using community and family resources more extensively than would be possible in hospital-based rehabilitation.

Training CRWs is seen as crucial to the implementation of CBR. There are, however, many issues that need discussion to ensure sustainability of services. This article begins with a brief outline of the history of CRWs and goes on to discuss some of the issues surrounding the introduction of CRWs.

A Brief History of CRWs

In 1976, Dr. Hollander of the World Health Organisation (WHO) introduced a new category of health worker to the World Federation of Occupational Therapists (WFOT). This new health worker was to be called a Rehabilitation Assistant. It was envisaged that the training of rehabilitation assistants would draw on the disciplines of occupational therapy, physiotherapy and speech and hearing therapy to enable them to deliver rehabilitation within the community with few resources and more specifically to disadvantaged, under-served rural communities. This concept was supported by WFOT which included South Africa. Subsequently discussions took place in South Africa.

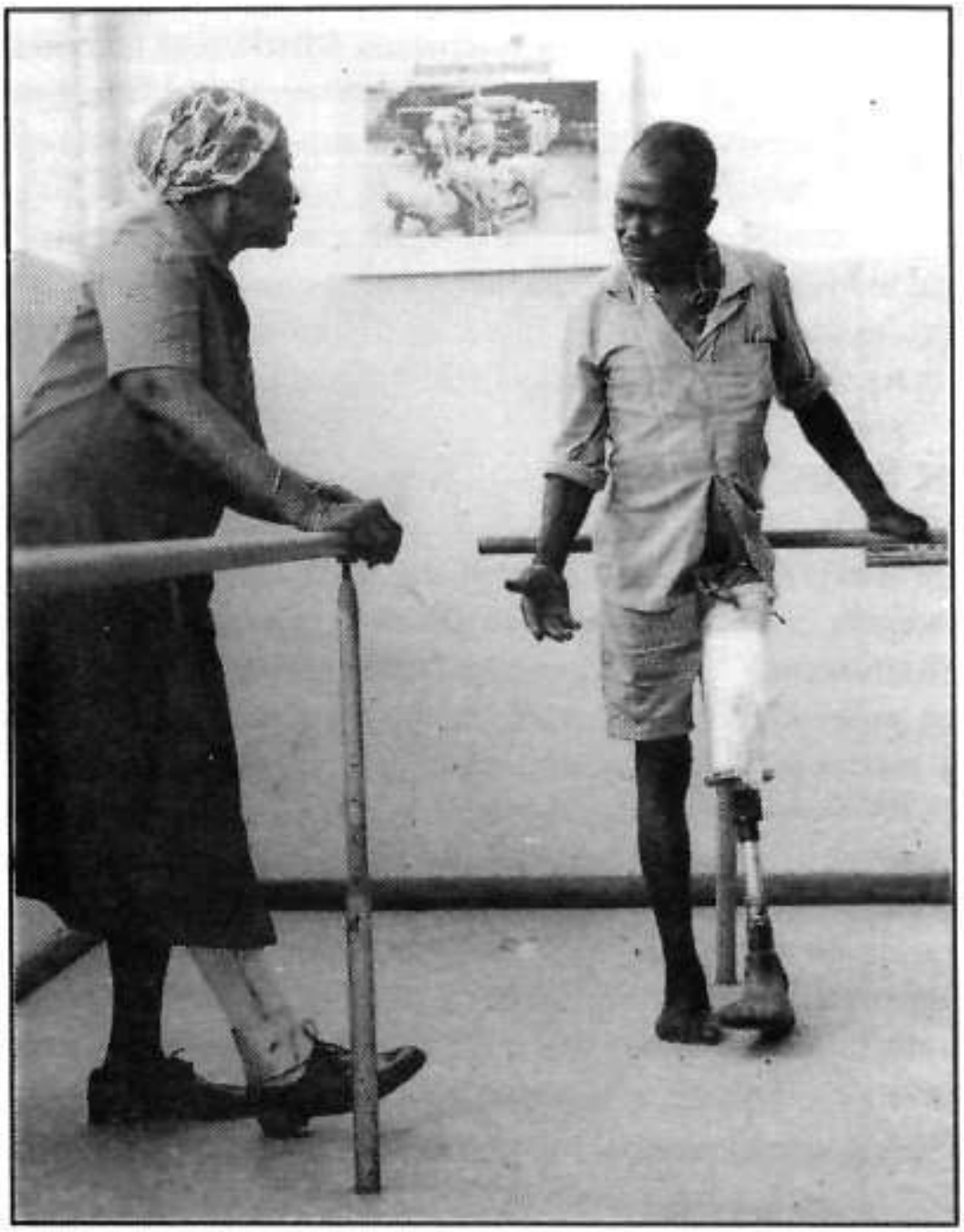
However, approximately ten years passed before a policy on CBR was proposed. It became increasingly clear that there would never be

enough therapists (even in the populated urban centres) to meet the rehabilitation needs of the country. Thus, in the late 1980s representatives from the three professional associations - Speech and Hearing Therapy, Occupational Therapy and Physiotherapy, came together to discuss the need for CBR and to determine the tasks and function of a rehabilitation assistant for South Africa. A committee called the Coordinating Committee on Rehabilitation Education (COCORE) prepared a memorandum motivating for the implementation of a community based rehabilitation programme, including the training of rehabilitation assistants, called Community Rehabilitation Workers (CRWs). This memorandum was presented to the South African Medical and Dental Council (SAMDC) and the Department of Health in 1986. This resulted in the acceptance of the plan by the three professional boards representing the above professional groups.

A special work group was constituted which consisted of representatives from the three boards; the SAMDC, the Social Work and Nursing Councils and the Department of Health. At its meeting in 1989, three pilot training projects were identified: one run by SACLA Health Project in Cape Town, one by Wits University Occupational Therapy Department and the Rehabilitation team at Tintswalo Hospital in Gazankulu and one by Alexandra Health Centre in Johannesburg. These three projects, each with a different orientation were to form the basis for future policy discussions. It has now become accepted nationally that a CRW will be a permanent member of health teams and together with other rehabilitation professionals be responsible for the delivery of CBR at the level of Primary Health Care (PHC).

Professional Boundaries

With the agreement to the introduction of CRWs, each rehabilitation professional group had to give some skills away in order to ensure progress. This along with issues surrounding professional boundaries which were long fought for had to be broken down. This step has been accomplished and the professional associations and professional boards have been working together for several years. While this is a remarkable achievement, the interdisciplinary cooperation which was so successful at the planning stage will have to continue at all levels to ensure the



Rehabilitation must be part of overall health policy and the implementation of the service must be clearly defined and resourced.
Photo: Cedric Nunn

implementation of CBR. Furthermore, professional boundaries and jealousies would have to be overcome and responsibility will have to be shared.

Legislation

The rules and regulation governing the practice of the professions concerned, although recently modified, will probably have to undergo further

modification to accommodate a category of professional with skills from all three professional groups. The realities of CBR where individuals are seen in their homes and where there has been no referral from a medical practitioner and probably only intermittent supervision from registered personnel, will have to be faced. Codes of conduct would have to be developed to ensure the protection of the rights of disabled people and their right to high standards of health care. The challenge to the SAMDC and its professional boards therefore is one of producing meaningful and workable regulations and minimum standards of education.

Career Structures

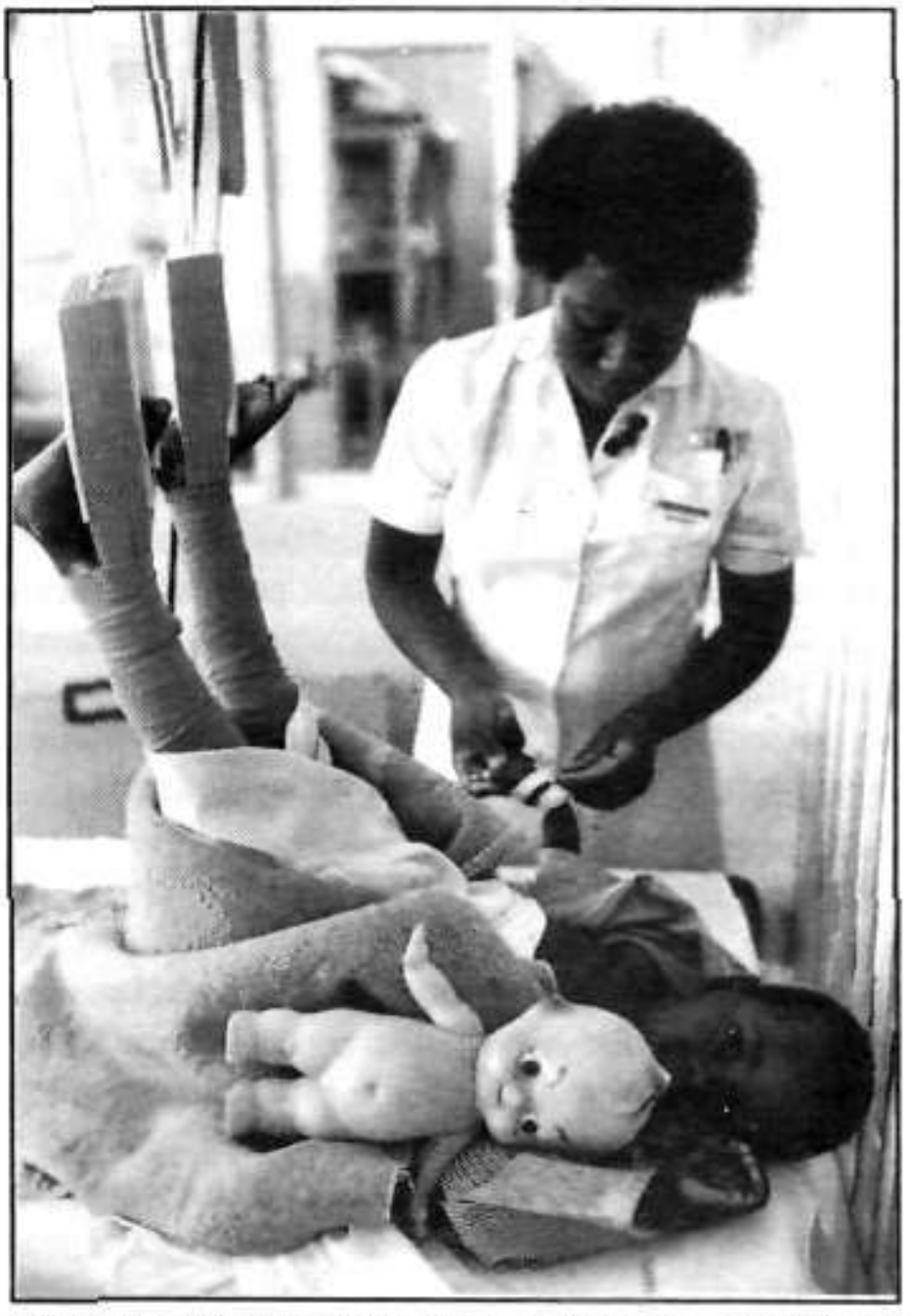
There are also practical questions that are raised with the introduction of a new category of health worker. For example, should training take place without a structure? Clearly, training programmes should not start without adequate provision for the employment of trainees at the end of the training period (and even during training). Although it is possible to employ CRWs within the current post structures, the professional associations cannot be absolved of the responsibility of preparing more realistic career structures and ensuring that this is implemented. This implies the restructuring of posts within the entire rehabilitation service.

One possible solution could be one salary continuum where professionals, assistants and CRWs would be employed according to their skills. In this way there would be a greater scope for promotion of competent individuals.

CBR versus Hospital Based Rehabilitation

Obviously CBR is not the only answer to rehabilitation services in South Africa. There is still a need for rehabilitation services at hospitals, as well as, the need for centres delivering specialised rehabilitation care to more complicated cases. It is important to view community rehabilitation in the context of the total rehabilitation process and the services needed to fulfil this process. South Africa urgently needs a rehabilitation policy in which the role of all levels of service are defined and resourced. Rehabilitation must be part of overall health policy and the responsibility for the implementation of the service clearly allocated and funded. As long as

doctors continue to be given the total responsibility for health service development, the less chance there will be that rehabilitative services assumes its rightful place in health care.



There is still a need for rehabilitation services at hospitals, as well as, centres with specialised care for more complicated services. *Photo: Medico Health Project*

Community participation

Central to CBR is the active participation of the disabled individual and the community in establishing the need for and a framework of the service. It follows that individuals have the right to decide on whether they need

a service and what their personal needs from the services should be. Having said that, community input is not easy to obtain especially from heterogeneous communities, particularly in urban areas. The question that should be asked before CRW courses are established and students recruited is: what does the community in general and the disabled community in particular want?

Sustainability of programmes

Of particular importance is the sustainability of training projects and the resulting service. The following questions need to be addressed: who will keep the particular training programmes running, who will monitor the effectiveness of the training and make the necessary modifications, who will motivate and support the CRWs, who will provide the continuing learning, how and to whom will the CRW and the rest of the rehabilitation team be accountable, and how should this process of accountability happen in practice, how will the growing need for this service be met especially in the light of financial restrictions? The question of whether a new government will recognise the importance of rehabilitation when the current one does not, is also an important issue to address.

Conclusion

As long as people become disabled and handicapped there will be a need for rehabilitation. Because rehabilitation processes are fairly slow and "manpower" intensive and therefore expensive, they have largely been ignored in South Africa. There is the danger that CBR and CRWs could be seen as cheap alternatives. While the service will be cheaper in that it will not need highly expensive structures for its administration, it needs personnel who are not cheap. CBR could be more cost effective, can improve quality of life and the burden placed on society will change to responsibility, reward and pleasure.

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