AN INVESTIGATION OF THE TRAINING OFFERED TO COMMUNITY-BASED REHABILITATION WORKERS WITH PARTICULAR REFERENCE TO THE FIELD OF MENTAL HANDICAP IN THE WESTERN CAPE

BY

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ABSTRACT

This study investigates the training offered to community-based rehabilitation workers in the field of mental handicap to ascertain whether the training provided has been perceived as appropriate in assisting with their tasks and functions.

Further investigation is done into the underlying theoretical approaches used in training, curricula designs, training objectives, location and training periods, the community-based rehabilitation workers level of participation and involvement in planning of the training programme, and whether creative, pragmatic and participatory training methods, techniques and materials were used. The nature of supervision was also explored.

The historical development of community-based rehabilitation, the lack of trained personnel, and the disparity in the provision of services in South Africa and the function of the community-based rehabilitation are discussed. It is against this background that the historical emergence and need for training of community-based rehabilitation workers are highlighted.

Different theoretical approaches to the development and presentation of training are discussed due to the considerable influence they have on the value base upon which training programmes are built. This includes an overview of the philosophy of Paulo Freire.

The research method used is of a qualitative nature. The researcher employs an exploratory - descriptive design to gain insight into an area which is relatively uninvestigated. By using this design, the researcher hopes to build a foundation of ideas and tentative theories which could later be tested through more complex methods.

The first population chosen included the total population of community-based rehabilitation workers employed at the South African Christian Leadership Assembly Health Project, (seven) and Cape Mental Health Society (two). The second population were the trainers associated with these organisations and the specific projects in which the community-based rehabilitation workers are employed. One trainer from each organisation was included.

Both organisations chosen are engaged in direct service delivery to the mentally handicapped in socially deprived communities in the Western Cape.
The primary source of data collection was acquired in two phases:-

Phase one - An interview schedule which included structured & unstructured questions was administered by the researcher to the community-based rehabilitation workers. The information was gathered with the assistance of an interpreter.

Phase two - A detailed self-administered, semi-structured questionnaire was completed by the trainers.

The data in these two phases was presented in a descriptive manner due to the size of the population.

The study found that there is no consensus regarding appropriate training models. Courses are often loosely structured with no theoretical base. A comprehensive-generic approach which includes promotive, curative, preventative, and rehabilitative aspects is suggested. In this study, the course focused mainly on curative and rehabilitative aspects to assist with tasks while promotive and preventative skills were neglected.

No prescribed training period can be stipulated. Constraints of distance and location would determine the duration of the training while the location of training should be within the confines of the community to prevent isolation and an unnatural environment. More creative and pragmatic methods and techniques should be carefully selected.

All components of supervision should be given priority and provided regularly in pragmatic and innovative ways.

Furthermore, trainers, trainees and communities need to have equal participation and involvement in all spheres of training.
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CHAPTER 1

RATIONALE & PURPOSE OF THE INVESTIGATION

1.1 INTRODUCTION

The World Health Organisation states that 98% of the disabled in developing countries have no access to rehabilitation services while institutional-based care service the other 2%. World Health Organisation Technical Report Series, 668 (1981). Institutional-based rehabilitation, which is primarily a Western rehabilitation approach, is based on the medical model.

Institutional-based rehabilitation has three main elements.

"Firstly, fancy buildings, elaborate equipment and highly specialised professional personnel. Secondly, the emphasis has been on the services that the professional provides primarily to the disabled person and to a lesser extent to their family. Rehabilitation has been viewed mainly as a medical exercise, with educational and vocational rehabilitation taking second place. Thirdly, the rehabilitation setting has by its very nature necessitated the problem and the person with that problem to be taken out of the social context in which he or she lives. It has made little use of the support structures in the home and in the community which are essential components for a meaningful solution to problems caused by impairment and disabilities." (Co-ordinating Committee of Community Rehabilitation Education, 1988 : 5-6).

Institutional-based rehabilitation is no longer regarded as financially viable as this model has placed too much emphasis on elaborate buildings, specialised personnel, expensive equipment and technology. The primary dilemma with institutional-based rehabilitation for the community of disabled and their families is that its facilities are city based and usually inaccessible.
To overcome this discrepancy in service delivery the World Health Organisation has called for "Health for all by the Year 2000", and regards the training and use of community-based rehabilitation workers as an important element in the rehabilitation process.

The training and use of community-based rehabilitation workers is seen as a vital force in changing the focus from institutional-based care to community-based care. Thus, the employment of community-based rehabilitation workers in socially deprived areas internationally and locally has mushroomed, and has become a prominent feature in the planning of services to the mentally handicapped and other disabled people. The community-based rehabilitation workers could also be regarded as indigenous village workers who are "native" to the communities which they serve. They are usually chosen by the people in the community for the people, and usually lack the traditional education credentials. They perform a vital link between the community, professional staff and organisations.


In more specific terms the role of the community-based rehabilitation worker is of the utmost importance in that they are expected to:

"..initiate and maintain a continuous dialogue with the community; to help identify community problems and those individuals at risk; to involve communities in planning and executing remedial action; and to ensure that the best use is made of available services. They are a focal point of the health system at the community level, a channel for health service in the promotion of health, prevention of disease, treatment of the afflicted, or care of the disabled."

Countries differ widely in the range of functions which the community-based rehabilitation worker has to fulfil. Despite the international variations, national experience is in agreement that the community-based rehabilitation workers require appropriate training to assist them develop skills and knowledge to cope with the diversity of tasks and environmental conditions.

Two organisations in the Western Cape have picked up on this need and have instituted various in-service programmes. Cape Mental Health Society, a private welfare organisation situated in Observatory, Cape Town, initiated their first mental health workers project on 1 August 1987 after researching the feasibility of this project.

South African Christian Leadership Assembly (SACLA) Health Project is another organisation that has been actively involved in the black squatter communities in Cape Town, i.e. K.T.C, Crossroads, Mbekweni in Paarl, and Site B, Site C, Town 2, and Greenpoint, Khayelitsha. They have trained community-based rehabilitation workers since 1988 to assist with the day care of mentally handicapped and other disabled children.

Since the inception of community-based rehabilitation workers, various in-service orientation programmes, in-service training and educational input have been provided by these organisations. The question which now arises is how appropriate the training has been in assisting the community-based rehabilitation workers with their awesome tasks and functions. The training and education of community-based rehabilitation workers create a particular dilemma due to their educational limitation, cultural background and the conditions of the socially deprived communities where an infrastructure barely exists.

The researcher endeavours to explore and investigate the suitability of the the training of community-based rehabilitation workers with particular reference to the field of mental handicap in the Western Cape.

More specific objectives arose from the researcher's own concern regarding the training of community-based rehabilitation workers which will be discussed below :-
1.2 SPECIFIC AIMS \ OBJECTIVES OF THE INVESTIGATION

1.2.1 The major objective of the investigation is to ascertain whether the training thus far provided has been perceived as being appropriate by the community-based rehabilitation workers in assisting them in their tasks and functions.

1.2.2 To ascertain the extent to which community-based rehabilitation workers are consulted and given equal participation in the planning of the training programme and course content. The study also focuses on the trainers’ and trainees’ opinions regarding the level of participation during the course and feedback after the course has been presented.

1.2.3 To ascertain whether specific training objectives were outlined by the trainer, and whether these were discussed with the community-based rehabilitation workers and whether they were achieved.

1.2.4 To determine whether systematically planned, predetermined models and curricula designs were employed by the trainer.

1.2.5 To explore whether the content presented had a body of theory and knowledge upon which practise was based.

1.2.6 To explore whether the locations used for training the community-based rehabilitation workers were appropriately located in the community and not removed from the actual practice situation.

1.2.7 To determine whether the training methodology, techniques, and nature of supervision experienced, were modified and adapted to the educational background of the adult learner within their socio-cultural context. The investigation intends to explore whether innovative-creative teaching materials have been used to narrow the gaps in learning. It also aims to explore the extent to which experiential, pragmatic and participatory methods have been included.
1.2.8 To investigate whether there are gaps or limitations in the present training programme which inevitably hinders the effective functioning of community-based rehabilitation workers.

1.2.9 To obtain guidelines for future planning of training programmes for community-based rehabilitation workers based on local research.

1.2.10 To contribute towards literature in this field.

1.2.11 To provide suggestions and recommendations which could improve the standard of training and service delivery.

1.3 ASSUMPTIONS

The assumptions upon which this study is based are listed below:

1.3.1 The present training of community-based rehabilitation workers often neglects to consider the educational limitations of the worker and therefore fails to consider pragmatic, experiential and participatory methods, techniques, content and supervision which are modified and adjusted to the educational and cultural level of the worker.

1.3.2 Training models and curriculum designs are often unavailable and remain unstructured.

1.3.3 Educational and training objectives are often too generalised and unspecific. Usually the objectives are known to the trainer and not the trainee.

1.3.4 The community-based rehabilitation workers are seldom included in the planning of the training programme and project.

1.3.5 The location used for training is seldom appropriate in terms of the principle of community-based rehabilitation.

1.3.6 The educational needs of the community-based rehabilitation worker are cumulative and ongoing and the initial training period is insufficient.
1.4 OPERATIONAL DEFINITIONS OF CONCEPTS AND TERMS

1.4.1 COMMUNITY BASED REHABILITATION

The World Health Organisation has defined community-based rehabilitation as follows:

"Community-based rehabilitation involves measures taken at the community level to use and build on the resources of the community, including the impaired, disabled and handicapped persons themselves, their families, and their community as a whole." (World Health Organisation Technical Report Series 668, 1981:7)

Community-based rehabilitation is further defined in the definition of rehabilitation recommended by the World Health Organisation Expert Committee on Disability Prevention and Rehabilitation (1981) as follows:

"Rehabilitation includes all measures aimed at reducing the impact of disabling and handicapping conditions, and at enabling the disabled and handicapped to achieve social integration.

Rehabilitation aims not only at training disabled and handicapped persons to adapt to their environment, but also at intervening in their immediate environment and society as a whole in order to facilitate their social integration.

The disabled and handicapped themselves, their families and the communities they live in should be involved in the planning and implementation of services related to rehabilitation." (World Health Organisation Report Series 668, 1981:9).

Hilton, D. (1988:3) asserts that community-based rehabilitation could be further described as:

".....originated by and from the people with the aid of an 'animator' whose only task is to facilitate this process."
1.4.2 COMPREHENSIVE PRIMARY HEALTH CARE

The declaration of ALMA ATA (1978) defines primary health as:

"... essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the economy can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both the country's health system, of which it is the central function and main focus, and the overall social and economic development of the community bringing health care as close as possible to where people live and work, and contribute the first element of a continuing health care process." (World Health Organisation Technical Report Series 717, 1985:15).

1.4.3 CAPE MENTAL HEALTH SOCIETY

Cape Mental Health Society is a registered private welfare organisation. The organisation renders services to the mentally handicapped, psychiatrically ill and those suffering from emotional stress, and is actively engaged in the prevention of mental disorders. (See Appendix I - Cape Mental Health Society Profile of Services). Cape Mental Health Society is registered as a welfare organisation in terms of the National Welfare Act of 1973.

The formation of the Cape Province Committee For The Care of the Feeble-Minded pioneered by Sir John Graham served as the forerunner of Cape Mental Health Society which was formed in 1913. The organisation is the oldest mental health society in the country. During the earliest days the society was run by dedicated volunteers and doctors who were motivated by deep concern for the mentally handicapped and those with psychiatric disorders.
Its area of operation, as indicated by its constitution, is the Western Cape and consists of all places within the boundaries of the Magisterial Districts of Riversdale, Ladysmith, Laingsburg, Sutherland, Fraserburg, Calvinia, Williston, Namaqualand, and along the West Coast and Southern Coast. Unfortunately, the facilities and resources to rural and outlying areas are few or totally unavailable.

The services rendered by the Agency are guided by the conditions outlined in the Mental Health Act No.18 of 1973 and by relevant social policies and regulations. The organisation has a formal structure through which services are rendered. (See Appendix 2 - The Organisational Structure of Cape Mental Health Society).

THE AIMS OF THE ORGANISATION ARE :-

"To improve the quality of life of mentally handicapped and psychiatrically ill people and their families.

To reduce the incidence of mental handicap and psychiatric illness in the community.

To initiate and develop appropriate services and facilities for the society's clients in co-operation with the community.

To provide an information service and raise awareness about mental handicap, psychiatric illness and mental health needs in the broader community. " (Cape Mental Health Society Profile, 1989).

The function of Cape Mental Health Society is guided by an overall statement of principles which are as follows :-

"We are opposed to all forms of discrimination and will strive for a just society which provides for the mental health of all people".
1.4.4 SOUTH AFRICAN CHRISTIAN LEADERSHIP ASSEMBLY (SACLA) HEALTH PROJECT

The South African Christian Leadership Assembly (SACLA) met at a conference in July 1979 where the organisation was forced to look at the meaning of being a Christian in the apartheid system.

Thus, The South African Christian Leadership Assembly (SACLA), under the auspices of the Church of the Province of South Africa (Anglican) started health projects in the black townships in 1980. The first clinic, Empilisweni SACLA Clinic, opened to patients on 4 June 1980 in Crossroads squatter camp which consisted of 50 000 people. The majority of the people who lived here were Xhosa speaking migrant labourers who deliberately lived there with their wives and children despite legislation which prohibited this. The main aim of the service provided at the Empilisweni SACLA Clinic was to provide mainly a curative health service. In June 1986, when faction fighting started in the area, Empilisweni SACLA Clinic was forced to move out of the area which had become unsafe and dangerous due to the political power struggles between the two factions.

In January 1987, a day care centre for physically and mentally handicapped children was established in Site B squatter area in Khayelitsha. Six community-based rehabilitation workers, some of whom were mothers of disabled children, were trained to assist in this project and with home-based care to assist with the improvement of the mental and physical functions of the disabled persons.

A third project consists of special clinics for elderly persons suffering from chronic conditions such as diabetes, hypertension, epilepsy, asthma and arthritis. These clinics operate from two bungalows in the grounds of St Mary's School in New Crossroads.
THE OBJECTIVES ARE :-

1.4.4.1 To meet the physical and spiritual needs of the inhabitants of the communities where SACLA works.

1.4.4.2 To concentrate on community participation in health care practices which are primarily curative and preventative.

1.4.4.3 To empower the communities in which the project functions with the hope that each community would democratically control their own programme. Urbanisation and Health Newsletter (1990).

1.4.5 MENTAL HANDICAP :-

"The essential features of this disorder are :

1. Significantly sub-average general intellectual functioning.

2. Significant deficits or impairments in adaptive functioning.


This is a permanent, irreversible condition which has its etiological roots in biological or psychological factors.

The following are the major causative factors cited in the Diagnostic Statistical Manual of Mental Disorders III-R (1987)

1.4.5.1 heredity, i.e., metabolic, genetic, and or chromosomal aberrations.

1.4.5.2 early alterations of embryonic development, i.e., prenatal damage due to toxins, unknown causes or chromosomal changes.

1.4.5.3 pregnancy or perinatal problems, i.e., fetal malnutrition, prematurity, hypoxia or trauma.
1.4.5.4 physical disorders acquired in childhood, such as, infections, trauma, lead poisoning, etc.

1.4.5.5 environmental influences and mental disorders, such as, deprivation of nurturance, social, linguistic and other stimulation and complications of severe mental disorders.

The degrees of severity range from:-

Profound to mild mental handicap, i.e. I.Q. 0 - 55 to approximately 70.

1.4.6 PARAPROFESSIONAL, UBIQUITOUS PARAPROFESSIONAL, INDIGENOUS PARAPROFESSIONAL, INDIGENOUS VILLAGE WORKER, AUXILLIARY WORKER AND INTERMEDIATE LEVEL WORKER - COMMUNITY-BASED REHABILITATION WORKER

The terms paraprofessional, indigenous village level workers, auxilliary worker, new professional, new careerist, rehabilitation worker, frontline worker, etc. are often used interchangeably leading to much confusion and uncertainty.

The definitions of these terms would need to be discussed to provide some clarity:-

PARAPROFESSIONAL

Brekelbaum, T (1984) and Kadushin, A (1976) agree that the prefix comes from the Greek word which means "by the side of" or "alongside" and also implies a subsidiary or an accessory relationship.

Austin, M J, (1978:70) defines the paraprofessional as,

"Any individual male or female, who lacks the traditional credentials - of either education or experience for social work and social welfare jobs. As a population, we are focusing primarily on these persons who are employed in public or private agencies in which the delivery of social welfare services is an important but not always the primary mission of the organisation."
Rigby, B D (1978) adds that the paraprofessionals are today a diverse group of frontline workers engaged in a variety of developmental programmes carried out in both rural and urban areas in many countries around the world. They are often village leaders, fieldworkers, rural development assistants and family visitors, etc.

Reiff and Riessman (in Kadushin, A, 1976) differentiated between ubiquitous paraprofessionals and indigenous paraprofessionals.

UBIQUITOUS PARAPROFESSIONAL

The ubiquitous paraprofessional "may be recruited from the same general background as the professional staff; they are widely distributed in population." (Kadushin, A, 1976:366). He further outlines that the "ubiquitous paraprofessional" is often an assistant to the professional, a means of removing "low-level functioning" from the "high-level" professional.

I personally disagree with Kadushin’s last statement as I feel that in all the review of literature it is quite clear that the paraprofessional or community-based rehabilitation workers job description does not pertain to "low-level functioning" but rather that they have an accessory relationship with the professionals. Community-based rehabilitation workers are actively engaged in promotion, prevention, rehabilitation and treatment.

INDIGENOUS PARAPROFESSIONAL / INDIGENOUS VILLAGE WORKER

The indigenous paraprofessional or indigenous village worker on the other hand is defined as, "a more limited group who are ‘native to’ the population to whom they will often service." (Kadushin, A, 1976:366). He adds that they may be specifically selected to match the ethnic, racial, educational and socio-economic background of the client group.
Kadushin, A (1976) furthermore highlights that the objective for the employment of the indigenous worker is the person's ability to form a link or bridge between professional staff, organisation and the community. He/She possesses special attributes which the professional does not have and is therefore in a far better position to teach and have an impact on his or her community. He adds that indigenous paraprofessionals have acquired social skills and capacities by virtue of being within a particular population.

"The term 'indigenous' has also been used to refer to those who were previously members of a group sharing a common problem - the former alcoholic, prisoner, drug addict or mental health patient." (Kadushin, A, 1976:367).

Brekelbaum, T, (1984:232) adds that the indigenous workers "have a unique contribution to make because they are peers of the target population."

Pangalangan, E and de Guzman, L (1980) outline that the term "paraprofessional" is not universally used or accepted. It is apparently less preferred in all countries of Asia. It is important to realise that different countries designate various titles to the same category of personnel.

AUXILIARY WORKER

The United Nations Administration Committee on Co-ordination defines the auxiliary worker as:

"A paid worker in a particular technical field, with less than full professional qualifications in that field, who assists and is supervised by a professional worker." (Report of the Ad-Hoc Inter-Agency Meeting on the Training of Auxilliary and Community Workers, 1950:2)

This report adds that the community-based rehabilitation worker is focal in the promotion of health, prevention, treatment and rehabilitation.

The community-based rehabilitation worker could be regarded as the frontline worker who has first contact with the population to whom services are to be rendered.

In comparing the definitions of the ubiquitous paraprofessional, indigenous paraprofessional, auxiliary worker and community-based rehabilitation worker, one sees similarities and obvious differences. It is clear that the community-based rehabilitation worker and the indigenous paraprofessional bear a close resemblance and only differ in the tasks they are expected to perform, while the ubiquitous paraprofessional is closely related in terms of assisting and facilitating the role of the social worker.

In this study, the term community-based rehabilitation worker would be used rather than the terms such as paraprofessionals, auxiliary workers and so on.

1.4.7. TRAINEES

Trainees are those community-based rehabilitation workers who are or were trained for a specific task.
1.4.8 TRAINERS

Trainers are those individuals who conduct the actual training. These are qualified personnel who are to assist with didactic input and practical on-the-job training and supervision. They may also be referred to as instructors.

Pangalangan, E and De Guzman, L (1980:42) define the trainer as someone who:

"...is concerned with the developments of the knowledge and skills of the trainees to bring about an attitudinal change for the effective performance of specific tasks within the goals of the Agency, social work and society in general."

Trainers could be, "faculty members, students from the institution and related university departments, or other persons representing government or private Agency interest." (Rigby, B D, 1978:8).

1.4.9 TRAINING

Hackerson, F and Middleton, J, (in Rigby, B, 1978:9) define training as:

"learning designed to change the performance of people doing jobs .... Training in fact, may be seen as a very important field of application for principles taken from education and communication - as well as from organisational science."

Training is also viewed as, "the overall attempt to modify behaviour so that trainees become more capable of performing tasks. In turn, this is dependent on the acquisition and refinement of skills and knowledge, gaining and deepening insight and self-understanding." (Sobey, F, 1970:17).

Training may therefore be seen as didactic, experiential, participatory and pragmatic.
CONCLUSION

Thus far this section of the research report introduces the rationale, aims and objectives of the investigation and provides an overview of the assumptions on which this study is based.

The definitions of terms and concepts endeavours to provide a guideline to the reader pertaining to the exact nature and meaning of terms.

Chapter Two provides an overview of the historical development of community-based rehabilitation focusing on the "Individual Care Era", "The Community Care Era" and "The Health for All (Population Care Era)". This chapter also focuses on the lack of trained personnel, disparity in the provision of services and the functions of the community-based rehabilitation workers which has lead to the historical emergence and need for training.

Chapter Three focuses on the overall training of community-based rehabilitation workers. Here the approaches to the training, course content, curriculum development and training, training methodology and techniques are discussed. The nature of supervision of the community-based rehabilitation workers are also examined.

Chapter Four looks at the research methodology sampling method, data collection procedure, design of the interview schedules and self-administered questionnaire. The difficulties encountered in the study, its limitations and strengths are also highlighted.

Chapter Five focuses on the descriptive presentation of the results while Chapter Six provides a discussion of the findings, areas for future research and practical recommendations.
CHAPTER 2

HISTORICAL DEVELOPMENT

2.1 INTRODUCTION

This chapter will focus on the historical development of community-based rehabilitation internationally and in South Africa, and encompasses a discussion of the "Individual Care Era", "Community Care Era" and "The Health for All (Population Care) Era."

In providing a historical overview of community-based rehabilitation and in discussing the lack of trained personnel, the need for and the role of community-based rehabilitation as a means of providing health for all will be highlighted. Furthermore, the various roles performed by the community-based rehabilitation worker which have considerable implications for training will also be discussed.

2.2 THE HISTORICAL DEVELOPMENT OF COMMUNITY-BASED REHABILITATION

HISTORICAL PERSPECTIVE:

The need for an alternative strategy for the current rehabilitation structure should be seen within the historical context in which it developed in the health field inclusive of mental health.

The World Health Organisation Expert Committee (1985) provides an analytical framework which traces the evolution of the development of community based care into three essential eras, i.e., "The Individual Care Era", "The Community Care Era" and" The Health for All (Population Care) Era".
2.2.1 THE INDIVIDUAL CARE ERA

Institutional based rehabilitation, which was prominent during the early part of the century, had its roots in the medical rehabilitation model. This was also the period of professionalisation within social work and the medical world. Austin, M. J. (1978) outlines that this period was also characterised as the clinical era in which teachings of Freud gained prominence.

This was essentially the period where curative medicine became the pre-occupation of the day. The medical model had prominence and those employed were mainly there to assist the medical practitioner. The same situation applied in South Africa where institutional based care with the emphasis on the medical model was held in high esteem.

2.2.2 THE COMMUNITY CARE ERA

The post World War II period was regarded as "the renewest" era where prevention as a new *modus operandi* was seen as the means of extending care to a broader and larger sector of the population.

The World Health Organisation Expert Committee outlines that,

"the single-tier system of doctor-centred care was replaced in most countries by a two-tier system - at one level doctors and nurses provided care in hospitals and major health centres and at a second level, auxiliaries staffed a network of health centres ...... ."


The auxilliary staff mentioned here often covered local communities through their mobile clinics.

This was also the period of de-institutionalisation in the field of mental health internationally and in South Africa.
Hundreds of mentally handicapped and psychiatrically ill persons were discharged and de-certified. Unfortunately the major manpower shortage and the lack of appropriate community resources and facilities complicated the functioning of the community care approach. Communities were ill prepared for these changes and lacked the necessary community rehabilitation services to cope with the needs of the mentally handicapped while curative medicine with its strong Freudian emphasis remained dominant.

The 1960's continued to place emphasis on community care in the mental health service structure. Oren, O (1974) adds that, it was during this period that non-professionals were considered as possible role bearers who could render services to those suffering from mental disabilities or emotional problems. He adds that, "already at the very beginning of the sixties Albee (1959) made a strong plea for the development of a new kind of worker who could be trained in a shorter period of time than the one mostly used for professional training." (Oren, O, 1974:9).

2.2.3 THE HEALTH FOR ALL (POPULATION CARE) ERA

The concept "Health for All by the Year 2000" represented a historical shift in international health care during the early 1970's.

The World Health Organisation Technical Report Series, 717 (1985:21) outlines the objectives for this era and the primary health care approach which is a,

"three-tier system of health service and manpower in the developing countries; the training and use of community health workers, or other forms of community engagement in health related activities; the preparation of middle-level workers to provide community health workers with essential supervision, technical and logistic support, continuing education; and the supervision and support of the preceding two levels by physicians, nurses, and other health professionals."
The following annexures represent various health manpower developments which arose from the World Health Organisations "Health for All by the Year 2000" proposal.
(See Appendix 3; The Ladder of Care, Appendix 4; Pyramid of Health Services, and Appendix 5; A Proposed Structure for Cape Mental Health Society.)

The health manpower development proposals made it possible for several community-based rehabilitation projects to develop in order to cope with the growing health care needs of all. This health manpower development and care would permit communities to lead socially and economically productive lives. The World Health Organisation Technical Report Series, 717 (1985:14) states that, "this long-term objective of health for all would be the impetus for concerted action to resolve the intolerably inequitable distribution of health resources throughout the world, particularly with respect to developing countries."

It was as a direct result of this that several community-based rehabilitation projects emerged, namely:

Western Mexico (1973)
Projimo (Project For Rehabilitation of Young People in Western Mexico) focuses on service for all disabilities. The number of community-based rehabilitation workers are unknown.

Kerala, Kanyakumari & Tamil Nadu, India (1975)
Health For One Million provides a comprehensive health based community development approach which is inclusive of assistance to the mentally handicapped and physically ill. They employ 1000 village level volunteers.

Botswana (1977)
Community-Based Psychiatric Care. They employ 300 village health workers chosen from the village by the village. The main focus is prevention.
Zimbabwe (1981)
Comprehensive Health Care. The number of community-based rehabilitation workers are unknown.

Lesotho (1984)
Scott Hospital Community-Based Rehabilitation Project. The number of community-based rehabilitation workers are unknown.

Khayelitsha (1987)
South African Christian Leadership Assembly Health project. They employ 8 community-based rehabilitation workers who provide services to physically and mentally handicapped children.

The exact number of community-based rehabilitation workers working amongst the mentally handicapped in South Africa is generally unknown due to a lack of research and national co-ordination.

It is clear that irrespective of South Africa’s present or future political dispensation, community-based rehabilitation, which includes community-based rehabilitation workers, will and must continue to develop and grow in order to overcome or reduce the lack of services in many communities.

2.3 LACK OF TRAINED PERSONNEL, DISPARITY IN THE PROVISION OF SERVICES AND THE FUNCTIONS OF THE COMMUNITY-BASED REHABILITATION WORKERS

2.3.1 LACK OF TRAINED PERSONNEL AND THE DISPARITY IN THE PROVISION OF SERVICES:

The concept "Health for All by the Year 2000", and the health manpower development proposed by the World Health Organisation emerged in response to the shortage of available professional manpower commonly found in the developing countries of the world. The World Health Organisation Expert Committee asserts that,
"In the least developed countries, there is 1 health worker per 2,400 people, compared to 1 per 100 people in the industrial countries. Moreover, the unsatisfactory deployment of these health workers is such that the majority of them, often 80%, are working in and around urban areas where only about 20% of the population live." (World Health Organisation Technical Report Series 717, 1985:12).

It is thus clear that on the international front, very few countries have a manpower distribution which is comparative to the needs of their communities. This situation is worse in the rural areas where there are generally few resources to cope with the health and mental health needs.

In South Africa, the lack of trained personnel, complicated by the gross disparity in the provision of service and facilities based on race, has contributed to the unsatisfactory quality of health and welfare services provided to the majority of the population.

In addition, 50% of the South African population live in rural areas and it is estimated that 80% of the disabled population (inclusive of mentally handicapped persons) live in these areas. Co-ordinating Committee of Community Rehabilitation Education, (1988).

Acton, N (1979) lists seven factors which further influence the quality of life of the rural disabled person, namely
2.3.1.1 Increased mortality and morbidity
2.3.1.2 High frequency of malnutrition and communicable diseases amongst disabled children
2.3.1.3 A lack of rehabilitation services
2.3.1.4 A lack of access to normal community services and facilities
2.3.1.5 Poverty
2.3.1.6 A lack of educational and employment opportunities
2.3.1.7 Negative and discriminatory attitudes by non-disabled people

The increase in reported and known cases of mentally handicapped remains approximately 4 per 1000 in a community. The unattended numbers especially in peri-urban squatter areas and rural communities are speculated to be high. In these deprived situations most of them live below the bread line.

Furthermore, the shortage of social work personnel to render community rehabilitation services or general social work intervention remains scarce in both rural and urban areas.

The document on the training course for social auxiliary workers proposed by the South African Council for Social Workers (1989) provided demographic particulars to highlight this shortage in manpower. They noted that, "In February 1989 the ratio of social workers to the various population groups were as follows :-

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Further alarm emerges at the ratio of social workers to the population in self-governing states, "independent states".

These are as follows :-
According to a projection made by Prof. W F van Delft of Unisa, 21000 black social workers will be needed by the year 2000." (Proposed Training Course for Social Auxiliary Workers, S A Council for Social Work, 1989:8)

It is therefore clear that in considering the above demographic ratios and the statistics cited by the World Health Organisation, professionals themselves would not be able to cope with the growing socio-economic needs and the numbers of mentally handicapped persons. This is true internationally as well as in South Africa, because of scarce resources and the lack of facilities, such as special care centres for the mentally handicapped, training centres, protective workshops, group homes, and nutritional and health clinics.

Oren, O, (1974:5) asserts that,

"...the number of helpers has remained limited in comparison with the growing needs in the community, the service is generally located outside the physical - social field of the consumer, most bureaucratic and of a complicated structure, as well as expensive and stigmatising."

It was as a direct result of these factors that the World Health Organisation at the Thirteenth World Health Assembly, May 1977, unanimously declared and agreed to the concept "Health for All by the Year 2000." The Assembly which represented 152 member states highlighted that,
"the main social target of governments and World Health Organisation in the coming decades should be the attainment by all citizens of the world by the year 2000 a level of health that will permit them to lead a socially and economically productive life." (World Health Organisation Technical Report Series 717, 1985:14)

2.3.2 FUNCTIONS OF THE COMMUNITY-BASED REHABILITATION WORKER

The World Health Organisation sees the employment of community-based rehabilitation workers as a vital force in providing community-based rehabilitation in order to obtain "Health for All by the Year 2000." The provision of services to the mentally handicapped should be seen within this framework of comprehensive primary health care where the role and tasks of the community-based rehabilitation worker could vary. The functions of the community-based rehabilitation worker could be promotive, preventive, curative and includes rehabilitation.

Sobey, F, (1970:123) who uses Gerald Caplan's three distinct but related levels of prevention, sees the functions of the community-based rehabilitation worker as being involved in the following:

"Primary Prevention Level : involves specific prevention activities in health promotion (for example, mental health education and anticipatory counselling to would-be mothers, to special age groups - the teenager, the senior citizen, etc.) All these activities are aimed at teaching people before they become ill.

Secondary Prevention Level : essentially involves locating those who have early symptoms (acute or mild) of mental disorder and reducing the number of serious disorders.

Tertiary Prevention Level : involves the reduction of the impairment which may result from severe and chronic disorder and usually requires long-term care and rehabilitation."
Brekelbaum, T, (1984:233) identified eight basic functions performed by community-based rehabilitation workers and lists these as follows:

"A) community education
B) delivery of services
C) organisation or mobilisation of the community, which involves leadership and problem-solving skills
D) acquisition of goods and services outside the community
E) referral of problems/cases that cannot be handled locally
F) keeping proper records and maintenance of equipment
G) collection of data
H) demonstration and testing of innovative technology."

Authors such as Lewis, J A and Lewis M D (1977) outlined that the programmes in which community-based rehabilitation workers are employed may be experiential, which means that they provide an opportunity for individuals to participate directly in new learning experiences. They may also be environmental, which means that they are meant to change the social surroundings that affect people. These authors delineate and explain this in the following annexure (See Appendix 6 - Experimental and Environmental Programmes).

It is within the diversity of these broad roles and functions that community-based rehabilitation workers are meant to perform. The tasks and functions vary depending on the area of comprehensive primary health care that the community-based rehabilitation worker is employed in. It is very important to realise that the community-based rehabilitation worker does not work in isolation but should be essentially regarded as fitting into the Pyramid of Health Services or Ladder of Care. (See Appendix 3 - Pyramid of Health Services & Appendix 4 - The Ladder of Care)
The World Health Organisation Expert Committee (1985) sees the role of the community-based rehabilitation worker as following the guidelines of the Declaration of ALMA ATA (1988). The Declaration of ALMA-ATA was compiled after the ALMA-ATA conference in November 1988 - they stressed the promotion of health, prevention of disease, diagnosis, treatment and rehabilitation but also emphasised community involvement in every step of the process as being essential and of the utmost importance.

2.4 HISTORICAL EMERGENCE OF NEED FOR TRAINING

It was during the period of Health for All (Population Care) Era that the training of community-based rehabilitation workers became an area of concern, as this group of workers required certain skills to cope with the comprehensive needs of the communities they served.

Rigby, B D (1978) sights the glaring gaps and inadequate training of various levels of social welfare personnel, especially frontline rehabilitation workers, in developed and developing countries. It was as a result of this, that the United Nations Headquarters and Regional Commissions surveyed and held various conferences to focus on the roles, tasks and training of rehabilitation workers.

Rigby, B D, (1978:iii) adds that,

"In recent years a United National Survey on Training of Social Welfare Personnel, Training for Welfare : Fifth International Survey, 1971, and the publication The Improvement of Social Welfare Training - Contributions From Related Fields 1977, as well as expert group meetings on related subjects have discussed at length the need to pay greater attention to the training of frontline workers."

The International Association of Schools of Social Work (IASSW), Regional Project of Paraprofessional Training (1976) was established to assist pilot schools of social work to adapt their curricula to the indigenous realities. (Pangalan, E and De Guzman, L (1980)
The assistance and involvement of the International Association of Schools of Social Work was followed by a regional seminar in Jakarta, Indonesia, on 14-19 July 1980 where the main focus was on, "The use of Paraprofessionals in Social Development - Implications for Social Work Education (Guidelines for curriculum development)". (Pangalangan, E and De Guzman, L, 1980:1)

Between 1970 - 1980 countries such as Malaysia, Sri Lanka, Korea, Philippines and others, have instituted curricula for the training of frontline rehabilitation workers at their schools of social work. This was initiated to assist with the preparation of the frontline workers in the tasks and functions which they are expected to perform (see Appendix 7 - Curricula for the Training of Frontline Rehabilitation Workers - 3 Models. Presented at the Proceedings of the International Association of Schools of Social Work, Asian Regional Seminar, July 14-18, 1980.)

The formalisation of training for rehabilitation workers in South Africa has only emerged in the late 1980’s. The Co-ordinating Committee on Community Rehabilitation Education, representing associations of occupational therapists, speech therapists and physiotherapists submitted a memorandum to the South African Medical & Dental Council in 1988, and to the Department of National Health and Population Development, emphasising the importance of training for community-based rehabilitation workers. This proposal was strongly supported by the various departments and unanimously accepted at a conference on 6 July 1989 at which the Council for Social & Associated Workers were present. This, including the amendment of the Social Workers Act, 1978 (Act 110 of 1978) in May 1989, influenced the South African Council for Social Work (February 1989) to focus on the training, minimum requirement and curriculum development of social auxiliary workers.

A Workshop on Community-Based Rehabilitation arranged by the Rural Disability Action Group held in Broederstroom in Johannesburg on 27 - 28 April 1990 focused on training of community-based rehabilitation workers.
This conference was attended by individuals from various professional disciplines which included physiotherapists, occupational therapists, doctors, nurses, social workers, speech therapists and disabled people. Minimum educational requirements of community-based rehabilitation workers, length of the course, course content, tuition and supervision were closely discussed in small groups and during the conference itself.

There are fundamental differences between the training proposed by the Co-ordinating Committee on Community Rehabilitation Education and that proposed by the South African Council for Social Work.

The following focuses on some of the differences in the proposed training of community-based rehabilitation workers:

ENTRY REQUIREMENTS

The Co-ordinating Committee on Community Rehabilitation Education proposes functional literacy with community-based rehabilitation workers preferably chosen from within the community. The South African Council for Social Workers requires Std.10 as an entry requirement or Std.8 with age 19 years on registration.

INFRASTRUCTURE OF TRAINING

The Co-ordinating Committee on Community Rehabilitation Education proposes that training should be relevant to the conditions of the community, which is in keeping with the World Health Organisation "Health for All (Population Care) Era. They furthermore propose that training facilities and courses taught and practised should be within the community that the community-based rehabilitation worker is due to serve.

The South African Council for Social Work proposed formalised institutions, such as technikons or possibly universities. This essentially removes the rehabilitation worker from the community he or she is meant to serve. This may improve the status of the social auxiliary worker but could lead to isolation by removing the worker from his/her indigenous roots.
It must though be stated that the South African Council for Social Work does not see auxiliary workers as indigenous and therefore the place chosen for training could be away from the area of operation.

TRAINING METHODOLOGY AND TECHNIQUES

The training methodology suggested by the Co-ordinating Committee on Community Rehabilitation Education aims to reduce formal lectures, and to replace them by informal class discussions and practical work with greater emphasis on audio-visual material which takes into consideration the communities' level of functioning and needs. Examinations could be oral and practical rather than written. The South African Council for Social Work proposes formal training courses of at least 1 year. The methods and techniques for the training of the auxiliary workers would include formal lectures, tests, laboratory work, workshops and practical training.

The level at which this is pitched is clearly aimed at a highly literate person and is not applicable for community-based training.

COURSE CONTENT AND FRAMEWORK

The Co-ordinating Committee on Community Rehabilitation Education proposes that the content would be on a basic structured level with repetition and practical application. This would be implemented over a period of two years, and focus on comprehensive care which includes promotive, preventive, curative and rehabilitation services of a generic nature. (See Appendix 8 - Co-Cores Proposed Training Course Content (1988)). The South African Council for Social Work agrees with the concept of generic training but this is followed by a chosen direction of in-service training. (See Appendix 9 - Proposed Training Course for Social Auxiliary Workers : S A Council for Social Work proposed Course Content (1989)).

At the Community-based Rehabilitation Workshop on 27 - 28 April 1990, several debates emerged concerning the exact nature of appropriate course content.
Many felt that the course content presented should be aimed at developing a multiply skilled community-based rehabilitation worker while others felt that this expectation might be unrealistic. It is clear from the above that there are fundamental differences in the proposed training. The South African Council for Social Work clearly seeks to create a social work assistant who is primarily agency or institution-based. There is a move towards creating sophisticated skills which fits in with the western rehabilitation model.

The Co-ordinating Committee on Community Rehabilitation Education proposal for training of community-based rehabilitation workers differs with the model proposed by the South African Council for Social Workers. The training proposed by the Co-ordinating Committee on Community Rehabilitation Education is aligned with the community-based rehabilitation model which moves away from expensive buildings, sophisticated technology and equipment and or highly specialised personnel. The training of the community-based rehabilitation worker is meant to take place in the environment of the disabled person utilising the available community resources and supports.

2.5 CONCLUSION

This chapter focused on the lack of trained personnel and gross disparity in the provision of services which has lead to the employment of community-based rehabilitation workers. The role and function of the community-based rehabilitation worker is discussed and seen as essential to alleviate the lack of services.

The historical development of community-based rehabilitation and the emergence of some community-based rehabilitation projects were discussed. The role of the community-based rehabilitation worker within community-based rehabilitation is given great priority with the realisation that training for the various roles is of the utmost importance. The approaches to, and development of, training is therefore discussed in greater detail in the following chapter.
CHAPTER 3
TRAINING OF COMMUNITY-BASED REHABILITATION WORKERS

3.1 INTRODUCTION :

This chapter will firstly outline the different approaches which could be chosen to train community-based rehabilitation workers. These approaches referred to are:

i. the "top-down" approach which incorporates principles of the conventional and progressive approaches.

and

ii. the "bottom-up" approach which focuses on the liberating model or approach.

The approaches chosen for training ultimately becomes the underlying philosophy or value which would influence the content and curriculum design, training methodology and techniques and the approach to supervision. These areas will be discussed in greater detail focusing on the implication which the above has on the training of community-based rehabilitation workers.

Furthermore, the underlying philosophy of Paulo Freire would be incorporated as the theoretical model on which many concepts for training of community-based rehabilitation workers are based.

3.2 APPROACHES TO TRAINING OF COMMUNITY-BASED REHABILITATION WORKERS

There are basically two primary approaches to the training and education of community-based rehabilitation workers, i.e., the "top-down" approach or the "bottom-up" approach.

Educators or trainers need to closely consider these two approaches. The choice of these approaches will inevitably become a value-laden decision which would determine and set the foundation for the implementation of the training programme and the project.
Werner, D and Bower, B, (1987:405) assert that,

"the top-down programmes or activities are mostly planned, started, organised and controlled from outside the community - by government, by an international organisation, or by distant 'experts.' And the local leaders are usually persons in position of authority, influence or power."

In this approach, the nature of the activities, programmes, funding and training have already been decided on by the outsider.

In the "bottom-up" approach,

"programmes or activities are those that are largely started, planned, organised and controlled locally by members of the community. Much of the leadership and direction comes from those who need and benefit most from the programmes activities. In brief, the programme is small, local and 'user-organised'." (Werner, D, and Bower, B, 1987:405).

The difference in the "bottom-up" approach is the emphasis on community involvement and participation. It implies that the local people decide on the needs and make community decisions about how the needs could be met. This approach does not preclude the involvement of outsiders or experts who are often employed to initiate the training of community-based rehabilitation workers.

Werner, D and Bower, B (1987) note that even though the "top-down" approach is easy to introduce, administer, organise and evaluate, it is often fraught with weaknesses mainly because it fails to have the support, backing and involvement of the local communities. The pre-packed training models often have no credibility with the local people as they fail to consider local cultural, political and economic values.

It is recognised that the "bottom-up" approach is time consuming but it has the advantage of respecting, giving power and control to the people it is meant to serve. Werner, D and Bower, B (1987) add that this approach is flexible and adaptable due to it being controlled locally.
It is generally recognised in community work organisations that this method is by far the most accepted. The "top-down" approach with predetermined structures, methods and procedures often aims to "normalise" the disabled rather than focusing on organising and empowering them.

Further criticism of the "top-down" approach is based on the rigidity of the programmes which often have stereotyped designs. The administrators are often more concerned about the success of the programme implementation rather than the success and advantages it has for the community. There is also the feeling of colonialism and over-professionalisation of these projects.

Werner, D (1989) visited a number of programmes for disabled persons in Latin America, the Caribbean, the Indian sub-continent and to a lesser extent, Africa. His interest was to mainly evaluate these programmes and ascertain the extent to which the disabled and their families were involved in the management and decision-making process. He inevitably found that many programmes were unsuccessful when the philosophy of the "bottom-up" approach was ignored or erratically followed.

Werner, D and Bower, B (1987) expound on these philosophies by outlining that there are basically three approaches to the education and training of community-based rehabilitation workers which are either based on the "top-down" approach or the "bottom-up" approach. The three approaches to education and training of community-based rehabilitation workers are:

i Conventional Approach
ii Progressive Approach
iii Liberating Approach

(See Appendix 10 - David Werner's Three Approaches of Education and Training of Community-based Rehabilitation Workers (1987)).

The Conventional Approach and the Progressive Approach are developed on the "top-down" philosophy while the Liberating Approach is built on the philosophy of the "bottom-up" approach.
Werner, D and Bower, B (1987) state that in the Conventional Approach people are mainly taught to "fit-in" and uphold the status quo while the Progressive Approach works towards certain improvements; little is done to change the social, economic and political injustice or inequalities. The Liberating Approach actively opposes these inequalities, injustice and actively works towards social change and action by those considered disadvantaged.

In considering the above approaches, it becomes apparent that the "bottom-up" approach and the Liberating Approach, have their roots in the philosophy and theory of Paulo Freire. Paulo Freire was born in 1921 and lived in the most extreme situations of poverty and underdevelopment. He was a professor of history and philosophy of education at the University of Recife. His work and theory arose out of his involvement with the literacy campaign which was aimed at assisting the peasants in Brasil to read but also to overcome their continued passivity. Freire’s methods were adopted by the Brasilian Ministry of Education with nearly two million people involved in 20,000 discussion groups.

His work was often inspired by people such as Chi Guevara, Moa, Lenin, Martin Luther King, Erik Fromm and others. His primary aim was to mobilise people to a point of certain awareness of their situation. During the literacy campaign the process of "conscientization" engaged people in determining their own goals and change process.

This therefore brings us to the point where we have to closely consider the involvement and inclusion of the trainee in the planning and decision-making process of the training programme where learning needs are to be considered.

Benseman, J, (1978:39) argues that, "the relationship between the educator and educatee therefore is based on equality where both have an equal contribution to make." He quotes Paulo Freire (1972) as stating :-
"the educator must 'die' as exclusive educator to the educatee in order to be born again as educatee. At the same time, he must propose to the educatee that he 'die' as exclusive educatee of the educator in order to be 'born' again as educator of the educatee. This is a continual passage back and forth, a humble creative movement, which both have to make."

It implies that the roles between educator and educatee continue to interchange from one position to another, where the educator is willing to learn and the educatee is willing to teach and vice versa. This therefore calls for greater participation and involvement from all concerned with the humble changes in status.

The western or conventional model of teaching community-based rehabilitation workers or general frontline workers often assumes a very authoritarian approach to teaching. The trainer frequently assumes the authoritarian position of knowledge and skill rigidly bound to a set curriculum. The liberating model in South Africa, known as progressive or alternative education, focuses on participation by the community for the community.

Werner, D and Bower, B, (1987:16) assert that,

"one of the main purposes of conventional or authoritarian education is to teach students to fit obediently into the existing social order. The teacher provides the approved knowledge and the students receive it."

He adds that unfortunately the same authoritarian approach is often used to train the village level rehabilitation worker. He notes that,

"students are taught to follow, not to explore; to memorize, not to think. They are taught to believe that their first responsibility is to the health system rather than to the poor."
(Werner, D and Bower, B, 1987:6).
The dilemma of this form of education unfortunately has its roots in the educational system of the country. The major problem with this authoritarian approach to training of community-based rehabilitation workers lies in the fact that this method is rigid and resists change.

The added dilemma of this approach is that it serves as a poor example or model to the community-based rehabilitation workers who will teach and educate the local community the way they themselves were taught.

Werner, D and Bower, B (1987) emphasise full participation and involvement of community-based rehabilitation workers in their training - to allow observation, criticism, analysis and work things out for themselves.

"These ways let the students discover that they are just as good as their teachers and everyone else. They learn to co-operate rather than compete in order to gain approval. They are encouraged to consider the whole social context of their people’s needs and to look for imaginative and courageous ways of meeting them. This we will call EDUCATION FOR CHANGE. Emphasis is more on learning than on teaching."
(Werner, D and Bower, B, 1987:16).

3.3 COURSE CONTENT, CURRICULUM DEVELOPMENT AND TRAINING MODELS

At the recent conference on Community-Based Rehabilitation arranged by the Rural Disability Action Group (RURACT) on 26 - 28 April 1990, much discussion emerged as to the content and curriculum design which would be appropriate for the training of community-based rehabilitation workers. The question which emerged was whether one was actually looking for the development of a community-based rehabilitation worker who has multiple skills, i.e. a combination of speech therapy, physiotherapy, occupational therapy and social work skills. If so, the training would be generic, focusing on several disabilities and developing the multiple skills mentioned. Others disagreed, believing that the nature and tasks or job description would determine the content and curriculum design.
The latter approach is potentially problematic as it is restrictive and exclusive in terms of the area of specialisation.

Austin, M J, (1978:101) notes that,

"The emerging trend towards comprehensive unified human service for the poor, mentally ill, retarded, delinquent and disabled has brought to the surface most dramatically the need to reconceptualise traditional approaches to staff development and training in the human service."

Thus, in reconceptualising curriculum design one sees an emphasis on generic, comprehensive care for all by the year 2000.

In the comprehensive primary health care approach this is feasible, if service rendering is to be broad and non-specialised. Unfortunately, many projects in South Africa function within the context of specialisation, e.g., The Association for the Physically Disabled - Physical Disabilities, Civilian Blind - Blind, Cerebral Palsy Association - Cerebral Palsy, and others. This clearly is in direct conflict with the expectations of the World Health Organisation as it is often regarded as being short-sighted and a waste in manpower utilisation.

On the other hand, if the curriculum is designed in such a way that the area or field of specialisation receives attention but includes a comprehensive care approach, one could then be considered as moving appropriately towards meeting the needs of all by the year 2000. It is therefore clear that the curriculum designed should focus on comprehensive - generic care with an added focus on the specialisation if indicated.

An added dilemma in curriculum design is the inclusion or exclusion of the adult learner in planning the content of the course. Austin, M J (1978) outlines that in traditional approaches to training, curriculii have often been developed with little consideration and regard for the needs of the trainee and without emphasis for job ladder scope and development.
One therefore finds that the traditional approaches to the training of community-based rehabilitation workers have been a "top-down" approach with curricula being formulated on a set of basic assumptions by the training institution or organisation.

I believe that it is these assumptions which fail to consider the uniqueness of the adult learner and the subtle transactions between the trainer and trainees in communities which have their own economic, social, cultural and political structures.

The effectiveness of course content and curriculum design in community-based rehabilitation is dependent on the inclusion of the community-based rehabilitation worker. Thus, the "bottom-up" approach is considered to be more effective as it would focus on a liberating approach to the training with the emphasis on the inclusion of community-based rehabilitation workers in the planning of the training content.

Werner, D and Bower, B, (1987:3-2) emphasise the inclusion of the community-based rehabilitation worker in the planning of the training content and cite several reasons for this:

1. Through guided practise the students learn firsthand about analysing, planning and organising relevant activities.

2. Students become more deeply involved in the teaching-learning process.

3. They become and feel more equal to their instructors. This will help them when they begin to plan and teach in their communities. They will be more able to relate to their own people as equals and to share responsibilities with others.

4. Students can help adapt the content of the training programme to the problems, needs and resources within their particular communities. This helps in making each training session a new, special, exciting and more relevant experience - for the instructor as well as the students.
5. The flexibility and shared responsibility of this approach is basic to achieving community health and fairer distribution of control."

Thus in an attempt to develop an innovative curriculum, certain objectives would need to be considered. The International Association of Schools of Social Work asserts that the objectives should be considered irrespective of the field. Austin, M J, (1978:101) outlines Buttons' objectives for training which have been used as a point of reference for designing an integrated framework for the training of community-based rehabilitation workers or paraprofessionals. He states: -

"First, not because it is most important but rather because it is most obvious and concrete, there is a body of knowledge and theoretical concepts upon which practise is based ....... Second, there will be a series of skills underlying successful practise....... Third, beneath the surface of personal skills lie the attitude and outlook of the people seeking to exercise those skills......."

Thus, in the overall objectives for training there needs to be a body of knowledge and theory upon which practise and skills are exercised.

For an innovative curriculum to be effective, the course content needs to have certain ingredients. This implies that the process of curriculum development needs to follow certain steps.

Several theorists on the subject of curriculum design and development for training community-based rehabilitation workers regard the following as important processes and models to follow.

Werner, D and Bower, B, (1987) provide an outline of important consideration for overall course planning. (Refer to Appendix 11 - Important Consideration for Course Planning- Werner, D and Bower, B, (1987)). They outline three major sections which include: -
Section A: Planning to be done before the training course begins.

Section B: Continued planning after the training course begins.

Section C: Planning and programming after the course is completed.

At the proceedings of the International Association of Schools of Social Work, Asian Regional Seminar, July 1980 - an outline was provided for the process which should be followed for curriculum development. This included the following steps:

Step I: Identification and assessment of training needs
Step II: Formulation of objectives
Step III: Determining training content
Step IV: Choosing the appropriate methodology and training resources
Step V: Evaluation


Rigby, B D (1978) proposes a systematic approach to training programmes and utilises a task-orientated integrated approach to training. He follows the guidelines proposed by the Generalised Training Model which was used by the Mobile Training Scheme being conducted under the auspices of the Economic and Social Commission for Asia and the Pacific.
Rigby, B D, (1978:37) presents this model as follows:—

GENERALISED TRAINING MODEL

ASSESS PROBLEM OR NEED

If training is not indicated, take other action.

ANALYSE TASKS NECESSARY TO MEET PROBLEM OR NEED

Decide evaluation—SET TRAINING OBJECTIVES TO PREPARE measures for each objective.

DESIGN TRAINING TO MEET OBJECTIVES—Consider: Methods, materials, field practice & available resources.

Consider: CONDUCT TRAINING—Select Trainees.

Evaluation measures to determine effectiveness of training during programme.

EVALUATION OF JOB PERFORMANCE

After training.

It is clear from the various models presented that the pre-training phase is regarded as the most important in designing the course content. All the theorists agree with assessing the exact nature of the training needs and the objective before designing the course content.

Both Rigby, B D (1978) and Werner D’s (1987) process of course development moves beyond the initial planning to the actual implementation of the course. Both stress constant evaluation and analysis of the appropriateness or effectiveness of the training programme.
It is Werner, D and Bower, B (1987) who appear to be the most methodical in their framework or model and propose approximately eighteen steps which should be followed. They emphasise continued planning after the training course with constant feedback between trainer and trainee. The involvement and participation of the community-based rehabilitation worker in the actual planning and feedback process is given great priority and attention.

On the other hand, the model for curriculum development proposed by the International Association of Schools of Social Work (1980) provides insufficient guidelines to ongoing curriculum development during the training and the post-training period. Rigby, B.D (1978) speaks about an evaluation of the job performance after the training period as a measure to determine whether the course content and curriculum was effective. Clearly, this should not be the only means of evaluating whether training has been appropriate. The inclusion of the community-based rehabilitation worker could assist in this area. Evaluations or post-training assessments should not be left solely as the responsibility of the educator. Paulo Freire (1972) regards the trainer and trainees as equals - both should be active in assessing and devising a model which is appropriate for their situation.

3.4 TRAINING METHODOLOGY AND TECHNIQUES

Most community-based rehabilitation workers have their roots in rural and peri-urban communities which would therefore have implications for the training methodology and techniques used.

Rigby, B.D (1978) notes that most community-based rehabilitation workers or paraprofessionals may have little academic preparation or background. Although some may have a high school level of education, the majority may barely have primary school. He notes that some of the best community-based rehabilitation workers may even be illiterate. Rigby B.D, (1978:18) states that, "their training must be experiential, participatory and pragmatic."
The teaching methodology and technique chosen will again be dependent on the approach chosen for training, i.e., a "top-down" approach (conventional or progressive) or a "bottom-up" approach (liberating approach).

Werner, D (1987) sees teaching methodology as once again fitting into the three approaches and describes them as follows:

3.4.1 CONVENTIONAL APPROACH

Within this approach traditional methods of teaching are used. The trainer assumes a dominant position while the adult learner receives knowledge in a passive manner through the methodology or techniques used.

3.4.2 PROGRESSIVE APPROACH

The trainer using this approach educates through dialogue and group discussions but still remains dominant in deciding the correct answer to a situation. The adult learner is slightly less passive but memorisation still remains basic.

3.4.3 LIBERATING APPROACH

Within this approach the teacher and adult learners are regarded as equals. There is usually open-ended dialogue with emphasis on people's experiences. Both trainer and trainees alike have a dual role of educating and learning. The emphasis is on "Active" while the norm for learning is through doing and discussing.

In the conventional or traditional methods of training the teacher is given the elevated status of being the symbol of knowledge. Paulo Freire (1972) highlights that the prestigious status should change to facilitate a mutual informal learning experience between trainer and trainee. Thus, non-formal educators do not subscribe to formal didactic methods of training. Rigby, B D, (1978:22) outlines that, "they believe that learning takes place more effectively when the trainer is actively involved in critical reflection rather than when he is treated as a vessel in which to pour information, or as an object to be manipulated."
Consideration of these factors is essential as it would ultimately determine the type of method chosen in the training of community-based rehabilitation workers. If one is to consider the philosophy of Paulo Freire, it becomes apparent that the appropriate methodology and technique chosen would also take into account the suggestions and recommendations of the community-based rehabilitation worker. Furthermore, the particular approach to training would form the foundation for the methods to be used. The types of teaching methods used obviously have advantages and disadvantages depending on the teaching or training environment.

Teaching methods include lectures, lecturettes, discussions, buzz sessions, case discussions, role-plays, observation, songs, stories, proverbs, drama, brainstorming, games, project groups, field visits or observators, field-work, field-practise, feedback, etc.

Rigby, B D (1978) asserts that the teaching materials or aids used in non-formal education should be aimed at:-

1. Providing scope for self-expression
2. Illuminating self-concept
3. Taking cognisance of valid differences in perception
4. Creating an awareness of perception of others
5. Understanding how others perceive one
6. Understanding the forces that rule people's lives
7. Learning to participate in problem-solving
8. Facilitating consciousness by the community-based rehabilitation worker of how they use themselves
9. Developing skills and understanding on a multi-track/multi level model.

The most important purpose of the training materials used could be easily described in an old Chinese proverb:

"If I hear it, I forget it
If I see it, I remember it
If I do it, I know it"
Thus, the art of creative visual presentation in the materials and practical experience or involvement has a profound effect on the learning process of the adult learner.

Werner, D and Bower, B (1987:11-2) asserts that,

"Appropriate teaching aids encourage :-

OBSERVATION

THOUGHT

THAT LEADS TO DISCOVERY & ACTION"

Werner also provides guidelines for the selection of appropriate teaching aids which correspond with the principles of community-based rehabilitation especially in underprivileged communities.

The guides for appropriate teaching aids are :-

1. Make your own teaching materials using lower cost local materials
2. When making teaching aids, use and build on skills students already have
3. Involve students or the local community in making them for themselves
4. Use real objects instead of just drawing things
5. Draw the human anatomy and signs of health problems on people, not on paper
6. Teach new ideas or skills by comparing them with familiar objects or activities
7. Make teaching aids as natural and lifelike as you can, especially when detail is important
8. Use teaching aids that call for doing as well as seeing - aids that students must handle and put together
9. Make them as fascinating or fun as possible
10. Use teaching aids that do not simply show or explain something, but that help the students to think things through and discover solutions for themselves
11. Use your imagination, and encourage students to use theirs
There are a multiple of teaching aids or materials which could be used but appropriateness should be carefully considered before actual implementation. Some teaching aids which could be used are:

- Flannel boards, string boards, magnet boards, flash cards, flash card games, flip-charts, puzzles, pictures, story-telling, poetry, filmstrips, slides, role-plays, health posters, drawing of anatomy on body, etc.

Each type of material used has its specific advantages and limitations and should be carefully considered before being used. (See Appendix 12 - International Association for Schools of Social Work - Advantages and Limitations of Teaching Materials).

3.5 NATURE OF SUPERVISION OF COMMUNITY-BASED REHABILITATION WORKERS

3.5.1 NEED FOR SUPERVISION

There appears to be general consensus (Kadushin, A, 1976; Werner, D and Bower, B, 1987) that the community-based rehabilitation workers, irrespective of the nature of tasks they are expected to perform, require ongoing supervision. The main reason for this relates to the fact that the majority of community-based rehabilitation workers have had limited specialised training and often requires practical assistance, support and ongoing education, to assist with the actual implementation of tasks.

The Co-ordinating Committee on Community Rehabilitation Education (1988) stipulates in a memorandum submitted to the South African Medical and Dental Council that the community-based rehabilitation worker would be supervised on a regular basis by an occupational therapist, physiotherapist, speech or hearing therapist or receive consultation from other rehabilitation professionals involved with the primary or tertiary care.
The proposed training course for social auxiliary workers as outlined by the South African Council For Social Workers (1989) highlights that the social auxiliary worker will function under the guidance and control of the social worker at all times.

It is generally agreed that the community-based rehabilitation worker will not work in isolation but will have the active support of the supervisor and team. The need for supervision usually ranges from formal to informal supervisory sessions. In my experience, there appears to be a great need for informal contact and supervision, as needs and concerns emerge regularly and usually cannot wait until the contracted day or time.

3.5.2. ROLE DILEMMA OF THE TRAINER AND SUPERVISOR

The dilemma or question which ultimately emerges is whether the trainer or supervisor should supervise the practical daily activities of the community-based rehabilitation worker. The trainer may be a qualified physiotherapist, occupational therapist, social worker or nurse who is skilled in the knowledge and field experience of the community-based rehabilitation worker. They may not necessarily be qualified as trainers of community-based rehabilitation workers. The supervisor, who may be of the same profession, oversees and guides the activities of the community-based rehabilitation worker through the administrative, educational and supportive process. In certain community-based rehabilitation organisations the training and supervision are performed by one professional while in other situations the training and supervision are performed by two different individuals.

The difficulties which have arisen appear to be that the supervisors usually have the broad co-ordinating skills to facilitate the actual functioning of the project while the trainer has the actual knowledge, theory and practical experience, and is clear about the expectations required for the practical implementations of tasks.
It is rare to find one individual who has both outstanding supervisory skills and knowledge about the training of community-based rehabilitation workers.

Austin, L, (1958:445) in the light of these dilemmas has recommended that,

"the administration and teaching functions be divided and performed by two different staff persons to mitigate the inherent strains and conflicts of the supervisory relationship and to facilitate the independent function and professional growth of the practitioner."

The dilemma is somehow decreased when the training and supervision is done by two individuals where roles are clearly defined.

3.5.3. KNOWLEDGE AND EXPERIENCE OF SUPERVISORS

The appropriateness of supervision which community-based rehabilitation workers receive is dependent on the knowledge and experience which the supervisor has in community-based rehabilitation, comprehensive primary health care, and supervision. The major dilemma which trainers or supervisors experience is that they themselves have not received the necessary training to regard themselves as qualified trainers or supervisors of community-based rehabilitation workers. Some of the recommendations made at the proceedings of the International Association Of Schools Of Social Work, (1980) pertaining to these issues were:

"Schools first prepare the trainers of paraprofessionals before they can effectively engage in professional training.... The preparation of social workers as trainers; ie, those who will train the trainers. For example, a school may wish to undertake the training of trainers, which it can eventually turn into an area of specialisation; starting with its own faculty..." (Pangalangan, E and De Guzman L, 1980:55)

Unfortunately, these recommendations have not been followed by any of the Schools Of Social Work in South Africa.
Thus, the situation still remains where we have unqualified trainers of community-based rehabilitation workers. The training which the trainers provide is usually based on literature and on personal experience in the field. There is no knowledge as to whether the training provided is appropriate or satisfactory.

3.5.4 NATURE AND TYPE OF SUPERVISION

During a group discussion at the recent Rural Disability Action Group (RURACT) Conference on Community-Based Rehabilitation Workers, April 1990, many professionals appeared unclear about the exact nature and process of supervision.

Kadushin, A (1976) is one of the authors who clearly outlines the process and nature of paraprofessionals' supervision which could be adapted for community-based rehabilitation workers, as no literature is presently available regarding the supervision of community-based rehabilitation workers. Kadushin, A (1976) outlines the process or different types of supervision as being:

3.5.4.1 ADMINISTRATIVE SUPERVISION

The nature of supervision of the community-based rehabilitation worker might be very different to the supervisee - supervisor role and relationship of professional social workers.

Social workers are usually familiar with the administrative policies and structures of an organisation whereas this might be completely new and unknown to the community-based rehabilitation worker. Kadushin, A, (1976:387) asserts that, "the usual supervisee is familiar with the 'culture' of the social-service organisation. For the paraprofessional, this is either unfamiliar territory or familiar in a distorted way.."
This therefore implies that the supervisor needs to create administrative structures which are pragmatic and imaginative. Supervisors need to realise that the community-based rehabilitation worker might barely have secondary school education, which therefore requires that administrative procedures are kept simple and uncomplicated. The supervisor in this context needs to creatively facilitate and guide this process by repeatedly explaining the purpose of adhering to procedures and policies.

Cudabeck, D, (1970:217) notes that,

"new careerists are likely to have had limited work experience, particularly experience in large bureaucratic agencies. They will need extra help in learning to maintain work schedules, keep records, use written resource material, explore agency channels of communication and participate productively in staff meetings. Simple office procedures - answering phones, leaving messages, filing material - may need to be specifically taught."

Kadushin, A (1976) notes that often short daily supervisory sessions rather than weekly supervision are often more desirable due to the needs of the community-based rehabilitation workers.

"Having more limited educational background in preparation for doing the job, having had less opportunity in a structured work situation to develop habits of punctuality, routine job organisation and efficient work procedure, experiencing difficulties with or resistance to written report forms which often serve as administrative control devices, the supervisor may initially need more frequent reviews of her work." (Kadushin, A, 1976:390).

Supervisors need to be cautious about exaggerating the differences between supervisor and supervisees. The relationship could be an interchangeable one where both supervisor and supervisee are able to learn from each other. A dominating-authoritarian supervisor could easily appear oppressive rather than liberating.
Here again, a "bottom-up" approach could have the advantage of giving power and independence to the supervisee. The contribution which the supervisee through involvement and participation makes in helping to set appropriate administrative structures for supervision should not be ignored.

3.5.4.2 EDUCATIONAL SUPERVISION

The educational approach to supervision requires individualised attention to the community-based rehabilitation worker. Much controversy exists in this area especially if the training and supervision is done by two professionals. It is usually difficult to supervise an area which someone else has taught unless the supervisor has been present in the actual teaching.

Nevertheless, there is definite consensus regarding the ongoing education of the community-based rehabilitation worker. The primary reasons for this is that, "educational supervision is the 'guidance mechanism' that makes explicit the workers knowledge and understanding, gives it purpose and direction and makes it consciously available for the use in job performance." (Kadushin, A; 1976:392).

In considering the educational and cultural background of the community-based rehabilitation worker — non-formal methods of educational supervision needs to be incorporated. The supervisor need to accept some basic new careerist concepts that,

"people learn in a variety of ways and that formal schooling may not be the best procedure for everyone; the lack of formal credentials is not indicative of what the supervisee is capable of doing; that the paraprofessional does bring some special knowledge; some unique qualities and a special kind of competence which results from life-experience learning; that previous lack of experience with formal training does not impair capacity to learn; ..." (Kadushin, A, 1976:393-394).
The need to adapt teaching approaches suitable to the needs of the community-based rehabilitation worker is imperative. Kadushin, A (1976) mentions that age, life experience of a struggling reality, educational background, etc., have implications for the method of education chosen. "Untrained does not necessarily imply unskilled or unknowledgeable." (Kadushin, A, 1976:397).

The same principles previously discussed under training methodology and techniques should be considered here. Kadushin, A (1976) agrees with authors such as Rigby, B D (1978) and Werner, D and Bower, B, (1987) and asserts that supervisors need to place less emphasis on teaching as a means of learning and should rather depend on didactic, repetitive, ongoing personal discussion with the community-based rehabilitation worker.

Self-actualising, pragmatic, experiential approaches are required. Arthur, P and Riessman, F, (1965:157) outline that training should be, "job related rather than general. An adequate training programme can be generated only if it is attuned to a precise job description. Training must provide the non-professional with a portfolio of specific skills." The danger of this approach is that the skills provided are narrowed to a specific task, and cause difficulties when job movement or change occurs. The community-based rehabilitation worker needs to be given broad primary health care skills which focus on promotion, prevention, diagnosis, treatment and rehabilitation. These therefore become the areas which the supervisor needs to focus on and could contract to work on specific areas during educational supervision.

3.5.4.3 SUPPORTIVE SUPERVISION

Life experience and community awareness are often insufficient background to assist the community-based rehabilitation worker with the tasks assigned. The function of the community-based rehabilitation worker within large organisations or being out in the community often leads to isolation and sometimes discouragement.
The lack of educational credentials might lead to insecurity and uncertainty. They may experience performance anxiety and question, or frustrate their own ability to meet organisational standards and expectations. The community-based rehabilitation worker might experience conflict in terms of the demands of the organisation which may be at the expense of the community or projects' demands and expectations.

The conflicts, difficulties, uncertainties, etc., experienced by the community-based rehabilitation worker might be extensive and often require intensive support from the supervisor. In my experience, community-based rehabilitation workers need to be encouraged and rewarded for good performance every step of the way. The relationship between supervisor and supervisee needs to be of such a nature that there is an openness and a relaxed atmosphere which encourages and gives the community-based rehabilitation worker the opportunity to express concerns, uncertainties, disillusionment and insecurity.

Kadushin, A, (1976:406) adds that, "Given the nature of the socio-economic background and current living arrangements that characterise a large percentage of the paraprofessional group, the supervisor can anticipate many situational problems that require support." Many community-based rehabilitation workers live in underprivileged - impoverished areas, and are often plagued by ill health, or socio-economic difficulties. This often means that support extends beyond the job situation. Kadushin (1976) suggests that in these instances organisations need to have "situational support" structures to support the community-based rehabilitation worker, i.e., childcare facilities, low-interest loans, medical schemes and special leave.
3.5.5 METHOD OF SUPERVISION

In social work supervision, reviewing of case notes appear to be the main technique or method for supervision. This method is clearly an inappropriate one to use when supervising community-based rehabilitation workers who barely have secondary school education. Many may be illiterate and may not have the written skills to convey specific kinds of information.

This therefore indicates that innovative, creative, pragmatic and experiential methods of supervision should be used to facilitate the supervisory process. Innovative methods such as, role plays, group discussions, sitting-in, co-working in projects and case studies, etc. are methods which add enjoyment and less stress to the supervisory process.

Hart, G, (1982:11) note that techniques such as, role plays, "is the least complex and most effective supervisory technique." He adds that specific skills could be acquired quickly through the actual participation by observing and practice. This method is also effective in allowing the supervisee and supervisor to reverse roles, and helps the supervisor to understand the supervisees concerns and difficulties and vice versa.

Sitting-in and observing could be perceived as anxiety provoking but if used correctly could serve as a supportive mechanism as well as assist with accountability. The sitting-in and observing could extend to the actual involvement and participation and in so doing the supervisee would feel less exposed. For example, when doing the physiotherapy stimulation exercises the supervisor could become as involved as the supervisee and could become the model for learning.

Observation of the supervisee from behind a one-way mirror is rarely, if ever, used. This is normally a sophisticated method and equipment which is seldom found in community-based rehabilitation settings.
Unless based at the project, one-way mirrors remove the client and supervisee from the natural environment and promote an artificial environment which is contrary to community-based rehabilitation principles. Audio-tape and videotape recordings are useful methods in institutional-based projects and are expensive tools for supervision. The community-based rehabilitation facilities utilise affordable methodology and it is therefore highly unlikely that these would be used.

Co-working in projects where there is enormous peer involvement is one of the more appropriate methods. If the correct environment is developed the workers could learn from their peers who might have valuable ideas and contributions to make.

The supervisors of community-based rehabilitation workers need to realise that there are several methods which could be used. There needs to be careful and appropriate selection of these to facilitate the learning process and acquisition or refinement of skills. Only some of these methods have been discussed here but the method and teaching aids used in the training process could also be used and incorporated in the method/s of supervision.

3.6 CONCLUSION

The approach which is ultimately chosen in the training and supervision of the community-based rehabilitation worker will inevitably become the guiding principles or value system on which training methodology, techniques, content and supervision are based.

The training of community-based rehabilitation workers clearly calls for a "bottom-up" approach in which participation and involvement by the community for the community is regarded as appropriate and in keeping with the principle of community-based rehabilitation. This then becomes the foundation on which content and curriculum design, choice of training methodology, techniques and supervision are based.
CHAPTER 4

RESEARCH METHODOLOGY

4.1 INTRODUCTION

The method used to conduct this study will be presented in this chapter.

A brief overview and rationale of the research method will be presented followed by a discussion of the sampling method chosen. Data collection procedure and the actual design of the interview schedule and self-administered questionnaire will be highlighted. Finally, the difficulties, limitations, and the strength of the study, will be discussed.

4.2 OVERVIEW AND RATIONALE OF THE RESEARCH METHOD

The research method used in this study is primarily of a qualitative nature as it, "proceeds from a particular social reality to a general social theory." (Grinell, R, 1988:196). The researcher employed an exploratory - descriptive design. This approach was used as the researcher hoped to gain further insight into an area which is relatively and generally uninvestigated, especially within the arena of training of community-based rehabilitation workers working with the mentally handicapped in the Western Cape.

Grinell, R, (1985:196) asserts that,

"qualitative methods are more suited to the study of relatively undrafted social terrain and may be used to generate hypotheses which can be tested later by quantitative methods. Qualitatively orientated research studies attempt to explain reality from the subjective viewpoints of participants in the systems studies and are expressed in the participants natural language."
The area of research chosen is relatively "uncharted" and uninvestigated. Little, if any, local information is available concerning the training of community-based rehabilitation workers with reference to those working amongst the mentally handicapped. The exploratory-descriptive design was used as the study explored and inquired upon a particular topic with the view to describing the phenomenon as it arises in the training of community-based rehabilitation workers.

By using this particular design, the researcher hopes to build a foundation of ideas and tentative theories which could be later tested through other more complex methods.

4.3 POPULATION AND SAMPLING METHOD CHOSEN FOR THE RESEARCH

No particular sampling method was chosen as the total population of community-based rehabilitation workers and trainers were used.

The first population chosen for the research were community-based rehabilitation workers employed at South African Christian Leadership Assembly Health Project and Cape Mental Health Society. Both organisations are engaged in direct service delivery to the mentally handicapped in socially deprived communities in the Western Cape, i.e. Khayelitsha, Crossroads, K.T.C. squatter area, Nyanga, Guguletu, etc. These are the only two health and welfare organisations in these locations who employ community-based rehabilitation workers for this purpose.

The total population of community-based rehabilitation workers chosen were :-

i Cape Mental Health Society - Two community-based rehabilitation workers; and

ii South African Christian Leadership Assembly Health Project - Seven community-based rehabilitation workers

Due to political unrest in the area only six community-based rehabilitation workers were interviewed from South African Christian Leadership Assembly Health Project.
The criteria for selection were that:

i. the community-based rehabilitation worker was employed in this capacity

ii. primary responsibility of the community-based rehabilitation worker is active involvement and assistance to the mentally handicapped

iii. located in the Western Cape

The second population chosen were the trainers linked to the various organisations and specific projects in which the selected community-based rehabilitation workers are employed. The total population of trainers were:

i. Cape Mental Health Society - 1 trainer; and

ii. South African Christian Leadership Assembly Health Project - 1 trainer

In May 1990, permission was requested from these two organisations to allow the researcher to conduct the interviews. (See Appendix 13 - Permission to conduct research at South African Christian Leadership Assembly Health Project and Appendix 14 - Permission to conduct research at Cape Mental Health Society). Permission was verbally granted.

4.4 DATA COLLECTION PROCEDURES AND DESIGN OF INTERVIEW SCHEDULE AND SELF-ADMINISTERED QUESTIONNAIRE

Considerable time was spent contacting individuals who are involved in community development, community work, and indigenous theory and practice projects and community-based rehabilitation in order to obtain relevant data in this field. Personal interviews were conducted with Ina Conradie, lecturer in Community Development, University of Cape Town, and Hans Norman, researcher, Indigenous Theory and Practice Organisation, to obtain relevant and available literature in this field.

A conference on Community-Based Rehabilitation was also attended between 26 - 28 April 1990 in Johannesburg, as a further source of collecting the most recent and updated data in this field.
A request for literature was made to the Zimbabwean Red Cross Society, Harare and the Christian Medical Commission World Council of Churches, Switzerland. (See Appendix 15 - Request for Literature - Zimbabwe Red Cross Society and Appendix 16 - Request for Literature - Christian Medical Commission World Council of Churches.) These organisations were respectively contacted due to their prominence in the development of training of community-based rehabilitation workers and the circulation of literature in this field.

Data was also obtained in the general literature review and were used in the preceding chapters.

The primary source of data collection were in two phases, i.e. :-

PHASE 1

An interview schedule was designed and included both structured and unstructured questions which was presented to the first population, i.e. community-based rehabilitation workers (See Appendix 17 - Interview Schedule).

Factors which influenced the development of the interview schedule were :-

i interviews held with relevant people and literature obtained and gathered through secondary sources
ii educational and language backgrounds of the community-based rehabilitation workers
iii the time factor with regards to finding the appropriate Xhosa translation for questions

The interview schedule was administered and conducted by the researcher who was assisted by an interpreter, Nomazizi Stuurman, who is based at the South African Christian Leadership Assembly Health Project in Khayelitsha. All the community-based rehabilitation workers employed at South African Christian Leadership Assembly Health Project spoke only Xhosa. The assistance of the translator was aimed at including all the community-based rehabilitation workers and to bridge the language and educational gap.
Interviews were conducted at the South African Christian Leadership Assembly Health Project, Site B, which is situated at the heart of the squatter area in Khayelitsha. The community-based rehabilitation workers employed at Cape Mental Health Society were interviewed at the central office in Observatory.

The community-based rehabilitation workers were interviewed from approximately 10 May 1990 - 12 June 1990. This in practical terms meant that interviews were arranged on an appointment basis and held in community active conditions which were often unconventional from traditional social work settings.

All the community-based rehabilitation workers interviewed were assured of anonymity and confidentiality in order to decrease the response bias or halo-effect.

The nature of the investigation was explained to all, who consented willingly to be interviewed. Some reported initial anxiety but were relieved at the nature of the questions.

The interview schedule included the following questions or data :-

i. Identifying data of the community-based rehabilitation worker, i.e. name, age, marital status, address, home language, organisation employed at, etc.

ii. Educational level, i.e. primary, secondary, tertiary or other.

iii. Description of specific project and area of operation.

iv. Experience in the field of mental handicap.

v. Knowledge in the field of mental handicap, i.e. prior to the involvement in the project.

vi. Training period for the specific project employed in.
vii Place and environment in which training took place, i.e. village, office, lecture room, home of the mentally handicapped, confines of the project, etc.

viii Inclusion in the planning of the training programme, i.e. direct involvement in the training and the opportunity to evaluate and give feedback.

ix Community-based rehabilitation workers knowledge of the objectives for his/her training.

x Course content and areas focused on.

xi Training methods used, i.e. formal lecture, talks, group discussions, field visits, participative activities, workshops, observationals, etc.

xii Training materials and aids, i.e. flannel boards, videos, films, cards, posters, drawings, etc.

xiii Nature and type of supervision while training, i.e. frequency of supervision, method of supervision and type of supervision obtained.

xiv Suggestions and recommendations to improve the training in order to assist the community-based rehabilitation worker in his/her tasks.

Most of the questions provided an opportunity for evaluation and recommendations.

PHASE 2

A detailed self-administered, semi-structured questionnaire was designed and given to the trainers engaged in the training of the community-based rehabilitation workers. (See Appendix 18 - Self-administered semi-structured questionnaire).

The essential factors which influenced the self-administered semi-structured questionnaire were interviews held with relevant individuals and literature obtained and gathered through secondary sources.
Each trainer completed one questionnaire for the group of community-based rehabilitation workers which they were assigned to train. The trainers had no access to the individual interview schedule in order to reduce the response bias and increase validity.

Both self-administered questionnaires were completed within a period of two weeks during May 1990.

The self-administered questionnaire incorporated questions in the following areas :-

i Identifying data of the trainer, i.e. name, age, marital status, home language, address, organisation employed at, etc.

ii Educational level and qualifications of the trainer.

iii A Community involvement and experience in the field of mental handicap.
   B Previous experience as a trainer of community-based rehabilitation workers in the field of mental handicap.

iv A Description of the project/s with which the trainer was associated.
   B Area of operation.
   C Function/s of the community-based rehabilitation worker in the project/s.

v Training period/s used for the community-based rehabilitation workers.

vi Place and environment in which training took place, i.e. village, confines of the project, home of the mentally handicapped, etc.

vii The extent to which the trainer included the community-based rehabilitation worker in the planning of the training programme or project.

viii Outline of the objectives of the training programme, i.e. long-term or short-term objective.
Theoretical models considered in the training including the advantages or disadvantages of the models used.

Course content and areas focused on.

Training methods used, i.e. formal lectures, participative activities, group discussions, etc.

Training materials and aids used, i.e. audio-visual, charts, drawings, flip charts, etc.

Nature and type of supervision, i.e. frequency of supervision, methods of supervision and the type of supervision.

Suggestions and recommendations to improve the training of community-based rehabilitation workers in the function/s.

Most of the questions asked were in retrospect to the training provided. An opportunity was provided for the trainer to evaluate and make alternative suggestions.

4.5 DIFFICULTIES ENCOUNTERED IN THE STUDY :-

The major difficulty encountered relates to the limited number of trainers and community-based rehabilitation workers employed within the field of mental handicap in the Western Cape.

An added problem is the lack of available literature in this field. There was a poor response to the letters sent abroad in which information was requested.

Practical difficulties were encountered in terms of distance travelled between the two organisations in order to complete the interview schedules. Delays were experienced in completing the interview schedules in the time allotted due to environmental and organisational constraints.
During late June 1990, and early July 1990, the increased threat of community unrest became a reality when shacks were burnt in Site B, Khayelitsha due to the alleged conflict between the Pan African Congress and the African National Congress. The situation brought a sudden end to interviews and meant that only six community-based rehabilitation workers instead of seven could be interviewed at the South African Christian Leadership Assembly Health Project.

Technical difficulties pertained mainly to the analysis of data obtained from the trainers. Due to the small sample, a descriptive analysis rather than a statistically orientated analysis was done.

4.6 LIMITATIONS OF THE STUDY:

4.6.1 The data collected in this study was retrospective to the various training programmes already undertaken by the community-based rehabilitation workers. Thus, the interviewees' responses were based and relied on memory.

4.6.2 The study only focuses on the training of community-based rehabilitation workers employed in specific communities and who specialise in the care of the profoundly and severely mentally handicapped. It is limited in so far as it does not include the broad spectrum of community-based rehabilitation workers employed in the comprehensive primary health care model.

4.6.3 Inferences made would be guarded as the study only pertains to a particular population employed at specific organisations. The generaliseability of the results would pertain only to this population and with reference to this field.

4.6.4 Even though interviewees were re-assured of confidentiality and anonymity, one cannot ignore the possibility of a halo effect in certain situations. Thus, the validity and reliability of the findings might be guarded.
The researcher attempted to keep the interviewer bias fairly constant by the fact that all the interviews with the community-based rehabilitation workers were conducted by herself.

The researcher's inability to control unknown extraneous factors within the environment of the community-based rehabilitation worker and trainers needs to be taken into account. Other extraneous factors which might have influenced the data collection were that the majority of community-based rehabilitation workers only spoke Xhosa. Interviews were therefore conducted with the assistance of an interpreter.

The final recommendations and suggestions concerning future training methodology, content, techniques, supervision, etc. are based on the subjective impression of the community-based rehabilitation workers and trainers.

Indigenous literature which focuses specifically on the training of community-based rehabilitation workers was difficult to obtain and was not always available within the formal academic institutions.

STRENGTHS OF THE STUDY:

This is the first time that an investigation into the training of community-based rehabilitation workers working specifically with the mentally handicapped in the Western Cape has been undertaken. Thus, the findings and recommendations might assist trainers and trainees to improve the present training programmes.

The study might lead to greater participation and involvement by community-based rehabilitation workers.

Certain modifications might be brought to curricula designs, training methodology, techniques and the nature of supervision.

Greater clarity and more specific educational and training objectives might become clear to both trainer and trainee.
The study might also lead to an improved training programme which could result in a more effective and appropriate service delivered by community-based rehabilitation workers.

The study in itself might highlight areas for future research in this field.

CONCLUSION

The exploratory-descriptive design used in this study aims at giving further insight to an area which is relatively uninvestigated.

No particular sampling method was chosen as the total population consisted of community-based rehabilitation workers and trainers respectively employed by South African Christian Leadership Assembly Health Project and Cape Mental Health.

The primary source of data collection was in two phases, i.e. the interview schedule and the self-administered questionnaire. The researcher was assisted by an interpreter while conducting the interview schedule as the majority of community-based rehabilitation workers were Xhosa speaking.

The limitations and difficulties of the study have been outlined to ensure that the results which are to be presented are evaluated and assessed within the methodological limitations of this investigation.
CHAPTER 5

PRESENTATION OF THE RESULTS

5.1 INTRODUCTION

The presentation of the results will be discussed according to the two phases, i.e. Phase 1 - Interview Schedule administered to the community-based rehabilitation workers and Phase 2 - Self-Administered Questionnaire completed by the trainers. In phase 2, T.1 and T.2 mentioned in the tables respectively refers to Trainer I (South African Christian Leadership Assembly Health Project) and Trainer 2 (Cape Mental Health Society).

Most of the data presented in these two phases would be presented in a descriptive manner due to the nature of this study and the explorative-descriptive methodology used.

Information or data obtained from the total population of community-based rehabilitation workers and trainers employed at South African Christian Leadership Assembly Health Project and Cape Mental Health Society will not be presented separately, i.e. according to the organisations, as this is not a comparative study. Certain significant findings will be presented separately when necessary.
5.2 RESULTS OBTAINED FROM THE INTERVIEW SCHEDULE

The following represents the results obtained from the interview schedule administered to the trainees.

5.2.1 IDENTIFYING DATA

TABLE 1 - IDENTIFYING DATA OF THE TRAINEES

<table>
<thead>
<tr>
<th>Age in Yrs</th>
<th>Single</th>
<th>Married</th>
<th>Divorced</th>
<th>Widowed</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-25</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>2</td>
<td>12.5%</td>
</tr>
<tr>
<td>26-30</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
<td>4</td>
<td>50%</td>
</tr>
<tr>
<td>31-35</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>2</td>
<td>12.5%</td>
</tr>
<tr>
<td>36-40</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41-45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46-50</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

The total population of trainees (6) were female, of which six were employed by South African Christian Leadership Assembly Health Project while the other two were employed at Cape Mental Health Society. The majority (62.5%) are married and 50% were within the age group 31 - 35 years.

87.5% of community-based rehabilitation workers employed lived in the area where the project is situated.
Six community-based rehabilitation workers were trained by the trainer at South African Christian Leadership Assembly Health Project while the other two were trained by the voluntary trainer at Cape Mental Health Society.

5.2.2 EDUCATIONAL LEVEL

TABLE 2 - EDUCATIONAL LEVEL OF THE COMMUNITY-BASED REHABILITATION WORKERS

<table>
<thead>
<tr>
<th>Standard of Education</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Education</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Primary School education</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sub A</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sub B</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Std.1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Std.2</td>
<td>1</td>
<td>12.5</td>
</tr>
<tr>
<td>Std.3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Std.4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Std.5</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>Secondary School education</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Std.6</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>Std.7</td>
<td>1</td>
<td>12.5</td>
</tr>
<tr>
<td>Std.8</td>
<td>1</td>
<td>12.5</td>
</tr>
<tr>
<td>Std.9</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Std.10</td>
<td>1</td>
<td>12.5</td>
</tr>
<tr>
<td>Tertiary education</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>100</td>
</tr>
</tbody>
</table>
The educational levels of the community-based rehabilitation workers fell within a broad range with no significant score. The lowest level of education was Standard 2 while the highest was matric. Of the total population of community-based rehabilitation workers, 37.5% had some level of primary school education while 62.5% had obtained some level of high school education.

None of the community-based rehabilitation workers had any tertiary education. One community-based rehabilitation worker is presently reading for her B.A. degree.

5.2.3 DESCRIPTION OF THE SPECIFIC PROJECTS ENGAGED IN

TABLE 3 - A DESCRIPTIVE ANALYSIS - DESCRIPTION OF THE PROJECTS CURRENTLY ENGAGED IN

<table>
<thead>
<tr>
<th>Name of Project</th>
<th>Area of Operation</th>
<th>Description of the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethembeni Special Care Project</td>
<td>Nyanga East</td>
<td>A day centre for profoundly-severely mentally handicapped children Daily activities are: - physiotherapy exercises for stimulation - feeding - potty-training - stimulating play and activities</td>
</tr>
<tr>
<td>(Cape Mental Health Society)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 community-based rehabilitation worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Project</td>
<td>Area of Operation</td>
<td>Description of the Project</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Imizamo Yethu Special Care Centre (Cape Mental Health Society)</td>
<td>Khayelitsha</td>
<td>A day centre for profoundly- severely mentally handicapped children Daily activities are : Monday : outreach/ home visits to contact prospective members Tuesday : in-service training at Bel Porto Special School &amp; Friends Day Centre Wednesday : home visits &amp; outreach Thursday : physio-therapy exercises for stimulation - feeding - potty-training - stimulating play &amp; activities</td>
</tr>
<tr>
<td>Vukani SACLA Health Project</td>
<td>Squatter areas of Khayelitsha i.e. Site B&amp;C Town 2, Greenpoint</td>
<td>A day centre for profoundly severely mentally handicapped children &amp; other disabilities Daily activities are : - physiotherapy exercises for stimulation - feeding - potty-training - stimulating play &amp; activities - dressing - sitting - home visits</td>
</tr>
</tbody>
</table>
It appears that the description of activities and tasks given by the total population of community-based rehabilitation workers has significant similarities.

5.2.4 EXPERIENCE IN THE FIELD OF MENTAL HANDICAP

Seventy five percent (75%) of the total population of community-based rehabilitation workers had no experience in the field of mental handicap before their employment in the present project.

The other 25% had experience by virtue of the fact that they were mothers of handicapped children. These community-based rehabilitation workers indicated that the previous knowledge gained through personal experience assisted them to have a better understanding of the concepts whilst undergoing training for the present project.

It is significant that the total population (100%) of the community-based rehabilitation workers had no formal training as community-based rehabilitation workers before being employed in the present projects.

5.2.5 TRAINING PERIODS FOR THE SPECIFIC PROJECTS

The majority of community-based rehabilitation workers employed by the South African Christian Leadership Assembly Health Project received one month intensive training followed by ongoing on-the-job training. Three of these community-based rehabilitation workers were contented with the one month training period offered and felt this was sufficient, while two community-based rehabilitation workers indicated that the one month was insufficient. They suggested three months intensive training as an alternative. The other (one) community-based rehabilitation worker received a year training and felt this was sufficient.
The two community-based rehabilitation workers employed at Cape Mental Health Society received training once per week since their involvement with their projects and suggested alternative training periods, i.e. blocks of three months followed by ongoing weekly training.

It appears that 50% of the total population of community-based rehabilitation workers suggested longer periods than the ones to which they were exposed to.

5.2.6 PLACE AND ENVIRONMENT IN WHICH TRAINING TOOK PLACE

The community-based rehabilitation workers employed by the South African Christian Leadership Assembly Health Project were trained in the village in the home of a community-based rehabilitation worker and once at a hospital. All agreed that these were good training venues.

The two community-based rehabilitation workers who obtained training at Cape Mental Health Society noted that training received within an office environment was a poor place for training but rated the training within the confines of the project as good.

All (100%) of the community-based rehabilitation workers agreed that it would have been preferable if other places were also chosen for training. Some of the suggestions given for an alternative training environment were:

5.2.6.1 observational visits to hospitals.
5.2.6.2 more training within the confines of the project, as these are the children with whom they are meant to work. It would also help with identification of various handicaps.
5.2.6.3 visits to other community-based rehabilitation centres providing care for the mentally handicapped.
5.2.6.4 training within the home of the mentally handicapped.
5.2.7 INCLUSION IN THE PLANNING AND FEEDBACK OF THE TRAINING PROGRAMME

TABLE 4 - A DESCRIPTIVE ANALYSIS OF THE COMMUNITY-BASED REHABILITATION WORKER’S INCLUSION IN THE PLANNING OF THE TRAINING PROGRAMME

<table>
<thead>
<tr>
<th>Inclusion in the Planning of the Training Programme</th>
<th>YES</th>
<th>NO</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement in the Planning of the Training Programme</td>
<td>-</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Community-based rehabilitation worker’s preference to have been included in the planning of the programme</td>
<td>7</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Opportunities given to the community-based rehabilitation worker to give feedback &amp; evaluate the training</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Were the suggestions given by the community-based rehabilitation workers considered</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>

It appears from the analysis that all (100%) of the community-based rehabilitation workers were not included or involved in the planning of the training programmes. 87.5 percent indicated that they would have preferred to have been included in the planning while only 12.5 percent disagreed. 75 percent mentioned that even though they were not included in the planning, suggestions or comments made by them regarding the training programme were considered.
5.2.8 THE COMMUNITY-BASED REHABILITATION WORKER’S KNOWLEDGE OF THE OBJECTIVES FOR HIS/HER TRAINING

Seventy five percent of the community-based rehabilitation workers indicated that they were aware of the objectives and knew what they were meant to learn from the course while the other 25 percent noted that they were not aware.

Those who expressed an awareness of the objectives of the training, list these as follows:

5.2.8.1 understanding the causes of disabilities
5.2.8.2 caring for disabled children
5.2.8.3 to help, advise and support mothers of disabled children
5.2.8.4 to relieve mothers
5.2.8.5 to assist with stimulation exercises
5.2.8.6 reach out and make contact with mothers of disabled children
5.2.8.7 to understand the environment in which the mentally handicapped child lives
5.2.8.8 how to plan a programme at the project

The 25% of community-based rehabilitation workers who indicated that they were not aware of the objects, highlighted that they would have preferred to know. They noted that if they had known what the objectives were, they would have understood better what they were meant to do.
5.2.9 COURSE CONTENT AND AREAS FOCUSED ON

The areas of learning (course content) which were focused on by the two organisations were listed by the community-based rehabilitation workers as follows:

TABLE 5 - A DESCRIPTIVE REPRESENTATION OF THE COURSE CONTENT

<table>
<thead>
<tr>
<th>SACLA HEALTH PROJECT</th>
<th>CAPE MENTAL HEALTH SOCIETY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. measuring of head circumference</td>
<td>1. community development</td>
</tr>
<tr>
<td>2. sitting of the mentally handicapped child</td>
<td>- different projects in the community</td>
</tr>
<tr>
<td>3. feeding</td>
<td>2. nutrition</td>
</tr>
<tr>
<td>4. blindness &amp; deafness</td>
<td>3. causes of mental handicap</td>
</tr>
<tr>
<td>5. walking a blind person</td>
<td>4. causes of physical disablement</td>
</tr>
<tr>
<td>6. causes of spina bifida</td>
<td>5. fund-raising</td>
</tr>
<tr>
<td>7. causes of polio</td>
<td>6. planning</td>
</tr>
<tr>
<td>8. causes of stroke</td>
<td>7. bookkeeping</td>
</tr>
<tr>
<td>9. mental handicap</td>
<td>8. filing</td>
</tr>
<tr>
<td>10. assisting a wheelchair person</td>
<td>9. development of a child inside &amp; outside the home</td>
</tr>
<tr>
<td>11. studying the skeleton</td>
<td>10. feeding</td>
</tr>
<tr>
<td>12. weighing of children &amp; reading of weight charts</td>
<td>11. stimulation, i.e. physiotherapy exercises and play</td>
</tr>
<tr>
<td>13. downs syndrome</td>
<td>12. management of a project</td>
</tr>
<tr>
<td>14. spastic children</td>
<td>13. reach out &amp; home visits</td>
</tr>
<tr>
<td>15. stimulating exercise &amp; play</td>
<td></td>
</tr>
<tr>
<td>16. prevention of disablement during pregnancy</td>
<td></td>
</tr>
<tr>
<td>17. hydrocephalus</td>
<td></td>
</tr>
<tr>
<td>18. immunisation</td>
<td></td>
</tr>
<tr>
<td>19. love &amp; general care</td>
<td></td>
</tr>
</tbody>
</table>

All (100%) of the community-based rehabilitation workers highlighted that the course content taught was helpful in assisting them fulfil their tasks. They indicated that what was taught helped them in the following functions, i.e.
- feeding disabled children
- sitting disabled children
- diagnosing & immediately identifying the disability
- how to manage stroke patients
- advice regarding toileting
- treatment & prevention
- planning & fundraising
- basic programme implementation
- outreach and contact with the parents

All the community-based rehabilitation workers were given an opportunity to evaluate the overall content given. The following represents their evaluation:

**TABLE 6 - PERCENTAGE DISTRIBUTION OF THE SAMPLE - AN EVALUATION OF OVERALL COURSE CONTENT**

<table>
<thead>
<tr>
<th>Evaluation of overall Course Content</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>too sophisticated</td>
<td>-</td>
</tr>
<tr>
<td>too simplistic</td>
<td>-</td>
</tr>
<tr>
<td>excellent</td>
<td>5</td>
</tr>
<tr>
<td>good</td>
<td>2</td>
</tr>
<tr>
<td>satisfactory</td>
<td>1</td>
</tr>
<tr>
<td>somewhat weak</td>
<td>-</td>
</tr>
<tr>
<td>totally inappropriate &amp; unsatisfactory</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
</tr>
</tbody>
</table>

It appears from the overall evaluation that 87.5% of the community-based rehabilitation workers evaluated the course content as ranging from excellent to good.
The community-based rehabilitation workers were also asked whether they were given an opportunity to evaluate the course content and to provide comments or suggestions concerning learning needs.

It appears that 87.5% of community-based rehabilitation workers were given an opportunity to evaluate the course content and were able to make a range of suggestions and comments. These were as follows:

- **5.2.9.1** difficulty measuring head circumference & weighing
- **5.2.9.2** difficulty reading immunisation cards
- **5.2.9.3** difficulty walking a blind person
- **5.2.9.4** difficulty explaining to a mother about her disabled child when she does not understand
- **5.2.9.5** needing more information about how people cope with the mentally handicapped amidst few resources
- **5.2.9.6** needing assistance with home-based care
- **5.2.9.7** management of hyperactive and aggressive mentally handicapped children
- **5.2.9.8** sitting positions for mentally handicapped children
- **5.2.9.9** toilet training
- **5.2.9.10** general care and management of the mentally handicapped

### 5.2.10 TRAINING METHODS USED

It appears that the teaching methods commonly used were formal lectures/talks (100%), group discussions (75%), field visits (100%), participative activities (75%) and the use of guest speakers (87.5%).

It also appears that these were evaluated fairly positively by the community-based rehabilitation workers, i.e. excellent to good.

Alternative training methods suggested by the community-based rehabilitation workers were:
5.2.10.1 videos
5.2.10.2 visit to other similar projects
5.2.10.3 formal lectures
5.2.10.4 workshops
5.2.10.5 games
5.2.10.6 role plays
5.2.10.7 poetry
5.2.10.8 and more group discussions

5.2.11 TRAINING MATERIALS AND AIDS

The data obtained indicated that the commonly used materials and aids were posters (75%), books (100%), drawings (75%) and flip-charts (75%).

Other teaching aids, i.e. black boards, videos, cards, slides and props, were the least used. Posters, books and flip-charts were primarily rated as good materials and aids.

Other useful materials and aids including some already mentioned were suggested as essential for ongoing training. These were listed as follows :-

Videos, slides, films, photographs, black boards, drawings, available resource at the centres, flannel boards, cards, flip charts.

5.2.12 NATURE AND TYPE OF SUPERVISION

5.2.12.1 All (100%) of the community-based rehabilitation workers indicated that they were receiving training while they were in practice and all were supervised during training on an ongoing basis.
5.2.12.2 AMOUNT OF SUPERVISION OBTAINED

The following table outlines the amount of supervision obtained and an evaluation thereof.

TABLE 7 - PERCENTAGE DISTRIBUTION OF SAMPLE - AMOUNT OF SUPERVISION OBTAINED AND AN EVALUATION

<table>
<thead>
<tr>
<th>Amount of supervision</th>
<th>Excellent</th>
<th>Good</th>
<th>Satisfactory</th>
<th>Somewhat weak</th>
<th>Unsatisfactory</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N %</td>
<td>N %</td>
<td>N %</td>
<td>N %</td>
<td>N %</td>
<td>N %</td>
</tr>
<tr>
<td>Daily</td>
<td>1 12,5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 12,5</td>
</tr>
<tr>
<td>Once per week</td>
<td>4 50</td>
<td>1 12,5</td>
<td></td>
<td></td>
<td>5 62,5</td>
<td></td>
</tr>
<tr>
<td>Twice per week</td>
<td>2 25</td>
<td></td>
<td></td>
<td></td>
<td>2 25</td>
<td></td>
</tr>
<tr>
<td>Fortnightly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once per Month</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1 12,5</td>
<td>6 75</td>
<td>1 12,5</td>
<td></td>
<td>8 100</td>
<td></td>
</tr>
</tbody>
</table>

It appears from the above table that the majority of community-based rehabilitation workers were supervised once per week (62,5%). 75% of the community-based rehabilitation workers evaluated the amount devoted to supervision as good.

Eighty-seven, five percent of the community-based rehabilitation workers noted that they were satisfied with the amount of supervision obtained. This included community-based rehabilitation workers who obtained supervision daily, once per week and twice per week.
The community-based rehabilitation workers who had the least experience indicated that the supervision obtained once per week was insufficient.

5.2.12.3 THE METHOD OF SUPERVISION USED

It appears from the data obtained that individual supervision (100%), group supervision (87.5%) and case studies (75%) were commonly used as methods of supervision.

Of interest, 50% who received group supervision rated it as a satisfactory to somewhat weak method.

Individual supervision and case studies were evaluated by the majority as an excellent to good method.

The least used methods were role plays, sitting-in and observing, coaching, i.e., from behind the one-way mirror, co-working in projects, peer supervision and audiotape and video recordings.

5.2.12.4 THE TYPE OF SUPERVISION OBTAINED

<table>
<thead>
<tr>
<th>Type of supervision obtained</th>
<th>Excellent</th>
<th>Good</th>
<th>Satisfactory</th>
<th>Some-what weak</th>
<th>Un-satisfactory</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative</td>
<td>5 62.5</td>
<td>3 37.5</td>
<td></td>
<td></td>
<td></td>
<td>8 100</td>
</tr>
<tr>
<td>Supportive</td>
<td>4 50</td>
<td>4 50</td>
<td></td>
<td></td>
<td></td>
<td>8 100</td>
</tr>
<tr>
<td>Educational</td>
<td>5 62.5</td>
<td>3 37.5</td>
<td></td>
<td></td>
<td></td>
<td>8 100</td>
</tr>
</tbody>
</table>
It appears that all community-based rehabilitation workers received administrative, supportive and educational supervision. They evaluated the type of supervision between excellent and good.

5.2.13 SUGGESTIONS AND RECOMMENDATIONS GIVEN BY THE COMMUNITY-BASED REHABILITATION WORKERS TO IMPROVE TRAINING

The responses given by the majority of community-based rehabilitation workers were listed as follows:

5.2.13.1 increase the length of training
5.2.13.2 more training within the project where the community-based rehabilitation workers are expected to work and where the reality of the children’s disabilities could be confronted
5.2.13.3 more creative methods and materials should be used
5.2.13.4 mothers of disabled children should also be exposed to some training
5.2.13.5 community-based rehabilitation workers should be given more opportunities to be involved in the planning of the training programmes and to give feedback
5.2.13.6 a willingness and need to meet with other community-based rehabilitation workers to discuss project-and-training related difficulties
5.2.13.7 to arrange workshops for education purposes
5.3 RESULTS OBTAINED FROM THE SELF-ADMINISTERED QUESTIONNAIRE GIVEN TO TRAINERS

The following represents data obtained from the self-administered questionnaire completed by the trainers.

5.3.1 IDENTIFYING DATA

The following data indicates the identifying information obtained from the trainers.

AGE, HOME LANGUAGE AND PLACE OF RESIDENCE

The age of the two female respondents ranged between age 30 - 47 years. Their home language is predominantly English and they live respectively in the Southern Suburbs of Observatory and Rosebank.

5.3.2 ORGANISATION EMPLOYED AT AND PERIOD OF EMPLOYMENT OF TRAINER IN THE PRESENT PROJECT

The one trainer has been employed in a voluntary capacity as a trainer at Cape Mental Health Society since July 1989 and is still in the employ of the organisation. The other has been employed at South African Christian Leadership Assembly Health Project as a trainer since 1988 and is still in their employ.

5.3.3 EDUCATIONAL LEVEL AND QUALIFICATIONS OF THE TRAINER

Both trainers obtained matriculation and progressed to complete their tertiary education. Both completed a degree course which was followed by further education. Their qualifications are as follows:

Trainer 1 (South African Christian Leadership Assembly Health Project) has the following qualifications:

Trainer 2 (Cape Mental Health Society) has the following qualifications:
B.A. Degree - 1963
Barkly House - Pre-primary Diploma (1964)
Diploma in Special Education (1982); and
Psychology I, II and III (1986-1988)

The trainers were respectively extensively trained in the fields of physiotherapy and education. Neither had any formal education in community-based rehabilitation or training as educators of community-based rehabilitation workers.

5.3.4 COMMUNITY INVOLVEMENT AND EXPERIENCE IN THE FIELD OF MENTAL HANDICAP

Both trainers have extensive experience in the field of mental handicap.

Trainer 1 (South African Christian Leadership Assembly Health Project) has considerable experience which was obtained through her employment at the neurology and neurosurgery departments, Groote Schuur Hospital, Royal Free Hospital, London and in South African Christian Leadership Assembly Health Projects, Cape Town since 1985.

Trainer 2 (Cape Mental Health Society) also has extensive experience in the field of mental handicap as a teacher at Vera School for Austistic Children and as principal of Bel Porto School for Specialized Education for physically and mentally handicapped children from 1980 - 1990.

Both agreed that their experience was useful in their roles as trainers of community-based rehabilitation workers. They identified that the experience helped in the practical implementation of techniques, practical application, teaching and the development of administrative structures through observation of others who were more experienced.

An analysis of the trainers' involvement with community-based organisation and activities revealed that:-
Trainer 1 (South African Christian Leadership Assembly Health Project) had previous experience and involvement in progressive community organisations, i.e., United Women’s Organisation and the United Democratic Front. Trainer 2 (Cape Mental Health Society) had been mainly involved on committee level at a conventional social work organisation which is primarily community orientated.

5.3.5 A DESCRIPTION OF THE PROJECTS AND FUNCTIONS

5.3.5.1 A DESCRIPTION OF THE PROJECT/S WITH WHICH THE TRAINERS WERE ASSOCIATED

**TABLE 9 - A DESCRIPTIVE PRESENTATION:**

<table>
<thead>
<tr>
<th>Trainers</th>
<th>No. of C.R.W’s trained</th>
<th>Names of Projects</th>
<th>Area of Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>SACLA Health Project</td>
<td>10</td>
<td>Empilisweni SACLA Health Project and Vukani SACLA Health Project FAAWU Stroke Clinic</td>
<td>KTC squatter area, New Crossroads &amp; Site B, Site C, Town 2, Greenpoint in Khayelitsha Mbekweni (no longer in operation)</td>
</tr>
<tr>
<td>Trainer 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cape Mental Health Society (Voluntary trainer)</td>
<td>2</td>
<td>Imizamo Yethu Special Care Centre/Project Ethembeni Special Care Centre/Project</td>
<td>Khayelitsha Nyanga referrals from KTC squatter area, Crossroads, Guguletu, etc.</td>
</tr>
<tr>
<td>Trainer 2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 9 outlines the number of community-based rehabilitation workers trained by each trainer in the various projects and areas of operation which are mostly in underprivileged, deprived communities in the Western Cape.

5.3.5.2 DESCRIPTION OF THE FUNCTION OF THE COMMUNITY-BASED REHABILITATION WORKERS FOR EACH OF THE PROJECTS LISTED

The functions of the community-based rehabilitation workers employed at Imizamo Yethu Special Care Project and Ethembeni Special Care Project, Cape Mental Health Society are:

i group leader of the special care project
ii practical involvement at the centre
iii home visits and outreach
iv co-ordinating, screening and admission of children
v record keeping
vi parent projects
vii training of assistants
vii organisation of other administrative functions

The following are functions of the community-based rehabilitation workers employed at the South African Christian Leadership Assembly Health Project.

The community-based rehabilitation workers employed at the South African Christian Leadership Assembly Health Project are involved in the following:

i home visits and support to families of disabled people
ii exercises and stimulation games to facilitate development and prevent the condition deteriorating
iii visits to creches and homes to do screening as the community-based rehabilitation worker is usually the first person to come into contact with the disabled/handicapped child
iv Primary health care skills and functions
   - to read immunisation cards
   - check growth and weight
   - nutrition
   - oral rehydration
   - breast feeding
knowledge of grants and pensions
where to refer people who are in need of medical
and social services

5.3.6 TRAINING PERIOD/S USED

Trainer 1 - (South African Christian Leadership
Assembly Health Project) commenced the training
with an initial 2 - 4 week block training period
which was followed by weekly input.
Trainer 2 - (Cape Mental Health Society) used
training periods of one or two days per week. Both
trainers rated the one or two days per week as
primarily satisfactory to somewhat weak, while the
initial block training period used by the South
African Christian Leadership Assembly Health
Project was rated as good.

The trainer at Cape Mental Health Society indicated
that she would have preferred lengthier training
periods but was prevented from doing so due to her
limited hours.
PLACE AND ENVIRONMENT IN WHICH TRAINING TOOK PLACE

A combination of venues were used by Trainer 1 - (South African Christian Leadership Assembly Health Project). These included training at the home of the mentally handicapped, hospital, confines of the project and at a university. Trainer 2 - (Cape Mental Health Society) also used various venues for training. These included training within the confines of the project and the premises of Cape Mental Health Society.

Trainer 1 - (South African Christian Leadership Assembly Health Project) felt that the places which she used for training were adequate and therefore did not feel that it would have been better if other places were chosen. She felt that even though the homes of the mentally handicapped were crowded, the community-based rehabilitation workers learnt to adapt techniques to the nature of the houses.

Trainer 2 - (Cape Mental Health Society) felt it would have been better if other places such as home-based training was considered.
5.3.8 INCLUSION OF THE COMMUNITY-BASED REHABILITATION WORKERS' IN THE PLANNING OF THE TRAINING PROGRAMME

TABLE 10 - INCLUSION OF THE COMMUNITY-BASED REHABILITATION WORKERS' IN THE PLANNING OF THE TRAINING PROGRAMME

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T1</td>
<td>T2</td>
</tr>
<tr>
<td>Inclusion of community-based rehabilitation workers in the planning of training programme</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Opportunity for community-based rehabilitation workers to give feedback and evaluate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were the suggestions of the community-based rehabilitation workers considered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Both trainers indicated that they felt that they included the community-based rehabilitation workers in the planning of the training programme. One trainer indicated that the reasons for this were that many community-based rehabilitation workers were themselves mothers of handicapped children and knew more than any outsider about needs and problems.

The trainers indicated that all community-based rehabilitation workers trained were given an opportunity to give feedback and evaluate their training. They noted that these suggestions were considered.
5.3.9.1 Trainer 1 - (South African Christian Leadership Assembly Health Project) outlined the broad objectives of the training course as follows:

i To empower the community-based rehabilitation workers as mothers of handicapped children to take responsibility for their children and their future. To facilitate other mothers to do this. Having hopefully gained confidence in this area, they will have the confidence to articulate the problems of the disabled in the community, the community's problems and needs and also to play a part in working out a solution.

ii To help disabled people and their families by working together with them to discover easier ways of coping and to facilitate their access to hospitals, social workers, etc.,

B The short-term objectives of the training course were listed as follows:

i To teach the community-based rehabilitation workers basic primary health care skills

ii To teach the community-based rehabilitation workers the common disabilities - how these are caused and how they can be prevented

iii To teach the community-based rehabilitation workers how to recognise the problems caused by a handicap, and how to facilitate improvement and prevent complications

iv To encourage community-based rehabilitation workers to teach the families how to care for the disabled person so that they reach their maximum potential

v To encourage community-based rehabilitation workers to be a support to families of disabled people and disabled people themselves

vi To teach the community-based rehabilitation workers what is available in terms of grants, welfare assistance, etc.

vii To teach the community-based rehabilitation workers their limits, so that they know when to refer the disabled.
5.3.9.2 Trainer 2 - (Cape Mental Health Society) outlined the broad objectives of their training course as:

A

i Provision of information on mental handicap
ii Hands-on training for parents of mentally handicapped children
iii Hands-on training of the community-based rehabilitation worker
iv Creation of a programme
v Creation of structures for the group, e.g.,
  - daily timetables
  - fortnightly planning
  - evaluation of children
  - group control by using the assistants in the most profitable way

B

The short-term objectives of the training course were listed as follows:

Helping the community-based rehabilitation worker to gain insight into the care and education of handicapped people with specific goals focusing on programme planning.

Both Trainer 1 - (South African Christian Leadership Assembly Health Project) and Trainer 2 - (Cape Mental Health Society) indicated that the community-based rehabilitation workers whom they trained were aware of the training objectives. They noted that the community-based rehabilitation workers knowledge of the training objectives assisted them in their training.
THEORETICAL MODELS CONSIDERED IN THE TRAINING

Trainer 1 - (South African Christian Leadership Assembly Health Project) based her training on particular training models. These models were based on :-

A. Experienced-based Participatory Learning which starts where the learners are at. This model takes into account the social and cultural understanding of disease and handicap.

B. Problem-Orientated Training, i.e., to observe and identify problems and how to solve them. These models concentrated on active rather than passive learning.

The advantages and disadvantages of the theoretical model used were listed by the above trainer.

The advantages of the experienced-based participatory learning model which incorporated a problem-orientated perspective were as follows :-

i Increases self-confidence because mothers of handicapped children can pick-up through observation

ii Problem-solving is very applicable, because it could be adapted to different individuals in different situations

iii Experienced-based learning is useful as each mother has a wealth of experience due to her own experiences with her handicapped child.

iv People can work out their own limitations and refer to appropriately.

v Increases confidences of community-based rehabilitation workers as they always discover that they know more than they think they know

The disadvantages of these models were listed as :-

In these models the trainer needs to be very clear and concise otherwise the trainer may lose direction and orientation regarding the purpose for training.

Trainer 2 - (Cape Mental Health Society) did not use any particular model for training.
5.3.11 TRAINERS' DESCRIPTION AND EVALUATION OF COURSE CONTENT

5.3.11.1 DESCRIPTION OF THE COURSE CONTENT

Trainer 1 - (South African Christian Leadership Assembly Health Project) listed the course content as follows:-

i HEALTH IN THE COMMUNITY

A. Handicap and the community
B. Nutrition and malnutrition
C. Breast feeding
D. Immunisation
E. Oral rehydration

ii NORMAL BODY FUNCTIONS

A. The skeleton and movement
B. Normal movement of the joints
C. Normal development
D. Growth and weight of children

iii CONDITIONS AND TREATMENT

A. Cerebral Palsy
B. Downs Syndrome
C. Mental Handicap
D. Hydrocephalus
E. Spina Bifida
F. Poliomyelitis
G. Blindness
H. Deafness
I. Strokes
J. Spinal cord injuries
K. Amputations

iv MANAGEMENT OF PATIENTS

A. Assessment and recording
B. Fits
C. Contractures
D. Pressure sores
E. Urine and bowel management
F. Chest infections
G. Feeding children with cerebral palsy
H. Toy making workshop
I. Welfare assistance
Trainer 2 - (Cape Mental Health Society) outlined the course content as follows:

The course content was described as a "first-aid" operation, as information and support were given on many fronts, i.e. educational, administration, practical and social/emotional. She noted that during the time she was employed in a voluntary capacity, none of these areas were explored in great depth.

5.3.11.2 AN EVALUATION OF THE COURSE CONTENT

Both trainers considered that from the time that the community-based rehabilitation workers became involved in their projects, the course content taught at times assisted them, while on other occasions it was meaningless.

Trainer 1 - (South African Christian Leadership Assembly Health Project) and Trainer 2 - (Cape Mental Health Society) indicated that the course assisted the community-based rehabilitation workers on a practical level with tasks and problem-solving.

They further outlined that the content taught was not helpful to the community-based rehabilitation workers for the following reasons:
Trainer 1 - (South African Christian Leadership Assembly Health Project) noted that community-based rehabilitation workers still continued to have difficulty in screening techniques. There was also an inability to extend interventive skills beyond the home visits done to the mentally handicapped.

Trainer 2 (Cape Mental Health Society) added that the community-based rehabilitation workers still had difficulty in the transfer of skills. They continued to have difficulties in constructive planning and maintaining structures. The trainer mentioned that difficulties in the above lead to gaps in communication and breakdown in group programmes.

The trainers evaluated the overall content presented as :-

**TABLE 11 - TRAINERS' EVALUATION OF OVERALL CONTENT PRESENTED**

<table>
<thead>
<tr>
<th>Evaluatory Comments</th>
<th>Trainer 1</th>
<th>Trainer 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Too sophisticated</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>2. Too simplistic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Excellent</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. Good</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>5. Satisfactory</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>6. Somewhat weak</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Totally inappropriate and unsatisfactory</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Trainer 1 - (South African Christian Leadership Assembly Health Project) who employed the experienced-based participatory learning models evaluated the overall content presented as good while Trainer 2 - (Cape Mental Health Society) gave a range of evaluatory comments.

Trainer 1 - (South African Christian Leadership Assembly Health Project) noted that the overall content was appropriate because the organisation had workers in the area for eighteen months before implementing the initial training course.
Trainer 2 - (Cape Mental Health Society) noted that she needed more experience in how and what to present in a course presented to community-based rehabilitation workers. An additional difficulty was related to the fact that her contact was on an intermittent and emergency nature as she was engaged in a voluntary capacity.

The trainers gave an outline of what could be included in the course if given an opportunity to restructure the course content.

Trainer 1 - (South African Christian Leadership Assembly Health Project) noted that she would like to make a few additions, namely :-

1. Using ice-breakers as part of the introduction (1 day)
2. Visiting of 10 houses of the disabled in the area and then visiting 2 houses with disabled who are known. This will enable them to get a feel of community work (2 days)

Trainer 2 - (Cape Mental Health Society) indicated that she would include the following :-

1. Physiological/medical aspects of mental handicap
2. Practical course work
3. Planning and programming
4. Team work - how to work well with other team members
5. How to initiate contact with parents
6. Discussions - joint problem-saving

Both trainers indicated that the community-based rehabilitation workers were also given an opportunity to evaluate the course and had considered and included the suggestions made.

Trainer 1 - (South African Christian Leadership Assembly Health Project) used an evaluatory system which allowed for evaluations at the end of a presentation or at the end of each week. The reason for allowing the community-based rehabilitation workers to evaluate the overall course content was aimed at assisting the trainer to respond to views expressed.
### 5.3.12 TRAINING METHODS USED

#### TABLE 12 - A DESCRIPTIVE PRESENTATION OF TRAINING METHODS USED

<table>
<thead>
<tr>
<th>Training Methods</th>
<th>Excellent</th>
<th>Good</th>
<th>Satisfactory</th>
<th>Somewhat weak</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T1 T2</td>
<td>T1 T2</td>
<td>T1 T2</td>
<td>T1 T2</td>
<td>T1 T2</td>
</tr>
<tr>
<td>Formal Lectures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Group discussions</td>
<td>X X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Field visits</td>
<td>X X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participative activities, eg role plays, games, field experiments</td>
<td>X X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observational</td>
<td>X X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workshop</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Guest speakers</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, ie visits to institutions and hospitals</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Both trainers agreed that other training methods could have been considered when taking the background of the community-based rehabilitation workers into consideration.

The suggestions given were:-
more role plays

working for short periods alongside and with the trainer with careful evaluation at the end of each period.

5.3.13 TRAINING MATERIALS OR AIDS

TABLE 13 - A DESCRIPTIVE PRESENTATION OF TRAINING MATERIALS OR AIDS USED

<table>
<thead>
<tr>
<th>Training Materials &amp; Aids</th>
<th>Excellent</th>
<th>Good</th>
<th>Satisfactory</th>
<th>Some-what weak</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T1 T2</td>
<td>T1 T2</td>
<td>T1 T2</td>
<td>T1 T2</td>
<td>T1 T2</td>
</tr>
<tr>
<td>Flannel Board</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black Board</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Videos</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Films</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posters</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cards</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Slides</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Photos</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Books</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Drawings</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flip charts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, ie newsprint,</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>flipfiles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A4 size posters</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>practicals</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
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</tr>
</tbody>
</table>
Both trainers agreed that books were a somewhat weak teaching aid to use while cards, drawings and posters were satisfactory materials. Newsprint and flip-files were considered good while practicals were rated as excellent.

Trainer 2 - (Cape Mental Health Society) who was employed in a voluntary capacity noted that she would have used more of the above teaching aids if she had had more time.

5.3.14 NATURE AND TYPE OF SUPERVISION

5.3.14.1 Both trainers indicated that community-based rehabilitation workers were supervised. At the South African Christian Leadership Assembly Health Project the community-based rehabilitation workers were supervised by the trainer, while the community-based rehabilitation workers at Cape Mental Health Society were supervised by both the trainer and another supervisor (social worker). The community-based rehabilitation workers at both organisations were supervised during training and practise.

In both situations, the community-based rehabilitation workers received weekly supervision. Both trainers indicated that they were satisfied with the weekly supervision which they provided.
### 5.3.14.2 Methods of Supervision Used

**Table 14 - A Descriptive Analysis of the Method/s of Supervision Used**

<table>
<thead>
<tr>
<th>Supervision Method/s used</th>
<th>Excellent</th>
<th>Good</th>
<th>Satisfactory</th>
<th>Somewhat weak</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual sessions</td>
<td>T1 T2</td>
<td>X X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Role Plays</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case studies</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case notes, ie process or progress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting in &amp; observing</td>
<td>X X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiotape &amp; video recordings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coaching</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-working in projects</td>
<td>X X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer supervision</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Both trainers used individual sessions, sitting-in and observing and co-working in projects, as methods of supervision and rated these as good.

Group supervision and case studies were rated as somewhat weak and unsatisfactory methods.
### TABLE 16: A DESCRIPTIVE PRESENTATION - AN EVALUATION OF THE TYPE OF SUPERVISION PROVIDED

<table>
<thead>
<tr>
<th>Type of supervision provided</th>
<th>Excellent</th>
<th>Good</th>
<th>Satisfactory</th>
<th>Somewhat weak</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1 T2</td>
<td>T1 T2</td>
<td>T1 T2</td>
<td>T1 T2</td>
<td>T1 T2</td>
<td>T1 T2</td>
</tr>
</tbody>
</table>

- Administrative, i.e. keeping records, statistics, completing forms etc.
  - Excellent: X
  - Good: X

- Supportive, i.e. being able to discuss needs, problems, anxieties and providing educational support
  - Excellent: X
  - Good: X

- Educational, i.e. giving guidance regarding skills and knowledge
  - Excellent: X
  - Good: X

Both trainers evaluated their educational supervision as good but it appears that administrative supervision and support were areas which they felt required more attention.

5.3.15 ADDITIONAL SUGGESTIONS AND RECOMMENDATIONS GIVEN BY THE TRAINERS TO IMPROVE THE TRAINING OF THE COMMUNITY-BASED REHABILITATION WORKERS IN THEIR FUNCTIONS

Besides the suggestions and recommendations already mentioned, the trainers felt that the following would also assist to improve training, i.e.
TRAINER 1 - SOUTH AFRICAN CHRISTIAN LEADERSHIP ASSEMBLY HEALTH PROJECT

More time is required for the trainer to organise ongoing training, workshops, and administrative functions. Trainers are often too busy to ensure that these are all working well.

TRAINER 2 - CAPE MENTAL HEALTH SOCIETY

A carefully structured course should be developed which focuses on training and home based aspects of the mentally handicapped to provide a clear, portable and practical foundation.

5.4 CONCLUSION

This chapter has concentrated on the presentation of the findings. All significant data will be discussed in the following chapter in which final conclusions were be clarified.

The discrepancies in the information obtained from the community-based rehabilitation workers as compared to the data obtained from the trainers will be briefly discussed and explained.
CHAPTER 6

DISCUSSION OF THE FINDINGS

6.1 INTRODUCTION

In this final chapter, the significant results and conclusions will be discussed and compared with other authors in this field.

Areas for future research will be highlighted while practical recommendations will be provided to hopefully assist with the future training of community-based rehabilitation workers in the field of the mental handicapped.

The discussion of the findings will be discussed under the broad headings used respectively in both phases of the interview schedule and the self-administered questionnaire.

6.2 DISCUSSION OF THE FINDINGS

6.2.1 IDENTIFYING DATA:

The total population of community-based rehabilitation workers are Xhosa-speaking females of whom 75% have an average age range of 21 - 35 years.

The majority live in the community where the projects are based. Werner, D and Bower, B (1987) assert that it is best if training and work take place under conditions which are familiar to community-based rehabilitation workers and where they would be expected to practice solving problems.

All community-based rehabilitation workers are functionally literate. The educational level of the community-based rehabilitation workers is of paramount importance as it has implications for understanding and conceptualising the information presented. It also has implications for the manner in which the training is provided.
The two female trainers are predominantly English speaking and both live outside the area of project operation.

Both are well qualified and respectively extensively trained in physiotherapy and in education. Even though their experience and professional backgrounds were useful, neither had any formal training to equip them as trainers of community-based rehabilitation workers in community-based settings. Pangalangan, E and De Guzman, L (1980:54) recommend that,

"For a start a school could consider the organisation of a continuing educational programme for social work graduates engaged in paraprofessional training so as to equip them with the necessary competence in the field. Such an action would require that the schools first prepare the trainers of paraprofessionals before they can effectively engage in paraprofessional training."

They added that even though training institutions may not be directly involved in training community-based rehabilitation workers, they may produce trainers. This may also require that faculty members obtain training in this field.

Lund, F. L. (1987) found that project leaders at Health Care Trust and Care Projects who respectively have community-based projects in Cala and Gazankulu noted that they would introduce a much more systematic and thorough course for trainers before recruiting community-based rehabilitation workers. At present, there are no formalised training courses for trainers in South Africa.

6.2.2 DESCRIPTION OF THE SPECIFIC PROJECTS AND EXPERIENCE IN THE FIELD OF MENTAL HANDICAP

The description of the functions listed by the community-based rehabilitation workers for the different projects were surprisingly very similar.
The community-based rehabilitation workers focused on the description of their practical daily involvement at the project while the trainers instead listed the overall job descriptions and functions.

Of interest, the community-based rehabilitation workers at Cape Mental Health Society were, as part of their function, also expected to train the rehabilitation assistants when they themselves required intensive ongoing training to equip them for the tasks.

The majority of community-based rehabilitation workers had no previous experience or training in the field of mental handicap before their employment in these projects, whereas the trainers had extensive work experience in the field.

Thus, work and training in this field was a new experience for the community-based rehabilitation workers who required intensive educational assistance and guidance to equip them in their tasks and functions.

### 6.2.3 TRAINING PERIODS FOR THE SPECIFIC PROJECTS

The training periods employed by Cape Mental Health Society were mainly once a week. Both trainer and trainees were not entirely satisfied with this arrangement and agreed that more time was required. The trainees suggested blocks of three months followed by ongoing educational input. The community-based rehabilitation workers and trainer at the South African Christian Leadership Assembly Health Project regarded the short block of four weeks as ideal as long as it was followed by ongoing training.

Even though the Co-ordinating Committee on Community Rehabilitation Education (1989) proposed a two year period for training, there appears to be no consensus amongst the various co-ordinators of community-based projects regarding the most appropriate training period. An example of this is seen above but also at the following projects:
At the Manguzi Community Health Project in Kwa-Ngwanase, Kwa Zulu, a three month block training period was used.

At the Manzimahle Village Health Workers Project in Cala, Transkei, no initial block training was used, only weekly training sessions in the village.

At the Elim Care Groups, Elim Hospital in Gazankulu, less intensive training periods are used. Education and training is done on a broad community awareness level.

Werner, D and Bower B (1987) suggest that village or community constraints of distance and location need to be considered. He outlines that,

"some training courses are taught in one continuous block of time. Two to three months is the average length of such a course. This is usually long enough for health workers to learn the basic skills needed for primary care. Yet, it is short enough so that villagers with families and responsibilities at home can afford time away." (Werner, D & Bower, B, 1987:3-10).

They also propose other options such as short blocks of one - two months or weekly training which enables the community-based rehabilitation worker to continue their work at the project.

PLACE AND ENVIRONMENT IN WHICH TRAINING TOOK PLACE

The data obtained indicated that the majority of community-based rehabilitation workers received their training within the community in which they live and where the project operates.

Alternative training venues suggested by the community-based rehabilitation workers and one trainer highlighted the need for greater use of community-based venues, i.e.,

- home-based training in the homes of the mentally handicapped
- training within the confines of the project; and
- visits to other community-based rehabilitation centres which provide care for the mentally handicapped.
Lund, F J, (1987:66) mentions that, "strong arguments have been put forward that community development training should ideally take place in the prospective workers' community." Van Rensburg (1976) has shown how difficult it is for trainees to transfer skills learned at a training base situated outside the community to their particular home areas.

Werner, D and Bower, B, (1987:5-9) assert that,

"It is best if training takes place in a situation close to that where health workers will work. Closeness in distance is convenience but closeness in terms of community setting is essential."

Other projects in South Africa, such as Manquzi Community Health Project, Manzimahle Village Health Workers and those previously mentioned all received training within the community. This is in keeping with the concept and principles of community-based rehabilitation where facilities within the community and the resources of local people are used. No elaborate or inappropriate buildings are used, making training more accessible and transferable. Thus, community-based training draws on the structures and resources of the community and its people, and helps to keep training within the indigenous nature of the community.

It is therefore apparent that in this study the training venues chosen for the majority of community-based rehabilitation workers were appropriate, while few were exposed to inappropriate venues.

6.2.5 INCLUSION IN THE PLANNING OF THE TRAINING PROGRAMME AND KNOWLEDGE OF TRAINING OBJECTIVES

There appears to be a discrepancy in the results obtained from the community-based rehabilitation workers and the trainers regarding the community-based rehabilitation workers inclusion in the planning of the training programme.
The community-based rehabilitation workers (100%) indicated that they were not included in the planning of the training programme but were given an opportunity to give feedback and make suggestions which were considered. The trainers disagreed and considered that the community-based rehabilitation workers had been included in the planning. One can only speculate that this discrepancy might have been a perceptual misunderstanding as to what inclusion meant to the trainers and trainees.

Seventy-five percent of community-based rehabilitation workers indicated that they were aware of the training objectives while the other 25 percent noted that they were not aware and would have preferred to know.

Again, there was a slight discrepancy in that the trainers of the 25 percent disagreed and noted that the workers were aware of the training objectives.

The objectives for the training programme closely resembled those listed by the community-based rehabilitation workers.

The principles of community-based rehabilitation emphasise the need for community-based rehabilitation workers' inclusion and participation in the planning of the training course to ensure that training objectives are met. The local people need to decide about the training needs, problems and objectives and how these could be met through participatory learning methods proposed by Freire, P (1972).

Community-based rehabilitation insists on the "bottom-up" approach in training. Thus, the inclusion and involvement of community-based rehabilitation workers in the planning phases and decision-making process of the training programme remains an important consideration if the educator and educatee are to have a reciprocal relationship as equals. It should not be assumed that the trainer has approved knowledge and that the community-based rehabilitation workers have none, due to their lack of experience.
Werner, D and Bower, B (1987) and Freire, P (1972) insist on full participation and involvement of community-based rehabilitation workers to allow for criticism, analysis, feedback and plans for areas of future learning. Trainees, instructors and the community together need to decide what should be taught. Pre-packaged training models have no credibility with the people as they fail to consider the full dimension of cultural, political and social factors pertaining to communities.

The community-based rehabilitation workers in this study clearly expressed the need for greater inclusion and participation in the planning of the training programme; an area which they feel was not considered. In considering the literature in this field and the principles on which community-based rehabilitation are based, it becomes imperative that community-based rehabilitation workers are included in planning, feedback, analysis and future plans.

6.2.6 COURSE CONTENT AND AREAS FOCUSED ON

6.2.6.1 THEORETICAL MODELS USED BY THE TRAINERS

Trainer 1 - (South African Christian Leadership Assembly Health Project) was the only one who based the development of her training on two particular training models, i.e., experienced-based participatory learning model and the problem-orientated training model.

Both models chosen by this trainer highlight the importance of participation. The adult learners' knowledge and experience is given importance, and therefore makes allowance for the trainer and trainees to have equal participation in the learning experience. These models are guided by Freire, P (1972) whose "bottom-up" approach to adult education influenced the principles of community-based rehabilitation. It is clear that only one organisation used a systematically planned, predetermined curricula design which was based on a body of theory and knowledge while the trainer at Cape Mental Health Society recognised that this was a limitation and recommended that a more structured course content and model be developed.
Austin, M J (1978) and Button, L (1971) emphasise the need for training to be based on a body of knowledge and theoretical concepts. Thus, the theoretical models for training community-based rehabilitation workers need to be carefully chosen as they will guide the training ethos and ethics within the communities. It is probably one of the important considerations which trainers need to take cognisance of as this has implications for training and project development.

6.2.6.2 COURSE CONTENT

The course content listed by the trainers and trainees at the South African Christian Leadership Assembly Health Project were very similar. From the analysis, it becomes clear that the trainer had divided the course content into sub-sections, i.e.,

- health in the community
- normal body functions
- conditions and treatment; and
- management of patients

The content taught to the trainees at Cape Mental Health Society placed greater emphasis on the area of specialisation, i.e., mental handicap, rather than the generic approach used by the South African Christian Leadership Assembly Health Project. Administration was also considered an important aspect in training and in this respect differed from the South African Christian Leadership Assembly Health Project.

Once again, there appears to be no consensus amongst project co-ordinators internationally or in South Africa regarding appropriate course content.

The course content models presented by the International Association for Schools of Social Work place emphasis on the area of specialisation rather than the generic approach argued for by the Co-ordinating Committee on Community Rehabilitation Education (Co-Core) and the South African Council for Social Work.

As previously discussed, Austin, M J (1978) calls for a reconceptualisation of traditional approaches to training due to the emerging trend towards comprehensive unified human service.

The World Health Organisation (1981) agrees, and emphasises comprehensive primary health care which focuses on providing promotive, preventive, curative and rehabilitative functions. Major financial funders of community-based projects insist on comprehensive care rather than focusing on areas of specialisation. They believe that a generic approach lends itself to greater cost-effectiveness and efficient manpower utilisation.

The course content presented by the two organisations in this study emphasises curative and rehabilitative measures, and make little provision in the present course content, and the fictitious course content for promotive and preventative work. This is also apparent in the trainees' functions and activities. If training is to move appropriately towards meeting the needs of all by the year 2000, then greater emphasis should be placed on the inclusion of promotive and preventive aspects. Werner, D and Bower, B (1987) assert that training courses need to be balanced in terms of preventive, curative, promotive and rehabilitative aspects.

The course content listed by the community-based rehabilitation workers (100%) noted that the course content taught was helpful in assisting them fulfil their tasks at the projects. Of these, 87.5% of the community-based rehabilitation workers evaluated the course content as excellent to good.
They added that they were given an opportunity to evaluate the course content presented but the feedback given was perceived differently by the trainers and community-based rehabilitation workers.

The trainers on the other hand, were more critical of the course content.

They felt the course content was helpful in assisting with more insight into the needs of the mentally handicapped, use of appropriate activities, better group control, and instilling confidence and initiative.

They added that the course was not helpful in assisting with screening techniques, constructive planning and maintaining structures, transfer of skills and ability to extend interventive skills beyond the home visits done.

Trainer 1 - (South African Christian Leadership Assembly Health Project) was satisfied with the course content presented while Trainer 2 - (Cape Mental Health Society) indicated that she needed more experience in how and what to present.

Werner, D and Bower, B (1987) and Rigby, B D (1978) stress the need for constant evaluation and analysis of the course to assess its effectiveness and appropriateness. Constant feedback between the trainer and trainee is of utmost importance to provide maximum participation. Clearly, methods of feedback and how this is done need to be carefully considered to guard against discrepancies and misunderstandings as seen in this study. The exact feedback needs to be carefully recorded to be absolutely sure that the areas and need for future learning are clear to trainers and trainees.
6.2.7 TRAINING METHODOLOGY AND TECHNIQUES

6.2.7.1 TRAINING METHODS

Rigby, B D (1978) and Werner, D and Bower, B (1987) agree that experiential, participatory and pragmatic methods and materials be used. These should consider the literacy level of the adult learner and the trainees’ experience and knowledge should at all times be considered. In this study, the community-based rehabilitation workers all had a level of functional literacy which meant that they could understand much of what was presented.

The methods and tools used for teaching are of primary importance irrespective of literacy level. This is essential to create a critical awareness which facilitates dialogue between trainer and trainee in an environment of dual responsibility and involvement.

The teaching methods which the majority of community-based rehabilitation workers were exposed to and reported by them as being commonly used, were formal lectures/talks (100%), group discussions (75%), field visits (100%), participative activities (75%) and the use of guest speakers (87.5%) which were all evaluated fairly positively.

There appears to be no major discrepancies in terms of what the trainers and trainees reported except that the trainer 1 - (South African Christian Leadership Assembly Health Project) said no formal lectures were used, while the community-based rehabilitation workers said no observations or workshops were held. The community-based rehabilitation workers at Cape Mental Health Society reported no exposure to participative activities.

It appears that the teaching methods commonly used were mostly of a conventional nature and it seems that more creative and innovative methods could have been used.

Additional training methods suggested by the community-based rehabilitation workers were :-
- observational visits to other similar projects
- workshops
- games
- role plays
- poetry and
- more group discussions

The trainers supported the use of more role plays and suggested a greater need for observational-experiential learning with supervision.

6.2.7.2 TRAINING MATERIALS AND AIDS

The data gathered from the community-based rehabilitation workers indicated that the majority were exposed to posters (75%), books (100%), drawings (75%) and flipcharts (75%). These were primarily rated as good. The least used materials and aids were flannel boards, black boards, videos, films, cards, slides, photos and props.

The community-based rehabilitation workers suggested that these be incorporated as additional teaching aids including drawings, flipcharts and the use of available resources at the centres. Even though the trainees evaluated the use of books fairly positively, the trainers disagreed and felt this was a somewhat weak teaching aid to use. They rated the use of newsprint, flipcharts and the use of practicals fairly positively. Trainer 1 - (Cape Mental Health Society) noted that she would have preferred to use more innovative methods but was unable to due to time constraints.

In non-formal education it is essential that the trainers and community-based rehabilitation workers are clear about the exact purpose for using certain materials. The advantages and limitations of each material should be clearly understood. (Refer to Appendix 12). Lund, F J (1987) found that the danger is often that materials or aids are mechanically used rather than used where appropriate and relevant. She states that, "what may start out as inventive and educational may in time become routinised and gimmicky." (Lund, F J, 1987:72).
As previously discussed, Werner, D and Bower, B (1987) guidelines for the use of appropriate teaching aids, need to be carefully considered to avoid some common pitfalls.

Once again, it appears from this study that the more conventional teaching aids such as, posters, drawings, books and flipcharts were used. It is my opinion, that more creative and innovative materials could have been included as suggested by the community-based rehabilitation workers including additional teaching materials and aids, e.g., story-telling, poetry, creative literature, folk songs, puppets, shadow-play, drama, illustrated stories and magazine or newspaper articles.

There needs to be more flexibility in the use of materials even though one realises the time constraints. The language dilemma is an added constraint as English materials often need to be translated.

Furthermore, caution needs to be exercised in terms of what is regarded as appropriate for each community.

It is therefore advantageous for community-based rehabilitation workers and the local community to be included in the development of a community-appropriate resource centre of teaching aids and materials. The World Health Organisation insists on using what is locally available within the community to reduce cost but also to ensure that materials and aids are culturally understood and available.

Ongoing feedback between community-based rehabilitation workers and trainers regarding appropriate or inappropriate materials and aids is essential.
6.2.8 NATURE AND TYPE OF SUPERVISION

6.2.8.1 All community-based rehabilitation workers (100%) received supervision. There was, though, a slight discrepancy in the information given by the community-based rehabilitation workers regarding the amount of supervision obtained. The trainers reported that weekly supervision was provided while 37.5% of the community-based rehabilitation workers reported differences in the amount of supervision received. Both community-based rehabilitation workers and trainers were satisfied with the amount of supervision provided. The least experienced community-based rehabilitation worker felt the amount of supervision received was insufficient.

The South African Christian Leadership Assembly Health Project’s supervision was provided by the trainer while supervision at Cape Mental Health Society was dually performed by the trainer and a social work supervisor.

There appears to be general agreement that irrespective of the nature of tasks which community-based rehabilitation workers are expected to perform, supervision is essential, as active support is required.

No consensus though, is apparent regarding who should supervise the teaching and administration aspects and whether these should be done by one supervisor or two different individuals. In my experience, where community-based rehabilitation principles are applied in a traditional social work organisation, the teaching and administrative functions should be supervised by either the trainer or separated due to conflict in expectations.

In the case where supervisory tasks are separated, it is preferred that the trainer supervise the teaching - educational aspects and to provide the necessary support while the social work supervisor supervise administrative functions.
Austin, L (1978) recommends the latter option as it reduces or mitigates the inherent strains in roles and supervisory relationships.

6.2.8.2 METHODS OF SUPERVISION USED

The data provided by the community-based rehabilitation workers indicated that the majority were exposed to individual supervision (100%), group supervision (87.5%) and case studies (75%). Few community-based rehabilitation workers were exposed to other methods such as role plays, case notes, sitting-in and observing, co-working in projects and peer supervision.

Both trainers and community-based rehabilitation workers agreed that individual supervision was a good method while group supervision was regarded as a somewhat weak method. They disagreed on the value of case studies.

It is clear from the above information that few community-based rehabilitation workers were exposed to other innovative or pragmatic means of supervision which could have been more educational and useful. Methods such as role plays and co-working in projects could be invaluable methods as there is immediate feedback, accountability and an indication of how certain tasks are performed.

The methods used for supervision were appropriate in terms of community-based rehabilitation as no expensive technology was used. Consideration needs to be given to other more creative methods of supervision.

6.2.8.3 TYPE OF SUPERVISION

The trainers and trainees all reported that administrative supervision, supportive supervision and educational supervision were provided.

The trainers indicated that the areas which required more attention were supportive and administrative supervision.
Community-based rehabilitation workers often feel extremely isolated in communities where the needs are often great. Authors such as Kadushin, A (1976) identified that support might not only be required in terms of the job situation but also in terms of situational problems which community-based rehabilitation workers might experience. This therefore implies that supportive structures need to be developed within organisations.

It has also been found that new community-based rehabilitation workers with the least experience often need support in adjusting to organisational structures and the community needs. Conflict may arise in this area if the organisation's perception of the needs within the community differ to those identified by the community. An inexperienced community-based rehabilitation worker might feel extremely uncertain and may not have the means to address these problems. This could lead to confusion about loyalties to the community and organisation.

Furthermore, it is essential that administrative functions are kept simple and uncomplicated to assist community-based rehabilitation workers who might have limited experience in bureaucratic administrative requirements of organisations.

Specific training might be required to assist with simple office procedures, recording and using communication channels.

Cudabeck, D (1970) and Kadushin, A (1976) recognise that community-based rehabilitation workers may have a limited educational background, and may not be comfortable with organisational structures. This therefore requires that supervisors provide ongoing assistance and include administrative supervision as an important process of supervision.
6.3 AREAS FOR FUTURE RESEARCH

The following are recommended areas for future research and investigation:

6.3.1 An investigation into the training of trainers involved in the training of community-based rehabilitation workers with the view to developing a post-graduate course.

6.3.2 Further research into the co-ordination and development of a national policy pertaining to the training of community-based rehabilitation workers in order to facilitate general consensus and consistency.

6.3.3 A study to focus particularly on methods and techniques of participation and empowerment of community-based rehabilitation workers and the disabled in all aspects of training.

6.3.4 An exploration of theoretical models and concepts appropriate in community-based rehabilitation which could assist with a body of theory and knowledge upon which training could be developed.

6.3.5 Research into various course content models which could be considered for training and which focus on comprehensive-generic approaches to assist with promotive, curative, preventative and rehabilitative functions.

6.3.6 Further research regarding the supervision of community-based rehabilitation workers and trainees and to develop additional literature in this field.

6.3.7 Ongoing research in the area of training of community-based rehabilitation workers due to varying needs of trainees and communities.

6.4 PRACTICAL RECOMMENDATIONS

The following are practical recommendations which could be considered in the training of community-based rehabilitation workers:
6.4.1 Schools of social work should offer continuing education for graduates interested in the training of community-based rehabilitation workers; the former thus effectively qualifying themselves as trainers.

This may require that faculty members obtain training in the field.

6.4.2 Various professionals involved in community-based rehabilitation, i.e., physiotherapists, occupational therapists, speech therapists, social workers, nurses, doctors, community-based rehabilitation workers and community-based rehabilitation worker assistants, should develop a policy about - and greater co-ordination of all aspects of training. The co-ordination needs to be done on a national level under the auspices of possibly the Co-ordinating Committee on Community Rehabilitation and Education who have already begun to attend to this area. This body should maintain links and liaison with the Progressive Primary Health Care Organisation which already functions on a national level.

6.4.3 In considering the training of community-based rehabilitation workers, it is essential that the community and the disabled are involved at all times to ensure adherence to the "bottom-up" approach. The community and the disabled should be regarded as the primary factor in all aspects of training to facilitate an empowering-liberating process and to guard against professionals’ need to normalise the conditions of the disabled. In this study, community-based rehabilitation workers requested more involvement in the planning of the training programme. Knowledge of the training objective was also an aspect they wanted to be aware of. Even though this might be a time consuming process, participation and involvement is vital.

6.4.4 Community-based rehabilitation workers should not be expected to train rehabilitation assistants unless they have the necessary experience or training in this sphere.
Decisions concerning the duration of training periods should take community constraints of distance and location into consideration. There is no consensus regarding the appropriate duration of training. Thus, co-ordinators of projects and communities need to consider the time frame which is most suited to their situation.

In terms of community-based rehabilitation it is essential that community-based rehabilitation workers are trained in the area of operation which is normally the community in which they live. Training at institutions outside the community usually leads to isolation and presents an artificial environment which causes difficulty in transferring skills. Training within the community creates a natural and real experience which leads to more realistic expectations. In this study, the trainers and community-based rehabilitation workers recommended and suggested greater use of community-based training.

Training needs to be developed and based on theoretical models which ultimately become the guiding principles for the manner in which the course is presented. Training courses cannot be loosely structured, and should be based on a body of knowledge and theoretical concepts.
6.4.8 Even though community-based rehabilitation workers are employed in areas of specialisation, it is essential that trainers re-conceptualise traditional approaches to training. A more wholistic approach, i.e., comprehensive-generic approach which includes promotive, curative, preventive and rehabilitative aspects, needs to be considered.

6.4.9 More creative, innovative training methods and techniques need to be considered in the training of community-based rehabilitation workers. These need to be experiential, participatory and pragmatic to create a non-formal teaching environment which carefully considers the literacy level of the trainees. The limitations and advantages of training methods and techniques must be carefully evaluated before choosing. Community resources need to be utilised and workshops to create teaching aids and materials could become invaluable.

6.4.10

6.4.10.1 Supervision of community-based rehabilitation workers need to be an ongoing process, irrespective of tasks which they are expected to perform. It is also essential that the trainers receive supervision if they are to be effective.

Furthermore, if supervision is to be done by two individuals, clear guidelines need to be drafted regarding supervisory functions to avoid confusion and unnecessary conflict.

6.4.10.2 The method of supervision used also needs to be pragmatic, innovative and inventive to facilitate greater learning, feedback and accountability. Methods such as role-plays, sitting-in and observing, co-working in projects and peer supervision could be considered.
6.4.10.3 All three components of supervision, i.e., administrative, supportive and educational supervision should be incorporated and regarded as important in the supervisory process. One component should not be given greater emphasis than another. Trainers in this study felt that more attention was given to the educational aspect.

6.4.11 Furthermore, ongoing analysis and evaluation needs to be done by the community-based rehabilitation worker and trainer to assess the effectiveness of the training presented.

Methods of feedback must be carefully considered to avoid misunderstanding and discrepancies.

6.5 CONCLUSION

In considering the discussion of the findings, areas for future research and the practical recommendations, it is hoped that this study has made a contribution to the various aspects of training of community-based rehabilitation workers.

The researcher hopes that the practical recommendations will be carefully considered in order to make training more appropriate and effective. It is further hoped that the trainers will discuss these findings with community-based rehabilitation workers to ensure that they are exposed to the information but also because they have been an integral part of this research. Without them, and the information provided by the trainers, this research and findings might not have been possible.

It is furthermore hoped that the data obtained has made a contribution to the limited literature and research in this field and that others will be encouraged to do further research.
Cape Mental Health Society

Profile

Cape Mental Health Society is a private, registered welfare organisation. It was formed in 1913 and is the oldest mental health society in the country. During the earliest days the Society was run by dedicated volunteers who were motivated by a deep concern for people with mental handicaps. Today we are a committed team of volunteers, social workers and others who work with all sectors of the community.

Our aims are:

- To improve the quality of life of mentally handicapped and psychiatrically ill people and their families.
- To reduce the incidence of mental handicap and psychiatric illness in the community.
- To initiate and develop appropriate services and facilities for the Society’s clients in cooperation with the community.
- To provide an information service and raise awareness about mental handicap, psychiatric illness and mental health needs in the broader community.

How We Work in the Western Cape

- Twenty five social workers providing supportive and counselling services.
- Three special care and activity centres serving 90 profoundly mentally handicapped children.
- Four training centres serving 500 mentally handicapped children.
- Four protective workshops serving 270 mentally handicapped adults.
- Two group homes providing accommodation for 12 mentally handicapped adults.
- Three Gateway Clubs providing social and recreational opportunities for 100 mentally handicapped young adults.
- Fountain House, a psycho-social rehabilitation club for 100 members who are discharged psychiatric patients.
- Four social groups serving 50 mentally ill people.
- Mental Health Awareness Projects reaching 1 000 people per annum.

We are opposed to all forms of discrimination and will strive for a just society which promotes the mental health of all people.
APPENDIX 2

THE ORGANISATIONAL STRUCTURE OF CAPE MENTAL HEALTH SOCIETY
ORGANISATIONAL STRUCTURE

CAPE MENTAL HEALTH SOCIETY
APPENDIX 3

THE LADDER OF CARE
Mental health should be included as an essential element of primary health care everywhere, "but only providing it is broadened to include the promotion of psychological well-being generally, and does not concern itself only with the prevention and treatment of mental disorders."

Whenever possible, decisions should be made at the level of the people they concern and affect. This referral ladder illustrates the "chain of command", and responsibilities in accordance with capabilities:

**Level 4**

*Mental Health Specialists (Psychiatrists)* can support level (3) workers while offering to take referrals which cannot be dealt with there. They also assist by visiting the hospital to support personnel, provide training and supervision.

**Level 3**

*Psychiatrically trained nurse(s) or medical assistant(s) supported by a medical officer with psychiatric knowledge,* provide direct therapeutic care and offer mental health education services, functioning as leader of a team responsible for patient follow-up and long-term monitoring. They also ensure constant adequate stocks of medication, encourage counselling to assist diagnosis, cooperate with workers in other disciplines, liaise with those in other sectors concerning treatment issues, such as police and teachers, hold discussions with community leaders and ensure that service provided is responding to community needs, as well as enlist local involvement in the provision of mental health care.

**Level 2**

*Non-physician trained health workers (nurses or medical assistants)* are able to initiate simple treatments or sedation in some states of excitement where immediate referral is not possible, and continue treatment begun at 1st referral hospital (Level 3), supervising and helping village health workers (Level 2), and working with those in other sectors at similar level (agricultural, community development). They ensure health promotion in development, activities, and can recognize significant numbers of people who come with physical ailments, but present more pressing psychological disorders, and refer or handle them accordingly avoiding unnecessary interventions.

**Level 1**

*Village Health Workers (VHWs) or Primary Health Workers* usually have had 6-10 years of schooling, 3 months of training, work part-time and have been selected from and by villagers, being paid by them. Their function is to monitor psychological as well as physical development of children, identifying major mental disorders and epilepsy, referring patients for treatment, identifying alcohol or drug abusers and child abuse or parental neglect, advising/referring as necessary, monitoring progress, and giving alcohol, drug and mental health education. VHWs are also qualified to teach villagers simple health promoting measures such as clean water and sanitation, simple malaria control, ensuring immunization of children, monitoring children's growth, giving nutrition advice, and encouraging family time together. They are ideally placed to practice and share the skills of interviewing, listening and caring.

Begin here:

Adapted by S.J. Freeman from WORLD HOSPITALS, Vol. XXII, No. 3, September 1986, from an article by The Division of Mental Health, WHO, Geneva, Switzerland, "First referral hospitals in support of mental health".
APPENDIX 4

PYRAMID OF HEALTH SERVICES
APPENDIX 4

PYRAMID OF HEALTH SERVICES

Ministry of Health

Specialised national institutes

University hospitals
Regional health services
District health services

Rural (or local) hospitals and related services

Rural (or local) health centres

Community dispensaries and village health posts

Specialised health care using increasingly sophisticated technology.

A limited number of community orientated professionals who manage primary health care services and form the first referral level.

Intermediate health care using intermediate technology, delivered by a corps of intermediate - level health workers who complement and supervise field activities.

Primary health care using primary technology, delivered by frontline workers at the community level who constitute the bulk of health service personnel.

Reproduced from WHO Technical Report Series No. 633 (17)
A PROPOSED STRUCTURE FOR CAPE MENTAL HEALTH SOCIETY
APPENDIX 5

A PROPOSED STRUCTURE FOR CAPE MENTAL HEALTH SOCIETY

Social Worker Co-ordinator

Trainer and Supervisor

Senior community-based rehabilitation worker

Community-based rehabilitation worker (active training)
- functional literacy
- from village
- provides curative, promotive preventative and rehabilitation services

Rehabilitation assistant
- from village
- minimal training
- ability to identify and feeds into system
- functional literacy not necessary

- Community - Based Rehabilitation within Primary Health Care Network
APPENDIX 6

EXPERIENTIAL AND ENVIRONMENTAL PROGRAMMES
## APPENDIX 6

### EXPERIENTIAL AND ENVIRONMENTAL PROGRAMMES

<table>
<thead>
<tr>
<th></th>
<th><strong>EXTENSIVE</strong></th>
<th><strong>INTENSIVE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>EXPERIENTIAL</td>
<td>Educational Programmes</td>
<td>Creation of self-help and volunteer programmes for special populations</td>
</tr>
<tr>
<td></td>
<td>Training in helping skills</td>
<td>Facing and preventing crises</td>
</tr>
<tr>
<td></td>
<td>Assistance to self-help groups</td>
<td>Accessible counselling services</td>
</tr>
<tr>
<td>ENVIRONMENTAL</td>
<td>Community planning and development</td>
<td>Linkage with helping network</td>
</tr>
<tr>
<td></td>
<td>Community action and change</td>
<td>Consultation with other helpers</td>
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<td></td>
<td></td>
<td>Advocacy on behalf of individuals and groups</td>
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</tbody>
</table>
APPENDIX 7

CURRICULI FOR TRAINING OF FRONTLINE REHABILITATION WORKERS – 3 MODELS
PRESENTED AT THE PROCEEDINGS OF THE INTERNATIONAL ASSOCIATION OF SCHOOLS OF SOCIAL WORK. ASIAN REGIONAL SEMINAR
JULY 14-18, 1980
APPENDIX 7

PRESENTATION OF CURRICULUM MODELS

"A. Training of Social Welfare Officers as Rehabilitation Workers with Drug Dependents

Presented by: Mr K N Singham - Malaysia

The Malaysian model focused on the training of social welfare officers as rehabilitation workers with drug dependents, specifically at intake, supervision, and after care. The programme is conducted by the Training Division of the Ministry of Welfare Services. Of two week’s duration, its general objective is to provide these officers with additional skills in counselling in the areas of empathy, exploration and values and attitudes, and problem-solving. There are about three sessions on empathy, about four on counselling and two on interviewing.

The most interesting part of the methodology is the use of the video tape which enables the trainee to observe immediately on the machine his own performance in specific situations during practicum.

The pre-recorded training tape is also used primarily to demonstrate and simulate discussion on the client’s statement and the counsellor’s responses.

A Manual on Client Management teaches the worker what tasks to undertake and how to administer these in the delivery of services for drug dependents.

Complete Text:

Training of Social Welfare Officers as Rehabilitation Workers with Drug Dependents

Agency: Training Division, Ministry of Welfare Services

1. Type of training - Non-formal; in-service
2. Duration - two weeks
3. Target population
6. conduct assessment interviewing for treatment planning in terms of client readiness, relationship, rationality, and resources;

7. work with other members of the rehabilitation team; and

8. utilize community participation in prevention and rehabilitation measures.

5. Course content

Specific topics:

5.1 Psycho-social concepts of human behavior in relation to drug abuse;

5.2 Drug abuse facts;

5.3 Developing initial client screening criteria;

5.4 Drug abuse treatment modalities;

5.5 Matching client to modalities;

5.6 Basic principles of counselling;

5.7 Video tape demonstration of counselling;

5.8 Empathy (3 sessions):
   5.8.1 listening
   5.8.2 understanding and responding
   5.8.3 counsellor effect as a tool

5.9 Interpersonal process recall (2 sessions);

5.10 Orientation to the rehabilitation programme of the Ministry of Welfare Services - field visit;

5.11 Counselling practice - (2 sessions);

5.12 Non-verbal behavior (video-tape analysis);

5.13 Client growth process;

5.14 Legislation pertaining to drug abuse;
8. Training Aids

Several training aids are used: the training manual for counselling skills, audio-visual and flat materials.

The manual for counselling skills is a supplementary teaching aid and is used only minimally. It is simplified so that the paraprofessional without extensive educational background can read and comprehend the concepts.

B. Training of Trainers of Child Care Workers

Presented by: Miss Anne V Kurian - Sri Lanka

This programme by the Sri Lanka School of Social Work focuses on the preparation of women who will become trainers of child care workers. They should at least be about 25 years old with experience in child care or child welfare work and possess a degree or a diploma related to pre-school or a Montessori education.

The training is of two weeks duration and has for its general objective the provision of the necessary knowledge, skills, and attitudes to function as trainers of child care workers in institutions. The curriculum content is divided into theory and practice of one month each. The theory consists of four core areas:

Area I  - Principles and Methods of Social Work;
Area II  - Child Development;
Area III - Estate Set Up and Estate Community;
Area IV  - Introduction to Curriculum Development.

After two months initial training, the trainers conducted residential training programmes under the supervision and guidance of the School Director, and the Training Officer.
This model shows what a school of social work, attached to a government ministry, can contribute to paraprofessional training. Although in the past they have concentrated on the training of child care workers, of whom there are several hundreds, they have moved up higher by initiating programmes on the training of trainers on a more systematic basis. Note is made of the fact that the future trainers are degree or diploma holders from a university with concentration on child welfare. The inclusion therefore of Principles and Methods of Social Work as one of the core areas in the curriculum content is well-placed.

Complete text:

Training of Trainers of Child Care Workers

Agency: Sri Lanka School of Social Work
Ministry of Social Services

1. Target Group

Trainers of Child care workers

Preferably females above 25 years having experience in child care or child welfare work with a degree of a diploma related to pre-school or Montessori education from a university.

2. Duration : Two months

3. Objectives:

3.1 General

To provide the necessary knowledge, skills and attitudes to function as trainers of child care workers in institutions.

3.2 Specific:

At the end of the training course the trainees should be able to:
3.2.1 handle a residential training course for child care workers;  
3.2.2 accept the basic principles of social work as a profession;  
3.2.3 identify training needs, develop training objectives, curriculum and annotated training schedules;  
3.2.4 develop suitable training materials;  
3.2.5 develop and effectively use different training techniques and materials;  
3.2.6 evaluate and document child-care training programmes for future use in developing other programmes.

4. Curriculum content

4.1 Theory - One month

4.2 Practicum - One month

THEORY

Core Area 1 - Principles and Methods of Social Work

- Personal assessment  
- Basic principles of social work  
- Methods of social work  
- Community organization  
- Developmental social work

Core Area 2 - Child Development

- Reproduction  
- Pre-natal development  
- Pre and post-natal care and services  
- Nutrition  
- Preparation of food and feeding  
- Infant and child diseases  
- Child welfare services  
- Creche and its services to the community  
- Creche as a family and child welfare center  
- Personality development in children  
- Child development through creative play
Core Area 3 - Estate Set up and Estate Community

- Estate administration
- Production
- Life of the estate worker
- Child welfare services in the estates
- The pre-colonial, colonial, and post-colonial era of the estates set up
- Development of estate creches and its objectives

Core Area 4 - Introduction to Curriculum Development

- Training methodology
- Curriculum development
- Planning of training programmes
- Evaluation and documentation
- Determining training needs
- Formulating training objectives
- General administration and administration of training programmes
- Methods of training
- Preparation of teaching materials
- Evaluation of training programmes

5. Training Methods

Lectures; discussions
Observation and field visits
Role play
Games
Practical work in child care institutions

After the 2 months initial training, the trainers conduct residential training programmes under the supervision and guidance of the School Director and the Training Officer.

6. Training materials used:

Slides
Films
Film strips
Charts
Posters

Handbook for Estate Creche Workers
Manual for Infant Nutrition
handouts
7. Training teams

A panel of resource persons is invited to handle the various aspects of the programme.

8. Assessment

At the end of the two months training course, the trainees are assessed on their performance by the Training Officer.

C. Training of Paraprofessionals to Work as Change Agents in Slums

Presented by: Mrs Nafisa D’Souza – India

This is a training programme managed and conducted by the Bombay College of Social Work to prepare young adults between the ages of 25 to 30, who are dropouts from the mainstream of formal education, to work as change agents in slums. Their functions are:

1. To educate the masses about the forces that create their problem situation, and

2. To organize people to deal with their problem situation with the ultimate goal of initiating a movement that will liberate them from their present situation.

The duration of the training is nine months.

The curriculum content is divided into core and supportive courses.

The core courses are divided into three general headings:

1. Slums in the context of society;
2. Poverty: A systematic perspective; and

The supportive courses lay emphasis on interventional skills such as ‘non-formal education’ or ‘strategies of intervention in relation to health’. Each course is of specific relevance in providing the trainees with the capacities to carry out concrete tasks as points of entry into the slums.
The training may be divided into three parts:

In the first part the trainees are exposed to the problem situation in slums so as to acquire beginning skills in analysis and intervention. Concepts related to analysis of the problem are included in the theory.

The second part of the programme is focused on analysis of solutions related to the problem situation. This is where the trainees' analytical and interventional skills are likely to be sharpened.

In the third part emphasis is on the acquisition of skills for independent analysis and intervention in terms of working with the problem situation.

Emphasis on the value of commitment and social justice is carried throughout the training programme.

Like the other models presented the non-formal education methodology is used extensively here. Movement from the concrete to the abstract is emphasized as the trainees are drop-outs from the formal mainstream of education and therefore tend to learn from concrete situations. In addition, the experiences of the trainees involving the self are utilized to provide discussion because trainees from slums are generally spontaneous and relatively uninhibited in relating their experiences."

(Pangalangan, E & De Guzman, L, 1980: 10-23)
APPENDIX 8

CO-CORES PROPOSED COURSE CONTENT (1988)
APPENDIX 8

CO-CORES PROPOSED COURSE CONTENT

"TRAINING THE COMMUNITY REHABILITATION WORKER"

Prevention and care must be taught in regard to the following disabilities:
moving, seeing, hearing and speech, mental (including learning, mental handicap, epilepsy and "strange behaviour").

Entry Requirements

Functional Literacy. Preference should be given to suitable mature individuals within the community and selected by interview.

Length of Course

A minimum of 1500 hours given over a period of not less than 2 years whilst in a training post (including supervised practical/in service training). During the training the student must be in a training post.

Tuition and Supervision

a) Tutors and supervisors should be experienced Occupational Therapists, Physiotherapists, Speech and Hearing Therapists, and other relevant personnel who are orientated to community based rehabilitation.

b) Tuition should be relevant to the conditions in the community i.e. rehabilitation procedures should be basic and not require sophisticated or elaborate equipment.

c) Facilities must be available for community based tuition and practice. Ideally the course should be taught within the community in which workers are to serve and should be relevant to the needs of the community. Sufficient principles and basic information should be given for the CRW to be able to apply the knowledge in a variety of settings so that employment possibilities are not limited, with the proviso that additional in-service training may be necessary.
CO-CORES PROPOSED COURSE CONTENT

EVALUATION AND EXAMINATION

There should be ongoing evaluation throughout the course.

Evaluation should be oral and practical rather than written.

Examinations must be conducted by training centre/s approved by the SAMDC.

Each successful candidate will receive a certificate issued by the training centre."

(Co-ordinating Committee on Community Rehabilitation Education, 1988: 8-9)
APPENDIX 9

PROPOSED TRAINING COURSE FOR SOCIAL AUXILIARY WORKERS = SOUTH AFRICAN COUNCIL FOR SOCIAL WORK (1989)
APPENDIX 9

PROPOSED TRAINING COURSE FOR SOCIAL AUXILIARY WORKERS — SOUTH AFRICAN COUNCIL FOR SOCIAL WORK

"Social auxiliary workers should be trained in the following aspects :-

(i) All employers are of the opinion that distinctive courses must be developed that are approved by the Council.

(ii) Most employers are of the opinion that a formal training course must be designed, integrating theory and practice and followed by a period of in-service training.

(iii) Employers are of the opinion that all training courses must cover the following aspects:

(a) Role explanation: Social, auxiliary worker, social worker, administrative officer and volunteer.
(b) Introduction to the methods of rendering assistance.
(c) Basic skills and principles of interviewing and report-writing.
(d) Principles of social auxiliary work.
(e) Ethics of social auxiliary work.
(f) Developmental psychology (life phases).
(g) Social Pathologies (merely take note).
(h) Office administration.
(i) Human relationships.
(j) Social legislation (take note).

(iv) Employers differentiate between the following directions of service-rendering:

(a) Community care.
(b) Group care.
(c) Institutional care.
(d) Service centre care.
(e) Probation services.
(f) Family care.
(g) Social security. "

APPENDIX 10

DAVID WERNER’S THREE APPROACHES TO EDUCATION AND TRAINING OF COMMUNITY BASED REHABILITATION WORKERS (1987)
### THREE APPROACHES TO EDUCATION

This chart gives a summary of 3 approaches to teaching. It may help instructors to evaluate their own teaching approach. But we do not recommend that this analysis be given to health workers. Analyzing stories and role plays will work better. So pass by this chart if you want.

<table>
<thead>
<tr>
<th>Function</th>
<th>CONVENTIONAL</th>
<th>PROGRESSIVE</th>
<th>LIBERATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim</td>
<td>Resist change.</td>
<td>Change society to transform</td>
<td>Change society to transform</td>
</tr>
<tr>
<td>Strategy</td>
<td>Teach people to accept and act in the social situation without changing its unjust aspects.</td>
<td>Actively oppose social injustices, inequality, and corruption. Work for basic change.</td>
<td>Work for certain improvements without changing the unjust aspects of society.</td>
</tr>
<tr>
<td>Intention toward people</td>
<td>CONTROL them—especially poor working people—food and city.</td>
<td>PACIFY or CALM them—especially those whose hardships drive them to protest or revolt.</td>
<td>FREE them from oppression, exploitation, and corruption.</td>
</tr>
<tr>
<td>General approach</td>
<td>AUTHORITARIAN (rigid, top-down control)</td>
<td>PATERNALISTIC (kindly, top-down control)</td>
<td>HUMANITARIAN and DEMOCRATIC (control by the people)</td>
</tr>
<tr>
<td>Effect on people and the community</td>
<td>OPPRESSIVE—rigid control, authority allows little or no participation by students and community.</td>
<td>DECEPTIVE—pretends to be supportive, but actually resists real change.</td>
<td>SUPPORTIVE—helps people find ways to gain more control over their health and their lives.</td>
</tr>
<tr>
<td>How students (and people generally) are viewed</td>
<td>Typically passive. Empty containers to be filled with standard knowledge.</td>
<td>Basic spontaneity. Must be cared for. Needs to be watched closely.</td>
<td>Basic activity. Able to take charge and become self-reliant.</td>
</tr>
<tr>
<td>What the students feel about the teacher</td>
<td>FEAR—Teacher is an absolute, all-knowing boss who stands apart from and above the students.</td>
<td>GRATITUDE—Teacher is a friend, a parentlike authority who knows what is best for the students.</td>
<td>TRUST—Teacher is a facilitator who helps everyone look for answers together.</td>
</tr>
<tr>
<td>Who decides what should be learned</td>
<td>The Ministry of Education (or Health) in the capital.</td>
<td>The Ministry, but with some local decisions.</td>
<td>The students and instructors together with the community.</td>
</tr>
<tr>
<td>Teaching method</td>
<td>Teacher lectures.</td>
<td>Teacher educates and entertains students.</td>
<td>Teacher educates and entertains students.</td>
</tr>
<tr>
<td>Main way of learning</td>
<td>PASSIVE—students receive knowledge, memorization of facts.</td>
<td>ACTIVE—everyone contributes. Learning through doing and through experiencing.</td>
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</tr>
</tbody>
</table>

| Area for studying | The classroom. | The classroom and other controlled situations. | Life in the classroom is itself. |

| How does the class sit? | | | |

| Class size | Often LARGE, emphasis on quantity, not quality of education. | Often fairly small, to encourage participation. | Often SMALL, to encourage communication and apprenticeship learning. |

<table>
<thead>
<tr>
<th>Flow of knowledge and ideas</th>
<th>school or health system</th>
<th>school or health system</th>
<th>students, group, school or health system</th>
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### PROGRESSIVE VS. LIBERATING

<table>
<thead>
<tr>
<th>Important subjects or concepts covered</th>
<th>CONVENTIONAL</th>
<th>PROGRESSIVE</th>
<th>LIBERATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>* the strengths and talents of the present social order</td>
<td></td>
<td></td>
<td>* critical analysis</td>
</tr>
<tr>
<td>* national history (historically taking the &quot;right side&quot; of all heroes)</td>
<td></td>
<td></td>
<td>* social awareness</td>
</tr>
<tr>
<td>* rules and regulations (instructing people to make &quot;our&quot; laws)</td>
<td></td>
<td></td>
<td>* communicational skills</td>
</tr>
<tr>
<td>* obedience</td>
<td></td>
<td></td>
<td>* teaching skills</td>
</tr>
<tr>
<td>* anatomy and physiology</td>
<td></td>
<td></td>
<td>* organization skills</td>
</tr>
<tr>
<td>* much that is not practical or relevant—&quot;it is taught because it always has been&quot;</td>
<td></td>
<td></td>
<td>* innovation</td>
</tr>
<tr>
<td>* unnecessary learning of big words and boring information</td>
<td></td>
<td></td>
<td>* self-reliance</td>
</tr>
</tbody>
</table>

### Flow of knowledge and ideas

<table>
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<th>students, group, school or health system</th>
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| Area for studying | The classroom. | The classroom and other controlled situations. | Life in the classroom is itself. |

| How does the class sit? | | | |

| Class size | Often LARGE, emphasis on quantity, not quality of education. | Often fairly small, to encourage participation. | Often SMALL, to encourage communication and apprenticeship learning. |

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<th>students, group, school or health system</th>
</tr>
</thead>
</table>

### Area for studying

| Area for studying | The classroom. | The classroom and other controlled situations. | Life in the classroom is itself. |

| How does the class sit? | | | |
APPENDIX 11

IMPORTANT CONSIDERATION FOR COURSE PLANNING

WERNER, D & BOWER, B (1987)
APPENDIX II

IMPORTANT CONSIDERATIONS FOR OVERALL COURSE PLANNING

"A. Planning to be done before the training course begins:

1. FIRST CONSIDERATIONS - PURPOSES AND QUESTIONS

   Whose needs will the training program be primarily designed to meet?

   Will it only extend the existing health system, or will it help to change it?

   How much will it prepare the health worker to understand and deal with the social (economic, cultural, political) causes of ill health?

   Will it make the poor more dependent, or help them to be more self-reliant? Will it promote or resist social change?

   What are the general goals and objectives of the program? (To express goals in terms of numbers and dates is probably unwise at this stage. Why?)

   Who is (or should be) involved in all these decisions?

2. OBSERVATION OF NEEDS AND RESOURCES

   (Talking with a few observant persons from the area can often provide more useful information than a census or elaborate 'community diagnosis', at far lower cost, more quickly, and with less abuse.)

   Information worth considering:

   Common health problems: how frequent and how serious?

   Causes of main problems: physical and social, coming from inside and outside the community.

   People's attitudes, traditions, and concerns.

   Resources: human, physical, economic, from inside and outside the area.
Characteristics of possible health workers: age, experience, education, interest, etc.

Possible choices of instructors and training organizers.

Possible sources of funding and assistance. (Which are more appropriate?)

Reports and experiences of other programs.

Obstacles: certain, likely, and possible.

3. EARLY DECISIONS –
Who? Where? How many? When?

Selection of health workers: by the community, by the health program, or by both? (How can selection of a health worker be a learning experience for the community?)

Selection of instructors and advisors:

How much understanding and respect do they have for village people? Do they treat them as equals.

How committed are they to working toward social change?

Do they have the necessary knowledge and skills (public health, education, group dynamics, community organization, medicine, etc.) or are they willing to learn?

Location:

Where will the training take place? Near or far? Village or city? Why?

Where will everyone eat and sleep? In hotels? In special facilities? With village families?

(How can these decisions influence what they will learn?)
Numbers: How many students will take part in the training course? (Beyond 12 or 15, quality of training usually decreases. This must be weighed against the need to train more health workers.)

Timing:

How long will the training course last?

What time of year is best?

(Consider how these decisions may affect who can take part in the course.)

Will the training be done in one continuous stretch, or be divided into short blocks so that students can return home (and practice what they have learned) between sessions?

(Whose needs and opinions should be considered in answering these questions?)

Funding:

From where? How much money should come from outside the local area?

What are the interests of possible funding groups?

What are the advantages and disadvantages of asking communities to pay part of the cost of training their health worker?

How can costs be kept low? How much is needed?

Follow-up and support:

What opportunities may there be for continued learning or training after the course is over?

What kind of support or supervision will the health workers receive?

(Why is it important to consider the follow-up before the training program begins?)
4. ANALYSIS OF PRIORITIES
   (deciding what is most important)

Problems can be compared by considering the following:

How common are they?

How serious are they?

How contagious are they?

How much concern do people feel about them?

How much do they affect other problems?

How much could a community health worker do about them in terms of ...

- diagnosis and treatment?
- referral, when needed?
- prevention?
- education of local people?
- community action?

How easy or difficult will it be to teach a health worker to take safe, responsible action with respect to the problem?

Then group the problems according to their relative importance, or priority, and decide which ones to include in the course. (Be sure to include common social problems that affect health - such as drinking, overuse and misuse of medicines, local forms of exploitation of the poor, and misuse of resources - as well as physical diseases.)
5. **RE-EXAMINING OBJECTIVES**

In view of the information you have gathered and analyzed, how can the training program be best designed ...

so that it prepares health workers to help the people in their villages solve their problems and needs?

so that it is adapted to fit the particular strengths and weaknesses of the students?

6. **ORGANIZING STUDY MATERIAL FOR APPROPRIATE LEARNING**

What general subject areas and specific topics might be taught in order to prepare students to act upon the important problems and needs in their communities?

How many hours of organized study time will there be during the course?

How much time is needed to adequately cover each topic?

How can the time available to best divided among the different topics, according to their priority?

Which topics are best approached through classroom learning, through practice (in clinic, community, or field), or a combination?

(At this point, some program planners make a list for each subject area, stating exactly what the health workers should know and be able to do. What are the strengths and weaknesses of this approach?)

7. **PLANNING FOR BALANCE**

How can the subject matter be approached so as to maintain an appropriate balance between ...

classwork and practical experience?
8. PREPARING A ROUGH TIMETABLE OR CLASS SCHEDULE
(without details, to be changed later)

How can different subjects and topics be arranged, according to hours, days, and weeks, so that ...

- there is enough variety to keep the students interested (for example, classwork alternating with farm work, community action, and learning of practical skills)?

- related subjects are scheduled close together or in a logical order?

- more difficult subjects come early in the day, and more fun subjects later (when people are tired)?

- all key subject matter is included?

- high-priority subjects are given more emphasis in the training course?

- skills and knowledge needed for immediate use and practice are learned early (for example, learning about medical history, physical exams, preventive advice, Road to Health charts)?
9. PLANNING APPROPRIATE TEACHING METHODS AND AIDS

What teaching approach is best suited to persons who are more used to learning from experience than from lectures and books?

What approaches to learning will help the health worker be an effective teacher in his community?

What attitudes on the part of the teacher will encourage the health worker to share knowledge gladly and treat others as equals?

What teaching methods might aid the health worker in helping community people to become more confident and self-reliant?

What teaching aids can be used that will lead the health worker to make and invent teaching aids after returning to his village?

What approach to learning will best prepare the health worker to help his people understand and work together to solve their biggest problems?

What approach to health problems will enable the health worker to learn how to approach the solving of other community problems?
What can be done to ensure that all learning is related to important needs?

How can classwork be made more friendly and fun?

How can tests and exams be presented so that students use them to help each other rather than to compete? How can tests and exams be used to judge the instructor as well as the students?

10. GETTING READY AND OBTAINING SUPPLIES

What preparations are needed before the course begins? (transportation, eating and sleeping arrangements, study area, wash area, etc.)

What furnishings and teaching materials are needed to begin? (benches, blackboards, etc.)

What can be done if some of these are not ready on time?

11. DETAILED PLANNING OF ACTIVITIES AND CLASSES FOR THE BEGINNING OF THE COURSE

How many days of classes and activities should be planned in detail before the course begins?

Why is it important that the details of all the classes and activities not be planned in advance?

12. INVOLVING STUDENTS IN PLANNING THE COURSE CONTENT (based on their experience and the needs in their communities)

Why is it important that the students take part in planning the course?

How can the students participation in planning help them to learn about ... examining and analyzing the needs in their communities?
recognizing both the strengths and the weaknesses of their people's customs?

ways to plan and organize a learning group?

the value of learning by doing, and of respecting and building on their own experiences?

shared decision making?

13. REVISING THE PLAN OF STUDIES (COURSE CONTENT) ACCORDING TO STUDENT SUGGESTIONS

To what extent to the priorities determined by the students, according to problems and needs in their own villages, correspond to those already considered by the instructors and planners? (How do you explain the similarities and differences?)

How important is it to revise the course plans in order to better meet the concerns and expressed needs of the student group?

14. PREPARING INDIVIDUAL CLASSES AND ACTIVITIES

How detailed should class plans be?

How far in advance should a class or activity be planned? Why?

Is it helpful to use a particular outline or formula for preparing a class? If so, what should it include?

Can each class or activity be planned to include ...

all of the basic points to be learned or considered?

active student participation and interaction?

use of appropriate learning aids?

opportunities for the students to explore questions and discover answers for themselves?
practice in solving problems similar to those health workers will meet in their work?

a chance for students to summarize what they have learned and to ask questions?

To what extent can students take part in the preparation of classes and of teaching aids? (Is this important? Why?)

15. CONTINUED REVISION OF THE SCHEDULE
- to make room for new ideas, learning opportunities, needs, and problems as they arise

What are the advantages and disadvantages to keeping the program open and flexible? (How might this influence a health worker’s ability to work toward, or tolerate, change in his or her community?)

16. EVALUATION DURING THE TRAINING PROGRAM
- to consider how it might be improved

In what ways can this be done?

Who should be involved?

What is the value of ...

round-table discussions in which all students and staff have a chance to express their feelings about the program and each other?

similar discussions with members of the community where the training program takes place?

tests and exams?

setting specific goals and seeing if they are met?

If evaluation studies (informal or formal, ongoing or final) are made, what can be done to help assure that results are useful and will be used?
C. PLANNING AND PROGRAMMING AFTER THE COURSE IS COMPLETED

17. FOLLOW-UP AND FEEDBACK

How can a supportive learning situation be continued between instructors and students, and among the students themselves, once the training course is completed?

How can the following be involved in supporting the health worker:

members of the community (a health committee)?

other health workers?

program instructors, leaders & advisers?

other support groups and referral centers?

How can the experiences, successes and difficulties of the health workers in their communities be recorded and used to make the next training course better than the last?

18. STARTING OVER

The whole process is repeated. "

(Werner, D & Bower, B, 1987: 3-5 - 3-8)
APPENDIX 12

INTERNATIONAL ASSOCIATION OF SCHOOLS OF SOCIAL WORK
- ADVANTAGES & LIMITATIONS OF TEACHING MATERIALS (1980)
APPENDIX 12

INTERNATIONAL ASSOCIATION FOR SCHOOLS OF SOCIAL WORK
- ADVANTAGES AND LIMITATIONS OF TEACHING MATERIALS

"Their specific nature as well as their advantages and limitations are as follows:"

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<th>Specific</th>
<th>Advantages</th>
<th>Disadvantages</th>
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<td>Flat materials</td>
<td>posters</td>
<td>Economical &amp; inexpensive to produce</td>
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(Pangalagan, E & De Guzman, L, 1980:20)
APPENDIX 13

PERMISSION TO CONDUCT RESEARCH AT
SACLA HEALTH PROJECT
I E Daniels  
9 Durrel Road  
MANDALAY.  
7785  

16 May 1990  

The Trainer  
SACLA Health Project  
P O Box 117  
PHILLIPI  
7781  

Dear Marion  

PERMISSION TO CONDUCT RESEARCH AT SACLA  

I hereby wish to extend my appreciation for your willingness to partake in my research project which is in partial fulfilment of my Clinical Social Work Masters Programme, at the University of Cape Town.  

I wish to bring to your attention that the study will be focusing on the training offered to community mental health workers who work in underprivileged communities. In the self-administered questionnaire reference is often made to the term paraprofessionals which in this situation refers the community mental health workers.  

Please do not hesitate to telephone me at 479040 or 3872734, if you have any uncertainties.  

Thank you once again.  

Yours faithfully  

I E Daniels  
M.SOC.SC (Clinical Social Work) Student
APPENDIX 14

PERMISSION TO CONDUCT RESEARCH AT
CAPE MENTAL HEALTH SOCIETY
9 Durrel Street
MANDALAY
7785

07 May 1990

The Director
Cape Mental Health Society
Private bag X7
OBSERVATORY
7935

Dear Madam

re: PERMISSION TO CONDUCT RESEARCH AT CAPE MENTAL HEALTH

I hereby kindly request permission to conduct interviews at Cape Mental Health with the paraprofessionals and trainers employed by your organisation.

These interviews are relevant to my research topic which was chosen as partial fulfilment of Clinical Social Work Masters Programme, February 1990. The title reads as follows:--

THE APPROPRIATENESS OF CURRENT TRAINING OFFERED TO COMMUNITY MENTAL HEALTH WORKERS IN RELATION TO THEIR FUNCTIONS WITH PARTICULAR REFERENCE TO MENTAL HANDICAP IN UNDERPRIVILEGED COMMUNITIES.

I have enclosed a copy of my proposal which explains the rationale for the study. The results of the research will be forwarded to the Agency following its completion.

Your permission and assistance regarding the above request would be highly valued.

Yours faithfully

........................
I E Daniels
M.SOC.SC.(Clinical Social Work) Student
REQUEST FOR LITERATURE -
ZIMBABWE RED CROSS SOCIETY
29 May 1990

Zimbabwe Red Cross
Box 1406
HARARE

Attention: Mr Engelbert Vengesa

Dear Mr Vengesa

I was really impressed with your presentation at RURACT Conference in April 1990, Johannesburg and the community based rehabilitation done and initiated by your Society.

As I had discussed with you, could you kindly send this Agency some literature about the work done by Zimbabwe Red Cross as we are intending to start a project in Khayelitsha, Cape Town.

Please telephone Mrs I Daniels at (021) 479040, if further information is requested.

Thank you for your assistance.

Yours faithfully

I E Daniels (Mrs)
DEPT HEAD: INTAKE
IED/fl
REQUEST FOR LITERATURE –  
CHRISTIAN MEDICAL COMMISSION  
WORLD COUNCIL OF CHURCHES
29 May 1990

The Editor
CONTACT
Christian Medical Commission
World Council of Churches
150, Route de Ferney
1211 Geneva
SWITZERLAND

Dear Sir/Madam

This Agency provides services to the mentally handicapped and psychiatrically ill individuals in the Western Province, South Africa.

I have read your publications, Contact No 69, April 1987 and Contact No 101, February 1988 and have found the information very relevant in terms of work which we do.

We therefore kindly request that this Agency receive the bimonthly distribution of this publication.

Thank you for your cooperation.

Yours faithfully

I E Daniels (Mrs)
DEPT HEAD : INTAKE

IED/f1
APPENDIX 17

INTERVIEW SCHEDULE

AN INVESTIGATION OF THE TRAINING OFFERED TO COMMUNITY-BASED REHABILITATION WORKERS WITH PARTICULAR REFERENCE TO THE FIELD OF MENTAL HANDICAP IN THE WESTERN CAPE
APPENDIX 17

PHASE 1

INTERVIEW SCHEDULE

TITLE:

AN INVESTIGATION OF THE TRAINING OFFERED TO COMMUNITY-BASED REHABILITATION WORKERS WITH PARTICULAR REFERENCE TO THE FIELD OF MENTAL HANDICAP IN THE WESTERN CAPE.


DATA OBTAINED WILL BE TREATED AS HIGHLY CONFIDENTIAL.

RESEARCHER: I E DANIELS
1. IDENTIFYING DATA OF THE COMMUNITY-BASED REHABILITATION WORKER

1.1 NAME:


1.2 AGE:

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1.4 HOME LANGUAGE:


1.5 ADDRESS:


Page 2/...
1.6 ORGANISATION EMPLOYED AT:

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1.7 NAME/S OF TRAINER:

-----------------------------------------------
2. EDUCATIONAL LEVEL

Indicate highest educational level passed.

2.1 NO EDUCATION

2.2 PRIMARY SCHOOL EDUCATION

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2.3 SECONDARY SCHOOL EDUCATION:

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</table>

2.4 TERTIARY EDUCATION:

Specify.

Name of College or University and Degree or Diploma obtained (e.g. University of the Western Cape, B.A. Social Science).
3. DESCRIPTION OF THE SPECIFIC PROJECT:

3.1 NAME OF THE PROJECT:

3.2 AREA OF OPERATION:

Where is your project based?

3.3 DESCRIPTION OF YOUR PROJECT:

Describe what you do on a daily basis in your Project:
5. KNOWLEDGE IN THE FIELD OF MENTAL HANDICAP :

5.1 OUTLINE WHETHER YOU HAVE ANY PREVIOUS TRAINING IN WORKING WITH THE MENTALLY HANDICAPPED :

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.2 IF YES, PLEASE SPECIFY WHERE AND BY WHOM AND THE AREAS COVERED :

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
5.3 INDICATE WHETHER PREVIOUS KNOWLEDGE AND EXPERIENCE
ASSISTED YOU IN THE PRESENT PROJECT:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

5.4 PLEASE STATE THE REASON/S FOR YOUR ANSWER:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
6. TRAINING PERIOD FOR THE SPECIFIC PROJECT:

6.1 (A) SPECIFY THE TRAINING PERIOD/S USED:

1. One to two days per week

2. Short block, e.g. 2 weeks/3 weeks or 4 weeks

3. Continuous training, e.g.2 to 3 months

4. Longer periods, e.g.1 year or more

5. Other (specify)

6.1 (B) SPECIFY, IF OTHER TRAINING PERIODS WERE USED:

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---------------------------------------------------------------------------------------------------------

Page 9./...
6.2 EVALUATE THE TRAINING PERIOD/S IMPLEMENTED:

<table>
<thead>
<tr>
<th>Excelent</th>
<th>Satisfactory</th>
<th>Somewhat</th>
<th>Unsatisfactory</th>
</tr>
</thead>
</table>

1. One to two days per week
2. Short block, e.g. 2 weeks/
   3 weeks or
   4 weeks
3. Continuous training,
   e.g. 2 to
   3 months
4. Longer periods,
   e.g. 1 year
   & more
5. Other
6.3 DO YOU THINK IT WOULD HAVE BEEN BETTER IF OTHER TRAINING PERIODS WERE CONSIDERED (E.G. TWO WEEKS INSTEAD OF 1 DAY):

| YES | NO |

6.4 PLEASE SPECIFY THE REASONS FOR YOUR ANSWER:

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7. PLACE & ENVIRONMENT IN WHICH TRAINING TOOK PLACE:

7.1 (A) SPECIFY THE PLACE/S & ENVIRONMENT IN WHICH TRAINING TOOK PLACE:

1. VILLAGE

2. OFFICE

3. LECTURE THEATRE

4. HOME OF THE MENTALLY HANDICAPPED
5. HOSPITAL

6. CONFINES OF THE PROJECT

7. UNIVERSITY

8. COLLEGE

9. OTHER (SPECIFY BELOW)

7.1 (B) PLEASE INDICATE, IF OTHER PLACE/S OR ENVIRONMENTS WERE USED:

-------------------------------------------------------------
-------------------------------------------------------------

7.2 EVALUATE THE APPROPRIATENESS OF THE TRAINING ENVIRONMENT:

<table>
<thead>
<tr>
<th>Good</th>
<th>Satisfactory</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. VILLAGE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. OFFICE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. LECTURE THEATRE/ROOM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>----------------</td>
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<td>--------------</td>
</tr>
<tr>
<td>4. HOME OF THE MENTALLY HANDICAPPED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. HOSPITAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. CONFINES OF THE PROJECT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. UNIVERSITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. COLLEGE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. OTHER EG. PREMISES OF CAPE MENTAL HEALTH SOCIETY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.3 DO YOU THINK IT WOULD HAVE BEEN BETTER IF OTHER PLACES WERE CHOSEN FOR TRAINING:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

7.4 PLEASE SPECIFY THE REASON FOR YOUR ANSWER:

----------------------------------------
----------------------------------------
----------------------------------------
----------------------------------------
----------------------------------------

Page 13./...
8. INCLUSION IN THE PLANNING OF THE TRAINING PROGRAMME :

8.1 INDICATE WHETHER YOU WERE INVOLVED IN THE PLANNING OF THE TRAINING PROGRAMME:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

8.2 IF NO, PLEASE INDICATE WHETHER YOU WOULD HAVE PREFERRED TO BE INCLUDED:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
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</tbody>
</table>

8.3 IF YES, PLEASE INDICATE WHETHER THIS HELPED TO FULFIL YOUR EDUCATIONAL NEEDS:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

PLEASE ELABORATE:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
8.4 WERE YOU GIVEN AN OPPORTUNITY/TIES TO EVALUATE AND GIVE FEEDBACK ABOUT YOUR TRAINING ON AN ONGOING BASIS?

YES | NO

8.5 IF YES, WERE THEIR SUGGESTIONS CONSIDERED:

8.6 IF NO, WOULD YOU HAVE LIKED THEM TO GIVE FEEDBACK ABOUT THE TRAINING?
9. COMMUNITY-BASED REHABILITATION WORKERS KNOWLEDGE OF THE OBJECTIVES FOR HIS/HER TRAINING:

9.1 SPECIFY WHETHER YOU KNEW WHAT YOU WERE MEANT TO LEARN BY THE COURSE:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

9.1
A. IF YES, PLEASE OUTLINE THESE OBJECTIVES:

1. __________________________________________

2. __________________________________________

3. __________________________________________

4. __________________________________________

5. __________________________________________

6. __________________________________________
9.1 (B) IF NO, INDICATE WHETHER YOU WOULD HAVE PREFERRED TO
(i) KNOW THE OBJECTIVES FOR YOUR TRAINING:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

(B) ELABORATE ON YOUR REASONS FOR THE AFOREMENTIONED:
(ii)

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10. COURSE CONTENTS AND AREAS FOCUSED ON

10.1 PLEASE LIST THE AREAS OF LEARNING (CONTENT) WHICH THE TRAINER FOCUSED ON, I.E. FEEDING, TOILET TRAINING, CAUSES OF MENTAL HANDICAP, RESOURCES, STIMULATION EXERCISES, MANAGEMENT OF THE PROJECT, PROGRAMME PLANNING, ETC.:
10.2 (A) NOW THAT YOU HAVE BEEN ACTIVELY WORKING IN YOUR PROJECT, DID YOU FIND WHAT WAS TAUGHT (CONTENT) HELPFUL IN ASSISTING YOU FULFIL THE TASKS:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>BOTH</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

(B) (PLEASE ANSWER B1 AND B2 IF BOTH WAS TICKED OFF)

B.1 IF YES, PLEASE INDICATE HOW IT HELPED YOU IN YOUR TASKS:

1. -----------------------------------------------
2. -----------------------------------------------
3. -----------------------------------------------
4. -----------------------------------------------
5. -----------------------------------------------
6. -----------------------------------------------
7. -----------------------------------------------
8. -----------------------------------------------

Page 19/...
B.2 IF NO, PLEASE INDICATE WHY THE CONTENT TAUGHT WAS NOT HELPFUL TO YOU:

1. __________________________________________________________
2. __________________________________________________________
3. __________________________________________________________
4. __________________________________________________________
5. __________________________________________________________
6. __________________________________________________________
7. __________________________________________________________
8. __________________________________________________________

10.3 PLEASE EVALUATE THE OVERALL CONTENT PRESENTED:

1. TOO SOPHISTICATED  
2. TOO SIMPLISTIC  
3. EXCELLENT  
4. GOOD  
5. SATISFACTORY
6. SOMEWHAT WEAK

7. TOTALLY INAPPROPRIATE & UNSATISFACTORY

10.4 WERE YOU GIVEN AN OPPORTUNITY TO EVALUATE THE COURSE

A. CONTENT?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

B. IF YES, WHAT WERE YOUR COMMENTS OR SUGGESTIONS?

1. __________________________________________________________

2. __________________________________________________________

3. __________________________________________________________

4. __________________________________________________________

5. __________________________________________________________

C. IF NO, WHAT WOULD YOU SUGGEST AS AREAS FOR FUTURE LEARNING, I.O.W., WHAT WOULD YOU LIKE INCLUDED IN YOUR COURSE?

1. __________________________________________________________

2. __________________________________________________________
3. 

4. 

5. 

10.5 (A) INDICATE WHETHER YOUR COMMENTS OR SUGGESTIONS CONCERNING LEARNING NEEDS WERE CONSIDERED AND INCLUDED IN THE COURSE CONTENT:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</thead>
</table>

(B) PLEASE ELABORATE ON YOUR ANSWER/S:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
11. TRAINING METHODS USED:

11.1 (A) PLEASE SPECIFY WHICH TRAINING METHODS WERE USED:

1. FORMAL LECTURES/TALKS
2. GROUP DISCUSSIONS
3. FIELD VISITS
4. PARTICIPATIVE ACTIVITIES
   E.G. ROLE-PLAYS, GAMES,
   FIELD EXPERIMENT
5. OBSERVATIONAL
6. WORKSHOPS
7. GUEST SPEAKERS
8. OTHER (SPECIFY)

(B) SPECIFY WHICH OTHER TRAINING METHODS WERE USED:

-------------------------------------------------------------

-------------------------------------------------------------

-------------------------------------------------------------

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-------------------------------------------------------------

Page 23...
11.2 EVALUATE THE TEACHING METHODS USED:

<table>
<thead>
<tr>
<th>Excel-lent</th>
<th>Satisfactory</th>
<th>Somewhat</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

1. FORMAL LECTURES/TALKS

2. GROUP DISCUSSIONS

3. FIELD VISITS

4. PARTICIPATIVE ACTIVITIES
   E.G. ROLE-PLAYS, GAMES, FIELD EXPERIMENTS

5. OBSERVATIONAL

6. WORKSHOPS

7. GUEST SPEAKERS

8. OTHER (SPECIFY)

11.3 COULD YOU SUGGEST OTHER TRAINING METHODS WHICH COULD BE HELPFUL TO YOU?

1. 

2. 

3. 

4. 

5. 

Page 24/...
12. TRAINING MATERIALS OR AIDS:

12.1 (A) PLEASE SPECIFY THE TRAINING MATERIALS OR AID USED:

1. FLANNEL BOARDS

2. BLACK BOARDS

3. VIDEOS

4. FILMS

5. POSTERS

6. CARDS

7. SLIDES

8. PHOTO’S

9. BOOKS

10. DRAWINGS

11. FLIP CHARTS

12. OTHER

12.1 (B) SPECIFY WHAT OTHER MATERIALS OR AIDS WERE USED:

--------------------------------------------------------------------------

--------------------------------------------------------------------------

Page 25./...
12.2 EVALUATE THE MATERIALS OR AIDS USED TO TRAIN:
(You have experienced the materials and aids used. Could you indicate how helpful these were?)

<table>
<thead>
<tr>
<th>Excelent</th>
<th>Satisfactory</th>
<th>Somewhat</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1. FLANNEL BOARDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. BLACK BOARDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. VIDEOS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. FILMS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. POSTERS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6. CARDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. SLIDES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. PHOTO’S</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. BOOKS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>10. DRAWINGS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. FLIP CHARTS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. OTHER</td>
<td></td>
<td></td>
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</tbody>
</table>
12.3 COULD YOU SUGGEST OTHER MORE USEFUL MATERIALS AND AIDS WHICH COULD HAVE BEEN USED:

---

---

---
13. NATURE AND TYPE OF SUPERVISION WHILE TRAINING:

31.1 (A) WERE YOU IN PRACTICE WHILE YOUR WERE TRAINING?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

(B) INDICATE WHETHER YOU WERE SUPERVISED:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(C) IF YES, PLEASE SPECIFY BY WHOM.

(NOT TO BE ASKED DIRECTLY)

13.2 INDICATE HOW OFTEN YOU WERE SUPERVISED:

1. DAILY

2. ONCE PER WEEK

3. TWICE PER WEEK
**4. FORTNIGHTLY**

**5. ONCE A MONTH**

**6. QUARTERLY**

**7. NEVER**

---

### 13.3 EVALUATE THE FREQUENCY OF THE SUPERVISION:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Excellent</th>
<th>Satisfactory</th>
<th>Somewhat</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. DAILY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. ONCE PER WEEK</td>
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<tr>
<td>3. TWICE PER WEEK</td>
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<tr>
<td>4. FORTNIGHTLY</td>
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<tr>
<td>5. ONCE A MONTH</td>
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<tr>
<td>6. QUARTERLY</td>
<td></td>
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<tr>
<td>7. NEVER</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
13.4. WERE YOU SATISFIED WITH THE AMOUNT OF SUPERVISION PROVIDED:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

B. IF NO, SPECIFY HOW OFTEN YOU WOULD HAVE PREFERRED THE SUPERVISION:

-----------------------------------------------------------------------------

-----------------------------------------------------------------------------

-----------------------------------------------------------------------------

-----------------------------------------------------------------------------
13.5 SPECIFY THE METHOD/S OF SUPERVISION USED:

(i) 

1. INDIVIDUAL SUPERVISION

2. GROUP SUPERVISION

3. ROLE PLAYS

4. CASE STUDIES

5. CASE NOTES, I.E. PROGRESS OR PROCESS REPORTS

6. SITTING IN AND OBSERVING, E.G. IN OR BEHIND THE ONE WAY MIRROR

7. AUDIOTAPE AND VIDEO RECORDING

8. COACHING, I.E. FROM BEHIND THE ONE WAY MIRROR

9. CO-WORKING IN PROJECT

10. PEER SUPERVISION

11. OTHER (SPECIFY BELOW)

(ii) SPECIFY, IF OTHER METHODS WERE USED:
13.6 EVALUATE THE APPROPRIATENESS OF THE METHODS USED:

<table>
<thead>
<tr>
<th>Method</th>
<th>Excelent</th>
<th>Satisfactory</th>
<th>Somewhat satisfactory</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. INDIVIDUAL SUPERVISION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. GROUP SUPERVISION</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>3. ROLE PLAYS</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4. CASE STUDIES</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5. CASE NOTES, I.E. PROCESS OR PROGRESS REPORTS</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>6. SITTING IN &amp; OBSERVING E.G. BEHIND ONE-WAY MIRROR</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>7. AUDIOTAPE &amp; VIDEO RECORDING</td>
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<tr>
<td>8. COACHING I.E. FROM BEHIND THE MIRROR</td>
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<tr>
<td>9. CO-WORKING IN PROJECT</td>
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<tr>
<td>10. PEER SUPERVISION</td>
<td></td>
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<tr>
<td>11. OTHER</td>
<td></td>
<td></td>
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</tbody>
</table>
13.7 WERE YOU SATISFIED WITH THE METHOD OF SUPERVISION USED:

A. 

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

B. IF NO, SPECIFY OTHER METHODS WHICH YOU WOULD HAVE PREFERRED:

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13.8 THE TYPE OF SUPERVISION OBTAINED:

A. Specify if you were assisted in the following areas:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

ADMINISTRATIVE, I.E. KEEPING RECORDS, STATISTICS, COMPLETING FORMS ETC.

SUPPORTIVE, I.E. BEING ABLE TO DISCUSS NEEDS, PROBLEMS, ANXIETIES & RECEIVING EMOTIONAL SUPPORT

EDUCATIONAL, I.E. GIVING GUIDANCE RE. SKILLS AND KNOWLEDGE
B. EVALUATE THE TYPE OF SUPERVISION RECEIVED:

<table>
<thead>
<tr>
<th></th>
<th>Excel-lent</th>
<th>Satisfactory</th>
<th>Somewhat Good</th>
<th>Weak</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ADMINISTRATIVE, I.E.</td>
<td>RECORDING, STATISTICS COMPLETING FORMS ETC.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. SUPPORTIVE, I.E. BEING ABLE TO DISCUSS YOUR NEEDS, PROBLEMS, ANXIETIES, ETC. AND RECEIVING EMOTIONAL SUPPORT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. EDUCATIONAL, I.E. GIVING GUIDANCE RE SKILLS &amp; KNOWLEDGE</td>
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</table>

14. SUGGESTIONS & RECOMMENDATIONS TO IMPROVE YOUR TRAINING IN ORDER TO ASSIST YOU IN THE TASK/PROJECT:

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APPENDIX 18

SELF-ADMINISTERED QUESTIONNAIRE

AN INVESTIGATION OF THE TRAINING OFFERED TO COMMUNITY-BASED REHABILITATION WORKERS WITH PARTICULAR REFERENCE TO THE FIELD OF MENTAL HANDICAP IN THE WESTERN CAPE
APPENDIX 18

PHASE 2

SELF-ADMINISTERED QUESTIONNAIRE

TITLE:

AN INVESTIGATION OF THE TRAINING OFFERED TO COMMUNITY-BASED REHABILITATION WORKERS WITH PARTICULAR REFERENCE TO THE FIELD OF MENTAL HANDICAP IN THE WESTERN CAPE.


DATA OBTAINED WILL BE TREATED AS HIGHLY CONFIDENTIAL.

RESEARCHER: I E DANIELS
1. IDENTIFYING DATA OF THE TRAINER

1.1 NAME:

1.2 AGE:

<table>
<thead>
<tr>
<th>25-30</th>
<th>31-35</th>
<th>36-40</th>
<th>41-45</th>
<th>46-50</th>
<th>51-55</th>
<th>56-60</th>
<th>65-70</th>
<th>OVER 70</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

1.3 MARITAL STATUS:

<table>
<thead>
<tr>
<th>SINGLE</th>
<th>MARRIED</th>
<th>DIVORCED</th>
<th>WIDOWED</th>
<th>CO-HABITING</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

1.4 HOME LANGUAGE:

1.5 ADDRESS:

Page 2/...
1.6 ORGANISATION EMPLOYED AT:


1.7 DATE OF EMPLOYMENT AS A TRAINER IN PRESENT PROJECT:


2. EDUCATIONAL LEVEL & QUALIFICATIONS OF THE TRAINER:

Indicate highest educational level passed.

2.1 NO EDUCATION

2.2 PRIMARY SCHOOL EDUCATION

Specify the standard last passed.

<table>
<thead>
<tr>
<th>SUB A</th>
<th>SUB B</th>
<th>STD 1</th>
<th>STD 2</th>
<th>STD 3</th>
<th>STD 4</th>
<th>STD 5</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.3 SECONDARY SCHOOL EDUCATION:

Specify the standard last passed.

<table>
<thead>
<tr>
<th>STD 6</th>
<th>STD 7</th>
<th>STD 8</th>
<th>STD 9</th>
<th>STD 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.4 TERTIARY EDUCATION:

Specify.

Name of College or University and Degree or Diploma obtained (e.g. University of the Western Cape, B.A. Social Science).

------------------------------------------------------

------------------------------------------------------

Page 4/...
2.5 OTHER:

3. COMMUNITY INVOLVEMENT & EXPERIENCE IN THE FIELD OF MENTAL HANDICAP:

3.1 INDICATE WHETHER YOU HAVE HAD PREVIOUS EXPERIENCE IN WORKING WITH THE MENTALLY HANDICAPPED BEFORE YOU BECAME A TRAINER.

| YES | NO |

3.2 IF YES, PLEASE LIST YOUR EXPERIENCE IN THE FIELD OF MENTAL HANDICAP:

(1) __________________________________________________________

(2) __________________________________________________________

(3) __________________________________________________________

(4) __________________________________________________________

(5) __________________________________________________________

(6) __________________________________________________________

(7) __________________________________________________________

3.2 INDICATE WHETHER THE EXPERIENCE IN THE FIELD AS LISTED ABOVE, WAS USEFUL IN YOUR ROLE AS TRAINER:

| YES | NO |
A. IF YES, PLEASE OUTLINE HOW THIS ASSISTED YOU:

B. IF NO, PLEASE OUTLINE REASONS:

3.3 (A) OUTLINE WHETHER YOU HAVE PREVIOUS EXPERIENCE AS A TRAINER OF COMMUNITY-BASED REHABILITATION WORKERS IN THE FIELD OF MENTAL HANDICAP.

| YES | NO |

(B) IF YES, PLEASE LIST YOUR PREVIOUS EXPERIENCE AS A TRAINER:

Page 6/...
3.4 (A) INDICATE WHETHER YOU ARE INVOLVED IN COMMUNITY ORGANISATIONS OR ACTIVITIES:

[ ] YES  [ ] NO

(B) IF YES, PLEASE STIPULATE THE ORGANISATIONS OR ACTIVITIES:

---
---
---
---
---

4. A DESCRIPTION OF THE PROJECT/S WITH WHICH THE TRAINER WAS ASSOCIATED:

4.1 LIST THE NUMBER OF COMMUNITY-BASED REHABILITATION WORKERS TRAINED, E.G. 1,8, ETC.

4.2 NAMES OF DIFFERENT PROJECTS FOR WHICH YOU WERE RESPONSIBLE FOR TRAINING THE COMMUNITY-BASED REHABILITATION WORKERS AND THE AREA IN WHICH THE PROJECT/S WERE BASED:

<table>
<thead>
<tr>
<th>A. NAMES OF PROJECT/S</th>
<th>B. AREA OF OPERATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
</tbody>
</table>

Page 7./...
<table>
<thead>
<tr>
<th>A. NAMES OF PROJECT/S</th>
<th>B. AREA OF OPERATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
</tr>
</tbody>
</table>

4.3 DESCRIBE THE FUNCTION OF THE COMMUNITY-BASED REHABILITATION WORKERS FOR EACH OF THE PROJECTS LISTED:

(You may attach job description or lists of functions).

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 

Page 8./...
5. TRAINING PERIOD/S USED:

5.1 (A) SPECIFY THE TRAINING PERIOD/S USED:

1. One to two days per week

2. Short block, e.g. 2 weeks/
   3 weeks or 4 weeks

3. Continuous training, e.g.
   2 to 3 months

4. Longer periods, e.g
   1 year or more

5. All of the above

6. Other

(B) SPECIFY, IF OTHER TRAINING PERIODS WERE USED:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Page 8/...
5.2 EVALUATE THE TRAINING PERIOD/S IMPLEMENTED:

<table>
<thead>
<tr>
<th>Excelent</th>
<th>Satisfactory</th>
<th>Somewhat</th>
<th>Unsatisfactory</th>
</tr>
</thead>
</table>

1. One to two days per week

2. Short block, e.g. 2 weeks/3 weeks or 4 weeks

3. Continuous training, e.g. 2 to 3 months

4. Longer periods, e.g. 1 year & more

5. Combination of all of the above

6. Other
5.3 Do you think it would have been better if other training periods were considered (e.g. two weeks instead of 1 day):

[YES] [NO]

5.4 Please specify the reasons for your answer:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

6. Place & Environment in which training took place:

6.1 (A) Specify the place(s) & environment in which training took place:

1. Village

2. Office

3. Lecture Theatre

4. Home of the Mentally Handicapped
5. HOSPITAL

6. CONFINES OF THE PROJECT

7. UNIVERSITY

8. COLLEGE

9. OTHER (SPECIFY)

6.1 (B) PLEASE INDICATE, IF OTHER PLACE/S OR ENVIRONMENTS WERE USED:

<table>
<thead>
<tr>
<th>Good</th>
<th>Satisfactory</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

6.2 EVALUATE THE APPROPRIATENESS OF THE TRAINING ENVIRONMENT:

1. VILLAGE

2. OFFICE

3. LECTURE THEATRE
<table>
<thead>
<tr>
<th>Good</th>
<th>Satisfactory</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. HOME OF THE MENTALLY HANDICAPPED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. HOSPITAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. CONFINES OF THE PROJECT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. UNIVERSITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. COLLEGE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. OTHER</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.3 DO YOU THINK IT WOULD HAVE BEEN BETTER IF OTHER PLACES WERE CHOSEN FOR TRAINING:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.4 PLEASE SPECIFY THE REASON FOR YOUR ANSWER:

------------------------------------------------------------------
------------------------------------------------------------------
------------------------------------------------------------------
------------------------------------------------------------------

Page 13./...
7.2 WERE THE COMMUNITY-BASED REHABILITATION WORKERS GIVEN AN OPPORTUNITY TO EVALUATE OR GIVE FEEDBACK ON AN ONGOING BASIS ABOUT YOUR TRAINING:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.3 IF YES, WERE THEIR SUGGESTIONS CONSIDERED:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.4 IF NO, WOULD YOU HAVE LIKED THEM TO GIVE (A) YOU FEEDBACK:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(B) PLEASE SPECIFY HOW THIS COULD BE MADE POSSIBLE:

-------------------------------------------------------------

-------------------------------------------------------------

-------------------------------------------------------------

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-------------------------------------------------------------

-------------------------------------------------------------

-------------------------------------------------------------

8. OUTLINE THE OBJECTIVE OF THE TRAINING PROGRAMME

8.1 (A) PLEASE LIST THE BROAD OBJECTIVES OF THE COURSE:

1. -------------------------------------------------------------

2. -------------------------------------------------------------

3. -------------------------------------------------------------

4. -------------------------------------------------------------

5. -------------------------------------------------------------

6. -------------------------------------------------------------

7. -------------------------------------------------------------

8. -------------------------------------------------------------

9. -------------------------------------------------------------

10. -------------------------------------------------------------
8.1 (B) INDICATE THE SPECIFIC SHORT-TERM OBJECTIVES OF THE COURSE:

1. 

2. 

3. 

4. 

5. 

6. 

7. 

8. 

9. 

10. 

8.2 (A) SPECIFY, WHETHER THE COMMUNITY-BASED REHABILITATION WORKER/S YOU TRAINED WERE AWARE OF OBJECTIVE, I.E. WHAT THEY WERE MEANT TO LEARN BY THE COURSE:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(B) IF YES, PLEASE SPECIFY WHETHER THIS ASSISTED YOU IN THE TRAINING:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(C) PLEASE OUTLINE THE REASONS FOR THE ABOVE:

1. _________________________________________________________________

2. _________________________________________________________________

3. _________________________________________________________________

4. _________________________________________________________________

5. _________________________________________________________________

6. _________________________________________________________________

7. _________________________________________________________________

8.3 (A) IF THE COMMUNITY-BASED REHABILITATION WORKER/S WERE NOT AWARE OF THE OBJECTIVES, PLEASE INDICATE WHETHER YOU WOULD HAVE PREFERRED THEM TO KNOW:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
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</tr>
</tbody>
</table>

Page 18/...
(B) ELABORATE ON YOUR REASONS FOR THE ABOVE:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
9. THEORETICAL MODELS CONSIDERED IN THE TRAINING:

9.1 (A) PLEASE INDICATE WHETHER YOUR TRAINING WAS GUIDED BY A PARTICULAR THEORETICAL MODEL:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

(B) IF YES, KINDLY DESCRIBE IN DETAIL THE THEORETICAL MODEL WHICH WAS USED:

---

---

---

---

---

---

9.2 (A) OUTLINE WHETHER THE THEORETICAL MODEL/S USED WERE MODIFIED IN ANY WAY:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

Page 20/...
(B) IF YES, KINDLY INDICATE HOW THIS WAS DONE:

Advantages:

1. 

2. 

3. 

4. 

5. 

9.3 INDICATE THE ADVANTAGES AND DISADVANTAGES OF THE THEORETICAL MODEL USED:

Advantages:
Disadvantages:

1. 

2. 

3. 

4. 

5. 

10. COURSE CONTENT & AREA FOCUSED ON:

10.1 PLEASE PROVIDE AN OUTLINE OF YOUR COURSE CONTENT BELOW OR ADD IT AS AN APPENDIX TO THE RESEARCH DOCUMENT:

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________
10.2 (A) NOW THAT THE COMMUNITY-BASED REHABILITATION WORKERS HAVE BEEN INVOLVED WITH THEIR PROJECTS, HAS THE COURSE CONTENT ASSISTED THEM IN THEIR TASKS:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>BOTH</th>
</tr>
</thead>
</table>

(B) (PLEASE ANSWER B1 AND B2 IF BOTH WAS TICKED OFF)

B.1 IF YES, PLEASE INDICATE HOW IT HELPED THE COMMUNITY-BASED REHABILITATION WORKERS IN THEIR TASKS:

1. -------------------------------------------------------------
2. -------------------------------------------------------------
3. -------------------------------------------------------------
4. -------------------------------------------------------------
5. -------------------------------------------------------------
6. -------------------------------------------------------------
7. -------------------------------------------------------------
8. -------------------------------------------------------------
B.2 IF NO, PLEASE INDICATE WHY THE CONTENT TAUGHT WAS NOT HELPFUL TO THE COMMUNITY-BASED REHABILITATION WORKERS:

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 

10.3 PLEASE EVALUATE THE OVERALL CONTENT PRESENTED:

1. TOO SOPHISTICATED
2. TOO SIMPLISTIC
3. EXCELLENT
4. GOOD
5. SATISFACTORY
6. SOMewhat WeAK

7. TOTALLY INAPPROPRIATE & UNSATISFACTORY

10.4 PLEASE ELABORATE ON YOUR ANSWER/S ABOVE :

-----------------------------------------------------------------

-----------------------------------------------------------------

-----------------------------------------------------------------

-----------------------------------------------------------------

-----------------------------------------------------------------

-----------------------------------------------------------------

10.5 IF YOU WERE GIVEN AN OPPORTUNITY TO RESTRUCTURE YOUR COURSE CONTENT, HOW WOULD YOU OUTLINE THIS (PLEASE GIVE A FICTITIOUS COURSE OUTLINE BELOW) :

-----------------------------------------------------------------

-----------------------------------------------------------------

-----------------------------------------------------------------

-----------------------------------------------------------------

-----------------------------------------------------------------

Page 25./...
10.6 (A) WERE THE COMMUNITY-BASED REHABILITATION WORKERS GIVEN AN OPPORTUNITY TO EVALUATE THE COURSE CONTENT:

YES | NO
---|---

(B) IF YES, WHAT WERE THEIR COMMENTS OR SUGGESTIONS:

1. ____________________________________________________________
2. ____________________________________________________________
3. ____________________________________________________________
4. ____________________________________________________________
5. ____________________________________________________________

(C) IF NO, COULD YOU LIST THE REASON/S FOR THIS:

1. ____________________________________________________________
2. ____________________________________________________________
3. ____________________________________________________________
4. ____________________________________________________________
5. ____________________________________________________________
10.7 (A) INDICATE, WHETHER THE COMMENTS OR SUGGESTIONS WERE CONSIDERED AND INCLUDED IN THE COURSE CONTENT:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

(B) PLEASE ELABORATE ON THE REASON/S FOR YOUR ANSWER:

---------------------------------------------------------------------
---------------------------------------------------------------------
---------------------------------------------------------------------
---------------------------------------------------------------------
---------------------------------------------------------------------
---------------------------------------------------------------------
---------------------------------------------------------------------
---------------------------------------------------------------------
---------------------------------------------------------------------
11. TRAINING METHODS USED:

11.1 (A) PLEASE SPECIFY WHICH TRAINING METHODS WERE USED:

1. FORMAL LECTURES

2. GROUP DISCUSSIONS

3. FIELD VISITS

4. PARTICIPATIVE ACTIVITIES
   E.G. ROLE-PLAYS, GAMES, FIELD EXPERIMENT

5. OBSERVATIONAL

6. WORKSHOPS

7. GUEST SPEAKERS

8. OTHER (SPECIFY)

(B) SPECIFY WHICH OTHER TRAINING METHODS WERE USED:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
11.2 EVALUATE THE TRAINING METHODS USED:

<table>
<thead>
<tr>
<th></th>
<th>Excelent</th>
<th>Satisfactory</th>
<th>Somewhat satisfactory</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. FORMAL LECTURES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. GROUP DISCUSSIONS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. FIELD VISITS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. PARTICIPATIVE ACTIVITIES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.G. ROLE-PLAYS, GAMES, FIELD EXPERIMENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. OBSERVATIONAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. WORKSHOPS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. GUEST SPEAKERS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. OTHER (SPECIFY)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11.3 (A) COULD YOU SUGGEST OTHER TRAINING METHODS CONSIDERING THE BACKGROUND OF THE COMMUNITY-BASED REHABILITATION WORKER/S:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11.3 (B) IF YES, PLEASE IDENTIFY THESE:

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12. TRAINING MATERIALS OR AIDS:

12.1 (A) PLEASE SPECIFY THE TRAINING MATERIALS OR AID USED:

1. Flannel Boards
2. Black Boards
3. Videos
4. Films
5. Posters
6. Cards
7. Slides
8. Photo's
9. Books
10. Drawings
11. Flip Charts
12. Other (Specify)

(B) SPECIFY WHAT OTHER MATERIALS OR AIDS WERE USED:

1. 
2. 

Page 31/...
12.2 EVALUATE THE MATERIALS OR AIDS USED TO TRAIN:

<table>
<thead>
<tr>
<th>Excel-</th>
<th>Satis-</th>
<th>Somewhat</th>
<th>Unsatis-</th>
</tr>
</thead>
<tbody>
<tr>
<td>lent</td>
<td>Good</td>
<td>factory</td>
<td>factory</td>
</tr>
</tbody>
</table>

1. FLANNEL BOARDS
2. BLACK BOARDS
3. VIDEOS
4. FILMS
5. POSTERS
6. CARDS
7. SLIDES
8. PHOTO’S
9. BOOKS
10. DRAWINGS
11. FLIP CHARTS
12. OTHER 1.
2.
12. OTHER

1. Could you suggest other more useful materials and aids which could have been used:

<table>
<thead>
<tr>
<th>Excelent</th>
<th>Good</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Somewhat Unsatisfactory</td>
</tr>
</tbody>
</table>

2. Weak factory
13. NATURE AND TYPE OF SUPERVISION

31.1 (A) INDICATE WHETHER THE TRAINEES WERE SUPERVISED:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(B) IF YES, PLEASE SPECIFY BY WHOM:

------------------------------------------------------------------------------------------------------------------
------------------------------------------------------------------------------------------------------------------
------------------------------------------------------------------------------------------------------------------
------------------------------------------------------------------------------------------------------------------
------------------------------------------------------------------------------------------------------------------

13.2 INDICATE WHETHER THE TRAINEE/S WERE SUPERVISED:

DURING TRAINING [ ]

DURING PRACTICE [ ]

SIMULTANEOUSLY [ ]
13.3 INDICATE HOW OFTEN SUPERVISION WAS IMPLEMENTED:

1. DAILY
2. ONCE PER WEEK
3. TWICE PER WEEK
4. FORTNIGHTLY
5. ONCE A MONTH
6. QUARTERLY
7. NEVER

13.4 EVALUATE THE FREQUENCY OF THE SUPERVISION:

<table>
<thead>
<tr>
<th>Excelent</th>
<th>Satisfactory</th>
<th>Somewhat</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. DAILY   |              |          |                |
|          |              |          |                |
2. ONCE PER WEEK |       |          |                |
|          |              |          |                |
3. TWICE PER WEEK |     |          |                |
|          |              |          |                |
4. FORTNIGHTLY |      |          |                |
<p>| | | | |
|          |              |          |                |</p>
<table>
<thead>
<tr>
<th>Excel-</th>
<th>Satis-</th>
<th>Somewhat</th>
<th>Unsatis-</th>
</tr>
</thead>
<tbody>
<tr>
<td>lent</td>
<td>Good</td>
<td>factory</td>
<td>factory</td>
</tr>
</tbody>
</table>

5. ONCE PER MONTH

6. QUARTERLY

7. NEVER

13.5 (A) WERE YOU SATISFIED WITH THE AMOUNT OF SUPERVISION PROVIDED:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

(B) IF NO, SPECIFY HOW OFTEN SUPERVISION IS REQUIRED:

---------------------------------------------------------------------------------------------------
---------------------------------------------------------------------------------------------------
---------------------------------------------------------------------------------------------------
---------------------------------------------------------------------------------------------------
13.6 (A) SPECIFY THE METHOD/S OF SUPERVISION USED:

1. INDIVIDUAL

2. GROUP

3. ROLE PLAYS

4. CASE STUDIES

5. CASE NOTES, I.E. PROGRESS OR PROCESS

6. SITTING IN AND OBSERVING, E.G. IN OR BEHIND THE ONE WAY MIRROR

7. AUDIOTAPE AND VIDEO RECORDING

8. COACHING, I.E. FROM BEHIND THE ONE WAY MIRROR

9. CO-WORKING IN PROJECT

10. PEER SUPERVISION

11. OTHER

(B) SPECIFY, IF OTHER METHODS WERE USED:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Page 37/...
13.7 EVALUATE THE APPROPRIATENESS OF THE METHODS USED:

<table>
<thead>
<tr>
<th>Excel-</th>
<th>Satis-</th>
<th>Somewhat</th>
<th>Unsatis-</th>
</tr>
</thead>
<tbody>
<tr>
<td>lent</td>
<td>factory</td>
<td>Weak</td>
<td>factory</td>
</tr>
</tbody>
</table>

1. INDIVIDUAL

2. GROUP

3. ROLE

4. CASE STUDIES

5. CASE NOTES, I.E. PROCESS OR PROGRESS

6. SITTING IN & OBSERVING

7. AUDIOTAPE & VIDEO RECORDING

8. COACHING

9. CO-WORKING IN PROJECT

10. PEER SUPERVISION

11. OTHER 1.

2.

3.

4.

5.
13.8 IN RETROSPECT, COULD YOU LIST OTHER MORE APPROPRIATE METHODS OF SUPERVISION WHICH COULD HAVE BEEN CONSIDERED:


13.9 THE TYPE OF SUPERVISION PROVIDED:

Specify whether you assisted the community-based rehabilitation worker in the following areas:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>ADMINISTRATIVE, I.E. KEEPING RECORDS, STATISTICS, COMPLETING FORMS ETC.</td>
<td></td>
</tr>
<tr>
<td>SUPPORTIVE, I.E. BEING ABLE TO DISCUSS NEEDS, PROBLEMS, ANXieties &amp; PROVIDING EMOTIONAL SUPPORT</td>
<td></td>
</tr>
<tr>
<td>EDUCATIONAL, I.E. GIVING GUIDANCE RE SKILLS AND KNOWLEDGE</td>
<td></td>
</tr>
</tbody>
</table>
13.10 EVALUATE THE TYPE OF SUPERVISION PROVIDED:

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<tr>
<th>Excel-</th>
<th>Satis-</th>
<th>Somewhat</th>
<th>Unsatis-</th>
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<tbody>
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<td>lent</td>
<td>factory</td>
<td>Weak</td>
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<thead>
<tr>
<th>ADMINISTRATIVE, I.E. RECORDING, STATISTICS COMPLETING FORMS ETC.</th>
</tr>
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<thead>
<tr>
<th>SUPPORTIVE, I.E. BEING ABLE TO DISCUSS YOUR NEEDS, PROBLEMS, ANXIETIES, EMOTIONAL SUPPORT ETC.</th>
</tr>
</thead>
</table>

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<thead>
<tr>
<th>EDUCATIONAL, I.E. GIVING GUIDANCE RE SKILLS &amp; KNOWLEDGE</th>
</tr>
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14. SUGGESTIONS & RECOMMENDATIONS TO IMPROVE THE TRAINING OF COMMUNITY-BASED REHABILITATION WORKERS IN THEIR FUNCTION/S:

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