SUPERVISION OF QUALIFIED COMMUNITY REHABILITATION WORKERS

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ABSTRACT: *Supervisors of Community Rehabilitation Workers (CRWs) have a critical role to play in supporting and developing the skills and effectiveness of CRWs. This paper reports on research conducted by the Wits/Tintswalo Community Rehabilitation, Research and Education (CORRE) Programme amongst past and present supervisors of qualified CRWs. The aim was to understand different approaches used in supervision, the problems encountered and possible solutions, and the perceived impact of CRWs within rehabilitation services.*

Thirteen supervisors of qualified CRWs completed a postal or hand delivered questionnaire, which contained a range of open-ended and semi-structured questions. The findings included the supervision activities, the problems around supervision and the benefit of a CRW service. The need for community based rehabilitation (CBR) practice protocols and standards was highlighted.

These findings were one of a series of steps towards the development of a CBR management manual for the Northern Province.

KEY WORDS: SUPERVISION, COMMUNITY REHABILITATION WORKERS (CRW'S), COMMUNITY BASED REHABILITATION (CBR), WITS/TINTSWALO COMMUNITY REHABILITATION, RESEARCH AND EDUCATION PROGRAMME (CORRE)

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

INTRODUCTION

The Wits-Tintswalo Community Rehabilitation, Research and Education (CORRE) Programme (previously the Wits-Tintswalo Community Rehabilitation Worker Training Programme (CRWTP)) started training community rehabilitation workers (CRWs) in partnership with the Gazankulu and later the Northern Province governments in 1991 (Concha, 1993). This was done in response to a dire need for rehabilitation services in rural areas (Concha, 1993). The CRWs work in the community (offering a service at people with disabilities' homes and in their rural villages) as part of the rehabilitation team of the local hospital or non-governmental organisation, thus helping to improve rehabilitation service provision (Homer and Hoffman, 1999). They receive regular supervision by therapists from the local hospital. At the time of the study, there were 52 qualified CRWs, each covering between one and four rural villages, mostly in the Northern Province, with a few in Mpumalanga, Lesotho and Swaziland.

Supervision of CRWs is necessary, as these workers need support, links with the hospital and upgrading of skills (Schneider, 1996). Hoffman (1992) emphasises the threefold role of the supervisor as being administrative, educational and supportive. Newly qualified therapists are often, however, not skilled as supervisors of support staff (Homer and Hoffman, 1999).

In order to equip supervising therapists for their role, CORRE has provided a series of seven workshops to train these supervisors of student CRWs since 1993 (Evans, 1997). Seven workshops for the supervisors of qualified CRWs have since also been conducted.

The study aimed to establish the supervisors' perceptions on supervising CRWs. It served as input into the development of guidelines and protocols for CRW supervision in the Northern Province, and to guide the newly appointed community based rehabilitation (CBR) manager.

METHOD

In February 1998 a questionnaire was distributed to 41 past and present supervisors of qualified CRWs (all the supervisors the authors could trace) who had supervised from 1993 to 1998.

The questionnaire was developed as follows: The authors (three with experience in the supervision of qualified CRWs and one a statistician) drew up a preliminary questionnaire, that attempted to establish the perceptions of the supervising therapists on supervision of CRWs. This questionnaire was then given to two therapists who supervise qualified CRWs to complete and comment on, as a pilot study. The final questionnaire then included the changes they suggested.

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The following areas were covered in the questionnaire:

1. Professional training and work experience of the supervisors
2. Supervision experience and training
3. Current supervision practice
4. Benefits of CRWs to the service and for the respondents
5. Problems of supervision
6. Current support for and requirements of supervisors

The questionnaire contained close-ended, open-ended, semi-open and filter questions. The information sought by each of these types of questions can be found in Table 1.

A five-point ordinal scale was used to capture frequency of activities (Table 1).

The questionnaire contained an explanation of how the five point ordinal scale should be used to answer the questions and gave an example. Each question had the scale (five blocks) next to it and the respondents had to tick one of the blocks. The five categories used in the scale were "always", "most of the time/often", "sometimes (about half the time)", "rarely" and "never". As both ends of the scale contained important information, the authors grouped the results of the categories "rarely" and "never" together and also the categories of "most of the time/often" and "always" together for data analysis. The authors thus reflected the results on either end of the scale.

RESULTS

Professional training and work experience of the supervisors

Thirteen (32%) of the supervisors of qualified CWRs responded, three (23%) were physiotherapists, three (23%) were community speech and hearing workers, one (8%) was a primary health care administrator and one (8%) was a community nutritionist. All the respondents had qualified as professionals at least 5 years previously and most were female (n = 11 (85%)).

Supervision experience and training

The most frequently given reason for becoming a supervisor (n = 5 (38%)) was that the supervision of CRWs is part of a therapist's job description in the Northern Province. Just over half (n = 7 (54%)) of the respondents had been supervising CRWs for less than one year. Seven respondents (54%) had training on supervising qualified CRWs, all this at CORRE. One supervisor (8%) had also received undergraduate training in CRW supervision.

Current supervision practice

Ten (77%) of the respondents were supervising CRWs at that stage. Of the three (23%) that were not, one (8%) did not give a reason, one (8%) had only supervised while the local hospital had a therapist shortage and the other (n = 1 (8%)) had CRWs who refused supervision. The number of CRWs each supervisor saw varied from two to six (mean = 3,7). Most respondents (n = 8 (62%)) visited their CRWs at least once a month. In most cases (n = 9 (69%)) the supervision was regular and did not only happen in response to the CRW asking for help. Respondents spent between 2 and 18 days (mean = 6,5 days) working in the community (ie. out of the hospital, in rural villages) each month.

TABLE 1. Information obtained from the questionnaire using open-ended, semi-open and filter questions and a five point ordinal scale

Open-ended	How the respondent became a supervisor of qualified CRWs What the respondent had gained from supervision How supervision problems could be solved Supervision skills still felt to be lacking The explanations of the answers given on the amount of support the respondent received from the superintendent, the provincial head office and CORRE Aspects the respondent wanted the CBR manager to help with
Semi-open	The five most important benefits of having CRWs in the respondent's rehabilitation service The five biggest problems he/she had with the supervision of qualified CRWs
Filter questions	If the respondent supervised qualified CRWs at that time Whether the respondent would encourage others in his/ her profession to also become CRW supervisors Whether any training on supervising qualified CRWs had been received Whether special supervision forms were being used Whether the respondent wanted CORRE to run workshops on supervising qualified CRWs (all of the above had sub-questions which had to be completed depending on whether the answer was YES or NO)
Five point ordinal scale	Various activities used during supervision Whether the CRWs work in the community and keep statistics on client- related and additional activities The CRWs' various responses to supervision

TABLE 2. Activities that happen most of the time or always during CRW supervision (ratings obtained using a five point ordinal scale)

ACTIVITIES	N*	%
Giving emotional support and encouragement to the CRW	12	92
Supervising in the CRW's village	10	77
Helping the CRW with therapy for clients	9	69
Observing the CRW working with clients	8	62
Going through administration	8	62
Problem solving	7	58
Improving the CRWs therapy skills	7	54
Transporting CRWs to distant clients	7	54
Individual work with one CRW in his/ her own village, rather than supervising a group of CRWs at once	6	46

* N = number of supervisors

TABLE 3. Desirable activities that happen rarely or never during qualified CRW supervision (ratings obtained using a five point ordinal scale)

ACTIVITIES	N*	%
Rarely or never liaising with the CRW and community leadership on CBR programme implementation	11	85
Rarely or never giving lectures/ workshops to CRWs on work-related topics during supervision	9	69
Rarely or never seeing the CRWs work with a group during supervision	8	62
Rarely or never improving the CRW's group skills	7	54
Rarely or never working with a small group of CRWs during supervision	7	54

* N = number of supervisors

The activities reported to happen most of the time or always during supervision can be seen in Table 2.

The majority of respondents said they rarely or never supervised their CRWs in the hospital (n = 12 (92%)). However, when asked how many supervision sessions would happen in the hospital in a three month period, eight respondents (62%) indicated that they would have one to three sessions.

Desirable supervision activities that rarely or never occurred during supervision are listed in Table 3.

All of the respondents (n = 13 (100%)) stated that their CRWs worked in the community always or most of the time. Two respondents (15%) remarked that their CRWs were hospital based, while one (8%) said that despite this fact, supervision would always happen in the community.

Eleven of the respondents (85 %) said that the CRWs kept client statistics always or most of the time. Only six respondents (46 %) were sure that the statistics were accurate. Eight of the respondents (62%) said that the CRWs kept statistics of other activities apart from client care, seven (54%) of whom thought these statistics were accurate.

The overall response to supervision was good: Twelve (92%) of the respondents stated that the CRWs were often or always ready for the supervisors at the correct time and place. Ten (77%) said that the CRWs often or always prepared clients for supervision, that they thanked supervisors for the supervision given and that they never refused supervision. Nine (69%) agreed that the CRWs were never resistant to supervision and that they often or always prepared questions in advance.

Benefits of CRWs to the service and for the respondents

The supervisors were very positive about supervision, as all but one (n = 12 (92%)) would encourage others in their profession to also become CRW supervisors. They gave many benefits of having CRWs for the service and for themselves, the most frequently mentioned of which can be seen in Table 4. The personal benefits most often mentioned by the supervisors were the associated learning and improvement of the supervisors' skills.

Problems of supervision

The main problems associated with supervising qualified CRWs and some solutions are given in Table 5.

Current support for and requirements of supervisors

Only five (39%) of the respondents felt that their superintendent gave them adequate emotional and organisational support, and four (31%) said that they received enough financial support.

Only five (39%) of the respondents felt that the provincial head office gave them adequate emotional support, while three (23%) felt that they got sufficient financial and organisational support.

The majority of the therapists felt that CORRE gave them adequate organisational support (n = 9 (69%)) and emotional support (n = 8 (62%)). All the respondents indicated that they would like CORRE to run workshops on supervising qualified CRWs, preferably annually or biannually.

The respondents requested the CBR manager to help them with a wide variety of aspects, the most frequently mentioned being help in setting up standards/protocols for the CRWs' work (n = 8 (30 % of the 27 requests)), including topics such as forms and duty sheets, work ethics, responsibility, accountability and promotion.

DISCUSSION

In spite of the low response rate in this study, which is one of its weaknesses, interesting trends can be seen: Most of the supervisors were from the three therapy professions (occupational therapy, physiotherapy and speech therapy),

TABLE 4. The benefits of having CRW's in the rehabilitation service and for the supervisor (summary of responses to a semi-open and an open -ended question)

BENEFIT	N*	%
Increased rehabilitation service provision	15**	6,3
The presence of CRWs enhances multi-disciplinary teamwork and skills, knowledge and understanding of all team members	13	14,1
Reduced community work load for hospital-based therapists and better referrals and follow-ups	7	7,6
Better awareness of disability, its causes and prevention and better acceptance of people with disabilities in the community	5	5,4
Empowerment of people with disabilities/ social problems associated with disability are addressed	5	5,4
CRWs refer clients to the therapists/ hospital and make them aware of specific community needs	4	4,3
The CRWs' knowledge of local culture and their community makes the service more acceptable	4	4,3
People are given hope/ encouragement that something can be done to help them	3	3,3
Supervisors gained knowledge about the CRW's profession, their impressive scope of work and how they access people with disabilities in the community	3	3,3
Supervisors gained experience about values in South Africa, local culture, customs, geography, beliefs and needs	3	3,3
Supervisors gained supervision skills: e.g. to ensure that the CRW uses different ways/ simple language for getting information from the client and to know how clean, neat and complete a CRW's work should be	3	3,3
Other	27	29,3
TOTAL	**92**	**100**

* N = number of responses; the 13 respondents gave a total of 92 responses

** 15 responses fitted this category, i.e. some of the 13 respondents gave more than one response in this category

which reflects the multi-disciplinary training of the CRWs (Concha, 1993). Although they were experienced therapists, they were less experienced with CRW supervision. This is due to rapid staff turnovers at rural hospitals, the appointment of staff in previously unoccupied posts and some of the long-standing supervisors not returning the questionnaires. Just over half of the respondents had received training on supervising qualified CRW's.

The respondents stated clearly that CRWs were beneficial, as they helped to improve the rehabilitation service provision. The therapists' community work load was lightened and the community made more aware of disability, its causes and prevention and how to integrate and empower people with disabilities. The CRWs served to enhance multi-disciplinary team work, which is in line with the observation of Homer and Hoffman (1999). They acted as a go-between between hospitals and clients, by making hospital staff more aware of the clients' needs and by referring clients and making the clients more aware of what hospital services are available. Supervising CRWs helped to improve the supervisors' skills and knowledge of disability, as well as their understanding of local customs and beliefs.

Although the questionnaire did not contain an initial open-ended question on what supervision was understood to be (a possible shortcoming), the authors are confident that the list of supervision activities that had to be rated was comprehensive, as it had been developed in consultation with supervisors. Supervision given included elements of administration, education and support (Hoffman, 1992). The respondents' emphasis on their supportive role is in line with the finding that CRWs experience considerable amounts of stress due to their isolated work environment, where they lack resources (Kromberg et al, 1999), and therefore need emotional support and encouragement. Although supervision aspects such as administration and educational activities were included, one would have expected a larger than reported emphasis on administrative tasks, problem solving and improving the CRWs' therapy skills during supervision, as these are some of the essential elements, which CORRE emphasises during the training of the supervisors of student CRWs.

CRWs have to keep daily client and personal statistics like any other government employed health worker. Their supervising therapists have to check these and hand them in to Northern Province head office every month. The CRWs' monthly statistics are very important monitoring, planning and evaluation tools and have been analysed as part of an evaluation of the effectiveness of CRWs before (Dolan et al, 1995). The present findings that not all supervisors were convinced that the statistics were being done or being done accurately, suggests that some of the supervisors possibly don't check the statistics regularly or that the CRWs need further in-service training in the necessity for and the method of doing statistics.

The CRWs that were being supervised by the respondents worked in the community (i.e. in the rural villages

TABLE 5. Main problems encountered with supervising qualified CRW's and suggested solutions (summary of responses to an open-ended question)

PROBLEM	N*	%	SOLUTION
Supervisor doesn't have enough time to supervise fully (e.g. the only therapist in the hospital with a lot of hospital work)	6	14,3	Do not train more CRWs than the rehabilitation team of that hospital can realistically supervise, as it is unlikely that more professional staff will be recruited. Advance planning and regular date setting to ensure supervision time is given high priority.
Lack of transport (shortage of hospital cars for therapists to get to the CRWs/ CRWs don't have transport and therefore don't see enough clients)	6	14,3	I don't know. A transport allowance **must** be worked out which the CBR manager can help with. Motivate for better transport and gain increased support for supervision from hospital superintendent, region and province.
CRWs resent supervision/ suspicion/ see themselves a professionals who don't need supervision	3	7,1	This may just require time and getting to know the CRWs better. Make sure receiving continual supervision is part of the job description. Prepare the CRW students for the fact that they will always be receiving supervision when qualified. Regular supervision. Tutors of the CRW training programme to communicate directly with the CRWs (not through the supervisors) so they can make independent decisions and feel qualified.
No budget for CRWs and lack of stationary/ photocopying facilities as provincial government is bankrupt	3	7,1	Apply pressure at hospital level to motivate for a budget. CRWs need their own budget for stationary and equipment. The hospital doesn't even have money for therapy departments. Increase pressure at provincial level to ensure that CRWs are considered when budgets are being drawn up and allocated.
Actually taking the step to get started formally, the supervisor not making time to get through the forms/ handouts to familiarise herself with them and not understanding the mechanism of supervision	3	7,1	A formal induction in supervising qualified CRWs to new therapists, especially if they come from another country (a pile of forms to go through is not helpful, half a day with someone from the training programme would be more helpful). Head office to encourage new therapists to spend a day observing another therapist doing supervision.
No agreed standards against which performance can be monitored/ difficulty monitoring CRWs (what are they doing/ work quality/ how much work)	2	4,8	Literature search, research, local negotiation. Monitoring may just require time and getting to know the CRWs better.
CRWs are not completing paper work properly so they are difficult to promote	2	4,8	Supervisors to improve their own supervision and paperwork and motivate the CRWs to do the same
CRWs don't understand professional etiquette, responsibility and accountability/ have a poor work ethic	2	4,8	Work for registration with the Health Professions Council of South Africa
Other	15	36	Other
TOTAL	**42**	**100**	**TOTAL**

* N = number of responses; the 13 respondents gave a total of 42 responses

where they live and in villages close by) most of the time and were being supervised in their villages and not in the hospital, in line with what they and their supervisors had been taught during student CRW training. This practice is advocated by the World Health Organisation (1994), as it helps to ensure that a community based service is delivered. Some parts of supervision such as checking administrative planning and statistics can, however, be done at

hospital, perhaps at a time when the CRWs have to come to hospital for a rehabilitation meeting. It is, however, of concern that some CRWs were hospital based, although they seemed to be working in the community most of the time.

Another area for concern was that some important elements of practice, such as community liaison and group work (working with support groups or groups for health promotion/disability awareness) were not emphasised during supervision. The CRWs need to be helped to improve these skills, as these form an integral part of CBR (O'Toole, 1991). Group work and community liaison are difficult activities and this is where CRWs need support (O'Toole, 1991; Peat, 1997). Supervising therapists may not feel comfortable with community development activities if they have not received training in these areas, but, if therapy skills alone are monitored, the community development aspect of the CRWs' task (such as gardening, health promotion, participatory rural appraisal techniques and the action - reflection method) will fall away. Further training in community development and CBR for therapists (Peat, 1997; Schneider, 1996), as well as learning from CRWs, are possible solutions.

Supervision of CRWs was in process in all the areas covered by the respondent group, except for one, a non-governmental organisation, where the CRWs did not want to be supervised. This is a concern, as without supervision any CBR programme may fail (Taukobong, 1999). Receiving supervision is part of the CRWs' scope of practice. Although the CRWs' overall response to supervision was positive, resentment or suspicion about supervision was reported by three supervisors. This may come about if supervision is not regular or if there is a poor relationship between the supervisor and the CRW. Whilst a recently qualified CRW will accept close supervision, a more experienced CRW who has had supervision for many years may see close supervision as a lack of trust. The experienced CRW still needs supervision, but in a way that gives her some form of recognition for her experience (Vanneste, unpublished), perhaps by putting the emphasis on the supervisor's supportive role. Resistance to supervision can be overcome by combined CRW and supervisors workshops on supervision, such as a provincial workshop held in 1998 in Pietersburg. Local meetings within rehabilitation teams can also help to rebuild trust and re-instate regular supervision.

Supervision of qualified CRWs required a considerable time-commitment. As most supervisors were in hospital posts, they had to carefully balance the time spent in the hospital and in the community, in order to be able to deliver the best possible service. Lack of time for supervision is a very commonly described problem within the health sector (Jung and Tryssenaar, 1998). However, by making CRW supervision a priority, a therapist has a wider impact on disability prevention and rehabilitation than simply dealing with one client at a time at a hospital level (Homer and Hoffman, 1999).

The lack of a CRW budget and resources was a widely felt problem. Lack of transport, particularly to reach the CRWs' villages, is a problem in many parts of the world (Rehabilitation World Health Organisation, 1994). According to the white paper for the transformation of the health system in South Africa all health professionals should serve all the people in their catchment areas, not only clients attending hospitals (Department of Health, 1997). The allocation of hospital vehicles to therapists for supervision visits should therefore be a high priority. The rehabilitation staff in an area of Kwazulu-Natal have solved this problem by fundraising for a CBR vehicle, which they now use for supervision. Transport can in many cases be shared (Rehabilitation World Health Organisation, 1994), e.g. the therapist could go out to the CRW's village with a mobile clinic and continue the supervision on foot. Vanneste (unpublished) used bicycles and motorcycles for CRWs and supervisors in Rwanda.

Supervisors need support because of the various stress-evoking aspects of supervision. A key time for support is during transition into the role of a supervisor (Homer and Hoffman, 1999). More support for the supervisors of CRWs is needed from superintendents and provincial head office. Superintendents would benefit from more exposure to and updates on the work of their CRWs. The provincial head office needs to define a strategy for offering more support to supervisors. CORRE offers a lot of support to the supervisors of CRW students (Homer and Hoffman, 1999), but less to supervisors of qualified CRWs, thinking that supervisors would continue in their role after the CRW student qualified and provide in-service training for new supervisors. Some supervisors who were not involved in student CRW training recognised their own lack of knowledge about CBR and requested orientation.

The results of the study showed a need for standards and protocols to guide the CRWs' work. During student training, CORRE defines the roles of supervisors and students. Student supervisors attend a transitional supervisors workshop that looks at the role of qualified CRWs and supervisors. When this research was conducted, supervision was largely determined by the local hospitals, hence the need for provincial protocols. The process of developing a CBR management manual (containing monitoring documents to address standards and protocols, based on a system used in Rwanda (Vanneste, unpublished)) had been started in 1996 and a CBR manager was appointed towards the end of 1997. It was established that compliance with the existing management guidelines was poor, possibly because there had not been a CBR manager to drive the process and not everyone had felt part of it. A new task team including all stakeholders was formed. This group planned and ran a workshop in 1998, designed to use existing documents and the experience of stakeholders as tools to produce workable, acceptable CBR management guidelines. After further discussions and amendments by the designated task team, the workshop agreements were compiled as the Northern Province CBR management manual (1998). This manual was implemented in August 1998, and following a two year trial period an evaluation is now required.

RECOMMENDATIONS

More emphasis should be placed on community development, group work and checking the CRWs' administration (including statistics) during supervision. Supervisors also need further training in community development and CBR. Realistic human resource planning, including limiting the number of CRWs trained to the amount of supervision available in an area can help to keep the supervision load manageable. Supervising therapists should continuing lobbying the support of their superintendent in terms of the provision of a CBR budget and resources, such as transport. Practical measures such as supervising small groups of CRWs at the same time may also help to reduce the driving load and expenses. CRWs and supervisors can fundraise for resources. The provincial head office needs to offer more support to supervisors of CRWs. In addition, more workshops for supervisors of qualified CRWs and support for new supervisors are strongly recommended.

CONCLUSION

The supervisors of CRWs saw many benefits of having CRWs as part of the rehabilitation team. Supervision of qualified CRWs was in place and despite some problems experienced, the supervisors were positive about it. Supervisors of qualified CRWs would like to have more supervisors workshops and requested help from the CBR manager. The CBR manager's post was filled for one year, after which funding for the post stopped. Negotiations are under way at present to establish a CBR management team or to appoint a CBR manager in a Northern Province post. It is clearly apparent that the supervisors of qualified CRWs continue needing support, due to the multi-skilled nature of this task. The CBR management team/ manager could provide some of this support.

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REFERENCES

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

Department of Health 1997 White paper for the transformation of the health system in South Africa, pp 13, 36. Republic of South Africa, Government Gazette 382(17910), Notice 667 of 1997: Government Printers, Pretoria

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

Evans R 1997 Bushbuckridge locals train to assist disabled: The Wits/ Tintswalo CRW Training Programme. In Focus Forum 4: 32 - 36

Hoffman W 1992 Field practice education. HAUM publishers, Pretoria

Homer S, Hoffman W 1999 Clinician and tutor: an educational partnership. South African Journal of Occupational Therapy 29: 3 - 6

Jung B, Tryssenaar J 1998 Supervising students: Exploring the experience through reflective journals. Occupational Therapy International 5: 35 - 48

Kromberg GJR, Crouch RB, Homer S, Zwane E 1998 Stress and the community rehabilitation worker. South African Journal of Occupational Therapy 28: 6 - 8

Northern Province Task Team on Community Based Rehabilitation 1998 Northern Province Community Based Rehabilitation management manual. Unpublished

O'Toole B 1991 Community Involvement in Rehabilitation Programmes for Disabled Children - A Guyanese Experience. Community Development Journal 26: 202 - 209

Peat M 1997 Community Based Rehabilitation. W B Saunders Company Ltd, London: 88, 101

Rehabilitation World Health Organisation 1994 Community - based rehabilitation and the health care referral services: A guide for programme managers. World Health Organisation, Geneva: 83

Schneider M 1996 Guidelines for developing rehabilitation services, The Centre for Health Policy, University of the Witwatersrand, Johannesburg: 68, 69

Taukobong N P 1999 The role of the community based rehabilitation worker within the primary health care service of the Odi district. South African Journal of Physiotherapy 55: 19 -22

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