SPEECH PATHOLOGISTS AND AUDIOLOGISTS IN THE TRAINING OF COMMUNITY REHABILITATION WORKERS: ETHICAL ISSUES

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DECLARATION

I hereby declare that this thesis is my own original work and that the assistance which I have received is detailed in the Acknowledgements of this report, and that I am responsible for the text of the study and the conclusions reached. No part of this thesis has been submitted in the past, or is to be submitted, for a degree at any other university.

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ABSTRACT

Health care professionals are expected to apply ethical principles such as non-maleficence, beneficence, autonomy and justice in their teaching of students and treatment of clients. Speech Pathologists and Audiologists (SPAs) in South Africa are responsible not only for educating members of their profession, but are often also involved in the training of Community Rehabilitation Workers (CRWs). Hence the aim of the present study was to explore the experiences, opinions and attitudes of a group of SPAs and CRW co-ordinators with particular reference to ethical issues related to CRW training. In order to investigate this aim, an interview schedule followed by a questionnaire were administered to SPA and CRW co-ordinators who had been involved in CRW training at The Wits/Tinstwalo CRW Training Programme in Gazankulu and at The Institute Of Urban Primary Health Care in Alexandra Township. Data elicited from the interview were analysed using content analysis and responses categorized according to respondents' background in ethics and knowledge regarding ethical principles. Results are discussed in terms of their implications for SPA and CRW co-ordinators.

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INTRODUCTION

Health care workers in South Africa have become increasingly involved in the training of Community Rehabilitation Workers (CRWs) in recent years. Such training, in the writer's opinion and experience, has raised for some therapists involved issues of ethical concern. The present study explored this aspect further in a single training context for CRWs. In order to provide a theoretical framework for the study, basic principles of professional ethics are discussed.

Basic Principles of Professional Ethics

Ethics is a field of inquiry about norms, rights values and attitudes of people based on common principles, standards and rules of conduct (Gillon, 1994). Professional ethical principles, likewise, are rules that guide the behaviour of members of a professional organization (Lewis, 1990; Resnick, 1991). Professionals are expected to comply with these ethical principles when making ethical decisions and to preserve their highest professional standards (Stromberg 1990; Resnick, 1991;Gillon, 1994). Conversely, non-compliance with minimum ethical standards may trigger sanctions from a professional board or organization (Resnick, 1991). Thompson (1985) contends that professionals can also apply ethical principles when resolving ethical dilemmas. An ethical dilemma is experienced when a professional person cannot adhere to professional values or when adhering to one ethic requires behaving counter to another (Proctor, Morrow-Howell & Lott, 1993). Wrestling with ethical problems and dilemmas are often experienced as a

continuing struggle for professionals (Aroskar, 1980; Levy, 1980; Reamer, 1983; Freedberg, 1989).

Specifically, professionals must examine these ethical dilemmas at three levels: individual, societal and situational (Jersild, 1990). Finally, professionals must be committed to rational thinking and be familiar with the ethical principles (Tennyson & Strom, 1986). Seven basic ethical principles are followed in most professional practices (Beauchamp & Childress, 1983; Singer, 1993; Purtillo, 1993; Gillon, 1994; Krauthammer, 1996).

Non-maleficence means that professionals have a prima facia (duty) to do no physical or psychological harm to their clients. Instead, clients should benefit from professional services. ***Beneficence*** similarly means that professionals must do good to clients physically, academically, socially, morally, cognitively, and personally. A beneficent professional will engage in the right action or rule of actions only if that action brings about more good than evil in the universe as a whole. ***Autonomy*** means that professionals have a moral duty to respect their clients' views and rights as long as they do not harm others. In other words, professionals should treat each client as ends rather than means to ends (Singer, 1993; Gillon, 1994). Thus, professionals have a prima facia not to interfere with autonomous actions of their clients; conversely, clients have a right to non-interference with their own autonomous actions. ***Confidentiality*** means that neither the professional nor client should disclose each other's secrets in public, unless by mutual agreement.

Confidentiality is regarded as a means to desirable ends, respecting people's autonomy, privacy and welfare. ***Justice*** means equal consideration, fairness and impartiality to clients by professionals. In pursuing justice, professionals must account for reciprocity; that is, equitable distribution of goods and services to individuals and groups in society who have legitimate claims on those benefits (Purtillo, 1993). Finally, ***veracity*** requires professionals to tell the truth and not deceive clients and colleagues, whereas ***promise-keeping*** requires that professionals fulfill their written and spoken obligations to their clients (Resnick, 1991; Purtillo, 1993; Gillon, 1994).

The above ethical principles are interrelated, though no single principle is more important than the others. Because of their equal status, these principles assist professionals in ethical decision-making and determining the appropriate course of action when confronted by ethical dilemmas. These principles, moreover, are not absolute, but relative. Members can modify them at any time due to advances in the profession, new terminology or changing societal norms and professional concerns (Resnick, 1991; CASLPA, 1992; ASHA, 1994).

Each principle, accordingly can be overridden by legitimate exceptions and context or ethical systems (Resnick, 1991; Gillon, 1994). Ethical principles also may be interpreted differently if they are derived from teleological versus deontological ethical systems.

Teleological theories rely on ends or consequences to determine when one is acting rightly or wrongly. One of the most important teleological theories is utilitarianism pioneered by moral philosophers like J.S.Mill, who held that the ultimate end is the greatest good, as long as it does not harm others. In contrast, deontological theories are means theories that rely on duties and rights. Proponents of the deontological ethical system, such as Immanuel Kant and W.D.Ross, contend that principles like promise-keeping and veracity can be morally right even if they do not promote the greatest possible good over evil for self, society or universe (Frankena, 1973; Taylor, 1978; Stumpf, 1982; Gillon, 1994). Although teleological and deontological ethical systems differ, they both can guide professionals in making ethical decisions (Stumpf, 1982; Gillon, 1994).

Application of Ethical Principles to Speech Pathologists and Audiologists

Knowledge of basic ethical principles, as well as their theoretical background, is vital for all SPAs. SPAs, for example, are expected to adhere to certain sets of professional ethics when dealing with their clients, other professionals and when training students in SPA (SASLHA, 1997). Likewise, SPAs should be in a position to question or modify their beliefs and behaviours scientifically, following ethical principles. Such ethical knowledge is likely to enhance their responsibility and accountability to clients, students and other professionals. The South African Speech, Hearing and Language Association's (SASHLA)

Ethics Committee (1997), for example, applies the five similar ethical principles when confronted with ethical problems of its members, namely: the principles of social responsibility; professionalism; competence; confidentiality and continuing education. The South African SPAs have adopted the code of ethics for their profession based on these principles. However, many of the issues that they confront in practice, may present unique challenges in this area. The present study explores some of these challenges in relation to the training of CRWs.

Background to the Training of Community Rehabilitation Workers (CRWs)

A profession that has not been widely studied from the viewpoint of ethics is that of CRWs. CRW is often used synonymously with community based rehabilitation. The concept of CRW was promoted by the World Health Organisation (WHO) in the 1970s as part of the primary health care goal of addressing people with disabilities globally. CRW was initiated to support the call for "Health For All By The Year 2000" (WHO, 1980), and has since gained recognition internationally (Concha, Dolan & Nyathi, 1993; Kemp, 1996; Schneider, 1996). Specifically, CRW was developed as a response to inefficient Western medical models of disability and rehabilitation.

Unlike the medical model, CRW advocates community-based and family-based care of disabled persons (Bjaras, Hagland & Riflain, 1991). CRW seeks

to ensure that people with disability have a place in the society by promoting positive change in societal attitudes about disability. This model also promotes equal rights for people with disability (Miles, 1992; Werner, 1993; Kemp, 1996). They should achieve as much functional and economic independence as possible, thereby empowering them to take control of their lives (Philport, Pillay & Voce 1995; Kemp, 1996; Schneider, 1996). Schneider (1996) further suggests that CRW provide an opportunity for initiating and maintaining equal partnerships between rehabilitation professionals and disabled people within the primary health care network. Hence CRW programmes are based on the following primary health care principles: appropriate and relevant technology; equity in community involvement; preventative and community based health care; accessibility of rehabilitation services and multi-sectoral approaches and training of disabled people themselves and their parents or care-givers as CRWs (Cornielje, Ferrinho, Coetzee & Reinach, 1995; Deetlefs, 1995; Mc Conkey & O'Toole, 1995; Philport et al, 1995). Based on the above principles, Miles (1992) defines CRW as intervention which aims to reach as many disabled people as possible in the most cost-effective and culturally appropriate way. Accordingly, CRW services should be implemented in the disabled person's home combining the existing community resources with the full participation of the family (Murphy & Gopalan, 1992).

Community Rehabilitation Work in South Africa

CRW was developed in South Africa as a response to the growing need to address the imbalances in rehabilitation services among South Africans,

especially in rural areas. The Rural Disability Action Group (RURACT) initiated the CRW services. This group consisted of disabled people and the rehabilitation personnel namely; SPAs, physiotherapists (PTs) and occupational therapists (OTs). RURACT campaigned for the training of CRWs who would pass on rehabilitation skills to the large numbers of disabled people in South Africa (Philpott et al 1995). According to the Reconstruction and Development Programme Report (1996), of the South African population which comprised 45 million people, 70% were Africans. Twenty-three percent of the African population were disabled and 19% of those with chronic illness had not attended a health care facility in the previous year (Kemp, 1996). For this reason, there was a need to train CRWs so that they could empower disabled people to be responsible for their lives and health and decrease their dependency upon medical professionals (Loveday, 1990). Furthermore, training of CRWs was necessary, as institution-based services were inaccessible and mostly inappropriate for the majority of the South African population. Disabled people needed to receive rehabilitation services in their home languages, within their homes and communities (Philpott et al, 1995; Schneider, 1996).

Werner (1993) posits that the level to which CRWs are trained depends on the roles and tasks that they will be expected to perform after they qualify. In South Africa, trained CRWs are usually either parents of disabled children (Loveday, 1990), people with disabilities (Werner, 1993), or local people within a geographical community (Helander, 1992) At present, there are

different programmes that train CRWs in South Africa: The South African Christian Leadership Assembly Rehabilitation Project (SACLA), The Institute Of Urban Primary Health Care Training Programme and the Wits/Tintswalo Community Rehabilitation Training Programme. To date, these programmes have not been standardised and there is no agreement as regards the name, role, level and scope of training (Schneider, 1996). In view of the fact that the present study focused on the Wits/Tinstwalo Community Rehabilitation Training Programme, this particular programme is described in more detail in the following section.

The Wits/Tintswalo Community Rehabilitation Worker Training Programme

The Wits/Tintswalo CRW Training Programme was developed in 1991 through a partnership between The University of The Witwatersrand Occupational Therapy Department and the Rehabilitation Unit at Tintswalo Hospital in Gazankulu. In 1988, a prevalence study identified a disability rate of 45% in the Mhala district in Gazankulu. Of these, 2,87% were communication and hearing difficulties (Philpott et al., 1995; Schneider, 1996). Therefore, there was a need to train CRWs who would have the skills to carry out a community-based rehabilitation service meeting the needs of disabled people in Gazankulu. Furthermore, CRWs would help address the shortage of rehabilitation personnel in the area. Like the Speech Pathology Assistants, it was envisaged that they would supplement, enhance and extend

communication services among others services, in all practice settings (ASHA, 1995). In addition, it was anticipated that they would develop a network of referral sources from the communities to the Tintswalo Hospital.

The Minister of Health, Dr Nkosazana Zuma supported this kind of a referral network, in 1995 in her opening speech to the National Assembly. In order for primary health care to succeed, she emphasized the need for an effective and efficient referral system from community-based level service through to higher levels of services (Kemp, 1996; Schneider, 1996). CRWs are trained for two years at Tintswalo Hospital. They are then registered with the Occupational Therapy Board of the South African Medical and Dental Council (SAMDC). The training programme was traditionally run mainly through the University of the Witwatersrand Occupational Therapy Department. Their permanent CRW training staff currently consists of two OTs who are co-ordinators and a secretary. The secondary staff consists of consultants, including representatives from all involved non-medical departments, including SPA. Other consultants include two former CRWs and an OT co-ordinator, representatives from the National Council for the Disabled Persons and representatives from other CRW training centres like the Institute Of Urban Primary Health Care. The three OT co-ordinators conduct some of the training and make most day-to-day decisions about the training. The other consultants are responsible for planning the curriculum. The CRW course covers modules from occupational therapy, physiotherapy, speech-language and hearing and community work. Specifically, the course includes training in

normal development, different categories of disability, therapeutic skills, counseling, community development, educational and vocational training (Philport et al., 1995).

This curriculum is similar to other CRW training programmes offered in countries like Mexico, Sri Lanka and Indonesia (Mc Conkey & O'Toole, 1995). Different SPAs train CRWs throughout the year in their respective areas of expertise for at least one intensive week. Teaching follows the principles of adult education and problem-based learning, where independent thinking skills are encouraged.

Rationale for Studying Professional Ethics in Community Rehabilitation Worker Training

The Department of Speech Pathology and Audiology at the University of the Witwatersrand is the oldest academic department for the training of SPAs in South Africa and has been in existence since 1936. Why is it appropriate at this stage of the profession's history that we should have an interest in ethics? There are both internal and external reasons. The most obvious internal reason is that SASHLA 's code of ethics is currently under review. In addition, the profession has begun to take more serious responsibility by revising its ethical codes and by ensuring that the university's educational programme gives explicit attention to ethics. Externally, the profession is confronted with challenges from clients, employers, politicians, economists, other professionals and the community to justify its activities.

The fullest and most basic form of justification comes from ethical reasoning (De Maria, 1997; Lawrence, 1997). In order to justify human conduct:

> "Ethics must be viewed to be time, place, resource and agent specific Statements of values, principles and more detailed prescriptions derived from them, can be grouped into codes to serve as an educational and/or public declaration" (Lawrence, 1997, pp 1.)

According to Lawrence (1997), ethics is a pervasive human activity, encountered whenever reasons or arguments are used to justify a course of action or assess a particular person or persons. It is an exercise in the public persuasion of the society in which we operate. If our profession becomes increasingly democratic, sympathetic to the communities' needs and not dominated by commercial interests, not hostile to intelligent discussion and not antagonistic to other professionals, we may be able to associate effectively with other professionals who share our concerns. Furthermore, ethics requires us to determine ends and means, identify agreements and disagreements, work for reconciliation whenever possible and examine the effects of what we do to ourselves and others (De Maria, 1997).

A review of the literature revealed a paucity of empirical research on ethical dilemmas confronting health care professionals. For example, Proctor et al. (1993) studied ethical dilemmas in hospital social workers and found that most ethical dilemmas involved conflict between client self-determination and

client best interest. Furthermore, ethical dilemmas were likely when patient mental status was impaired and when decision making was problematic. In the field of SPA writers such as Logeman (1990) have discussed ethical issues pertinent to the profession. However, there would appear to be little, if any, empirical studies in this area.

In view of the particular challenges of training CRWs and the context in which they work, it is possible that some of the ethical principles under which SPAs (and other professionals) operate, may be called into question. This view relates to observed practice in training and service delivery. Firstly, the SPAs who train the CRWs have not received any in-service training in CRW teaching. Hence the question arises whether it is ethical for persons who have not been trained within a particular occupation, to train students of that particular profession.

Secondly, there are as yet no standardized training programmes for CRWs and the scope and effectiveness of existing programmes has not been subjected to vigorous evaluation. Although the communication and hearing difficulties have been identified in the Mhala district in Gazankulu (Philport et al. 1995; Schneider, 1996), neither the needs of the community nor the needs of the CRWs have been examined in depth. Consequently, although SPAs may be acting beneficently in providing training, it is possible that they may be acting maleficently by doing more harm than good.

A third ethical issue relates to the supervision of CRWs on the communication module. Due to the geographical location of the Wits/Tinstwalo Training Programme, it is not feasible for SPA to provide regular supervision to CRWs. Are SPAs therefore acting maleficently by not supervising CRWs and allowing them to be supervised by CRW co-ordinators and other professionals?

A fourth issue relates to the fact that there is no SPA stationed at the training centre to oversee the communication module. The CRW co-ordinators therefore, are responsible for making sure that the whole programme, including the communication module runs efficiently. Hence the question may arise whether SPA's sense of autonomy is being infringed. A final ethical issue revolves around the question of justice. At present no single person in the Department of Speech Pathology and Audiology is specifically responsible for the training of CRWs. In addition to the fact that no specific position has been created for a co-ordinator of CRW training, no rewards or recognition are provided to persons undertaking these additional duties. Hence the question raised is whether benefits and burdens are distributed equitably among persons in the Department of Speech Pathology and Audiology who have legitimate claims on these benefits. The purpose of the present study was therefore to explore further, CRW training by two groups of professionals namely SPAs and CRW co-ordinators in a specific South African context, in order to shed light on some of these issues.

METHODOLOGY

Aims

The broad aim of this study was to investigate the ethical practices of SPAs and OTs co-ordinators involved in CRW training.

Sub-aims

1. To elicit information regarding general experiences opinions and attitudes of SPAs and OTS with regard to CRW training.
2. To determine the SPAs and OTs respondents' background in ethics as well their identification of possible ethical issues related to CRW training.

Subjects

Four groups of subjects were selected for this study:

- *Group A* comprised four part-time CRW trainers at Tintswalo Hospital who were currently or previously employed at The University of Witwatersrand as SPAs. Two were senior clinical tutors and the other two were clinical tutors. All subjects were involved in CRW training voluntarily. They taught for a minimum of one intensive week at Tintswalo Hospital CRW Training Centre.

The areas of training included: deafness, sign language, hearing disorders and aural rehabilitation, normal development of speech and language, speech and language stimulation, general speech and language disorders, cerebral palsy, and aphasia. All subjects had experience in teaching and supervising SPA students. However, they had no formal training in CRW teaching.

- *Group B* consisted of one full-time SPA, who was a former clinical tutor employed at Wits/Tintswalo Training Programme Centre. Her area of specialty was speech/language disorders and human development.

- *Group C* comprised two full-time CRW trainers who were OTs. They co-ordinated the programme and supervised the communication module at Tintswalo Hospital. Their areas of training included rural development, occupational therapy, mental health and mental disabilities.

- *Group D* consisted of two SPAs employed at the Institute of Urban Primary Health Care at Alexandra Township. One was a trainer and co-ordinated the CRW programme. She taught neurology, speech/language disorders and hearing disorders. The other person was involved in CRW training only and taught community development.

The sample size was determined by the availability of subjects. The researcher realizes the small number could compromise the generalizability of results. Thus the researcher used a purposeful, non-probability, non-

representative method of sampling which ensured all subjects met the criteria; however the results could not be generalized to the broader population (Bailey, 1994). Nevertheless, the number reflected the current situation in CRW training in South Africa and also enabled an in-depth analysis of the responses. The description of subjects is illustrated in Table 1.

TABLE 1: The description of subjects involved in CRW training. N=9.

Group	Subject	Age	Sex	Years of Professional Experience	Years in CRW Training
A	S1	40	F	15	2
	S2	35	F	8	1
	S3	27	M	3	2
	S4	36	F	11	1
B	S5	35	F	10	3
C	S6	30	F	11	3
	S7	35	F	15	4
D	S8	40	F	3	1
	S9	37	F	15	6

Procedures

Each subject was required to sign a written consent form as an indication that they had understood the nature, risks and benefits of the research (S.A.M.R.C. 1993; Bailey, 1994). The written consent also reassured subjects regarding confidentiality and anonymity as their names were not required anywhere on the questionnaire (Meyers & Grossen, 1974; Leedy, 1993; Singleton, Straits & Straits, 1993) (See Appendix I). The purpose as well as the importance of participating in the study were highlighted (Bailey, 1994). In accordance with recommendations by de Vaus (1996), the researcher indicated her willingness

to provide feedback after the data had been collected on all subjects.

Method

The research was conducted in two parts. The first part involved in-depth interviews with each subject. The second part required each subject to complete a questionnaire. These research instruments and procedures are described below:

1. Interviews

Rationale for Using Interviews

The interview is a face to face exchange of communication (Meyers & Grossen, 1974; Rosenthal & Rosnow, 1991). Its purpose is to find out from the participants those things that cannot be observed directly. The interview, therefore allows one to enter into the other person's perspective (Patton, 1980). In addition, this method supplies information regarding attitudes, opinions, and feelings on a given issue (Meyers & Grosson, 1974). Furthermore, interviews provide a framework within which the interviewee can respond comfortably, accurately and honestly. The interviewees can also use their own language style and non-verbal behaviours which tends to assure them that the interviewer is non-judgmental (Coolican, 1994; Hallberg & Barrenes, 1995; Hallberg & Janson, 1996).

Content and Structure of the Interview

The researcher conducted separate interviews during the month of July 1997. All ...ts were interviewed at their workplaces. Each interview was an hour long and no interruptions occurred. The researcher interviewed each subject using an informal conversational approach. This approach maintains maximum flexibility for obtaining information (Patton, 1980). Patton (1980) maintains that i is possible to obtain the desired information or responses about certain issues by asking indirect questions. For this reason the format of questions was adapted to the CRW situation. Instead of starting with direct questions about ethical issues such as non-maleficence, beneficence and so forth, respondents were therefore asked about their involvement in the Wits/Tinstwalo CRW Training Programme, the strengths and the weaknesses of the programme, ways of building on limitations, implications for CRW training as well as satisfa...ns and dissatisfactions with the programme. It was hoped that discussion of these general areas would elicit views and comments on ethical principles.

To further reduce interviewer bias, the questions were open-ended, permitting the respondents to answer in their own words (Leedy, 1993; Coolican, 1994; Babbie, 1995; Hallberg & Janson, 1996; Hallberg & Barrenes, 1995). Furthermore, the interviewer asked questions based on Patton's (1980) categories of interview questions that examined experiences, opinions and feelings. The interviews were taped using a high quality audio tape recorder and later transcribed. The interviewer only took notes during the interview to

follow up responses and formulate new questions. Examples of the questions included in the interviews are given in Appendix II.

Piloting the Interview

The researcher and the original supervisor of this research as well as four other SPAs conducted a pilot study. They were not used in the final study. The supervisor was a senior lecturer at The University of the Witwatersrand SPA Department. He had experience in CRW training but has since left South Africa. The interviewer underwent some training as suggested by Coolican (1994) and Patton (1980). The interviewer was trained on listening skills, using non-verbal cues effectively, asking questions naturally and how to maintain interest in what the interviewee was saying. Interviewing skills and formulating questions were practised. The researcher and the supervisor discussed any biasing questions and statements and ways of eliminating them during the interviews with the nine subjects (Babbie, 1995).

2. Questionnaire

Rationale for Using A Questionnaire

The questionnaire was used in order to supplement the interview (Babbie, 1992). A questionnaire is considered as a timesaving and cost-effective survey technique (Meyers & Grossen, 19974; Singleton, Straits & Straits, 1993). It allows for anonymity and confidentiality that are not provided by the interview. Furthermore, it gives the participant an opportunity to think about

his/her answer. In addition, a questionnaire provides a basis for deciding how to deal with certain issues (Babbie, 1992; de Vaus, 1996) (See Appendix 111).

Questionnaire Development

A copy of the questionnaire is set out in Appendix 111. The written questionnaire included open and closed-ended questions as suggested by Dillman (1983) and Coolican (1994). Both forms of questions were incorporated so that responses could be compared (Behr, 1983; Leedy, 1993). Clear instructions were given for responding to questions. Closed-ended questions allowed the respondents to choose their answers from a fixed set of responses. These formats are quicker for the respondents to answer and easier for the researcher to classify and code (Behr, 1983; Rossi, Wright, & Anderson, 1983; de Vaus, 1996;). Closed-ended questions adapted from the University of Massachusetts Ethics Survey were employed. Questions that dealt with similar ethical issues were grouped together and adequate spaces were provided for answering open-ended questions (Leedy, 1993; de Vaus, 1996). Open-ended questions comprised 12 items. The questionnaire was 9 pages long and took approximately one hour to complete (Berh, 1983; Babbie, 1995).

Areas Covered In The Questionnaire

Demographic Data

Demographic data where included in the questionnaire because such information is viewed as an important section of the questionnaire. In addition, demographic data provide relevant information about the subjects and it serves to explain the obtained information and to assess the realization of the samples (Schnetler & Botha, 1988). Therefore, closed-ended questions elicited biographical information and respondents' background in ethics. Demographic information included respondents' age; sex; years of CRW training; number of weeks training CRWs; number of people involved in training; years of training SPA students; previous job position; current job position; work setting and employing authority. This information was placed at the beginning of the questionnaire so that the respondents should feel unthreatened by answering relatively easy questions at the beginning (Singleton, et al.1993).

Background In Ethics

The rationale for including background in ethics was to find out whether the subjects were knowledgeable about ethics. Furthermore, the purpose was to ascertain whether they were aware of the ethical principles and were able to use them as a guideline when confronted with ethical dilemmas. According to Lawrence (1997) and Thompson, (1985) such background in ethics allows one to be in a better position for making ethical judgements. Therefore,

background in ethics tapped the respondents' knowledge on ethics. Closed-ended questions comprised 27 items.

Ethical Principles In Community Rehabilitation Worker Training

The rationale for including ethical principles such as non-maleficence, beneficence, autonomy and justice was highlighted in the foregoing discussion. The questionnaire consisted of three open-ended questions for each of the ethical principles relating to CRW training, namely, non-maleficence, beneficence, autonomy, and justice. Open-ended questions allowed the respondents to justify the answers and elaborate freely (Dillman, 1983) (See Appendix III).

Administration of the Questionnaire

The questionnaire was administered two months after the interviews have been conducted, so that the interviews would not influence how the subjects responded to the questionnaire (Dillman, 1983). The researcher handed out the questionnaires and collected them after one week (Rossi, et al. 1983). They were all completed and returned in an unmarked A4 size envelope. Consequently, the return rate was 100% which is regarded as high according to Babbie (1992). The researcher randomly opened the envelopes on the same day in order to prevent researcher's bias and ensure confidentiality (Leedy, 1993; Singleton et al., 1993).

Piloting the Questionnaire

The questionnaire was pre-tested before administering it in the final study (de Vaus, 1996). Four SPAs who were familiar with questionnaire development were selected for the pilot study. They were not involved in CRW training and were excluded from participating in the final study. They were required to evaluate questions in relation to: bias, length of the questionnaire, validity and reliability, ease of administration, clear language and instructions, as suggested by Dillman (1983). Some changes were made in grammar and ordering of questions. Two questions were changed that were thought to be leading. It should be noted that although the questionnaire probed relevant areas, some respondents felt that it limited their responses as no provision was made to elaborate if the response was "no".

Research Design and Analysis of Data

This study was a qualitative evaluative research design. In the words of Patton (1980), this design:

> "Consists of quotation from people and descriptions of situations, events, interactions, and activities. The purpose of these data is to understand the point of view and experiences of other persons" (Patton, 1980, pp 36).

Each interview was transcribed verbatim and written responses were analysed qualitatively using content analysis (Patton, 1980). Content analysis is based on Glaser and Strause's (1967) grounded theory. This procedure is a qualitative research strategy in which data are broken into discrete parts by coding units. That is, responses are categorized by common words, themes, characteristics, similarities and differences in responses within and between subjects (Patton, 1980; Ventry & Schiavetti, 1980; Coolican, 1994; Babbie, 1995). Outlying responses not shared among subjects were assigned their own categories (Stern, 1980). The questionnaire was analysed according to background in ethics and ethical principles.

RESULTS AND DISCUSSION

The results of the analysis are discussed in accordance with the broad aims and sub-aims of the study. The main aim was to investigate the ethical practices of SPAs and OT co-ordinators involved in CRW training.

The first sub-aim was to elicit information reggarding the general experiences, opinions and attitudes of SPAs and OTs with regard to CRW training.

In accordance with Patton's (1980) categories of interview questions, responses were analyzed in terms of similarities, differences, common themes and an outlier. Results of this analysis are set out in Table 2.

(a) **General Views on the Wits/Tinstwalo Community Rehabilitation Worker Training Programme**

The following table summarizes the data elicited in response to the questions on experiences, opinions and attitudes toward the CRW training programme.

Table 2. General Views from SPAs and OTs who were involved in CRW training (N=9)

SIMILARITIES	DIFFERENCES	COMMON THEMES	OUTLIER
-input on the communication module is valuable -concretize the communication module -CRWs need basic skills -Trainers do not need training -Dual job descriptions -Two or more Trainers involved in teaching CRWs	-OTs and Non-Staff SPA have more experience than part-time SPAs -OTs require assessment forms -SPAs do not require assessment forms -OTs and Non-Staff report that the scope of the communication module was well defined -SPAs reported the scope of the communication module was not well defined -SPAs require more time to teach than others	- All respondents felt they had a better understanding of disability after being involved in the teaching of CRWs - All respondents realized that CRWs are recognized globally - SPAs require more time to train CRWs - All respondents felt that CRWs provide valuable services in their communities - All respondents felt a greater need to start and maintain self-help groups -CRW training is viewed within a functional approach	-Part-time SPAs felt that CRW training was an inconvenience - Part-time SPAs also felt that CRW training was problematic

(I) Similarities

The OTs and SPAs agreed that SPAs' input was valuable as communication was generally recognized globally as an underdeveloped area in CRW training. For example, Subject 9 (non-staff SPA) said that "CRW seems to be international and the literature shows that communication is an underdeveloped aspect in CRW training". Whereas Subject 7 (OT) indicated that "the contribution from the speech department is a plus for us because even the WHO publications indicate that communication aspects are not fully developed in CRW training". It was evident that SPAs should improve and concretize the communication module, for the benefit of the CRWs. For example, Subject 7 (OT) said that "speech and communication is the thing that CRWs find the most difficult to deal with because it's such an abstract concept". This view was also echoed by Subject 1 who stated that "there is a need to concretize more what communication is and be able to provide a few recipes to start the CRWs off and I'm not sure that we managed that well".

Generally, it was felt that the communication module was presented in too abstract a fashion. Hence the OTs indicated that CRWs could have benefited more from video illustrations and hands on practical experience. This view emerged from an informal evaluation of the communication module by CRWs. Furthermore, the respondents emphasized that CRWs should be taught basic skills for identification and prevention, should know how to treat

specific disorders and know when to refer appropriately. For example, Subject 8 (non-staff SPA) stated that "we should focus on identification, prevention and community development. CRWs should be viewed as social activists rather than therapists". Similarly, Subject 2 (SPA) said "basic skills involve being able to go to the community and identify a problem, to be aware that at a certain stage, a child should be able to say this and that and be able to refer".

It was interesting to note that all respondents expressed the view that they did not require training to train CRWs. Subject 4 (SPA) for example, mentioned that "I don't think we need training to train CRWs. If you know your topic, you can teach provided you have the motivation, but that's not to say that we don't need to learn to be better teachers". However, they felt that all trainers should meet before teaching commenced in order to co-ordinate and integrate the different modules. Hence the lack of training did not appear to pose an ethical issue.

All respondents held dual job descriptions and were therefore not responsible for training CRWs only. This sharing of duties arises because of the current lack of resources that necessitate the assumption of generic roles by SPAs, rather than specialization in CRW training. However, specialization may not be feasible in the South African context due to the limited number of registered and practising SPAs (Aron, 1991).

Finally, all respondents indicated that two or more people were involved in training CRWs. Purtillo (1993) supports this type of arrangement in her discussion of the ethical responsibility of health professionals as team members. She discusses the need for team members to make arrangements in which everyone carries a fair distribution of the work load. This viewpoint is in accordance with Resnick's (1991) conceptualization of justice.

(ii) **Differences**

The OTs and one non-staff SPA had had more experience in training CRWs (3-6 years) than the other trainers. The OTs on the one hand felt that the assessment and checklist forms given to CRWs by SPAs represented an improvement for the communication module, but needed to be simplified. Subject 7 (OT) for example, stated that "the very detailed assessment form and a checklist on communication problems, particularly the one you gave them, was a big improvement to the communication module but sometimes the students didn't understand them". Most SPAs on the other hand, felt that there was no need for such assessment forms. Subject 8 (SPA) also disagreed with the OTs and expressed the view that "we try not create mini therapist because we feel that there are therapists who are trained to assess communication problem efficiently".

Subject 2 (SPA) indicated that "although checklist and assessment forms are useful,they are not applicable to CRWs because the aim is not to teach them to be competent testers supported this view". Most SPAs indicated that the scope of the communication module was not clearly defined. For example, Subject 3 (SPA) mentioned that "I don't think that the scope of the CRWs is well defined sufficiently for us to know how much to give them". In addition, Subject 5 (SPA) indicated that "we aimed to be comprehensive, to cover everything. It is not easy to cut down anything but at the same time we don't expect CRWs to do speech therapy like speech therapists". The OTs and non-staff SPAs felt however, that the scope was adequate. Unlike the OTs, SPAs indicated that they required more time to concretize communication skills and promote the concept of language stimulation. For example, Subject 9 indicated that "more time is needed to base the communication module on functional abilities rather than on diagnosis and say this person with a language problem communicates using one or two words or sentences". Although these differences in opinion did not raise any ethical concerns, nevertheless there seemed to be a need for both groups of trainers to reach a compromise on time allocated for teaching CRWs, the use of checklists and assessment form so that they could be acceptable to all concerned.

(iii) **Common Themes**

All respondents indicated that by working with CRWs, they understood disability holistically and learned how disabled people can be integrated into society. Subject 9 (non-staff SPA) for example stated that " I have learned to look at disabled people and disability issues in a broader sense and how to develop the community". Like his counterpart, Su.. : 3 (SPA) said that "one gets to understand disability holistically and our role in the society".

In addition, all respondents were aware that CRWs were recognized globally and were efficient in servicing the underprivileged communities. Subject 2 (SPA) mentioned that "the whole world acknowledges CRWs and their work in the impoverished communities".

Furthermore, most SPAs felt that they should spend more time teaching CRWs how to run self-help groups and set realistic goals for and with the communities. Subject 1 for example, was concerned about "restricting the communication module to how to run self help groups and how to stimulate language and not the whole speech therapy in one week. Respondents reported that CRW training was based on the functional approach rather than on the diagnostic approach. Subject 6 (OT) stated that "one of the strengths of the functional approach was that all stakeholders including CRWs and disabled people are involved in designing the curriculum for CRWs".

These viewpoints demonstrate the respondents' commitment to the ethical principle of beneficence because they have the desire to improve the quality of life of the communities and empower the stakeholders by involving them in curriculum design. This idea is supported by Resnick (1991), who believes that helping professionals should extend themselves beyond the call of duty. After completion of the course, the CRWs impart the knowledge and provide rehabilitation services to their communities.

(iv) Outlier

According to Patton (1980), outliers refer to the responses that differ drastically from those furnished by the other respondents in that they are neither similar nor different in terms of common themes expressed by the majority of the respondents. One part-time SPA (Subject 5) viewed CRW training as an inconvenience. She stated that "CRW training is an inconvenience and I'm not crazy about being involved in making CRWs second rate professionals with no where to go". She felt that CRWs were involved in a profession that was filled with problems such as lack of promotion opportunities, the absence of regular supervision, no opportunity to study further, and restricted work openings in their communities.

If one considers that the principle of justice refers to the equitable distribution of goods and services, then are we acting justly in training CRWs so that they are limited to working within certain geographical communities? They are also

restricted in terms of furthering their qualifications and extending their educational and career paths. This situation poses an ethical dilemma for CRWs because they are bound by the OT code of ethics to constantly strive to enhance their knowledge and skills by engaging in continued education. Be that as it may, the OT department is currently involved in dialogue with the University of the Witwatersrand to assist the CRWs to gain access to the first year degree course in occupational therapy. The fact that CRWs are expected to be constantly supervised would appear to represent an infringement of their autonomy. However, the course co-ordinators are in fact aware of this problem and are seeking ways of encouraging greater independence and autonomy for CRWs.

(b)Interview Responses Related to Ethical Principles

Ethical principles extrapolated from the interviews are summarized in Table 3.

TABLE 3. Identification of ethical issues from interview responses of SPAs and OTs involved in CRW training.

ETHICAL PRINCIPLE	Group A: P/T SPAS	Group B: F/T SPA	Group C: F/T OTS	Group D: NON-STAFF SPAS
Subjects	1 2 3 4	5	6 7	8 9
Autonomy	+ + - -	+	+ +	0 0
Non-Maleficence	- - - -	-	- -	+ +
Beneficence	+ + + +	+	+ +	+ +
Justice	0 0 - -	0	- +	0 0

KEY: += No Ethical problem identified. - =Ethical problem identified.
o = No comment. P/T SPA= part time SPA employed by the University of the Witwatersrand. F/T SPA= full time SPA employed by the Tintswalo Hospital. F/T OT= full time OT employed by the Wits/Tintswalo CRW Training Programme. Non-Staff SPA= SPA employed by the Institute Of Urban Primary Health Care.

With regard to ***autonomy***, Subjects 1 and 2, felt that the strength of the communication module was that SPAs were responsible for it. On the one hand, Subject 5 indicated that she "had the freedom to do what she wanted in the communication module". On the other hand, Subjects 3 and 4 felt that "the OTs had too much control over the communication module". Subject 6 indicated that a SPA should be stationed at the Tintswalo Hospital Training Centre in order to co-ordinate the communication module efficiently. Furthermore, she believed that SPAs should be involved in supervising CRWs. Unlike her counterparts, Subject 7 mentioned that she's "got control of the

staff down here and responsible for CRWs". Subjects 8 and 9 did not have comments in this regard.

It would appear that that Subjects 1,2,5 and 7 felt that their autonomy was respected, whereas, Subjects 3 and 4 were conscious about OTs infringing their autonomy. Despite the fact that these Subjects feel that their autonomy was being violated, it would seem that the situation is unavoidable since there is no SPA stationed at the training centre to oversee the communication module and supervise the CRWs. The fact that the OTs appeared to be in control of the communication module was not due to any desire on their part to usurp the authority of the SPAs but emerged from the unavoidable situation where no SPAs were located at the training centre and hence were unavailable to supervise the CRWs. The ethical principle of ***non-maleficence*** was of concern. Subject 1, 2 and 3 mentioned that too many aspects were covered in the communication module within a short period, while Subjects 4 and 5 felt that SPAs did not know enough about the cultural needs of the communities in order to select relevant areas for the communication module. In addition, subject 4 felt that she was "giving CRWs something, at the cost of something else". However, part-time and full-time SPAs were in agreement that the communication module was not integrated into the other modules. Furthermore, they concurred that speech and language concepts were difficult for the CRWs to comprehend.

This statement was also supported by the Subjects 6 and 7 who indicated that many speech and language concepts were highly abstract and too much information, which was sometimes confusing, was given to the CRWs. Contrary to the above, Subjects 8 and 9 were satisfied with the contents of their communication module and indicated that their students had no difficulties grasping speech and language concepts. Nevertheless, they were engaged in consultation with the OTs about the competency profile for CRWs.

Regarding ***beneficence,*** all Subjects emphasized that CRW training was a positive experience for them and that they derived feelings of satisfaction from providing a worthwhile service. Subject 1 for example stated that "training was crucial for CRWs and their communities and provided a link between them and people who would otherwise not receive any rehabilitation services". They also indicated that they wanted CRWs to work in conjunction with therapists from other disciplines in order to provide an effective service to the communities.

With regard to ***justice,*** Subjects 3 and 4 stated that they would like to see CRWs afforded the same professional respect as other professionals and SPAs being acknowledged for their involvement in CRW training in their own academic department. Similarly, Subject 6 mentioned that although the work of CRWs was seen as positive, "CRWs are not accepted by all therapists", while Subject 7 commented on how "CRWs are treated as equals after

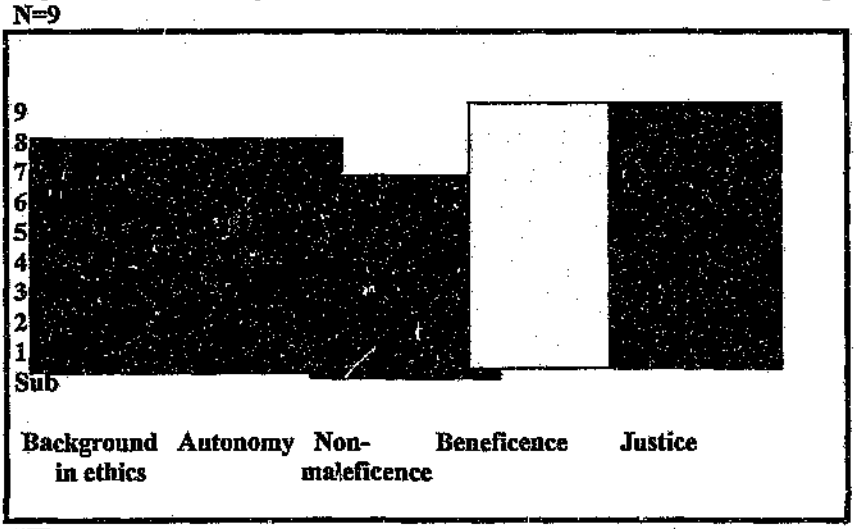
completion".

The second sub-aim of the study was to determine the SPA and OT respondents' background in ethics and identify possible ethical issues related to CRW training.

Respondents' Background in Ethics and Their Identification of Ethical Issues

Responses from the questionnaire administered to SPAs and OTs are illustrated in Figure 1.

Figure 1. Ethics background of SPAs and OTs involved in CRW training. N=9



KEY:

Subj = number of subjects illustrating awareness of individual ethical principle on the questionnaire

= knowledgeable in ethics

= ethical principles of concern to SPAS

= ethical principle raised as relevant

(a) **Responses related to background in ethics**

The Subjects responded as follows to the questions on ethics:

- *Have you taken a course in ethics?*

Only two respondents (Subjects 4 and 5) had taken a course in ethics, presented at either a lecture, seminar or on the job training.

- *What is ethics?*

Eight subjects referred correctly to ethics as moral values and common principles, standards and rules of conduct.

- *Define the following ethical principles*

All respondents indicated correctly at least one statement defining ethical principles such as autonomy, non-maleficence, beneficence and justice. For example, autonomy was referred to as the right to do anything one want to, as long as other person's rights were respected . Non –maleficence was defined as the duty to do no harm while beneficence referred to the duty to do good to others.

Although few respondents had taken a course in ethics, they appeared to be knowledgeable about ethical principles and how to make ethical decisions. This finding is related to Loewenberg & Dolgoff (1992)'s statement

mentioned previously, namely, that there is no proof that studying ethics will result in ethical behaviour and that knowledge about ethics will necessarily lead to the acquisition of desired attitudes among professionals. The respondents, however, realized the importance of and the need to study professional ethics as suggested by Logemann (1990) and Kitchener (1986).

According to Logemann (1990) professional ethics should be included in undergraduate and postgraduate SPA curricula. She believes that SPA students must be aware of and integrate ethical issues into their clients' treatment. Kitchener (1986), also believes that ethics should be integrated into the curricula by focusing on four main goals: Firstly, the course must sensitize students to ethical issues permeating the profession. She suggests using reading material describing ethical cases and their implications. Students should also be encouraged to generate hypothetical cases and try to problem-solve. Secondly, students should be taught how to think critically, using the critical-evaluative model. This model prepares students for challenging unexpected situations by providing a protocol for evaluating moral intuition, moral rules, laws and ethical principles. Thirdly, the course should develop students' moral responsibility by generating and justifying ethical decisions through modeling. Finally, students should learn to tolerate the ambiguity involved in ethical decision-making.

- Which of the following factors do you consider when faced with an ethical dilemma?

All respondents relied on the following common sources to make ethical decisions: colleagues, work experience and education settings. They also considered the following when confronted with an ethical dilemma: ethical principles, facts, legal issues and professional reputation.

- Do you think it is important to learn about ethics?

Although all respondents indicated that it was important to learn about ethics, the non-staff SPA did not think that lectures should specifically be related to communication disorders. All respondents knew that a code of ethics existed governing their professional behaviour, but only 2 respondents were familiar with contents of the code (one OT and one non-staff SPA).

-How did you hear about the code of ethics?

All respondents came to know about the code of ethics governing their profession from either

SASHLA, ASHA or from colleagues.

(b) Responses relating to ethical principles

The Subjects responded as follows to questions from the questionnaire on ethical principles:

- Do you think that there are any ethical p. 'ems in the decision- making process about CRW
training? Yes/No

Full-time and part-time SPAs as well as one OT replied in the affirmative. Their main concerns were that there were no long-term prospects for CRWs and ..ey were not sure whether they were passing on skills adequately to ensur.. that clients' needs were met. Furthermore, they indicated that although they trained CRWs, CRWs were unable to achieve much in the community because of lack of knowledge and resources. It would seem that the ethical principle of justice has been compromised because there are no career pat.. for CRWs.

Therefore, it would seem unrealistic to expect them to adhere to some of the ethical codes which expects them to improve their knowledge and skills by upgrading their qualifications. Furthermore, the trainers were trying to empower the CRWs to enhance the quality o.. life of the people in their communities by providing resources and services. However, CRWs can not do this effectively and efficiently if they lack the resources. Therefore trainers may be acting unjustly by not providing an equitable distribution of services.

- Do you think that there is a problem in OTS supervising CRWs' practicum for the communication module? Yes or No

Full-time and part time SPAs were not happy about OTs supervising CRWs on the communication module because they mentioned that OTs did not have the practical understanding of the areas covered in the communication module. Furthermore, OTs were not involved in the teaching of the specific areas so they did not how and what was taught. On the other hand non-staff SPAs and OTS did not have a problem in supervising CRWs on the communication module because some of them had had extensive experience in CRW training

and also in working with SPAs. Similar views emerged from the questionnaires as in the interviews, namely that, SPAs felt that their autonomy was compromised. However, this situation would appear to be inevitable since there is no SPA available to supervise CRWs. The SPA may not get as good a service from the CRWs and OTs. The OTs also have a duty to provide and monitor rehabilitation services. They could be acting non-maleficently while SPA maleficently. The solution to this problem is to have a SPA employed at the training centre.

- Do you think that there is a problem in CRW co-ordinators occasionally observing in class when SPAs are teaching? Yes/No

All respondents answered in the negative, stating that they appreciated peer reviews so that they could improve their standards and the effectiveness of their teaching for the benefit of the programme and CRWs.
Therefore, they did not feel that their autonomy was infringed.

- Do you think CRW training is beneficial to the CRWs as well as their Communities? Yes/No

All respondents said yes and indicated that CRWs provided services to communities who otherwise might have no or little access to primary health care services. CRW was perceived to be good for the CRWs as well as for their communities. Similarly, trainers appeared to be acting beneficently by providing training.

- Do you think that the scope of rehabilitation areas covered in the communication module is sufficient? Yes/No

Full-time and part-time SPAs responded negatively indicating that the scope was too broad. As a result CRWs sometimes experienced difficulty understanding speech and language concepts. This finding may be the reason why CRWs found other modules to be easier as they were presented in a more

concrete manner. McKenzie (1992) reported similar results from her study. She noted that CRWs tended to have problems understanding the basic anatomy and physiology of speech and language, possible due to their low level of education. This could be expected as many of the students accepted for CRW training at the Wits/Tinstwalo CRW Training Programme have not matriculated with exemption. As a result SPAs suggested that certain terminology should be used with caution and CRWs should be taught basic skills in order to identify and prevent communication disorders and refer appropriately when the need arose. These suggestions are consistent with training strategies advocated by Mc Conkey & O' Toole (1995) and Schneider (1996). Concretizing the communication module may be one way for improving the course since communication is reported to be an underdeveloped area in CRW training (Werner, 1993). In contrast, non-staff SPAs and OTs were satisfied with the scope of the communication module

- Do you think that trainers are adequately trained in CRW training?

Full-time and part-time SPAs indicated that trainers were not adequately trained. However, all respondents stated that they had experience in teaching the degree students so they do not think that training is necessary. OTs and non-staff SPAs reported that they had had training on the job with experienced trainers. It is of interest that SPAs at the University of the Witwatersrand are provided with guidelines for teaching SPA students, although these guidelines are not available for SPAs to teach CRWs. This situation raises the question whether justice is being served by providing guidelines for one group of students and not the other. Despite the fact that the respondents did not see a need to undergo training in order to teach CRWs, Purtillo (1993) posits that health professionals have an ethical responsibility to improve themselves through continuing education and training. It would therefore seem, that it would be the benefit of all trainers to undergo training to teach CRWs.

-Do you think that SPAs should be acknowledged for their involvement in CRW training?

All respondents said yes. Most part-time SPAs reported that they feel discriminated against and not treated in a fair and just manner in their department as their work with CRWs was not recognized. If they do not get recognition, they may not continue to do as good a job as possible.

CONCLUSIONS

The present study aimed to investigate the experiences, opinions and attitudes of SPAs and OTs involved in CRW training. Furthermore, respondents' background in ethics as well their identification of possible ethical issues related to CRW training were examined. The results indicated that similarities and differences existed within and between SPAs and OTs. Responses showed that part-time and full-time SPAs felt that their autonomy was being compromised when OTs supervised the CRWs' practicum on the communication module, although this situation seems unavoidable, since there are no SPAs available to supervise the students. The same SPAs also indicated that the scope of the rehabilitation covered was too broad. Therefore, it is possible that they may do more harm than good by concentrating on too many aspects of the communication module. All respondents indicated that CRW training was beneficial to the CRWs and their communities. Therefore, trainers are probably acting beneficently by providing CRW training. In addition, all respondents reported that SPAs should be acknowledged for their involvement in CRW training. Although few respondents had taken a course in ethics, they appeared knowledgeable about ethical principles and how to make ethical judgements. While the results of this exploratory study found that there are issues of ethical concern with therapists involved in CRW training, it should be borne in mind that the context in which service delivery takes place is very important. The particular demands of the Tinstwalo training context as well as the socio-political context in which service delivery takes place in South Africa as a whole seems to make it appropriate to consider some flexibility in terms of western application of ethical principles.

Furthermore, the limitation of the study was that respondents felt that the questionnaire restricted their responses as no provision was made to elaborate if the answer was "no". Not all trainers were included in the sample size because their responses may have baised the results.

Nevertheless, despite these limitations the findings of the study have important implications in terms of the following:

1. Future management of CRW training should include a permanent SPA at the Wits/Tintswalo CRW Training Programme.
2. An appointment of a full time SPA co-ordinator from Wits SPA Department . This will enhance a sense of autonomy on behalf of the trainers concerned.
3. Since CRWs are receiving an input on the communication module, SPAs should be involved in facilitating their transition from CRW to first year SPA course. By doing this justice might seem to be served.
4. All training institutions should endeavor to have a single training curriculum for all CRWs which meet minimal standards of excellence and integrity. In this way, trainers will be acting beneficently and minimizing chances of acting malificently.
5. Blame cannot be laid at either SPAs or OTs involved in CRW training, which could have caused possible violation of ethical principles.

It would seem that future research is required in the following areas: Firstly, more information is needed regarding the handling of ethical issues that may arise in CRW training. Socondly, further research is necessary to provide maximal training and education of CRW trainers. In conclusion, "although it appeared that mistakes were made by professionals, there were not deliberate and therefore can be corrected" (Purtillo 1993 pp 84).

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UNIVERSITY OF THE WITWATERSRAND

SPEECH PATHOLOGY AND AUDIOLOGY DEPARTMENT

APPENDIX I: SUBJECT CONSENT FORM

As part of the requirement for M.A. in Speech Pathology at the University of the Witwatersrand, I am conducting a survey on the involvement of SPAs in community rehabilitation worker training (CRWT).

Your participation in this survey will add to our knowledge and understanding of the SPAs's involvement in CRW training. The survey will involve participating in an interview for one hour and completing a written questionnaire for one hour, two months after the interview. Please note that you may withdraw from the survey at any time without penalty. The results of this study could be published in a professional journal. But at all time responses will be kept confidential and you will remain anonymous. If you have any questions, I will answer them before we proceed with the interview. If you are interested in the results, I will be only too willing to give you feedback after the data has been collected on all Subjects. I can be contacted at (011) 716-2374 during office hours or (011) 484-1273 after hours. My supervisor, is Prof Penn and can be reached at the same office number. If you agree to participate in this study, please sign below.

_____ _____

Signature of the Respondent Date

Witnessed by

_____ _____

Nosisi (P) Jenga Date
Second Year M.A. Student
In Speech Pathology

APPENDIX II: PATTON'S CATEGORY OF INTERVIEW QUESTIONS

1. Tell me about your involvement in the Wits/Tintswalo CRW training programme (Experience question).

2. What do you see as strenghts of the communication module? (Opinion question).

3. What do you see as weaknesses if any of the communication module? (Opinion question).

4. If there were weaknesses, what would you do to strengthen them? (Opinion question).

5. What are the implications of CRW training for SPAs? (Opinion question).

6. What have you learned from training CRWs? (Opinion question).

8. How have you been satisfied about your involvement in CRW training? (Feeling question).

9. How have you been dissatisfied about your involvement in CRW training? (Feeling question).

APPENDIX III: QUESTIONNAIRE: THE TRAINING OF CRWs

Please answer each question as openly and honestly as possible. There are no wrong or right answers. Rather, I am looking for responses that are most accurate to you. Responses will be kept confidential at all times. Please circle your answers.

DEMOGRAPHIC DATA

1.Gender
(a) Male
(b) Female

2.Age
(a) 20-30years
(b) 30-40years
(c) 40-50years
(d) above 50years

3.What is your current position?
(a)clinical tutor
(b)seniour tutor
(c)lecturer
(d)seniour lecturer
(e)doctor/professor
(f)other(specify)_____

4.Where are you employed?
(a)hospital
(b)school
(c)university
(d)private practice
(e)other (specify)_____
Full time_____
Part time_____

5. How long was theCRW training?
(a) 1 week
(b) 2 weeks
(c) 3 weeks
(d) more than 3 weeks

6. How many people were involved training CRWs?
(a) 1
(b) 2
(c) more than 2

7. What was your area of speciality
(a) neurological
(b) speech/language disorders
(c) cerebral palsy
(d) human development
(e) hearing disorders
(f) other (specify)_____

8. How long have you been involved in CRW training?
(a)Number of years full time
_____
(b)Number of years part time
_____

9.**How many years of work experience in the communication disorders field have you had?**
(a)Number of years full-time_____
(b)Number of years part-time_____

11.**How many years of volunteer work experience in the communication disorders field have you had?**
(a) Number of years full-time _____
(b) Number of years part-time _____

10.**How many years of work experience outside the communication disorders field have you had?**
(a) Number of years full-time_____
(b) Number of years part-time_____

BACKGROUND IN ETHICS

12.**Have you taken a course in ethics?** (Circle one).
(a) Yes
(b) No

13.**Have you taken any courses(excluding ethics courses)that included ethics as a related topic?** (Circle one).
(a) Yes
(b) No

14. **If yes,how was the training presented?** (Circle all that apply).
(a) On-the-job training
(b) Seminar
(c) Workshop
(d) Lecture
(e) Other (specify)_____

15. **What is ethics?** (Circle all that apply).
(a) Moral values
(b) Absolute principles
(c) Common principles, standards and rules of conduct
(d) Duties of fidelity

16. **What is beneficence?** (Circle all that apply)
(a) Duty to love others
(b) Duty to self improvement
(c) Duty to do good for others
(d) Duty not to harm others

17. **What is justice?** (Circle all that apply)
(a) Duty of reparation
(b) Duty to treat others fairly and impartially
(c) Duty of gratitude
(d) Duty to do good for others

18. **What is autonomy?** (Circle all that apply).
(a) Duty to promote the distribution of happiness
(b) Duty to respect yourself
(c) Duty to respect others' views and rights
(d) Duty to do anything you want

19. **What is non-maleficence?** (Circle all that apply)
(a) Duty not to disclose people's secrets
(b) Duty to do good for others
(c) Duty to do no harm
(d) Duty to engage in the right action

20. **Have you had any formal training in ethical decision making?** (circle one).
(a) Yes
(b) No

21. **From which of the following sources did you learn how to make ethical decisions?** (Circle all that apply)
(a) Colleagues
(b) Religion
(c) Employment/work experience
(d) Family/friends
(e) Educational setting
(f) Other (specify)_____

22. **Which of the following factors do you consider when faced with an ethical dilemma?** (Circle all that apply)
(a) Emotions/feelings
(b) Ethical principles
(c) Facts
(d) Legal issues
(e) Professional reputation
(f) Peer opinions
(g) Easiest way out
(h) Other (specify)

23. **Do you believe that it is important to learn about ethics?** (Circle one).
(a) Yes
(b) No

24. **Do you believe that you would benefit from an ethics lecture specifically related to the communication disorders?** (Circle one).
(a) Yes
(b) No

25. **Do you expect to face ethical dilemmas as a SPA?**
(Circle one).
(a) Yes
(b) No

26. **Do you know if a code of ethics exists governing your professional behaviour?** (Circle one).
(a) Yes
(b) No

27. **How familiar are you with the code of ethics?**
(Circle one).
(a) Not at all familiar
(b) Not very familiar
(c) familiar
(d) Very Familiar

28. **How did you hear about the code of ethics?**
(Circle all that apply).
(a) SASLHA
(b) ASHA
(c) Lecture
(d) Colleagues
(e) Employment
(f) Other (specify)_____

ETHICAL PRINCIPLES

29.(a) **Do you think that there are any ethical problems in the decision making process about CRW training?** Yes/No.

(b) If yes, please elaborate

_____
_____
_____

(c) How can this be rectified?

30(a). **Do you think that there is a problem in OTs supervising CRWs' practicum for the communication module?** Yes/No

(b) If yes, please explain

(c) How can this be rectified?

31 (a) **Do you think that there is a problem in OTs occassionally observing in class when SPAs are teaching?** Yes/No

(b) If yes, please elaborate

(c) How can this be different?

32 (a). Do you think CRW training is beneficial to the CRWs as well as their communities? Yes/No

(b) If yes, please elaborate

(c) How can this be different?

33(a). Do you think that the scope of rehabilitation areas covered in the communication module is sufficient? Yes/No.

(b) If yes, Please elaborate

(c) How can this be rectified?

34 (a). **Do you think that CRW training by SPAs addresses the needs of the communities regarding communication disorders?** Yes/No

(b) If yes, please explain

(c) How can this be resolved?

35 (a). **Do you think that SPAs should be involved in CRW training?** Yes/No

(b) If yes, please elaborate

(c) How can this be resolved?

_____
_____
_____
_____
_____
_____
_____
_____

36 (a). **Do you think that trainers are adequately trained in CRW training?** Yes/No.

(b) If yes, please explain

_____
_____
_____
_____
_____
_____
_____

(c) How can this be resolved?

_____
_____
_____
_____
_____
_____
_____

37 (a). **Do you think that a SPA should be a member of the training team at Tintswalo Hospital?** Yes/No.

(b) If yes, please explain your response

_____
_____
_____
_____
_____
_____
_____

(c) How can this be accomplished?

38(a) **Do you think that SPAs should be acknowlegded for their involvement in CRW training?** Yes/No

(b) If yes, please explain your response

(c) What can be done differently?

39 (a). **Do you think that CRW trainers should be treated equally?** Yes/No.

(b) If yes, please elaborate

(c) What can be done differently?

_____

_____

_____

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_____

_____

THANK YOU FOR YOUR TIME AND ASSISTANCE.

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