

Geneva, 17-23 February 1981



SOME EXPERIENCES WITH FIELD TESTING OF THE MANUAL  
"TRAINING THE DISABLED IN THE COMMUNITY" AS A TOOL  
FOR COMMUNITY-BASED REHABILITATION

Mrs Padmani Mendis  
Colombo, Sri Lanka

Having drafted the manual "Training the Disabled in the Community", one of the primary considerations was whether we should go into a country with the principal idea of evaluating the manual, or of introducing a community-based programme. The approaches in each case would be different.

If the decision was that our interest lay solely in field-testing the manual, it would be sufficient to restrict the programme to selected areas and to a specific period of time.

This would perhaps mean that being a "trial", decisions and changes made would be considered as being applicable only temporarily. Such a decision, at higher levels, results in lessening of interest and thought; at lower levels, such as with Field Health Workers, it would not stimulate the higher level of motivation that this programme requires of these workers.

On the other hand, the approach of introducing a community-based programme has many advantages. Primarily, the country would be implementing its community-based rehabilitation policy, and so a continuing process would be initiated. One would still start with selected areas but with the intention of increasing the population served. For a long-term strategy careful forethought and planning would be required. The pioneering spirit of Field Health Workers in promulgating PHC would once again be involved in another new approach and provide enthusiasm and interest.

Although the situation is little different from the problematic "who came first, the chicken or the egg?", the decision was made that my task in Botswana would be to introduce a community-based programme and, while doing so,

to evaluate the manual. This proved to be the correct decision for one of the first questions asked wearily by a Family Welfare Educator (Primary Health Worker) was whether they had once again to do a field trial for three months, and when the answer was to the contrary, the quickening of interest was obvious.

Several possibilities exist for implementation of rehabilitation in the community using the manual as a tool. Keeping in mind the limited resources developing countries set aside for rehabilitation, the ideal in terms of cost-saving would be the use of existing infrastructure for PHC services. This was the obvious method of choice for our programme in Botswana, a country with one of the best PHC networks in the developing world. It was also apt that the WHO's first community-based programme should be started in Serowe, a village in the Central District of Botswana where the tradition of the use of Field Workers for community health care goes back to the nineteen-sixties. Similarly, in India and Nigeria, field trials have commenced, using Primary Health Workers.

The possibility also exists for the non-governmental sector to use the manual for implementation of rehabilitation programmes. Members of grass-roots organizations, such as rural womens organizations, boy scouts, etc., can play the role of local supervisors, as can motivated community members. Such volunteers already perform health care roles in many of our countries on a purely voluntary (unpaid) basis; others may be recompensed for their services in whole or in part by their organizations, local councils, etc. These volunteers may be multipurpose workers or rehabilitation workers only. Use of the manual by such motivated individuals and by members of village-level organizations has been made possible by its preparation, both as a self-learning text and as a text for instruction for training workshops. It is hoped that both these methods will be evaluated. In Sri Lanka, a non-governmental organization, the Sarvodaya Shramadana movement, has introduced

rehabilitation in the villages by adapting both the approach and the material suggested in the manual to suit its own purse and organizational structure. Their experience should prove interesting.

At the time of writing, little feedback has been obtained from results of field testing. The first draft of the manual is being tested in Botswana and Nigeria; in India, the second version is being tested; three of the booklets have been translated into Spanish and adapted for use in Latin America and is currently being tested in Mexico. Since the field trial has only been underway for a short time, and due to its limited area, only a few general comments are possible.

To date, a follow-up visit has been made only to Botswana. Early results from this country appear favourable. The benefits accrued by the disabled, assessed at three months (Appendices I and II) and at six months (Appendices III and IV) indicate that this approach is well suited to the country's needs.

Discussion with my colleague, Miss Gunnel Nelson, who is supervising the field testing in Nigeria (Appendix V) and India, leads me to believe that the better the primary health infrastructure, the better the results of our approach would be. Two factors are chief contributors to this. Firstly, the existence of a PHC service creates community awareness of its health needs, and with this an awareness of the needs of the disabled can be created. Secondly, PHC teaches the community to take responsibility for its own health care, so that our programme would be more readily acceptable; more importantly, the potential for harnessing the motivation of the community and its members is increased.

Our experience with institutional rehabilitation has taught us the importance of motivation in the rehabilitation process. Motivation is demanded both from the trainee and from the providers of the training, but more so perhaps from the trainee. This short experience with community-based

rehabilitation has made it clear that motivation will be the key to its success - motivation being particularly needed from the providers of training. One cannot dismiss as being purely a subjective observation the difference in the quality of results of rehabilitation obtained by apparently motivated Field Health Workers and apparently non-motivated Field Health Workers. It is also clear that with the unfortunate hierarchical structure that prevails even with PHC services, the motivation must necessarily first be generated at the highest levels. In this respect, it is encouraging that more and more developing countries are converting to a policy of community-based rehabilitation. With the country committed to this approach, the ministries, departments and organizations responsible must necessarily take steps to effectively implement policy. This should motivate those responsible for the planning and the implementation of programmes. These will then be an example to motivate local supervisors who, in their turn, would stimulate family members and the community so that maximum benefit will be gained by the disabled.

A reverse demand is also essential to maintain motivation, making it a two-way process. Disabled persons and their families are becoming increasingly aware of their rights and are seeking social justice at last. Where this is still absent, it should be created to ensure success of community-based rehabilitation.

A deep commitment must permeate downwards from the providers and a demand must diffuse upwards from the consumers to ensure success of social reform. Many social development programmes in developing countries have fallen short of expectations due to the lack of political will, resulting in the absence of commitment and sustained motivation. Governments should demonstrate this will by significant transfer of resources from institutional systems to community-based programmes. It is only then that commitment will be translated into action by the bureaucracy, and not remain as mere paper plans. In my own country, Sri Lanka, community-based rehabilitation has been included

as one of fifteen aspects of basic health to be delivered in the PHC package by multipurpose Field Health Workers in its governmental health sector in our pursuit of the goal of Health for All by the Year 2000. However, no programmes have yet been started. The meagre resources provided for rehabilitation continue to be swallowed up by institutions. Plans are still being made to enlarge and increase institutions, often supported by international organizations. Although its policy is positive, there appears to be a lack of commitment to making rehabilitation accessible to the rural disabled.

The basic training received by Field Health Workers appears to influence their ability to use the manual. One group of primary health workers had been "community-selected" and trained over a period of eleven weeks in the basic elements of maternal and child care, nutrition, environmental sanitation and health education. They also had long experience in the field, motivating the community towards improvement of the health of their members. This background was an obvious advantage when it came to the implementation of our programme. With the contact that they had with their communities, they were aware both of the disabled members in their communities and of their problems. The medical and administrative experience gained helped them to identify the disabled, select the appropriate training material and to guide, supervise and motivate the training programmes of the disabled. This contrasts with another set of primary health workers who apparently did not have sufficient knowledge or experience to be able to identify the disabled and their problems nor to select appropriate training material. Although this could perhaps be due to the inadequacy of the local supervisor guide (which has since been completely redrafted), it must be added that the first group had hardly any need for this guide.

This leads on to another noticeable feature which has been the reluctance on the part of implementors at all levels to "read" the manual. In the developed world it is usual that all material is read and studied carefully before any action is taken. Unfortunately, in developing countries, there is a certain reluctance to follow the same method. However, I do not consider using a written manual as a tool for practical application a disadvantage. It is common practice to read relevant material only when confronted with particular situations. It is at these times that sufficient interest is aroused for users of the manual to read and absorb the contents applicable to the situation so that knowledge can be imparted to others. For example, those responsible for running a programme in a certain area, having followed an introductory course, were familiar with the material contained in the manual, but not having read it themselves they were not aware of its specific content. But this did not necessarily prove a hindrance to their ability to select training packages. When confronted with a particular disability, the appropriate training packages would be selected and read and the family instructed accordingly. Repeated application in this manner would in time familiarize users with the detailed contents of the manual. This reluctance in the developing world to read texts (except for examinations!) more often necessitates an introductory course, the nature of which would be that users are oriented to the problems faced by the disabled and strategies used to overcome these problems as suggested in the manual.

In this context, the size of the manual is also relevant - the larger the size the greater the reluctance to read it! This calls for careful evaluation to determine whether all the material contained therein is necessary to fulfill the manual's aims and objectives. Reductions should be made wherever possible.

A complaint often heard in efforts to include the delivery of rehabilitation as part of PHC is that multipurpose Field Health Workers are already overburdened with an excess of tasks. Associated with this is the idea that rehabilitation of the disabled is not a priority. It should then be kept in mind that 1½-2% of the population are disabled in immediate need of training. To them rehabilitation is "essential health" referred to in the definition of PHC, so that it should be "made universally accessible to (disabled) individuals and families in the community at a cost that the community and country can afford". More particularly, if the goal of HFA 2000 is to be achieved, then community-based rehabilitation should be available as an integral component of PHC.

It is true that where Field Health Workers serve populations of 4 000 - 5 000 and more, they are overburdened and unable to perform their role effectively. With the planned increase in numbers of Field Health Workers in developing countries over the next few years, these workers will serve increasingly smaller populations so that all aspects of essential health care are made available to all members of the community.

Another observation must also be made at this point regarding the manpower for providing supervision of Field Health Workers in their rehabilitative role. It is logical to assume that a "second-level supervisor" with a knowledge of rehabilitation would contribute to the greater success of community-based programmes. Such a rehabilitation worker would be able to train Field Health Workers in their local settings, give them the necessary technical guidance for implementation and provide the basic first-level referral services.

Many developing countries already have skilled professionals such as occupational therapists, physiotherapists, social workers, etc. The cost of orienting such professionals to the new approach would be more economical than training other health workers for a supervisory function in rehabilitation. In

my own experience more often than not skilled professionals are clearly under-utilized, performing only therapeutic functions in urban institutional settings so that the general quality of available rehabilitative services is poor. Where educational programmes for such professionals do exist, they appear to be based on western patterns, geared only to urban populations. Keeping in mind that 80% and more of our populations live in rural areas, it is perhaps time that our countries eschewed unsuited patterns and developed manpower relevant to our needs.

The community-based approach calls for support from adequate referral services. Projecting into the future, a first-level referral service should be available within reach of the community. Rehabilitation professionals manning first-level referral services would then also serve the function of supervising community-based programmes. The cost of making available, at the first-level, professional skills along the lines of western manpower patterns would not serve the purpose of the community-based approach - the cost of stationing an occupational therapist, physiotherapist, social worker and a speech therapist in a peripheral rehabilitation service would be both prohibitive in terms of cost, and a phenomenal waste in terms of skills. The community-based approach then appears to call for the development of a rehabilitation professional capable of performing the basic rehabilitative functions of occupational therapy, physiotherapy, medical social work and speech therapy. A professional capable of performing these multiple roles would not only facilitate a greater coverage of population, but enhance the quality of rehabilitation by adding another dimension to the concept of "total patient care".

Despite initial difficulties and problems, I am firmly convinced that the community-based approach to rehabilitation is the only way we can reach the rural disabled in developing countries, who form the majority of the disabled. There is also no doubt in my mind that the use of a training manual is the most

appropriate, effective and efficient method of implementing this approach, and one which is the least demanding on the slender resources of developing countries. I am certain that the results of field-testing the manual over the next few years will prove my assumptions correct.

With regard to field-testing, the first draft of the manual contained questionnaires for users for the purpose of obtaining feedback; these questionnaires were framed so as to evaluate both the approach and the content of the manual. Subsequently, in the second version, the questionnaires were rephrased so as to make them more specific. However, it appears that few, if any, questionnaires have been returned from the field so that a scientific evaluation for the purpose of this paper is not possible.

The preliminary experience gained by consultants in the introduction of the first two programmes in Botswana and Nigeria and comments of an informal consultation group meeting in Mexico City\* were used to revise the first draft of the manual. With this preliminary experience a more appropriate tool has been designed to field-test the manual by assessing it in the following areas:-

1. Understanding of the manual by trainers;
2. Understanding of the manual by local supervisors;
3. Effectiveness of training packages in each booklet;
4. Effectiveness of training the disabled using this approach;
5. Costs of programmes;
6. Manpower density.

However, it is feared that there are still some difficulties in conducting an extensive field trial of this nature. To assess the manual accurately it must be used in the mother tongue of the consumers. Although steps are being taken in some countries to do so, translation and printing of the manual in developing

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\* Informal Consultation on Community Training for the Disabled, Mexico City, 19-24 November 1979

countries may take a long time. Mention was made earlier of the reluctance in the developing world to read written text - it may be added that this reluctance also appears to extend to the filling-in of forms, keeping written records, etc. Hence the poor return of feedback material. The onus then lies with the consultants to make assessments themselves, and in view of the limited period of time available to them in the field, coverage is necessarily restricted. Besides which, in view of the fact that the programme commenced only recently, the countries participating in the field trial are, as yet, few in number and the programme area in each of them is necessarily limited. Therefore all the different types of disabled may not be adequately covered and its content may not be scientifically evaluated before publication of the manual.

What I have stated above are the teething troubles of implementing what could be described as a revolutionary programme in basically conservative societies historically subjected to institutional systems. Therefore, new programmes necessarily take time to be accepted by both governments and peoples. Though the prospects may sometimes appear daunting, we must persist with it as we are convinced of its need. Vested interests have exploited the fears and hesitancy to change from familiar patterns. They must be overcome if social justice is to be provided to our disabled.

#### APPENDICES

- I. Introduction of community-based rehabilitation in Botswana - Report of a Mission, 16 September - 14 December 1979
- II. Report from Serowe - Training the Disabled in the Community Project. 28 December 1979
- III. Report on Assignment to follow-up field-testing of manual "Training the Disabled in the Community", 23 June - 4 July 1980.
- IV. Report on Evaluation of Field-testing WHO Manual, 26 June 1980.
- V. Assignment Report. Introducing community-based rehabilitation programme using the manual "Training the Disabled in the Community" by Gunnel Nelson, WHO Consultant, 2 January - 26 March 1980.

APPENDIX I

INTRODUCTION OF COMMUNITY BASED REHABILITATION  
IN BOTSWANA

Report of a Mission

16th September - 14th December, 1979

Mrs. Padmani Mendis, MOSP. Dip. TF. CNC

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1. OBJECTIVES OF THE MISSION:

- To introduce community based rehabilitation to Botswana. (Vide document AFR/REHAB/10 1978, "Planning of community based rehabilitation services in Botswana" - Paras 2, 3, 5 and 6.2)
- To commence field-testing of the manual "Training the Disabled in the Community".

2. LENGTH OF MISSION:

The total stay in Botswana was from 16th September - 14th December. There were two periods of absence from the country as follows :-

- October 5th - 12th to attend a Consultation of Directors of Medical Rehabilitation at Brazzaville.
- November 17th - 28th to participate in "Informal Discussions on Training the disabled in the Community" in Mexico City.

3. DECISIONS RE MISSION

A meeting was held on the 19th September at the Ministry of Health to discuss the consultants programme in Botswana. The following were present -

Dr. A. Sunde , Senior Medical Officer  
Mrs. S. Campbell, Senior Planning Officer  
Miss. Adelaide Kgosidinsti, Commissioner for the Handicapped  
Dr. B. Dando, World Health Organisation.

The following decisions were taken :-

- i. The community-based rehabilitation programme would be introduced in Serowe and Palapye with the cooperation of the Regional Health Team.
- ii. Family Welfare Educators from this region would be selected to supervise the training programmes of the disabled.  
  
A short educational course will be arranged for them to introduce the programme.
- iii. While the Commissioner for the Disabled will be the National Counterpart of the consultant, the Regional Social Welfare Officer will be the Local Counterpart.

The Regional Social Welfare Officer will then continue to run the programme in the region under the guidance of the Commissioner on the completion of the consultants mission.

The Commissioner will attend the informal discussions on "Training the Disabled" to be held in Mexico City so that she will be in a position to supervise the programme in Botswana.

- iv. The Senior Medical Officer will explore the possibilities of obtaining more copies of the manual and also of translating the manual into Setswana.
- v. Officials from the Ministry of Health will visit Serowe at a date to be arranged to observe the programme in action.

#### 4. INTRODUCTION OF THE PROGRAMME

##### 4.1. Preliminary Discussions (two weeks)

In consultation with the Regional Medical Officer it was decided that the 15 Family Welfare Educators from Serowe and Palapye would be included in the programme.

The consultant held discussions with persons from Serowe and Palapye who would in any way be involved in the programme and with those responsible for the Family Welfare Educators. (Annex 1).

Visits were made to the homes of several disabled persons so that an assessment of their immediate needs could be made.

##### 4.2. Referral Facilities (one week)

During the first week of the mission which was spent in Gaborone, visits were made to the following institutions in order to gain knowledge of the present referral facilities available -

Tlanelong Rehabilitation Centre  
Mochudi Centre for the Blind  
Camphill Community in Rankoromane  
Ramotswa Centre for the Deaf

(For description of above vide AFR/REHAB/10 1978, Para 4).

##### 4.3. Discussions with Social Welfare Officers and Public Health Nurses.

Since the Special Services Unit for the Handicapped would have the overall responsibility for the programme, the consultant held discussions with the members of the unit to explain the programme to them.

The Regional Public Health Sister and Nurse were also included in these discussions since they are administratively responsible for the Family Welfare Educators.

The Community Psychiatric Nurse (Palapye) was also included because the programme would involve the training of persons being treated medically by her. The Physiotherapist from the Jubilee Hospital, Francistown also attended the discussions and will participate in the field-testing. (Programme - Annex 2A).

#### 4.4. Course for Family Welfare Educators

The course commenced with two days of discussions the objectives of which were to make the participants aware of the problems faced by the disabled, and to introduce the contents and use of the manual "Training the Disabled in the Community" to the participants. (programme annex 2B).

This was followed over the next 3½ weeks with field work, the objective of which was to teach the participants how to use the manual. The Consultant and the Social Welfare Officer accompanied each Family Welfare Educator on home visits to the disabled selected by them for training.

During the first visits practical instruction was given in the following :-

- identification of the disabled;
- assessment of disability;
- selection of training material;
- finding a trainer;
- instructions and advice to the trainer.

During subsequent visits the Family Welfare Educators were given instruction in guiding, supervising and motivating the trainers, and in the continuation of the training programmes of the disabled.

Each Family Welfare Educator was asked to commence the training of at least 2 disabled persons in her area during this time.

#### 4.5. Follow-Up Discussions

Six weeks after the programme was first introduced a half-day course was held to enable the participants to share their experience of the programme, to discuss problems and to find solutions for such problems. The future of the programme was also discussed. (Programme Annex 2C).

The Ministry of Health was represented at these discussions by the Senior Medical Officer.

#### 4.6. Completion of the Mission

Over the last two weeks the consultant continued to accompany the Social Welfare Officer on field work to ensure that she would be able to continue the programme on her own.

### 5. FEATURES OF THE PROGRAMME

#### 5.1. Number of Disabled Under Training

During the period of the Mission the training of 32 disabled persons was commenced. The ages of the disabled varied from 14 months to 77 years.

The disabilities that these 32 persons had were as follows :-

Fits	...	...	1
Difficulty with hearing	...	...	2
Difficulty with learning	..	..	9
Difficulty with moving	...	...	4

Difficulty with seeing	...	8
Difficulty with speech	...	2
Show strange behaviour	...	1
Multihandicapped	...	5
1 Difficulty with hearing, fits		
1 Difficulty with hearing, fits, moving		
3 Difficulty with learning, fits.		

### 5.2. Schooling

The incidence of disabled children of school-age who were not getting any schooling was found to be high. Among the 32 persons under training, 16 came into this group.

- The Head Teachers of 7 Primary Schools serving the areas where 11 of these children lived were interviewed and all expressed willingness to accept the children to their schools next year.

The disabilities of these 11 children were as follows :-

Fits	..	1
Difficulty with learning	..	5
moving	..	2
seeing	..	2
speech	..	1
hearing	..	1

- Two children in this age group with mental retardation were not considered ready for schooling as yet. They need some basic training first and should be assessed for schooling next year.
- No success re schooling was achieved in the case of a 8-year old boy who is partially sighted. In this case the mother is adamant that the child should not go to school. Further counselling is necessary to change the mothers attitude.
- A deaf child of 8 years whose parents are both teachers will commence schooling next year in the school where his father is Deputy Head Teacher.
- Another blind child will commence schooling in the school where his sister is a teacher.

At the time of completion of the mission registration for the new school year had begun, and it is hoped that all the children referred to above will be registered.

However, with the commencement of the new term it will be necessary for the Social Welfare Officer to meet the teachers of these disabled children, distribute the "Guide for Teachers" and discuss with them any problems that may arise. Regular follow-up with guidance, support and advice will also be necessary to keep the disabled children in the schools to which they have been so readily accepted.

5.3. Job Training

The Personnel Coordinator of the Serowe Brigades and the Coordinator-in-Charge Palapye Trust Brigades were both approached regarding the possibility of providing disabled adolescents and young adults with job training, and their response was most encouraging.

An application has been forwarded on behalf of a 15-year old multihandicapped boy (fits, hemiparesis, deaf and dumb) for simple training in carpentry or agriculture.

6. FIELD TESTING

The programme was started with 17 copies of the manual, and a further 16 copies were received later, with which the programme could be continued for at least a year.

At the time of completion of the mission the following booklets and training packages were being used.

Number of Training Packages in Use

<u>Number of Training Packages</u>	<u>Fits</u>	<u>Hearing</u>	<u>Learning</u>	<u>Moving</u>	<u>Seeing</u>	<u>Speech</u>	<u>Strange Behaviour</u>
1	6	2			1	3	1
2			6		1		1
3			3		1		
4			4		5	2	
5	2	1	6		2	1	
6	1	6	1		1		
7	1	1					
9				1			
13				2			
14				1			

No booklets were used for three persons.

7. OTHER ACTIVITIES

The consultant was invited to address the following on the community-based rehabilitation programme.

- Seminar on Work with the Handicapped held on 7th November, 1979.
- Public Health Nursing Conference held on 10th, 11th and 12th December, 1979

8. RECOMMENDATIONS

8.1. The manual currently being used in the English Language is acceptable, but there is no doubt that written in Setswana it would be more valuable and more easily used. Also, a more accurate assessment of the results of field-testing would be obtained if it could be read in Setswana by the trainers.

Therefore the steps already taken to obtain funds for translation and printing should be followed up so that translation could be effected at an early date.

Part 'A' of the manual (i.e. the guides for the local supervisors, teachers and community leaders) may profit considerably by adaptation of some parts to suit the country more specifically, so it is suggested that this part is not translated as yet. Since it is to be used by staff at the second level it can be done so quite easily as it is, in English.

8.2. The programme should be continued in Serowe and Palapye alone until the manual has been developed and is finally published by the World Health Organisation.

At the same time as the Manual is being field tested for the WHO, experience will be gained as to its relevance to local conditions.

The programme in Serowe and Palapye may be evaluated after a period of 18 months.

Then, on the basis of the evaluation and the experience gained in its use, the manual should be adapted for use in Botswana and the programme then expanded to other areas of the country.

8.3. With a view to expanding community-based programmes to other parts of the country it is suggested that steps be taken early to develop the manpower that would be necessary to meet this on the lines recommended by a previous WHO Consultant (AFR/REHAB/10, 1978, para 6.1 and 6.2).

8.4. The success of the programme depends on the motivation of the Social Welfare Officer and the Family Welfare Educators.

The consultant would like to make particular mention that the choice of Mrs. E. Matiza, Regional Social Welfare Officer, to be her local counterpart greatly facilitated the introduction of the programme as she is ideally suited for the task. She will no doubt be of much help to the Commissioner for the Handicapped in the implementation and the expansion of the programme in Botswana.

In order to maintain the motivation of the Family Welfare Educators, it is suggested that periodic (perhaps every six months), follow-up courses be held at which not only would problems and suggestions be discussed, but also results presented and assessed.

It is also suggested that the Social Welfare Officer and the Family Welfare Educators give talks about the programme to community-based groups such as community leaders, Red Cross, Boy Scouts etc., and utilise these groups to identify the disabled in their communities. This is in view of the fact that disability surveys as described in the manual may be too time consuming to be carried out by Family Welfare Educators.

- 8.5. The Commissioner for the Handicapped should send a periodic report (at least every six months) to the WHO Headquarters through the Regional Office. This should contain information regarding the progress of the programme and problems faced in implementation. The forms provided in the manual for field-testing should also be completed periodically and forwarded with the reports.

The WHO will prepare and distribute information related to the progress of the programme and the field-testing, to the other countries participating in the programme.

Towards the end of the field-testing period the marginal cost increases related to the programme should be ascertained and forwarded to the WHO.

#### ACKNOWLEDGEMENTS

The consultant would like to thank all those who assisted with the introduction of the programme. Special thanks are due to the Commissioner for the Handicapped, the Regional Social Welfare Officer and all the other members of the Regional Health Team, Serowe for their active support and cooperation.

ANNEX I.

LIST OF PERSONS CONTACTED

GABORONE

Dr. A. Sabina,  
Permanent Secretary, Ministry of Health.

Dr. A. Sunde',  
Senior Medical Officer, Ministry of Health

Mrs. S. Campbell,  
Senior Planning Officer, Ministry of Health

Mrs. K. M. Makhwade,  
Chief Nursing Officer (Admin), Ministry of Health

Miss. Adelaide Kgosidinsti,  
Commissioner for the Handicapped.

Dr. B. Dando,  
World Health Organisation.

SEROWE AND PALAPYE

Mr. Mokoacha Mokoadi,  
Tribal Authority

Dr. David Shin,  
Regional Medical Officer

Mrs. G. B. Kgari,  
Senior Matron, Northern Region

Mrs. K. P. Samson,  
Acting Senior Sister, Central District Council

Mrs. C. Vuna,  
Sister-in-Charge, Palapye Health Centre

Mrs. Kgaimena,  
Sister-in-Charge, Serowe Health Centre

Mrs. Ontumetse,  
Sister-in-Charge, K.P. Samson Health Centre

Mrs. G. Moatlhod,  
Sister-in-Charge, Nutrition Village Health Centre

Mr. T. J. Sathokge,  
Health Inspector, Regional Health Team

Mrs. E. Dijeng,  
Public Health Sister, Regional Health Team

Mrs. B. Libello,  
Public Health Nurse, Regional Health Team

Mrs. E. Matiza,  
Social Welfare Officer, Regional Health Team

Mrs. Motswaledi,  
Head Teacher, Centrel School.

Mr. B. Sebina,  
Head Teacher, Western School

Mr. Leroy Williams,  
Coordinator, Palapye Trust Brigades.

ANNEX I (Continued)

Mr. Gidi,  
Personnel Coordinator, Serowe Brigades

Mrs. Minnie Shaw,  
Director, Red Cross, Palapye.

ANNEX 2-4.

DISCUSSION ON COMMUNITY-BASED REHABILITATION  
MONDAY, 22nd OCTOBER, 1979

PROGRAMME

Morning Session :

8.00 a.m. - 12.15 p.m. Disability Problems in Botswana  
Aims of Training the Disabled  
Community Programmes in Rehabilitation  
The Training Manual as a Tool for  
Community-Based Rehabilitation.

Afternoon Session :

2.00 p.m. - 4.00 p.m. Course for Family Welfare Educators  
on Training the Disabled.

ANNEX 2-B.

COURSE ON COMMUNITY TRAINING OF THE DISABLED

PROGRAMME

Tuesday, 23rd October

- |               |   |
|---------------|---|
| 8.30          | - Prayer  |
| 8.35          | - Opening Address - Dr. D. Shih,<br>Regional Medical<br>Officer   |
| 8.50          | - Disability Problems in Botswana   |
|               | - A Training Manual for the Disabled  |
|               | - Role of the Family Welfare Educator<br>in the Training of the Disabled  |
| 9.15          | - Group work on problems faced by persons<br>who have difficulty with moving,<br>learning, and persons who have fits.   |
| 10.30 - 12.30 | - Group Presentations and General<br>Discussion.  |
|               | - Aims of Training the Disabled   |
|               | - Introduction to booklets and training<br>packages for persons who have<br>difficulty with moving, learning<br>and persons who have fits.                        |
|               | - General Discussion  |
| 2.00 - 4.00   | - Group work on problems faced by persons<br>who have difficulty with hearing,<br>speech, seeing and persons who show<br>strange behaviour.                       |
|               | - Group presentations and General<br>Discussion   |
|               | - Introduction to booklets and training<br>packages for persons who have<br>difficulty with hearing, speech,<br>seeing and persons who show strange<br>behaviour. |

Wednesday, 24th October

- |      |   |
|------|---|
| 8.30 | - Schooling for the disabled.                                       |
|      | - Jobs for the disabled   |
|      | - Social activities for the disabled.                               |
|      | - introduction to the guides for teachers<br>and community leaders. |
|      | - Identification of the disabled and<br>disability survey.          |

ANNEX 2-3 (Continued)

Wednesday, 24th October

10.30

- Training programme planning
- Introduction to the guide for local supervisors

2.00 - 4.00

- Group work - discussion of programme
  - Group presentations and General Discussion.
  - Selection of disabled for training
  - Chairman's remarks.
  - Closing remarks.
- 

ANNEX 2-C.

FOLLOW-UP DISCUSSIONS ON TRAINING THE DISABLED

PROGRAMME

1. Description of the experience of the Family Welfare Educators in training the disabled.
  2. Group work; problems met with in training the disabled, and possible solutions to these problems.
  3. Group presentations and General Discussion.
  4. Clarifications regarding use of booklets and training packages.
  5. Future plans for community-based programmes in Botswana.
-

APPENDIX II

FROM REGIONAL MEDICAL OFFICER, SEROWE.



DR. DAVID SHIH.

TO PERMANENT SECRETARY, MINISTRY OF HEALTH.

REF: M3/78/31 (55)

28TH DECEMBER 1979.

REPORT FROM RMO SEROWE :- TRAINING FOR THE DISABLED IN THE COMMUNITY PROJECT.  
(IN SEROWE AND PALAPYE FROM 3RD OCTOBER TO 14TH DECEMBER 1979 BY MS.P.MENDIS)

PLEASE REFER TO THE REPORT ISSUED BY MS A.D. KGOBIDINTSI :- "REPORT OF INFORMAL CONSULTATION ON COMMUNITY TRAINING FOR THE DISABLED".

1. INTRODUCTION

IN THE ABOVE REPORT, THE GOAL OF THE TRAINING FOR THE DISABLED PROGRAMME WAS TO IMPROVE THE "QUALITY OF THEIR LIVES". THE OBJECTIVE WAS TO PROVIDE A REALIST AND APPROPRIATE SERVICE TO THE DISABLED (HANDICAPPED) IN THEIR OWN COMMUNITIES. THE APPROACHES WERE TO UTILIZE "FAMILY MEMBERS" FOR THE TRAINING, AND TO DEVELOP "LOCAL MANPOWER WITHIN THE COMMUNITY ITSELF FOR SUPERVISION OF THE TRAINING AS WELL AS APPLICATION OF THE NEWLY DEVELOPED TECHNOLOGY".

TO ACHIEVE THIS OBJECTIVE, THE W.H.O. HAS PRODUCED A DRAFT MANUAL ENTITLED "TRAINING THE DISABLED IN THE COMMUNITY" (TDC) CONTAINING MATERIAL FOR "DEVELOPMENT AND DISCUSSIONS WITH THE FINAL AIM TO INSPIRE THE PREPARATION AND DISTRIBUTION OF NATIONAL MANUALS AND TRAINING PACKAGES, ADAPTED TO LOCAL CONDITIONS, IN ORDER TO IMPROVE THE PRESENT CONDITIONS OF THE DISABLED IN THE DEVELOPING COUNTRIES IN AN EFFECTIVE WAY."

2. FIELD-TESTING OF THE MANUAL

MRS. P. MENDIS JOINED THE SEROWE REGIONAL HEALTH TEAM ON 3RD OCTOBER 1979 AS THE WHO CONSULTANT PHYSIOTHERAPIST FOR THE TDC PROJECT. A SEMINAR WAS HELD ON 22ND TO 24TH OCTOBER 1979 TO INTRODUCE AND TRAIN THE 15 FAMILY WELFARE EDUCATORS (FWE) FROM SEROWE AND PALAPYE. THE COMMISSIONER FOR THE HANDICAPPED, FOUR SOCIAL WELFARE OFFICERS (SWO), AND SEROWE PUBLIC HEALTH NURSE ALSO ATTENDED.

EACH FWE WAS ASKED TO SELECT AT LEAST TWO HANDICAPPED PERSONS IN THEIR WARDS FOR TRAINING. THE FOUR SEROWE CLINICS AND PALAPYE HEALTH CENTRE, TO WHICH THE FWEs ARE ATTACHED, WERE GIVEN COPIES OF THE MANUAL FOR THE FWEs TO USE. MS MENDIS AND MS MATIZA (ASWO-SEROWE) MADE VISITS EACH DAY WITH THE FWEs TO THE HOMES OF THE HANDICAPPED TO SUPERVISE THE FIELD WORK.

A FOLLOWUP SEMINAR WAS HELD ON 30TH NOVEMBER 1979, AT WHICH 10 FWEs PRESENTED REPORTS OF THE TRAINING ACTIVITIES. THE OTHER FIVE FWEs WERE EITHER SICK OR ON LEAVE.

3. RESULTS

I HAD RECORDED THE 20 CASES PRESENTED BY THE 10 FWEs AND I GIVE THE FOLLOWING ANALYSIS:-

A. AGE DISTRIBUTION

<u>AGE GROUP</u>	<u>NUMBER OF CASES</u>
0 - 1 YR	1
2 - 5 YR	4
6 - 10 YR	9
11 - 15 YR	2
16 - 25 YR	1
26 - 45 YR	1
46 YR AND OVER	2

B. SEX DISTRIBUTION

MALE 11  
FEMALE 9

COMMENT:- AGE AND SEX DISTRIBUTION OF HANDICAPPED IN THE POPULATION STUDIED NOT KNOWN. ALTHOUGH SAMPLING WAS STRATIFIED BY SELECTING CASES FROM DIFFERENT AREAS IN THE VILLAGES, IT WAS NOT RANDOM, BECAUSE CASES WERE SELECTED BY THE FWEs.

0. CASE DISTRIBUTION AND ANALYSIS

TYPE OF HANDICAPPED	NO. OF CASES	NO. OF CASES SHOWING:-	
		POSITIVE CHANGE*	NO. CHANGE SEEN**
EPILEPSY	4	2	2
DEAF/DUMB	3	1	2
BLIND	6	3	3
MENTALLY RETARDED	1	0	1
MOTOR HANDICAPPS	6	5	1

\* POSITIVE CHANGE MEANS NEW DESIRED CHANGE IN BEHAVIOUR SEEN, WHICH IS ATTRIBUTABLE TO THE TRAINING (E.G. WALKING, GARDENING, INCREASED ROLE IN FAMILY).

\*\* NO CHANGE MEANS NO NEW BEHAVIOUR SEEN, ALTHOUGH ADVICE WAS GIVEN OR CLIENT WAS REFERRED FOR MEDICAL OR WELFARE SERVICES (E.G. REFERRED TO SEE DOCTOR, ENROLLED IN PRIMARY SCHOOL FOR NEXT YEAR). I CLASSIFIED THESE AS NO CHANGE, BECAUSE EITHER THE BENEFIT OF THE TRAINING HAD NOT YET BEEN APPARENT AT THIS TIME OR THE SERVICE GIVEN WAS NOT UNIQUE TO THIS PROJECT (I.E. ADVICE, COUNSELLING, AND REFERRAL SERVICES WERE ALREADY PRESENT AND RESPONSIBILITY OF THE S.W.O.)

THEREFORE 11 OUT OF THE 20 CASES TRAINING SHOWED POSITIVE CHANGE (55%) AFTER FIVE WEEKS OF TRAINING.

4. PROBLEMS ARISING FROM THE TRAINING

AT THE FOLLOWUP SEMINAR, THE FWEs RAISED THE FOLLOWING PROBLEMS:-

- A. FAMILIES CANNOT READ THE MANUAL BECAUSE IT IS IN ENGLISH.
- B. SOMETIMES THERE WAS DIFFICULTY IN FINDING A TRAINER FROM THE FAMILY.
- C. THE SEVERELY MENTALLY RETARDED CASE WAS VERY DIFFICULT TO TRAIN.
- D. LACK OF TRANSPORT TO TAKE THE PHYSICALLY HANDICAPPED TO SCHOOLING.
- E. TRAINING CANNOT BE FOLLOWED-UP WHEN THE HANDICAPPED CHILDREN ARE TAKEN TO THE LANDS.

THE FWEs RECOGNIZED THE INADEQUATE SITUATION AND SUPERSTITIONS TOWARDS THE HANDICAPPED:-

- A. DISABLED WERE BEING SOCIALLY REJECTED AND NEGLECTED BY THEIR FAMILIES.
- B. SOME PARENTS HID THEIR HANDICAPPED CHILDREN.
- C. SOME PARENTS TOOK THEIR HANDICAPPED CHILDREN TO FAITH HEALERS.
- D. SOME PARENTS FELT THERE WAS NO NEED FOR TRAINING BECAUSE THEY CONSIDERED THE PRESENCE OF A HANDICAPPED CHILD AS A PUNISHMENT FROM GOD.

5. RESOURCES IN THE SEROWE-PALAPYE FIELD TESTING

- A. MANPOWER:-
  - I. PROJECT CONSULTANT FROM W.H.O. (FULLTIME)
  - II. SECOND-LEVEL SUPERVISOR - S.W.O. SEROWE (FULLTIME)
  - III. LOCAL SUPERVISORS - 15 F.W.E.s (SPENDING ONE DAY PER WEEK)
  - IV. ONE DRIVER FROM REGIONAL HEALTH TEAM (FULLTIME)
- B. OTHER RESOURCES:-
  - I. ONE LANDROVER VEHICLE FROM REGIONAL HEALTH TEAM (FULLTIME)
  - II. SOME TYPING
  - III. FUNDS FOR CATERING OF TWO SEMINARS (ABOUT P300)

- ALTHOUGH RELUCTANT AT FIRST, ALL FWEs BECAME INTERESTED AND WILLING IN THE TRAINING FIELD WORK, ONCE THEY SAW THAT IT WAS WITHIN THEIR ABILITIES, NOT REQUIRING EXTRA TIME FROM THEIR HOME VISITING, AND RESULTS WERE POSSIBLE.
- THE REGULAR VISITS BY THE CONSULTANT AND S.W.O. ALSO HELPED TO DEVELOP THIS PARTICIPATION.
- THE CONSULTANT AND S.W.O. ALSO RALLIED INTEREST AND WILLINGNESS IN THE PRIMARY SCHOOL TEACHERS TO ACCEPT HANDICAPPED CHILDREN INTO THEIR SCHOOLS.

6. COST-BENEFIT ANALYSIS

ASSUMPTIONS: - A. UTILIZATION OF SAME MANPOWER AND RESOURCES. (ONE YEAR = 250 WORK D<sup>T</sup>)  
 B. TRAINING 30 HANDICAPPED EVERY 6 WEEKS (2 PER FWE) = 240 TRAINED IN ONE YEAR.  
 C. ESTIMATE POSITIVE CHANGE OBTAINABLE IN 55% = 240 x 55% = 132.

COST:- PER ANNUM	MINIMUM		MAXIMUM		ESTIMATE FOR 30 FWES	
	MINIMUM	MAXIMUM	MINIMUM	MAXIMUM	MINIMUM	MAXIMUM
A. S.W.O. FULLTIME (GRADE T3)	P3708	P4908				
B. 15 FWES (GRADE LN7:P1680-2400) ONE DAY PER WEEK	P5040	P7200	P10080	P14400		
C. DRIVER FULLTIME (T5)	P1680	P2760				
D. ONE LANDROVER STATIONWAGON (P9000 OVER 5 YEARS USE) PETROL (8000KM AT 8KM/LIT = 1000 LIT AT 50THEBES PER LIT.)	P1800	P1800				
SERVICING (8/YEAR AT P12 EACH)	P 96	P 96				
REPAIRS	P 300	P 300				
TUNE UP (2/YEAR AT P32 EACH)	P 64	P 64				
E. MISCELLANEOUS	P1000	P1000				
TOTAL =	P14188	P19128.	P19228.	P26328.		
BENEFIT:- CASES WITH POSITIVE CHANGE ONLY.	+ 132	+ 132	+ 264	+ 264		
COST PER POSITIVE CASE =	P107.5	P150.0	P 72.8	P 99.7		
	MINIMUM	MAXIMUM	MINIMUM	MAXIMUM		

AS THE PRESENT FWES BECOME MORE SKILLED AND EXPERIENCED IN THE TRAINING, THE SUPERVISION OF THE S.W.O. WILL BE LESS INTENSIVE. THE S.W.O. CAN THEN EXPAND TO INCLUDE MORE FWES IN THE TDC PROGRAMME, THEREBY INCREASING THE PRODUCTIVITY OF THE PROGRAMME AND DECREASING THE COST PER CASE WITH POSITIVE CHANGE.

7. SUMMARY

FIELD-TESTING OF THE "TRAINING THE DISABLED IN THE COMMUNITY" MANUAL IN SEROWE AND PALAPYE, USING 15 FAMILY WELFARE EDUCATORS AS LOCAL SUPERVISORS AND THE SOCIAL WELFARE OFFICER AS THE SECOND-LEVEL SUPERVISOR, PRODUCED POSITIVE CHANGES IN THE QUALITY OF LIVING OF 55% OF THOSE TRAINED IN THE PROJECT.

THE COST OF PRODUCING A POSITIVE CHANGE IN ONE HANDICAPPED PERSON WAS ESTIMATED AT BETWEEN P107.5 AND P150.0, IF THE PROGRAMME WAS ESTABLISHED THROUGH<sup>OUT</sup> THE YEAR USING THE PRESENT TEAM. WITH FURTHER DEVELOPMENT OF THIS PROGRAMME, THE COST COULD DROP TO BETWEEN P72.8 AND P99.7 PER CASE WITH POSITIVE CHANGE.

THIS PROJECT HAS DEMONSTRATED THAT THE HANDICAPPED CAN BE TRAINED IN THE COMMUNITY.

8. RECOMMENDATIONS FROM REGIONAL MEDICAL OFFICER-SEROWE

THE EVALUATION ABOVE IS SHORT-TERM. WHETHER THE POSITIVE CHANGES PRODUCED BY THE TRAINING WILL PERSIST IS NOT KNOWN AT PRESENT. PERMANENCE OF RESULTS WILL DEPEND ON THE CONTINUAL FOLLOWUP BY THE FAMILY WELFARE EDUCATORS AND MOTIVATION BY THE REGIONAL HEALTH TEAM.

THEREFORE I RECOMMEND:-

1. THE PRESENT PROJECT BE CONTINUED IN HEALTH REGION 3 BY THE S.W.O. AND 15 FWES IN SEROWE AND PALAPYE. THE TEAM WILL CONTINUE TO TRAIN AND FOLLOWUP THE HANDICAPPED IN THESE TWO VILLAGES ACCORDING TO THE PROJECT.
2. A DETAILED EVALUATION BE PERFORMED IN 6 TO 12 MONTHS TIME TO ASSESS THE LONG-TERM RESULTS. IT SHOULD INCLUDE NOT ONLY RETENTION OF TRAINED BEHAVIOUR OR SKILLS, BUT ALSO EVALUATE DEGREES OF INCREASED SOCIAL INTEGRATION AND OF IMPROVED PERSONAL FUNCTIONING.
3. ADOPTION AND/OR EXPANSION OF THIS PROJECT WILL DEPEND ON THIS LONG-TERM EVALUATION.



### APPENDIX III

#### REPORT ON ASSIGNMENT TO FOLLOW-UP FIELD-TESTING OF MANUAL

#### "TRAINING THE DISABLED IN THE COMMUNITY"

23 June - 4 July 1980

Mrs Padmani Mendis

Botswana

#### ACTIVITIES

On 23 June, preliminary discussions were held in Gaborone with the Commissioner for the Handicapped regarding the progress of the programme in Serowe and Palapye and the use of the manual.

The next ten days were spent in Serowe and Palapye, the area in which the manual is being tested. This time was spent making home visits to the disabled included in the programme. The Regional Social Welfare Officer responsible for running the programme accompanied the consultant on these home visits.

#### OBSERVATIONS AND RECOMMENDATIONS

1. At the end of the consultant's first assignment (16 September - 14 December 1979), thirty-two disabled persons had been included in the programme. At the time of this visit, only eleven new persons had been introduced, making a total of forty-three.

This is disappointing. One understands, however, that this was chiefly because a new Regional Social Welfare Officer had only just taken over the responsibility of running the programme, the previous one having left the service some time earlier. Although such a change was unavoidable, it has been unfortunate from the point of view of the field trial due to failure to maintain the targets set for providing more disabled with rehabilitation and to increase the availability and use of the manual.

2. Also because of changes in this post of Regional Social Welfare Officer, it was not possible to trace accurate figures regarding the distribution of training packages. No questionnaires about the training packages and booklets had been filled in and collected, and this has now been requested.

3. With regard to the content of the manual, the following observations have been made:

i. The Guide for Local Supervisors does not appear to be of use to Family Welfare Educators. To some extent, this is due to their higher levels of education, experience and motivation. But more information on the actual implementation of training programmes is necessary for use both as a self-learning guide and as a text or reference for training workshops.

ii. The Guide for Community Leaders has not been used sufficient to warrant comment.

iii. The Guide for Teachers has been recommended as valuable by users.

iv. There is unnecessary duplication of material in Booklets II and V (Hearing and Speech). Also, because of the difficulty users appear to have with differentiating between these two disabilities, and of the similarity in the training techniques, it is suggested that these two booklets be combined. More details regarding training in communication methods is also necessary.

v. Selection, both of play activities and of methods of mobility training in the respective packages is difficult. It must also be mentioned that the former package has proved particularly useful.

vi. The package on household tasks has, in theory, been criticized because it is the same for all types of disabled. However, in the field, it has presented no problems and serves well the purpose for which it was introduced.

4. The progress made by the disabled under training was on the whole very satisfactory.

The eleven children who had commenced schooling at the start of the programme were still at school. Three more children had since commenced schooling,

one of whom had dropped out. Following discussions with the head teacher and the family, the child started schooling again.

A 15 year-old multihandicapped boy (fits, hemiparasis, deaf and dumb) is undergoing training in carpentry in the Serowe Brigades. A 19 year-old partially deaf girl is being taught handicrafts at the Palapye Red Cross Society.

One blind boy of eight years had shown no change in status (no independence in mobility and self-care, no schooling) due to objection by the family. A great deal of counselling has been to no avail. Attempts will be made to admit him to the Mochadi School for the Blind.

The progress of four disabled could not be followed because they were still on the lands. Although the pattern of families spending 5-6 months of the year on the lands is a constraint to the success of a programme such as this, it must be accepted. Where disabled children are of school-age, however, parents should be persuaded to leave them behind in the village with other family members, as they do with other children of school-age.

5. The family welfare educators must be commended for the very good work they have done with the disabled under training so far. The varying number of hours they have to spend in clinic work necessarily limits their field work, and many of them appear to be unable to spend even half their working time in the community. With an increase in its cadre of nurses and family welfare educators, the latter would no doubt be able to do more work in the community, and this would greatly enhance the improvement of the lives of the disabled.

6. Early steps should be taken to translate the manual into Setswana and to make copies available to all those involved in rehabilitation in the country. This would help to increase support for the programme.

7. The consultant has observed that the demands on the Regional Social Welfare Officer are many, and does not leave her adequate time to spend on the programme.

Requests from family welfare educators for guidance appear to be met with delay and difficulty. If this situation continues, motivation on their part may decline. Since the programme appears successful despite initial constraints, it is recommended that arrangements be made to release the Social Welfare Officer to assume full-time responsibility for the programme. She could then no doubt meet the demands of the family welfare educators, sustain the motivation of all concerned and increase the size of both the programme and the field trial.

8. At a meeting of those concerned with the programme held on 26 June, the general consensus was that the manual has produced positive results in improving the lives of the disabled, and that "the programme is cheap and therefore is ideal for a developing country like Botswana".

A serious constraint to expanding the programme to other parts of the country is the lack of skilled manpower to be responsible for programmes at the second level, i.e. at the level of social welfare officers.

The consultant repeats the recommendation made at the end of her first assignment\* that steps be taken early to develop the manpower that would be necessary to expand community-based programmes, on the lines recommended by a previous WHO consultant (AFR/REHAB/10 1978, paragraphs 6.1 and 6.2).

In this connexion, the consultant would also recommend that developing countries be given the necessary guidance and support to educate a multipurpose rehabilitation professional, capable both of training and supervising field health workers in their rehabilitative role, and of providing basic rehabilitation at the first referral level. This would greatly enhance the success of community-based programmes.

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\* Introduction of Community-based Rehabilitation in Botswana - Report of a Mission, 16 September - 14 December 1979 (8.3).

APPENDIX IV

SPECIAL SERVICES UNIT FOR THE HANDICAPPED

OF THE MINISTRY OF HEALTH - BOTSWANA

REPORT OF EVALUATION ON FIELD - TESTING W.H.O. MANUAL

ON

TRAINING THE DISABLED IN THE COMMUNITY

SEROWE, 26th JUNE 1980

CONTENTS

1. Introduction
2. List of Participants
3. Case Presentations
4. Conclusions and Recommendations

1. INTRODUCTION

The evaluation meeting was convened by the Special Services Unit for the Handicapped in Serowe held in the Sekgoma Memorial Hospital - School of Nursing. The purpose of the meeting was to discuss the feasibility of the W.H.O. manual on training the disabled in the community; whether the material provided in the manual is adequate for the needs of all the disabled in the community; whether the material led to effective results in the training of the disabled in the community.

The manual was field tested in Serowe and Palapye by fifteen Family Welfare Educators ( Primary Health - Care Workers ) and Special Services Unit for the Handicapped Social Welfare Officer in Serowe. The programme was introduced to Botswana in October 1979 by a W.H.O. consultant Mrs. Padmani Mendis who is a physiotherapy tutor in her home country - Sri Lanka.

The manual consists of guides and booklets. The guides contain material for those who work with the disabled in the community like local supervisors, community leaders and teachers. A guide for policy planners was not available at the time of the field - testing, it is still being prepared. The booklets contain training material for the disabled or family members of the disabled prepared for people with the following disabilities: -

1. Fits
2. Hearing difficulties
3. Learning difficulties
4. Moving difficulties
5. Seeing difficulties
6. Speech difficulties
7. Strange behaviour

Each booklet consists of several training packages concerning different aspects of life. The aim is to improve and promote physical, educational and vocational potentialities and independence for the disabled. The emphasis is on using family members to train their disabled; also, community participation. It has been noted that not all the disabled can go to rehabilitation centres / institutions and special schools, the majority remain home and need some form of rehabilitation.

The evaluation meeting was chaired by Miss O. Mpaesele - Social Welfare Officer for the Central District Council based in Serowe.

## 2. LIST OF PARTICIPANTS

### Family Welfare Educators

#### KADIMO SAMSON CLINIC ( SEROWE )

Miss Caroline Sebedi  
Miss Sarah Mosinyi  
Mrs. Tlhalefang Bareki

#### SEROWE HEALTH CENTRE

Mrs. Daphe Galeage  
Miss. Idah Mathiba  
Mrs. Dominica Seeletso

#### NEWTOWN CLINIC

Mrs. Rebecca Mabina

#### PALAPYE HEALTH CENTRE

Mrs. Edith Samson  
Miss Emily Golele  
Miss Azane Charre

#### MALAKA CLINIC ( not involved in the field - testing )

Miss. Ogorogile Monyenga

#### Nursing Staff

#### SEROWE HEALTH CENTRE

Sister Kgainena

#### PALAPYE HEALTH CENTRE

Senior Sister Vuma

#### Social Welfare Dept. - Central District Council

Miss Ottilda Mpaesele

#### Speech Therapist

#### RAFOTSAM SOCIETY FOR THE DEAF

Miss Rose Forney

N.B.C. Consultant:

Mrs. Padmani Lendis

Special Services Unit for the Handicapped

Miss. Cheloketo Omphile  
Social Welfare Officer  
Serowe.

Mrs. Joyce Coengae  
Social Welfare Officer  
Masepe.

Mr. Sandy Alexander Stuart  
Social Welfare Officer  
Francistown.

Miss Adelaide D. Krosidintsi,  
Commissioner for the Handicapped,  
Gaborone.

N.B. Five family Welfare Educator's were not able to attend. The Psychiatric Nurse in Palapye and S.S.U. Social Welfare Officers in Gaborone and the Mental Hospital who attended the orientation programme in October 1979 were also unable to attend.

3. CASE PRESENTATIONS

Forty three ( 43 ) cases were dealt with using the manual.

Case	Sex	Age	Disability	Progress Report
1. MR	F	10 yrs.	Hydrocephaly	- Could not walk and did not go to school. * After given crutches, practised walking and was registered in Central School ( Serowe ). She is of average intelligence and has socially improved. Used to cry and run away from workers but is now friendly
2. EM	F	7 yrs.	Mental retardation	* Does not go to school and is at the lands with parents. Arrangements are being made to refer her to Camphill Community ( special school ) in 1981.
3. ME	M	7 yrs.	Partially deaf	- Does not speak and did not go to school. * Goes to school and is able to write. He is happy at school, although he is slow. Mother is a T.B. case which requires follow up. * Arrangements are being made to send him to the audiology clinic and to be seen by the Speech therapist.

Case	Sex	Age	Disability	Progress Report
4. KS	F	6 yrs.	Cerebral palsey	<p>- Could not walk and did not go to school.</p> <p>* Now walks with the support of a stick around the house and goes to Manenye school carried in a wheel - barrow. She has been given crutches which were high and have been shortened by Serowe Brigades to practise using at home.</p>
5. GG	M	8 yrs.	Deafness (profound)	<p>- Does not speak and did not go to school.</p> <p>- Used to lock himself in the house.</p> <p>* Goes to Motetshwane school where his father teaches. He is doing well at school and is now sociable - no longer locks himself in the house.</p>
6. KS	F	2 yrs.	Partial Blindness	<p>- Did not walk when met by worker.</p> <p>* Referred to the ophanologist - not yet seen.</p> <p>* Mobility training and is coping.</p>
7. BA	M	7 yrs.	Kypho-scoliosis	<p>TB ( tuberculosis case, did not go</p> <p>* Parents at first reluctant to send him - to school, now goes to Serorone Primary school.</p> <p>* Takes T.B. treatment.</p>
8. B	M	7 yrs.	Blind	<p>- Rejected at home; no training in self - care activities and would not be accepted into either ordinary school at home or the special school for the blind.</p> <p>* Regular visits to parents to try to change their attitude towards the child and check if the package on self - care activities was used. No improvement yet.</p>
9. GM	F	28 yrs.	Hard of hearing	<p>- Neglected by mother and becomes hostile when instructed to do anything - would only work voluntarily</p> <p>Client and mother drink alcohol daily and are in disputes all the time.</p> <p>* Improvement in client - mother relationship has been noted.</p> <p>* Encouraged to do daily tasks and goes to the Red Cross Centre for lessons in hand - crafts.</p> <p>* Arrangements are being made to refer her to the E.N.T. specialist.</p>

Case	Sex	Age	Disability	Progress Report
10. SK	M	15 yrs.	Mobility and Fits	<ul style="list-style-type: none"> <li>- Could not walk and was rejected by family.</li> <li>* Now on treatment for fits and no longer gets regular seizures.</li> <li>* Relationship with family improved (Vost change noted.)</li> <li>* Arrangements to send him to Polopye Development Trust Brigade in 1981.</li> <li>* Can now walk with crutches</li> </ul>
11. TS	M	7 yrs.	Blind	<ul style="list-style-type: none"> <li>- Mother is unco-operative, no patience for workers, has taken client to the lands.</li> <li>* Schooling advise given and mother promised to send the child to school in 1981.</li> </ul>
12. WL	F	37 yrs.	Fits	<ul style="list-style-type: none"> <li>- Had regular fits.</li> <li>* On treatment for fits, no seizures since treatment.</li> <li>* Does household tasks.</li> <li>* Arrangements are being made for her to see the psychiatrist.</li> </ul>
13. MO	M	10 yrs.	Mental Subnormality	<ul style="list-style-type: none"> <li>- Did not go to school.</li> <li>* Now goes to Swaneng Primary School and enjoys school, although he is very slow.</li> <li>* Gets on well with other children</li> </ul>
14. MT	F	6 yrs.	Mental retardation and fits	<ul style="list-style-type: none"> <li>- Does not go to school, is shy and has delayed speech.</li> <li>* Mother refused to take the child to school but promised to send her to school in 1981. She needs a follow - up.</li> <li>* Still has seizures once a month like before treatment.</li> </ul>
15. KP	M	4 yrs.	Mental retardation Fits, Hearing/speech impaired	<ul style="list-style-type: none"> <li>- Had regular fits</li> <li>* No fits since treatment - ( one month observation )</li> </ul>
16. MN	F	77 yrs.	Blind	<ul style="list-style-type: none"> <li>- Confined to the house</li> <li>* Now uses a walking stick and moves around. The only draw-back is that family members are not keen to train her. Client herself is keen to follow what the package suggests. Arrangements to look for a volunteer.</li> </ul>

Case	Sex	Age	Disability	Progress Report
17. MK	F	3 yrs.	Mental retardation, Mobility, Defective speech	- Could not sit, nor walk nor speak nor hold. * Now sits, moves while seated (moving buttocks from one place to another and produces sound. ( was practised to sit on a card box and mother encouraged to speak to her all the time ).
18. K	M	50 yrs.	Blind	* Seen by the ophthalmologist - no correction can be done. * Motivated, moves around and does house - hand tasks
19. OG	F	6 yrs.	Mental retardation, Speech, Fits	- Was neglected by parents - Could not look after herself * Was sent to the Nursery school but could not cope * Parents were given play activities training package and they went to the lands with client.
20. TH	M	10 yrs.	Blind	- Did not go to school * Now in school at Tshinyospula
21. KL	M	15 yrs.	Fits, Hearing, Speech	- Had psycho - migraine problems and did not go to school nor work * Referred to the psychiatrist * On treatment for fits. * Does carpentry training at the Brigade ( Serowe ) and is happy.
22. GM	M	27 yrs.	Strange behaviour	- Does not go to work nor does any household tasks * Father encouraged to involve him in house - hold tasks including those that he does like building but not yet motivated. More visits will be made to the father. * Plans to apply to the Brigades.
23. MT	M	9 yrs.	Blind in one eye	- Did not go to school * Now in school and does well.
24. KT	F	60 yrs.	Blind	- Was unable to move around the neighbourhood * Mobility training using a walking stick * Does house hold tasks

Case	Sex	Age	Disability	Progress Report
25. SD	F	10 yrs.	Mental Retardation, Fits, Speech	* No improvement. Needs to be taught self - care activities
26. MI	F	11 yrs.	Defective speech	- Did not go to school * Accepted in Western school - neglected at school and manipulation of environment anticipated so that she could go to St. Gabriel school where other children from her family go.
27. MR	F	20 yrs.	Fits, Mental-illness	* Psychiatric treatment and drugs for fits * Training in house hold tasks ( progress not known)
28. LO	M	15 yrs.	Hearing	- Does not go to school * Mother refused to send him to school * Plans to check if St. Gabriel could not take him for occupational group work.
29. LG	F	1 yr.	Seeing, Moving	- Child does not even crawl. * Given playing activity package and arrangements to train her to walk and move around; the child is in Tshimoyapula and the follow-up is irregular.
30. OK	M	5 yrs.	Mental retardation	- Child had problems with his eyes, looked jaundiced. * Referred to eye specialist * Follow up difficult because child is at the lands. * Child stays with grandmother who cannot cope with the child's problems or demands; the mother works in Orapa. Social Welfare Officer in Francistown was requested to get in touch with the mother and find out ways of helping the case.
31. OK	M	7 yrs.	Mental retardation, Speech	* Referred to a nursery school but could not cope. * Plans to refer him to Camphill Community Bankororane ( special school ) in a different district, South East District.
32. MJ	M	18 yrs.	Mental retardation, Fits	* Drugs for fits * Social activities training package - client went to the lands; therefore, progress not known.

Case	Sex	Age	Disability	Progress Report
33. NO	F	13 yrs.	Blind, Mental Retardation	* Referred to the Ophthalmologist for consultation. * Given a training package on house hold tasks - went to the lands
34. ML	M	7 yrs.	Mental Retardation	* Now goes to Camphill Community Rankoromane ( special school ) in South East District.
35. VL	F	27 yrs.	Mental Retardation, Speech	* Fits are now controlled by drugs * Has learnt some house hold tasks
36. RR	M	10 yrs.	Mental retardation	- Did not go to school and had problems with his eyes. * Now goes to St. Augustine school and gets eye treatment. Parents escort him to school.
37. OQ	F	30 yrs.	Mental retardation, Defective vision	- operated for cataract in 1976 and 1978 but still does not see clearly, eyes discharge and are painful. * Does house hold tasks * Referred to eye specialist
38. IE	M	70 yrs.	Blind	* Mobility training
39. NF	F	65 yrs.	Blind	* Referred to the ophthalmologist - appointment for an operation was made and later cancelled. * Mobility training - can now move around her home * Does house hold tasks  ( F.W.E. ) to check in her medical record card, why the appointment for eye operation was cancelled.
40. RN	F	16 yrs.	Mental Retardation	* Training in house hold tasks - went to the lands and has not been followed up since then.
41. ML	M	10 yrs.	Strange Behaviour	* Goes to Khama Memorial School - needs regular follow - ups because at times he refuses to go to school * Attends psychiatric clinics
42. MS	F	3 yrs.	Mobility, Hydrocephaly	- Could not stand nor walk * Can now hold the wall and walk supported
43. AT	F	21 yrs.	Mentaly Subnormality	- Was once at Tlanelong Rehabilitation Centre ( vocational ) but discontinued * Referred to the Community centre for group-work (handicraft)-not followed up. * To check if Tlanelong Rehabilitation Centre can take her back.

#### 4. CONCLUSIONS AND RECOMMENDATIONS

How can the programme be improved? - Through:-

1. Involving other field officers ( extension workers), clubs, voluntary organisations, health committees, teachers and community leaders so that a wider section of the nation participates in care of the handicapped and is also made aware of the problems and needs of the handicapped. In this respect, the message would reach the entire nation quicker to change their attitudes towards the handicapped. The objective could be achieved through organising seminars where the above groups would be brought together; visits to individual schools; Keotla meetings etc. discussing successful cases and existing programmes for the handicapped in Botswana.
2. Increasing the number of Family Welfare Educators so that they could visit their clients regularly to follow - up the training programme.
3. Introducing parents support groups.
4. Translating the manual into setswana so that the users could read and understand without any difficulty.

How can the manual be improved

1. Translating the manual into the local official language ( setswana ).
2. Placing more emphasis on the case of patient or client to first see a doctor, audiologist, ophthalmologist or either specialist before training is begun.
3. Sign language should be more in cultural context.

What problems were met during the field - testing?

1. Reading the manual by some handicapped persons or their trainers who did not understand english. Some ignored it because they felt it a strain to read without understanding, or a bother to get a neighbour or another person to read for them.
2. Unco - operative parents or family members who felt it a bother to be asked to train the handicapped in their families.
3. Parents blaming themselves for having handicapped children thus over - protecting them or neglecting / rejecting them; traditional beliefs of not wanting to interfere with God's will and taking it for a permanent problem or disability.
4. The Botswana life styles of going to the lands during ploughing and harvesting seasons and also going to the cattle post which interrupted regular follow up of the cases being trained; transportation difficulty also facilitated this problem.

5. Rejection of handicapped children by some school teachers.
6. Poverty amongst families with handicapped persons.
7. Tight schedules of Family Welfare Educators in clinics - they would like to have more time with family members.

How were these problems tackled?

1. Tried to involve neighbours as trainers where family members couldn't do it for various reasons: this did not always work as some neighbours gave up shortly because they felt it wasn't their problem.
2. Regular visits to educate the families with disabled persons and change their attitudes towards disabled, motivating them to accept the responsibility of training their disabled with the understanding that it is their responsibility.

Any problems that could not be overcome?

1. Children who are severely mentally retarded.
2. The life style of going to the lands and cattle posts.
3. Traditional beliefs which would take a long time to move away from.

Suggestions to overcome problems experienced

1. Educational programmes for parents, teachers and the entire community.  
An element of special education should be included in the teacher training curriculum.
2. Financial support to families with disabled persons.
3. Getting employment for at least one responsible family member and for disabled persons where possible.
4. Emotional support to families with disabled persons to relieve them of the stress or tension of self - blame and the problems shouldered.

Could the manual be introduced in other parts of the country

The use of the manual has proven positive results. From presentations made by Family Welfare Educators, most cases have improved since the use of the manual; their disabilities and social behaviour have improved. The community's attitude towards the disabled is gradually changing; children at school accept disabled children because they see that they can go to ordinary schools like them and that some of them are equally intelligent.

The programme is cheap and therefore ideal for a developing country like Botswana.

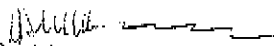
Comments:

The programme should be decentralised and seminars for community leaders, teachers, voluntary organizations, Health Field workers, Social Welfare Officers and other extension workers should be arranged to give them information on various aspects of rehabilitating the handicapped viz social, vocational, economical, educational and medical.

There should be continuous family sessions with families of the disabled.

It is recommended that W.H.O. should consider allocating funds for educational programmes, transport and support of families with handicapped persons.

W.H.O. consultant on the programme should find time to tour the country and meet more disabled persons - to have an overview of the problems of the handicapped in this country.

  
Adelaide Kyosidintsi  
COMMISSIONER FOR THE HANDICAPPED

14th August, 1980.



APPENDIX V

ASSIGNMENT REPORT

INTRODUCING COMMUNITY BASED REHABILITATION  
PROGRAMME USING THE MANUAL "TRAINING THE DISABLED  
IN THE COMMUNITY"

by

Gunnel Nelson, WHO Consultant

January 2, 1980 - March 26, 1980

Occupational Therapist  
Göteborg, Sweden

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## I. PURPOSE OF THE ASSIGNMENT AND GENERAL BACKGROUND

The purpose of this assignment was to introduce a community-based rehabilitation programme and to set up a research project for testing of the manual "Training the Disabled in the Community". Representatives from WHO Headquarters and from the WHO Regional Office for Africa visited Nigeria from 8 to 21 February 1979 and recommended a collaboration between the Government of Nigeria and WHO in setting up a research project related to the development of community-based rehabilitation.

The WHO Collaborating Centre for Research and Training in Orthopaedics and Rehabilitation at the National Orthopaedics Hospital, Igbobi, Lagos, was suggested to undertake this research project in coordination with the members of the National Youth Service Corps.

General guidelines and recommendations for the field trial were formulated at the WHO Informal Consultation on Community Training of the Disabled held in Mexico City, 19 to 24 November 1979. The objectives of the testing were to determine whether:

- i. the approach used in the manual is feasible and acceptable;
- ii. the organizational structure, including that of manpower training, is appropriate for implementing the training programme for the disabled in the community;
- iii. the material provided in the manual gives sufficient coverage for the reasonable needs of all the disabled in the community; and
- iv. the material presented in the manual leads to effective results in the training of the disabled in the community.

The following guidelines for the field testing were suggested:

- (i) Planning and direction of the trial should be done with involvement of a centre or agency having necessary expertise in rehabilitation, applied social services and field work.

- (ii) Community development services must be invited to participate in the field testing wherever possible.
- (iii) Testing should be carried out reproducing, as nearly as possible, the conditions under which the manual is intended to function. The techniques should be tested under field conditions on appropriately disabled persons.
- (iv) Conducting training of necessary manpower after identifying selected communities for the field testing.

## 2. PROGRAMME OF ASSIGNMENTS

The consultant arrived in Lagos on 2 January 1980. During the first two weeks briefings, interviews and discussions were carried out with representatives of the Federal Ministry of Health, Basic Health Service Scheme at the National Health Planning Directorate, Special Education Unit at the Federal Ministry of Education, Federal Ministry of Social Development, Youth and Sports, National Youth Service Corps Directorate, and WHO National Programme Coordinator. During the same period institutions related to the area of rehabilitation were visited by the consultant.

Mrs Kemi Ogunkoya, Acting Head of Physiotherapy at the National Orthopaedics Hospital, Igbobi, was assigned as the national counterpart.

A workshop was arranged by the Institute of Child Health of the University of Lagos in community based rehabilitation in which the consultant participated as lecturer and supervisor.

It was recommended by the authorities that at least five states, although desirably seven, should be used for the field trial to give a good representative sampling of Nigeria's size, population, literacy, language, culture, religion, ethnic composition and environment.

The following states were selected for the field trial: Anambra, Borno, Kano, Kaduna, Kwara, Lagos and Oyo.

During the next six weeks the states recommended for the field trial were visited by the consultant and the counterpart. Briefings, discussions

and interviews with representatives from the Ministry of Health, Ministry of Social Development, Youth and Sports and National Youth Services Corps, in their respective states, were carried out.

Institutions related to the area of rehabilitation were visited in order to gain knowledge of the present referral facilities available.

Local governments were selected for the field trial and the staff that were chosen for undertaking the testing were introduced to the research project.

Over the last four weeks the consultant and her counterpart supervised the local supervisors in the community survey to locate the disabled, identifying their disabilities and their problems, selecting the appropriate packages, teaching the family members to train the disabled and referring them if necessary to a higher level of health care and rehabilitation. The consultant also assessed the performance of the local supervisors, their acceptance of the approach, their ability to implement the project and the progress evaluation of the disabled.

### 3. THE FIELD TRIAL

#### 3.1 *Project areas*

Nigeria is a federation of 19 states and every state has a number of local governments. The Federal Government formulated the national policy in health care. In addition to Federal and State Health Services, there is a network of Local Government Health Services.

The selection of the local governments was done on the criterion that they should be accessible by road, but at least one hour's drive by car, from the state capital, that they should have limited health facilities in the area, and that manpower is available in the area for testing.

The following states and local governments were selected:

Anambra State, UDI Local Government

Borno State, BAMA Local Government and KODUNGA Local Government

Kano State, GWARZO Local Government, TUNDUN WADA Local Government and DAWAKIN KUDU Local Government

Lagos State, IKEJA Local Government, MUSHIN Local Government and SHOMULU Local Government

Oyo State, ATAKUNMOSA Local Government.

In Kaduna State and Kwara State the project was not started during the period of this consultant's assignment, but will be started at a later date by the national counterpart.

### *3.2 Manpower used for the testing*

In order to determine whether the proposed organizational structure, the manpower, the training of these people were appropriate for implementation of the training programme, it was decided to use three various groups of manpower for testing, i.e.:

- members of National Youth Service Corps (see Annex II)
- community health aides
- community health officers

The members of the first group were working under three different conditions, such as primary assignments (full time limited period); secondary assignments community development work during Easter vacation (full time limited short period) and secondary assignments community development work year round (part-time long period).

The members of the second and third groups were doing the testing integrated into their daily work in the community health field. There were a total of 44 local supervisors serving the project which was started. These local supervisors were divided into different groups: 28 male and 5 female Youth Corpers, 6 female community health aides and 5 male community health officers.

### *3.3 Time for the testing*

It was recommended that the research project should have a duration of at least three months. The projects were started individually at different times due to local circumstances and therefore the projects in some states

will not be completed before the end of June 1980 (see Annex II). By the end of the consultant's assignment, the research project was completed in Lagos State. The evaluation for this report is based on experience from this state and from periodic assessment of the process and progress in the other states.

#### *3.4 Data available at the end of this consultant's assignment*

- A total of 431 households were surveyed
- The total number of persons living in these households was 2 481
- The number of disabled found by the survey was 70
- The ages of the disabled were from 7 months to 85 years
- In training the disabled, 41 packages were used.

#### 4. WORKSHOP IN COMMUNITY BASED REHABILITATION

A one-day workshop arranged by the Institute of Child Health of Lagos University was held on 15 February at the Lagos University Teaching Hospital.

The aims of the workshop were to determine the community health aides' ability to identify various disabilities, the functional problems of the disabled, the selection of appropriate packages, to instruct and demonstrate the training of the disabled children to their parents, as well as to motivate the parents, and to help them understand and interpret the training packages. Twelve disabled children with parents or siblings plus the six community health aides from Shomolu Local Government were participating in the workshop. Professionals in the field of rehabilitation were supervising the workshop.

#### 5. EVALUATION OF THE FIELD TRIAL

The final evaluation of the research project will be done after the project has been completed in all the states and all the data is available for assessment.

5.1 *The first objective was to determine if the approach used in the manual is feasible and acceptable*

- In introducing the community based rehabilitation programme, the authorities have shown a great interest in the approach, and have shown willingness to take action that will support the programme.

- The community leaders seem to accept their role as promoters, and as responsible for introducing the rehabilitation of the disabled on a community level, but actions taken in the community to facilitate rehabilitation for the disabled in employment, schooling, and community health is too early to evaluate.

- The family members of the disabled in the rural areas seem to have a very positive attitude towards rehabilitation of the disabled and are taking on the responsibility of training their disabled.

- The family members of the disabled in the urban areas show less acceptance to the approach. They prefer institutional rehabilitation programmes, certainly due to small family sizes and the changes in the socioeconomic structure of the urban family.

- The public attitude towards disabilities such as epilepsy, leprosy and schizophrenia seem to be the hindrance of rehabilitation for these disabled persons.

- It seems to be more complicated to rehabilitate the disabled when primary health care facilities are not available. The lack of medicine is one example which illustrates this point.

- The approach of integration of the disabled children into ordinary primary schools seems to be accepted by the parents, the community and the teachers and is in practice in some states.

5.2 *The second objective is to determine if the organizational structure, including that of manpower training, is appropriate for implementing the programme*

- The community based rehabilitation programme could easily be integrated in the Basic Health Services if the manpower received adequate training in the use of the manual.

- It seems that the community trained health aides do not have sufficient medical knowledge or experience to be able to identify the disabilities and the problems of the disabled, or to select the appropriate packages.

- It seems that the supervisors' guide does not give sufficient medical information or instruction on how to identify various disabilities.
- The manpower with higher education, but no specific medical knowledge, needs more medical information to be able to use the manual adequately.
- The motivation of the local supervisors is a very important element in their successful implementation of the programme.
- There is a need for training courses for the local supervisors, not so much to teach facts and methods in the manual, but rather to motivate and influence the attitudes towards various disabilities such as leprosy, schizophrenia and epilepsy, and to understand and accept the total approach of rehabilitation of the disabled.
- There is a need for manpower, with knowledge and experience in the field of rehabilitation, to supervise the programme in the states.

5.3 *The third objective is to determine if the material provided gives sufficient coverage for the reasonable needs of all disabled in the community. There is a need for:*

- Packages covering the following diseases: disabilities or syndromes such as sickle cell anemia, albinos, asthma, cerebral palsy in different ages, drug addiction, left and right hemiplegia, paraplegic children with behaviour disorders and children with perceptual deficiencies.
  - Addition and amendment in the speech booklet, communication.
  - Training packages for partially sighted and partially deaf.
  - Training packages in transfer, lifting, transportation, housing, walking patterns, care of persons who are incontinent and care of persons who have pressure sores.
  - Rearrangement, addition and more examples in the play activities in all the booklets.
  - Packages for pre-school and school activities for severely disabled children.
  - More medical information in all the booklets.
  - Packages for training of the multiply disabled.
  - Additions in the teacher's guide giving more examples of how to manage the education of different subjects for disabled children.
  - Additional examples in training the disabled in urban areas and adapted pictures for this training.

- Information in all the booklets about the psychological problems faced by the disabled and the influence on the rehabilitation process and progress and training packages to overcome these problems.

- General principles to facilitate learning and behaviour changes and these should be integrated into the packages given to the family members who are training the disabled.

*5.4 The fourth objective is to determine if the material presented in the manual leads to effective results in the training of the disabled in the community*

In order to determine if effective results are achieved in the training of the disabled, there is a need for more than three months testing of the manual. The rehabilitation of the disabled is a time-consuming process and therefore it was suggested by the consultant that the project should continue for some time.

## 6. RECOMMENDATIONS TO THE GOVERNMENT OF NIGERIA

1. The community based rehabilitation programme should be integrated into the Basic Health Service Scheme and necessary action for implementation of the programme should be taken.
2. The first step in the implementation of the programme is to educate the manpower. One training course for teachers who are training the manpower for the Basic Health Service Scheme should be started during 1980 and two more courses should be held during 1981. The duration of the courses is suggested to be of three weeks and to be located at the WHO Collaborating Centre at the National Orthopaedics Hospital, Igbobi. The Government may request WHO cooperation for five weeks in the form of a consultant who can develop teaching material and assist in conducting the first training course (see Annex IV).
3. The Government should employ a person as programme coordinator who has professional knowledge of rehabilitation, and experience preferably in the community based rehabilitation programme. The person should work full time with implementation of the programme in all the states, education of the manpower at the local as well as at the supervision level and evaluation of the progress of the programme.

4. The community based rehabilitation programme should be included in the curriculum for all community health manpower training (see Annex VI).
5. Workshops in community based rehabilitation for staff in the rehabilitation field, with the aim that the participating staff should be able to supervise the programme in the various states. The Government may request WHO cooperation in the form of an expert's assistance in conducting the workshop.
6. The community based rehabilitation programme should be included in the curriculum for the training of occupational therapists and physiotherapists in Nigeria.
7. The programmes should be continued in the states where they are started, new Youth Corpers should be trained to take over as local supervisors in September. It is recommended that the national counterpart should be responsible for the introduction of the courses, for the new Youth Corpers and should visit the programme areas.
8. All the other states where no programmes have been started should be visited by the programme coordinator and the state authorities should be informed about the programme and agree upon the implementation, and the necessary provision of transportation for the local supervisors in implementing the programme should be considered. National Youth Service Corpers should be trained in a four-day introduction course to start the programme and as soon as the Basic Health Service Manpower is available, the responsibilities for the programme should be transferred to them.
9. There is a need for more manuals in order to start the programme in new states. It is recommended that WHO provide the programme with the most current edition of the manuals. After the final edition has been published, it is the Government's responsibility to translate the manual into the local languages, to print it and to distribute it.
10. At the prospect of the International Year for Disabled Persons (1981), it is recommended that the Government conduct a campaign promoting the community based rehabilitation programme and influence the public's attitude towards the disabled, especially those with epilepsy, leprosy and schizophrenia.

11. Seminars (workshops) for countries in the WHO Region for Africa should be held to plan and implement the community based rehabilitation programme in 1982. Government may request WHO or other international agencies' cooperation and economic support in arranging the seminars.

12. Descriptions of steps taken and the problems faced in the implementation of the programme should be sent periodically, or at least every six months, to WHO Headquarters through the Regional Office. WHO will prepare and distribute information related to the progress of the programme to other countries participating in the implementation of the programme.

13. It is recommended that the WHO consultant visit Nigeria three weeks during 1980 to do a follow-up study of the results of the field trial and to evaluate the effective results of the project.

## 7. RECOMMENDATIONS TO WHO

1. During the testing in Nigeria, the consultant experienced the need for a guide for policy makers and planners, and it is recommended that this guide be developed and made available before testing the manual in other countries.

2. There is a need for guidelines and material for the rehabilitation of the disabled on the referral level, and it is suggested that WHO develop these guidelines and this material.

3. In the Report on Disability Prevention - Rehabilitation, of 8-21 February 1979, WHO representatives recommended that a new cadre of multi-purpose therapists should be trained in Nigeria. The consultant suggests that it is both urgent and necessary for new guidelines to be developed regarding the training of multipurpose therapists, job descriptions and the contents of the curriculum.

4. On the request of the Government of Nigeria, WHO is recommended to support and provide the community based rehabilitation programme with material and manpower in the way suggested in the Recommendations to the Government of Nigeria.

5. From experience gained during the administration of the field trial in Nigeria it is clear that the following changes, amendments, improvements and additions have to be made in order to facilitate testing in another country:

- The evaluation questionnaires should be in different colours, so that the answers can be easily identified and returned to the coordinator.
- The manuals should be in separate booklets. They should be made easy to take apart and easy to put back together, with different symbols, such as an eye, etc.
- Every booklet should contain all the packages belonging to that booklet.
- The questions in the survey should be reformulated into positive questions.
- The supervisors' guide should be arranged in a more process-oriented structure to facilitate the learning process of the local supervisors.
- Extra questionnaires for the survey should follow with the guide.
- The use of the evaluation questionnaire for measuring progress of the disabled must be more clearly explained in the supervisors' guide.
- At least two copies of the manual should be given to each person carrying out the field trial.
- The questions in the training package, which should be answered by the family members who are training the disabled, should be more precise and specific as they are to give useful information and evaluation of the packages as a basis for changes of the packages.

## 8. ACKNOWLEDGEMENT

The consultant wishes to express her gratitude and appreciation to all those who assisted her with the introduction of the programme and the research project. Special thanks are due to the Chief-in-Charge, National Orthopaedics Hospital, Igbobi, Lagos; to the national counterpart and all those who acted as local supervisors during the field trials for their contribution and cooperation.

## ANNEX I

### PERSONS CONTACTED

#### Anambra State

Mr. Nwankwo  
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Dr. Ozo  
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#### Kaduna State

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Mr. Adewumi  
Head Health Officer, Atakunmosa Local Government

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## ANNEX II

### NATIONAL YOUTH SERVICE CORPS

The National Youth Service Corps was promulgated in 1973 and embraces graduates of Nigeria or overseas universities to serve the nation for 12 months.

During the first six weeks of the service year, corps members undergo an orientation course comprising drills, physical exercises, lectures and leadership training activities, as well as a tour of all administrative divisions of the state of deployment to familiarize themselves with the state, its people and its particular problems.

#### Primary Assignment

After the orientation course, corps members are sent to work in various fields, both in the public and private sectors of the economy, in areas bearing relevance to their academic and professional training.

#### Secondary Assignment (Community Development Work)

During the Easter vacation, Corps members are engaged in community development projects, such as road construction, building and repairing local schools, bridges, culverts, drains, market stalls, etc.

#### Secondary Assignment

As a supplement to the Easter community development exercise, Corps members are expected to undertake, in conjunction with their primary assignment, at least one community development project in their local neighbourhoods on a year-round basis.

MESSAGE OF THE DIRECTOR OF THE NATIONAL  
YOUTH SERVICE CORPS  
Federal Republic of Nigeria

## ANNEX III

### COMMUNITY BASED REHABILITATION FIELD TRIAL IN NIGERIA

#### *Areas, manpower, timetable*

1. Anambra State, UDI Local Government  
Local supervisors: 7 male and 1 female NYS Corpers  
Secondary assignment, community development year-round  
(Primary assignment - teachers)  
Time: 15 February 1980 - end of June 1980
2. Borno State, Kodunga and Bama Local Governments  
Local supervisors: 12 male and 2 female NYS Corpers  
Secondary assignment, community development year-round  
(Primary assignment - teachers)  
Time: 15 March 1980 - end of April 1980
3. Kano State, Gwarzo, Tundun Wada, and Dawakin Kudu Local Governments  
Local supervisors: 9 male NYS Corpers in teams with students from Social  
Welfare Education  
Secondary assignment, community development programme during Easter  
vacation  
(Primary assignment - Local Governments)  
Time: End of March 1980 - end of April 1980
4. Lagos State, Shomulu Local Government  
Local supervisors: 6 male community health aides  
Time: 11 February 1980 - 26 March 1980
5. Lagos State, Ikeja and Mushin Local Governments  
Local supervisors: 2 female NYS Corpers  
Primary assignment  
Time: 25 January 1980 - 26 March 1980
6. Oyo State, Atakunmosa Local Government  
Local supervisors: 5 male community health officers  
Time: 25 March 1980 - end of June 1980

## ANNEX IV

### PROPOSED TRAINING PROGRAMME FOR TEACHERS AT THE COMMUNITY HEALTH MANPOWER PROGRAMME IN NIGERIA

Field: Community based disability prevention and rehabilitation programme

General objectives: To educate the community health manpower in the community based disability prevention and rehabilitation so that it will be able to teach the following:

- a. How to screen the disabled
- b. Identify their disability
- c. Identify their problems
- d. Motivate, teach, train and supervise family members of the disabled or the disabled themselves in disability prevention and rehabilitation

Duration of course: three weeks, full time

Contents of course:

1. Objectives for the course
2. Working processes
3. Magnitude of the disability problems
4. Disability process and causes
5. Aims for rehabilitation of the disabled
6. Prevention of disability
7. Principles and methods for training the disabled in the community and in the family
8. Principles for community survey
9. Community participation in rehabilitation
10. Identification of different disabilities and their problems
11. The process in using the manual on rehabilitation
12. The administrative process in using the manual on rehabilitation for the disabled
13. The evaluation of the progress of the disabled
14. Attitudes towards the disabled
15. Referral services in rehabilitation
16. Evaluation of the course

The course can be carried out at the World Health Organization Collaborating Centre at the National Orthopaedics Hospital, Igbobi. Different methods of learning will be used in the course, such as:

- Lectures
- Group method
- Demonstration of the disabled
- Practical training of disabled persons
- Case study
- Field work
- Problem-solving method

## ANNEX V

### PROPOSAL ON HOW THE TRAINING PROGRAMME FOR COMMUNITY HEALTH ASSISTANTS COULD BE EXTENDED TO INCLUDE COMMUNITY BASED DISABILITY PREVENTION AND REHABILITATION PROGRAMME

Care of the handicapped is included in the curriculum under Unit II.2.4 in the Training Programme for Community Health Assistants, Federal Ministry of Health, National Health Directorate, B.H.S.S. Coordinating Unit. The heading and the general objectives, as well as instructional objectives, should be changed to the following:

#### Care of the disabled

*General objectives:*

- Screen the disabled
- Identify the disability
- Identify the problems
- Motivate, teach, train and supervise the family members of the disabled or the disabled themselves in disability prevention and rehabilitation.

#### *Instructional objectives:*

On completion of this Unit, the community health assistant should be able to:

- 2.4.1 Describe the aims of training the disabled in the community.
- 2.4.2 Describe the principles and methods for training the disabled in the community and in the family.
- 2.4.3. Do a household survey to collect information and find out the number of disabled and where they live in the community.
- 2.4.4 Contact the community leaders and other authorities in the community and inform and teach them the aims for training the disabled, the method of training the disabled, the disabled's needs for education, employment, housing, transportation, social activities and other community services.
- 2.4.5 Do home visits to disabled persons' houses.
- 2.4.6 Identify the person's disability, such as:
  1. Person who has fits
  2. Person who has hearing difficulties
  3. Person who has learning difficulties
  4. Person who has moving difficulties
  5. Person who has seeing difficulties
  6. Person who has speech difficulties
  7. Person who has strange behaviour

2.4.7 Identify the disabled problems and describe them in functional terms, such as:

1. Cannot get up from bed
2. Cannot walk around house
3. Has difficulties in walking around village
4. Has difficulties to squat or bend back
5. Cannot use arms or hands
6. Has reduced feeling in hands/feet
7. Has difficulty with learning
8. Has difficulty with seeing
9. Has difficulty with hearing
10. Has difficulty with speaking
11. Behaves strangely
12. Cannot feed himself/herself
13. Cannot dress himself/herself
14. Cannot wash and bathe alone
15. Cannot go to latrine alone
16. Has fits
17. Does not do daily household tasks
18. Does not participate in work/not employed
19. Does not go to school as other children
20. Does not eat meals with family, go to marriages, birthdays, feasts, pilgrimages
21. Does not go to places of worship, community meetings as other people do
22. Any other problem that worries family

2.4.8 Inform the family of the possibility of training the disabled, motivate and get their cooperation in training of the disabled.

2.4.9 Select the appropriate package for the disabled person

2.4.10 Supervise the family members of the disabled person in the training of the disabled using the package

2.4.11 Do home visits from time to time

2.4.12 Identify the following disabilities and follow-up treatment:

- epilepsy
- leprosy
- asthma
- diabetes
- cardiac problems

and other conditions mentioned in the supervisors' guide.

2.4.13 Keep progress records on the disabled person in your area.

2.4.14 Recognize and take appropriate action to prevent disabilities such as: environmental hazards, unprotected wells, open fires, unprotected machinery, traffic, pools of water, drains and potholes. Counselling the family in genetic disorder.

- 2.4.15 Teach the family members of the disabled how to teach the disabled the importance of hygiene, balanced diet, activities and how to prevent bedsores, infections and further disabilities.
- 2.4.16 Recognize the different attitudes towards the disabled person living in the community. Take action to overcome this attitude to facilitate the rehabilitation of the disabled in the community.
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