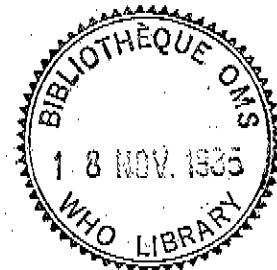




COMMUNITY BASED REHABILITATION

Report of a WHO Interregional Consultation
 Colombo, Sri Lanka, 28 June-3 July 1982



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SUMMARY

This report outlines the opinions of twenty-two experts meeting in Colombo, Sri Lanka, to consider community-based rehabilitation (CBR). CBR is an innovative approach introduced by WHO in 1976.¹ The World Health Assembly then adopted a resolution² recommending the provision of essential services and training for the disabled through CBR, especially in developing countries. The approach forms part of the WHO strategy "Health for All by the Year 2000".

The Present Situation for the Disabled

Survey results have indicated that in all countries some 7-10 per cent of the population is disabled. Disabled persons form the most underprivileged group in the societies of developing countries. They have higher incidence of disease and malnutrition and have higher mortality than others; many of them live a life without dignity in absolute poverty. They are victimized by superstition and beliefs that they are possessed by evil spirits or that their presence is proof of divine punishment of the family. Disabled persons are often socially isolated and are denied education and job opportunities.

In developing countries, 98 per cent of the disabled have no access to services at the present time. For those few who receive services, institution-based rehabilitation (IBR) is usually employed. Such rehabilitation generally requires teams of highly specialized professionals, expensive technology and boarding facilities. IBR is therefore not well suited to countries where there is a lack of professional manpower. Services in general are very expensive and have low through-put. Since IBR is mainly provided in large cities, it is inaccessible to the majority of people, who traditionally live in rural areas. To extend IBR to meet the needs of all the disabled in developing countries is unlikely to succeed. The number of specialists required are not available now or in the foreseeable future. Further, the costs would be prohibitive.

Thus a new approach is needed.

The New Approach

CBR aims at giving the disabled the necessary training, providing them with education and jobs, involving them in normal family and community life and restoring their dignity.

CBR promotes community responsibility and reliance on local resources. Family and community members take care of the essential training for their own disabled, using local technology. A referral system is set up to meet needs that cannot be handled locally. To make it effective, training is done in the following way. Rehabilitation programmes of proven value are chosen. These are broken down into modules, arranged in so-called "training packages" (TPs). TPs include a short instruction for the person who introduces and supervises the training, a detailed description of the various training steps and an evaluation sheet. The language is very simple, and the text is supported by many drawings. The TPs are given directly to the disabled person or to the family member responsible for the daily training.

CBR is carried out in the following way. A "local supervisor" is recruited from the community and trained. The local supervisor identifies the disabled by making house-to-house visits. Then the disabled and their families are motivated to take part in CBR. A "trainer", normally a family member of the disabled or a friend, receives instructions on how to do the training. Practical demonstrations are given. The local supervisor checks that the training is done correctly, and evaluates results together with the disabled and the trainer.

1 WHO document A29/INF.DOC/1 (1976).
2 Resolution WHA 29.68 (1976).

The WHO Manual

In 1979, the first version of a WHO manual "Training the Disabled in the Community" was printed and distributed for field testing. A second, amended version was printed in 1980, following reviews by a large number of experts on rehabilitation and community health. The manual contains booklets for six groups of disabled persons: those who have fits; hearing and speech difficulties; learning difficulties; moving difficulties; seeing difficulties; and persons with strange behaviour. Each booklet contains the appropriate TPs, instructions and evaluation sheets. There are also four guides: for policymakers and planners; for local supervisors; for community leaders; and for teachers.

Field Testing

The manual has been field tested from 1979-82. The following countries have taken part: Botswana, Burma, India, Mexico, Nigeria, Pakistan, The Philippines, Saint Lucia and Sri Lanka. The field testing in each area lasted from a few months to 2 years and involved populations varying from a few thousand to 60,000. Result sheets regarding 576 disabled in nine project areas showed that 73 per cent of the disabled improved with training. There were no improvements in the remaining 27 per cent for several reasons: the training period was too short, the person too old, the disabilities too severe, referrals were needed, or it was not possible to find and motivate a suitable trainer. The results were deemed highly satisfactory and qualitatively comparable with those of IBR.

Interregional Consultation in Colombo

An interregional consultation in Colombo, Sri Lanka, was held 28 June - 3 July 1982. Twenty-two experts from 14 countries (mainly those which had been involved in the field testing) reviewed the outcome of all CBR test programmes. Furthermore, they gave detailed suggestions for amendments of the WHO manual, and opinions on further publications needed to make the teaching/learning material more comprehensive, yet flexible. Suggestions for further development of the CBR programme were made. The experts stressed the urgency of increased promotional efforts and of better coordination. They agreed that manpower, technological and research aspects should be given more attention.

Conclusions and Recommendations

The experts concluded:

1. The CBR approach has proven to be an appropriate, effective, feasible and economically viable approach to provide the most essential rehabilitation to the disabled in developing countries not reached now by services.
2. The WHO manual "Training the Disabled in the Community" is a valuable, practical tool. Its training techniques have been proven to be effective and its results equal to those of IBR.

It was recommended that:

1. Governments: take urgent action to plan for and implement CBR within the context of primary health care; develop the manpower necessary at all levels; involve nongovernmental organizations; and strengthen national coordination and cooperation.
2. WHO: continue and strengthen technical cooperation to promote, plan and implement CBR; adapt the WHO manual and then translate, print and distribute it; develop and distribute other teaching/learning material needed for the programme; and cooperate with other organizations.
3. Intergovernmental and nongovernmental organizations: promote the CBR concept in cooperation with governments and WHO; and increase their involvement in the planning and implementation of CBR.

1. INTRODUCTION

The WHO Interregional Consultation on Community-Based Rehabilitation was held in Colombo, Sri Lanka, from 28 June to 3 July 1982. Twenty-two experts from 14 countries participated. There were also representatives from other organizations. The participants are listed in Annex 1. The meeting was inaugurated by the representatives of the Sri Lanka Ministry of Health and WHO (see Annex 2).

The objectives of the meeting were:

- to review the development of the WHO programme for community-based rehabilitation, especially the results of applying the WHO manual "Training the Disabled in the Community" and
- to recommend what action governments and WHO should take in the promotion, implementation and evaluation of the CBR programme.

2. THE CONCEPT OF COMMUNITY-BASED REHABILITATION

2.1 Definitions

A WHO Expert Committee recommended in 1981³ the use of the following definitions:

Rehabilitation:

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

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

The disabled and handicapped themselves, their families, and the communities they live in should be involved in the planning and implementation of services related to rehabilitation".

Community-based rehabilitation:

"Community-based rehabilitation involves measures taken at the community level to use and build on the resources of the community, including the impaired, disabled, and handicapped persons themselves, their families, and their community as a whole".

Social integration:

"Social integration is viewed as active participation of disabled and handicapped persons in the mainstream of community life. In order to achieve this aim it is necessary to provide adequate rehabilitation for all the disabled and handicapped and to reduce to a minimum all handicapping conditions in all aspects of their environment".

2.2 The present situation

According to surveys sponsored by WHO in some developing countries, it may be estimated that between 7 and 10 per cent of the population in these countries is disabled. Disabled persons form the most severely underprivileged group in the societies of developing countries. Disabled persons suffer more disease and have higher mortality than others; many of them live a life without dignity in absolute poverty. They are victimized by superstition and beliefs that they are possessed by evil spirits or that their presence is proof of divine

³ WHO Technical Report Series 668 (1981).

punishment of the family. Such beliefs lead to social isolation and lack of education and job opportunities.

Resources for health care are still scarce in most developing countries. This is especially true in rural areas where in many countries about 80 per cent of the population lives. Rehabilitation services are among the least developed, and it has been calculated that 98 per cent of the disabled have no access to services in their lifetime. For those few who now receive services, these mainly come in the form of institution-based rehabilitation (IBR). IBR is concentrated in the large cities and only very rarely available to rural populations. Institutions are often highly specialized and expensive. They are dependent on teams of highly trained professionals who work according to Western standards. Their methods include use of sophisticated technology. Institutions are usually residential and require a great number of staff, in several examples 2-3 for each residential disabled person. Expenditure for institutions sound very high, especially when one considers the low through-put. In many instances institutions are dependent on expatriate manpower, or training abroad. Also, foreign resources may provide for part of or the entire budget.

As services have covered only a small proportion of those in need, many countries have made attempts at planning to extend IBR so it would cover the population needs to a greater extent. But such plans have usually met with economic problems. An attitude commonly found is that services for the disabled are a luxury only a rich country can afford. Their development has thus often been left to private organizations, and been dependent on charity rather than on public funds.

2.3 The CBR approach

Community-based rehabilitation is a concept closely related to primary health care (PHC). It forms an integral part of the programme to develop "Health for All by the Year 2000".

The CBR approach tries to solve the problems in a way different from IBR. The CBR approach:

- promotes awareness, self-reliance and responsibility for rehabilitation in the community;
- builds on manpower resources in the community, including the disabled themselves, their families and other community members. The disabled and their family members are called on to take an active part in the training efforts;
- encourages the use of simple methods and techniques which are acceptable, affordable, effective and appropriate to the local setting;
- uses the existing local organization and infrastructure to deliver services, especially primary health care services; and
- takes into consideration the economic resources of the country and thus allows for an eventual extension to provide total coverage according to perceived needs.

In implementing CBR, the following steps were followed. Rehabilitation processes have been broken down into component parts, or modules. Any module chosen for implementation through CBR must satisfy the condition that its effectiveness is scientifically established. Rehabilitation techniques of doubtful or marginal value are excluded.

Furthermore, the technique must lend itself to implementation within the setting of developing countries. Thus, sophisticated Western technology is replaced by locally appropriate technology.

Rehabilitation modules have been arranged in so-called "training packages" (TPs). TPs include a short instruction for the person who introduces and supervises the training, a detailed description of the various training steps and an evaluation sheet. The language is very simple, and the text is supported by many drawings. The TPs are given directly to the disabled person or to the family member responsible for the daily training.

CBR is carried out in the following way. A "local supervisor" is recruited from the community and trained. It is preferable to use existing community manpower, such as a person already working as - or being trained to be - a community health worker, social worker or school teacher. The local supervisor identifies the disabled by making house-to-house visits. Then the disabled and their families are motivated to take part in CBR. A "trainer", normally a family member of the disabled or a friend, receives instructions on how to do the training. Practical demonstrations are given. The local supervisor checks that the training is done correctly, and evaluates results together with the disabled and the trainer. In some cases referrals to facilities at a higher level are needed.

CBR includes training in the essential physical, mental, educational, vocational and social tasks, all of them based in the community.

3. POLICIES AND STRATEGIES OF WHO REGARDING CBR. THE ROLE OF OTHER UN ORGANIZATIONS AND THE INTERNATIONAL YEAR OF DISABLED PERSONS

3.1 General WHO policies and strategies

At the 30th World Health Assembly in 1977 it was decided to "call upon all countries to urgently collaborate in the achievement of the goal..." of attaining "...by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life".⁴

In accordance with this Resolution the work of WHO has been reoriented. The key to the attainment of "Health for All by the Year 2000" is the implementation of primary health care. Governments have been called upon "to formulate national policies, strategies and plans of action to launch and sustain primary health care". WHO's role is now seen as "to encourage and support national strategies and plans for primary health care" and to "promote and facilitate the mutual support of countries for accelerated development of primary health care".⁵

The "Seventh General Programme of Work Covering a Specific Period (1984-1989 Inclusive)"⁶ reflects these new priorities. It states that "The main thrusts of the Strategy of Health for All are the development of the health system infrastructure starting with primary health care for the delivery of country-wide programmes that reach the whole population. These programmes include measures for health promotion, disease prevention, diagnosis, therapy and rehabilitation. The Strategy involves specific measures to be taken by individuals and families in their homes, by communities, by the health service at the primary and supporting levels, and by other sectors. It also involves selecting technology that is appropriate for the country concerned in that it is scientifically sound, adaptable to various local circumstances, acceptable to those for whom it is used and to those who use it, and maintainable with resources the country can afford. Crucial to the Strategy is making sure of social control of the health infrastructure and technology through a high degree of community involvement. Also spelled out is the international action to be taken to support the above national action through information exchange, promoting research and development, technical support, training, ensuring coordination within the health sector and between the health and other sectors, and fostering and supporting the essential elements of primary health care in countries".

3.2 Specific policies related to CBR

As stated above, rehabilitation forms an integral part of primary health care (PHC) and should use the PHC delivery system. The technical content of rehabilitation delivery should be designed in accordance with the general principles guiding PHC, and in cooperation with other sectors (educational, vocational and social) with the appropriate knowledge and experience.

4 WHO document WHA30.43 (1977).

5 WHO document WHA32.30 (1979).

6 WHO document A35/4 (1982).

The target for WHO programme activities is "fostering national and international action so that by 1989, at least 50 per cent of all countries will have initiated community-based rehabilitation programmes that are available and acceptable to all sectors of the population, especially the rural and urban poor, concentrating on the major categories of disabilities or handicaps caused by locomotor, speech, hearing, seeing and mental disorders".⁷

3.3 Role of other UN organizations

In 1981 UNICEF and WHO signed a joint statement on cooperation in supporting community-based rehabilitation.

In 1982 a note with similar content was prepared jointly by UNDP, UNICEF and WHO. UNESCO and ILO, the agencies primarily providing guidelines and technical cooperation for the educational and vocational rehabilitation sectors respectively, have taken up community-based activities as well.

3.4 International Year of Disabled Persons

During the International Year of Disabled Persons, 1981, a plan was developed by the United Nations, the Vienna Affirmative Action Plan. National plans of action were also worked out. These plans form possible starting points for the planning and implementation of CBR.

4. FIELD TESTING OF THE CBR APPROACH

4.1 Aims of field testing

The first version of the WHO manual "Training the Disabled in the Community" was drafted and printed in a limited number of copies in 1979. It was discussed by a group of experts at an Informal Consultation in Mexico in November 1979.⁸ A second version was drafted and printed in 1980. The changes in this version were based on the results of earlier field tests and expert reviews. The second version was printed and bound in two ways: one for reviewers and one for field testing purposes. The objectives of field testing are:

- to test the soundness of the concept of CBR of disabled persons; also the feasibility, acceptability and effectiveness of the approaches in various settings;
- to determine further requirements for service delivery, such as organizational infrastructure, manpower, transportation facilities, referral needs, budget, etc.
- to evaluate the technical content of the manual, especially in the following areas:
 - a) whether it gives technically correct, easy to understand and relevant information and guidance;
 - b) whether the disabilities covered are those deserving priority; and
 - c) which inputs are required for local adaptation, translation, printing, etc.

4.2 Selection of project areas for field testing

National and local authorities, organizations, institutions and individuals were approached to suggest areas for testing the manual and its concepts. Information was channelled through the mass media, meetings, country visits and discussions about the manual. WHO has given technical and financial support to start the field testing, e.g. provision of short-term consultants, manuals, small grants for training activities, translations/adaptations of the manual. Cooperation has been established with UNICEF.

⁷ WHO document A35/4 (1982), p. 105.

⁸ WHO document SHS/79.6 (1979).

The following factors were considered in the selection of project areas:

- that the government and local authorities, organizations, institutions expressed their interest and willingness to incorporate a CBR component in their activities;
- that there was a resource centre (rehabilitation institution, medical college) willing and able to collaborate in the project and provide resources for training, supervision, referrals, monitoring and evaluation of the programme;
- that there was an operating primary health care scheme and related infrastructure (this was not an absolute requirement; the programme has also been tested successfully in areas without PHC).

4.3 Description of activities in the project areas

A summary of activities regarding field testing and introduction of community-based programmes is given below by country project:

1. Botswana
2. Burma
3. India
4. Mexico
5. Nigeria
6. Pakistan
7. The Philippines
8. Saint Lucia
9. Sri Lanka

4.3.1 Botswana

Introduction and field testing of the community-based approach to rehabilitation services started in October 1979 in the Serowe and Palapye areas, initiated by a WHO consultant in collaboration with the Ministry of Health, Special Services Unit, and a regional health team. The first version of the manual was used at the beginning, being replaced by the second version in 1980/81.

A 3-day training course was held for 15 primary health workers (family welfare educators) with attendance by the Commissioner for the Handicapped, four social welfare officers and a public health nurse. It was followed by 3-1/2 weeks of field training. The programme thus started was periodically evaluated by the Special Services Unit and by the WHO consultant during her follow-up visits in 1980 and 1981.

In spite of some passing difficulties the programme has been accepted as "ideal for a developing country like Botswana".⁹

In August-September 1981, Botswana hosted a WHO-sponsored Intercountry Workshop on CBR. It drew participants from seven countries of the African region. In September 1981, a plan to extend CBR to cover the whole country had been prepared by the WHO consultant and submitted to the Ministry of Health. Consequently, a series of training workshops has been planned by the Special Services Unit in the Ministry for the period February-August 1982. The first National Workshop was held in February 1982 for public health nurses and local authority nurses responsible for training and supervising family welfare educators (village health workers). This workshop will be followed by district workshops for local country workers (family welfare educators and Red Cross volunteers). The adaptation and translation of the manual into Setswana is well advanced.

4.3.2 Burma

A nationwide programme of CBR has been drawn up by the Government of Burma and financial support from UNDP is foreseen. The programme will start in a selected area consisting of 15

⁹ Report of Evaluation on Field-testing WHO Manual on Training the Disabled in the Community, Ministry of Health, Serowe, Botswana, 26 June 1980, p. 11.

villages with a population of about 2000 or more each. The WHO manual will be used to implement services in the project area. For this purpose, it has been rearranged, adapted and translated into Burmese.

A WHO consultant visited Burma in December 1981 and January 1982 to assist in getting the programme started. The project manager and 10 instructors (5 medical officers and 5 physiotherapists) completed a 4-week training course. They in turn will train 15 community health workers to act as local supervisors, 15 midwives and 3 townships medical officers to guide the local supervisors in their day-to-day activities. In addition, a team consisting of one instructor medical officer and one instructor physiotherapist will be appointed to provide supervision and ongoing education to the local supervisors in their respective villages. The project will be evaluated after one year.

4.3.3 India (Kerala State)

CBR was initiated and a field trial of the manual started in late 1980 during the visit of a WHO consultant to Trivandrum. In agreement with the Government of India, Kerala State had been selected for CBR testing. The testing area initially covered two subcentres (with populations of some 27,000) within the catchment area of the Medical College Health Unit in Pangappara. The Physical Medicine and Rehabilitation Department and the Social and Preventive Medicine Department of the Medical College of Trivandrum were involved in the programme.

In late 1981, a Technical Services Agreement was signed with the Medical College and the Department of Physical Medicine and Rehabilitation. Its aim was to set up a model project of CBR. The Agreement provides for CBR services to cover all the people living in the Health Unit area. It has been proposed that the project also be supported by UNICEF (for a vehicle and printing of locally adapted manuals).

In February 1982, the project hosted a WHO-sponsored Intercountry Workshop on CBR for professionals to encourage similar integrated PHC/CBR programmes in other countries of the South-East Asia Region, as well as other regions of India.

The Kerala project continues and is being extended. During the February workshop, the Minister of Health committed himself to expanding the programme to other parts of Kerala.

4.3.4 Mexico

The feasibility of CBR using the manual was first studied in the Toluca region of Mexico in 1980, after disability surveys made in the area. Out of a population of some 8,000 people, about 300 were identified as disabled (an additional 100 were found later on).

The first version of the manual has been adapted for use in Latin America. It was translated into Spanish in 1980 and then field tested.

The investigation was coordinated by the Regional Adviser on Rehabilitation from the WHO Regional Office for the Americas/Pan American Health Organization and the primary health services. A small grant from WHO Headquarters was provided. This study revealed that when simple CBR was carried out at the place where the disabled live, the problems could be solved or the situation significantly improved for 70 per cent of them. Of the remaining 30 per cent, about 20 per cent needed help (e.g. assessment, guidance) from intermediate-level referral services and could then carry on training at home; about 10 per cent needed the more specialized care provided by a hospital or rehabilitation centre.

This investigation showed that community health workers - given some additional training in disability problems as suggested in the manual and properly supervised in the early stages of their work - can give training and advice and significantly assist the disabled to solve their problems at the community level.

4.3.5 Nigeria

Field trials started in January-March 1980 during a visit by a WHO consultant. The study was designed as a time-limited exercise lasting a few months in selected areas of 7 states (out of 19 states in the confederation). Members of the National Youth Service Corps,

community health aides and community health officers (a total of 44 local supervisors) participated. By June 1980, this programme was phased out, with the exception of one area in Lagos, where it still continues.

In 1981, a renewed promotion of the programme was launched, mainly from the WHO Collaborating Centre, Igbobi-Lagos, the National Committee for the International Year of Disabled Persons and the Institute of Child Health and Primary Care, Lagos University Teaching Hospital. Four workshops on CBR were planned for 120 participants from all states to initiate permanent programmes in every state.

During the second visit of the WHO consultant (April-May 1981), a workshop was held for community health workers and their supervisors in the states of Anambra, Kano and Lagos. Altogether 49 persons have been trained. In addition, a training programme was started by the WHO Collaborating Centre to create a task force of eight persons, including nurses, physiotherapists, orthopaedics and social workers. The task force is expected to draw up strategies for implementation of CBR in the country and to supervise the programmes once they have begun.

In November 1981 a National Workshop on CBR was held in Jos under the auspices of the Federal Ministry of Social Development and the Institute of Child Health and Primary Care, Lagos University. Forty-one participants from 11 states attended the workshop. Another National Workshop is planned for August 1982 at the WHO Collaborating Centre, Igbobi-Lagos. To add momentum to the programme development, a Contractual Services Agreement was signed with the WHO Collaborating Centre for training, research and service delivery.

4.3.6 Pakistan

A WHO consultant visited Pakistan at the request of the Pakistan Government in June 1981. He submitted a report recommending the introduction of CBR in collaboration with WHO. In December 1981, the Government organized a National Workshop on CBR.

An agreement was signed in September 1981 between WHO and the Department of Rehabilitation Medicine, University of Göteborg, Sweden, for the research project "Evaluation of the WHO Community-Based Rehabilitation Programme in Pakistan". Under this agreement, introduced through a voluntary agency, a field project is being set up in the Lahore area and the manual is being translated into Urdu. Interim evaluation is foreseen by the end of 1982 and final evaluation in 1983.

4.3.7 The Philippines

Field trial activities began at the end of 1980 with the agreement and support of the Ministry of Health and the National Committee Concerning Disabled Persons (NCCDP). In December 1980, a WHO consultant assisted in the initial training course for the PHC workers involved and introduced them to the use of the manual. The project area, Cainta in the Rizal District, is 50 km from the centre of Manila; it is both rural and suburban in character and comprises approximately 4,800 households with a population of some 30,000. About 90 disabled persons were identified and provided with training as suggested by the manual.

Project activities diminished during 1981 due to transportation difficulties and insufficient supervision but were continued by some local community workers.

In April 1982 the incorporation of the project in the Integrated Comprehensive Primary Health Care system of the Ministry of Health was proposed by National Orthopaedic Hospital authorities. It was approved in principle by the Ministry. Another positive development is the inclusion of the existing government community health workers, called Barangay Health Ladies Brigade, as local supervisor assistants.

During 1981 two other similar projects were started by national and local authorities and communities. One is in Bacolod City where a brief training was given to 57 community volunteers and 159 disabled were identified for CBR. Another was initiated on Cebu Island. The WHO manual is being used as a tool for service delivery at the community level.

4.3.8 Saint Lucia

The programme of CBR and field testing of the manual was started in St. Lucia in May 1981. A 2-week workshop was held to train 28 participants, including 16 future trainer/supervisors (nurses, physiotherapists) and 12 community health aids (PHC workers). The workshop was followed by 4 weeks of supervised field work.

The programme was designed from the beginning as countrywide (total population: 140,000). The activities initiated with the assistance of a WHO consultant have subsequently been continued by national staff.

In the early phase of the programme, 12 areas with a population of about 60,000 were covered by community-based activities. Training activities continued under the auspices of the local government and the Ministry of Health.

Three additional courses on community rehabilitation for nurses and community health aides (second-level supervisors and local supervisors, respectively) were organized by the National Coordinator in March, April and June 1982. CBR has been incorporated in the country's National Health Development Plan for 1981-85.

The report of the St. Lucia programme development, May-June 1981, was submitted to the Conference of Ministers of Health from 17 countries of the Caribbean Commonwealth held in Belize in July 1981. The conference recommended to consider initiating similar programmes in other countries of the region. Consequently, a programme was begun in Jamaica in March 1982 with WHO assistance, and exploratory missions were undertaken by WHO consultants in the Bahamas, Barbados and Haiti.

4.3.9 Sri Lanka

In 1981 two students from the School of Social Work field tested the manual in a village some 50 km from the capital city of Colombo. The WHO manual has been partly translated into Sinhala and the remainder will follow.

In 1982 the detection and management of disability related to child mental health problems was included in the child care component of primary health workers and other community health workers within the PHC system in Sri Lanka.

A CBR pilot project in 20 villages of 5 health areas has begun with Ministry of Health approval. The WHO manual has also been used as a guide for parents working in informal self-help groups.

4.4 Summary and comments on field testing

To date, field testing activities in about 10 countries have been carried out for periods ranging from a few months up to 2 years.

Most projects have been initiated and actively supported by WHO, but some were started by voluntary organizations with WHO action being limited to encouragement and provision of manuals (e.g. Sri Lanka and two projects in The Philippines). The ILO has supported a CBR programme in Indonesia. This programme has been very successful; however, no details were available to the participants of the consultation.

Population size in the test areas has varied from several thousand people to 60,000; the number of disabled people under rehabilitation training has ranged from 45 to 400. Some projects have experienced high and low tides (Nigeria, The Philippines, Botswana) but have recently consolidated and are expanding.

Result sheets have been obtained on 576 disabled persons in nine project areas. Of these, 56 per cent were male and 44 per cent female. 70 per cent were under age 15; the most common group was children aged 6-10 years, which constituted 32 per cent of the total. Persons over 61 years made up 5 per cent of the total. Disabled persons with moving difficulties accounted for 44 per cent of the total, followed by hearing/speech difficulties with 16 per cent and multiple disabilities (mostly moving and learning difficulties caused by cerebral palsy) 16 per cent. Learning difficulties appeared in 10 per cent, seeing in 7 per cent, fits in 4 per cent and strange behaviour in 3 per cent of the total.

The results reported showed that 73 per cent improved with training, whereas 27 per cent had not improved at the time the result sheets were submitted. Rather strict rules were applied to determine if a person was improved or not improved. There had to be a description of a particular disability or handicap existing prior to the training. Further, it had to be shown that after the training there was a clear change or diminution of the degree of disability/handicap.

Results have been judged as unimproved in several cases of disability where obviously the training period was too short (e.g. a few weeks only). It may thus be expected that the proportion of improved cases will be adjusted upwards.

The most common reasons for no improvement were insufficient length of training, drop-outs and lack of a suitable trainer. Inadequacy of the technical parts of the training packages, illiteracy or inability to understand the text or drawings were extremely rare as a cause of failure. Elderly disabled persons generally did less well than younger ones.

The participants concluded that the results were highly satisfactory, considering the constraints under which the project centres operated, such as lack of supervision in some of the project areas and insufficient means of transportation and communication. Rehabilitation results were deemed equal to IBR if all factors are considered. In some respects results are better, such as social integration in the family and community; in others, results were less good, such as school performance.

The participants pointed out that the following factors contributed to the success of the field tests:

- a) an existing, well-developed primary health care infrastructure and adequate development of related socio-economic sectors in the community;
- b) transportation facilities;
- c) communication system;
- d) sufficient training of PHC workers prior to the field testing, and adequate supervision during this period;
- e) information to health and other professionals in the project area;
- f) involvement of local authorities in the project, with the leadership of the community fully understanding and accepting it; information to the community in order to create awareness of the disability issue; and acceptance of community responsibility for solving the problem.

It was further explained that some of the above requirements were specific to the field-testing situation and would not necessarily be required in the final phase of implementation of services. For example, transportation and communication problems should be solved within the framework of the PHC structure.

The participants discussed how to proceed with the field testing and whether the final version of the manual should be delayed to await further results. It was decided that the experience during the field testing allows the following conclusions to be drawn:

- a) The CBR approach has proven to be technically viable, effective, feasible and appropriate in all the different settings in which it has been used.
- b) The CBR approach is estimated to be economically maintainable and organizationally feasible if implemented as a component of primary health care and community services.
- c) The results of the CBR approach are sufficiently documented at the present time to be deemed equal to those of IBR. It is justified to print and distribute the final official version of the manual, amended as described in Section 5 of this report. It is suggested that a continuous process be set up to amend the manual in light of future experience.

The participants further recommended that field testing should proceed in order to gain more experience on the technical effectiveness of the various training packages. New evaluation forms were drawn up in order to better standardize the reports in the future. A further 3,000-4,000 results should be collected and submitted to WHO Headquarters for analysis. These results will be used to amend individual training packages and serve as a guide in future revisions of the manual.

5. REVIEW OF THE CONTENTS OF THE WHO MANUAL

The participants thoroughly reviewed the contents of the manual based on their experience in using it. Recommended changes follow. Detailed suggestions are not included below but are available in the group reports.¹⁰

5.1 The size and format

The present format of about 1,100 pages bound in the A4 size volume is difficult to handle. It is suggested that the manual be produced in smaller size if possible. No efforts should be spared to reduce the present version of the text to the minimum necessary.

It might be useful to publish some of the material in other manuals or handbooks, e.g. as reference material for first- or second-level supervisors.

5.2 The Introduction and Subject Index

The Introduction could be included in the suggested new short Guide for Policymakers. The Subject Index and a glossary of terms could be included in a new introductory booklet aimed at informing various groups on the principles and approaches of CBR (e.g. for medical students, nursing students).

5.3 The Guide for Policymakers and Planners

The participants suggested that this guide be divided into two parts, one for policymakers and one for planners.

5.3.1 Guide for Policymakers

The Guide for Policymakers should aim at the political and higher administrative levels and provide a short (2 to 3 pages) description of the CBR approach including annexes with additional material for the reader who wants more information. Such annexes could include a list of international and national documents of importance (e.g. the UN Universal Declaration of Human Rights; the UN Declaration on Rights of Disabled Persons; the UN Declaration of the Rights of the Child; the UN Declaration of the Rights of Mentally Retarded Persons; various documents from WHO, ILO, UNESCO, UNICEF; the IYDP World Plan of Action; IYDP National Plans of Action).

Also to be included among annexes would be a short statement on the disability situation in the world and the number of disabled in specific countries. Chapter 7 of the present guide could be reworded and included. Examples of training packages could also appear in annexes.

It was also suggested that some audio-visual material might be developed for the Guide for Policymakers.

In order to stimulate action, it was also suggested that a checklist be made to show the progress of policymaking, planning and implementation in all countries of the world.

¹⁰ Copies of these reports are available from the Rehabilitation Programme, Division of Diagnostic, Therapeutic and Rehabilitative Technology, WHO Headquarters, 1211 Geneva 27, Switzerland.

5.3.2 Guide for Planners

This guide would contain the same material as now, with a few amendments and corrections. The material could, however, be arranged in such a way to lend itself directly for the training of planners and managers.

There is a need to include the definitions by the 1981 Expert Committee in Chapter 1. A chapter on evaluation and research should be added. Also, more information is needed on staff career and development.

The participants also discussed the possible role of the second level (intermediate) supervisor and recommended that a method for curriculum development be suggested and a training booklet be developed as soon as possible. Some of the recommendations of the 1981 Expert Committee were to be included in Chapter 10, e.g. as regards the structure of national organizations and coordination of efforts by different UN agencies.

5.4 Guide for Local Supervisors

The term "local supervisor" is not ideal as it might inspire thoughts that the supervisor is not a "worker". However, it was realized that no other suitable title could easily be found and that in any event almost all countries used other titles. In most cases these are of the health cadre. It was suggested that an appropriate time frame for the curriculum be prepared, e.g. 2-3 weeks for theoretical and 2-4 months for practical training. The time frame should be flexible to allow organizers in each country to freely decide their own schedules. Material for refresher courses should be prepared.

It was also pointed out that other learning material might be needed for local supervisors who received in-service training rather than a formal course.

The present guide does not include sufficient material on early detection of some of the disabilities such as hearing difficulty. Also, some of the recognition techniques could be refined. The report sheet was amended and more instructions for its use suggested. The authors were asked to provide a scoring system for determining the degree of disability. Local supervisors should be given more scope in follow-up cases referred back to the community from institutions; there might be a need to devise further training packages to train such disabled.

More material is needed to motivate parents to better accept disabled children.

For the referral system it might be desirable to develop instruction sheets on drug treatment of persons with fits and strange behaviour.

The matter of referral of disabled persons, especially children, needing orthopaedic surgery was discussed. Existing surgical techniques may have to be reviewed and carefully assessed, and new techniques may need to be developed in order to satisfactorily improve movement functions. To give recommendations on how local supervisors will handle referrals might prove difficult until such a review has been made.

5.5 Guide for Community Leaders

A more detailed text is needed to describe how to create greater awareness and a sense of responsibility among community members towards the issue of disability. The CBR approach can be described in detail. Community leaders should be given credit for what is being done for the disabled persons.

It might be advantageous to include the information on disability in this guide in a publication of a larger scope, e.g. a general health guide for community leaders.

The stories could be placed in this guide or appear separately. There should be more feedback from community leaders and the results of community participation should be evaluated, e.g. by the intermediate-level supervisor.

5.6 Guide for Teachers

This guide will be further elaborated in cooperation with UNESCO. It might be advantageous to include this information in a health guide for teachers.

5.7 Booklet for Persons Who Have Fits

There was considerable difference of opinion between some participants who wanted to keep the booklet in its present form (with amendments) and those who wanted it included in one of the other booklets (e.g. hearing or strange behaviour). Some participants felt that persons with fits might be labeled as disabled by the presence of the booklet. It was pointed out that many persons with fits do not have any disability, but they are handicapped.

However, persons with fits are a large group and may be estimated to be some 1-2 per cent of the population in developing countries. How to go about the publication needs to be considered, and the final answer as to where to include the training packages will be settled after further consultation.

5.8 Booklet for Persons with Hearing/Speech Difficulties

Sign language is culture-dependent and thus most participants shared the view that a universal sign language should not be sought. They foresaw further development of local habits regarding sign communication, and one of the main efforts needed was greater encouragement of this development. More instructions are needed on how to detect early any hearing impairment (see above).

5.9 Booklet for Persons with Learning Difficulties

The package on play activities has been found most useful. Mothers have greeted it with enthusiasm, in spite of its length. It has also proved to be a useful introduction on how to start training their disabled children. Some alternative approaches were suggested, e.g. as regards activities of daily living (ADL) training, e.g. backward chaining. Training package 2 should include milestones and a linked explanation of mental age. Severely retarded may not benefit in any respect from participating in normal schooling, and thus some instruction in how to deal with such children could be included.

More material relating to adult mentally retarded is needed. The degree of social competence needs to be explained and the training should be geared towards achieving such competence. Other adults should avoid treating adult persons with learning difficulties as children.

5.10 Booklet for Persons with Moving Difficulties

Packages which now take over 15 pages should be divided up into shorter ones. A new package dealing with prevention of deformities might be considered.

Separate instructions for the local supervisors regarding children with combined disabilities such as those seen in cerebral palsy might be considered.

It was pointed out that the number of disabled persons with hemiplegia and paraplegia is increasing. Training manuals are needed in order to facilitate their return home from institutions. But, as there already exist a number of such manuals, the authors of the manual could adapt an existing book for use in developing countries.

For appropriate technology, see section 5.13.6 below.

5.11 Booklet for Persons with Seeing Difficulties

More material is needed to expand this booklet.

5.12 Booklet for Persons with Strange Behaviour

It was pointed out that there were many different words for "strange behaviour" in the various languages. The description of what is considered "strange" in Package 1 seemed to be adequate but in some cultures it may need to be adapted.

Realistic goals for the training of persons with strange behaviour should be included. It should be made clear that the booklet is meant for persons with chronic problems.

5.13 Suggestions for further changes.

5.13.1 Breastfeeding

The breastfeeding package might be excluded from the various booklets and instead produced for distribution by the local supervisor or the community leaders. Material for disabled mothers who breastfeed should be developed.

5.13.2 Income-generating activities, including job placement

The training packages in the different booklets will be replaced by simpler and shorter material, including a checklist. A detailed booklet or several booklets will be worked out in cooperation with the appropriate agencies.

There is a need to distinguish between activities carried out by individuals, e.g. family members, neighbours, in the community and those for which community leaders must assume responsibility, such as setting up of simple job assessment, training facilities and economic help to start an activity. Development of entrepreneurial skills and cooperation among disabled persons should be covered in the detailed booklet referred to above.

5.13.3 Play activities

This package may be printed as a separate booklet instead of being repeated in every package.

5.13.4 Social activities

A common package might be produced to be distributed by local supervisors or community leaders.

5.13.5 Schooling/education

The training packages in the various booklets will be amended in cooperation with the appropriate agencies.

5.13.6 Appropriate technology

Special material dealing with appropriate technology will be extracted in a form that can be published separately, e.g. for prosthetic and orthotic workshops. This may need to include low cost hearing aids, spectacles and other appliances.

5.13.7 Leadership training

To promote awareness of the disability issue and to ensure planning and action to establish CBR, the disabled must themselves become actively involved. Leadership training could be useful to prepare disabled persons for an increased role in these matters. It was recommended that WHO should prepare and print useful learning material.

5.13.8 Sex and marriage counselling

It was felt that these matters should be dealt with, especially in the booklets on fits and learning.

5.13.9 The elderly disabled

As the number of disabled elderly is rapidly rising in developing countries, some brief instructions for local supervisors should be developed on this subject.

5.14 Translation and adaptation

The manual has already been translated in part into about ten languages. There is a need to provide the future translators with instructions, e.g. terminology and advice on how to use simple language which is suitable even for the illiterate and semi-literate.

Detailed advice should be given on how to adapt the manual to local cultural and social conditions. Also, drawings may have to be changed so disabled persons can identify with them; clothing and gestures might need changes, etc. Artists must be given instructions to make them understand the intention of the drawings.

The least expensive way to print large numbers of training packages is possibly by using electro stencils.

6. SUGGESTIONS FOR FURTHER DEVELOPMENT OF THE CBR PROGRAMME

6.1 Promotional activities

Promotional activities were given high priority by the participants. One should try to first raise the level of awareness of the people, especially among those in authoritative positions; second, seek political commitment from the national authorities; and third, encourage action aimed at implementation. The level of awareness has been raised in many countries during the International Year of Disabled Persons (IYDP). Further action could include mass media (TV, radio, newspapers) and local promotion (posters, pamphlets). Nationwide and local organizations, both official and nongovernmental, should be approached and take part in promotion.

Health authorities of all countries have officially committed themselves to the development of primary health care (PHC), but a CBR programme is not yet always recognized as an integral component of PHC. Political decisions should be sought which clearly specify CBR as a part of the commitment in the future. Action groups could be created for networking and to meet with and explain this to the policymakers at the national level. A development area with ongoing CBR activities could be useful when efforts are made to involve the policymakers. Action to establish such an area could start either in the public or the private sector. In the event of insufficient activities in the near future, nongovernmental organizations should offer to help. Wherever an implementation phase has started, monitoring should be provided to ensure steady progress.

Promotion of implementation could include intergovernmental and international organizations as well as national and nongovernmental ones. The IYDP Global Plan of Action and National Plans of Action could be used.

Nongovernmental organizations should become recognized partners with the government in countries where implementation of CBR is delayed by financial constraints but can be funded by NGOs.

Organized participation of the disabled themselves, their families and their associations should also be included in planning and implementation of CBR services.

6.2 Coordination

Coordination at the national level is necessary. The participants took note of an earlier recommendation by the 1981 WHO Expert Committee on Disability Prevention and Rehabilitation (TRS 668) which recommended that:

"Governments should establish national mechanisms for the formulation of policies and planning, and for the coordination, implementation and evaluation of disability prevention and rehabilitation services including:

- a) a high-level interministerial body for formulation of policy and for ensuring that financial resources are made available and
- b) an executive body for planning, providing guidelines, coordinating and evaluating all rehabilitation services."

The participants of the Consultation fully endorsed this recommendation.

As several UN agencies may soon participate in the CBR programme, it was also suggested that there be coordination of their activities on the national level. IYDP National Committees have in several countries become a permanent institution and may assume the role of coordinators.

6.3 Manpower development

The participants expressed the view that more training material prepared by WHO would be welcome and opportune. As CBR programmes were planned in many countries to begin by training the intermediate-level supervisors, priority should be given to the production and publishing of suitable curricula, manuals and teaching/learning materials for this group.

In addition, attention should be paid to the needs of other personnel in the health sector such as physicians, medical students, nurses, etc. Also, curricula development and books for rehabilitation specialists and therapists now working in hospitals or institutions are desirable in order to familiarize them with the CBR approach. Traditional healers should be involved wherever feasible.

Manpower outside the formal health sector, e.g. teachers, social workers, community leaders, also need appropriate information on CBR, and they could use an introductory booklet, as described above in section 5.2.

6.4 Technology

WHO has in the past supported the development of workshops for the production of various prosthetic and orthotic appliances. Such institutions need a reorientation so they can better fulfill their role as part of the referral services for CBR. Thus their staff should receive additional training to become familiar with the technical requirements at the community level and how to use local materials and adapt their workshops better to more appropriate types of appliances and aids.

Village carpenters, blacksmiths, etc. could be involved in the production of appliances and aids such as those described in the manual.

6.5 Research

It was recognized that research is a valuable component in all health services. Without proper evaluation, it is unlikely that services can be developed in a dynamic and effective way.

Some resources should thus be earmarked for research. Areas to study could include disability epidemiology, effectiveness of CBR services, delivery systems, the social and developmental aspects of CBR, appropriate technology development, and evaluation of the role and methods used by traditional healers. Research training should be promoted.

7. CONCLUSIONS AND RECOMMENDATIONS

7.1 Conclusions

The participants, after having reviewed the present results of the CBR approach, concluded that community-based rehabilitation is an appropriate, effective, feasible and economically viable approach to provide the most essential rehabilitation to the disabled persons not reached now by services in the developing countries. CBR should form part of the primary health care programme.

The WHO manual "Training the Disabled in the Community" is a valuable, practical tool and its techniques for training have proved effective. The participants recognized that the aim of the manual is to provide background material to inspire production of national manuals in the local languages and adapted to the local social and cultural setting. Recommendations for amendments in the manual are summarized above; many of them deal with suggestions for development of further training material.

Based on these conclusions, the participants concluded that all the necessary tools for implementation of the CBR approach are now available, will soon be available, or could be developed nationally on the basis of the present experience in the ten countries which have taken part in the field testing. Thus there was no reason for governments to delay the integration of CBR into their national PHC programmes.

The participants considered the recommendations made by the 1981 WHO Expert Committee on Disability Prevention and Rehabilitation (TRS 668) and expressed their support.

Attention was also drawn to Resolutions WHA29.68, WHA30.43, WHA32.30 and WHA34.30 and to the IYDP Global Plan of Action and IYDP National Plans of Action.

7.2 Recommendations for governments

All governments are now implementing primary health care services as part of their commitment to the goal of "Health for All by the Year 2000". Rehabilitation services are an integral part of PHC services and the CBR approach should be given priority in implementation. The introduction of CBR will contribute to the social and developmental relevance of the PHC programme.

It is recommended that:

- a) Governments should take urgent action to include CBR in their plans for development of health services and other related sectors.
- b) Should PHC services already exist, CBR should be included as soon as possible. In countries where PHC still awaits implementation, CBR should be included in the very early phases. Governments could also implement CBR as a part of other programmes such as those aimed at community development.
- c) Particular attention should be paid to the promotion and provision of manpower (within and outside the health sector) at all levels needed for the development and supervision of the CBR programme. Appropriate referral services should be established, thus using in the most productive way present technical expertise now most often engaged in institutions for the disabled.
- d) Governments should recognize the role of nongovernmental organizations as potential partners in the process of implementation. The disabled themselves, their families and their associations should be involved in consultations, planning and implementation, and be given official support in leadership training programmes.
- e) Efforts should be made to strengthen national coordination and cooperation in CBR at all levels.

7.3 Recommendations for WHO

WHO, in cooperation with governments and nongovernmental organizations, is already involved in the promotion, development and evaluation of the CBR approach, as reviewed above, and it is recommended that these efforts continue and be strengthened.

It is recommended that:

- a) WHO's technical cooperation in developing the manual "Training the Disabled in the Community" should be continued and the manual should be officially published, translated and widely distributed; and additional parts of the manual should be developed as suggested in this report.
- b) Cooperation with other UN organizations, such as UNICEF, UNHCR, FAO, ILO and UNESCO, should be further promoted in order to facilitate the inclusion of technical material to cover all aspects of rehabilitation in the manual, and to ensure full cooperation on the national level in the implementation of the CBR approach. Other UN organizations must be encouraged to actively participate in programme implementation.

7.4 Recommendations for other organizations

Nongovernmental organizations have in the past played an active role in the provision of services for the disabled in most countries. The participants encouraged the continued participation of NGOs in the CBR approach. Nongovernmental organizations pioneering the CBR approach should plan such efforts in coordination with governments and be involved in the promotion, planning, implementation and evaluation of CBR programmes.

ANNEX 1

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ANNEX 2

INAUGURATION OF THE MEETING

Dr Malinga Fernando, Director of Health Services of Sri Lanka, welcomed the participants. The meeting was inaugurated by Mrs Sunethra Ranasinghe, Deputy Minister of Health, Sri Lanka. Mrs Ranasinghe said that the Government of Sri Lanka was firmly committed to providing appropriate primary health care in order to achieve the objective of Health for All by the Year 2000. Programmes to train the disabled in the community are already established in the country as part of this development.

Dr Balu Sankaran, Director of the Division of Diagnostic, Therapeutic and Rehabilitative Technologies, WHO, Geneva, extended greetings from the Director-General of WHO, Dr Halfdan T. Mahler; the Deputy Director-General, Dr Thomas A. Lambo; and the Assistant Director-General, Dr Lu Rusham. Further speeches were given by Dr K.H. Notaney, WHO Programme Coordinator and Mrs Padmani Mendis, National Organizer of the Consultation.

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