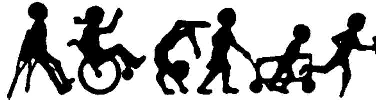

FRIDAY MEETING TRANSACTIONS

[Associate publication of Asia Pacific Disability Rehabilitation Journal]

CONTENTS Vol. 5 • No. 1 • 2003

EDITOR'S PAGE 2

FRIDAY MEETING TRANSACTIONS

Psychiatric Disability and Rehabilitation 3

REHABILITATION NOTES

Poverty and Disability 9

A Study on the Status, Family and Socio Economic Conditions of the Persons with Disabilities in Vallioor Panchayat Union 14

Mobilisation of Resources for CBR Programmes – The Example of Bangladesh Protibondhi Foundation 21

List of Journals, Compiled by Healthlink, UK 39

EDITOR'S PAGE

After 6 years, it is curtains down for this newsletter and the Friday Meetings that were held in Bangalore, on the last Friday of odd months through the year. The Friday Meetings were a public discussion about non-institutional forms of rehabilitation, where people agreed to disagree about differing views. When the meetings were first started, the discussants were unused to the idea of expressing dissent in a public forum. These meetings were held at the same venue in Bangalore at a regular interval, to explore different perspectives and divergent opinions on disability rehabilitation. On an average, 50 people from different walks of life attended these meetings. The deliberations from these meetings were published later in Friday Meeting Transactions twice a year, and mailed to readers in association with the Asia Pacific Disability Rehabilitation Journal.

These discussions primarily served as a capacity building exercise for practitioners of community based rehabilitation around Bangalore. The discussants are now able to analyse their methods and apply appropriate strategies better than earlier in their programmes. However, after 6 years, the Friday Meetings have outlived their utility, because there are many other alternatives available now for the meeting as well as the newsletter. Many of these alternatives are also located closer to the discussants' places of work. A survey of opinions from the discussants at the Friday Meeting, and the readers of Friday Meeting Transactions about the need to continue these activities, showed that a majority could now access similar activities near their places of work, with greater ease. Hence they felt that under the present circumstances, the Friday Meetings had lost their uniqueness, and did not currently serve any special purpose. As a result, it was decided to close the Friday Meetings, and the Friday Meeting Transactions which has no independent existence without the meetings.

The participants and I thank all the individuals and groups who supported these activities during the last 6 years.

The Editorial team wishes all our readers a Happy New Year!

Dr. Maya Thomas
Editor
J-124 Ushas Apts, 16th Main, 4th block, Jayanagar, Bangalore – 560 011, India
Tel and fax: 91-80-6633762, email: thomasmaya@hotmail.com

FRIDAY MEETING TRANSACTIONS

PSYCHIATRIC DISABILITY AND REHABILITATION

DISCUSSION LED BY

Bijumon K. Mathew, Suman K. Murthy, Sheeba Mathew
Richmond Fellowship PG College, 'Asha', 501, 47th Cross, 9th Main, 5th Block
Jayanagar, Bangalore -560 041, India

PSYCHIATRIC DISABILITY AND REHABILITATION

Psychosocial rehabilitation can be defined as a PROCESS initiated by a health or mental health professional, in collaboration with the patients' families and community, and supported by policy planners, focused on developing and implementing an individualised programme that seeks to MAXIMISE THE PATIENT'S ASSETS AND MINIMISE DISABILITIES IN THE AREA OF SOCIO-OCCUPATIONAL FUNCTIONING, centering around the philosophy of mobilising and utilising resources available to the community, with the final objective of mainstreaming the client.

Psychiatric disorders - prevalence in India

- 10-20 per thousand population is affected by serious mental disorder at any point in time
- Neurosis and psychosomatic disorders are 2 to 3 times higher
- Mental retardation is diagnosed in 0.5 - 1% of all children
- Rates of alcoholism and drug dependence are on the increase

Existing mental health services

- 20,000 beds in 42 mental hospitals
- 2,000 to 3,000 beds in general and teaching hospitals, with one half being occupied by long stay patients.
- Shortage of beds for active treatment
- Not more than 10% of those who require urgent mental health care receive it
- Woefully inadequate number of mental health professionals
- Unequal distribution between urban and rural areas

Disability due to mental illness

- Schizophrenia and other acute psychiatric disorders like affective psychoses lead to temporary disability, and can lead to chronic disability if not treated properly
- Disability can lead to loss of productivity, loss of income, loss of life due to illness

- Suffering is often not confined to the individual
- Severe social dysfunction can lead to social disability
- Affected areas include self care, interpersonal relationships, family life, social life and occupational life

Assessment of psychiatric disability

- Quantification of disability
- Scientific methods now available
- Helps in evaluation of rehabilitation programmes

Components of psychosocial rehabilitation

- Medical management
- Psychosocial interventions
- Rehabilitation settings
- Approach in rural areas

Service delivery options

- Hospital based
- Community based
- Residential
- Non-residential
- Governmental setting
- Non-governmental setting

ROLE OF FAMILY IN PSYCHOSOCIAL REHABILITATION

Rationale for role of family in psychosocial rehabilitation

- Family care is the most predominant type of care in the Indian setting
- By choice
- Because of tradition/values
- Because of lack of facilities for care
- Family has been more a part of treatment setting, compared to the West
- Home care has been shown to lead to lesser number of relapses and to better social adjustment
- Expressed emotions are less in Indian families
- Indian families have a higher rehabilitation potential

Family expectations

- Performance related high expectations
- Emotional over-involvement
- Long term treatment and care
- Lack of understanding of residual symptoms

- Marriage related issues
- Rehabilitation

Family burden

- Research findings reveal:
- Severe psychopathology leads to high burden
- Greater the disability, greater the burden
- Burden is higher in urban families
- Burden is found in areas of finance, leisure, family routines and interactions, emotions, physical and mental health, care-giver's occupation and the affected member's bhaviour

Family needs

- Psycho education
- Support
- Therapy
- Rehabilitation plan

Living setting

- Home care measures include:
- Psycho education
- Access to treatment and rehabilitation options
- Medication compliance
- Relapse management
- Emergency management
- Long term rehabilitation and care options

Care options

- Day care
- Home visit / visiting nurse
- Vocational guidance
- Occupational therapy
- Job placement
- Supported employment
- Access to welfare measures through collaboration with available community resources

'Empowerment' in the context of psychosocial rehabilitation means facilitation of family participation to give knowledge, bring about attitudinal change, provide professional expertise and support to gain competence to deal with a mentally ill family member. It also means helping families to grow beyond personal grief, and to promote self-help approaches leading to advocacy for the cause of psychiatric disabilities.

INTERVENTION STRATEGIES IN PSYCHOSOCIAL REHABILITATION

Objectives of interventions

- Reducing symptomatology
- Improving social competence
- Enhancing vocational competence
- Strengthening social support
- Reducing discrimination and stigma
- Consumer empowerment

Rehabilitation settings

- Hospital based: Occupational therapy, vocational rehabilitation, social skills training
- Community based residential: Half way homes, group homes, hostels, long stay homes
- Community based non-residential: day-care centres, vocational training centres, counselling centres, community outreach programmes

Process of psychosocial rehabilitation

- Rehabilitation assessment
- Rehabilitation planning
- Rehabilitation interventions
- Evaluation

Rehabilitation assessment

- Detailed history and diagnosis
- Current psychopathology
- Disability assessment
- Current social and environmental factors
- Resources
- Family
- Needs

Rehabilitation planning

- Stating main problems
- Prioritising problems
- Selecting the mode of intervention
- Monitoring the plan

Areas of psychosocial rehabilitation

- Personal hygiene / self care
- Interpersonal relationships
- Social skills
- Money management

- Work habits
- Leisure activities
- Time management
- Family therapy
- Home management skills
- Crisis management skills
- Resource mobilisation
- Self esteem
- Motivation
- Vocational skills

Interventions
- Client-centred
- Family-centred
- Community based

Client-centred interventions
- Activity schedule
- Medication
- Counselling
- Social skills training
- Independent living skills
- Group therapy
- Vocational training
- Cognitive re-training
- Behaviour modification techniques
- Work habit training
- Community living
- Utilisation of leisure time

Family-centred interventions
- Psycho education
- Counselling
- Supportive psychotherapy
- Coping skills training
- Problem solving skills training
- Crisis management skills
- Other supports – resource mobilisation, job placement, training for income generation, self-help groups

Community based interventions

- Creating awareness
- Involving communities
- Resource mobilisation
- Advocacy
- Empowerment
- Reduction of stigma
- Networking
- Outreach programmes

Objectives, activities and outcomes in psychosocial rehabilitation

Objectives	Activities	Outcomes
To improve personal hygiene	• Time allocation • Monitoring • Observation • Feedback	Adequate self care skills
To improve communication skills	• Group living • Group activities • Positive reinforcement • Group therapies	• Maintains eye contact • Initiates conversation • Relates constructively in family and community • Attains social competence
To improve level of motivation	• Counselling • Positive reinforcement • Peer pressure • Supportive work	• Takes interest in activities • Decides to start working on something • Sense of self worth
To develop work habit	• Vocational training in a supportive environment • Feedback • Counselling	• Builds up a routine • Learns to be on time • Develops and maintains positive habits
Reduction of stigma	• Creating awareness • Work with media • Work with NGOs, government agencies	• Greater the facilities, lesser the stigma

REHABILITATION NOTES

POVERTY AND DISABILITY

*Rakesh Arora**

INTRODUCTION

There appears to be at least two broad and distinct paradigm shifts in the philosophy, approaches and practices in rehabilitation of persons with disabilities (PWDs). In the beginning and in the mid-eighties, the purely medical model of rehabilitation of PWDs was abandoned in favour of a CBR model, with focus on social integration and community support of PWDs, in undertaking activities of daily living. The mid-nineties and the early part of the millennium however, appear to be witnessing a completely new approach- one of providing equal opportunities and empowerment. The philosophy of PWDs as equal partners and productive citizens rather than those living on welfare and charity has been ushered in. The theme for the World Day of Disabled Persons (1996) was 'poverty and disability'. This was a global expression of concern about the deplorable conditions that disabled persons live in, and the need to provide them equal access to services, especially employment. It was noticed that they are acutely affected by a shortage of basic necessities like water, food and housing, apart from bad or non existent public transportation, health care, employment or other income opportunities. Even when these services are at close proximity, the PWDs find it difficult to access them due to various inhibiting factors like handicapping physical environment, lack of assistive devices, tools that cannot be used by the PWDs etc. The most critical element of empowerment that is universally accepted is economic rehabilitation. Economic emancipation is therefore taking a central stage in the contemporary thinking on disability issues. Accordingly, disability is also considered as a development issue by planners and policy makers in an increasing number of countries across the world. It has therefore, become imperative and even fashionable in both international and national fora, to be discussing the correlation and the causality between poverty and disability. Disability and development are closely linked in a cycle of cause and effect. Multilateral agencies like the UNDP in the project, 'Support to Children with Disabilities' and in the 'ASIAN DEVELOPMENT BANK-REGIONAL TECHNICAL ASSISTANCE(ADB-RETA), being undertaken in India, consider including studies on disability and poverty as an important and integral part of the projects. The government of India has also given significant weightage to the issue. The People With Disabilities (PWD) Act has provided for reservation of 3% of the vacancies in government and government supported institutions. Benefits to the extent of at least 3% of all poverty alleviation programmes are meant for PWDS. The PWD Act also states that the appropriate government and local bodies shall provide incentives for

employers, both in the public and private sectors to ensure that at least 5% of their work force is composed of PWDs. The Swaranjayanti Gram Swarozgar Yojana accords a special focus on the vulnerable groups among the rural poor. Identification of jobs suitable for PWDS, vocational training, modification of tools and equipment, incorporating barrier free features in training, are all aimed at fulfilling the objective of promoting employment opportunities to PWDs and alleviation of poverty.

VICIOUS CIRCLE OF POVERTY AND DISABILITY

There is a strong and definite, vicious cycle of poverty and disability. The propensity for the poor to be disabled and for disabled people to be poor, is very strong. People living in poverty tend to become disabled because of aggravating factors such as malnutrition and squalid housing, hazardous occupations and so on. Measures for disability prevention, including health care measures such as immunisation, maternal and child care, nutrition, screening for early identification of disability, and so on, are largely not accessible for poor and illiterate persons. Environmental sanitation and hygiene which are equally important for disability prevention are also poor in areas occupied by the poor, especially in urban slums and shanty towns. Conversely, people with disabilities tend to become poorer because they lack access to income, jobs, basic medical services and rehabilitation. The constraint on the demand side is that governmental and private sectors are hesitant to employ people with disabilities because of myths about low productivity and efficiency. The low level of demand is further compounded by lack of information and awareness about the employment potential of people with disabilities. On the supply side, are limitations related to lack of facilities for vocational training, education, skills development and the limited number of vocational trades available for PWDs. This is further compounded by lack of confidence, awareness, and information among PWDs about possible areas of employment.

CRITICAL ISSUES

Most studies attempt to resolve all issues related to income generation simultaneously. While a holistic approach is most desirable, the problem must be broken down into its various components – long term, short term, demand side, supply side and so on, otherwise the result would only be a superficial analysis and a wish list, rather than pragmatic solutions to each component of the problem. The author contends that region-specific, disability-specific and issue specific evaluation of the problem is necessary. For example, the factors determining the supply of vocational training for persons with mobility problems in a hilly region, would differ from those in the plains.

There are other factors that need to be analysed at the conceptual, theoretical and practical levels, before one can even begin to address the issues at hand. Firstly, definitions of concepts such as disability, poverty and cost of living, for example, in the context of PWDs need to be more precise. In the example of poverty, can we estimate poverty among PWDs by applying

the poverty line in the same way as the rest of the population, or do we need a different poverty line to more accurately estimate the poverty and cost of living among PWDs?

The author contends that the poverty line is higher for PWDs as compared to the rest of the population. As a result, using the conventional poverty line is likely to give a much lower estimate of the number of PWDs living below the poverty line. While it is beyond the scope of this paper to estimate the exact poverty line for PWDs, an attempt is made to suggest some items that could be considered to derive a realistic poverty line for them, giving only an indicative cost range for the additional minimum facilities to be added in the poverty line.

POVERTY LINE FOR PWDS

It is well known that PWDs require certain facilities to even live independently, and this would be much more, if they are to be given a wage or are self employed. The poverty line for PWDs should include the cost of facilities that enable PWDs to live independently and to undertake activities of daily living, or the imputed wage of person(s) assisting PWDs to carry out those activities. There is accordingly a need to have a number of add-ons to the general poverty line to get the true minimum cost of living for PWDS. The cost of these additional facilities should preferably be provided by the government, free of cost to PWDS. This can be an important and definite step towards providing equal opportunities to PWDS.

It is contended that cost of living for PWDs includes cost of living for the non disabled, plus, cost of assistive devices, cost of converting living areas into non handicapping environments, cost of modification in gadgets, tools, equipment, appliances etc. to make them useable by PWDs, and cost of attendant, even if it is a family member, the imputed cost or opportunity cost of his/her input.

Most of the PWDs require various types of aids and appliances for functional independence, mobility and activities of daily living. The type of assistive devices required by a PWD depends on the type and degree of disability and the living environment of the PWD. The cost of the assistive device is an additional cost without which the PWD may not be able to carry out activities of daily living This is an additional minimum cost for the PWD. The government already implements a scheme of assistance for disabled persons for purchase/ fitting of aids and appliances, with the main objective of assisting the needy disabled persons in procuring durable, sophisticated, and scientifically manufactured modern, standard aids and appliances. Assistive devices costing between Rs. 50 and Rs. 6000 are provided under the scheme free of cost to the eligible PWDs (income is a primary criterion for determining eligibility). Hence, as far as assistive devices are concerned, the necessary step for providing equal opportunities has already been taken by the government. However, its coverage and reach, especially at the grass root level, needs to be strengthened.

In order to permit easy mobility and for activities of daily living, there is a need to modify the houses that PWDs stay in (here we are focusing on PWDs basically as consumers). The modifications needed, again would depend on the type and degree of disability. For example, an orthopaedically handicapped person on a wheel chair requires doors, including that of the toilet, to be minimum 90 cm, with horizontal and vertical grab bars, especially in toilets. A visually impaired person may require embossed markings on different parts of the house, including on the floor, to carry out activities of daily living. It is estimated that it can cost about 5% to 7% of the building costs to incorporate barrier free features. The author opines that even if locally available materials and skills are used for adding these features in a house of a PWD, the additional cost that may be incurred is about Rs. 300 to Rs. 500. Since this is a one-time expenditure, the cost needs to be annualised and included in the minimum cost of living, along with the costs of maintaining these features.

To permit PWDs to live independently and carry out activities like cooking, cleaning, personal hygiene etc., the gadgets used need suitable modifications. For example, a visually impaired person may need a milk boiler (which whistles when milk boils) rather than an ordinary container. A person with cerebral palsy may require a flexible handle in a spoon, a handle for holding a plate for eating, a special chair to sit and so on. Here again, the requirements may differ from person to person, but an element of additional cost needs to be built in. A minimum expenditure of Rs. 100 to Rs. 200 could be provided for this and included in the poverty line.

In many cases, houses may not have been modified, and suitable assistive devices and gadgets may not be available. In such cases, the assistance of family members or professionals may be required for the PWD to carry out activities of daily living. Here, there is the need to cost the payment made to professionals along with the opportunity costs to the family or community. In most instances, the family members care for PWDs, along with their other duties, hence only a part of their wages could be imputed to be included in the cost of living of PWDs. It could be estimated to be about Rs. 500 to Rs 1000 per month.

As stated earlier, these are only rough indicators and are by no means precise and accurate. The endeavour is to highlight the components of additional costs for PWDs rather than provide an accurate estimate of these costs. Much more empirical research is needed to estimate the actual costs, which could possibly be worked out separately for different disabilities, regions, and for urban and rural areas separately. Hence, the additional minimum cost that needs to be incurred by a PWD is either the sum of cost of assistance devices, barrier free features and modifications in gadgets, equipment; or the imputed/actual cost to the family member/community member/professional rendering these services. The costs of some of these services provided by Government (e.g. assistance devices, modification in equipment), need not be added to the poverty line as the individual PWDs do not have to bear the additional cost.

RECOMMENDATIONS

1. A specific, more precise estimate on additional cost of living for PWDs should be worked out. International bodies, Governments at different levels, independent bodies, professionals and NGOs should provide technical and financial support for such research. These studies should also focus on working out separately the poverty line for persons with different disabilities, from different regions and for urban and rural areas.
2. To bring the PWDs on par with the rest of the population, schemes, programmes and projects should be initiated and the existing ones strengthened to provide the different facilities highlighted above, so as to promote equal opportunities to PWDS. The endeavour should be to provide facilities like non-handicapping environment, suitably modified gadgets and tools, requisite assistive devices 'to reduce' the dependence on family and community members for carrying on activities of daily living
3. To break the vicious circle of poverty and disability, access facilities need to be provided throughout the nation at the earliest. An attempt may be made to provide, in phases, a universal design, for both buildings and the transport sector.
4. Pension and financial support to PWDs should be fixed, keeping in view the additional costs that they have to incur, compared to the rest of the population.
5. The wages/remuneration to PWDs may be worked out in terms of a realistic minimum cost of living rather than pegging it on the basis of the poverty line for the rest of the population.

Acknowledgement

The author expresses his gratitude to the officials at the UNDP and those undertaking the ADB-RETA study for the focus on the area, and for discussions on critical issues relating to poverty and disability.

* Director
Planning Commission, Yojana Bhavan,
New Delhi – 110 001.

A STUDY ON THE STATUS, FAMILY AND SOCIO ECONOMIC CONDITIONS OF THE PERSONS WITH DISABILITIES IN VALLIOOR PANCHAYAT UNION

M.A Novemoney*, S. Johnson Raj **

INTRODUCTION

A systematic and scientific approach with planned strategies will yield better results whilst working with the persons with disability. A better understanding about their rehabilitation needs will enable a better implementation of rehabilitation programmes for them. This study was a base-line survey conducted for the rehabilitation project of Rucode, India. The objectives of the study were to understand the nature and extent of disability, to know the socio-economic conditions of persons with disability, to identify children with mental retardation and cerebral palsy and explore the possibility of providing day-care services to them, to understand the attitude of the community towards persons with disabilities and to understand their rehabilitation requirements.

METHODOLOGY

The study was undertaken in 41 villages, in the southern part of Vallioor Panchayat Union in Tirunelveli District of Tamil Nadu, in India. The Vadakkankulam and Sanganapuram Primary Health Centres cover this area. Vallioor Panchayat Union has about 160 villages/ hamlets with a total population of a little over 1,00,000. It is about 40 kilometres from Tirunelveli and about 15 kilometres away from Kanyakumari, which is the southernmost tip of India.

Vallioor union is a drought prone area and the rainfall there is very low. Most of the population in this union is farmers and agricultural labourers. Since they depend mostly on the rains for cultivation, the employment opportunities are seasonal and therefore very limited.

The objectives of the study were a to understand the nature and extent of disability, b) to know the socio-economic conditions of the persons with disability, c) to identify children with mental retardation and cerebral palsy and to explore the possibility of providing day care services for them, to understand the attitude of the community towards persons with disabilities, d) to understand their rehabilitation requirements.

A questionnaire was used for data collection and primary data was collected directly from 1086 respondents, using the questionnaire. All the persons with disabilities who were identified were studied, except a few, who were unwilling to respond. When the persons with disabilities were small children or unable to respond, their parents /guardians responded to the questions. The responses to the questionnaire are analysed and recorded under different heads.

A door-to-door survey was conducted to identify persons with disability. False negatives were primarily due to the fact that the family members denied the presence of a disabled person in their family. In some instances, the guardians of such persons were unwilling to respond to the questions stating that they had no interest in the exercise. Some had given inappropriate responses, which created difficulties in data analysis, and hence had to be excluded. The extent of the false negatives were not checked any further.

RESULTS

1. Personal Data

The study showed that from among the persons with disability, 54% of the persons with disability were males and 46 % of persons with disability were females, indicating that the number of males with disability was slightly more than the females. Further, this was in keeping with the general trend as observed in India.

Polio induced disability was practically absent among children below 5 years of age and nearly 85 per cent of the children identified below 5 years of age were with mental retardation and cerebral palsy.

Thirty per cent of the survey sample was married; 66 per cent were not married; the remaining 10 per cent were either separated or divorced. Among those married, 43 per cent had 1or 2 children, 39 per cent had more than 2 children; 18 per cent had no children.

2. Educational Status

Among the persons with disability, 42 per cent of the persons were illiterate; 22 per cent had studied upto the eight standard; 14 per cent had studied up to the 12th standard; 6 per cent had undergone special training. A sex-wise analysis of the educational status revealed that while the percentage of illiterate persons was almost the same in both sexes, that of those who had studied upto the 12th standard was higher among the females, whilst more numbers of males had gone in for higher studies and special training than the number of females.

Of the respondents, 10 per cent of them were students. Of them 55 per cent were studying in the 1st to the 8th standard, 35 per cent were studying from the 9th to the 12th standard; 7 per cent were undergoing college education; 3 per cent were undergoing special training.

Those who had not undergone any formal studies or discontinued their education were asked to state the reason for doing so. Twenty seven per cent cited economic reasons; 52 per cent stated that their disability was the preventing factor; 7 per cent had discontinued due to lack of transportation facilities and 14 per cent had to discontinue because of the lack of interest on the part of their parents. When asked whether they would continue if they received assistance, 39 per cent of these persons were willing to restart their education. The students were asked how their co-students and teachers treated them. Whilst 91 per cent of the students stated that their teachers treated them without any discrimination, only 77 per cent stated that their co-students treated them without discrimination. The remaining 23

per cent said that they were discriminated against on account of their disability. This shows that the teachers were able to treat the students with disability on par with the normal students, more than what their own peers were able to do.

3. Occupation

As far as occupation was concerned, 46 per cent of disabled persons were unemployed; 22 per cent were daily wage coolies; 4 per cent were self-employed; 6 per cent had Government or salaried jobs. This implies that though various welfare schemes are designed to provide self-employment for the persons with disabilities, these schemes have not yet reached the persons with disabilities in rural areas.

4. Cause of disability and treatment

As regards the cause of disability, 45 per cent of disabled persons cited diseases as the reason, 35 per cent were born with a disability at birth; the remaining 20 per cent were either disabled due to an accident or due to old age. Besides the 35 per cent who were disabled at birth itself, another 35 per cent of them had developed a disability before the age of 10 years. Of these, 73.5 per cent had undergone treatment. A sex-wise analysis showed that the percentage of males who sought treatment was slightly higher than that of the female.

5. Nature of disability

The different categories of disabled persons identified are given in Table no. 1.

Table 1. Nature of disability

SL No.	Nature	Total
1.	Visually Impaired	102
2.	Hearing Impaired	134
3.	Orthopaedically handicapped	611
4.	Leprosy deformity	25
5.	Mental Illness	33
6.	Mental retardation	166
7.	Others	15
	Total	**1086**

6. Use of aids and appliances

With regard to aids and appliances, 89.5 per cent did not use any aids. 2.5 per cent used crutches and 2 per cent each were using tricycles, callipers and hearing aids. Other types of aids were used by only less than 2 per cent. Among those who were not using any aids, only 3 percent said that they needed a hearing aid. 2.5 per cent expressed the need for tricycles,

2 per cent each expressed the need for wheel chairs and callipers. 1.5 per cent each needed spectacles and crutches. This shows that even those disabled persons who needed aids did not receive them.

The numbers of persons with disability involved in common endeavours and social activities are also a reflection of the degree of community support. 44 per cent of persons with disabilities were sometimes involved in communities; 34 per cent were never involved and 12 per cent were always involved in community activities. Among those persons with disability who never involved themselves in social activities, the majority (52.3%) stated their disability as the reason; 19.8% attributed it to their age; 18.9 per cent pleaded an inferiority complex; and 9 per cent said that they were not interested. This shows that quite a large number of persons with disabilities felt that the community did not accept them and hence, they isolated themselves from social activities.

9. Government programmes

About their knowledge on Government programmes designed for the welfare of persons with disabilities, 87.5 per cent said they were not at all aware of such programmes and only 12.5 per cent said that they were aware of at least one programme. As regards their participation in such programmes, only 6.5 per cent participated in Government programmes.

Among those who had never participated in Government programmes, 75 per cent said that they were not aware of such programmes and 4 per cent said that they had no faith or hope in such programmes due to their delays, 13 per cent said that there was no one to guide them and 8 per cent of the persons with disability did not respond.

DISCUSSION

Promotion of awareness on disabilities

The study showed that there is a greater degree of disability among illiterate families, probably due to a lack of awareness on disability. Further, there exists a negative attitude among the public and the students towards persons with disability and disability issues. One of the basic reasons was that their knowledge about disability was neither fully scientific nor complete. The promotion of scientific knowledge is possible through "Intensification of Information Education and Communication (IEC) Campaigns". This requires the development of various IEC materials, for specific target groups and carrying out awareness campaigns for all segments of the population. IEC campaigns could adopt various methods such as:

a. Use of traditional media

It is a fact that traditional media is more familiar to the common person. Various political, religious, reformative and revolutionary movements have effectively utilised this medium. Thus the use traditional media can be harnessed for awareness creation on disability. Some form of folk arts peculiar to, or popular in the community, such as "villu pattu", "cummi", could be used effectively.

b. Exhibitions

Exhibitions are another form of awareness creation, leaving a lot of room for innovation. Being a visual medium and highly effective, the lively combination of audio-visuals will prove befitting in the promotion of awareness on disability. Exhibitions could be timed during local festivals and occasions when the village people gather in large numbers.

c. Advertisements

A part of the IEC campaigns can also be roadside advertisements, either on walls or display hoardings. Advertisements could also be displayed in common area public places where large numbers of people do gather. For e.g. bus stands, markets and important junctions.

d. Rural documentation and information centre

The respondents have a low level of knowledge with regard to disability, thus necessitating the need to provide them with the latest information on the subject. A Documentation and Information Centre can be initiated to update the rural masses on the subject of disability, as well as keep track of the latest developments in this field.

e. News clipping services

As part of the documentation and information process, could be the news clipping services. Relevant and necessary information on disability could be circulated to various target groups and mantrams, libraries, educational institutions, factories and labour associations. This would help to reach out a varied and numerous target audience. These news clippings can also be used as a follow-up for the people who have been trained, to essentially reinforce and update their knowledge.

f. Development of trained manpower

In spite of the availability of numerous social workers, health workers, voluntary organisations and government establishments, the services available in the disability area are minimal. Given the existing circumstances and nature of disability, it may be a desirable proposition to provide training on the care of persons with disability, to all people. In order to facilitate such a process, a team of volunteers could be selected and correctly trained, and they in turn, can train their own people as well as people from the nearby village, on disability care and rehabilitation. A network comprising of health volunteers could be established by providing them refresher training and supplying them updated IEC materials on a regular basis. This will help to circulate scientific and the latest in knowledge to the village people.

g. Prevention of disabilities

The survey clearly indicates that the incidence of disability is more among economically poor and illiterate families. A major reason for this is ignorance. The study further shows that for 68 per cent of them, diseases caused disability and 45 per cent of them suffered a disability before the age of 10. This fact emphasises the need to initiate preventive measures.

h. Rehabilitation of persons with disability

Various studies and experiences have highlighted the importance of community based rehabilitation, and the factors that need to be taken into account in this regard. The process of rehabilitation must take cognisance of the important aspect of family tradition and the cultural ethos of the community. One of the means of the rehabilitation effort is to enable the participation of persons with disabilities in the government programmes designed for them. From the study it is seen that 88.8 per cent of the persons with disabilities are not even aware of such programmes. Hence, maximum efforts should be taken to promote awareness among the persons with disability about the existing government programmes and schemes.

Another point worth noting, is that even among those persons with disabilities, who were aware of government programmes, only about half the number of these persons, have participated in the programmes. The major reason cited was the lack of hope in such programmes. The implementing agency must play the role of a facilitator by creating a linkage between the client and the resource agency. In the process, the implementing agency should identify the obstacles that come in the way of their participation and train these persons with disabilities, to overcome them.

An important aspect of rehabilitation that requires attention is the education of children. The study shows that 46.5 percent of these children discontinued their education due to economic reasons and 31 percent, due to the nature of disability. A noteworthy point is that 32 per cent of them are willing to resume their education, if assistance is provided. This willingness should be capitalised upon and all possible efforts should be made, to enable them to continue their education.

Yet another area in need of intervention, is in the use of aids and appliances by persons with disabilities. As per the study, 89.5 per cent of the persons with disabilities did not use any aids or appliances and they expressed different needs. These expressed needs, need not necessarily be their real needs. In order to ensure that the really deserving persons with disability get the right aids and appliances, and use them correctly as well, the following strategy could be adopted:

1. Assessment
2. Rehabilitation and counselling
3. Provision of aids and appliances
4. Follow-up:
    a. review
    b. repair or replacement

If all these steps are systematically followed, it could ensure the right use of aids and appliances by the deserving ones, as part of the rehabilitation process.

i. Community involvement in rehabilitation

An essential aspect of community based rehabilitation is the involvement of the local community in the process of rehabilitation of persons with disabilities. The study highlights certain aspects that are in need of community support and involvement. The students with disability expressed the opinion that whilst their teachers treated them on par with the other students, some of their own class mates did not treat them as their own equals. This aspect must be taken into consideration, and the attitude of the students towards their classmates with disability, should be changed for a positive one. Training the teachers and thereon influencing the attitude of the students, can bring about this attitudinal change.

CONCLUSION

The findings of the baseline study are only one of the many sources of guidelines available for community based rehabilitation of persons with disabilities. The experiences of other organisations could be shared and adapted to suit the needs of the project area. Hence, all possible efforts must be made, so that the persons with disabilities can become productive citizens of society by their participation in programmes designed for their development.

*Director
RUCODE India, 18/15 Municipal Staff Colony Road
Housing Board, Nagercoil, 629 004, Kanyakumari Dist., Tamil Nadu, India

* * Faculty Member
College of Social Work, Nirmala Niketan
38, New Marine Lines, Mumbai, India

WORTH TRUST

WORTH stands for workshop for the Rehabilitation and Training of the Handicapped. It has a network of Training Centers and Production Centers - a two-level programme that turns raw talent into usable skills and utilises those skills to manufacture or assemble products of high quality.

WORTH TRUST has Production units for its various products, Training units, an outreach programme, and a Transitional school.

The workshop for the rehabilitation and Training of the Handicapped, assists the person with visual handicaps to communicate through the use of the braillers it manufactures. It also provides other assistive devices.

Its workshop for the Rehabilitation and Training of the Handicapped, manufactures several kinds of mobility aids for the persons with disabilities thus helping them to lead a normal and productive life. The workshop also transforms the contemporary material of various plastics into an array of elegant and functional components and products.

For more details, please contact

48, New Thiruvalam Road, Katpadi 632 007, Tamilnadu, India
Tel: +91 (0) 416 - 242739, Fax +91 (0) 416 243939, E-mail: worth@md3.vsnl.net.in

MOBILISATION OF RESOURCES FOR CBR PROGRAMMES – THE EXAMPLE OF BANGLADESH PROTIBONDHI FOUNDATION

Sultana S. Zaman *

INTRODUCTION

Before presenting the success story of the Community Based Rehabilitation (CBR) programme of Bangladesh Protibondhi Foundation (BPF), the author will discuss the concept of CBR, its evolution to date and related issues. This paper highlights how the resources of Man, Material and Money were mobilised for the CBR programme of BPF.

The concept of a Community Based Rehabilitation (CBR) programme probably arose with the alma mater declaration of 1978, by the various heads of the ministries of health all over the world. It was apparent that it would be impossible to provide rehabilitation services, unless there was a base built at the community level. Subsequent to the declaration, the CBR programme of the World Health Organisation was officially launched in 1981, the International Year of the Disabled.

The concept of CBR essentially crystalised many trends and built upon all the resources used at the community level. UNICEF began to actively support CBR programmes in the poorest countries during the early eighties, which concentrated on disabled children and in areas where most services were linked with general child health and organised social services.

Essentially, the problems of disabled children are the same, whether they live in towns or in rural areas. Since the vast majority of poor as well as disabled children live in rural areas and in poor urban communities, the only realistic approach is community rehabilitation. David Werner, argues that responses to the problems of children with disabilities should be a high priority in social welfare policy. Werner further states that "Without rehabilitation of the child and the community, the disabled child is likely to become an unhappy, unemployed and possibly completely dependent adult; with rehabilitation, often that same child will become a more fulfilled, more independent adult, who actively contributes to society".

DEFINITION OF CBR

Helander, a co-author of the World Health Organisation's landmark manual "Training in the community for people with disabilities" defined Community Based Rehabilitation (CBR) as a strategy for improving service delivery, for providing more equitable opportunities and for promoting and protecting the human rights of disabled people. It calls for the full and co-ordinated involvement of all levels of society: community, intermediate and national. It seeks the integration of all relevant sectors – education, health, legislative, social and vocational and aims at the full representation and empowerment of disabled people. Its goal is to bring about a change; to develop a system capable of reaching all disabled people in need, and to educate and involve governments and the public, using in each country a level of resources that is realistic and maintainable.

TRANSFER OF KNOWLEDGE FROM PROFESSIONALS TO CBR PERSONNEL

The success of CBR programmes depends on a number of factors, which need to be analysed in the process of planning. Whether one starts CBR through education, primary health care, integrated community development or through any other organisation, professionals have to play an important role. The need to understand the conceptual philosophy of CBR must be emphasised. Professionals need to change their own attitude first, then that of the people in the community towards disabled people. Conventionally, the so-called professionals tend to give more importance to the medico-model of rehabilitation, which is only one aspect of rehabilitation. Once the disabled person returns to the community, no follow-up is available, which is when the person needs most support.

A CBR programme is not effective without professional involvement. But the professionals must show acceptance and appreciation of disabled people and their abilities, through experience sharing in the social and cultural activities in the community. Professionals must learn to respect their beliefs and practices without undermining their knowledge and skills, which could be of great help in the process of rehabilitation.

From the inception of CBR in 1981, to date, there has been a major shift in the philosophical value system of the programme. Some of these are discussed in this paper.

CHANGES IN THE UNDERSTANDING OF COMMUNITY BASED REHABILITATION

The initial version of the International Classification reflected the way in which Community Based Rehabilitation developed in the eighties. The ICIDH relies on a model where there is a progression from disease, impairment, and disability to handicap, in a linear fashion. Impairment is defined as abnormality of structure or function of the body or of an organ. Disability is defined as a restriction or lack of ability as a result of impairment. Handicap is defined as a social disadvantage resulting from either impairment or disability. This classification led to an 'impairment' bias in many of the earlier community based rehabilitation programmes.

In the nineties, with the increasing conceptual shift in emphasis to accept the disabled person in the community, and to promote better human rights, the definition of community based rehabilitation changed, as reflected in the 1994 Joint Position Paper of ILO, UNESCO and WHO. The changes are also reflected in the revised version of ICIDC brought out in 1999 called "International Classification of Impairments, Activities and Participation". In this version, the term 'disability', which has a negative connotation, is replaced by 'activity'. 'Handicap' is replaced by 'participation' to indicate the person's nature and extent of involvement in life situations in relation to impairment, activity and 'contextual factors' that are extrinsic factors determining participation. This classification is not linear anymore and explains the degree of interaction of the health condition and the contextual factors simultaneously on participation.

CHANGE IN FOCUS FROM RESTORING FUNCTIONS IN THE DISABLED INDIVIDUAL TO CHANGING THE CONTEXTUAL FACTORS

In the nineties, community based rehabilitation shifted its focus from medical rehabilitation and restoration of functioning in the individual, to manipulation of contextual factors related to social integration of the disabled person in the community. Similarly, instead of services for restorative therapy in the community, the focus of interventions has shifted to human rights of disabled people, promotion of self-help groups of disabled people and their families, and a change in attitude in the non-disabled population in the community.

CHANGES IN THE SIZE OF OPERATIONS OF COMMUNITY BASED REHABILITATION

Though their resources are limited, most developing countries have a need for larger coverage of services. In such situations, the resources are often spread thinly, so the quality of services are poor. While the votaries of universal coverage maintain that some services, even of poor quality, are better than nothing, others argue that poor quality of services would destroy the expectations from rehabilitation, and hence may become counter-productive. The challenge for planners in most developing countries is to see how best to achieve an 'optimum' quality of services, given the limitations of the need for large coverage and limited resources.

SOME CRITICAL ASPECTS IN PLANNING OF COMMUNITY BASED REHABILITATION

Planning for community participation

Community participation was considered an essential part of community based rehabilitation ever since it was promoted as a suitable approach for rehabilitation in developing countries. In practice, however, most programmes have found it difficult to achieve adequate levels of community participation for several reasons. Concepts of decentralisation and bottom-up approaches are relatively new in many of these countries, even today.

In developing countries, it is often necessary to enhance community participation in a planned manner, from the inception of the project, keeping in mind the difficulties that can be encountered, as the concept of full community responsibility is introduced. In the context of community based rehabilitation programmes, ways have to be found to motivate the marginalised groups of disabled persons, their families, and communities to achieve a participatory mode of development, in which the community will assume some of the responsibilities to begin with, and move on at a later stage to take on most of the responsibilities of the rehabilitation programme.

Planning for sustainability

"Sustainability" is a long term concept, that addresses peoples' central concerns and values, looks to the future, strengthens a community's ability to deal with change, develops processes

for finding common ground, strives to benefit all members of the community, emphasises the involvement of people, improves accountability, develops a vision for the future, keeps track of the progress and meets the basic resource needs. Sustainability may be defined as the ability of the system to perpetuate itself, using locally appropriate strategies, so that the system continues till its goals are achieved.

In planning for sustainability, it is important for planners to first identify the different factors that influence sustainability of a programme in its given social and cultural milieu, and then to develop strategies to improve sustainability in relation to the different factors identified through this exercise.

MODELS OF PARENT-PROFESSIONAL RELATIONSHIP

As the status of the parents of disabled children have been elevated from being passive recipients to active consumers during the last two decades, the issues of parent-professional relationship in a CBR. programme is becoming highly complex. The involvement of parents as partners in the enterprise provides a continuous system, which not only reinforces the programme but also sustains effects of the programme after it ends.

A review of the literature on community based rehabilitation and parental involvement in disability services reveals a number of models which can be used to guide policy and practice. The models should be considered as tools for thinking, rather than roadmaps for practice. Cunningham and Davis delineated three models to show relationships between parents and professionals, which they have described as the expert model, the transplant model, and the consumer model. Appleton and Minchom described a fourth model, the social network/ systems model that is evident in American literature. Appleton and Minchom also described a fifth model, the empowerment model that was also quoted as partnership model. This fifth model combines the rights of a parent as a consumer, to choose a service at a level which suits them personally with a professional recognition that the family is a system and social network. Dale proposes a sixth model, called negotiating model, which focuses on negotiation as a key transaction for parent-professional partnership (Table 1).

TABLE 1 : MODELS OF PARENT-PROFESSIONAL RELATIONSHIP

	1	2	3	4	5	6
	Expert model	**Transplant model**	**Consumer model**	**Social system model**	**Empowerment/ Partnership model**	**Negotiating model**
Role of parents	To comply with treatment	Learning and carrying out	There is a choice for services	Standard home environment for child development	Differs according to self-defined needs	Differs according to self-defined needs
Role of professional	Expert	Instructor	Consultant	Facilitator	Differs according to needs of family	Differs according to needs of family

Control of decision-making	Professional	Professional retains ultimate control	Parents	Joint control	Joint control	Differs according to situation and needs
Main assumption	Professional knows what is best	Professional knows how to design the intervention	Parents can represent their needs	Professionals can facilitate the good effects of social system	Agreement between the two can be reached	Negotiation can lead to consensus or dissent
Advantages	Reduce responsibility and stress of parents	Parents are considered as resources and therefore increases coverage	Parents' first, recognises difference in needs, interventions flexible	Social integration of the child is promoted, recognises interactive effect of environment on child's, values care-giving roles of family members	Active promotion of parents' control and power	Defines process of negotiation by which consensus is achieved or dissent overcame
Dis-advantage	De-skills parents, complete dependency on professionals	Child skills are generalised, ignores family differences, parents are still dependent on professionals	No attention to child's autonomy	Does address problems arising from disagreement	Does address problems arising from disagreement	May require social and political changes e.g. legal right, unsuitable for many develop ing countries' situation

Most of the developing countries possibly follow the traditional 'expert model', which is a rather top-down approach. Both, the parents of a disabled child and the professionals, tend to be comfortable with this approach as most of the parents are illiterate and poor, and giving the responsibility to the professionals may decrease the level of stress, they have been experiencing. In the developing countries the common belief that frequently prevails is, 'the doctor knows the best'.

However, the fifth model, which combines the rights of a parent as a consumer and empowers the parents as partners of the professionals, could be a good model to follow for a successful CBR programme, either in a developed or developing country.

COMMUNITY BASED REHABILITATION PROGRAMME OF BANGLADESH PROTIBONDHI FOUNDATION

In Bangladesh, there are many challenges to be overcome by professionals who provide services for young disabled children. There is a high density of population, with 1,000 people per square mile, with half the population of 120 million people under 18 years of age. It is estimated that 86% of the population live below the absolute poverty line, with infant mortality at 85 per 1000 and 50% low birth weight.

Bangladesh is a country of many rivers with a poor infrastructure of roads, bridges and railways, making communication difficult. 81% of the population lives in the rural areas. A large detailed epidemiological study conducted during 1987-88 in the late 1980's, indicated that 1.6% of the child population has severe disability, which translates into 1 million disabled children under the age of 10 years. Yet, there are few services. There are very few special schools in cities and almost nothing for children under the age of five. Therefore, there is a need for innovative thinking to develop appropriate services particularly in rural areas.

Although in a CBR programme disabled persons of all ages are served and catered for, the emphasis of the CBR programmes of BPF has been on children, as they are the most vulnerable group in terms of disability, malnutrition and mortality.

Before starting the CBR programme, BPF embarked upon two significant research projects nationwide, which finally was of great assistance and support in (i) screening the disabled children at the community level and (ii) provision of services for disabled children at their door step. These two research projects, each lasting for a period of 2 to 3 years, are detailed in the following.

(1) Rapid Epidemiological Assessment of Childhood Disabilities in Bangladesh

The Department of Psychology, University of Dhaka, with the support of Bangladesh Protibondhi Foundation and Gertrude Sergievsky Center, Columbia University, New York, provided collaborative assistance, during 1987-88. A study was conducted to develop a rapid and low cost method for assessment of the prevalence and risk of disability in children, between 2 to 9 years of age and identify possible causes. The study was aimed at developing a simple screening instrument for childhood disability.

The study was carried out in five sites of Bangladesh, to validate TEN-QUESTIONS (TQ) as a tool for screening childhood disabilities, in communities where resources for disabled children was scarce, if available at all. The type of disability covered by the TQP was blindness, deafness, mental retardation, motor disability and epilepsy.

A two-stage design was followed to test the validity of the TQ for screening disabilities. Stage I consisted of the household survey conducted by community workers and screening of all children in the sample, by the TQ. Stage II consisted of comprehensive professional (medical and psychological) evaluations of all children who were screened as having some

problem i.e TQ positive, plus a random sample of those who were screened as having no problem i.e TQ negative.

A total of 10,306 children, 2 to 9 years of age from five sites of Bangladesh, were screened in the 1st stage by the community workers using the TQ. The results indicated that by using a simple screening questionnaire such as TQ, the workload of the doctors and specialists could be significantly reduced.

However, as seen from the preliminary results, it was encouraging to note that TQ also picks up conditions which could be attended to immediately with intervention (such as night blindness, ear infection, mild seizure etc), before it can become a disability. The study indicated a prevalence rate of 6.8% in Bangladesh, for all levels and types of disabilities (motor, vision, hearing, cognition, epilepsy) and 1.6% for serious disabilities in children aged between 2-9 years. WHO and UNICEF have accepted TEN QUESTIONS as a screening instrument for disability at the community level. TQ today, is being used for screening disability among children in CBR programmes all over the world.

(2) Effectiveness of Distance Training Packages for training the outreach families of Disabled Children in Bangladesh

The Distance Training Package (DTP) Programme is a home-centre based training programme of Bangladesh Protibondhi Foundation, for the parents/caregivers of disabled children residing in areas where there are no services available for disabled children. Training is offered in the centre to the parents/caregivers in the overall management of their disabled child, through pictorial training guides. The DTP is a pictorial training manual/guide, which comprises of different activities sequenced in order of developmental milestones explained through simple written instructions and pictures, which are compiled in booklets called "packages". These packages have been developed in the areas of motor development, speech and language development, cognitive development, social and daily living skills (for cognitive development Portage Guide to Early Education has been converted to Portage Pictorial Packages).

The study compared the effectiveness of this low-cost intervention through Distance Training Packages (DTP) for young disabled children in Bangladesh, with a high cost centre based intervention programme. A total no. of 85 children with disability, aged between 1.5 and 5 years, with disability, living in urban and rural areas were selected for the study.

The result indicated that such low-cost advisory services like DTP in a country like Bangladesh, shows promise in helping mothers to improve the skills of their young children with disability.

INITIATING CBR PROGRAMME OF BPF

Bangladesh Protibondhi Foundation (BPF) has been providing services to disabled children and adults through home and centre based programmes for more than a decade. The services had been extended to a large number of families of disabled persons, almost all over the

country, even to the remotest villages through the Distance Training Package Programme. The services, which had been experimentally proved through detailed research, were undoubtedly of a high quality. But the question was, what percent of the disabled population who were living in the rural areas (81% of the total population live in the rural areas), were receiving the services? Of those who were getting the services, was there any participation of the families and community in terms of finance, or any form of support for the services? How long would BPF be able to provide one-way services to disabled persons, with its limited resources and personnel? Considering these facts, BPF started its services for disabled persons in the community, through the Community Based Rehabilitation (CBR) programme in August 1996, in 20 villages of Dhamrai and Savar (45 km north-west of Dhaka city) initially, and later in 30 more villages in Kishoregonj, 150 km north of Dhaka city, Narshingdi, 45 km north from Dhaka city and Faridpur, 100 km south west of Dhaka city in 1997 and 1998.

The vision of BPF's CBR programme was to help disabled persons became self-reliant and improve their quality of life. The services of CBR were to undertake programmes and activities to make disabled people independent and self-reliant.

The major objectives of the CBR programme were:

- To identify all persons with disability in the community.
- To provide required rehabilitation services to disabled people.
- To create awareness about all issues related to disability.
- To transfer rehabilitation related skills to the community members.
- To mobilise available resource and raise funds to carry out the programme.
- To raise the level of community participation to an optimum level.
- To make the CBR programme sustainable until the needs of the disabled people are adequately met.
- To prioritise services for disabled children.

The CBR programme of BPF was targeted mainly towards service delivery for children and a provision for a small coverage for prevention of disability among high-risk children.

INITIAL SELECTION OF THE AREAS, NEEDS ASSESSMENT OF DISABLED PEOPLE AND ACTUAL SURVEY RESULT

A number of villages from each selected area, were earmarked to start a CBR programme. Next, in each area, four or more community workers with a high school education and a supervisor (who acted as a link between the CBR programme and BPF), were recruited from among the local people. Community workers and the supervisor were then trained by the professionals from BPF, in CBR as well as TQ survey, either at the central office of BPF or in the village itself.

(a) Needs assessment of persons with disability

To fulfil the mission of CBR, a survey was conducted by BPF in the programme areas to "Assess the Needs of the persons with Disability and their Families", with a focus on the

need for the different types of intervention as well as the resources available, in terms of personnel, materials, finance and technology at the Government and Non-Government level.

(b) Screening of disabled children by the community workers

To obtain the base line data on disability and also collect information on the number, age, gender and types of disability, the TQ was administered door-to-door in each household, in all the selected villages, along with other questionnaires on household and community, such as health and nutritional status of children, types of disability, causes of handicap; who cares for the disabled, what is the daily activity and work load of the care giver, what is the coping strategy of the family etc.

(c) Diagnosis by the professional team

After the administration of the TQ for screening disability in all the villages, the professional team comprising of a pediatrician, a psychologist and a special educator visited the site and medically examined and administered psychological tests on children who had been screened by the community workers with TQ (Table II).

BPF has been involved in CBR programmes in 5 rural areas of Bangladesh, in a total of 50 villages. The areas are:

(1) Dhamrai
(2) Savar
(3) Kishoregonj
(4) Narshingdi
(5) Faridpur

TABLE - II Result of screening of disability in 5 areas by TQ

Area	Total population	2-9 year old children in each area	Children with severe disability in each area	Percentage of prevalence of childhood disability 2-9 year old
Dhamrai	9227	1753	34	1.94
Savar	7492	981	23	2.34
Kirhoregonj	7855	2197	72	3.28
Narshingdi	13032	2107	65	3.08
Total	37606	7038	194	2.76

After the needs assessment and actual survey, service delivery by the professionals and community workers was begun and is still being continued.

SERVICE DELIVERY BY THE PROFESSIONALS AND COMMUNITY WORKER, STARTING CLINIC AND SCHOOL FOR ALL CHILDREN

(i) Clinic for All Children

A team of community workers trained in physiotherapy, speech therapy, and special education and also in the use of Distance Training Packages (DTP), first, along with professionals, visited the homes of disabled persons who were diagnosed as severely handicapped, in the villages. The family members were first trained by the professionals and then the community workers continued the training regularly. The professionals however, supervised the programme by periodic visits. During professional assessment by the medical team, the sick children from and around the area, also started coming to the centre where they were medically examined and treatment and advice was given. Later, the centre became a "clinic for all children in the village".

(ii) Inclusive schools in all the CBR programmes

As BPF's work with the disabled children became more and more known in and around the area, people demanded more services for their children, both normal and those with disability. This was a demand for 'education' of their children. Spontaneously, regular "school for all children" have been opened in all CBR programme areas where disabled children are willingly enrolled with normal children.

(iii) Kalyani Primary School for all children at Kishoregonj

Kalyani Primary School for all children was started at Kishoregonj by the parents of local children and BPF willingly extended a helping hand. Construction of the school building (bamboo structure) was a joint venture by parents and BPF. Books, blackboard, exercise books, papers, educational toys etc. were contributed by the "parents club", BPF and encouraged by the Government as well. On 8th February, 2000, there was an inauguration ceremony of the school in the presence of the BPF Board members, the thana executive officer who is a representative of the government and local leaders who were invited guests. At the inauguration ceremony, the General Secretary of BPF in her speech, emphasised the necessity of "Education for All", and the urgency of starting a school for all children in the area. The large gathering of local people appreciated the concept and willingly came forward to help promote the programme of Inclusive Education, by immediately announcing personal donations and other forms of help. Within one hour Tk. 15,000 was raised from among the public who came to the inaugural ceremony.

Evaluation and monitoring of the CBR programme in Kishoregonj

From the beginning, BPF's CBR team of professionals have been involved in the diagnosis/ identification of disability among children, service delivery, medical treatment of the severely handicapped children and overall improvement of disabled as well as the normal children, within the community. Later, "Parents Clubs" were formed and the activities of CBR continued. The BPF professionals and the co-ordinator carried out monitoring of all the

CBR activities. Gradually, however, the professional skills were transferred to the community workers and the mothers.

Regular meetings, dialogue between parents of the disabled, community workers and the CBR supervisor were held to discuss different issues and problems. The outcome of the meeting was reported to the CBR co-ordinator who always tried to solve the problems after discussion with the CBR supervisor. The supervisor was also responsible for monitoring the activities planned and the success of the CBR programme. This was periodically reported to the co-ordinator and assistant co-ordinator who visited the programme area either once a month or fortnightly. Every six months, the CBR programme was evaluated on the basis of the following factors:

- Whether the training and activities planned, were appropriate or effective in meeting specific objectives.
- Impact of the training on attitudinal changes.
- Effectiveness relating to improvement in the quality of life of disabled persons and enhancement of their participation in community activities.
- Attitudinal changes towards inclusive schooling and overall improvement.

(i) Overall improvement made by the disabled children

Evaluation was carried out by observing the improvement made by the disabled children and overall attitude change of the community members. The overall improvement made by the disabled children in their daily living skills was evaluated by administering the Denver Developmental Screening Test (DDST). Tests after 1 year were compared with the results of the initial test conducted during diagnoses. One of the evaluation results obtained from some children from the villages of Kishorgonj is given in Table III.

Table – III Comparing Test scores of DDST given during diagnosis and test scores after one year

SL	Name	Village	Age	Scores obtained in pre test	Age	Scores obtained in post test
1	Mobarak	Koromuli	2	32	3	45.00
2	Faruque	,,	8	15	9	32.00
3	Tumpa	,,	4	35.68	5	53.33
4	Imran	,,	3	34.38	4	45.35
5	Roksana	Bwueail	3.64	13.37	4.64	42.00
6	Rima	,,	2	53.00	3	57.77

SL	Name	Village	Age	Scores obtained in pre test	Age	Scores obtained in post test
7	Aklima	,,	7	28.27	8	35.50
8	Ramin	,,	2	54.77	3	75.00
9	Sultana	,,	5	31.00	6	31.72
10	Wasim	,,	6	8.10	7	23.75
11	Sabina	Bogadia	6	27.77	7	66.46
12	Afraja	,,	7	21.87	8	23.75
13	Wasim	,,	6	8.10	7	14.87
14	Aklima	,,	1.69	47.92	2.69	51.00
15	Ramim	,,	2	37	3	46.00
16	Samsul Alam	,,	7	8.03	8	14.38
17	Saiqul Islam	Salpomari	9	30.00	10	58.01
18	Hawah	,,	4	20	5	25.00
19	Arifein	,,	7	31	8	52.77
20	Tania	Dhamrai	4	34.38	5	45.35
21	Jamal	,,	3	48.26	4	77.50

Table – III indicated that all the 21 children who were pre-tested during diagnoses and post-tested after one year by DDST, have improved considerably. The Developmental Quotient (DQ) represented by scores obtained by the children in post-test are higher than in the pre-test. The survey conducted to ascertain the attitude of the community through a questionnaire, given to the parents of disabled children as well as normal children, other members of the parents club, union council members and community workers, was very favorable.

(ii) Stimulation and Improvement

The Community is already receiving services from the BPF CBR programme i.e. medical treatment and medication, physiotherapy, speech therapy and training in cognitive development through Portage Pictorial packages for their severely disabled children. As a result, considerable improvement has been found among these children, in their daily living activities. After getting enough stimulation and training by the therapists, some children

have learnt to sit, walk and to speak. Some children have also been operated for clubfoot. Others improved so much, that they have started going to school. With medication and stimulation, a number of "at risk" children have almost became normal. Epileptic children have stopped getting convulsions, or at least it has reduced considerably. The eye sight of children who were night blind, has became normal as a result of taking high potency Vitamin A tablets. Health and Family Planning awareness programmes have helped many mothers in taking precautions in this regard.

(iii) 'Situation of Kalyani Primary School for All (after six months)

Presently, there are 10 disabled children and 65 normal children i.e. a total of 75 children who are attending school. Nursery and grade I have been started in the school. All the children have been provided with picture books as well as books for numbers and vocabulary. In the courtyard of the school premises, children play local games. Two teachers with high school education after undergoing a brief training in "Inclusive Education" from BPF, have been employed as teachers in the Kalyani Primary School, Kishoregonj.

Improvement noticed among the disabled children enrolled in Kalyani School for All within 6 months

(1) Tumpa, an 11 year old withdrawn girl with very little speech gradually became social, and now counts numbers upto 100, and tries to write numbers and words.

(2) Imran, a 4 year old autistic child had the habit of spitting all the time and could not speak. His spitting behavior improved and he can now name common items, if they are pointed out.

(3) Murad, an 11 year old hyperactive boy, did not communicate with others but screamed if approached, has calmed down and now tries to talk to others by saying "How are you"?, greets the teachers, and participates in singing in the class.

(4) Afzal, a 13 year old physically disabled boy sat at home because of his disability and never went to school. Considerable changes were noticed in the child, after he started going to school with his support stick and is now able to sing, recite from the holy book and participate in other class activities.

(5) Azharul, a 7 year old hyperactive child with very little speech has improved considerably after attending school. He now loves to play, sing and read books with normal children.

(6) Arefin, a 9 year old child with no speech, can now communicate with others through sign language and is also able to copy numbers and words.

(7) Selina, a 7 year old withdrawn girl was unable to mix with others, is now gradually coming out of her shell and is trying to read and write a little bit.

(8) Saiful, a 13 year old physically handicapped child only sat at home and talked very little. Now, he comes to school with his bamboo stick also tries to speak to other children in the class.

(9) Shirin, a 7 year old girl who had no strength in her right hand. With physiotherapy she has improved and has learnt numbers and vocabulary after attending school.

(10) Latifa, a 13 yard old girl who never attended school because of epileptic fits is now learning considerably better after attending the Kalyani Primary School.

MOBILISATION OF RESOURCES : TO MOBILISE THE LOCAL RESOURCES IN TERMS OF MAN, MATERIAL AND MONEY

I. MOBILISATION OF THE RESOURCE "MAN"

(i) Formation of "Welfare Association for the Disabled" or "Parents Clubs"

In each CBR area after the first service delivery, "Parents Clubs" or "Association for the Welfare of the Disabled" were formed. Besides parents of the disabled children, parents of normal children from neighbouring households, teachers of local schools, women members of the union council and any other person interested in the disability issue or overall welfare of the children in the village, became a member of the club/association. Several Clubs have been formed, depending on the distances between the villages. A chairperson has been elected by the members in each club. The local supervisor was also co-opted as a member and always attends the meetings. Each club holds regular meetings at least once in a week or sometimes twice a week. Members attending the meeting sometimes exceed beyond 40 to 45 people.

In the Parents Club, the following issues and topics are usually discussed :

(i) How was Kalyani Primary School for All running?

(ii) Were all the children receiving therapy/services in time and according to their needs by the professional team and the community workers, or not.

(iii) Do any children require special medical treatment or not.

(iv) How can they help towards the overall improvement of their children.

(v) Health awareness by all.

(vi) Cleanliness of the environment.

(vii) Knowledge regarding better nutrition.

(viii) Disability Awareness.

(ix) How to help meet the needs of normal children as well.

(x) Advocacy of "Inclusive Schooling" among public and government sectors.

To increase community participation, "Parents Clubs" have been formed in a number of villages, and membership has been extended to all interested local people. They have been coming forward willingly, to become members after realising the benefits of the CBR programme.

By becoming members of this club, the villagers as a whole group, are getting a number of benefits such as :

(i) Awareness regarding "Education for All".

(ii) Awareness regarding disability.

(iii) Awareness regarding health, family planing and cleanliness of the environment.

(iv) Knowledge regarding nutrition.

(v) The greatest benefit is that the villagers are becoming united.

(ii) Community Participation

There are certain levels of community participation which need a clear understanding of them and the expected target of achievement after a period of time. The following table suggests a simple method of grading different levels of participation.

There were five levels of community participation (See Table–IV). The levels were as follows:

TABLE – IV Different levels of community participation in development projects

Level I	Level II	Level III	Level IV	Level V
Community receives benefits from the service but contributes nothing.	Some personnel financial or material contri-bution from the community but not involved in decision making	Community Participation Lower level Management Decision making	Participation Goes beyond Lower level Decision making to monitoring and policy making	Programme is entirely run by the community except for some external financial and technical assistance

Amongst the five levels of participation mentioned in Table–II, the CBR programme of BPF has undoubtedly reached the third level.

(iii) BPF and the communities as stakeholders

We all know and believe that community participation in a CBR programme is an essential component. However, in developing countries, due to economic, social and political unrests and constraints in many places, community participation in CBR programmes remains at a lower level. But it is of great satisfaction, that in overcoming all these obstacles, CBR programmes of BPF can claim to have achieved a moderate level of community participation. BPF could designate the communities of Dhamrai, Savar, Kishoreganj, Narshingdi and Faridpur as stakeholders as they are providing the disabled children in these areas, medical service, physiotherapy, speech therapy, training in cognitive development (through Portage

Pictorial Packages), micro-credit, counselling for parents etc. On the other hand, the CBR programme is getting benefits from the community through encouragement by the local people in the form of donation of land, with funds for construction of a school as well as contribution by some local people to the "Welfare Fund". And finally, Kalyani Primary School for All, is a large stride forward, in promoting "Education for All" in the area.

(iv) Social Security for the BPF CBR team

When the CBR team comprising of a pediatrician, psychologist and therapists from BPF visit the villages for a few days, some local people sometimes try to create a hindrance, but the majority of the villagers stand by them and guarantee security for the CBR team by helping them in various ways.

II. MOBILISATION OF RESOURCES : MATERIAL

(i) Donation of land and construction of a centre

By observing the activities of CBR as well as the improvement made by not only the severely handicapped children of the villages, but the normal children as well, some well-wishers of the disabled have come forward with the offer of donating a piece of land, as well as the construction of a simple structure to be used as a Primary School for All and as well as an office or training center, for the community workers and mothers. Such structures have already been built in some areas and presently, it is used as the CBR Centre and "School for All" in the village.

(ii) Help from villagers

The villagers today, have become sympathetic and helpful towards the disabled children who remained totally neglected in the past. During training sessions of the mothers, the local people extend a helping hand sometimes by providing food, communication facilities, arranging places where training can take place etc. It is very clear from the present discussion of the CBR programme of BPF, that no CBR programme can be sustained without community participation. More and more local people should be invited to participate in the CBR programme. Eventually, BPF expects people from the community to spontaneously come forward and take the responsibility of running the programme by contributing on their own : man, material and money for the success of CBR.

III. MOBILISATION OF RESOURCE : MONEY

(i) **Fund Raising** : Some of the associations have formed a "welfare fund" for the disabled children and have opened an account in the local banks, which are operated jointly by signatures of the Chairman of the club and the supervisor. This fund is being raised for any emergency required for any child.

(ii) Micro-Credit Programme of BPF

BPF has already disbursed small funds to the very poor families of disabled children, to improve the financial condition of the family. At present, micro-credit has been given to 21 families – in one of the areas of the CBR programme. Each family has been given Tk. 5,000/- per year. The loan is returned in installments. Only 10% interest on the principal amount is charged. The strict rules for the micro-credit programme followed by other banks, as well as the "Grameen Bank" has been changed by BPF's micro-credit programme. The conditions of BPF for micro-credit are simple and relaxed, so that the families are not threatened. The CBR Supervisor helps and oversees whether the families are utilising the loan properly. If necessary, the supervisor advises the families on how to spend their money profitably. The most encouraging factor is that during the last one year, BPF has received 100% recovery of the money given to the families.

CONCLUSION

Before embarking on its CBR programme, BPF has taken into consideration several issues related to changes in the philosophy and concept of CBR from the past to the present, which have been discussed in the introduction of this paper. All these issues have been successfully implemented in the programme.

Firstly, the inauguration of the Kalyani Primary School is a big step forward towards the philosophy of "Inclusive Schooling". In the CBR programme areas today, the disabled children are not seen as a separate entity and are happily integrated with the normal children in the villages.

Secondly, there is an emphasis on participation of the parents of the disabled children in the programme. The parents are contributing more than receiving, services for the disabled. Moreover, the professionals are trying to transfer their skills to the parents and the community workers. PBF has observed that Parent-Professional Partnership is also Empowerment of Parents in the CBR programme. This has also been discussed in Table – IV : **Models of Parent Professional Relationships**. Parents were also active members of the club and were contributing to the overall development of the CBR programme.

Thirdly, the programme also lays emphasis on **social integration of the disabled children** into regular inclusive schools and community rather than medical rehabilitation. The parents have also been integrated into CBR by taking full responsibility of organising the "Parents Club" and bringing in parents of normal children to understand and help them in their problems. This way they contribute not only towards rehabilitation of their children, but in awareness building among the community.

Fourthly, as far as **size of the CBR programme** is concerned, it may not be large but the **quality of service** is very high. Moreover, in a developing country like Bangladesh and an

NGO like BPF with limited resources, this is the best that can be achieved, that is, an **optimum quality** of services with available resources, within a **small coverage**.

Fifth, Community Participation has been quite successful as the local people have not only come forward and become members of the "Parents Club" but have donated land and contributed to welfare funds.

Finally, the CBR Programme of BPF has been planned and has evolved in such a manner, that the social and cultural factors have been integrated into it. In this way **sustainability** has been perpetuated in the philosophy of the CBR programme of BPF, as locally appropriate strategies have been used as much as possible, and therefore it was expected that the system would continue till its goals were achieved, in that, the community would take over all the responsibilities (the 6th level of Community Participation given in Table –II).

The description of the total CBR programme of BPF given in this paper, gives clear evidence of how **Man, Material** and **Money** have been **Mobilised** for the purpose of rehabilitation of the disabled children in the Community.

Mobilisation of Man :The "Parents Club" has successfully integrated the parents of disabled and normal children, local union council members and other local people into their activities through awareness building and community participation. Besides the disability programme, CBR has motivated the people in health, environmental cleanliness and family planning programmes for the community members, and last but not the least, in inclusive schooling for all children.

Material and money : The CBR programme through its good and high quality services have attracted the members of the community to come forward and donate land and money for building a school for all children, as well as contributing money to the "Welfare Fund" of the "Parents Club".

The Community Based Rehabilitation Programme of BPF is undoubtedly a clear example of **"Development of Community for All through Disability Programme,** which has successfully **mobilised the resources Man, Material and Money.**

LIST OF JOURNALS, COMPILED BY HEALTHLINK, UK

AFRICAN JOURNAL OF SPECIAL NEEDS EDUCATION

Uganda National Institue of Special Education (UNISE)
PO Box 6478, Kampala, Uganda
Fax: +256 41 222961 E-mail: unise@swiftuganda.com
Website: www.unise.ac.ug/publications.php
Price: Free (some institutions and contributers) / US$10.00 East Africa (per issue) / US$15.00 Rest of Africa (per issue) / US$20.00 Outside of Africa (per issue)
Subjects: disability / community-based rehabilitation / special education
Research based papers on Special Needs Education and community based rehabilitation. Readership is based largely in Africa. Special issues feature specific disablities.
Geographic focus: AFRO Languages: English / French Frequency: Twice a year Approx number of pages: 70

AGEWAYS

Practical Agecare for Development
HelpAge International, PO Box 32832, London N1 9ZN, UK
Fax: +44 (0)20 7843 1840 E-mail: hai@helpage.org
Website: http://www.helpage.org
Price: Free (developing countries) / £18/US$35 (elsewhere)
Subjects: health care of the elderly / appropriate technology / disability / primary health care / nutrition / rehabilitation. Aimed at all health workers, Ageways has an international focus on health issues, projects and programmes for older people. Provides practical ideas and information for people working with older people.
Languages: English / Spanish Frequency: Four times a year Approx number of pages: 28 ill Internet - PDF

ASIA PACIFIC DISABILITY REHABILITATION JOURNAL

Asia Pacific Disability Rehabilitation Journal
J-124, Ushas Apts, 16th Main, 4th Block
Jayanagar, Bangalore 560 011, India
Fax: + 91 80 6633 762 E-mail: thomasmaya@hotmail.com
Website: http://www.dinf.ne.jp/doc/prdl/othr/apdrj/apdrj.html
Price: Free
Subjects: disability / community-based rehabilitation / policy / research
Aimed at researchers, planners, administrators, professionals, donor organisations and implementing agencies involved in disability and rehabilitation. The major emphasis of the journal is on articles related to policy develpment, concept clarification, development of methodology in the areas of service delivery, training, programme evaluation, and develpment of technology related to rehabilitation.

Geographic focus: WPRO / SEARO Languages: English Frequency: Two times a year Approx number of pages: 40. Internet

---

COMMUNITY EYE HEALTH
An International Journal to Promote Eye Health Worldwide
International Centre for Eye Health
11-43 Bath Street, London EC1V 9EL, UK
Fax: +44 207 250 3207   E-mail: eyeresource@ucl.ac.uk
Website: http://www.ucl.ac.uk/ioo/courses/journal.htm
Price: Free (developing countries) / £25 (elsewhere)
Subjects: eye care / community health care / disability / health education / primary health care / vision impairment. Provides continuing education for ophthalmologists, doctors, ophthalmic assistants, nurses and community health workers in developing countries. Features review articles and research updates on prevention of blindness as well as practical information on clinical procedures and treatment. Covers all aspects of eye care, with up-to-date information on ophthalmic practice and opinion. Places particular emphasis on the methods of prevention and cure available to community health workers.
Languages: English Frequency: Four times a year Approx number of pages: 16 ill
Internet - PDF

CRIN NEWSLETTER
Child Rights Information Network (CRIN) c/o Save the Children
17 Grove Lane, London SE5 8RD, UK
Fax: +44 207 793 7626   E-mail: crin@pro-net.co.uk
Website: http://www.crin.org
Price: Free (children's rights organisations)
Subjects: child rights / advocacy / child abuse Contains profiles of member organisations, project updates, new publications, Internet developments and forthcoming meetings on children's rights.
Languages: English / French / Spanish / Arabic (selected articles) Frequency: Three times a year Approx number of pages: 12 E-mail Internet

---

DISABILITIES AND IMPAIRMENTS
An Interdisciplinary Research Journal
Department of Psychology, University of Delhi, Delhi 110007, India
Price: Rs 200 / year Institutions in India / US$40 / year Institutions elsewhere / Rs100 / year Students in India
Subjects: impairment / research
Geographic focus: SEARO / India Languages: English Frequency: Twice a year

DISABILITY DIALOGUE (FORMERLY CBR NEWS)
Healthlink Worldwide (formerly AHRTAG)
Cityside, 40 Adler Street, London E1 1EE, UK
Fax: +44 207 539 1580 E-mail: publications@healthlink.org.uk
Website: http://www.healthlink.org.uk
Price: Free (developing countries & students from developing countries) / £6 / US$12 (students elsewhere) / £12 / US$24 (individuals elsewhere) / £24 / US$48 (organisations elsewhere) / Discount for bulk orders
Subjects: disability / advocacy / appropriate technology / community-based rehabilitation / primary health care / training. Disability Dialogue (formerly CBR News) exchanges information between disabled people and development, health and rehabiliation workers, and aims to promote disability equality, and good policy and practice. It focuses on practical information about community approaches and appropriate equipment. Regional language, braille and audio-cassette editions are produced in collaboration with partner organisations in developing countries as follows:
(Bangla) Social Assistance for the Physically Vulnerable (SARPV), PO Box 4208, Dhaka 1000, Bangladesh. E-mail: shaque@bd.drik.net. (English for Africa and Portuguese - planned) Southern Africa Federation of the Disabled (SAFOD), PO Box 2247, Bulawayo, Zimbabwe. Email: safod@telconet.co.zw. (French) Mauritium, 5 Avenue Buswell, Quatre Bonnes, Mauritius. (English for India and Hindi) Amar Jyoti Rehabilitation and Research Centre, Kakardooma, Vikas Marg, Delhi 110 092, India. E-mail: amarjoti@del2.vsnl.net.in. Audio-cassette - International edition) Action on Disability and Development (ADD), UK - distributed by Healthlink Worldwide at the address above. (English braille and Indian language audio-cassette) Blind People's Association of India, Dr Vikram Sarabhai Rd Vastrapur, Ahmedabad 380 015, India. E-mail: blinab@ad1.vsnl.net.in.
Languages: English / English for Africa / English for India / English braille / Bangla / French / Gujarati / Hindi / Portuguese / Tamil / Audio-cassette editions are available for most languages Frequency: Three times a year Approx number of pages: 12 ill E-mail Internet

---

DISABILITY FRONTLINE
Newsletter of the Southern African Federation of the Disabled
Southern African Federation of the Disabled (SAFOD)
PO Box 2247, Bulawayo, Zimbabwe
Fax: +263 9 62944 E-mail: safod@telcouet.co.zw
Price: Free
Subjects: disability / advocacy / community-based rehabilitation Aimed at all health and development workers as well as the public as part of SAFOD's Conscientisation and Public Education (COPE) Programme. Describes work taking place in frontline states with practical information on working with people with disabilities.
Languages: English / Portuguese Frequency: Four times a year Approx number of pages: 20

DISABILITY INTERNATIONAL
Disabled People's International
101-7 Evergreen Place, Winnipeg, Manitoba Roc 220, R3L 2T3
Canada, Fax: +1 204 453 1367 E-mail: dpi@dpi.org
Price: US$15.00
Subjects:
Has an international coverage of disability issues, including country and organisational profiles, in addition to features and discussion articles on specific themes.
Languages: English / Spanish / French Frequency: 3 issues a year

---

DISABILITY & REHABILITATION
Taylor & Francis Group
Rankine Road, Basingstoke, Hampshire RG24 8PR, UK
Fax: +44 (0) 1256 330245 E-mail:
Website: http://www.tandf.co.uk/journals
Price: £218.00
Subjects: Languages: English
Internet - sub Contents internet Contents e-mail

DISABILITY TRIBUNE [FORMERLY DISABILITY AWARENESS IN ACTION]
The International Disability and Human rights Network
Disability Awareness in Action (DAA)
11 Belgrave Road, London SW1V 1RB, UK
Fax: +44 207 821 9539 E-mail: info@daa.org.uk
Website: http://www.daa.org.uk
Price: Free (disabled individuals and organisations working in the field of disability)
Subjects: disability / advocacy / appropriate technology / community-based rehabilitation / policy / human rights. DAA was established to provide an information network for disabled people and their organisations worldwide, to support their self-help activities and to ensure their equality of opportunity. The newsletter looks at all aspects relating to international disability issues. Also available on computer disk in ASCII format.
Languages: English / English braille / French / Spanish / Large print / Audio cassette
Frequency: Monthly Approx number of pages: 12 E-mail Internet Disk (ASCII format)

DISABLED PERSONS BULLETIN
United Nations (UN)
2 United Nations Plaza
Room 1342, New York, NY 10017, USA
Fax: +1 212 963 3062 E-mail: ito@un.org
Website: http://www.un.org/esa/socdev/disbltin.htm

Price: Free
Subjects: disability / community-based rehabilitation / rehabilitation services / policy issues
Information on international disability projects and initiatives by international agencies, including comprehensive country reviews.
Languages: English / French / Spanish Frequency: Three times a year Approx number of pages: 20 Internet

---

ENABLING EDUCATION
Enabling Education Network (EENET)
Centre for Educational Needs
School of Education, The University of Manchester
Oxford Road, Manchester M13 9PL, UK
Fax: +44 151 275 3548 E-mail: eenet@man.ac.uk
Website: http://www.eenet.org.uk
Price: Free
Subjects: inclusive education / children / disability / education. EENET is an information sharing network which supports and promotes the inclusion of marginalised groups in education worldwide. Enabling Education provides a forum for the sharing of ideas, experiences and useful publications on inclusive education.
Languages: English / Portuguese / Spanish / Braille Frequency: Twice a year Approx number of pages: 12 Internet

---

EPILEPSY BACK-UP
Newsletter of Epilepsy Support Foundation of Zimbabwe
Epilespy Support Foundation (ESF)
PO Box A104, Avondale, Harare, Zimbabwe
Fax: +263 4 724071 E-mail:
Price: Z$80 (individuals) / Z$200 (institutions)
Subjects: epilepsy / community-based rehabilitation / community health care / disability
Deals with all issues relating to living with epilepsy.
Geographic focus: AFRO / PAHO / SEARO Languages: English Frequency: Six times a year Approx number of pages: 4

HEARING NETWORK NEWS
Hearing Impairment Research Group
School of Tropical Medicine
Pembroke Place, Liverpool L3 5QA, UK
Fax: +44 151 707 1702 E-mail: karljlogan@msn.com
Price: Free (developing countries & members)
Subjects: hearing impairment / disability / research

A free four monthly update on research into assessement and prevention of hearing impairment and deafness in developing countries.
Languages: English Frequency: Three times a year Approx number of pages: 6
Hesperian Foundation News
Hesperian Foundation, PO Box 11577
Berkeley, California 94712-2577, USA
Fax: +1 510 845 9141 E-mail: hesperian@hesperian.org
Price: Free
Subjects: community health care / primary health care / community-based rehabilitation / disability / environmental health / health promotion / mother and child health / politics of health / training / women's health
The Hesperian Foundation News is a quarterly newsletter about health issues, self-help and community-based health care, and the politics of health. Articles include profiles of groups around the world working to improve health in marginalised communities, tips on producing accessible materials, and information about new and upcoming books and other Hesperian Foundation projects.
Languages: English Frequency: Four times a year Approx number of pages: 8 ill

---

HOPEFUL STEPS - CBR NEWSLETTER
CBR Programme, National Rehabilitation Office Ministry of Health
Brickdam, Georgetown, Guyana
Fax: E-mail:
Website: http://www.sdnp.org.gy/cbr/
Price:
Subjects:
Languages: English

IAPB NEWS
International Agency for the Prevention of Blindness (IAPB)
Grosvenor Hall, Bolnore Road
Haywards Heath, West Sussex RG16 4YF, UK
Fax: +44 144458810 E-mail: mhaws@dircon.co.uk
Price: Free
Subjects: eye care / disability / rehabilitation / vision impairment / vitamin A deficiency
IAPB promotes the development of national eye care programmes through the collaborative work of its members. The newsletter is a forum for the exchange of information and ideas and for demonstrating successful approaches leading to the development of comprehensive eye care and the prevention of blindness.
Languages: English Frequency: Two times a year Approx number of pages: 16

INTERNATIONAL JOURNAL OF REHABILITATION RESEARCH
Lippincott Williams & Wilkins
12107 Insurance Way, Hagerstown, Maryland 21704, USA
Fax: +1 301 824 7390 +44 171 940 7517 (editorial office)
E-mail: jnewberry@lww.co.uk (editorial office)
Website: http://www.intjrehabilres.com
Price: US$109 / £66.00
Subjects: disability / rehabilitation
Languages: English
Internet - sub

INTERNATIONAL REHABILITATION REVIEW (IRR)
Rehabilitation International
25 East 21st Street, New York, NY 10010, USA
Fax: +1 301 838 3029 E-mail: rehabintl@rehab-international.org
Website: http://www.rehab-international.org
Price: Free (developing countries or exchange for disability periodicals) / US$45 (elsewhere)
Subjects: disability / community-based rehabilitation / appropriate technology / policy
For all those working in the disability and rehabilitation field internationally. Carries original articles and news reports concerning disability policies, practices and projects throughout the world. Also features book reviews, selected resources and variety of announcements.
Languages: English Frequency: Two times a year Approx number of pages: 60
Internet - selected issues

IPA NEWS
International Portage Association (IPA)
Civitan International Research Center
The University of Alabama at Birmingham
Suite 313 Birmingham, Alabama 35294-0017, USA
Fax: +205 975 9664 E-mail: dshearer@uab.edu
Price: Free
Subjects: disability / community-based rehabilitation / children. Contains information submitted by those who work with young children with disabilites and their families, including news on portage-related conferences and training.
Languages: English Frequency: Four times a year Approx number of pages: 8

NEWSLETTER FROM THE SIERRA MADRE
HealthWrights, PO Pox 1344
Palo Alto, California 94302, USA
Fax: +1 650 325 1080 E-mail: healthwrights@igc.org

Website: http://www.healthwrights.org/spanish/Libros/news.htm
Price: Free (developing countries) / US$15 (elsewhere)
Subjects: community health care / appropriate technology / community-based rehabilitation / disability / health education. Provides examples of successful community health care programmes in developing countries in particular a disability and rehabilitation centre in rural Mexico called Projimo.
Geographic focus: PAHO / Mexico Languages: English Frequency: Three times a year Approx number of pages: 10

ONE IN TEN
Rehabilitation International
25 East 21st Street, New York, NY 10010, USA
Fax: +1 301 838 3029 E-mail: rehabintl@rehab-international.org
Website: http://www.rehab-international.org
Price: Free (developing countries)
Subjects: disability / community-based rehabilitation / appropriate technology / children
Newsletter of the rehabilitation/UNICEF technical support programme to prevent disabilities and to help disabled children. Each issue covers a topic related to childhood disability from an international perspective with emphasis on developing countries and practical applications of low-cost techniques and approaches.
Languages: English / French / Spanish Frequency: Two to three times a year Approx number of pages: 16-24

PARTNERS MAGAZINE
The Leprosy Mission International
80 Windmill Road, Brentford
Middlesex TW8 OQH, UK
Fax: +44 181 569 7808 E-mail: s&d@tlmint.org
Price: Free
Subjects: leprosy / communicable diseases / community-based rehabilitation / disability
Written in an accessible style and aimed at paramedical workers assisting people affected by leprosy. It contains articles on current leprosy care and practice, with articles on associated issues such as development, dermatology and public health.
Geographic focus: AFRO / SEARO Languages: English / Bengali / Chinese / French / Hindi
Frequency: Twice a year Approx number of pages: 20, ill

SIGHT AND LIFE NEWSLETTER
(Formerly Xerophthalmia Club Bulletin)
Incorporating the Xerophthalmia Club Bulletin
Task Force Sight and Life, PO Box 2116, 4002 Basel, Switzerland
Fax: +41 61 688 19 10 E-mail: sight.life@roche.com

Website: http://www.sightandlife.org
Price: Free (for those concerned with xerophthalmia)
Subjects: nutrition / disability / vitamin A deficiency / vision impairment / community health care / community-based rehabilitation / health promotion. Covers all aspects of visual impairment due to vitamin A deficiency. Includes abstracts of scientific papers, UN and NGO reports and project reports from many developing countries. Places particular emphasis on methods of prevention and treatment available to community health workers.
Geographic focus: AFRO / SEARO Languages: English Frequency: Three times a year
Approx number of pages: 8

THE WORLD BLIND UNION
World Blind Union
C/o ONCE, La Coruna 18, 28020 Madrid, Spain
Fax: +34 915 715 777 E-mail: umc@once.es
Website: http://www.once.es/wbu
Price: Free
Subjects: vision impairment / community-based rehabilitation / disability / eye care Feastures interviews with people involved with blindness and eye health, provides news from regions and countries affiliated to the World Blind Union. Includes photographs, news and new technology updates, announcements of upcoming events and reviews of new publications.
Languages: English-French / English braille / English cassette / Spanish braille / Spanish cassette / Spanish inkprint Frequency: Twice a year Approx number of pages: 80
E-mail Internet

RESOURCE DIRECTORY ON COMMUNITY BASED REHABILITATION AND RELATED ISSUES

This Directory is the outcome of a research to study the applicability of the WHO concept of CBR in rural Tamil Nadu, undertaken by the Avinashilingam University. The Directory includes about 800 resources, and is expected to be useful for persons with disabilities, their caretakers, grass-root level workers, professionals and organisations working in the field of disability rehabilitation. The Directory has a detailed list of sources, and separate indices by author, user, title and subject, for ready reference.
More details from:
Dr. N.Jaya, Professor and Head, Department of Human Development, Avinashilingam Deemed University, Coimbatore – 641 043, Tamil Nadu, India.
Tel: 0422-2435436, email: drnjaya@yahoo.com

Associate publications:

1. SELECTED READINGS IN COMMUNITY BASED REHABILITATION

Series 1

CBR in Transition

Series 2

Disability and Rehabilitation Issues in South Asia

2. ASIA PACIFIC DISABILITY REHABILITATION JOURNAL

3. TRAINING NOTES IN CBR 2001

4. TRAINING NOTES IN CBR A Tool to Assist Trainers for CBR 2002

All publications available at: http://www.aifo.it/english/apdrj/apdrj.htm

Editor :
DR. MAYA THOMAS
Desk Editor :
Ms. NINA AGTEY
Technical Advisor :
Dr. M.J. THOMAS

Produced by: Shree Ramana Maharishi Academy for the Blind, 3rd Cross, 3rd Phase J.P. Nagar, Bangalore - 560 078, Karnataka, India. Tel: 91-80-6581076 Fax: 91-80-658 8045

Printed at : National Printing Press, 580, K.R. Garden, Koramangala, Bangalore - 560 095 Tel : 91-80-5710658

For Private Circulation only

Catholic Organisation for Relief and Development
Organisation catholique d'aide et de développement Organización
catól1ica para ayuda de emergencia y desarrollo

CORDAID

P.O. Box 16440
2500 BK The Hague, The Netherlands
Lutherse Burgwal 10

telephone + 31 70 3136 300
telefax + 31 70 3136 301
email cordaid@cordaid.nl