

# TRAINING OF CBR PERSONNEL

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## ***ABSTRACT***

*The issues around appropriate training for community based rehabilitation (CBR) are as varied and numerous as the issues around CBR practice. It is only by exchanging ideas and by evaluating and promoting good practice that the training of CBR personnel can progress in a way which will enhance rather than restrict the development of appropriate CBR in varied communities. This chapter addresses some issues related to training of CBR personnel, starting with an overview of levels of training, such as grass root level workers, mid-level workers, planners and trainers, and professionals, focusing more on the latter 3 levels. The author goes on to discuss the types of CBR programmes for which personnel are being prepared, namely, CBR as rehabilitation, CBR as equalising of opportunities, CBR as part of development programmes ensuring that all development programmes consider the needs of people with disabilities and so on. The chapter concludes with a brief review of the more readily available training materials in CBR.*

## **INTRODUCTION**

This chapter addresses some issues of training, and the first question which must be asked is who are the personnel who are to be trained? Helander (1) and others have described the three levels of community based rehabilitation (CBR) as perceived by WHO and by UNDP. These descriptions clearly refer to three levels of service;

- grass roots (or level one) workers who deliver service in a community
- mid-level workers who organise and support these workers
- professionals to whom referrals can be made from the community or who refer users to the community

Too often CBR projects which follow, in broad terms, the WHO model fail to recognise the need for training and organisation of the second and third levels of service. Other programmes which would not subscribe to the WHO model may have active Disabled People's Organisations (DPO) involvement in planning and training at community level but have little training focus or support for those professionals on whom all community services will have to call at some time.

The basic and most numerous group of personnel involved in CBR are grass roots workers. Such grass roots workers (sometimes called first level workers) may be volunteers or salaried, but the most important fact about their training is that it must be local and geared to the needs of the project they are to serve. Some questions which arise are: how does one include hierarchical complications if volunteers and staff, or staff and parents are trained together? However, most issues related to grass roots training are local and have no real place in a volume such as this and certainly not in a chapter written by someone in London.

## **MID-LEVEL WORKER TRAINING**

Reference to mid-level workers is common in the literature but there seems to be less shared reference as to the role of this cadre of workforce. Are they supervisors of volunteers and grass roots workers with monitoring and record keeping roles, sharing this information with programme managers? Or are they the project managers? This has important implications for training, if management skills are to be part of the battery of skills which mid-level workers require. Is this to be man-management and financial management skills or will the financial management of a project (other than expenditure accounting) be undertaken by more senior staff in the programme?

Do mid-level workers remain operational, seeing families and persons with disabilities (PWD), or are their responsibilities concerned with monitoring and managing volunteers? If they are to be effective managers and to retain credibility with their teams of grass roots workers and the community, it is necessary for them to retain some operational duties. This means that they will need more advanced training in topics such as further rehabilitation techniques, public relations and attitude changing, than those of their grass root worker colleagues. If they are to do their job well as supervisor managers they must be prepared to support and advise their less experienced colleagues.

These demands begin to describe an individual who has a range of skills and knowledge which he can use creatively, either by himself or by supporting others, and begs the question as to the type of training such a person requires. Is training predicated upon the idea of skills transfer where mid-level workers are taught what to do in certain circumstances or upon problem solving? Is the assumption that mid-level workers in different projects will have similar demands from training and should be taught together or should training be project specific?

There are arguments for and against project specific training as opposed to training which is open to people from a variety of projects. If training of mid-level workers is open to people from different projects there is always a danger that good staff will be 'poached' during or after training. Employers may seek project specific training in the guise of being able to meet specific needs, in order to avoid such temptations. Projects of non-governmental organisations (NGOs) are freer to be more innovative and to change focus in response to need than government services. Is it possible therefore to design a common mid-level training which can meet the needs of both mid-level workers from NGO and government service?

## **TRAINERS AND PLANNERS OF CBR**

An important determiner which people bring to the beginning of a course, is their experiences of disability, of the community and their personal technical skills. This discussion of what people bring to training is divided with reference to:

- expectations of training
- expectations of services
- expectations of the rehabilitation process

Disabled activists in the UK have led the world in the creation and development of theoretical frameworks with which to construe disability issues and thus foster lively debate (2, 3, 4). British

disabled academics have had an important impact on the development of policy and practice in the UK and perhaps in other parts of Europe but as yet none of these theorists have addressed the issue of how their ideas may impact in the South. Nor have any disabled activists of the South explored theoretical bases for their (often very effective) advocacy work. Stone (5) is one of the few who have addressed the dilemma of how to introduce ideas of disabled research activists to Southern partners whose current preference is for the medical model. This is a situation common at the Centre for International Child Health (CICH), London, where we have students who want to move their ideas of planning towards a social model but anticipate little support for this on their return to their home countries.

Lang (6) provides a challenging discussion of the limitations of Northern change for the majority world. One frequently quoted difference between the disability struggles of the North and the needs of CBR is the emphasis on independence (7). Northern society values independence and choice for disabled people as the cornerstones of the disability movement (8). In many countries of the South interdependence rather than independence is the key value and in such a setting, rehabilitation for disabled people which is predicated on the need for independence, is of questionable value (9, 10).

Course participants who are trainers of trainers, or professionals working within CBR settings are much more likely to undertake training in heterogeneous groups. There will be disparity in the countries from which such participants come, in their experiences of disability and of how and why training is provided. The experience of working with such groups, often in London but also on shorter courses overseas, forms the basis of this paper. It is important to consider:

- the course structure including; expectations about the objectives, the process and the outcomes of training (what is sometimes referred to as the “How” of the course)
- expectations of the content (the “What” of the course) of training, (11)
- Ramsden (12) expands this division still further by stressing that course planners must ascertain whether the course structure remains “holistic” with a recognisable composite course ethos, or becomes “atomistic” with such emphasis on the detail of course structure that the overarching objectives become lost.

**The expectations of the objectives of training** may include; becoming able to do the job better, having enhanced career opportunities and/or higher salary, the chance to be away from home and the day to day activities of the job, opportunity to stand back and consider strategic moves of a personal or service nature, or to improve the lives of people with disabilities. The objectives stated by the trainer are more likely to include both content and personal development focus. The difficulties arise when the huge variation of expectations for undertaking a course are not examined early. In some cultures, the opportunity to take a course of study away from home is seen as an opportunity for personal enhancement and the nature of the training (be it a CBR trainers course, a human resources training or a social policy course) is somewhat irrelevant. For such a candidate, completing the course is the objective rather than the learning opportunities offered by the course. Such a course participant may be unable (because of previous conditioning about frankness of expression) to be frank about his/her motivation for attending the course and will almost certainly not have shared expectations of objectives with other course participants, who have either saved hard personally

or striven to seek funding in order to achieve a place on the training course, nor with the course leader who, at some level, hopes that all participants are there for altruistic reasons.

There is equally wide variation in the **expectation of the process of the training**. Depending upon the cultural experiences of group members there will be a wide variation between those who expect the training process to be active or passive, curriculum led or learning centred, or to follow an expert model of learning as opposed to participatory learning. In many cultures in developing countries, learning is seen as an entirely passive activity, decisions as to what is to be taught are made in advance and participants follow the course, rehearsing and regurgitating narrow answers to closed questions in order to demonstrate that they are learning! Such a “cook book” approach to learning is very seldom successful in any domain, but is doomed as an approach for CBR which relies on developing the creative skills of people. Similarly, in cultures which are resource poor and where a large class size is the norm, especially at school, students are expected to follow a prescribed curriculum rather than a learning centred approach to the course, where participants’ needs are addressed throughout the course and affect the nature of the course. A further example of curriculum led activity is where the course leader is seen as the “expert” and the participants as people who “absorb” the expertise. Such cultural expectations of the learning process can lead to difficulties in courses with participants from different cultures.

At CICH course participants following Masters degree and Diploma courses come from both developing countries and from Western countries with work experience (often in NGOs) in developing countries. The first group is often used to passive learning following a curriculum led model with expert input. The following are three examples of recent quotes from students who found the interactive style of teaching at CICH difficult when they first arrived in London,

*“I find it difficult to challenge the Tutor”* (28 year old from India)

*“I have never been expected to argue with the teacher”* (32 year old from India)

*“In my culture I cannot disagree with the teacher”* (39 year old from Southern Africa).

Such comments are very typical in early tutorials with new students from the South. In contrast their fellow students with different educational experiences (but often less practical experience) will feel comfortable with an active learning approach. These different experiences influence the style of teaching and learning for an international course. All participants need early in the course to accept responsibility for their learning, to recognise that in an active learning programme it is possible for students to follow the same course while working towards different individual educational objectives. There may well be a single course with common classes, workshops and tutorials but students will chose different emphases for their own study within the confines of the course. In contrast there may be some optional courses which students on an international course can choose in order to develop their specific skills.

Just as there is variation in the style of learning which students from very different backgrounds bring to a course, so too there will be variation among students’ constructs of what the **course content** should be. Some participants will expect a course to produce facts and others to develop their ability to know where to find answers. Some will expect a course to develop skills, others to improve their confidence as practitioners. Similarly there will be variation among tutors as to

whether facts or information seeking behaviour is the central theme of a course, and tutors too will be influenced by their personal constructs. The need to explore expectations by course participants and an understanding by the group of how their different cultural experiences have influenced these expectations is essential if any group with diverse cultures is to work well together and if all are to achieve their goals. Time has to be set aside to ensure that this exploration happens, or the dominant group members or an insensitive tutor will impose their constructs upon the group in sharp contrast to the ethos of CBR.

### **PREPARING HEALTH PROFESSIONALS TO BE INVOLVED WITH CBR**

CBR is delivered by at least two, if not three, levels of service; a grass roots (often home based) programme, central CBR resources ( perhaps with training facilities, workshops etc.) and the physicians or therapists ( the health professionals) to whom referrals are made. This involvement by professionals is an integral part of most CBR programmes but they are seldom given any training to prepare them for this role. Professionals may be involved in CBR because they are motivated by a wish to provide services which address the needs of people with disabilities, or they may be motivated by their own employment/ income generation needs. It is easy for people committed to CBR to sanctimoniously assume the first, but we must recognise that in many countries to carve a practice which meets income generation needs is also a valid motivation.

Professionals rooted in the practice of expert diagnosis of impairments may have different perceptions of who is considered disabled, from CBR workers and families of PWD. In addition there will be cultural variation as to who is considered disabled. Vreede (13) refers to this as ADL, IDL ODL. Wirz and Lichtig (14) note the contrast between two pairs of siblings. One pair has a 10 year old boy with mild/moderate learning difficulties in a rural African society with 30% school enrolment, and his sister of 12 years who is unable to raise her arms above elbow height. Among this pair the boy, able to help with goat herding, is able to perform the tasks of his peers, while she who is unable to lift to carry things on her head or to pound grain, was considered disabled. An identical pair of siblings in London, with 100% school enrolment and supermarket shopping for food, would consider the boy who was unable to keep up with the learning activities of his peers to be disabled, and the sister (with the slight modifications which she and her mother could make to her choice of clothes to avoid over-the-head dressing) as able to undertake all the activities of her peers and hence not disabled. That there is this variation in perception as to who is disabled is very challenging for health professionals who have been trained to be 'experts' who assess and diagnose symptoms rather than observe and discuss with people with disabilities.

Hartley, Lichtig and Wirz (15) discuss the difficulties which arise when Western professionals collaborate with services for people with communication disabilities in the South where the agent of change may be a professional or another person. In Uganda ( where there are no speech and language therapists) CBR workers or support teachers (who have had brief training about communication disabilities), work with parents and teachers of children with communication disabilities and are seen as the agents of change. This is in contrast with the biomedical approach by professionally qualified speech and language therapists in other Southern countries. It is tempting to say that the client centred approach is appropriate and that the British collaborator should change the behaviour of colleagues away from the biomedical approach. But such a solution is naive. Wirz and Hartley have Brazilian colleagues who work as a team of around 20 academic therapists in a

medical school. They are in a university system and are preparing students to deliver a service which meets very different targets from those of the UK. The closer they are to a medical model the more credibility they have as a profession, and the more biomedical their research, the greater their standing within the university system. These are realities and well meaning liberal collaborators interested in CBR cannot move in as change agents without taking cognisance of the pile of cards which may come crashing down if changes occur.

Despite changes in attitudes towards people with disabilities, and despite a much greater understanding of the discriminatory practices towards disabled people and greater respect for differences, most parents, on learning that their child has an impairment which will lead to a disability, look for a cure. This search for a cure, with all the financial, emotional and time resources which it involves in the early months and perhaps years of a disabled child's life, is perhaps more marked in the developing world, where the parents know (often at an uninformed/instinctive level) that the facilities for their disabled child are very few, maybe expensive, and may be of poor quality.

Parents of young children in the developing world also know that a disabled child is less likely to be a productive member of the family team and the search for a cure may be as an attempt to redress this economic pressure of the future. Estimates of how much ill afforded family income is spent upon a cure (using traditional and western medicine) are hard to come by in the published literature but observation and practical experience suggest that this is huge. Many parents' first construct of rehabilitation is to seek a medical cure. Sadly, many medical professionals condone this practice, taking considerable fees to see a disabled child and the parents, knowing that there is little or no rehabilitation service and that all they can do is provide a (often inadequate) medical label for the condition which the parents know to be disabling for their child.

The question arises as to whether medical or therapy education prepares professionals for CBR work? This discussion will concentrate upon therapists' education. The majority of therapy services provided in northern countries have developed from the medical model, where people with disabilities are 'referred' for assessment and, if appropriate, they are 'treated' by professional therapists. Therapy delivered by a medical model is characterised by features such as;

- Services being offered FOR or TO people with a disability
- The term PATIENT is used to refer to healthy people who have a disability.
- Services are provided FOR PATIENTS
- The onus for change is with the PATIENT.

The use of such vocabulary reflects a belief that it is the professional who holds the knowledge as to what is best. Knowledge is seen as power ensuring professional control. It is also true that knowledge as power is used in inter-professional rivalry, in the battle for resources and for salary hierarchies.

In the early 1980s, in the UK, pressure from disabled people raised an awareness of a social model of services where the disabled person's needs are central rather than professional practice directed at that person's impairment (3). Swain et al (16) review this issue. However, fifteen years

after the beginning of this debate in the UK, and despite a passing interest in shared responsibility and a nod in the direction of equity for disabled people, it is still primarily the professionals who arrange service delivery for disabled people in the UK.

Services are usually organised from a centre, be it a community clinic, a hospital or a school. With community care initiatives there may well be outreach from that centre to address community needs but the professional is perceived as being centre based.

Student therapists in the South work hard to be awarded a scholarship to follow a degree course in North America, Europe or Australia, or they have been dynamic professional leaders who have established a training course (often against great fiscal and medical opposition) in their home country. In either situation the reality is that students in the South are attending courses where they are exposed to professional training and practice which may have been appropriate when the medical model reigned supreme in the North. Current training questions whether this provides appropriate professional training for social models which accommodate community care needs for any student, from North or South. If training to which overseas students are exposed in the North is inappropriate, it is doubly so in their own home settings.

Course directors in the South, anxious to maintain equality with courses in the North, veer away from innovative training in case it affects the international standing of their course. They too are then shackled to a training which neither prepares therapists for the realities of new working practices of community care in the North, nor to community based working practices of the South. What often happens is that newly trained therapists in the South find difficulty in adapting their new skills to community based service and end up in the relative safety of private practice where they can use their (inappropriate) professional skills.

In order to be effective in a CBR setting therapists have to

- be prepared to “give up” their exclusive rights to knowledge about impairments, to a cadre of workers without professional expertise.
- be able to work as trainers and to support these CBR workers
- develop referral patterns of support to CBR workers
- continue to listen to PWDs and relate to disabilities rather than the impairments as a basis for intervention
- be innovative in service planning

Colleagues in South Africa have taken the lead in the training of co-workers for an alternative form of service delivery through CBR (17). From this base, therapists in South Africa have seen the need to co-operate with CBR, to become involved in training of CBR workers as a way of improving access to therapy services for all the population and not to restrict their services only those who can access central, urban centres (18).

In the Philippines too, innovations have been made in the education of therapists. All undergraduate therapy students at the University of Manila (occupational therapy, physiotherapy or

speech and language therapy) undertake a placement in a rural CBR programme, thus ensuring that all therapists have at least an understanding of other ways of working with disabled people (19).

If we support improved access to services for the vast majority of people with disabilities in the South by understanding the aims of CBR and supporting them, we should not continue to provide professional training for students from the South which concentrates upon the needs of the very small minority (20).

### **TYPES OF CBR PROGRAMMES FOR WHICH PROFESSIONALS ARE BEING PREPARED**

A further consideration in training is to concentrate not on the trainees (be it different levels of CBR personnel or professionals with whom CBR personnel must work) but the variation in the type of programmes for which personnel are being prepared. There are many definitions of CBR and the CBR movement gathers great strength from this diversity of interpretation. This paper takes the Joint Declaration (21) as a working definition of CBR. The advantage of this definition is that it is not prescriptive and leaves flexibility of interpretation for programme planners and trainers and educators.

*“Community Based Rehabilitation is a strategy within community development for the rehabilitation, equalisation of opportunities and social integration of all people with disabilities. CBR is implemented through the combined efforts of disabled people themselves, their families and communities, a,-id the appropriate health, education, vocational and social services”* ILO,UNICEF,WHO, Joint Position Paper, Geneva 1994.

There is a continuum of interpretations of the Declaration reflected in different practice. At one end of the continuum are those with a technical rehabilitative focus and at the other, those with a human rights focus for their activities. Best practice of course involves a range of different approaches to meet differing needs, and CBR programmes may well be involved with activists, activities and services at different points along this continuum.

Creative use of this definition by UNESCO, ILO, WHO promotes dynamic and multifarious definitions which allow for greater manoeuvre among planners and service providers than more traditional classifications such as:

- Whether it follows a medical model or social model (22, 2)
- Whether it is professional led or DPO led
- Whether the programme focuses upon impairment, disability, or handicap (23,24)
- Whether it is a disability programme or a development programme with disability awareness (25, 26, 27)

Such classifications emerged in the literature of the west over the past 20 years as disabled peoples’ organisations asserted their rights to self determination and challenged attitudes, policy and practice.

Traditional CBR programmes have often been classified using some of the four dichotomies listed above (medical vs social model, professional vs DPO led etc.) but simplistic classifications can be misleading. It is possible for organisations seated in a health base to adopt a clear social model to their CBR work, or for organisations which are led by disabled people to have a strong technical focus to their work. Wyller (28) proposes the term “comprehensive model” to encompass concepts of social and medical approaches and to move practice forward.

CBR has then a wide diversity of interpretation, starting from the initial model of CBR as conceived by WHO in the 1980s (culminating with the publication of the WHO Manual (29). There are many other interpretations of CBR e.g.,

- emphasis upon early childhood intervention (30),
- the use of volunteers in a small country with a commonly held expectation of voluntary activity (31),
- the emphasis upon local community committees in the Middle East (32)
- devolving CBR activities from institutions (33).

Because CBR depends upon local activity it is not surprising that there is variation. Culturally appropriate models of CBR have arisen to meet local need. It is interesting that the most widely written about CBR activity that was developed by disabled people themselves, at Project Projimo (34), has never been replicated. On the one hand it seems sad that such an excellent sounding model has not spawned others, on the other one has to accept that Project Projimo, however successful in rural Mexico, was not culturally appropriate to other settings. The lesson, fifteen years after the first moves toward CBR as a way of ensuring culturally appropriate, affordable and accessible services for disabled people, is acceptance of cultural diversity as to how CBR is interpreted in different settings (35, 26).

In much writing about CBR, there is an assumption that there are common community values, and that these must be met by the CBR programme. In reality however, values may differ within a geographical community by caste, by educational or economic status, or by minority groups, and this diversity of values must be described in the planning process. This requires great skill by the planners who bring their own cultural norms to the process. It is enormously helpful to understand something of the cultural norms of a setting which is new to a trainer or planner. Unfortunately CBR is impoverished by a lack of sociological or anthropological literature. Ingstad and Whyte have brought to a wider readership, issues of cultural diversity about disability (36). Cultural variation has not been recorded by people working for and with disabled people in countries of the South and/or in CBR programmes, and the passing of knowledge (which undoubtedly exists) depends upon the unreliable transfer of knowledge through conversation. Orally transmitted knowledge of cultural values can be inaccurate either in the telling or in the understanding, but is also in danger of being out of date. There is, for example, great change in extended family systems with wide urban/rural variation. The idea of the disabled child being sent “back to the grandmother in the village” may have had some reality 15/20 years ago but observations in a CIH project with the Spastics Society of India in Dharavi slums in Mumbai suggest that the modern 40 year old grandmother who was herself an urban migrant is no longer the easy recipient of the role which her mother adopted.

## **PUBLISHED TRAINING MATERIALS FOR CBR**

There are a selection of published training materials suitable for the training of CBR personnel. Some are very well known and widely available and others while equally useful are less well known on the international CBR stage. Thomas and Thomas (37) provided one of the few published reviews of several different training materials. If the training of CBR personnel is to move beyond local boundaries there is a need for more widespread awareness, use and availability of published materials.

### **Established Training Materials from the 1980s**

1. Disabled Village Children (DVC) was a very welcome document when it was published 15 years ago and its great strength is its comprehensiveness. The volume contains information about most disabling conditions and ideas for low cost interventions. The great disadvantage (which is the downside of its comprehensive nature) is that it can be daunting for those who are less comfortable with indexes and cross referencing to find their way around the book.
2. The WHO Manual (29), widely known throughout the world is more user friendly. The material is broken into sections, most pages have a mix of text and illustration and are less frightening for those less comfortable with books. Its disadvantage is that the booklets, if separated from their pack binding, can become lost or misplaced.

Both DVC and WHO manual are products of their time, the mid 1980s, and are predicated on the idea of skills transfer to field workers (or volunteers/parents) by professionals who will use one of the volumes as a training manual. There was, and remains, a place for such training materials but they reinforce the idea of professional “expertise” and do not reinforce community/non-specialist strengths nor the place of DPOs and other non-professional organisations, in training. In addition, both concentrate on the medical aspects of disability and less on the disabling consequences of lack of income, poor access to school and other inclusion issues which are faced by disabled people and their families in the majority world.

### **More Recent Training Materials**

3. The training materials produced by the CBR Training and Development Centre (CBRDTC) in Solo, Indonesia have gone some way to updating the material available in DVC or the WHO Manual. The CBRDTC material comprises a set of training materials addressing the needs of most disabling conditions. There is a simple booklet for different disabling conditions, and some are related to specific disabilities e.g., “Helping Children who have Eating and Drinking Difficulties” while others are more generic e.g., “Early Detection of Disability for Children under Five” or “Helping to Prevent Disability” The CBRDTC set of training materials also includes information about disabilities which are common but infrequently addressed by CBR training materials e.g., “Helping People with Severe Mental Illness”.
4. The Spastics Society of Eastern India has produced an interesting set of training materials that include a series of booklets suitable for trainees, and another set of simpler materials for parents. The booklets for trainee CBR workers have titles such as “Physical Management for the Cerebral Palsied Child” and “Happy Talking: for children with special communication needs”. Those

for parents tackle subjects which concern parents e.g., “Toileting for the child with cerebral palsy”, “Feeding for the child with cerebral palsy”. Both sets are well illustrated and use simple language. In addition to the sets of material concerning different disabling conditions, the series also includes more generic training materials such as “Learning Together: a manual for trainers on CBR”.

5. Handicap International have published a set of training materials ( comprising about 40 booklets), which are available in French and English. They concentrate upon physical disability and chronic disease with four sections. Two sections relate to basic anatomical theory and clinical evaluation, while Section 3 relates to physical therapy techniques and devises e.g., booklets entitled “Walking Aids”, “Home Adaptations”, “Respiratory Treatment” or “Stretching”. Section 4 provides specific information on different pathologies such as “Burns”, “Osteoarthritis”, and “Leprosy”. The materials are firmly rooted in the medical model but are useful as training materials for such specific topics.
6. More recently, Hesperian Foundation, who were the original publishers of DVC, is piloting a series of training materials directed more specifically at the parents of children with disabilities. Early, pilot versions of these materials look interesting and should be useful in the future.
7. In addition to the manual “Training in the Community for People with Disabilities” (29), the WHO have produced a small series of training materials which give more specific information about working with people with disabilities. For example, “Promoting the Development of Young Children with Cerebral palsy” and “Guidelines for the Prevention of Deformities in Polio” and “CBR and Health Care Referral Services and “Let’s Communicate: a handbook for people working with children with communication difficulties”. Most of these are soft-bound books but “Let’s Communicate” is produced in the style of the original WHO Manual as a loose leaf folder with a series of booklets. It was produced in collaboration between the Rehabilitation Unit of the Ministry of Health in Zimbabwe and WHO.
8. “Helpful Steps’ is a set of training materials produced for the Guyanese CBR programme with accompanying video materials.

An important issue in training is that of acceptability of materials which have been produced and illustrated in other countries. Hartley and Wirz (38) investigated the “acceptability” of different illustrations to planners of CBR workers and were rather surprised at how narrowly tolerant most planners felt their CBR workers would be of different illustrations. For example:

*“mothers do not cover their heads in my country”*

*“women do not wear saris in my country “*

*“it is not acceptable for a father to be feeding a child in my culture”*

We also found that our group of South America informants did not find line drawings of Asian and African people acceptable, African informants felt their CBR workers would want African line drawings, South American informants felt their CBR workers, parents and volunteers would not identify with the messages of training materials if they had Asian people as illustration. This was a very small informal investigation but suggests that work needs to be done as to the acceptability of illustrations of training materials.

## CONCLUSION

The issues around appropriate training for CBR are as varied and numerous as the issues around CBR practice. It is only by exchanging ideas and by evaluating and promoting good practice that the training of CBR personnel can progress in a way which will enhance rather than restrict the development of appropriate CBR in varied communities.

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