CHAPTER FOUR: THE CONVENTIONAL SYSTEM

In this chapter I will describe the conventional, still existing system for rehabilitation. The description is based on visits made to some 70 developing countries. It also draws on discussions with central and local authorities, professionals, representatives of organisations for and of disabled people, international development and donor organisations and local non-governmental organisations experience gathered during visits to several hundreds of centers, institutions, schools, training centers, hospitals and so on, as well as to hundreds of small rural communities and marginal urban settlements. The description is also based on the reports and documents that I have received and insights obtained from interviews with disabled people and their families in their homes.

1. POLICY APPROACHES

The first subject for review concerns policies of interest to disabled people. Each country has a number of general policy statements, of which the constitution is the most important. Often the constitution was adopted after decolonisation, formulated in modern terms and revised in the light of more recent reforms. The constitution generally lays down the rights of all citizens: to education, to work, to public services, to freedom of association and expression, to legal protection, and so on. It may sometimes include passages relating to disabled people, in which it is stressed that these share the same rights or that they should be given the special services they need.

The activities of each government sector are regulated by specific laws, decrees, rules or similar, based on the constitution. To give an example, the parliament, at the initiative of the Ministry of Education, may approve policies and legislation governing education, training of teachers, curricula and examination procedures. These instruments may include guidelines on how to educate disabled children and adults.

Some policy documents are specific and exclusively concern disabled people. For example, numerous countries provide welfare contributions and/or assistance in the form of transport facilities or higher school allowance rates for disabled children. Many have also special labour regulations such as quota legislation or sheltered workshops, subvention schemes in respect of orthopedic appliances, and so forth. Or the country's social security system may provide for workmen's compensation, rehabilitation services, etc.

Finally, there exists today a wide range of international resolutions, conventions, declarations that may or may not have been ratified and implemented by a particular country.

However, policies related to disabled people often fail to achieve their goals. This is because

(a) implementation of such policies is inadequate or non-existent. Most governments have not done enough to inform their citizens about their rights and their duties. In addition, there is a deficiency of administrative, political and service structures to ensure the implementation/enforcement of the relevant policies;

(b) policies related to disabled people are seldom integrated and consistent because of the lack of clearly defined general political objectives in this area.

2. PLANNING APPROACHES

Few countries have any detailed medium- or long-term plan as to how disabled people's needs are to be met. The plans I have seen often fail to address the problems as a whole in a realistic way. Nor have they set precise targets in terms of population coverage.

External donor or development organisations which set up or contribute to services - sometimes in co-operation with the government or with a national non-governmental organisation - are not receiving enough guidance. The lack of govern-ment planning contributes to the haphazard and uncoordinated use of the resources set aside for disabled people. External initiatives clearly suffer from a lack of co-ordination at the national level. As a matter of fact, some countries have attracted over a hundred different small projects each, most of which are planned and executed in ways that leave much to be desired.

With a clear plan to follow, governments could redirect the use of external funds. Better planning will yield long-term benefits, as services and other facilities will be set up, which are economically and professionally maintainable. In addition one would expect that they will better fit into the pattern of general socio-economic and human development.

3. TYPES AND STRUCTURES OF CONVENTIONAL SERVICES

I will now attempt to review the types and structures of existing services.

The conventional system of services exists in many different forms, for example:

- rehabilitation centers, usually for one category of disabled persons;
- orthopedic workshops, some also produce wheelchairs, crutches or ADL appliances;
- outpatient clinics for physiotherapy and occupational therapy;
- ordinary hospitals, which may have a physiotherapy department designed for acute patients (with fractures, stroke, post-operative treatment, etc.);
- rehabilitation hospitals, sometimes with their own department of orthopedic surgery, an orthopedic workshop and wards;
- special schools or integrated special classes and/or ADL training centers, e.g. for blind, deaf, physically disabled or mentally retarded children;
- vocational centers, almost none of which have facilities for assessment, so the main thrust is for training;
- sheltered workshops and co-operatives for disabled people;
- psychiatric hospitals, where one might find large groups of mentally retarded, autistic or epileptic children/adults, and patients with chronic mental illness;
- leprosaria, for patients undergoing leprosy treatment. Some of them are sent home after the treatment, others remain for a life-time;
- orphanages, where most children stay for only a short while (before being adopted). But disabled children often remain until they have reached maturity, because few people want to adopt them;
- beggars' homes or detention centers, where disabled beggars (after being rounded up and removed from the streets) may stay for very long periods of time;
- rehabilitation services, which form part of another activity, e.g. those of an ophthalmologic assistant in a district hospital, who may train blind people, or that of a bicycle manufacturer producing wheelchairs.

The services are provided either in boarding or in day centers and mostly to be found in the capital. Some have made attempts to set up an outreach programme.

4. ORIGIN AND FUNDING OF CONVENTIONAL SERVICES

The beginnings of some of the services go back to the 19th century. But most of them are the result of expansion since World War Two.

Many early services for disabled people in developing countries were started by religious organisations. Missionaries and others observed the large number of disabled people everywhere and began looking for ways of helping them. They called for experts and professionals to design services and, in the early phases of development, these services tended to be copies of institutions in the industrialised countries. Such services multiplied and became the standard pattern.

In the years to follow, one trend was to train nationals in certain well-established centers in the industrialised countries. Some of the returning professionals successfully convinced their governments to set up or, at least, to support a national centre in the capital. In a handful of countries, the government created decentralised services, e.g. on a regional basis.

Many non-governmental organisations followed suit, providing special services for small groups of disabled people, the majority of them children. Support also came from multi- and bilateral donors. Today, thousands of different service-providing projects receive external funds.

The funding of existing services is mixed. In the beginning, many facilities were built and equipped by funds provided by foreign donors, and the personnel consisted for the major part of expatriates. Most donors now try to create, or get in contact with, a local organisation prepared to take over management and funding of the services. Nationals later on often replace expatriate staff, which helps to reduce costs

After a while, the national or local governments may start contributing funds, on an initially rather symbolic scale. Some services have been set up by social security funding, but in most developing countries these will cover but a small proportion of the population.

It is not easy to calculate the amount of funds currently used for providing services for disabled people in the developing countries. The total amount spent by external contributors (multi-lateral, bilateral and international NGOs) is at least US$ 300-400 million annually.[1] National governments, social security systems and NGOs spend probably over US$ 100 million for rehabilitation annually. This would bring the total to something in the order of US$ 500 million a year. But this is a conservative estimate. Using another approach, one could, for instance, calculate that about 2 million disabled people receive services (funded either by local or external donors or by their own government) at an annual cost conservatively estimated at US$ 500. Then the total comes to US$ 1,000 million per year.

5. THE GAP BETWEEN NEEDS AND AVAILABLE SERVICES

To judge from country visits and reports, the number of disabled people throughout the developing countries known to receive organised, active rehabilitation functional training, receiving special education or undergoing preparation for jobs was estimated to be about two million in 1998. In other words, about 3 per cent of the requirements for rehabilitation calculated in Chapter Three have been met.[2] Others were given care by the family, a proportion of whom were receiving effective "spontaneous" training. Still others had been integrated in local schools or were earning an income. In the past few decades, the provision of rehabilitation has been lagging behind the population growth in many developing countries, where the combined effects of economic stagnation, high birth rates and structural problems tend to widen this gap. Still others stay in institutions, which have little to do with rehabilitation and more with “storage” (see below).

The following three factors may help to explain what gave rise to this gap of some 97 per cent.

(i) *Costs*

Cost estimates in a number of conventional rehabilitation centers of acceptable quality in developing countries vary between US$500 and US$5,000 per disabled person per year. Based on this, the annual cost (including capital costs, administrative overheads, etc.) could reasonably be assumed to average roughly US$ 1,000 (or about US$ 3 per day).[3]

If we were to provide conventional services for all those moderately and severely disabled people, conservatively estimated at 70 million, who need a rehabilitation programme, the price tag would amount to some US$ 70 billion annually. This has made many decision-makers reluctant to embark on anything but small-scale services.

(ii) *Personnel*

In a large number of developing countries, there is a serious shortage of professional personnel. Many countries lack schools, while in others trained personnel "disappear" into the private sector or emigrate to countries which offer better salaries or career prospects. In most countries the professionals remain in the capital and prefer to work in institutions.

In addition, the "early expatriates" may have contributed to the problem. When their profession was introduced in the developing countries, they frequently insisted that there should be no change in personnel policies, in distribution of tasks between various categories of personnel (working as teams), in duration of training, and in curricula. This considerably increased the price for providing rehabilitation. It is hard to conceive of a better way of blocking the setting up of public services for disabled people in the developing countries; and a more effective instrument to make governments delay even the necessary policy decisions.

(iii) *Public perceptions*

The service gap is partially due to the percep-tion that rehabilitation does not bring about any significant change in the life situation of a disabled person, that services are very costly and that they require a large number of qualified professionals.

At the origin of this perception is that, for a small group of severely disabled individuals, the situation is too grave to allow for more than marginal improvement. Some conventional institutions, which concentrate on functional training and segregated special education have also had a part in forming such perceptions. Many of them have not had appropriate programmes for the social and vocational integration of their clients; in such centers disabled people remain "for ever".

Another part of the explanation of the lack of services is prejudice. Disabled people are a low-status group with few "political resources", subjected mainly to charity-generated care, and this has slowed down the provision of the public services needed.

6. ACHIEVEMENTS

The international efforts to provide services for disabled people in the developing world have had a significant influence. We must recognise the importance of what has been done by all those dedicated workers who, in spite of all the negative reactions and the difficulties encountered, managed to get a service off the ground. We may sum up their achievements as follows:

- they demonstrated that disabled people are able to take care of themselves, to learn as well as others, to work and to earn an income;
- they created awareness of the fact that disability is a common problem and that next to nothing has been done about it;
- they encouraged nationals (governments and NGOs) to start services on their own, provi-ding funds and personnel;
- they helped to develop a sense of international concern for an area that previously had a very low priority.

Therefore, the following comments should be read bearing in mind the substantial achievements of those dedicated pioneers.

7. COMMENTS ON THE COST-EFFECTIVENESS AND QUALITY OF THE CONVENTIONAL SYSTEM

I have chosen to comment on the conventional system by providing some examples of existing services (see Boxes 4.1 - 4.12).

The examples do not give the name of the country or the location. I feel this to be immaterial. The situation varies, of course, considerably from country to country. But when it comes to type of problems they do not differ much. Nor are the situations described in the following text unique to rehabilitation. Many other development projects (e.g. in agriculture, education, health and transport) have their share of similar problems.

Box 4.1 is an example of a well-funded project. It exemplifies several important problems with the conventional system:

- the relationship between the family and the disabled person is often broken, and those admitted to a centre have no way out;
- the costs are very high, and there are few chances for the system to be taken over by national authorities/NGOs without a major loss in quality, so the donor has no way out.

BOX 4.1 NO WAY OUT.

The Centre at X consists of a very large villa and a number of outbuildings, surrounded by a beautiful, well-kept garden. It receives about thirty boarders, all of them were initially mentally retarded children in the age groups 3 to 10 years. There are several small classrooms, which look more like playrooms than a school. It has eight professionals (of whom four are expatriates) and 15 additional staff for cooking, cleaning, gardening, etc. The rehabilitation programme consists of ADL training and special education and is of excellent quality. The personnel are well motivated and have activities in-and outdoors, games, etc., the whole day.

There are two children to a bedroom, and plenty of bathrooms. The buildings are luxurious, with marble floors, high-quality furniture, and carpets. The food is excellent, the whole place is tidy and orderly, the children look happy and love the staff.

Of course, the costs for the Centre are very high and are totally donated by a foreign NGO. I visited it when it had just been inaugurated 16 years ago, and there were then some vague ideas of transferring it to a local NGO or to the government "later on". The principal felt that a few families might take home their children when their "education" was completed. Otherwise the Centre might have to keep them and build a sheltered workshop.

Since then, almost no children have left the school, and the contacts with the parents are thinning out. Over half of the children have had no visit from a family member during the last year. There is no way out for them. The annual cost per child is now about US$ 9,000, and the donor organisation has desperately been looking for a national organisation to take it over. So far, nobody has shown any interest - so there is no way out for the funding NGO either.

Box 4.2 gives an example of a well-funded government project for mentally retarded children and adolescents.

BOX 4.2 TIE THE HANDS OF THE CHILDREN SO THE PERSONNEL CAN WATCH TV IN PEACE

In 1989 a UN expert visited a centre for mentally retarded in an Asian developing country and reported the following:

"... there is no consistent program of activities proposed to the children: besides eating and bathing, there are no activities where the children are actively involved; they are placed in a large room, without any stimulation of any kind, where they spend their time moving around, or sleeping on the floor, or indulging in self-stimulatory behaviour, until next feeding-time or bathing-time. Moreover, there is no furniture in the room besides a floor-rug. In order to prevent self-stimulatory behaviour, some of the children are either tied down all day long in their beds, or have their hands tied back. Occasionally, one of the care-takers interferes to take one or two children to the bathroom. Two or three times over a period of three months, the children were taken to the "club-room", another room on the same floor, over-equipped with decorative items and dolls. This room contains a video-set, but it was noticed that the video-system was never used; instead, regular television programs were put on for the pleasure of the care-takers.

"The relationship between the care-takers and the children is very distant: there is no corporal contact other than for punishment purposes, or for accompanying the child to the bathroom or to his bed.

"Feeding practices are as follows: two of the children are fed in a sleeping position on the floor or on a wooden bench; the others are seated in a row on a bench and the care-taker spoon-feeds them all using the same spoon and one single dish. This entire feeding procedure covering four to five children simultaneously does not last for more than ten minutes. There is no control as to whether the children washed their hands and mouths after the meals. During the time we spent there, only three children out of the entire group are allowed to eat independently at a table. No supervision is exerted upon their eating-habits. No training attempt was observed.

Other remarks in the same report are:

"... The services offered ... are merely at the level of boarding. No attempt has been made at implementing any systematic educational training program to clients. The staff directly involved with the children are not competent. There does not seem to be any control or follow-up of the staff performance" ...There is no clear-cut job-description to identify the proper responsibilities of each of the personnel, a factor which is greatly responsible for the general chaotic atmosphere.

"... the total lack of parental involvement in the training process of the clients: some of the children have

been institutionalised for years [average time 8 years and 3 months] without any parental visit.

"... The structure of [the programs for another institution in the same country] were designed to fit the needs of the teachers for frames and forms rather than the actual priority needs of the children they are supposed to serve. In addition, there does not seem to be any planned program for the future of the clients served today."

My comments are:

- in spite of adequate facilities, salaries and training, the personnel neglect their duties, probably because of their negative attitudes and of the lack of supervision both by technical staff and family members (who rarely come for a visit).
- in that country, schooling is compulsory and free. The centre has been set up mainly to "rid the normal school" of children who are “unwanted by the teachers - and not out of concern for the welfare and education of these children.
- many disabled people lack the necessary resources to protect themselves against abuse in all its forms– a fact the personnel might be taking advantage of.

Box 4.3. gives an example of sexual abuse of disabled young boys. Such abuse, of girls and boys, unfortunately, is very common, in particular when it comes to mentally retarded or deaf adolescents.

BOX 4.3. ABUSE IN AN INSTITUTION

A physically disabled expatriate went to an African country and through contacts in his home country obtained funds to pen a “home” for disabled adolescents. He rented a large villa and had some simple boarding houses set up on the land. After a few years ha had “collected” a dozen disabled boys, who were lodged and fed. He employed some help to look after them, but there4 was no rehabilitation programme.

By court order, ha had also been made custodian of four or five young male criminals, who were out of jail. These were not disabled.

One day the expatriate suddenly had a fatal accident. The local church, which had given some economic support to the ”home””, decided to take it over and employed a young couple to look after the boys. When they went though the belongings of the expatriate, they came across his diary. In it he had recounted his sexual experiences in great detail with all those who had been in his care. Interviews with the boys confirmed the story. The boys said that they had never dared to say anything or complain, for the expatriate had threatened them with being thrown out to the street or sent back to jail. Besides they did not think that anybody would believe hem - the expatriate had an excellent reputation and good connections with a number of high-ranking officials.

Box. 4.4. concerns a training programme for physiotherapy students, and Box 4.5. illustrates the practical outcome of a similar trainng course in another country.

BOX 4.4. REHABILITATION EQUALS ELECTRICITY

This is a large rehabilitation hospital in the capital of a Middle Eastern country. The medical doctor in charge has received training in the United States and takes pride in showing his signed photos of some physiatrists of worldwide renown.

A physiotherapist takes me to the therapy areas, consisting of the usual dry swimming pool. It leaks, she says, and is awaiting repair. There are a few Hubbard tanks, a large gym hall (unused), as well as some twenty small booths for physiotherapy occupied by a number of patients with paralysis after polio, with hemiplegia or paraplegia. They are receiving one or the other of the following three types of electrotherapy: electrostimulation of muscles, diathermy, and ultrasound. I inquire about exercises such as training to walk, ADL, prevention of contractures - No, they do not have that. Physiotherapy is taught at a national school. It is a three-year course, and I am told that it is real tough and that the international professional federation approves the curriculum.

BOX 4.5 . PHYSIOTHERAPY STUDENTS FAIL - THE REASONS WHY

In a UN organisation where I worked for several years, I inherited a project: a physiotherapy school in an Asian country. The school received each year about thirty female students, and the course was for three years. Its principal was an expatriate, and it had been a very costly project.

I wrote to the principal and asked for an evaluation. She sent me the course plan and the records of the examination results.

We then entered into a lengthy exchange of letters regarding the course contents. I wondered how this typical Western curriculum fitted into this very poor country. The course was quite adequate for learning about, say,

cerebral palsy, multiple sclerosis and stroke, all these unusual diseases in this Asian country. On the other hand, the students did not receive sufficient training for polio patients. One third of the time was devoted to learning physics, the theory of electricity and the handling of various electrical appliances. The explanation for this was that the professional international federation had given advice about the course plan. Many of the students, so I was told, were taking the course in order to emigrate to an industrialised country and "needed" to follow what they perceive as the guidelines of the federation. It appeared that over a third of the students dropped out or failed their examinations, and that the theory and practice of electrotherapy was the big obstacle. I suggested cutting down on the "electricity" and to concentrate instead on active exercises. This was rejected immediately.

I then received a lengthy letter saying that it was after all not the "electricity" that accounted for the failures. The problem, wrote the expatriate principal, was that these students were all small and rather frail girls. They were not eating enough, and they were tired out by their job, so that they could not study as much as needed.

I should perhaps add that without the "electricity" component the students could not emigrate at the end of the course.

My comments are:

- transferring a course for rehabilitation professionals from an industrialised to a developing country rarely yields the desired results;
- students attending such professional courses put their own interests first (such as emigration or starting private practice) and may not see themselves as serving the public;
- the educational objectives of many courses have not been formulated taking into account the realities of the particular country and do not always address the needs of the public;
- introduction of high-cost technology (such as electrotherapy) often leads to a neglect of the tasks to be done with low-cost technology (in this case, active exercises and ADL-training) or it fails completely (most swimming-pools in rehabilitation centers are dry).
- breakdown of machinery, power and water cuts, with the personnel eventually acquiring a resigned attitude to work; control of the means of production is to a large degree out of their hands;
- costs are high; very few people can afford to pay for their appliances, even if only in part; the subvention system often breaks down or is inadequate;
- the authorities who should help to correct problems and provide/import materials and spare parts consider this activity as a low priority, so the delays are long - sometimes years.

It is difficult to understand, why training courses of this and similar types receive public funding in countries, where 70-90 per cent of those who graduate emigrate to an industrialised country. There is no doubt that rehabilitation personnel are needed, not the least in hospitals and in rural areas, where almost nobody serves now.

Box 4.6 relates a story of how well-wishing people sometimes set up facilities without ever giving a thought to what will happen in the future, thus causing serious frustration to those they wanted to help.

This story reflects the lack of sustainability of such enterprises. Clearly rehabilitation services are most often seen as domains for private action, in this case something to do between cocktail parties. People set it up without experience, technical knowledge, skills, ability to plan for, manage, sustain and evaluate what they have in mind. Unfortunately some other organisations are no better. (Box 4.7.)

BOX 4.6. ON ORTHOPAEDIC WORKSHOPS

By now, I must have seen over one hundred orthopedic workshops, in some sixty developing countries. Millions of dollars have gone into equipping them as well as into the training of thousands of technicians, who should be able to do a good job. No other technical area of rehabilitation has received so much external support. Yet the output of these workshops is lamentably low, very often not more than ten per cent of the potential output. Some of the products being of acceptable quality, others a far cry from it. And another big problem is alignment - a poorly understood subject.

The picture that presents itself is almost invariably that of a very run-down building, full of old, costly machinery, most of it in a state of disrepair; and with technicians who for many reasons are unable to master the technology.

There are some good examples, such as the highly effective and attractive workshop managed by expatriate staff

that I saw in an African country. Another one, in Latin America, had an excellent staff and well-kept machinery in spite of a leaking roof. The building had not been repaired since they moved in 25 years ago, so the floor was covered by five centimeters of water, and we had to step on bricks placed here and there to move about. But this Centre had no materials for the appliances because government "savings" measures and inflation had reduced the budget to well-nigh zero.

In another workshop I visited in Asia, they made no secret about the fact that they spent most of their time producing spare parts for private vehicles - a way of complementing their meager salaries of a few US dollars a month. Here the machines were in very good order.

And yet another one comes to mind - a workshop run by the military for their soldiers. This one was highly efficient and low-cost, turning out excellent products, with a network of 20 annexes covering the whole of the country. It was all paid for through the army budget.

A leading physician in another Asian country had the idea of producing all the required modules for the entire country in a central industry, from where they were then sent out to annexes for fitting and local alignment. Although run by a retired general, the undertaking turned out to be a costly flop.

There are some examples of efforts to manufacture appliances using low-cost technology, e.g. by having them produced by local blacksmiths or by introducing production relying exclusively on simple tools/equipment that can be totally controlled, requiring no or few external inputs. These techniques are as a rule more productive than the "conventional" ones. Box 4.7

Box 4.7. SORRY, I HAVE TO LEAVE NOW.

Once in an African country I received a telephone call from a diplomat's wife. She told me that 18 months ago she had "managed" to open a "Rehabilitation Centre" for young adolescents who were physically disabled. By now, 14 boys had been admitted. The "Centre" consisted of a large apartment she had rented, and she was supplying food, clothes and shelter for these boys. She had thought of starting some vocational training and finding jobs for them but had not yet got around to organising these activities. She had obtained some funds from the embassy, but these had now run out. Her husband was going to be transferred, and she was leaving the country. As she said that she did not want to put the boys out in the street again, she wanted the UN organisation I represented to take over this activity. Of course there was no chance for this transfer - so the boys indeed went back in the street.

Box 4.8 depicts an example of what happens when the conventional system is falling apart. Similar descriptions will be obtained in many countries when one is in a position to review the entirety of the institutions rather than the few show-cases normally shown to visitors from abroad. My comments are:
we are here confronted with a decaying system. The reasons for this decay are many. withdrawal of resources by foreign donors, lack of interest and motivation among the staff, segregation, lack of contacts between the children and their parents, negative attitudes, and discriminatory behaviour toward disabled people; there seems to be no legal protection against this enormous abuse of disabled children, adolescents and adults.

Box 4.8 WHEN CHARITY FAILS

The following text is quoted from a complete review of the existing services in an Asian country printed in a document made available to the author. There are no government institutions, all institutions are managed by NGOs. A national university department of sociology carried out the study.

Questionnaires were sent out to a total of 57 institutions, and then between two and four visits were made to all but one (which refused entry). The institutions cared for some 900 persons (in 24 centers) as boarders and for about 3,300 on an outpatient basis. Sixteen of the centers were for physically disabled, six for mentally retarded, and ten for both of these groups. Eight were for blind and four for deaf people. The rest was not specified.

Ninety-three per cent of the institutions said that they had problems of one sort or another; half of these said that they had financial problems; dealing with families of disabled people caused problems to 28 per cent, and 14 per cent reported problems in dealing with employees, etc.

The following observations were made: "Many of the institutions were initially unwilling to provide the information needed". "It was practically impossible for the team to reach the disabled for interview purposes...those responsible found this request rather threatening and expressed a distaste for the idea, to say the least...".

"Many of the institutions were located in isolated places...it continues to be unclear to the research team why the institutions...need to be located in 'out of sight' places...This raises the question of suitability of these locations

for active community participation...and the ease of access for parents and families. Many of the institutions, especially those dealing with the mentally handicapped, suffered from inadequate physical conditions. Some...required major repair, others lacked proper sanitation, and others were found simply unsuitable for being inhabited at all. In one case, the mentally disabled ward was located completely underground. It was dark and humid, with a smell mixed with a stench of human excrement. In contrast another institution - for the blind - was characterized by a sunny building, well aerated, clean, well-painted and generally full of life.

"...the large majority of the institutions that were visited lacked programmatic action. A special weakness was noted in the areas of social work, counseling and entertainment and learning through play...tended to concentrate around the areas of education and...physiotherapy... heavily dependent on mechanical manipulation of the patients...it seemed as if the organizers...saw these institutions as merely places to 'physically keep' the disabled...strong tendency...to think of technical solutions to disability problems in contrast to other forms of care needed...an excellent example...is the amazing proliferation of mechanical physiotherapy...to provide machine stimulation and relief...another example is the shamefully low level of counseling services...only [seen] in seven...The third is the lack of awareness...of social work...as a key element... Thus the machine substitutes for problem solving, socially aware, behaviorally oriented programmes...

"Personnel either lacked adequate training or was not trained at all. Some seemed to function more like attendants than persons actively involved...staff were lacking in both knowledge and attitudes...some dealt with the disabled - notably the mentally disabled - in shamefully inhuman ways. In one institution...we saw a group of about 15 children all with heads completely shaven, almost all rather smelly and obviously not receiving even the minimal amount of physical sanitation and care. It took us about half an hour to come to the stunning realization that these children were in fact girls; nothing from their external appearance could have indicated this fact. Nothing, not even the most difficult financial conditions, could justify these unspeakable conditions.

"[Administration personnel] generally lacked training in administrative skills - for instance proper record keeping - as well as a good understanding of disability care...we noted a lack of problem-solving orientation ...a general lack of interest in making the conditions in the institutions better; many were simply apathetic. It was as if...their bad fortune...led them to 'land' their present employment.

"... We noted an unmistakable absence of participation of families and of the smaller and larger community in assisting, managing and overseeing the activities. "... We noted an unmistakable absence of participation of families and of the smaller and larger community in assisting, managing and overseeing the activities.

"The attitude of those caring for the disabled in some of these institutions leaves something to be desired... We noted a sense of lethargy, a lack of enthusiasm...many of those who worked in these institutions...did not have a real commitment to working with the disabled, but rather saw their role in terms of a job and livelihood ...so why 'rock the boat'...the old 'charitable' in contrast to the 'empowering' orientation ... was strongly felt...Some of the names of these institutions reflect this approach, for instance, 'The House of Light' for the blind, or 'The Four Homes of Mercy' and...'The Charity School'."

Boxes 4.9, 4.10 and 4.11 illustrate various approaches to vocational training. These represent classical examples of respectively government- and NGO-managed conventional centers.

BOX 4.9. WHAT A WASTE OF MONEY

This Centre was built at the request of the national government and intended primarily to cover the rehabilitation needs among the heroes of the liberation war. An external donor provided the funds. It is situated at forty minutes' drive from an African capital, consists of about ten huge buildings and, so I hear, is a replica of the one in the donor's country capital. Agricultural fields and some forest, and not a house within sight surround it, if one discounts the remainder of the farm that used to be in its place, with a handful of chickens and sheep suggesting that some farming still goes on.

This Centre comprises an administration building with a big auditorium, a large number of offices, several gym halls and physiotherapy rooms to hold several hundred patients, a 25-metre-long swimming pool plus two Hubbard tanks, all empty. There are other areas for various types of therapy, a building with a big unit for surgery, pre- and post-operative emergency rooms, three theaters, several smaller units for sterilisation, and several large halls for vocational training. Six years after its construction, it stands mostly empty and unfurnished.

On our way to the vocational training unit - the purpose of our visit - we pass two very spacious rooms meant to hold twelve paraplegic patients each. It must be difficult under these conditions to prevent urinary tract infection with antibiotic-resistant bacteria from spreading among their occupants.

There are some 85 boys and ten girls receiving vocational group training in such trades as bookkeeping, carpentry, typing and basket-weaving. Accorded a cursory examination of the trainees for the type and degree of their

disabilities, I find almost all of them to be physically disabled, with sequel after polio, a few amputated, and one or two having poor eyesight. Except for one young man in a wheelchair, all of them can walk (with some minor difficulties), and all of them are able to perform ADL.

The boarding trainees are put up in simply furnished rooms and taken good care of by a staff of some 100 persons.

At the end of this visit, I calculated that the annual cost for this affair came to roughly US$4,000 per person, not counting the amortisation and the interest on the buildings and other capital costs (which amounted to some US$ 15 million). With perhaps one or two exceptions, all of the trainees could have participated in a vocational training programme for non-disabled - at a fraction of the current price.

I wondered what the Centre, with a built-in capacity for several hundred more, would look like - and cost to operate - the day it was fully occupied, when the swimming pool would have its heated water, the surgeons would operate, and an army of personnel would be there. one or two exceptions, all of the trainees could have participated in a vocational training programme for non-disabled - at a fraction of the current price. I wondered what the Centre, with a built-in capacity for several hundred more, would look like - and cost to operate - the day it was fully occupied, when the swimming pool would have its heated water, the surgeons would operate, and an army of personnel would be there.

Maybe there would be no room left for the chickens and the sheep.

BOX 4.10. SOME DO IT EXPENSIVELY, WITH NOT MUCH RESULT

This is a vocational training unit for about 25 mentally retarded adolescents in an Asian country. Some of them come from the neighborhood and go home every day by a special bus. Others come from far away and are boarding.

The trainees are taught carpentry. They have four well-trained instructors. The Centre is equipped with several expensive pieces of woodworking machinery. But these are not used, for the trainees could not learn how to operate them, and besides, they were potentially dangerous. Thus the training consists of sawing and drilling by hand and of polishing various pieces of wood with emery paper. These are then painted and sold as part of a toy set used in nursery schools.

The vocational training project had been going on for three years. During this period, just one of the trainees had been placed in a job. However, in order for the boy to get the job, one of the teachers was sent along for four months to help him adjust to the job.

The annual cost of training was US$4,000 per trainee. These costs were covered by donations, mostly from external sources.

BOX 4.11 TRAINING FOR TRAINING'S SAKE?

In this African country, the government has set up several vocational training centers for disabled people. The one I was shown was housed in some extremely spacious buildings; one could easily have had 200 trainees here. As it was, the total came to not more than about forty.

"As usual", the disabled people were trained along conventional lines. The deaf boys and girls did carpentry. The blind youths were making baskets, and the physically disabled were learning how to sew.

As regards the carpentry, the products were of such poor quality that there was no way they could ever induce anybody to buy them. The tables or chairs had uneven legs, surfaces scratch marks, etc. The basket-weaving was done with acceptable quality, but selling these baskets would earn a hard-working disabled person not more than one US dollar a day. Those who did sewing turned out fine products. But with a sewing machine available in so many households nowadays, the prospects of earning an income from this activity are nil.

The government's austerity programme did not allow the vocational training centers in that country to operate for more than about eight months last year. The trainees were sent home to wait for the next budget year to come around. Though idle over all these months, the teachers' jobs were protected by law and they continued to draw their pay.

The comments are:

(1) a lot of vocational training has been set up without previous market studies, so it is common to see that the skills acquired are of little use when it comes to earning an income;

(2) some centers are facing serious problems both concerning the quality of the training and the provision of funds;

(3) training costs as related to results in terms of probable future income-generation have not been the subject of sufficient concern;

(4) all vocational training should be preceded by vocational assessment or screening, and those capable of undergoing vocational training and of holding a job later on should be identified. In this way the costly and often-unproductive trial-and-error training can be avoided;
(5) some vocational training programmes or workshops (e.g. for mentally retarded) have been set up to provide a place where parents can send their adolescents to be looked after during day-time - a legitimate need for recreational activities that can be met adequately at a much lower cost. Including these people in a vocational training programme evidently increases the expectations of both the disabled person and the family that there will be a job later on. When this does not materialise, frustration will will grow.
(6) In the vocational area, there has been a tendency to create sheltered workshops and co-operatives. These have been set up because in many instances disabled people even when qualified, had difficulties finding a job. The underlying idea of the sheltered workshop was to provide a range of opportunities. Later on, it was thought of turning these institutions into cooperatives, i.e. units managed by the disabled people who worked there. Unfortunately, the experience has not been very positive, as will be illustrated in Box 4.12.[4]

Box 4.12.[4] CO-OPERATIVES

A review of economic co-operatives for disabled people carried out in 1985. It was estimated that there existed 400-500 such co-operatives, employing some 8,000 to 10,000 members, in the developing countries. Most of these were situated in Asia, predominantly in India. However, a large proportion of them was "dormant", and most of them experienced a quickly diminishing membership.

I have seen about 50 such co-operatives in some 30 countries. Some of these counted a few non-disabled persons among their members. Almost none of them had lived up to the expectation of providing their members with an income sufficient to support themselves or their families. A large proportion of them had for years been receiving subventions, or had subsisted on "charity income" from sales of goods 'manufactured by disabled people' organised on special occasions. The most common problems mentioned were: selling the products, low productivity of the members, products of insufficient quality, and high travel costs. Many of the co-operatives were conceived with the idea of providing "rehabilitation services", but more often than not the idea came to nothing. The review referred to above describes a number of co-operatives, but cites just one example of a successful enterprise, i.e. a co-operative in Ethiopia. I have seen five or six more where the members were able to earn an income comparable to that of an able-bodied person.

8. ANALYSIS OF THE CONVENTIONAL SYSTEM

In the following part of this chapter I will analyse some factors associated with the problems of the conventional system of rehabilitation. I do not intend to criticise the pioneers of rehabilitation. The shortcomings of the system did not become evident until after several years, and many people believed that they would be able to overcome the problems with time and patience. Besides, there were no alternatives.

I have chosen to comment on nine different factors - all interrelated. These factors are:

(a) the charity factor;
(b) the attitudes and policies concerning financing;
(c) the transfer of technology and the type of professions;
(d) the vested commercial interests;
(e) the apartheid of service delivery;
(f) the lack of parental and community involvement, including representation of disabled people;
(g) the lack of a credible evaluation system;
(h) the structuring of the conventional system,
(i) the lack of legal protection and human rights.

(a) the charity factor

The charity factor is an historical one, but continued reliance on charity may be doing more harm than good. Services for disabled people in the developing countries continue to be to a large extent concentrated in the private sector, funded by contributions collected by charity organisations.

The result is a system in which the role of the government is very small or nil. Consequently disabled

people in the developing countries rarely see public services set up to meet their needs. This has created a dependency on charity organisations, either national or international. These in their turn use lotteries, telethons, mailing, etc. as approaches, often painting a picture of disabled people that many characterise as over-emotional. In some developing countries one can see the involvement of some rich people who in reality pay very low taxes or no taxes at all. Some of these will "tax themselves", for example by providing funds for a project concerned with disabled children.

The presence of charitable funding is one of several different explanations why so many governments in the developing countries fail to provide even the most essential services for disabled people. For other "vulnerable groups" the situation is similar. Governments know that these groups are likely to attract external funds from concerned donors. Also, they might have the perception that rehabilitation is costly and not effective, and hence undeserving of public funds.

To be “charitable” is mostly seen as a positive trait. It demonstrates kindness and willingness to help less fortunate people. But charitable action in favour of disabled people is mostly “charity at a distance”: providing funds while avoiding true personal contact. It is often poorly organized, unreliable in the long run, and on a scale not large enough to achieve what is needed. Gross injustice can never be corrected by petty charity.

Some organisations are known to project images of disabled people that create feelings of guilt or pity, serve to reinforce fear, distancing and stereotyping. (Box 4.13). This type of action has developed into a pattern, as well-meaning people all over the world in the advertising and the information field have learned how to exploit the charitable emotions of the people in the industrialised countries. People donate large amounts, responding to dramatic television images showing helicopters landing at sunrise, yellow bulldozers flattening out the landscape, tent cities with mountains of blankets and canned food, and energetic young doctors seriously administering blood transfusions, their white coats flapping in the wind. One month later most is forgotten.

BOX 4.13,. NO PITY, PLEASE.

Comments on the "Jerry Lewis Muscular Dystrophy Association Telethon" made by Evan J. Kemps, Jr., Executive Director of the Disability Rights Center, USA, who himself has a disability caused by a neuromuscular disease.

"The very human desire for cures for these diseases can never justify a television show that reinforces a stigma against disabled people...With its emphasis on "poster children" and "Jerry's kids," the telethon focuses primarily on children. The innocence of children makes them ideal for use in a pity appeal. By celebrating disabled children and ignoring disabled adults, it seems to proclaim that the only socially acceptable status for disabled people is their early childhood...The telethon emphasizes the desperate helplessness of the most severely disabled. In doing so, it reinforces the public's tendency to equate handicap with total hopelessness. When a telethon makes disabling conditions seem overwhelmingly destructive, it intensifies the awkward embarrassment that the able-bodied feel around disabled people. By arousing the public's fear of the handicap itself, the telethon makes viewers more afraid of handicapped people. Playing to pity may raise money, but it also raises walls of fear between the public and us... Barriers to employment, transportation, housing and recreation can be more devastating and wasteful of our lives than the diseases from which we suffer."

The consequences for disabled people are serious. Their services need to be permanent, nothing must be hasty or likely to be forgotten next month. When the enthusiasm of donors is short-lived, disabled people become “victims” of charity.

There is no reason why disabled people should not have public services, financed with government funds - just like all other groups of people with "special needs".

Closely connected with this dependency on charity is the difficulty of getting out of emotionalism when it comes to evaluating the conventional system. Attempts at a rational review of how funds are spent and with what results frequently meet with a considerable amount of resistance. In the long run, such attitudes to accountability will lead to a loss of credibility among people who have been willing to contribute.

b) the attitudes and policies concerning financing

Some of the problems are related to attitudes or policies concerning financing. In countries where the government is responsible for the institutions, it is not infrequent to observe a "contraction" in periods of economic restructuring, with curtailment of the funds allocated for social services, including rehabilitation centers. (Box 4.11) As a consequence, the number of disabled "clients" admitted to such centers, whose funds may not allow them to stay open for more than a few months a year, is reduced. In some countries, the personnel belongs to the civil service and will be retained even if there is nothing to do.

When it comes to projects financed by external donors, one can observe that it has become customary for donors to start by insisting that they will themselves implement the project in question. After having paid considerable amounts over several years, the donor most often arranges for the project to be "taken over by the nationals". In most cases this has meant the future fund-raising is left to a national NGO. Most of these lack the necessary connections and the fund-raising capacity of the expatriates. Therefore, the situation following such transfers has tended to deteriorate quickly. Buildings are soon in a severe state of unrepair, electricity and water cut, professional staff forced to leave. The situation may slowly approaches a point where there is barely enough to clothe or feed the "inmates" (Box 4.8).

Why have so many donor projects gone wrong? It seems that many international organisations prefer to support action where a lot of money can be dispensed in a hurry, with high visibility and no intention of sustaining long-term effects.

Fortunately enough, international donor agencies exist which have understood that one needs to stay on and continue to economically support what has been started until the services are financially maintainable using national resources.

The conclusion is that one should try to re-orient the long-term role of donors. The charity approach should disappear, and contributions from the outside should be directed toward co-operating with the government in implementing the national rehabilitation plan. Rehabilitation should be an integrated part of a general community development programme. Community-based services, as opposed to institutions, will then have "grassroots", and local people who have initiated their own projects are better able to sustain them in times of austerity.

(c) the indiscriminate transfer of Western technology and types of profession

To put it in a nutshell, this transfer has not been very successful, for a number of reasons:

- some technologies do not fit well with the priorities and realities of the developing countries, while other parts are culturally not compatible;
- the effort to train personnel and to create rehabilitation teams after Western models has largely failed to give the expected results because of an inadequate understanding of how one can set up appropriate service delivery systems and rely on community self-management.

A thorough rethinking is called for. To start with, it is necessary to analyse the needs. Then, building on existing local experience, the tasks should be described and shared out realistically as part of a decentralised delivery system. Dissemination of appropriate technology - built on already existing experience - is needed; not transfer of Western technology. Further, new strategies concerning the personnel at all levels in such a system have to be developed. Relevant educational objectives should be formulated and facilities set up for training such personnel, without attempting to copy Western models. Finally, the system should be evaluated and - whenever necessary - better adapted to local conditions.

(d) the vested commercial interests

There are many organisations that, against a fee or against a certain percentage of the funds provided for the particular purpose, offer services to plan and/or execute projects, to construct and equip buildings and/or recruit personnel for rehabilitation programmes. Those responsible for such "consultant services" are primarily interested in large-scale projects and do not question the concepts, the usefulness or the cost-effectiveness of the programmes in question. They have an interest in keeping the business going and will

certainly not welcome a change.

One might also find that certain projects include training of personnel directed at the exclusive use of specific Western techniques, which necessitate the import of components or supplies. This ensures continuous sales from a particular exporting company. Attempts to change such technology meet with resistance.

(e) the apartheid of service delivery

The goal of rehabilitation is the social integration of disabled people. Unfortunately, many of the activities of the conventional system have been counterproductive and have promoted segregation. Disabled people are often kept in boarding institutions in far-away places for years, losing all contact with their families and their communities. Whenever education, vocational training or jobs are provided, a parallel system is often created. This is not done out of concern for the special needs of disabled children and adults. The main reason seems to be the wish to keep them separate, so they will not interfere with the training given to non-disabled pupils or trainees, or will not negatively influence the work performance of non-disabled employees.[5] Furthermore, services are fragmented, with components aimed at various groups of disabled people delivered separately. Services at home, at school, concerning vocational aspects, the elderly, for example, mostly have each their own separate system.

Services are maldistributed. Most of them located in the capital, with the remainder in other large cities. Rural services are rare, even in countries where between 70 and 80 per cent of the population lives in villages. Services are costly, reflecting high building, equipment and personnel costs. In addition, many of these institutions and their personnel are underutilised. In a centre that could easily receive hundreds, one might find not more than 25-50 people.

(f) the lack of parental and community involvement, including representation of disabled people

There are many examples of parents who leave their disabled child in an institution, never to return. (See Boxes 4.1, 4.2 and 4.7). Some such infants or children are secretly left on the doorstep of a centre or an orphanage in the early morning hours, leaving the centre no other choice but to take care of them. Rich parents may “export” their disabled child to another country and pay huge sums for "lifetime care".

These are examples of parental attitudes. Examples of lack of co-operation between institu-tional staff and parents have been given elsewhere (Box 4.2). Such attitudes are not easy to change.

All rehabilitation systems must build on full family involvement. Parental education should therefore be a standard component of any system.

Disabled persons who have been institutionalised for a long period of time will find it difficult to return to their communities. This is particularly true of children. Social integration can come about only if the community accepts its disabled members, takes an active role in their rehabilitation and makes an effort to re-integrate those who have been away in an institution.

Disabled people who remain in their respective communities are today seldom consulted about their views of services provided for them. All communities should find ways and means of affording them adequate representation and influence and developing their political capacity. This is not an easy task, considering that many of them are unable to take care of themselves, to move about or to communicate, in addition to lacking schooling and employment.

There are two ways in which disabled people can be represented in matters that concern them. The first is through direct participation of disabled people in political bodies such as parliament/congress, local and district councils, political parties, women's and youth organisations, labour unions and social security boards. The second is by forming their own organisations to act as pressure groups. Needless to say, all disabled people cannot be represented in such organisations. Their parents, for instance, should represent children.

Normally, organisations of this type will have very little say unless they form a national union or federation. Where this is the case, they may be officially recognised by the authorities as partners in the policy-making, planning and implementation processes concerning services for disabled people.

At present, groups of disabled people have limited direct or indirect representation in the developing countries. In some countries, the regulations in force require legal recognition of such organisations, limit

their number, and place them under government tutorship. There are examples of governments dissolving some such associations by special decree, which is equivalent to denying disabled people freedom of association.

In many instances it is the government that appoints the chairmen and executive officers from among the ranks of non-disabled professionals.

Organisations of disabled people are often split up into small groups, making themselves power-less. There are numerous problems related to their internal cohesion and administrative capacity. Most such organisations are only present in the capital or in the big cities. Very few associations have been organised in rural settings. Unions or federations are uncommon, a fact that has seriously weakened these organisations' potential role as advisors or partners of the government. Where organisations exist, they are not very representative, with "normally" just a handful of young men, either physically disabled or blind. Among their members are seldom any women or elderly persons, other groups of disabled persons and parents are often under-represented.

Today disabled people and their families are, generally speaking, powerless, lacking political influence in their own society and with little or no say in matters of immediate concern to them.

(g) the lack of a credible evaluation system

The evaluation systems applied by most organisations involved in conventional rehabilitation are either non-existent or superficial. More on this problem in Chapter Fourteen and Fifteen.

(h) the structuring of the conventional system

The problems associated with the structuring of the system into its various levels: macro-level, intermediate level and micro-level, are already mentioned in the Introduction.

The conventional system operates mainly on the intermediate level, with the macro-level (the government, the legislative and executive bodies) being mostly involved in providing symbolic policies, plans and services. At the micro-level communities and families have rarely been engaged in any activities.

The inputs from external resources - such as development/donor agencies - contribute for the most part to strengthening the intermediate sector, leaving the government believing that this is how the problems related to disabled people will finally be resolved. What is more, these inputs do not lead to community involvement, creating as they do the impression that families and communities have no part to play but merely to wait for the institutions to eventually acquire enough capacity to address the totality of the needs.

Structured that way, the system contributes to passivity on the macro- and the micro-level. What has been missing is a willingness to challenge the system as such, to point out that the conventional approach will not and cannot succeed in meeting more than a tiny proportion of the needs. And to insist that it is conceptually wrong, unrealistic and has serious side effects.

(i) the lack of legal protection and human rights

It is a matter of fact that most national constitutions accord all citizens a number of rights. These include the right to education, to employment, to services, to personal property and so forth. But there are many examples of disabled citizens being deprived of these rights. They are often refused entry to the local school; not accepted for vocational training; not given employment, even if fully qualified. They rarely receive legal assistance when their property or their land is stolen or when they suffer physical, psychological, economic or sexual abuse in institutions.

What is needed is not so much more laws to protect disabled people but application of the existing ones. To provide such protection is a major challenge for any rehabilitation programme.

9. THE BEGINNING OF THE END OF THE CONVENTIONAL SYSTEM

In the late 1960s and 1970s experts were beginning to express concern about the effecti-veness of the conventional system. One such clear expression of criticism of the way services for rehabilitation were developed was the report of a meeting of experts held in Killarney, Ireland, on 21-24 September 1969[6]; the

report stated that:

"...it is obvious that the pace at which personnel were being trained and other necessities for rehabilitation services were being developed was not adequate to meet the current problem and certainly incapable of coping with the predictable growth in the number of persons requiring professional help...

"...it is possible that an objective analysis of methods of delivering rehabilitation services will suggest measures which can serve to provide at least the most essential assistance to large numbers of people with the resources available now or in the immediate future...

"...experience in the less developed areas makes it clear that essential help may be given to disabled persons in ways which are often different from those methods established for use in industrialized and economically developed areas but are consistent with the available resources and the cultural, social, and educational patterns of the developing countries...

"...it may be possible to identify forms and patterns of services which by requiring fewer trained personnel, less advanced levels of training, simple facilities, etc., may enable the delivery of essential services to be expedited and expanded."

Having reviewed the conventional system, the experts suggested in principle:

- a change of technology,
- a new service delivery system, and
- new types of personnel.

They did not, however, propose any practical solutions. To find these was left to others, and it is easy to see why. A solution was being sought to a problem that had the appearance of being intractable. The only existing system was the "conventional" one, and it certainly did not easily lend itself to the changes discussed by the experts.

In spite of all that was said in Killarney, experts and organisations still went on claiming that the only hope for services in the future lay in the extension of the existing pattern. Well knowing that there were insurmountable problems associated with the conventional system, they had in reality concluded that rehabilitation in the developing countries is not feasible in our times.

The following summary of the situation was given in a 1976 WHO document[7]:

"...rehabilitation services are practically *non-existent or grossly inadequate in developing countries*;...

"...there is an apparent *lack of national planning and coordination* of services (medical, educational, vocational, social, etc.) in most countries...

"...medical rehabilitation services have usually concentrated on institutional care, with a *low turnover of patients at a high unit cost;...*

"...when *advanced rehabilitation services and technology have been introduced in developing countries, the result has often been discouraging or a complete failure*."

These judgments are still valid.

A recent UNESCO document states that: "The stark reality is that the great majority of children and young people with special education needs do not receive an appropriate education, if they are offered any education at all."[8]

In the last few decades, the ranks of disabled people in the developing countries needing rehabilitation have annually increased by over two million people. The resources available have remained more or less static. Thus in reality **the situation has rapidly deteriorated. We have on our hands a growing moral, social, health and economic problem of vast proportions, which we are incapable of dealing with by using the conventional system.**

COMMENTS AND REFERENCES

[1]Spending on development programmes funded by the industrialized countries is at present estimated at a total of US$ 50 billion. Based on the estimate of US$ 300-400 million, the amount spent on programmes concerning disabled people is not more than 0.6% to 0.8% of the total. Only 0.3% of the UNDP budget for the period 1988-91 was used for projects concerning disabled people, and other UN agencies spent an even smaller percentage of their regular budgets for that group. Evidently, rehabilitation programmes do not rank high on the list of development priorities.

[2]A UNESCO document reports from a study carried out in 13 African countries in 1983. These countries had a total population of 107 million. The number of disabled children receiving special education was 13,067.
Source: Children with handicaps at school in Southern and Eastern African countries. UNESCO, Paris, France, 1983.
Another example appears in E. Klingberg: Specialundervisning för blinda barn i utvecklingsländerna från 1975 till år 2000. (SHIA, Stockholm, Sweden, 1987). She estimates that in sub-Saharan Africa, the proportion of blind children receiving special education has increased from about 1% (1970) to 1.6% (1985), a very marginal increase. During the same period, primary school attendance has gone up from about 30% to about 50%.

[3]Many centers with funding problems have tried to create sheltered workshops, hoping that this would help to pay for their running costs. It appears, however, that this effort almost invariably fails.

[5]J. Gudmundsson: Cooperatives of Disabled People. The Committee for the Promotion of Aid to Cooperatives (COPAC) and the Centre for Social Development and Humanitarian Affairs of the United Nations, Vienna, Austria, December 1985.

[6]These tendencies have been described by many others. T. Jönsson quotes several reflections in this vein, among them those of Chambers and Hartman, who write that disabled children "interfere with instruction" and "absorb the energies of the teacher and make so imperative a claim upon her attention that she cannot under these circumstances properly instruct the number commonly enrolled in a class". Chronbach remarks that intelligence tests have frequently been used as an instrument to drop children "by the wayside or to vegetate in an underdemanding slow classroom". Jönsson states that "the schools these children are de-selected from are characterised by a rigid examination-oriented system with the main task of identifying children with potential for a further academic career", and he ends with a UNESCO quote: "This elitism, that is still frequently advocated, seems to justify the educational institution in rejecting in some cases over one third or even half of the children entrusted to it. Such wastage would not be tolerated in any other sector of activity."
J. G. Chambers and W.T. Hartman: Special Education Policies. Their History, Implementation, and Finance. Temple University Press, Philadelphia, USA, 1983.
L.J. Cronbach: "How can instruction be adapted to individual differences? in R.M. Gagne (Ed.) Learning and individual differences. Columbus, Ohio, USA, 1965.
T. Jönsson: Special needs education, UNESCO, Paris, France, 1992.
UNESCO: Working document ED/C/27. Paris, France, 1991.

[7]This report was published by the International Society for Rehabilitation of the Disabled and entitled "The Development of Rehabilitation Services in Relation to Available Resources".

[8]Disability Prevention and Rehabilitation. WHO document A29/INF.DOC./I, p.26, Geneva, Switzerland, 1976.

[9]T. Jönsson, ibid.