REPORT

REGIONAL WORKSHOP
ON TRAINING OF COMMUNITY HEALTH AND WELFARE WORKERS
IN REHABILITATION AND DISABILITY PREVENTION

Bacolod City, Philippines
11-25 January 1984

Manila, Philippines
June 1984
REPORT

REGIONAL WORKSHOP ON
TRAINING OF COMMUNITY HEALTH AND WELFARE WORKERS
IN REHABILITATION AND DISABILITY PREVENTION

Convened by the
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NOTE

The views expressed in this report are those of the participants in the Regional Workshop on Training of Community Health and Welfare Workers in Rehabilitation and Disability Prevention and do not necessarily reflect the policies of the World Health Organization.

This report has been prepared by the Regional Office for the Western Pacific of the World Health Organization for governments of Member States in the Region and for the participants in the Regional Workshop on Training of Community Health and Welfare Workers in Rehabilitation and Disability Prevention held in Bacolod City, Philippines on 11-25 January 1984.
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1. INTRODUCTION

The Regional Workshop on Training of Community Health and Welfare Workers in Rehabilitation and Disability Prevention (Community-Based Rehabilitation) was held in Bacolod City, Negros Occidental, the Philippines from 11 to 25 January 1984.

Participants were from the following countries or areas: Australia, China, Hong Kong, Japan, Malaysia, New Zealand, Papua New Guinea, the Philippines, the Republic of Korea, Singapore, Solomon Islands, Tonga and Viet Nam. There were four observers from the province of Negros Occidental, Philippines, and one from the WHO Collaborating Centre, at the Cumberland College of Health Sciences, Australia (Annex 1).

The 18 participants included five physicians, three occupational therapists, two social workers, one special education teacher, one vocational evaluator, one public health nurse tutor, one nursing officer, two health educators, one educational researcher and one administrator of a non-governmental organization.

2. AIM AND OBJECTIVES OF THE WORKSHOP

2.1 Aim

The aim of the workshop was to train supervisors and trainers of community health and welfare workers for their roles in preparing community health and welfare workers to care for the disabled in the community, including:

(a) collaboration between health and welfare workers in rehabilitation;

(b) planning, organization and conduct of national courses for community health and welfare workers;

(c) effective teaching of the skills of managing the various common disabilities of locomotion, sight, hearing, learning, speech, etc. in the community;

(d) elements of health education;

(e) assessment and referral of the disabled for higher level care;

(f) construction and use of simple aids for the handicapped;

(g) simple social, occupational and leisure skills;

(h) barrier-free environments for the disabled.
2.2 Objectives

The objectives of this workshop were to enable the participants:

(1) to make a plan of training courses for local supervisors on community-based rehabilitation (CBR);

(2) to organize a national workshop for local supervisors on community-based rehabilitation;

(3) to teach local supervisors how to use the manual "Training the Disabled People in the Community";

(4) to supervise the local supervisors in:

- how to involve the community,
- how to locate all the disabled in the community,
- how to identify disabilities,
- how to find out if the person needs training,
- how to select training materials,
- how to find and teach a trainer how to use training packages,
- how to guide, supervise, motivate the trainer,
- how to assess the progress made by each disabled person,
- how to keep records,
- how to achieve cooperation with the school teacher,
- how to select and refer the disabled who need other available services.

3. WORKSHOP VENUE

The reasons for the selection of the workshop venue were:

(a) It is representative of a provincial area of a developing country.

(b) It has an on-going operational community-based rehabilitation project conducted in the rural as well as the urban settings.

(c) It has the conditions where participants can gain first hand experience as to how disabled persons live and the community in which they should be rehabilitated.

(d) It has the basic components of primary health care: active community involvement, use of indigenous technology, intersectoral linkages and support mechanisms.
4. CONDUCT OF THE WORKSHOP

The opening session was convened by Dr Z. Kalinowski, workshop operational officer. Dr Liu Guo-bin, Officer-in-Charge, delivered the opening address on behalf of the Regional Director of the WHO Regional Office for the Western Pacific, Dr H. Nakajima, and subsequently officially opened the workshop.

As a group dynamics exercise, each participant was introduced by a fellow participant.

In order to distribute responsibility among participants, it was decided not to elect a workshop chairman and rapporteur. Instead, participants took turns serving as moderator for each plenary session.

The agenda was adopted by the participants (Annex 2).

The documents utilized as the basis for presentations, group work, general discussions, teaching and homework are listed and attached as Annex 3.

The working methods of the workshop emphasized active interaction among the participants, organizers, and resource persons. This was achieved through group work.

Groups were formed in various ways, i.e. arbitrary groupings, random groupings, by pairs, by professional mix. The size of each group ranged from two to nine members.

The teaching methods used were: topic presentations, demonstrations, role-playing, reviewing materials, problem-solving, case studies, working directly with disabled persons and local supervisors. There were three slide shows and two audio-visual presentations.

Plenary sessions were intended for open discussions on the results of group work.

At the end of each plenary session, a summary of the achievements of the day's activities was presented.

To measure the achievement of workshop aim and objectives, participants formulated their expectations of the workshop, evaluated the usefulness of the topics, made observations/reactions on the field studies. Besides giving an overall assessment of the workshop, participants also rated their level of understanding and capability in carrying out a community-based rehabilitation (CBR) programme.

Two field studies were conducted to learn the community-based rehabilitation system (CBRS) operations in the rural and urban sites. In the first visit, participants were divided into three groups each headed by a local team leader. In the second visit, only two groups were formed.
The purpose of the field work was to give participants the opportunity to observe the actual implementation of the CBRS project, the living conditions of the clients and families, the nature of community involvement, the use of rehabilitation intervention measures, the performance of local supervisors and impact of the project.

In the first visit, each group studied an average of eight disabled clients. Participants interacted directly with clients, their families, local supervisors and community leaders and members.

In addition, the participants gained an insight into the differences in approach encountered by the local supervisors in the implementation and management of the CBR programme in rural and urban areas. In the rural areas, there were problems such as logistical constraints due to distances, while in contrast, the urban areas showed greater density of population, more crowded living conditions and lack of sanitation facilities.

Local resource persons were invited to present special topics related to the CBR project representing the primary health care programme in Negros Occidental, special education, referral services linked with community-based rehabilitation system (CBRS), local political structure, the Association of Disabled Persons.

Several special extracurricular activities were included such as a cultural show featuring folk dances and songs presented by the CBRS clients and their families. Participants visited a vocational facility where sewing and ceramic activities were being taught to disabled clients.

Participants attended a regular "Saturday recreational programme" of CBRS clients and able-bodied children consisting of play activities aimed at socialization of children and young adults.

5. OVERVIEW OF THE COMMUNITY-BASED REHABILITATION SYSTEM IN BACOLOD CITY AND TALISAY

In 1981, the National Commission Concerning Disabled Persons launched in Bacolod City a pilot project known as the community-based rehabilitation system (CBRS) in order to field the effectiveness of the new approach conceptualized by the World Health Organization in dispensing services for disabled persons. The pilot project represents the first Philippine experience in decentralization and integration of the delivery of essential rehabilitation service in poverty areas, both urban and rural, with a view to lowering the cost of rehabilitation services and tapping a wider coverage of the disabled population.

To plan, manage and implement the pilot project, a CBRS Project Committee was organized composed of representatives from government and non-government organizations. The responsibility of the Project Committee included the drafting of the organizational structure of the CBRS programme, implementation mechanics, manpower development, and detailed planning of the CBRS programme component based on the WHO manual Training the Disabled in the Community.
Since the primary health care system of Bacolod City was still in the planning stage when the community-based rehabilitation system (CBRS) began, the Committee identified eighteen depressed barangays (slum area barangays) where volunteer workers were recruited to be trained as local supervisors. The leaders from these barangays were tapped to select their own community volunteers and discussed with their barangay residents the objectives and purposes of the community-based rehabilitation programme.

The selected volunteer workers were briefed on the project and went through two training workshops of three-day duration. The training workshops were intended to develop these volunteer workers into local supervisors. According to the WHO manual, local supervisors are responsible for training a family member to care for the disabled person in the home. The training workshop provided the local supervisors with basic knowledge on: (1) identifying disabled persons based on their needs and disabilities, (2) selecting training packages to be utilized, and (3) training family members of disabled person in the use of selected training packages.

A total of 1598 disabled persons were identified in the barangays which participated in the pilot project. Of these, only 274 are actively under the supervision of 53 local supervisors. A minimum of three disabled persons are directly under the care of a local supervisor. As soon as a client starts going to school or work, the local supervisor places the client in the second priority group and then takes on a new client. The second priority clients, who are of school or adolescent age, are encouraged to attend the Saturday recreational and vocational workshop. Special programmes like mini-olympics, educational field trips, leadership training seminars, cultural and talent development programmes are also part of the activities of the community-based rehabilitation system (CBRS).

Referral services in the Bacolod City community-based rehabilitation system (CBRS) are made accessible to local supervisors. During the initial stage of the programme, all referrals pass through the project chairman on the recommendation of the CBRS social worker. The client is then referred to the physiatrist of the Negros Occidental Rehabilitation Centre, who will refer the client to a higher level (hospital or specialist), if needed.

Part of the continuing education of the local supervisor is the organization of the weekly study sessions on the WHO manual, bi-monthly meetings conducted by the Project Chairman, and periodic seminars to which resource persons are invited such as the physiatrist, physical therapist, health educators, welfare officer and organization specialist.

To provide a parallel experience of the effectiveness of the community-based rehabilitation system (CBRS), the Project Committee piloted a rural area in August 1982. The identified town was Talisay, specifically in the barrio of Conception, a 30-minute drive from Bacolod City. The set-up that was organized in Barrio Conception was quite different for it utilized the existing primary health care manpower under the Municipal Health Office. The CBRS function was integrated into the other primary health care function, which included immunization, family planning, early intervention, nutrition, sanitation, herbal medicine and first aid.
Referrals that need special rehabilitation services are referred to the rehabilitation centre, provincial hospital or volunteer medical specialist such as the orthopaedic surgeon, eye specialist, ear specialist or psychiatrist.

Apart from the medical referral, other agencies or institutions like the special education centre, Ministry of Labour, Bureau of Employment Services, Social Welfare Department, Manpower Development Institute and technical/vocational schools are included in the referral services network of community-based rehabilitation system (CBRS).

The programme is now entering the third phase of its project implementation. This involves the following: (1) upgrading the performance of the local supervisors, particularly in the urban area which is Bacolod City; (2) evaluation of the programme as to its cost and coverage effectiveness, fulfilment of the objectives set for the disabled persons, satisfaction index of the community, changed attitude of the public and its impact; (3) development and training of the intermediate level supervision; (4) viability of expanding the community-based rehabilitation system in other barangays of Bacolod City as well as in other towns of Negros Occidental.

6. SUMMARY OF PROCEEDINGS

In order to attain the objectives set forth, the workshop covered the following topics and activities:

(1) Introduction to community-based rehabilitation;
(2) Planning and implementation of community-based rehabilitation;
(3) Involvement and role of the community;
(4) Use of the Guide for local supervisors and training packages;
(5) Manpower development;
(6) Supervisor of community-based rehabilitation;
(7) Referral services;
(8) Evaluation of community-based rehabilitation.

6.1 Introduction to community-based rehabilitation

Survey results have indicated that in all countries some 7-10 per cent of the population is disabled. Disabled persons form the most underprivileged group in societies of developing countries. They have a higher incidence of diseases and malnutrition and a higher rate of mortality; many of them live a life of absolute poverty, without dignity. They are victimized by superstition, by the belief that they are possessed by evil spirits or that their disability is a manifestation of divine punishment. Disabled persons are often socially isolated and are denied education and job opportunities.
In developing countries, 98 per cent of the disabled have no access to services at the present time. For those who receive services, institution-based rehabilitation is usually employed. Since institution-based rehabilitation is provided mainly in large cities, it is inaccessible to the majority of people who traditionally live in rural areas. Extension of institution-based rehabilitation to meet the needs of all the disabled in developing countries is unlikely to succeed.

In the 29th World Health Assembly, a resolution was adopted recommending a new policy providing essential services and training for the disabled through community-based rehabilitation, especially in developing countries. This innovative approach is an integral component of primary health care and forms part of the WHO goal of health for all by the year 2000.

The CBR approach is related to the new definition of rehabilitation formulated by a WHO Expert Committee in 1981, which states that rehabilitation not only aims at training disabled persons but also at intervening in their immediate environment to facilitate their social integration. The disabled persons themselves, their families and community should be involved and take responsibility for their rehabilitation.

Community-based rehabilitation has three essential features:

(1) focus on community involvement;
(2) use of simplified rehabilitation technology;
(3) its service delivery system.

The WHO Manual Training the Disabled in the Community was drafted in 1979, and field trials of it commenced shortly after. The feedback obtained from field tests and numerous comments from individuals and organizations were considered at the time of the first revision in 1980.

The 1980 "Experimental Manual On Training the Disabled in the Community" was then field tested more extensively. It was, by arrangement, partly or entirely translated into 15 languages. Disabled people, health workers of all categories, and experts gave their views and suggestions for improvement. Field testing was extended to cover 10 countries, and project staff carefully evaluated the content of the manual.

Now in its final version, the manual is being used as the major guide in the implementation of the community-based rehabilitation. A supplementary document "Guidelines for Translation and Adaption of the Manual" has been developed to facilitate the development of national manuals to suit different cultures, languages and conditions.
Community-based rehabilitation promotes community responsibility and reliance on local resources. Family and community members take care of the essential training for their own disabled, using local technology. A referral system is set up to meet needs that cannot be handled locally. The community with its leaders takes on the responsibility for making necessary changes in the physical environment in order to give the disabled freedom of access. It also takes on the responsibility of positively influencing societal attitudes to further the acceptance of the disabled as equal.

To make it effective, training is done in the following way. Rehabilitation programmes of proven value are chosen. These are broken down into modules, arranged in so-called "training packages" (TPs). Training packages include a short instruction for the person who introduces and supervises the training, a detailed description of the various training steps, and an evaluation sheet. The language is very simple, and the text is supported by many drawings. The training packages are given directly to the disabled person or to the family member responsible for the daily training.

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

**6.2 Planning and implementation of community-based rehabilitation**

Since rehabilitation of disabled persons is viewed as a specific health sub-programme, WHO recommends that in the planning and implementation of CBR programmes, the managerial process for national health development be used as a frame of reference. This is fully described in a document still under development entitled "A Guide on Management of Community-Based Rehabilitation".

The guidelines cover the different steps of the managerial process such as:

1. Formulation of national health policies pertaining to rehabilitation.
2. Situational analysis of the disability problem.
3. Determination of priorities.
4. The setting up of strategies: disability prevention, institution-based rehabilitation, community-based rehabilitation.
5. Outlining of programmes, manpower development and time plan, which all result in the national plan of action.
(6) Organizational structure and financial requirements.

(7) Detailed programming.

(8) Implementation, monitoring, evaluation and reprogramming.

The workshop was briefed on examples of the CBR implementation by the governments in two developing countries: Burma and Lao People's Democratic Republic. The former began with a small-scale CBR project in a selected rural area closely linked with the primary health care system. In Lao People's Democratic Republic, the starting point was augmenting the training of rehabilitation personnel to serve as a nucleus group to initiate and supervise the community-based programme.

Only certain aspects of the managerial process were taken up in the workshop and these related to the practical application of management and implementation.

Another approach is implementing community-based rehabilitation through the initiatives of non-governmental organizations such as the Bacolod City CBR project. The workshop acknowledged the important role of the nongovernmental organizations in undertaking pilot demonstration programmes, but since these would be faced with constraints of limited coverage it was recommended that for long-term operations, there would be a need for these pilot projects to be linked or integrated within existing government health systems such as primary health care.

Participants had the opportunity to describe the possibilities of planning and implementing community-based rehabilitation in their respective countries.

**Australia**

Australia has a comprehensive health and rehabilitation system which is integrated with other services, e.g. education, infant health, public health, housing and transport. There are many nongovernmental agencies for disabled people. Recently, these agencies and disabled consumers have started to establish disability resource and information centres to assist other disabled people. These agencies also provide a range of other services for disabled people such as training and education for the visually impaired, vocational training and placement, independent living, training and social rehabilitation programmes.

Despite the many services available for disabled people, there are some people who are still not reached by the services, for example: (a) people in isolated areas, (b) aboriginals who live in their tribal way, and (c) ethnic groups who may not understand English or who may have cultural reasons for hiding their disabled.

In addition, current costs are very expensive and different ways of providing some services may be appropriate.
Special programmes are now run by the Government to train aboriginal health workers who can work in their own local community. These programmes could perhaps be extended and other CBR type services introduced in the other communities mentioned. The biggest problems in introducing the CBR model will be in overcoming the entrenched attitudes of professionals currently working in an institutional model, as well as the expectation the public has that health and rehabilitation services will be provided by experts.

China

Urban areas have some form of rehabilitation services. In recent years, three rehabilitation centres have been built. A health infrastructure already exists in China with an extensive manpower base, including barefoot doctors. While rehabilitation has not been seen as important in the rural areas, it may be feasible to use the barefoot doctors to introduce community-based rehabilitation and serve as intermediate level supervisors.

The CBR concept and the many parts of the training manual could be incorporated into the content of training courses, so that the views of the social workers might be broadened, and they might help to promote this idea in the community.

Hong Kong

Rehabilitation work has long been carried out by voluntary agencies and the Government. A systematic and well-coordinated rehabilitation programme plan for the next 10 years was started in the mid-1970s, involving all the government departments concerned.

The approach of community-based rehabilitation has not yet been carried out since people are able to receive the services by direct approach or referral. In view of the increasing need of rehabilitation services and the shortage of trained personnel, it would be desirable to have a community-based rehabilitation project carried out, motivating the participation of the people in the community and making use of their own resources.

Hong Kong has many housing estates and it might be possible to start off a pilot project in the housing estates. The departments and local organizations concerned would need to be consulted first. Many practical problems might arise, depending on the support of government and local organizations. Once consent is given, it would be appropriate to involve the family members of the disabled and then the volunteers from the community.
Japan

To enable disabled persons to participate fully in society and to implement the necessary preventive, rehabilitative and protective measures, rehabilitation programmes in Japan are being carried out by the various ministries and private organizations based on major legislation enacted since the Second World War. While the State is obliged to take the final responsibility for welfare administration for the disabled, governors and mayors of local public bodies are entrusted with the task of setting up welfare offices to implement and supervise individual and concrete welfare measures. These welfare offices are systematically organized throughout the country.

The comprehensive range and scope of rehabilitation programmes in Japan are traditionally and predominantly institution-based and to introduce the CBR concept would be a new approach. Since the country already has a vast number of professionally trained personnel in every field of rehabilitation, the development of community-based rehabilitation could start with this existing resource instead of creating the different levels of manpower specified in the WHO manual Training the Disabled in the Community.

The logical move will emanate from the institutions, then out to the communities. The professionals, in order to initiate and lead the movement, will need to undergo a thorough reorientation training to enable them to understand and adapt the essential features of community-based rehabilitation. What is envisaged is that communities which are located near the area of the institutions could be the first recipients of community-based rehabilitation.

It is felt that there is great potential in exploring the usefulness of the CBR approach in the industrialized setting of Japan. However, a lot of ground work with government, local officials and bodies and private rehabilitation-related resources must be accomplished first. This process will need time, promotion, close coordination and collaboration.

Malaysia

It is necessary and important that this new concept of community-based rehabilitation be made fully known to all involved in the total health care of the individuals, families and community including the disabled. A WHO consultant has already been requested and is coming soon to Malaysia. This will provide an opportunity for Malaysia to get all the assistance required to get the message through and to promote the idea.

A workshop at the national level should be held with all related agencies such as the Ministries of Health, Education, Social Welfare Services and voluntary organizations concerned with the rehabilitation of the disabled. Thus, a task force consisting of members from related agencies may have to be formed to look into the matter. Follow-up workshops may be necessary depending on the outcome of the workshop conducted at the national level. Support from the WHO in terms of finance and materials may be required for the conduct of the workshops.
One of the training programmes conducted at the Public Health Institute which comes under the Ministry of Health is the Public Health Nursing course for public health nurses. The public health nurses provide a family-centered service and as such she has also a role to play in the care and management of the disabled and prevention of disability. The concept of community-based rehabilitation can be incorporated into the existing PHN curriculum. This would enable her not only to acquire new knowledge and greater understanding of this innovative approach, but will also enable her to become more effective in dealing with the disabled.

However, aspects related to the implementation of rehabilitation technology and its delivery system have yet to be determined by the decision-makers.

**New Zealand**

New Zealand is a self-governing country with a structured system of government services which are involved with disabled people. Many voluntary organizations have also been formed to meet the needs of disadvantaged and disabled people in the community.

It is evident that in New Zealand the health services and particularly the rehabilitation services need to be better coordinated and probably more cost-effective. The disabled persons and consumers of health services need to take more responsibility for themselves to allow better access and use of existing services.

The CBR programme as developed through WHO may be an alternative, particularly in areas which have been identified as the health service requirements of the future:

- the increasing population over age 80
- people with chronic and progressive disabilities
- the socially disadvantaged.

**Papua New Guinea**

Rehabilitation for handicapped individuals is provided for by the non-governmental organizations. However, the Government through the National Board for the Disabled recognizes and supports the importance of services for handicapped individuals.

Services for the handicapped in Papua New Guinea have increased over the years. The concept of community-based rehabilitation for handicapped individuals seems to be generally accepted among the organizations concerned. Individual organizations conduct their own CBR programmes. The CBR approach has been endorsed and promoted by the National Board for the Disabled. The setting up of rehabilitation institutions is being discouraged.
Philippines

The Philippines was among the first ten developing countries to participate in the international field-testing of the WHO manual. Thus, the concept of community-based rehabilitation was introduced into the country as early as 1979 and has been widely received with fervor. In a nation with a population of 50 million and with 80% of its people living in far-flung, inaccessible rural areas, community-based rehabilitation makes sense and seems most relevant. It truly is responsive to the needs of the disabled sector. This concept has been developed and incorporated into rehabilitation policy and is the strategy thrust for the next decade.

From the early experimentation of the pilot projects concerned with this unique approach, what has been discovered and highlighted is that local communities have their own resources in terms of political will, manpower, money and materials which could be harnessed if only the community would learn to recognize and appreciate their potential. The pioneering role and leadership of voluntary groups have been a noteworthy feature of the spread and acceptance of the concept.

Community-based rehabilitation in the country must now be integrated into the service delivery system and the establishment of the necessary linkages with existing patterns of services becomes crucial and urgent.

The Philippines can look forward to the successful implementation of community-based rehabilitation nationwide in the years to come.

Republic of Korea

The CBR system can be introduced successfully through integration into the existing health service network, which will need strengthening in its staffing and referral services. Volunteer services can also be linked with the so-called "New Community Development Movement" in the rural areas.

Before embarking on community-based rehabilitation, extensive consultation with Government authorities and concerned organizations will be necessary.

Singapore

There are residents' committees in the various housing estates. These are voluntary workers who offer their services to the community outside their normal working hours. They may be able to implement CBR programmes with the help of various clubs and associations such as the Rotary Club, Lions' Club and the Occupational Therapist Association, the Singapore Trained Nurses' Association and the People's Association, etc. Educational and vocational rehabilitation is provided by many specific voluntary welfare organizations. The training packages in the manual could be used as a reference guide. Some content may need adaptation to suit urbanized Singapore.
It might be difficult for the residents' committee and members of the various clubs and associations to give much of their time as they hold full-time employment. Community-based rehabilitation will require publicity and the setting up of an ad hoc committee to determine if there is a need for such an approach.

Solomon Islands

The Red Cross is the only agency which provides services for the handicapped who are referred by the doctor. While there is a need for community-based rehabilitation, especially on the smaller islands, it would be difficult to implement without Government funding. Non-governmental organizations cannot afford the funding needed to move around the islands.

A Government representative, especially from the Ministry of Health and medical services, should be present at this workshop. While it will take a long process to get to the right people, community-based rehabilitation should be introduced in Solomon Islands.

Tonga

Rehabilitation is carried out mainly by the Red Cross and Handicapped Children's Society.

Community-based rehabilitation is primary health care of the disabled; it should be implemented therefore as part of primary health care but not as a separate independent programme. A separate programme will only increase the already excessive bombardment of villages by agencies advocating vertical programmes and the blurring of the perception of village priorities. Rehabilitation of the disabled must be viewed in the context and perspective of the villages' total need. Thus, the training packages for specific disabilities will be useful if a family wishes to rehabilitate a disabled member. A holistic approach to the community's needs will enhance the development of realistic programmes for primary health care that are within the resources and comprehension of the people of any given community.

Rehabilitation skills should be part of the in-service training of village health workers when there is a demand from the community for such services. Intermediate supervision should be provided by public health nurses and health officer/medical assistants. The village health workers are paid or rewarded by the community whereas public health nurses and health officers are Ministry of Health employees. The non-government agencies (Red Cross and Handicapped Children's Society) should provide resources and facilities for the training of personnel and CBR services. The Ministry of Health should provide higher technical assistance, referral system and the infrastructure necessary for continuous supervision, maintenance, monitoring and quality control.
Community-based rehabilitation should be implemented in stages:

(a) The manual should be adapted and translated.

(b) A workshop for intermediate and higher level supervisors should be carried out to define disabilities needing rehabilitation, to rank rehabilitation in order of need, and to establish and accept a formal structure for community-based rehabilitation as part of the social health services.

(c) Training of health officers and public health nurses as local and intermediate supervisors.

(d) Social preparation.

(e) Implementation of client rehabilitation.

(f) Assessment and programming.

**Viet Nam**

After the war, there has been a great number of disabled persons in the country. Since the 1945 August Revolution, concrete and active measures have been taken to improve the care of the disabled. The programme of activities for the disabled is decided by the Government and the Ministry of War Invalids and Social Affairs.

It seems that what has been seen and studied in the workshop can be applied to the conditions and services for the disabled in Viet Nam.

6.3 Involvement and role of the community

There is marked evidence of the active involvement of the community in the Bacolod City project. This is a vital ingredient for the success of community-based rehabilitation. The local officials have expressed full support of the project since it encourages self-reliance and develops community awareness and acceptance of the disabled.

The families feel relieved of the heavy burden of caring for the disabled in their midst, having received new knowledge and skills in training the disabled. All this has resulted in the improvement of the quality of life of the disabled by their gaining access to the basic services of the community such as schooling, recreation, religion, culture and income-generating activities.

The disabled persons who have benefited from the project are beginning to organize themselves and are taking responsibility for the training of other disabled people to achieve social integration. It is vital that they eventually participate in decision-making activities which affect their welfare and also take part in the evaluation of the quality of services.

It is significant that attitudes towards disabled persons are changing at different levels of the community. This can be attributed to the new information made available to the community and to its increased exposure to and interaction with disabled persons.
6.4 Use of the Guide for local supervisors and training packages

The workshop discussed the different parts of the Local Supervisors Guide. The simple methods of location and identification of different disabilities were analysed and subsequently the participants demonstrated these methods through role-playing. The instrument used for initial screening and identification of individuals who need training is the same instrument used in assessing the progress of the disabled. The local supervisors indicated that they had no difficulty in using the questionnaire. The problem was in the updating of the information.

The more commonly used training packages were reviewed by the participants, who had the opportunity to apply the training techniques on the disabled themselves. They also demonstrated the most effective ways of teaching local supervisors, particularly training skills.

Emphasis was placed on the use of indigenous materials in fabricating low-cost appropriate aids and devices for disabled people. During the field visits, participants actually saw these aids used to enhance mobility, physical support and independence. A video-tape movie was shown to demonstrate the actual production of low-cost aids out of indigenous materials.

6.5 Manpower development

The workshop pointed out the need to develop different categories of manpower for CBR programmes.

The training of local supervisors is outlined in the "Guide for Intermediate Local Supervisors".

The next level of manpower needed is the intermediate level supervisor responsible for the teaching and supervision of local supervisors. In view of the different health manpower structures, each country must identify and determine its manpower resources suitable for community-based programmes. Personnel such as the community health nurse can serve as rehabilitation supervisor upon completing an additional course on community-based rehabilitation. Existing rehabilitation professionals could be reoriented to serve as intermediate supervisors or at a higher level.

6.6 Supervision of community-based rehabilitation

The workshop discussed the tasks involved in supervision of local supervisors, which include coordination, communication, control and assessment of the performance of local supervisors, teaching, motivating and dealing with problems and conflicts. The time element used in supervision is an important factor to be considered in planning community-based rehabilitation. This will vary according to whether or not the supervisor is paid or on a voluntary basis. Incentives to local supervisors should be forthcoming in order to sustain their interest and enthusiasm.
The ultimate quality of the programme will be dependent on the calibre of the intermediate level supervisors and continued training of the local supervisor.

6.7 Referral services

A comprehensive presentation on the referral services associated with the Bacolod City project was given, which highlighted the array of community resources available, both government and non-government.

It was stressed that community-based rehabilitation personnel should know how, when and where to make a referral, and how to follow up the services given at the referral level. It was also emphasized that not all clients would benefit from a referral. Referral services would therefore involve making right judgements and it was indicated that the local supervisors needed assistance in this respect.

6.8 Evaluation of community-based rehabilitation

An overview of "Guide to Management of Community-Based Rehabilitation - Module Nine: Evaluation and Programming" was presented. The terms used in the module were defined and explained. These included reporting, monitoring, evaluation, reprogramming and information.

Reporting was seen as the relaying of requested information and was examined in terms of what to report (content), how to report (form), and to whom the reports are made (procedure).

Monitoring involves checking the reports for accuracy, completeness and reliability and the processing of data into usable statistics.

The definition of evaluation as judgement was discussed. The factors defined by WHO for evaluation were then considered. These include:

(1) Relevance - Did the programme respond to an essential need?
(2) Adequacy - Did the programme fit into the general health policy of the country?
(3) Progress - Were the time targets achieved?
(4) Efficiency - In view of the resources used, are the results adequate?
(5) Effectiveness - Did the programme lead to the planned change?
(6) Impact - Did the programme affect the development in a positive way?

Reprogramming was seen as a response to evaluation where modifications to a programme are required.
Information is important for policy making and may be provided for external audiences, such as the general public, or as internal information for programme staff.

7. EXPECTATIONS AND EVALUATION RESULTS

Evaluation instruments were distributed at the mid-point of the workshop. Evaluation I with 21 questions was intended to measure the participants' opinion on the usefulness of the key workshop teaching methods and topics.

The results showed that group work scored as the most useful teaching method, followed by field study. "Attitude towards the Disabled Persons" and "The Role of the Community" were the most appreciated among the topic presentations.

Evaluation II focused on the overall evaluation of the workshop and consisted of 23 statements, which were rated on a four-point scale indicating agreement or disagreement. Participants were free to make any additional comments on the workshop.

The evaluation on the administrative aspects of the workshop was not too satisfactory. It was strongly felt that not enough information on the workshop format and travel arrangements were given to the participants prior to their departure from their country.

Aspects related to the relevance and utility of working methods were very satisfactory as well as those related to organization of the workshop. The time allocated for discussion, field study, and homework was considered satisfactory. With respect to the knowledge gained at the workshop, participants indicated that they gained a high degree of confidence to enable them to start a community-based rehabilitation programme and conduct a community-based rehabilitation training workshop in their own country.

8. RECOMMENDATIONS

(1) WHO should continuously remind the Member States to strengthen efforts aimed at the development and implementation of the CBR and disability prevention programme as a strategy for Health for All by the Year 2000.

(2) In view of the need to intensify the promotion of the CBR concept, WHO should take action on the collection and development of information, reference/technical materials and their dissemination to concerned parties throughout the Region.
(3) WHO should support national workshops on community-based rehabilitation within the Region in order to develop a task force of intermediate level supervisors.

(4) WHO should provide support to Member States in the translation, adaptation, and printing of the Manual on "Training the Disabled People in the Community".

(5) Several participants expressed the view that WHO should collaborate with those developed countries which intend to adopt the CBR approach as complementary to their existing rehabilitation delivery system.

(6) WHO should organize subsequent regional workshops for potential implementors of community-based rehabilitation (CBR), taking into account those Member States not represented in this first Regional Workshop on Training of Community Health and Welfare Workers on Rehabilitation.

(7) Future workshops on community-based rehabilitation should be conducted in areas where ongoing CBR programmes are operational to enable participants to have actual exposure to CBR field conditions.

(8) The duration of WHO regional workshops on training of CBR implementors should not be less than two weeks.

(9) Composition of the workshop participants should always include professionals of different backgrounds to encourage a holistic approach in the exchange of ideas, knowledge, skills, and experiences (educators, therapists, doctors, administrators, social workers, nurses, psychologists, mental health workers, community leaders, etc.).

(10) In order to ensure the appropriate integration and linkage of community-based rehabilitation with the primary health care system, administrators and/or practitioners involved in the implementation of primary health care should be included in the workshop.

(11) To give participants a broad perspective of the community, the workshop suggested that local community people serve as resource persons in future workshops (teachers, local officials, family members, civic leaders, other primary health care providers, health educators, social welfare workers, etc.).

(12) Future workshops should invite representatives of disabled persons' organizations to be participants, observers, and/or resource persons so that participants can gain a better insight into the total situation of disabled persons.
(13) As a follow-up of this Regional Workshop, it is recommended that WHO should maintain continuous communication with the participants, through channels to assess the developments in the implementation of community-based rehabilitation in their respective countries.

(14) The workshop believes that WHO should initiate and/or support the conduct of action-oriented research projects on community-based rehabilitation.

(15) WHO should take urgent steps to determine the specific functions and role in disability prevention and rehabilitation of the designated WHO regional collaborating centres to enable both developed and developing countries to avail themselves of their resources and services.

(16) In anticipation of the growing demand for assistance in the development of community-based rehabilitation (CBR) within the Region, there is a need for the strengthening of the resource capability of the Regional Office to meet the demand.
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AGENDA

Wednesday, 11 January

0830 Registration
Convenor: Dr Z. Kalinowski

0900 Welcome Programme

1030 Introduction

Opening address by the Regional Director of WHO
Read by Dr Liu Guo-Bin

1100 Introduction of Participants

Administrative remarks

Objective and conduct of the meeting

Adoption of the agenda

1145 Introduction to "Training the Disabled People in the Community" - Slide show
- Ms G. Nelson

1230 LUNCH BREAK

1400 WHO Community-Based Rehabilitation (CBR) Programme - Ms G. Nelson

1530 COFFEE BREAK

1545 Presentation

Community-Based Rehabilitation System (CBRS) in Bacolod City, Concepcion and Talisay
- Ms J. Valdez

1545 Summary of day's activities - Professor C. Floro

1700 Adjournment

Thursday, 12 January

0830 Field Visit No. 1 to Bacolod City and Talisay, Concepcion (3 groups)

1330 LUNCH BREAK

1500 Adjournment
Annex 2

Friday, 13 January

Moderator: Dr Sitaleki Finau (Tonga)

0830 General discussion on the observations during the field visit

1030 COFFEE BREAK

1045 Presentation

Primary Health Care Programme in Negros Occidental - Ms H. Rivera

General Discussion

1230 LUNCH BREAK

1400 Field testing of the manual and the magnitude of the disability problem - Ms G. Nelson

1530 COFFEE BREAK

1545 Managing Community-Based Rehabilitation (WHO RHB 83.3) - Ms G. Nelson

1645 Summary of day's activities - Professor C. Floro

1700 Adjournment

Homework: Read Guide for Local Supervisor

Saturday, 14 January

0915 Departure from the Hotel

1000 Visit to CBRS recreational workshop at Negros Occidental Rehabilitation Center

1200 LUNCH BREAK

1500 Visit to CBRS vocational workshop

2000 Cultural show of disabled persons
Monday, 16 January

Moderator: Mr Kanetoshi Hattori (Japan)

0930  Presentation
Planning and implementation of the CBR Programme
- Dr Z. Kalinowski
- Ms G. Nelson

0945  Group discussion (3 groups)

1030  COFFEE BREAK

1045  Group discussion (cont'd)

1230  LUNCH BREAK

1400  Group Reports

1530  COFFEE BREAK

1545  Guidelines for translation and adaptation of the manual (WHO Document RHB/83.2)
- Ms G. Nelson

1645  Summary of day’s activities
- Professor C. Floro

1700  Adjournment

Homework: Read Guide for Community Leaders

Tuesday, 17 January

Moderator: Ms Laura Yeung-Youan Chi-Kwan (Hong Kong)

0830  Presentation
Attitudes Towards Disabled People
- Professor C. Floro

General discussion

0930  The Role of the Disabled Persons in the Community
- Mr F. Tuazon
- Ms M.C. Regis

Panel discussion with disabled people

1030  COFFEE BREAK
Annex 2

1045  Role of the Community - Mr E. Parenas

Barangay Captain's view and his role and Community Involvement in the CBR Programme
- Mr E. Deorna
- Mr C. Mejorada

Group discussion (3 groups)

General discussion

1230  LUNCH BREAK

1400  How to identify people with disability
- Ms G. Nelson

Introduction of group work

1530  COFFEE BREAK

1545  Demonstration of group work

1645  Summary of day's activities
- Professor C. Floro

1700  Adjournment

Homework: Read Training Package Nos. 3, 4, 5, 12, 13, 27

Wednesday, 18 January

Moderator: Dr Kwang-Yoon Seo
(Republic of Korea)

0830  How to find out whether the disabled need training - Ms G. Nelson

0900  Presentation

Importance of Breastfeeding - Dr S. Elegado

Training Package No. 26 - Ms G.L. Chua

0930  Play Activities Training Package No. 27
- Ms J. Valdez

Group Work (5 groups)

Disabled and non-disabled children are participating

1030  COFFEE BREAK
1045 Group work (cont'd)
1145 General discussion on: "Use of Play Activities"
1230 LUNCH BREAK
1400 Presentation
Special Education in Bacolod City
- Ms Tenerife
General Discussion
1500 "Schooling for Disabled Children and Adults"
Guide for School Teacher
- Ms G. Nelson
1530 COFFEE BREAK
1545 How to teach a family member of a person who has fits using Training Package No. 1, 2.
Demonstration/Local Supervisor
- Ms J. Valdez
General discussion
Summary of day's activities
- Professor C. Floro
1700 Adjournment
Homework: Group 1 - Read TP Nos. 1, 2;
Group 3 - Read TP Nos. 6, 7, 8; Group 4 - Read
TP Nos. 9, 10, 11; All Groups - Read TP Nos.
17, 18, 19, 20, 21, 22, 23, 24, 25

Thursday, 19 January

Moderator: Ms Hazel Beth Gordon (New Zealand)
0830 Training of Local Supervisors, Teaching Methods
- Professor C. Floro
0900 How to Teach Local Supervisors to Use the Training Packages - Participation of disabled persons
Group work - Ms G. Nelson
Group 1 : TP Nos. 1, 2
Group 2 : TP Nos. 3, 4, 5
Group 3 : TP Nos. 6, 7, 8
Group 4 : TP Nos. 9, 10, 11
Group 5 : TP Nos. 12, 13
Annex 2

1030  COFFEE BREAK

1045  Demonstration of group work

1200  General discussion

1230  LUNCH BREAK

1400  How to Teach Local Supervisors to Use the Training Packages Nos. 17, 18, 19, 20, 21, 22, 23, 24, 25: Introduction - Ms G. Nelson

Group work (5 groups)

1530  COFFEE BREAK

1545  Demonstration of group work

1630  General discussion

1645  Summary of the day's activities - Professor C. Floro

1700  Adjournment

Homework: Read Training Package 30, 31, 32

Friday, 20 January

Moderator: Ms Molong Taita (Papua New Guinea)

0830  Field visit No. 2: (2 Groups)

1230  LUNCH BREAK

1400  Group reports on the field visit

General discussion

1515  Recording, Reporting on the Community-Based Rehabilitation - Ms G. Nelson

1530  COFFEE BREAK

1545  Job placement

Introduction: How to use the training packages No. 32 - Ms G. Nelson

Group discussion (3 groups)

Group reports - general discussion
Monday, 23 January

Moderator: Mr Charlie Kelly (Solomon Islands)

0830  Supervision of the Community-Based Rehabilitation
      - Ms G. Nelson
      Group work (3 groups)

0945  Group reports
      General discussion

1030  COFFEE BREAK

1045  Presentation
      Training of Manpower for the Community-Based Rehabilitation and Referral Rehabilitation Services in Lao People's Democratic Republic
      - Dr Z. Kalinowski

1130  WHO Recommendations on Manpower Development for CBR
      - Ms G. Nelson

1230  LUNCH BREAK

1400  Presentation
      Manufacture of low cost, locally designed rehabilitation aids, video tape
      - Dr Z. Kalinowski
      General discussion

1530  COFFEE BREAK

1545  Presentation
      Evaluation of the Community-Based Rehabilitation Programme
      - Mr H. Davey
      Group work (5 groups)

1615  General discussion

1645  Summary of the day's activities
      - Professor C. Floro

1700  Adjournment
Annex 2

1645 Summary of the day's activities
- Professor C. Floro

1700 Adjournment

Tuesday, 24 January

Moderator: Ms Halimatulsaadiah Haji Mahmud (Malaysia)

0830 Presentation
Referral Services for CBRS, Bacolod City and Talisay, Concepcion
- Dr P. Cammayo

0930 Referral Services, Local Supervisors Guide, Intermediate-Level Supervisor Guide
- Ms G. Nelson

General discussion

1030 COFFEE BREAK

1100 Presentation
Disability Prevention as Component of CBR
- Dr Z. Kalinowski

1230 LUNCH BREAK

1400 Introduction: Designing with Care, slide show - Ms G. Nelson

1445 Open for topics that participants want to highlight

1530 COFFEE BREAK

1545 Open for topics that participants want to highlight (cont'd)

1645 Summary of the day's activities
- Professor C. Floro

1700 Adjournment
ANNEX 3

WORKING DOCUMENTS

1. "TRAINING DISABLED PEOPLE IN THE COMMUNITY"
   A Manual on Community-Based Rehabilitation for Developing Countries
   E. Helander, P. Mendis, G. Nelson (WHO/RHB/83.1)

2. "MANAGING COMMUNITY-BASED REHABILITATION"
   E. Helander (WHO/RHB/83.3 - Draft)

3. "INTERMEDIATE LEVEL SUPERVISION OF COMMUNITY-BASED REHABILITATION"
   P. Mendis, G. Nelson (WHO/RHB/83.4 - Draft)

4. "GUIDELINES FOR TRANSLATION AND ADAPTATION OF THE MANUAL"
   E. Helander, P. Mendis, G. Nelson (WHO/RHB/83.2)

5. REPORTS ON SPECIFIC TECHNICAL MATTERS, DISABILITY PREVENTION AND
   REHABILITATION (WHO A29/INF DOC/1/1976)

6. COMMUNITY-BASED REHABILITATION REPORT OF A WHO INTERREGIONAL
   CONSULTATION, SRI LANKA, 1982 (RHB/IR/82.1)

7. DISABILITY PREVENTION AND REHABILITATION, TECHNICAL REPORT SERIES 668
   WHO 1981

8. "DESIGNING WITH CARE, A GUIDE TO ADAPTATION OF THE BUILT ENVIRONMENT
   FOR DISABLED PERSONS, UN 1981" HABITAT, WITH ACCOMPANYING AUDIO-VISUAL
SUMMARY OF PAPER PRESENTATIONS

I. PRIMARY HEALTH CARE IN NEGROS OCCIDENTAL - by Mrs D. Rivera

The right to health is as basic human right as the right to live.

While the promotion and protection of health is the responsibility of government, the responsibility for making a healthy citizenry is as much the concern of the individual, his family and of the community.

Many children die not only for lack of medical attention but also from ignorance and indifference. Thus understanding good health is the key to a strong and healthy people. A strong and healthy citizenry means a strong and healthy nation.

Primary health care is an approach to health development carried out through a set of activities to ensure the continuous improvement and maintenance of the health status of the community. This envisages the community defining its own health problems and needs; and deriving and carrying out programmes or activities to solve them in partnership with the government and the private sector.

As an approach to health development, primary health care must provide, among others, essential health care which is: community-based, accessible, acceptable, sustainable at a cost which the community and the government can afford and interrelated with the overall socioeconomic development.

This implies health knowledge made available to the community; health services within the reach of the people; health programmes using appropriate technology and resources available in the community; in short, self-reliance in health.

The essential health service includes: education on prevailing health problems and the methods of prevention and control; adequate shelter; maternal and child care, including family planning; immunization; prevention and control of common diseases and injuries; and availability of essential drugs.

Primary health care is a programme based on the community's awareness of its health needs, planned and designed in the light of its socio-economic and practical conditions and sustained by active community involvement in concert with government and private agencies.

It is also a programme in which people are actively involved in: understanding and assuming their own condition; identifying their health needs; and planning and carrying out solutions with the support of the various sectors in the community.
II. ATTITUDES TOWARDS DISABLED PEOPLE - by Professor C.A. Floro

An attitude has been defined as a tendency to behave or react in a certain way and is considered both a psychological and social phenomenon long linked with disabled people. Attitudes have a role in the origin of impairment and its progress to functional limitation and eventual disability.

Attitudes vary from society to society. A disabled person may be rejected or neglected in one society yet in another society he may be revered or considered valuable. In recent years, attitudes towards the disabled have undergone remarkable changes although some prevailing attitudes of the non-disabled can still be characterized by misinformation, discrimination and wariness.

Yuker (1977), in his article "Attitudes of the General Public Toward Handicapped Individuals", aptly described the nature of attitudes wherein he indicated that attitudes have three major elements: a belief element, emotional element, and an action element. Beliefs may be positive or negative which consequently generate corresponding positive or negative feelings. Positive beliefs and feelings result in a tendency to move and to act favourably toward the object of the attitude, while beliefs and emotions which are uncomplimentary or negative will produce tendencies to avoid or behave negatively towards the object.

Attitudes are learned and are acquired through specific experience, contact and information relating to disabled people. There is no absolute correspondence between beliefs and feelings on the one hand, and behaviour on the other since it is common to see inconsistencies between what people think and feel, what they say, and how they act. All these are influenced by a combination of social and physical environmental factors, prevailing societal standards, norms and values, level of public understanding and commitment.

In his article, Yuker also stated some common attitudes towards different disability groups, and related these with a disability hierarchy, where different handicaps were ranked according to comparative acceptability under various sets of conditions. Five classes were summarized: (1) Among the most acceptable disabilities are those comparatively minor such as partial blindness, deafness, speech impairments; (2) Next most acceptable are those having lost one or two extremities through paralysis or amputation; (3) In the middle category were those with complete sensory losses; (4) The mentally ill were not accepted and usually rejected; (5) At the bottom of the list of acceptability were those who had deformities, exhibited, uncoordinated and unpredictable behaviour.

Various ways of changing attitudes was suggested by Yuker: (1) education and information; (2) messages through a media mix; (3) people delivering messages should have credibility, stature and power; (4) understanding the dynamics of recipient behaviour; (5) improvement in the kind and frequency of interaction between the disabled and non-disabled; (6) public commitment; (7) indirect techniques such as integration, changing disabled persons, removal of social and physical barriers.

III. IMPORTANCE OF BREASTFEEDING - by Dr Suzette Elegado

Studies have shown that mother's milk is the best milk for babies. Several advantages of breastfeeding have been cited. Most of all, mother's milk contains adequate nutrients and it is more digestible. It is rarely allergenic and is safer - as it is practically free from pathogenic microorganisms. The milk needs no sterilization and is readily available to the infant at the proper temperature. And besides, the milk will cost nothing to the family, thereby making it very economical.

But despite all these advantages, a large number of women are still resorting to bottle feeding. It can be said that when women found more opportunities to work outside the home, the practice of breastfeeding declined. For one thing, women want to go back to work soon after delivery.

Women also now regard breastfeeding as unsophisticated, old-fashioned and bad for the figure. Psychological factors like pain, fear or embarrassment and other feelings of anxiety or repression have also contributed to the low appeal of breastfeeding.

Moreover, breastmilk substitutes are being extensively promoted by infant formula manufacturers.

It is hoped that in the coming years, the campaign for breastfeeding will be intensified, more particularly, in developing countries.

IV. TRAINING OF LOCAL SUPERVISORS AND TEACHING METHODS - by Professor C. Floro

The teacher-learner interaction takes place in all phases of community-based rehabilitation involving the intermediate supervisor, local supervisor, family, trainers, disabled person and the community itself.

The training of the local supervisor is aimed at preparing them to adequately function in the job of providing meaningful and appropriate community-based rehabilitation services within their immediate community. Teaching, then, should selectively be focused on the real disability-related problems of the community and on concrete content and specific tasks the "learner" is expected to master and do.

To achieve this, optimal learning conditions should be created to enable the local supervisor to grasp and use new knowledge and information, develop the ability to understand, analyse and evaluate situations, gain practical skills, establish good habits, and foster positive attitudes.

Prerequisite data are needed in order to draw up a personality profile of each local supervisor as a potential and unique student and teacher. His/her level of education, ability, special qualification, social and cultural background, motivation, interest and expectations are vital.
A wide variety of teaching methods can be incorporated into training workshops or on-the-job experience. Each different method offers multidimensional opportunities for learning, and some of these methods are: group discussions and presentations, field work, role-playing, real life situations, demonstrations, self-learning, talking and lectures, plenary sessions. Through the creative combination of teaching media, these methods can be greatly enhanced and reinforced; flip charts, blackboards, photographs, graphics, overhead projection, movies, audiovisuals and cassette recordings.

Adopting the principles of teaching and learning is a key to implementing effectively community-based rehabilitation where training is viewed as a dynamic and continuous process.

V. AN APPROACH TO THE DEVELOPMENT OF REHABILITATION MANPOWER IN LAO PEOPLE'S DEMOCRATIC REPUBLIC - by Dr Z. Kalinowski

The presentation was focused on the training programme of the intermediate level medical and technical rehabilitation personnel, i.e. physiotherapists and orthopaedic technicians.

Physiotherapists

The present school curriculum has been gradually reoriented toward community-based rehabilitation tasks and functions. The ultimate purpose of this reorientation programme is to develop a multipurpose medical rehabilitation therapists (MMRTH). In this view, the training syllabus comprises four main components:

(1) General background preparation. It aims at providing the essential knowledge on the function of the human body, biomechanics, physiology, conditions leading to disability, hygiene, principles in management and organization of functional rehabilitation and vocational/social integration, etc.

(2) Standardized rehabilitation technology. The basic objectives of this component is to train MMRTH in more advanced techniques of functional assessment of the disabled, initial diagnosis of a definite impairment or disability, activity type of rehabilitation therapies, corrective and identification of the disabled for specific medical or rehabilitation treatment.

(3) Basic rehabilitation technology. As the tasks of trainers/supervisors of the community health workers will be assumed by MMRTH, he/she is trained in basic rehabilitation techniques included in the WHO manual Training Disabled People in the Community.

(4) Prevention of disabilities. This fourth training component is directed towards education on appropriate measures and techniques relating to primary, secondary and tertiary prevention.
The main tasks and functions of MRRTH are: the delivery of functional therapies for various key disabilities, at appropriate referral levels, the development of community-based rehabilitation including training and technical back-up to community health care workers, the referral of the disabled and support to the ongoing preventive country programmes.

This overall approach tends to develop a category of personnel who can be equally used at all levels of care including the management of community-based rehabilitation project. The benefit of such linkage is many-sided, e.g. allows the elaboration of an integrated school syllabus; generates a better involvement in and comprehension of the overall disability problem; saves available funds, qualified manpower and material resources to be used for training of two-level rehabilitation personnel and finally ensures a unified organization and/or integration of rehabilitation into the primary and general health care systems.

Orthopaedic technicians

Like the physiotherapists, this category of technical rehabilitation personnel has been trained since 1981. The school curriculum and tasks of the orthopaedic technicians have been gradually reoriented towards the development and production of low-cost rehabilitation aids and components based on the locally available materials.

The orthopaedic technicians are assigned at the provincial level and are the members of the provincial rehabilitation teams. Their professional assistance and technical skills will be used to support CBRD, including training of local manufacturers in the production or installation of simple rehabilitation aids at the disabled home and surrounding.

VI. REFERRAL SERVICES FOR THE COMMUNITY-BASED REHABILITATION PROGRAMME - BACOLOD CITY PILOT PROJECT - by Dr Primitivo T. Cammayo

Referral services and a system of referral is an integral part of any community-based rehabilitation programme. The rehabilitation process is often facilitated and shortened if a referral service is available.

The referral services that may exist in a community from which disabled people may benefit are: (1) health posts, health dispensary, health centres; (2) hospitals; (3) vocational training and agricultural training schools; (4) several development organizations; (5) religious institutions and civic organizations; (6) social welfare organization, social assistance programme and child care programme; (7) rehabilitation centres; (8) special schools and vocational training institutions for disabled persons.
Annex 4

From the start of the CBRS in 1981 up to the present, more than four hundred clients have been referred in various agencies and in different levels. Out of the total, 314 clients with different disabilities have been diagnosed by a psychiatrist. After the initial assessment of the disabled person, he is referred to a specialist if there is a need. So far, 38 have been referred to an ophthalmologist; 21 to an internist; 19 clients with strange behaviour and mental disorders to a psychiatrist; 22 to a general surgeon and 12 children to a paediatrician.

CBRS communities have also referred clients for surgery. These surgeries, mostly sponsored by civic organizations, include cleft lip/palate, cataract extraction, eyeball enucleation, amputations, squint correction and suprapubic systostomy. Still part of the medical referrals are X-rays, blood examination, routine urine analysis, stool examination, ENG-NCV, EEG and audiometry. This is made possible through the cooperation extended by the provincial hospital.

A total of sixty technical aids have been provided to disabled clients through the local supervisors. These aids are divided into 19 crutches, 14 wheelchairs, 5 braces, 5 walking sticks, 1 prosthesis, 1 pair eyeglasses and 15 other appliances like chairs, play, home modifications and educational materials.

In the programme, one hundred sixty disabled children and youth comprise the school age group. Out of this total, forty-three are enrolled in normal schools; eight are with the Special Education Centre and ten pre-schoolers are enrolled with the barangay day care centres.

Working age group population totals a number of seventy five. Sixteen disabled adults are employed and three have been placed by the CBRS project committee after undergoing a skill training programme at the National Manpower Training Centre.

Special programmes are also organized by the Project Committee. These are mini olympics, cultural shows, talent enhancement programme, recreational workshop, picnics, educational field trips and leadership seminars.

The referral services network of CBRS, at its current organizational level, cannot yet fully respond to the needs. Vulnerable areas include skills training, job placement and livelihood programmes and accessibility as limited by barriers in the community.
VII. PREVENTION OF DISABILITIES - by Dr Z. Kalinowski

Developing countries

Essential preventive measures and services which could be provided by the intermediate level rehabilitation personnel (physiotherapists, multipurpose rehabilitation therapist) at the community level were outlined in relation to the primary, secondary and tertiary preventive interventions.

(1) Primary prevention

Primary prevention comprises all measures that have to be taken to reduce the incidence rate of any kind of disability.

Preventive measures:

- child nutritional programme, nutritional education, immunization, safe water and sanitation, maternal and child improved care and health education.

Training programme:

- factual knowledge on typical communicable diseases, mechanisms of their spread, interrelated environmental conditions and their control, selected topics on food hygiene and standards and anthropometric indicators of nutritional status.

Tasks: health education at the community, family, school and center level.

(2) Secondary prevention

Secondary prevention includes all measures (medical, rehabilitative and social) which are necessary to correct or to reduce an aggravation of the already existing impairments.

Preventive measures:

- early detection and treatment, early stimulation of a child's overall development, prophylaxis of unfavourable conditions due for example to immobilization or disuse, community support, income maintenance, counselling and education.

Training programme

- fundamental measures of early detection (first level) of definite defects, early stimulation and application of appropriate corrective measures (active or passive), functional assessment, identification of the disabled for referral to other forms or levels of care.
Annex 4

Tasks

Provision of the above-mentioned services and training of the community health care workers.

The experience from Lao People's Democratic Republic has demonstrated that the physiotherapists have competently performed these tasks at the centre or home levels. At this stage, their training syllabus is being reoriented toward community-based tasks.

It has also been emphasized that the training in the secondary preventive measures has to be competency-based.

(3) Tertiary prevention

Tertiary prevention involves all health and non-health actions which tend to limit the impact of an impairment or disability on the social, professional or personal life of an individual.

Preventive measures

- appropriate technology and environmental adaptation, prosthetics/orthotics (low cost), training the disabled in self-care and vocation, mobility and transport assistance, employment possibilities, community support and income assistance, good management, training opportunities for leisure and recreation and psychological support and administration.

Training programme

- training the disabled in self-care, mobility, utilization of rehabilitation aids, organization of community support and opportunities for leisure and recreation.

Tasks

Training of the community health care workers and supervision of their activities and provision of the services outlined above to the disabled at the home and centre level.

In order to assure the disabled of a specific adaptation of their closest surrounding or the provision of rehabilitation aids, a rehabilitation therapist works in close cooperation with the orthopaedic technician.

The implementation of a full scale tertiary preventive programme requires, however, the support and cooperation of other national institutions and non-health sectors.
VIII. MANUFACTURE OF LOW-COST, LOCALLY DESIGNED REHABILITATION AIDS AND THEIR PRACTICAL APPLICATION AT THE COMMUNITY LEVEL -
by Dr Z. Kalinowski

The activities of the above-titled training course conducted in Vientiane, Lao People's Democratic Republic (20 December 1983-4 January 1984) were presented to the workshop participants. The course was organized within the framework of the WHO project LAO/RHH/001 and the National Centre for Medical Rehabilitation in Vientiane.

The video movie showed a technological process of manufacture of rehabilitation aids from indigenous materials (bamboo, rattan, wood) with the use of simple tools (machetes, hammers, hand saws), organization of group work, evaluation of the items produced, practical utilization of aids by the disabled and students and the opening and closing ceremonies.

Forty five students from the Physiotherapy School and 17 students from the Orthopaedic Technician's School participated in this two-week course. The instructors were: 5 national orthopaedic technicians and 4 physiotherapists. The course was conducted in the national language.

The participants were divided into 5 working groups. Each group was trained in the manufacture of bamboo sticks, walkers, parallel bars, stall bars, crutchers, handrails and inclined platforms.

The movie ends with the presentation of each group outcome. This was as follows: 62 sticks, 5 walkers, 5 parallel bars, 3 inclined platforms, 7 single of double handrails and 5 stall bars.

During the closing ceremony, each participant was handed a certificate and the textbook in the Lao version. The textbook with appropriate technical drawings was prepared jointly by the national staff and WHO technical officer.

The financial support in the amount of US$1384 was provided by WHO.
OPENING ADDRESS BY THE REGIONAL DIRECTOR TO THE REGIONAL WORKSHOP ON TRAINING OF COMMUNITY HEALTH AND WELFARE WORKERS IN REHABILITATION AND DISABILITY PREVENTION

Dear Participants and Colleagues,

It gives me great pleasure to welcome you to this Workshop on Training of Community Health and Welfare Workers in Rehabilitation and Disability Prevention. As you are aware, the World Health Organization Regional Office for the Western Pacific has long endorsed and supported Member States' efforts in developing rehabilitation and disability prevention programmes.

In this Region, both the Health and Welfare Ministries have realized that only a small number of disabled people have any access to rehabilitation services, particularly in rural areas.

In some developing countries in fact, as much as 98% of the disabled have no access to rehabilitation services.

In December 1981, the WHO Regional Office for the Western Pacific held a Regional Working Group on Rehabilitation and Disability Prevention. One of the working group's recommendations was that WHO should organize the present workshop on community-based rehabilitation with the objective of training supervisors and trainers of community health and welfare for their roles in preparing the community health and welfare workers to care for the disabled in the community. In this connexion, the workshop will cover such topics as collaboration between health and welfare workers, strengthening of health manpower skills in rehabilitation work, health education, assessment and referral, construction and use of simple aids for the handicapped, simple social, occupational and leisure skills, and barrier-free environments for the disabled.

The basic premise is that community-based rehabilitation should be an integral part of the health service, including primary health care and the welfare services. Community-based rehabilitation focuses on community participation and the use of simple, appropriate rehabilitation technology.

Your deliberations this coming week will not be easy and a number of questions will need to be discussed and clarified. For example: How can emphasis be shifted towards a community-based rehabilitation programme, and how can this be integrated in the existing primary health care services? How can non-governmental organizations be involved in initiating community-based rehabilitation? How can the disabled themselves and their families participate in the planning, implementation and evaluation of services? How to achieve responsible participation by the community, so as to provide the disabled with access to rehabilitation? How can we get members of the community to understand that their norms, attitudes and behaviour need to be changed in order to achieve full integration of disabled persons? How can children with various disabling conditions be integrated into the village school? And so on. Other questions concern
the important issue of manpower, training, supervision of local supervisors, and the need for referral services. With an appropriate delivery system, we can reach the majority of the disabled and give them equal opportunities to achieve full integration. In this way, we shall enable governments to achieve the goal of Health for All by the Year 2000.

It is not going to be easy to tackle all these questions and issues, during the limited time assigned to this workshop. However, I am confident that you will devote all your efforts to these important matters during the next two weeks.

Allow me, before I conclude, to express my appreciation to the Negros Occidental Rehabilitation Foundation Incorporated for making available its excellent facilities for this Workshop. I would also like to thank Ms Gunnel Nelson, WHO Consultant, Professor Charlotte Floro and Ms Joy Valdez, our Temporary Advisers, for their preparation of and contribution to this workshop.

Let me wish you all a successful meeting and a happy and memorable stay in Bacolod City.

I now declare open this Regional Workshop on Training of Community Health and Welfare Workers in Rehabilitation and Disability Prevention.
CLOSING ADDRESS BY THE REGIONAL DIRECTOR
TO THE REGIONAL WORKSHOP ON TRAINING OF COMMUNITY HEALTH
AND WELFARE WORKERS IN REHABILITATION
AND DISABILITY PREVENTION

Ladies and Gentlemen:

In the past two weeks, you have been exchanging views and debating
issues in the area of community-based rehabilitation. You have also had
opportunities to experience the community-based rehabilitation system in
practice. You have observed how the training of the disabled can be
carried out by family members and you have also seen the improvements that
can be achieved. You have had a chance to communicate directly with the
disabled, their families, the barangay captain, the school teacher and the
local supervisor and you have learnt about their views, their experiences,
their problems and their achievements in trying to provide the disabled
with the opportunity to fully participate in our society.

As you all know, this workshop has been conceived within the context
of health for all by the year 2000.

Several important problems have been discussed by you including the
training of the manpower needed to implement rehabilitation for all through
the adoption of community-based rehabilitation programmes.

I have been informed about your wide-ranging and thorough discussions
both inside the meeting rooms and outside during the field visits. All of
you will now be fully aware of the need to shift the emphasis in
rehabilitation towards the community-based approach, and I am sure that you
will do all in your power to disseminate the knowledge and learning
material you have acquired during this workshop.

Before I conclude, allow me to congratulate and thank the
representatives of Negros Occidental Rehabilitation Foundation,
Incorporated, for their dedicated work in implementing community-based
rehabilitation and for providing their timely and invaluable support during
these two weeks. I would also like to thank the temporary advisers and
consultant for their assistance in making this workshop a success.
Finally, let me thank all participants for sharing with us their experience
and knowledge and wish all of you a safe return home.


IBGOKWE K.O. (1980) Teachers Handbook on Total Communication - pre-primary and primary levels (Published by Nigeria Educational Research Council, Lagos)


OBER J. (1981) Assignment Report on Medical Rehabilitation, India South-East Asia Region, World Health Organization (not Pub)


SRINIVASA M.R., WIG N.N., Manual of Mental Disorders for Primary Health Care Personnel, Department of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigard - India (not pub)

WERNER D. (1982) Where There is No Doctor - A village health care handbook, (Published by: The Hesperian Foundation, P.O. Box 1692, Palo Alto, California 94302, USA

WERNER D., BOWER B. (1972) Helping Health Workers Learn, Palo Alto, California, The Hesperian Foundation


Development of Basic Community Services through Primary Health Care (1982) Economic and Social Commission for Asia and the Pacific, UNICEF/EAPRO, Bangkok

Formulating Strategies for Health for All by the Year 2000 (1979) Guiding principles and essential, Geneva, World Health Organization
Annex 7


Speaking from the Heart (1980) Parents of disabled speak (Published: on of Disabled, Inc.)
EVALUATION I

Could you please circle the figure that correspond with your opinion in the usefulness of the TOPIC

<table>
<thead>
<tr>
<th>THURSDAY, 12 JANUARY</th>
<th>Not Useful</th>
<th>very useful</th>
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<tbody>
<tr>
<td>1. Field visit to Bacolod and Talisay</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<th>FRIDAY, 13 JANUARY</th>
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<tbody>
<tr>
<td>2. General discussion on the observation during the field visit</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>3. Primary health care programme in Negros Occidental</td>
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<tr>
<th>TUESDAY, 17 JANUARY</th>
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<tr>
<td>4. The attitudes towards disabled people</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>5. The role of the disabled persons in the community</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>6. The role of the community</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>7. How to identify people with disability Groupwork</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>Demonstration, discussion</td>
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<th>WEDNESDAY, 18 JANUARY</th>
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<th>very useful</th>
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<tbody>
<tr>
<td>8. Importance of breastfeeding</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>9. Play activities T.P. 27</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>Groupwork</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>Report, discussion</td>
<td>1 2 3 4 5 6 7</td>
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</tbody>
</table>
Annex 8

10. Special education in Bacolod City 1 2 3 4 5 6 7
11. Guide for school teacher 1 2 3 4 5 6 7
12. How to teach a family member of a person who has fits using TP 1 & 2 1 2 3 4 5 6 7

THURSDAY, 19 JANUARY

13. Teaching methods 1 2 3 4 5 6 7
14. How to teach L.S. to use TP 17, 18, 19, 20, 21, 22, 23, 24, 25 1 2 3 4 5 6 7
   Groupwork 1 2 3 4 5 6 7
   Demonstration 1 2 3 4 5 6 7
   Discussion 1 2 3 4 5 6 7

Any comments you like to make, please.

Thank you...
QUESTIONNAIRE FOR EVALUATION II

INSTRUCTIONS FOR QUESTION

Use the following code to indicate the extent to which you agree or disagree with each of the statements made below:

Code
1. Strongly disagree
2. Disagree
4. Agree
5. Agree strongly

The difference between 1 and 2 or between 4 and 5 is one of degree only.

Example: If you want to express your disagreement with the statement, circle the number 1 as follows: 1 2 4 5

Please feel free to make any comments you think necessary in the space reserved for purpose on each question.

I. ASPECTS RELATED TO THE PLANNING OF THE WORKSHOP

1. I was given sufficient information on the aims and methods of the workshop before my arrival. 1 2 4 5

II. ASPECTS RELATING TO THE RELEVANCE AND UTILITY OF THE WORKING METHODS

3. I found the documentation provided of an acceptable quality. 1 2 4 5
Annex 8

4. Enough documentation was provided to allow me to take an active part in the discussion of the subject concerned. 1 2 4 5

5. The working methods used during the workshop encouraged me to take an active part in it. 1 2 4 5

6. I have already put new knowledge into practice during the workshop. 1 2 4 5

III. ASPECTS RELATING TO THE WAY THE WORKSHOP WAS RUN, AND TO THE ATTITUDES OF THE ORGANIZATIONS

7. The organizers display a satisfactory open-mindedness 1 2 4 5

8. The general atmosphere of the workshop was conducive to serious work. 1 2 4 5

9. The organizers gave me opportunity for critical comment. 1 2 4 5
10. The organizers made use of any critical comments I made during the workshop.

11. The organizers made every effort to help me reach the objectives for the workshop.

12. Enough time was given to clarifying the documents.

13. I consider that enough time was given for plenary discussions.

14. Enough time was given to small group work discussion.

15. Enough time was given for the field visits.

16. Enough time was given for individual homework.
Annex 8

17. Enough time was given for the presentation of group work in plenary session.  

IV. ASPECT RELATING TO THE BENEFITS GAINED BY THE PARTICIPANTS

18. The workshop helped me to improve my knowledge of Community-based Rehabilitation. 

19. The workshop has encouraged me to put the knowledge I have gained into practice AFTER the workshop is over. 

20. I have confidence that I will be able to start a CBR programme if requested. 

21. I am able to conduct a workshop to train Local Supervisors in CBR. 

22. I am able to teach others how to train and supervise the Local Supervisors.
23. I feel confident to describe the manpower needed in my country for the CBR programme (at the various level).

24. Please make any comment on the
- arrangement of your travel from your country to Bacolod.
- the provision of the daily subsistence allowance.
- the accommodation in Bacolod.
- the organization of the workshop.
- composition of participants.
- social activities.

THANK YOU VERY MUCH.