TRAINEES MANUAL

FOR

HEALTH WORKERS

ON

DISABILITY

Developed by:
Human Resource Development Division &
Disability and Rehabilitation Section
Ministry of Health
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- Children's Mental Health
- Adult's Mental Health
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- Hearing Impairment
- Orthopaedic Appliances and aids
- Polio and other movement disabilities
- Cerebral Palsy

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Foreword:

Quality training of Health personnel and continuing Medical Education (CME) are the pre-requisite to good health worker performance and provision of quality health care. To enhance this quality, all health training curricular and CME learning materials must be designed to respond to the health needs of the community and incorporate new health knowledge and skills.

This is particularly pertinent and imperative to the update of health workers on the prevention and rehabilitation of Disability in the community.

This trainee manual for health workers on disability has been developed with a view to take care of the concept of the Uganda National Minimum Health Care Package (UNMHCP) among whose components Disabilities is an element under essential clinical care.

The development of this manual has particularly taken into account the role of all front line cadres of health providers. The manual has been developed to create balanced health workers. It offers individuals the opportunity to acquire knowledge, skills and attitude to provide rehabilitative services with full awareness that both the impairment and the environment contribute to disabling a person.

With this manual and appropriate training of frontline health workers, I am confident that we will realize our goal of reducing morbidity and disability among the people of Uganda.

I am indebted to all individuals, government and non-governmental organisations and in particular the Norwegian Association of the Disabled (NAD) who contributed to the development of this manual.

Pro. F. G. Omaswa
DIRECTOR GENERAL
Ministry of Health.

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BACKGROUND:

Colonial and Early independence Era

The history of disability in Uganda is a reflection of global events. Before western civilization made its mark on our history, disabled persons were an integral part of society. The Impairment decided the care given to the disabled person. For example, persons with polio and other movement disabilities were largely accepted and given a role in the community for example: as entertainers while those with communication difficulties were largely neglected.

With colonization, approach to disabled people shifted from community care to charity approach based on institutions. This development seemed to shift responsibility from the community to the state. Institutions were few and were impairment specific. For example, schools for the blind, vocational training for those with physical impairment. Very few disabled people benefited from these institutions.

1982-1983 was declared the International decade for People with Disabilities (PWDs). Three major shifts took place during the decade which have had a profound effect on rehabilitation in Uganda.

These are:

1. The powerful voice of disabled people that declared, 'Nothing for us without us'.
2. The shift in approach to service delivery to disabled people from institutional based to community based rehabilitation.
3. The shift from impairment approach, social approach of rehabilitation.
4. The embracement of the above two by UN bodies and governments including the government of Uganda.

The CBR Era

In 1986, the single disability groups and a number of disabled people in Uganda formed a National Umbrella NGO called 'The National Union of Disabled Persons of Uganda (NUDIPU). In 1989 Nightingale Kalinda started the first CBR programme.

NUDIPU grew in number and its biggest achievement was the drafting of the 1995 constitution of Uganda. Article 35 of the Constitution states that: *"(1) Persons with disabilities have a right to respect and human dignity and the state and society shall take appropriate measures to ensure that they realize their full mental and physical potential. (2) Parliament shall enact laws appropriate for the protection of persons with disabilities*". This has led to a number of positive changes in laws, policy and delivery of government services in favour of disabled people.

In 1992 the Ministry of Social Services started a CBR programme. Today, the government and NGO, CBR programs cover 20 districts.

The Ministry of Education at about the same period started a special education programme called Educational Assessment Resource Services (EARS).

Health Care for PWDs

The movement of disabled people, the CBR programme and special education faced problems of no linkage with the health sector at National and health unit level.

Medical rehabilitation services were mainly available in the capital city, Kampala.

This led to the establishment of the Disability and Rehabilitation Section. The section through a survey found that rehabilitation knowledge among health workers was extremely limited. In addition, the impairment approach was used instead of the social approach.

The Ministry of Health together with NUDIPU developed this training manual to help orientate first line health workers to offer comprehensive care to PWDs.

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The Ministry of Health, Disability and Rehabilitation Section is grateful to the following for their invaluable contribution in making this manual.

- Task forces for epilepsy, mental health, orthopaedic appliances and aids, cerebral palsy, hearing impairment, visual impairment and movement disabilities,
- Human resource development division
- The National Union of the Disabled Persons of Uganda (NUDIPU).
- Community Based Rehabilitation Alliance (COMBRA).
- Uganda National Institute of Special Education (UNISE).
- National T.B and Leprosy programme.

Sincere appreciation goes to the Norwegian Association of the Disabled for funding and technical assistance.

INTRODUCTION:

This trainee's manual presents the update of knowledge, skills and attitude for all front line health workers on disability.

This manual has been developed after studying the current health service delivery system, the knowledge, skills and attitude acquired by health workers at basic training and consideration of the minimum health care package.

The manual focuses on the management of movement, mental disabilities and prevention of blindness and deafness.

The aim of this document is to develop competencies in the health workers who will address the impairment to the person and the environment. The target group is mainly qualified frontline health care providers, (certificate to degree holders). The manual has been developed in such a way that it encourages self-study. It can also be used as a reference material and for teaching.

The manual is divided into 7 units. Each unit has topics, which address specific aspects of prevention and management of impairments. The last two units stress the role of the environment in disabling persons with impairment.

The units are independent of each other and can be used individually depending on the prevailing need. This manual presents a well-reformed and implementable document that aims at serving the current service gap in the health care delivery to the persons with impairments.

The terms impairment, disability and handicaps are used as opposed to the newer approach of impairment, activity and participation. This is because the authors of the manual had not yet received the precise definition and application of the new terms. Later editions will probably use the more modern terms.

UNIT ONE: TRENDS IN DISABILITY AND REHABILITATION

The following are general objectives for the unit

1. **Outline a general overview of the prevalence, attitudes and rehabilitation proceeds and complementary services pertaining to disability.**
2. **Outline government commitment to rehabilitation.**
3. **Discuss the impact of society's attitude to the development of People with disabilities.**
4. **Outline different approaches to rehabilitation.**

TOPIC 1: OVERVIEW OF DISABILITY

Disability is a worldwide phenomenon, a challenge in every country that will occur irrespective of family, background, wealth or status. The poor, however, are more prone to incidences of disability. The problem is made worse where there is lack or poor health services and low development.

The society at large is not aware of the causes and management of disability and the possible preventive measures. Society often has superstitions and negative attitudes. As a result, PWDs suffer partial or total physical, social and psychological isolation and are not supported to have optimal development of their potential.

Many countries are making efforts to address rehabilitation and all round development of the PWDs. Emphasis is placed on physical, education, social-economic development and total integration of the PWDs in mainstream society.

Disabilities spring from physical, and psychological impairments. This makes the medical personnel central in the rehabilitation process. Because PWDs are in constant touch with medical people for treatment, the latter should, at all levels, be well versed with the various disabilities and their management. This unit gives an overview of what disability is, and the basic elements of rehabilitation. It has the following objectives:

Objectives:

By the end of the topic, you will be able to:

1. **Define disability, impairment and handicap.**
2. **Discuss national and international disability prevalence.**
3. **List causes of disability.**
4. **List the types of disabilities.**
5. **Discuss possible preventive measures.**

What Is Disability

Introduction:

In your work as medical personnel, you have met a variety of people with disabilities. As key people in the rehabilitation intervention, health workers tend to focus on correcting the disability and ignore the total person. Some health workers, like the general populace, often avoid supporting and giving services to people with disabilities for lack of knowledge and skills of intervention. This unit gives health workers opportunity to understand disability and its health, social and economic implications. It highlights the broader role of the health worker and the ministry of health as well as government, in the rehabilitation process. The society, national and international commitment to the development of people with disabilities.

Definition:

Until the 80s the words *Disability, impairment* and *handicap* were used interchangeably to explain disability, which was confusing. World Health Organisation (WHO) gives distinction to the three words as follows:

Impairment:

- This is any loss or abnormality of psychological, physical or anatomical structure or function, *or*
- It is the physical or mental disease, loss, abnormality or injury of an organ.

Disability:

- It is any restriction or lack (resulting from impairment) of ability to perform any activity in the manner or within the range considered normal for a human being *or,*
- Disability means not being able to do something because of impairment, i.e., loss of function.

Handicap:

- It is a disadvantage for a given individual, resulting from an impairment or disability that limit or prevents the fulfilment of a role that is normal (depending on age, sex, or social and cultural factors) for that individual, or
- It is the loss or limitation of opportunities to take part in the life of the community on an equal level with others, or
- The loss of social and economic roles because of a disability arising from an impairment.

Looking at the above definitions, it is possible to have impairment but not have a significant disability or handicap. i.e., a person who loses one eye is impaired but is not disabled since he/she can use the second eye to carry out the activities and social roles without impediment. These are categorized as minor impairments.

The Disability Process:

The concept of handicap includes the role of society in creating barriers and limiting opportunities for people with disabilities. Handicap is a result of social attitudes towards disability, as the focus is placed on an inability other than the individual's potential.

In addition, social and physical barriers limit participation of the impaired person thus as disabled people say, 'it is not the impairment disabling me but the external environment.
A person with physical disability for example, is not taken to school because *"money will be wasted."* The illiterate PWD is, therefore, not able to develop economically.
He/she does not fit in society, sometimes even in their own family, if all other siblings received education. The disabled person is unable to marry because he/she is poor and remains a dependant for life. Such a person is handicapped because of lack of education.

Rehabilitation deals away with handicap by finding solutions to overcome the impairment and the negative environment.

Types of disabilities:

Disabilities are categorized according to loss of function. The following are the most common types of disabilities:

Non-medical terms	Medical terms
Difficult in seeing	Visual (ocular) impairment
Difficulty in speech/ hearing	Hearing impairment / Communication difficulty
Difficulty in learning	Mental retardation
Difficulty in feeling	Loss of sensation
Difficulty in moving	Mobility disability / Skeletal impairment
Strange behaviour	Mental illness
Epilepsy	Epilepsy

Prevalence of Disability:

The World Health Organisation (WHO), estimates that 10% of the world population has disabilities and 7% have moderate to severe disabilities that require medical, educational and social economic rehabilitation. This percentage however, varies from country to country depending on the level of development and historical background. In China for example, the percentage is 4.9%, and in Canada, it is 10%. These international facts should also be considered:

- There are 300 million moderately to severe disabled people.
- 80% of the 300 million come from developing countries, the majority from Africa. Only 20% come from developed countries
- 27% of people with disabilities in developing countries are children.
- In developed countries, the majority of people with disabilities are older persons where as in developing countries the number of Older persons with disabilities is minimal.
- In Developing countries, especially Africa, many children with disabilities die young due to lack of specialized medical services and general lack of knowledge. In developed countries, even children with severe disabilities are able to survive.

Basing on the above statistics, developing countries especially Africa, face a challenge to improve services, empower people economically, and improve the knowledge base in society to reduce this high incidence.
In Uganda the prevalence is estimated to be:

Type of Disability	% of the population	Estimated number of people
• Visual (ocular) impairment	1	200,000
• Hearing impairment / Communication difficulty	2	400,000
• Mental retardation	0.4	80,000
• Loss of sensation	0.2	40,000?
• Mobility disability / Skeletal impairment	2.5	500,000
• Mental illness	0.2	40,000
• Epilepsy	4	800,000

- Note that epilepsy scores the highest percentage although it is not easily noticed in society. This is because epilepsy is highly stigmatized, attached to superstitions. The situation is made worse by it's unusual presentation. Most people affected by epilepsy live and suffer in secrecy.

- Recent findings by the World Psychiatric Association put mental illness in Uganda at 1.05% of the population (210,000). The high prevalence is due to increasing civil strife's, HIV/AIDS, work related stress, poverty and natural disasters. Epilepsy and mental disorders need more attention.

- Approximately, 500,000 people in Uganda have movement disabilities. Of these, 1% (200,000) are in the moderate to severe category and require assistive devices to overcome their disabilities.

The above categories do not explain all the disabilities. In your work, people will approach you for help, identifying themselves as PWDs even though they do not fall among the conventional categories, i.e., People who are barren, Impotent, those with hypertension, severe asthma etc. Such people should not be ignored. They have genuine problems and need treatment and counselling.

Causes of Disability:

There is a whole range of causes of disabilities as follows:

Direct Causes:
These are conditions that directly affect a person and cause impairment. Knowing the causes gives lead to prevention and better management of the impairment.

- Before birth:
  - Hereditary defects: e.g. dwarfism, clubfoot (sometimes, not always),
  - Non-genetic disorders e.g. congenital absence of limbs, clubfoot, cleft palate, rickets, Down's syndrome
  - Conditions of the mother such as: diabetes, measles, rubella in pregnancy.
  - Alcoholism and drug abuse of the mother.

- At Birth: - Birth trauma.
- After Birth: - Neonatal problems e.g. jaundice, neonatal infections like meningitis
- Diseases:
  - Communicable Diseases e.g. poliomyelitis, trachoma, leprosy, malaria, measles, meningitis, ear infections.
  - Non-communicable diseases.
  - Degenerative conditions
  - Diabetes mellitus
  - Sickle cell disease
- Trauma / Injury: e.g. traffic accidents, occupational accidents, domestic accidents, wars and violence
- Malnutrition.
- Drug and Alcohol abuse.

Indirect Causes:

These are conditions that may not directly cause disability but are predisposing factors to causing impairment.

- Malnutrition.
- Poor environmental sanitation.
- Lack of information about proper health measures.
- Lack of proper stimulation and early education of children.
- Drug and alcohol abuse.
- Poor infrastructures.
  - Few health services.
  - Long distances from the health services.
  - Poorly equipped health services.
- Poverty.
- Social stress and emotional disturbances.

What do people believe to be causes of disability? Discuss.

Lack of awareness of the causes has made people to attach witchcraft to disabilities. You hear statements in the community such as,

"He was bewitched"
"She is possessed"
"Ancestors were angry"
"He is married to the gods"
"The mother committed adultery during pregnancy"

These fatalistic beliefs are good excuses for doing little in helping the person overcome the impairment and work for the development of the PWDs. There is therefore need for consistent awareness raising to change these beliefs and redirect efforts to prevention, early identification and intervention strategies.

Prevention of disabilities:

Understanding causes of disability is a guide to ways and means of preventing the occurrence of disability. Prevention is best done at three levels:

First Level Prevention: Preventing impairment.

This means reducing the indirect causes of disability. Examples are as follows:

- Reduce poverty and the risk of disease.
- Better Primary Health Care (PHC) for example better reproductive health and childcare, immunization, improved nutrition, water supply and sanitation.
- Improve home installations and work environment.
- Improve infrastructure, agriculture, health services and education for all.
- Information dissemination

Second Level Prevention: Prevent Disability:

These are actions to detect and identify early, the occurrence of disability resulting from the impairments, or preventing an impairment from getting worse. These require measures in three areas:

- Early identification of impairments that lead to disability i.e., diagnoses Leprosy, T.B, a fracture, tests for any suspected infection or condition.
- Proper care of impairment in the acute stage to avoid subsequent disability. For example, skills for first aid for simple splinting of a fractured limb, exercise to prevent contractures, avoiding infection on burns and wounds, etc.
- Proper care of disease and injury in chronic stage. This involves medical rehabilitation done by medical professionals and specialists for example doctors, physiotherapists, occupational therapists, psychiatrists, speech therapists who help to reduce the impact of the disease or injury on the patient and their family. Activities of daily living, providing technical assistive aids such as: hearing aids, callipers and artificial limbs are part of secondary prevention.

The aim of the second level intervention is to reduce the extent to which impairment prevents the functional ability of an individual.

Third Level Prevention: Preventing Handicap.

These are measures to prevent a handicap once an impairment or disability has developed. It is done with a range of activities and actors playing varied roles in:

- Changing negative attitude to disability.
- Removing physical barriers to integration
- Setting laws to prevent discrimination against people with disabilities.
- Helping people with disabilities and their organizations become strong and directed towards self-actualisation.

The third level intervention focuses on creating an environment for equalisation of opportunities and full integration of PWDs in society.

Because the magnitude of work in the prevention process is extensive, it is important for health workers to link with other complementary sectors and service providers in community development, education, agriculture, nutrition, security, police, and administration. It is only in working in partnership and collaboration that prevention, rehabilitation, and development can be done successfully.

TOPIC 2 ATTITUDE

Objectives:

By the end of the topic, you should be able to:

1. **Define attitudes**
2. **Explain how people develop attitudes**
3. **Explain how right attitudes contribute to the development of a PWDs**
4. **List some of the negative attitudes towards PWDs.**
5. **Discuss the Health worker's role in developing right attitudes in the community about disability and rehabilitation.**

Introduction:

A mother gave birth to a child with Spinal Bifida and when she was told her child had a problem, the mother refused to see the child and returned to her home without the baby. The child Katrina grew up in hospital. She has a gift of learning many languages but has never gone to school.

20 years later, the hospital staff requested family members to take Katrina in their care. No family member was prepared to take on the responsibility. Katrina's parents never visited. The mother of Katrina made it clear that she does not want to see a daughter with useless legs. Eventually, Katrina's sister and brother in-law took her in their home.
Namibia. 1999

A six-year-old child, Vumba, gets cerebral Malaria, severe convulsions and stiffness of the body. The child now has cerebral Palsy. Recognizing that this was possibly caused by evil spirits, the neighbours now prevent their children from stepping in the compound of the family with the disabled child.
Namutamba, Uganda. 1999

Madina is a 14-year-old girl with moderate disability from cerebral palsy. Her father abandoned the family because of Madina's disability. Madina was sleeping on grass while the rest of the family had better bedding. Even when a CBR worker gave Madina a pair of bed sheets, the mother kept them that they can be used to wrap Madina's corpse as the girl did not have long to live.
Luwero, Uganda, 1994

The cases above are reflective of the attitudes and behaviour that may not be appropriate but is all too common when facing challenges of disability. Behaviour and practice are influenced by a number of factors.

Top on the list are values, beliefs, experiences knowledge and attitudes. This topic looks at society's behaviour and attitudes towards PWDs and the impact it creates.

What is attitude?

Attitude is what underlies behaviour. Attitude is basically a result of beliefs, values and experiences. Attitudes may be positive or negative according to the knowledge base, beliefs and experiences of an individual or society. Attitudes are largely reflected through our behaviour and response to situations. The situation of PWDs in developing countries is often reflective of strong negative attitudes:

- Katrina was abandoned because the mother refused to accept a child with disabilities. In Namibian culture, young mothers do not take care of such children. A child with disability belongs to the old.
- She was not taken to school not because she was incapable of learning, but because she was disabled.
- She did not belong to any family because no one wanted her.
- Vumba's family is isolated because the neighbours live is perpetual fear of being infected by evil spirits.
- Madina cannot even sleep in bed sheets because she is believed (wished) to be dying.

Negative attitudes towards PWDs are reflected not only at family level, but also at community, national and international levels. For example, because the attitude of society is that PWDs are useless and are not expected to be influential citizens of society:

- They are not given opportunity to exercise activities of daily living at home.
- They are often not involved in family decision making processes.
- They are not considered (or are considered last) for education.
- They are not prepared to have friends and socialize.
- They do not participate in community activities, meetings, and decision making for the community, often, even on matters concerning them.
- They are not prepared with skills for income generation, management of people and businesses, holding jobs, marrying or managing their own families.
- When a public or individual building is constructed, we do not think that a person with disabilities may rent or work in it, and therefore do not facilitate accessibility.
- Some non impaired people avoid to make friendship with disabled people because they fear that the people with disabilities will be become a burden.
- Over protection of persons with impairment kills initiative leading to dependency.
- Children with visual or hearing impairments are not provided for in general schools. It means that such children are not expected to go far in education or to be useful in society.
- There was a clause in the old constitution that PWDs cannot stand in for someone in court.

Health workers have also played a role in enhancing negative attitudes, for example:

- A person affected by polio comes to hospital to be treated for malaria and is sent to the polio clinic.
- People of various disabilities being tossed from one department to another, even without explanation.
- A pregnant woman with disability is ridiculed on the ward and ante natal clinic.
- Parents of children with disabilities are not given proper information about the state of their children.
- Disabled people are perceived as beggars and not patients even when they are contributing to the cost of the service.

Our beliefs have made a profound impact on people with disabilities. Because of this attitude confirmed in our behaviour, PWDs:

i. Consider themselves useless and fail to make efforts to improve themselves.

ii. A few who attempt to go to schools have been laughed at, teased and sometimes tortured by fellow children who are never reprimanded. This leads to a high school drop out rate.

iii. Lack of education and employment has left them poor and socially isolated.

iv. Absence of facilities and medical attention has increased their disabilities and isolation.

v. On the whole, PWDs become shy, withdrawn, and suspicious. Some develop bitterness against society. A few have had to fight their way and have been labelled "aggressive".

vi. In secrecy, some men make sexual advances, women with disabilities accept feeling grateful to be loved 'even under cover'. So women with disabilities become single parents which reinforces the poverty cycle.

It is therefore said that society's attitude to people with impairment is their biggest disability. People with disabilities who have been well looked after and supported physically, socially, and psychologically have grown very positively and are well integrated in the community. Focus is no longer on the impairment and limitations but on what the person can do.

What brings negative attitudes within a community?

Lack of appropriate knowledge:

Most people in communities do not know what causes the disabilities among them. They only see that a person got fever and became weak, paralysed, or blind. Others are born with the disabilities. They do not understand the cycle of diseases like Polio, and therefore, do not take steps to prevent it or intervene early.

Fear:

Due to limited knowledge there is fear and speculation on how the disabilities and diseases are spread.

Superstitions:

Because of limited knowledge, people attach many unexplainable incidents to the supernatural. Statements like "Disability is a sign that the person is married to the gods", "that was God's will", "He /she was bewitched or cursed", "it was a punishment from the gods or God" are indicative of a helplessness from the community that the problem is beyond them. A person believing in witchcraft and vindictive gods will take a child with disabilities to remove curses and charms instead of running for early intervention.

Beliefs:

Beliefs about disability based on superstitions and misinterpreted experiences that have been passed on in the community. In Kitgum, when a person gets an epileptic seizure, all the people run to a safe distance and pull their earlobes until the seizure is over. This is done to avoid getting infected with epilepsy.

Difficult experiences:

- These are challenges PWDs and their families face because of the disabilities. As a health problem, impairments, and disabilities require a lot of attention, money for hospital bills and transport, especially when one has to lift or carry the PWD. Mothers often have to give up other work to concentrate on the disabled child. Such a situation can easily result into resentment and negative attitudes among the caretakers.
- Refusing to accept the disability and live in denial. This may be true for both the individual PWD and the parent or care taker.
- Lack of appropriate services and facilities for people with disabilities. Lack of services limits opportunities for PWDs to integrate into society. Provision of a wheel chair could enable a person affected by polio go to the market to trade. Giving a child callipers and crutches can enable a child to walk upright and go to school. These examples demonstrate how provision of rehabilitation services brought dignity, independence and social integration to disabled people. Lack of service condemns PWDs to a life of degradation and isolation.

Developing the right attitude:

Right attitudes are developed with the fundamental belief:

- That every human being has a right
  - To life and fair treatment.
  - To equal opportunity and equal access to health, education, income, food, legal protection and information.
- That PWDs have a right and a responsibility to contribute to national development like every one else and must be supported with the necessary skills to develop their maximum potential.

- That Disability is not total inability. Focusing on one's abilities will bring out the very best of the person.
- That it is individual, community and national responsibility to support the total development of a person with disability.

Right attitude will be developed through:

- Giving the right information to people in order to dispel fears, superstitions and hopelessness. The right knowledge will also lead to right actions once a disability has occurred or is suspected.
- Counselling the family and supporting parents through the difficult stages of accepting the disability in the family. Helping them find solutions to the functional problems of the child/person with disabilities.
- Showing that you care for the welfare of the whole person and the family. Knowing that they have a friend out there who gives them physical and psychological support.

Your role as a health worker:

From the onset of an impairment and often throughout life, a person with disability interacts quite often with health workers. Health workers, therefore, play an important role in changing attitudes of the individual PWD and the family, as well as the community. The points below are important:

- Develop a positive attitude yourself. Remember the PWD, like any other patient, deserves equal treatment and respect. A health worker's attitude can make or unmake the person with disability, so be careful. It is important to note there are legal instruments in place and different legal aid projects protecting PWDs.
- Be careful how you react, what you say, what your facial expression is. A positive reaction is a great encouragement to a worried mother. A negative reaction may be the mother's last straw of hope.
- Have a listening ear to the PWD, parent and/or care taker.
- Be patient and tolerant.
- Be sure your advice is helpful. If you are not sure, consult or refer.
- Lastly, promote the right / correct values for development. Use every opportunity to give the right information to fellow health workers and the community.

Discuss:

- *What incidents have you witnessed or experienced that you feel were due to negative attitudes?*
- *What did you do?*
- *What could you have done?*

TOPIC 3 EMPOWERMENT AND EMANCIPATION OF PEOPLE WITH DISABILITIES (PWDS)

Objectives:

At the end of this topic, you will be able to:

1. **Describe the disability movement in Uganda**
2. **List UN Standard Rules that relate to medical care and rehabilitation**
3. **Explain Uganda's commitment to rehabilitation and development of people with disabilities.**

The Disability Movement

Introduction:

For so long, persons with disabilities have been marginalized, segregated and under served by society. Throughout history, disability is associated with poverty, dependency and loss of personal autonomy. Parents of children with disabilities are not aware of existing services and underrate the potential of their children. There is very low investment in PWDs and therefore minimum or no productivity at all, leading to perpetual poverty and dependency. People with disabilities face discrimination in their families, society, service provision, employment, and social circles. Local Governments which should take the lead to change the trend, do not take disability as priority and are either "too poor" to give a hand or give minimum budgets that are not helpful. Government planners underrate the magnitude of the problem and allocate few resources to the development of people with disabilities.

Many people with disabilities have as much to contribute to national development as anyone else. If they do not receive full rehabilitation services, their potential they would have contributed is lost. Communities and families need the contribution of these people.
This negative situation forced PWDs to take an active role to convince society of their needs, rights and potentials. There is an outcry from PWDs for:

- More information and knowledge
- Better access to medical care,
- More power and control over their lives
- Better living and working conditions,
- A move from recipients to service provision
- Better empowerment, involvement and participation, especially in their own development.

People with disabilities should have the same rights as every one else to:

- Health services
- Education,
- Work,
- Marriage and full life,
- Making decisions,
- Taking responsibilities

- Transport and access to buildings
- Recreation

What is the response?

For three decades, there has been an effort to respond to this outcry and there is now an evident worldwide movement towards empowering PWDs and addressing their demand for equal rights. Nations recognised that it is very important to help more people in the community to access rehabilitation services so that they too can become full active members of society.

THE UN STANDARD RULES

International response:

The United Nations (UN) set out 22 Standard Rules that work as an international instrument on disability. The rules carry a strong moral and political commitment on behalf of the united member states. Other international instruments were incorporated from ***The Universal declaration of human rights,*** and ***The Convention on the rights of the child,*** in formulating the standard rules.

The purpose of the Standard rules was:

To ensure that all people with disabilities are members of their societies and enjoy the same rights and obligations as others.

The rules aim at removing obstacles that prevent PWDs from enjoying their full rights and obligations. Uganda government participated in the formulation of these rules and adopted the resolutions that established the rules in 1995. Below are seven of the twenty-two rules:

Rule 1: **Awareness raising:**

"States should take action to raise awareness in society about persons with disabilities, their rights, their needs, their potentials and their contribution."

Rule 2: **Medical care:**

"States should ensure the provision of effective medical care to persons with disabilities"

Rule 3: **Rehabilitation:**

"States should ensure the provision of rehabilitation services to persons with disabilities in order for them to reach and sustain their optimum level of independence and functioning"

Rule 4: **Support Services**:

"States should ensure the development and supply of support services including assistive devices for persons with disabilities, to enable them increase their level of independence in their daily living and to exercise their rights."

Rule 5: **Accessibility:**

"States should recognise the overall importance of accessibility in the process of the equalisation of opportunities in all spheres of society. For persons with disabilities of any kind, States should introduce programmes of action to make the physical environment accessible"

Rule 6: **Education:**

"States should recognise the principle of equal primary, secondary and tertiary education opportunities for children, Youth and adults with disabilities, in integrated settings. They should ensure that the education of persons with disabilities is an integral part of the education system."

Rule 18: **Organisations of Persons with Disabilities:**

"States should recognise the right of the organisations of persons with disabilities to represent persons with disabilities at national, regional and local levels"

The other rules cover issues of employment, income maintenance and social security, family life, culture, religion, recreation and sports, information, training, legislation and planning and policy formulation.

Every member country is expected to plan and initiate programmes that address these rules.

You can get a full copy of the *UN Standard Rules* from the District NUDIPU office or Ministry of Health –Disability Section.

Uganda Government Response/Commitment:

The government of Uganda is committed to uplifting the standards of living for PWDs. This has been done in several ways basing on the 22 standard rules:

- **Providing for the concerns of PWDs in the constitution:**

During the Constitutional amendment and subsequent parliamentary procedures, provisions were made aimed at reducing the plight of people with disabilities in society. Various articles in the constitution emphasizes the following:

- Equal treatment and enjoyment of equal rights by all people.
- Affirms that PWDs have a right to respect and human dignity and the state to take appropriate measures to ensure that they realize their full mental and physical potential.
- All people with disabilities above 18yrs to vote
- The state to take affirmative action in favour of marginalised groups such as children, people with disabilities and women.
- Representation in Parliament and all council levels, with PWDs forming the Electoral College. One of the representatives should be a woman.
- Provision of facilities and ramps to access public buildings, office latrines and road safety.

- **Ensured implementation of constitutional provisions by establishing special departments in various ministries to address the specific needs of PWDs.**

For example:

- Ministry of Health has the **Disability and Rehabilitation division**.
- Ministry of Education has the **EARS programme and UNISE** for special needs training of teachers and various CBR courses.
- Ministry of Gender, Labour and Economic Development has the **Disability and Elderly department**.

Each of these play key roles in specifically addressing the medical, educational and development needs of PWDs.

- **Provided a positive environment for PWDs to express themselves, form associations groups, and participate in their own development.**

The freedom of association has facilitated formation of many groups and organisations either,

- Based on type of disability such as Uganda National Association of the Blind (UNAB), Uganda National Association of the Deaf (UNAD), Uganda Association of the Mentally Handicapped, etc.
- Others are territorial such as district unions or regional organisations such as Foundation of People with disabilities (FPD), covering the Western region.
- Some are based on gender such as women's organisations and associations.

Such organisations have played a key role in advocating for the emancipation and self-awareness of people with disabilities.

- **Provided representation of PWDs at all levels of governance.**

    - There are five representatives of PWDs in parliament followed by representation at all council levels from the district to the village council, to ensure that their needs are represented.

The positive environment provided by government, has greatly supported exponential change of opportunity from being isolated and ignored to being recognised leaders and the focus of so much activity.

TOPIC 4 REHABILITATION

Introduction:

Because of the impairment and disabling environment, People with impairment find challenges in doing things that able-bodied persons would do easily. Sometimes a PWD fails completely and has to rely on other means to accomplish the task. As discussed earlier, it is a means of overcoming barriers brought about by disability and the impairments and the inaccessible environment. This topic will focus on rehabilitation:

Objectives:

By the end of this topic, you will be able to:

- **Explain the meaning of rehabilitation.**

- **Describe the history of rehabilitation.**
- **List areas of rehabilitation essential for the total development of a PWD.**
- **Identify the relationship between community based health rehabilitation and primary health care.**
- **Explain the emotional and psychological challenges of disability.**
- **Outline the roles of a health worker in rehabilitation**
- **Describe the composition of a multidisciplinary team.**

Definition:

Rehabilitation is a goal-oriented process aimed at enabling an impaired person to reach an optimum physical, mental, spiritual and social functioning level.

Rehabilitation is based on giving people with disabilities:

- More information and knowledge;
- More power and control over their lives
- Better living conditions
- Better working conditions and
- Better access to medical care and social services.
- Reducing the impact of the disability.

Rehabilitation evolution:

Rehabilitation has not always been well streamlined. It has been a gradual process improved by increased knowledge, industrialization and socio-economic development. The attitudes and knowledge base of the society have largely governed the mode or basic standard of rehabilitation at the time.

In Africa, PWDs were largely left to the care of parents and the extended families. Efforts for rehabilitation included consulting the local traditional healer for treatment. Some, especially the severely disabled were eliminated. In topic 1, it was discussed that Africa has a high percentage of children with disabilities, which is also followed by a high mortality rate so that those who survive have mild and moderate disabilities. Functional rehabilitation was minimal hence secondary disabilities are many even today.

Rehabilitation models are standard approaches used in rehabilitation. There are many models that have been used in rehabilitation down the centuries but each has been carried out basing on the beliefs and attitudes of the society at the time. Below are some examples:

The charity model vs. the Human Rights approach
The Medical model vs. social model
Institutional model vs. CBR

The charity model:

The charity model sprung from beliefs in acts of charity to help humanity, especially the destitute. This model became fashionable in Europe during the 19th Century and spilled over

Advantages	Disadvantages
• Facilitates training in ADLs, education and medical attention at the same time. • Special personnel i.e., professional medical personnel, Special teachers, and technicians available. • Negative attitudes within the institution are minimized because everybody is the same. • Accessibility is easy since structures are specifically designed to address the disability challenges. • Food and clothing provided	• Isolation from the society since the institution is self-reliant. • Expensive to maintain • Isolation from family. The individual misses the attention of family and siblings. • Life is very easy, leading to difficulties to move out into the society. • When donors let go, institutions collapse. • Accommodates few people.

The Medical model:

There is a tendency to view disability as a medical problem. As a medical issue, the problem lies in the individual and not society. Rehabilitation is in attempting to reconstruct the individual through medication, surgery, and other therapies until the person is as near to normal as possible. PWDs are seen as perpetual patients and are therefore not able to contribute to society. Just as severely sick people are hospitalised, people with severe impairments are cared for in institutions.

The belief that PWDs are patients reinforces the helpless / dependency tendencies displayed by some PWDs. The medical model empowers professionals who become the miracle workers, while the disabled person is seen as a case number and a file. The focus is on the impairment not on the person.

Outreach Rehabilitation Model:

Such services are normally provided by rehabilitation personnel based in institutions. Rehabilitation personnel visit homes of people with disabilities or centre near the homes. With a focus on repairing the impairment, but will not include education and vocational training. Community involvement in these programmes is usually limited resulting in limited social change. The cost per person visited is also very high. Outreach model works best where community rehabilitation worker is present ,in the community to follow up on interventions offered by the experts in the out reach team.

Community-Based Rehabilitation (CBR) Model:

Community based rehabilitation (CBR), enlarges the concept of rehabilitation to include all services that assist disabled people to develop their abilities.

CBR is characterized by the active role of people with disabilities, their families, and the community in the rehabilitation process. In CBR, PWDs are active in their own rehabilitation rather than being recipients of services. Knowledge and skills for the basic training of disabled persons are transferred to disabled persons themselves, their families, and the

community members. In CBR, therefore, disabled people assist each other in the rehabilitation process and join in the advocating for people with disabilities. The community become educated about disabilities through sensitisation programmes, witnesses change and development among PWDs and this gradually changes their attitude. In CBR there is a dynamic move to improve educational, social, medical and economic provisions for PWDs, springing from within the community. CBR also enhances referral.

This model of rehabilitation emphasizes everyone's participation especially the PWD who should spearhead their own development.

Human Rights Approach:

The human rights approach bases service delivery and integration on the various human rights declarations and conventions. The rights of PWDs are embedded in these conventions and nations that are signatory have a mandate to ensure the rights of PWDs are not abused. Disability is not a charity issue but a human rights issue.

The Social Model:

The social model of rehabilitation is the corner stone of CBR. It recognizes that it is not the impairment that disables a person but the environment and attitude of people towards people with impairment. Today PWDs prefer to be called disabled people because they are disabled by factors outside themselves. For example a wheel chair user may not be able to attend and contribute to a meeting on a third floor because of lack of lifts. He/she has the capacity to contribute but the environment keeps him out. The social model therefore aims at removing barriers to integration rather than focusing on the impairment.
It aims at making the environment accessible (ramps, low switches, sign languages and Braille, provision of personal assistance e.t.c.) and changing the negative attitude towards PWDs.
flights
In conclusion, rehabilitation trends have moved from taking persons with disability as a problem that should be got rid of, to looking at persons with disability as people with equal rights and critical members of society that should be supported to join in the development process of their country.

The government of Uganda as discussed before, is committed to this cause and has adopted CBR strategy for rehabilitation. Uganda is carrying out rehabilitation activities that include:

- Medical rehabilitation, that is, treatment, provision of Assistive aids and Counselling;
- Special or inclusive education (Educational Assessment and Resource Services).
- Social economic rehabilitation such as provision of vocational training, income generating projects and participation in cultural activities.
- Psychological support for self-acceptance and self-realization.

Because Uganda has adopted CBR as a strategy and the Ministry of Health contributes to CBR, it is important that we look closely at this strategy.

What is CBR?

Community-based Rehabilitation, according to WHO, UNESCO, and UNDP is a strategy within community development for the rehabilitation, equalisation of opportunities and social integration of all people with disabilities. CBR is implemented through the combined efforts of disabled people themselves, their families, communities, appropriate health, education, vocational and community development services.

The strategy was arrived at after noting that institutional rehabilitation is expensive, requires highly specialized personnel, reaches less than 2% of the target group and is not sustainable. It also creates an artificial environment for the PWD, isolation from the family and the community.

Implementation of CBR:

CBR should be implemented at various levels with a wide range of involvement as follows:

The Person with Disability:

The PWD is the centre of all rehabilitation activities. Rehabilitation is done for the physical, sensory, mental, social, and economic improvement of the person. Efforts are made to achieve social integration and access to services first in the family, the community and beyond. The individual and the family need to identify the needs and effectively address them.

The Family:

Family members of the person with disabilities are the major partners in the rehabilitation process. They need to be positively supportive to the PWD to encourage him develop skills to live a successful independent life. In many instances where there are no rehabilitation services, efforts of the family are the basic source of rehabilitation activities. A child is taught to move around, deformities are prevented with massage and correct positioning, sticks are provided to improve mobility. Many families develop their own communication with the deaf person in the family. With support of outside expertise, the family can contribute tremendously in the rehabilitation process.

The Community:

A Local administrative unit in Uganda's case is LCIII (Sub-county). The unit contains elements of social, education, health and economic development. To apply these services for the benefit of the PWD, a local committee should be identified to ensure that the various sectors: health, education, and social development are actively addressing the needs of PWDs.

It is also essential to have a specially trained rehabilitation worker or volunteer or both who can work hand in hand with families, the local committees and the various sectors within the community.

At District level:

At district level especially in Uganda, with decentralisation, the District should offer referral services, health, education, skills development and employment opportunity.

There should be an established system for running CBR programmes, manage and evaluate them. There should be a District committee responsible for CBR to ensure that District level services respond to community needs.

Rehabilitation workers at this level travel throughout the area to provide technical supervision. In Uganda, there are rehabilitation workers in the District Rehabilitation Office who team up with rehabilitation teams from the District hospital, EARS programme and other relevant services.

The District Rehabilitation office also co-ordinates activities with other sectors, i.e., education, social services, sports, labour, health Disabled Peoples' Organisations (DPOs), Institutions and NGOs related to rehabilitation. They all need to agree on the mechanisms of referral and information exchange.

The Education sector is responsible for providing enough trained teachers at community levels and to ensure inclusion of PWDs in schools.

The District hospital is the first referral level service for PWDs. It is therefore the responsibility of the hospital to ensure that physicians, prosthetics, or othortists, occupational therapist, speech therapists, and physiotherapists.

National Level:

The major activity at this level is the formulation of policies that support the CBR concept and programmes. When CBR is established at national level, it should be reflected in policy programme priorities within all sectors and at all other levels. Ministries in turn establish guidelines for implementing policies at district and community level. The participation of persons with disabilities in all these activities is essential.

Other participants include:

These are external stimuli that help to catalyse internal community development. They include local NGOs at all levels that are working with communities in CBR programme. They carry out specialized activities, provide financial support to local initiatives or offer CBR training.

International NGOs' advocate to government to adopt and implement international rehabilitation policies. They also support national CBR programmes.

A successful CBR programme should have the following:

- Community leaders and organisations that agree to support and participate in the programme.
- Community rehabilitation workers who will be available.
- Personnel who will train and support the community workers.
- Rehabilitation personnel who will be available within the district and referral hospitals.
- Referral services that will provide basic appliances and equipment.
- PWDs represented on rehabilitation committee at all levels.

In order to ensure sustainability of the programme, the following are crucial and interrelated. The community should own the programme. This can be done if:

- They clearly articulate the needs of PWD..
- They have the commitment to address the need
- They are assured of support from the various referral levels.
- They receive adequate knowledge and skills to overcome cultural beliefs and negative attitudes, and are empowered to promote their own rehabilitation.
- Government policies promote community efforts in favour of PWDs i.e., representation at various levels of governance.

What can you do as a health provider to strengthen the above attributes?

Challenges of CBR:

- Slow process
- Less skilled personnel used
- Expensive
- Low technology
- Inadequate unequipped social services
- Difficulty in changing attitudes and beliefs
- Poor funding

PHC vis-à-vis CBR:

A question that is always asked: Isn't Primary Health Care sufficient without Community Based Rehabilitation?

CBR as a strategy overlaps with Primary Health Care since it involves the aspects of primary health care but it differs in that it has special concerns.

Many elements of Primary Health Care are crucial for CBR such as immunisation, reproductive and child health services. These correspond to the primary and secondary prevention of diseases and injuries to prevent impairments. The PHC personnel therefore contribute significantly to disability prevention.

CBR however, covers aspects that are specific to rehabilitation and are not inclusive in the PHC elements. These are mainly the economic aspects of rehabilitation.

In their various roles, Physicians, Nurses, Midwives, Health Assistants and Primary Health Care workers provide preventive, promotive, curative and rehabilitative health care services. They are well placed to detect impairments or disabilities. All these Health Care Personnel should, therefore, be trained to work hand in hand with CBR personnel.

Discussion:

- *What position are you holding as Health Care Personnel?*
- *How are you involved in the rehabilitation process?*
- *List the personnel, other than those in Health Care, that you consider vital to work with in the rehabilitation process*
- *What is your role in their work?*
- *Outline the referral system in your region for the following:*
- *Person with visual impairment*

Person with epilepsy
Person with cerebral palsy
Person with hearing impairment
Person with amputation of the lower limb
Person with mental illness
Person with a stroke
Person with mental handicap.

Interdisciplinary Team in Rehabilitation

Physiotherapist

Physiotherapy is a mode of medical rehabilitation where the physiotherapist assists physically disabled persons to cope with activities of daily living through:

- Exercise therapy
- Provision and training in the use of orthopaedic appliances/Assistive devices;
- Stimulation of milestones in delayed development;
- Counselling of persons with disabilities and their families in the prevention, reduction of impact of disability, encouraging continuous and proper use of appliances and performance of prescribed exercise for effective results.

Contribution to Positive Difference

By assisting a disabled person to move more easily, the physiotherapist improves the productivity of the PWD and increases his/her chances to access social services including education.

Physiotherapy services are available at the following hospitals:

Mbale, Tororo, Lira, Gulu, Masindi, Nakaseke, Mbarara, Arua, Masaka, Mulago, Hoima, Gombe, Nsambya, Mengo, Rubaga, Kisiizi, Kabale and Moyo.

A Psychiatric Nurse:

- Provides nursing care for patients with mental disorders and epilepsy;
- Carries out health education on mental disorders and epilepsy;
- Runs a mental health clinic in the absence of a psychiatric clinical officer;
- Helps in the formation of parent support groups;
- Counsels and appropriately refers persons/children with mental disorders and epilepsy.

Contribution to Positive Difference:

Psychiatric Nurses educate, counsel and treat the mentally ill and those with mental disabilities. They also counsel the families of the PWDs thus assisting both parties to cope with the situation and to live positively.

Psychatric Nursing services are available at the following hospitals:

Butabika, Mbarara, Mbale, Tororo, Arua, Masaka at the Director of District Health Services' office, **Kabarole, and Gulu.**

Psychiatric Clinical Officer

- Treats persons with mental disorders and epilepsy;
- Refers patients with mental disorders and epilepsy ;
- Trains other health workers to care for persons with epilepsy and mental disorders;
- Counsels the affected persons and their families;
- Advises employers on placement and working conditions for people mental disorders and epilepsy.

Contribution to Positive Difference

The Psychiatric Clinical Officer is a key person in the treatment of mental disorders and epilepsy. He/She helps in reducing the impact of social stigma on the mentally ill/mentally disabled persons and their families. In addition, the families themselves are taught not to stigmatise their handicapped members and to live with them more positively.

Psychiatric clinical services are available at the following hospitals:

Butabika, Mbarara, Jinja, Soroti, Arua, Mbale, Kabale, Mbuya military hospital and Nakasongola military hospital, Gulu and Kabarole.

Occupational Therapist:

Provides mental, physical and social services to the PWDs through:

- Training in activities of daily living;
- Assessment of the impairment or disability,
- Providing guidance and prescribing activities for rehabilitation,
- Prescribing relevant activities in form of work, leisure and personal care such as feeding and dressing,
- Adopting the environment for accessibility.

Contribution to Positive difference

Occupational therapy equips PWDs with tools for independence in activities of daily living.

Occupational therapy services are available at the following hospitals:

Mulago, Butabika, Masaka, Buluba, Nakaseke, Mengo, Mbarara, Fort Portal, Hoima, Kisizi, and Arua.

Orthopaedic Technologist

Measures, designs, and makes prescribed assistive devices such as wheel chairs, callipers, crutches, special chairs, walking sticks, splints, special shoes and artificial limbs.

Contribution to Positive Difference

By providing a wide range of assistive devices, the Orthopaedic Technologist improves the movement ability of PWDs thereby increasing their capacity for self reliance:

Orthopaedic Technology services are available at the following hospitals:

Adjumani, Buluba, Kumi, Mulago, Fortportal, Gulu, Mbale, Mbarara and Kabale Federation of disabled People workshop.

Ear Nose and Throat (ENT) Clinical Officers

- Diagnose ear, nose and throat related problems, administers treatment for minor problems by carrying out minor surgery and prescribing cleaning of ear and drugs.
- Refers ENT patients for major surgery;
- Counsels both ENT patients and their relatives;
- Refers patients for ENT special services such as schools for the deaf;
- Trains the family and the deaf child to communicate;
- Advises patients and their caretakers on integration into ordinary schools;
- Provides health education for prevention of hearing loss and impairment;
- Prescribes hearing aids for those with severe loss of hearing.

Contribution to Positive Difference

Treatment of ear, nose and throat related health problems and this helps to minimize the occurrence of hearing impairment or total loss of hearing.

It also leads to provision of better communication skills between the disabled persons and the public.

At the moment, ENT clinical services are available in **Mulago hospital** only.

- As a health worker, at what level of prevention would you take the most active part? Give reasons.
- List the key persons /sectors in your area that are important in the prevention process.
- How best can you work together?

Responsibilities of a health worker in disability.

Health workers in their practice in the Health Units in rural and urban communities meet patients with various disabilities, unfortunately these patients rarely come complaining of disabilities. While interventions for most of the disabilities exist, the health workers, People with Disabilities and the community in general are not sensitized about the available opportunities.

Health workers should be able to:

1. Recognise the various disabilities in the community
2. Prevent potential causes of disabilities

3. Identify disabilities early
4. Manage disabilities
5. Refer PWDs appropriately
6. Follow up disabled people and their care takers
7. Sensitize the community about disabilities
8. Counsel PWDs and their relatives about disabilities
9. Collect, maintain and use data on PWDs using HMIS.
10. Net work with partners in rehabilitation.

UNIT TWO: MOVEMENT DISABILITIES

What is movement disability?

Difficulty in moving parts of the body. This may involve difficulties in moving parts of the body such as hand to mouth, or difficulty moving from one place to another.

In this unit you will be able to learn about:

- Poliomyelitis
- Traumatic injuries
- Bone and joint infections
- Club foot
- Cerebral Palsy
- Spinal lesions/Injuries

TOPIC I POLIOMYELITIS

Objectives:

By the end of this topic, you will be able to:

1. **Define poliomyelitis**
2. **List the causes of poliomyelitis**
3. **Describe the mode of spread**
4. **List the clinical features of poliomyelitis**
5. **List complications of poliomyelitis**
6. **Manage poliomyelitis**
7. **Carry out preventive services**

What is Poliomyelitis?

Poliomyelitis is a systemic viral disease that affects the Spinal Cord and the brain stem with resulting partial or complete paralysis of muscles. Once muscles are completely paralyzed, they cannot cause movement.

Causes

Poliomyelitis is caused by polio virus.

Mode of transmission: Oral faecal contamination
Droplet infection (where sanitation is good)

Prevention

1) Encourage parents to immunize their children
2) Offer health education regarding:
   - Personal hygiene
   - Food hygiene
   - Disposal of human excreta

3) Report all cases of acute flaccid paralysis to the office of the District Director of Health Services (DDHS).
4) Prevent secondary disabilities (deformities and contractures) through proper nursing care, exercises, follow up and the use of assistive devices.
5) Encourage community surveillance for acute flaccid paralysis.

SIGNS AND SYMPTOMS

Acute stage: Fever, headache, cough, running nose, diarrhoea, neck pain, muscle tenderness, general body aches, nausea, vomiting, muscles spasms, multiple joint pain

Paralytic Stage:
Depends on the nerves affected
May affect one to four limbs and the trunk. In mild cases only a small group of muscles is affected. Paralysis is of flaccid type. Muscle wasting is asymmetrical.
Sensation and intelligence are not affected.

Residual (Permanent) Paralysis:
This is the paralysis which occurs 60 days after the onset of paralysis.

Permanent paralysis:
This is the paralysis which persists one year after the paralytic stage, when no further recovery of muscle function is expected.

Complications of Polio
When muscles are paralysed they cannot contract. This leads to the following complications:

- Loss of muscle function
- Contractures
- Deformities.

Typical Contractures in Polio
A Chid with paralysis who crawls around like this and never straightens her legs will gradually develop contractures so that her hips, knees, and ankles can no longer be straightened.

Picture of person affected by Polio

Typical Deformities of Ankle and Foot


bending down at ankle (tiptoe contracture)


bending down at mid-foot


bending out at ankle


bending in at ankle

MANAGEMENT OF POLIO

It is important to identify and manage polio early in order to avoid complications.

Management of Acute Phase:
Management of Acute Polio depends on the capacity of the Health Unit. If acute Polio is suspected:

- do not give injections.
- give Paracetamol and Oral Chloroquine
- refer to hospital or health centre,

If at HC IV or hospital and acute polio is suspected

- Identify and Isolate acute cases
- Bed rest of acute cases and proper positioning of limbs to prevent development of deformities.
- Splint the limbs to reduce pain and prevent contractures.
- Give analgesics by oral route – paracetamol for children below 12 years of age and Acetylsalicylic Acid for those above 12 years old.
- Do not give any Intra-muscular injections
- Do not exercise during this acute phase (4 weeks from on set)
- Carry out laboratory tests e.g. ESR, WBC, and Blood Smear to rule out malaria
- Send the stool to Virus Research Institute using reverse cold chain within 2 weeks of onset of paralysis. This is important for surveillance.
- Identify and refer to hospital for management

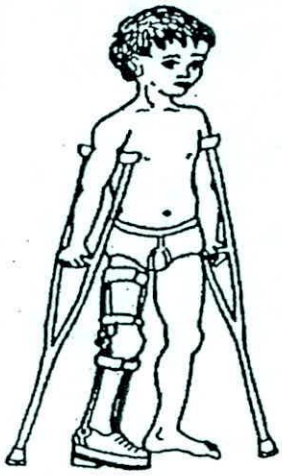
Take two stool samples 24 hours apart and transport to Virus Research Institute within 72 hours.
Avoid intramuscular injections
Do not exercise during this acute phase (4 weeks from on set)

Paralytic Stage
When paralysis is established and pain has reduced start passive movements with the help of a physiotherapist.

Residual Stage
Many patients will come to you at this stage. Refer them to hospital for further management. Give information on available opportunities so that the PWDs can make informed decisions.

Note: Children below 15 years may benefit from corrective surgery.
Appliances should be prescribed by Occupational Therapists, physiotherapist and surgeons.

Picture showing a child with callipers, special boot and crutches



Early identification and rehabilitation is important in order to avoid complications.

COMPLICATIONS

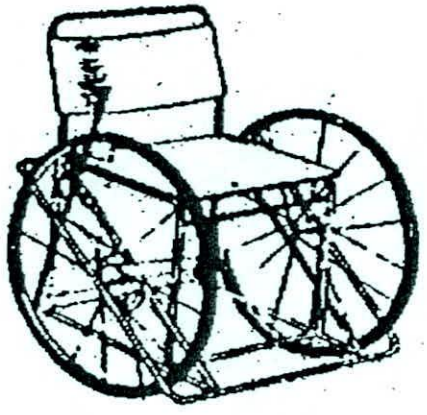
Limb deformities (Contractures)
Skeletal muscle paralysis
Pressure sores

FOLLOW UP

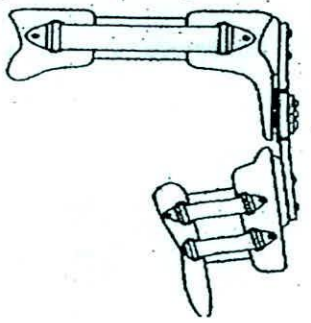
Assistive devices need to be checked regularly because they wear out and children out grow them.

For children, assistive devices should be changed after every six weeks to six months because some children grow faster than adults. Parents and families therefore need to be involved in monitoring the devices.
For adults, change of appliances can be done annually, or whenever there is a problem with the device.

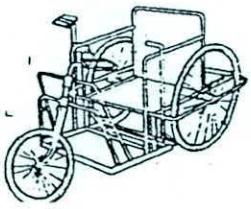
Wheel Chair



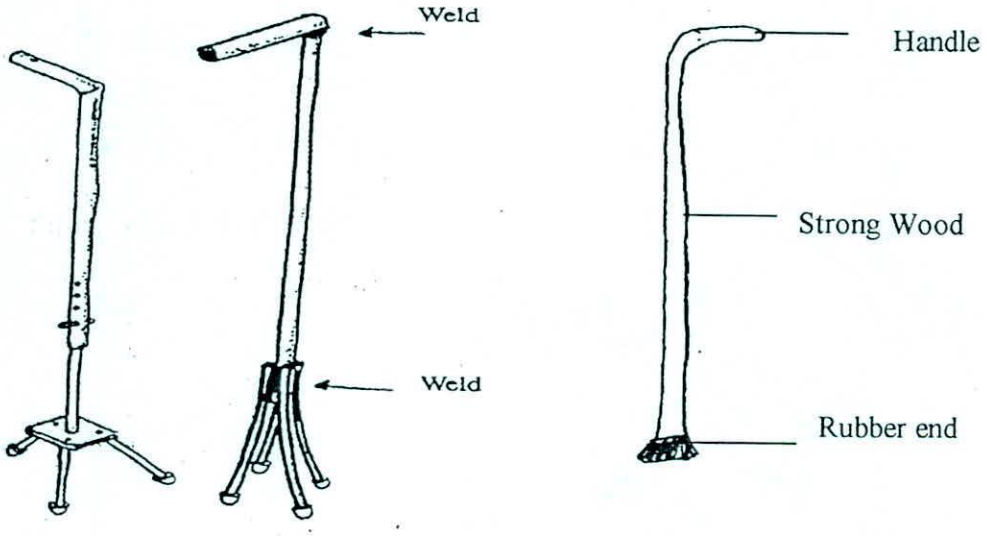
Standard Newport Hip Orthosis



One-hand Driven Tricycle



Metal sticks are useful – their height can be adjusted to suit individual needs. To obtain the correct height, measure in the same way as the wooden walking stick.



Check on appliances of PWDs who come to the health unit for other medical problems.

For post surgery clients, there is need for close follow up to ensure proper use of prescribed assistive devices, exercises and reviews. This will prevent occurrence of the deformity.

Health Education and counselling

Inform the PWDs, family members and relevant service providers such as teachers about polio using information from this manual.

Counsel the individual and family to come to terms with the disability and its consequences and the role they can play in disability management.

People with polio have normal intelligence.
Polio does not affect the ability to have children.
Encourage the PWDs to take responsibility for their rehabilitation.

TOPIC 2: TRAUMATIC INJURIES, (FRACTURES, JOINT INJURIES AND AMPUTEES)

Objectives:

By the end of this topic, you will be able to:

1. **Define traumatic injuries.**
2. **List the causes of traumatic injuries.**
3. **List characteristics of traumatic injuries.**
4. **Manage traumatic injuries.**
5. **List complications of traumatic injuries.**
6. **Carry out health education on prevention of traumatic injuries.**

Traumatic Injuries

What are they? These are open or closed wounds caused by an impact on the body.

Causes:

1. Trauma from:

- Road Traffic Accidents
- Falls from Heights
- Violence such as child abuse, assault ,wars, gunshot wounds, landmine blasts e.t.c.
- Sports
- Industrial accidents,
- Home accidents

2. Pathological causes such as:-

- Osteomyelitis
- Tumours
- Osteoporosis (lack of calcium)
- Brittle bone diseases

SIGNS AND SYMPTOMS

1. There is pain, swelling, restricted movement/function of affected limb or joint or limb function.
2. Fracture may be open or closed
3. In case of spinal injuries there may be quadriplegia (paralysis of four limbs) or paraplegia (paralysis of lower limbs and incontinence of urine and faeces).

MANAGEMENT

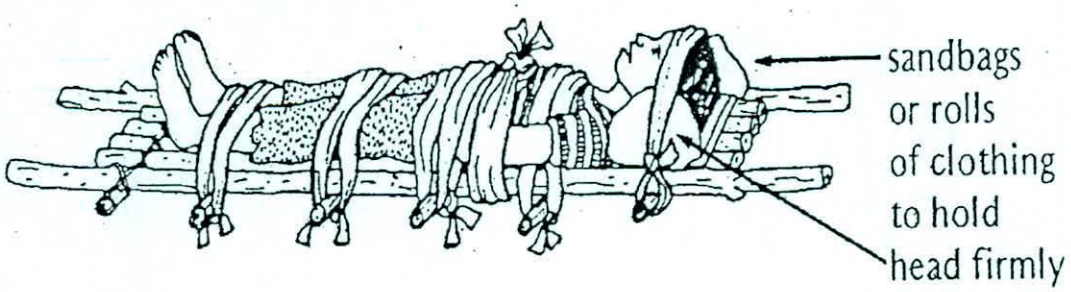
Pre-Hospital Care

- Continuous re-assurance to the patient and relatives is important.
- Arrest bleeding with clean cloth
- Immobilize the affected limb by using splints or tying the patient firmly on the stretcher.
- Avoid unnecessary movement
- Check breathing
- Check the pulse
- If unconscious put in semi prone position.
- Avoid forcing anything down the mouth in case of unconscious patients.
- Avoid tight tourniquets.

If you think the spinal cord might be injured:

- Do not move the person until a health worker with a large board or stretcher arrives. Especially **avoid bending the person's neck and back.**
- Lift the patient without bending him, onto a board or stiff stretcher. (A stiff rack is better than a soft stretcher. Make one stiff rack out of poles from trees or whatever is available). Make ties of strips of clothing, or whatever you can.
- Tie him down firmly and stabilise his head.
- Carry the patient to medical centre or hospital. Try not to bounce or jiggle him.

Picture showing how to handle and transport a person with traumatic injuries



Health Unit Management:

Patients and relatives should be reassured continually.

- Take history
- Do physical examination with emphasis on the Musculo-skeletal system for characteristics of fractures and dislocations.
- Give first Aid
  - check breathing
  - check pulse

- arrest any bleeding in case of open wounds.
- if in shock, treat for shock.
- give analgesics
- splint the limb with well padded splint
- do surgical toilet in case of open wounds.
- give tetanus toxoid in case of open wounds
- give antibiotics
- refer all fractures and dislocations for further management in hospital.

Spinal injuries should be handled with caution to avoid further damage to the spine.

Post-Hospital Management/Rehabilitation

Some patients referred to hospital may return to the community with permanent disability necessitating follow up by health facility, family and community support.

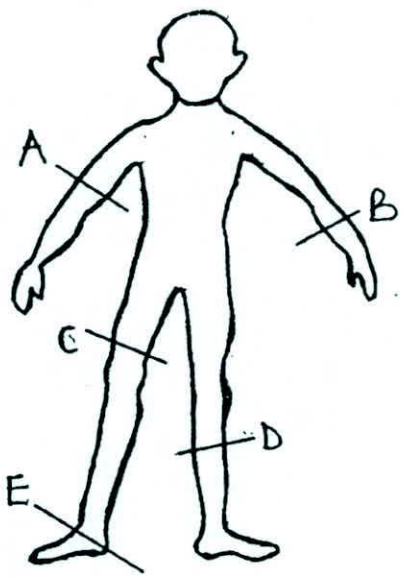
SPINAL INJURY

Refer to section on spinal cord lesions (Unit 2 –Topic 6).

AMPUTEES

This is a sub-topic which refers to amputation of limbs.
The commonest are amputations of the lower limb. These are named after the level of amputation.

Picture showing different locals of Amputations



Levels of Amputations

A - Above Elbow
B - Below Elbow
C - Above knee
D - Below knee
E - Through the ankle

- Encourage independence in the amputee.
- Train in taking care of stump, crutches and or artificial limb.

COMPLICATIONS OF TRAUMATIC INJURIES OF BONE AND JOINTS

Early - Haemorrhage, Shock, infection, Injury to the surrounding structures – nerves and blood vessels, Gangrene.

Late: - Mal-union, Non-union, Delayed union, Pressure sores, Infection e.g. osteomyelitis, Joint stiffness & contructures.

In order to avoid complications, ensure:-

1. Early management of fractures
2. Training of traditional bone setters
3. Sensitization of the community
4. The patient is informed of the available and affordable appliances and the presence of locally trained artisans who make and repair them.

Follow up:

- Settle the PWDs in the community by counselling the clients, family and community.
- Give relevant health messages.
- Help PWDs to adapt to the environment
- Ensure that the PWD complies with discharge instructions
- Monitor for any complications.

PREVENTION

- Give Health Education about causes of various injuries and fractures.
- Advise communities to take injured people to the nearest health facility immediately.
- Teach the communities basic principles of First Aid.
- Encourage communities to resolve conflicts.

TOPIC 3: BONE AND JOINT INFECTIONS

Objectives:

By the end of this topic you will be able to:

1. **List the causes of bone and joint infections.**
2. **List the clinical features of bone and joint infections.**
3. **Manage bone and joint infections.**
4. **List complications of bone and joint infections**
5. **Carry out health education on bone and joint infections.**

Although bone and joint infections are not disabilities they are disabling because they are chronic.

This is an invasion of bones and joints by pathogenic microorganisms like bacteria leading to pathological changes.

These infections include osteomyelitis septic arthritis, tuberculosis of the spine.

Signs and Symptoms of Osteomyelitis:

1. Pain, tenderness and swelling of affected limb.
2. In the acute stage there is loss of function of the affected limb. (The acute stage lasts for only 24 hours).
3. In chronic osteomyelitis there is pus- discharging sinuses. Thickening of the bone may occur.
4. Osteomyelitis may cause pathological fractures

Signs and Symptoms of Septic Arthritis:

1. Pain, tender swelling of the joint,
2. Fever
3. The affected joint is hot
4. Loss of function of the joint
5. Flexion deformity
6. May be complicated by dislocation of the joint

Management of Osteomyelitis & Septic Arthritis:

1. Admit acute cases.
2. Splint the limb.
3. Give antibiotic (Refer to National treatment guidelines).
4. During the first 48hrs, joint aspiration can be done.
5. Monitor patients temperature to assess progress.
6. Monitor function of limb to assess progress.
7. Carry out the following investigations:
   - Blood smear for malaria parasites,
   - Sickling test to rule out sickle cell disease,
   - Do full haemogram and ESR as baseline investigations,
   - Refer to the nearest hospital for further management as soon as possible.

Complications of Osteomyelitis and Septic Arthritis:

- Chronic discharging sinuses.
- The discharging sinuses are foul smelling and may cause social isolation.
- Joint stiffness.
- In children and adolescents bone growth may be affected leading to shortening or lengthening limbs.

- Weakness of bones
- Pathological fractures

REHABILITATION

During the chronic phase exercises are important to avoid contractures. The person may require crutches and raised shoes to help with movement. Sinuses require daily dressing. Teach the client or family to do this.

HEALTH EDUCATION

The patient should be made to understand that the treatment is long term. For example treatment for arthritis can take 6 weeks while oesteomyelitis tends to keep recurring.

PREVENTION OF OSTEOMYELITIS AND SEPTIC ARTHRITIS

Give health education during community out reach and at health unit. Include the following:-

- Daily bathing with plenty of water and soap
- Practice hygienic dressing of wounds
- Discourage traditional method of treatment of wounds that are unhygienic. For example using clay on wounds.
- Encourage communities to treat cellulitis, pyomyositis, arthritis and wounds early by trained health workers.
- Sensitise communities that cellulitis and pyomyositis ("ettalo") are bacterial infections and are not caused by witchcraft.

TUBERCULOSIS OF THE SPINE (POTT'S DISEASE)

This is when the spine is infected by tuberculosis bacteria (mycobacterium tuberculosis). The infected section of the spine – the vertebrae collapses and this causes damage to the spinal cord. The subsequent signs and symptoms of the disability depend on the level of the damaged vertebrae.

The tuberculosis bacteria commonly spread from the lungs or kidney through blood to infect the spine.

Signs and Symptoms:

- Pain in the back which develops gradually.
- A hump called a gibbus develops gradually.
- May present with or without paraplegia.
- Signs and symptoms of tuberculosis of the lungs may be present.

Management:

- If identified in lower health units, refer to a hospital for treatment of tuberculosis, rest and exercises.
- During outreach, ensure that patients complete the anti T.B. course.
- If paraplegia has occurred manage as spinal injury (see Unit 2 topic 2).

Complications:

The main complications is paraplegia. (see unit 2 topic 2) Others include kyphosis..... (spine bending outward), scoliosis (spine twists sideways), stunted growth.

Prevention:

- This involves prevention of tuberculosis and early treatment of pulmonary tuberculosis. Completion of the course is very important for disability prevention and preventing the spread of T.B.
- Prevention of tuberculosis includes:-
  - Good nutrition
  - Immunization
  - Avoid HIV infection
  - Early identification and treatment of family members with tuberculosis.
  - Avoiding consumption of unboiled milk

TOPIC 4: COMMON CONGENITAL ABNORMALITIES OF MOVEMENT

Objectives:

By the end of this topic, you will be able to:

1. **Define congenital abnormalities.**
2. **Identify congenital abnormalities (club foot and spina bifida)**
3. **Manage congenital abnormalities (club foot and spina bifida)**
4. **Carry out sensitisation and health education on preventive measures (club foot and spina bifida).**
5. **List the complications of congenital abnormalities.**

Introduction:

These are many types of congenital abnormalities but in this topic you will learn about club foot only.

Definition:

These are defects present at birth and affect movement /locomotion.

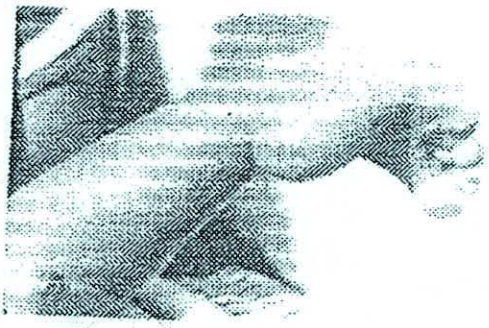
Causes:

The causes are unknown, however, the strongly suspected causal factors in most deformity or congenital abnormality are -pressure on the developing foetus by the uterus, drugs, genetic factors etc.

CLUB FOOT

Definition:

Club foot is a congenital malformation where both the front and hind of the foot are turned to give it a bean shaped appearance.
One or both feet may be affected



club foot before correction

Bent foot does not straighten: If you cannot put the foot in a normal position, it will need to be straightened with strapping or casts.

Examining a club foot

Causes:

The real causes of club foot like many other congenital abnormalities are unknown; however, the suspected causes include:

1. Mechanical: The feet of the growing foetus in the womb/uterus are held in the deforming position for long due to little space to turn around during pregnancy.

2. Hereditary: Club foot can run through families (Genetic)

Types of Club Feet

- Flexible -The deformed foot is flexible and moves easily to the corrective position.
- Rigid - The deformed foot resists movement to the correct position. Club foot/feet may be associated with spina bifida and muscle weakness of the legs.

Management

Club foot, if neglected regardless of the type, can progress into very severe permanent deformities leading to considerable social and health problems.

Club foot must be identified early, managed properly and for the correct length of time.
Refer all children with club foot to the hospital as soon as possible.

Professionals in managing club foot in patients, include orthopaedic officers and technologists, physiotherapists, medical officers and surgeons. Midwives play an important role in early referral of new born babies with club foot.

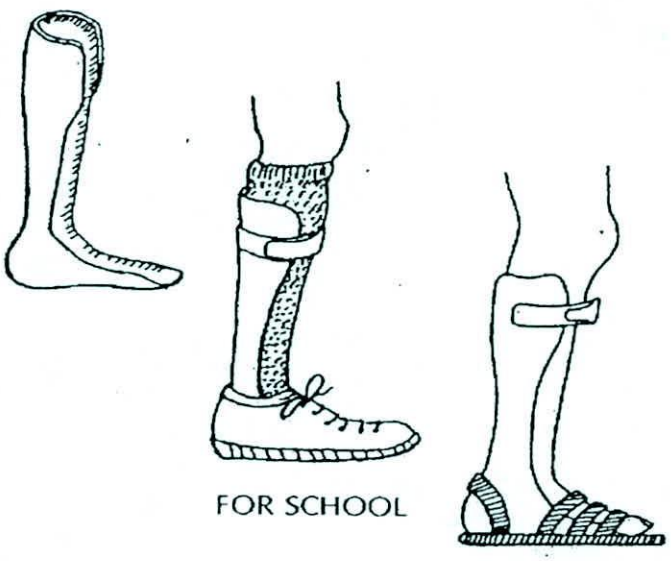
Flexible Type:

1. Stretching Method:

For the Flexible type, if referral is not possible, teach the mother to do the following:

- Move the foot with both hands to the corrective position.
- Hold it in the position while counting 1-10-(if you have a watch maintain for 10 seconds).
- Let go
- Repeat this for 10 minutes.
- Do this whole exercise at least 5 times a day or after breast feeding the baby.
- Review the child weekly.
- Refer to hospital as soon as possible.
- After manipulation for 1-year or when child starts walking, they must wear interchanged shoes (left shoe on right foot and right shoe on the left foot) during the day.
- Use a special splint at night. The diagram is shown below.

Pictures of different splint types



All children with club foot/feet must be referred to hospital early.

2. *Strapping Method*

- The foot/feet are manipulated/stretched in the corrective position and strapped in the position with an adhesive material e.g. zinc oxide or elasto plaster or P.O.P.
- Ensure there is blood circulation in the toes.

Both methods can be continued as long as the deformity persists.

RIGID TYPE

If the deformity is rigid, it can only be corrected by surgical means by a Doctor.

After operation, P.O.P, exercises, corrective boots are required for about 6-months-1 year to avoid the deformity from recurring.

The operation may require about 2-weeks admission in hospital.

HEALTH EDUCATION

- Mothers/care takers who have been taught to stretch the deformed foot/feet should be monitored regularly to ensure the correct procedure is done.
- Monitor progress of club foot correction.
- If plaster has been used ensure that:
  - it is kept dry
  - It is not loose
  - It is not smelling
  - It is not tight (check for gangrene)
  - It is removed on the appointed day and another re-applied in a further corrective position.
- All newly born babies must be examined for deformities and referred to appropriate health units immediately.

Complication of neglected club foot.

- Dislocation of ankle joints.
- Injuries to skin and formation of callosities
- Problems with posture.

TOPIC 5: CEREBRAL PALSY

SUB-TOPIC I: Child Developmental Stages

Objectives:

By the end of this topic, you will be able to:

1. **Define the term"Cerebral Palsy" (CP).**
2. **Describe the normal stages of child development.**
3. **Differentiate between a child with cerebral palsy from the normal.**
4. **Outline the common causes of CP.**
5. **Describe the management of CP.**

Definition: What is Cerebral Palsy?
It's a condition that disables children. It causes difficulty in moving and positioning of the body. There is un-coordinated movement which causes difficulty in feeding and controlling saliva. This is because part of the brain is damaged. The muscles receive wrong messages from the damaged part of the brain which may make the child stiff or floppy. Cerebral palsy may be associated with fits, difficulty in seeing, hearing, speaking and learning difficulty. It is a multi-faced condition where the child has more than one disability and usually affects the child between 0-5 years. As a result of the brain damage, milestones are delayed.

Assessment Tools:

Below are some of the assessment tools used:

i) Normal child development chart showing and explaining what a child is able to do at different stages.
ii) The chart showing comparison between the normal child development and that of cerebral palsy.

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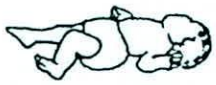
More Signs to Look For

The drawings on the left show the way normal babies move at some important stages of development. The drawings on the right show how the same movement might look when done by a child with cerebral palsy. **To be sure that the child has cerebral palsy, see a doctor.**

Age	Normal Development	Cerebral Palsy
By 3 months	 Lies straight on stomach; holds head up well; pushes up on arms. Lies on back; brings two hands together.	 .Stiff legs. .Cannot lift head. .Cannot push up on arms.  .Pushes back, head to one side. .One arm and leg bent, the other arm and leg straight. .Cannot bring hands together.
By 6 months	 Sits leaning on hands; takes weight on feet when held in standing.	 .Cannot lift head. .Round back. .Stiff arms and fisted hands.  .Head falls back or pushes back when he is pulled to sitting.  .Tiptoe standing. .Arms pull back. .Stiff legs which are crossed like scissors.
By 9 months	 Sits alone; reaches out; supports self when placed in standing.	 .Round back. .Poor use of hands for play. .Stiff legs, pointed toes.  .Does not take weight on legs. .Poor head lifting.
By 12 months	 Pulls to stand holding something; crawls well.	 .Difficulty pulling to stand. Stiff legs, pointed toes.  .Cannot crawl. .Uses only one side of body or drags self by only using arms.
By 18 months	Stands and walks alone; moves into and out of sitting; sits straight; uses both hands. 	One arm stiff and bent. Tiptoe walking on one side. Poor standing balance  Uses mostly one hand to play. .One leg may be stiff. .Sits with weight to one side 

Head and Body Control **Sitting** **Moving from Place to Place**

identified.

Common Causes:

Before Birth

- Infection of the mother during pregnancy e.g. German measles, syphilis.
- Hereditary causes.

At Birth

Birth injuries (Brain Damage) arising from:

- Premature delivery
- Lack of oxygen at birth (Asphyxia)
- Cephalopelvic Disproportion

After Birth

- Jaundice (Yellowing of the skin, urine and eyes)
- Brain infection e.g. meningitis, cerebral malaria, tetanus
- Accidents causing head injuries
- Rhesus factor incompatibility (ABO)
- High fever causing severe convulsions

Important Facts about Cerebral Palsy

- **Most children with Cerebral Palsy are intelligent.**
- **Children who are malnourished are vulnerable to getting diseases which may lead to Cerebral Palsy.**
- **Cerebral Palsy is not contagious .**
- **Cerebral Palsy is a very common problem in Uganda. 1 in every 300 children are affected.**
- **Children with Cerebral Palsy can grow to adulthood if well cared for.**

Signs and Symptoms

The symptoms below vary from child to child.

- Excitement makes some of them increase muscle tone.
- Muscles are stiff and tight.
- Movements may be slow and awkward or in some severe cases very limited.
- The child has abnormal postures and gradually develops deformities
- The pattern of stiffness varies from child to child.
- Slow or quick movement of the feet, arms, head, hands or face muscles without purpose (wriggling).
- A child may get unsteady shaky movements when he/she tries to balance, walk or do something with his/her hands .
- Slow development .

- Unusual behaviour for example, the child is irritable, cries a lot or is quiet and sleeps too much.

Early Signs of Cerebral Palsy

The early signs of stiffness or floppiness may be noticeable soon after birth. Other signs may take several months before they become obvious. **To be sure that the Child has cerebral palsy, take him to a doctor.**

The following signs are of concern if they are seen most of the time. Not every child will show all of these signs.

Jerky, or slow wriggly movements of her legs, arms, hands and face. Poor balance.

Unsteady shaky movements. Unsteady walking. Poor balance.

Things Families Notice

Sudden Stiffening
In some positions, like lying on the back, it becomes difficult to bend the baby's body, to dress or cuddle him.

Floppiness

The baby's head flops and he cannot lift it.
His arms and legs hang down where he is held in the air.
The baby moves too little.

Slow development
Learning to lift his head, sit and use his hands takes longer than expected. He may use one part of his body more than another. For example, some babies only use one hand rather than learning to use both.

Poor feeding
Sucking and swallowing is poor. His tongue pushes the milk and food out. He has difficulty closing his mouth.

Usual behaviour
He may be a crying, irritable baby who sleeps badly. Or he may be a very quiet baby who sleeps too much. He may not smile by the age of three months.

MANAGEMENT OF CEREBRAL PALSY

After identifying a child with Cerebral Palsy :

- Re-assure the parent/patients/caretakers.
- Teach the parent/care taker the appropriate feeding, positioning, carrying and physical stimulation techniques which are described later in this topic.
- Refer to the Hospital for further management preferably to the physiotherapist or occupational therapist.

COUNSELLING

- Re-assure the parent/caretaker, give her information about the condition and what can be done for the child.
- Encourage the parent/care taker to care for the child and visit the health centre/hospital whenever the child is sick. Cerebral Palsy children get frequent pneumonia, dental carries.
- Let the parent/cater taker know about the importance of early intervention for better out come.
- Inform the parent/care taker of the nearest clinic for cerebral palsy either outreach or static.
- Encourage the child to participate in family activities
- Encourage the parent/ care taker to be patient because progress is slow, improvement may not be seen quickly.
- Assure the parent/caretaker that Cerebral Palsy is not contagious.
- Inform the parent/ care taker that a child with CP can grow to adult hood and be a

useful citizen if well cared for.

- Inform the parent/care taker that, like all children, children with cerebral palsy can be equally sexually abused and therefore need to be protected.

INTERVENTION

Some of the suitable ways of handling a child with cerebral palsy.

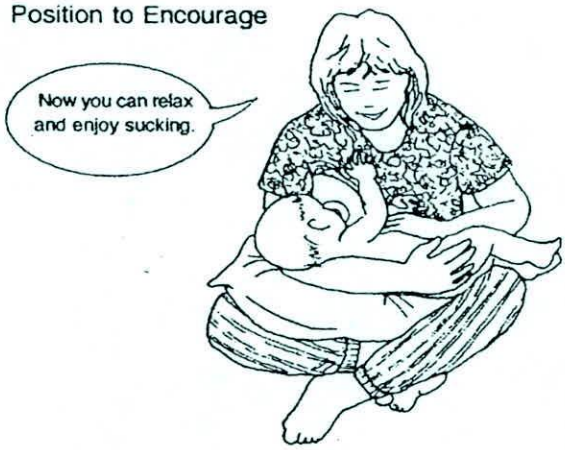
a. Feeding:- The child should be put in a position where she/he will be able to swallow.

Position to Avoid

- Child lying flat
- Head pushing backward

This makes sucking and swallowing more difficult

Position to Encourage



- Turn his body towards you as much as possible
- Hold him in a more upright position.
- Keep both his arms forward.
- Press on his chest to tilt his head forward.
- Keep his hips bent over your knee.
- Any traditional way of sitting can be used as long as the instructions above are followed. A pillow may help position the child.

b. Carrying:- The child should be carried in a position that breaks abnormal patterns

Carrying

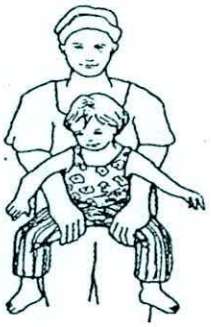
Carry him in a way which corrects abnormal positions and which brings both his arms forward. A more upright position helps him learn to hold his head up and look around.

All very young children can be carried like this.

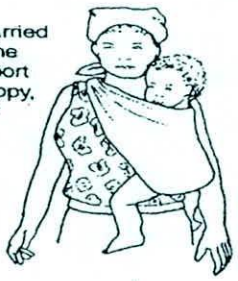
A good position to straighten a spastic child.

A good position to carry a spastic child whose legs cross, or a floppy child.

A good position to carry a spastic child whose legs cross, or an athetoid child.
Use this for short distances.
You can swing him from side to side in this position.



A child can be carried on your back. If he needs more support or his head is floppy, carry him on your side.



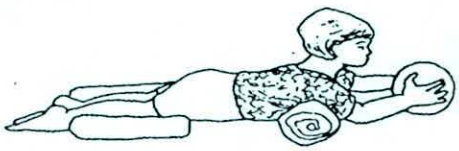
- Lying: The child should be placed and supported in a comfortable position which breaks abnormal postures.

Choose the position which corrects your child best:

Lying on his front

. Place him on a roll, wedge or cushion.

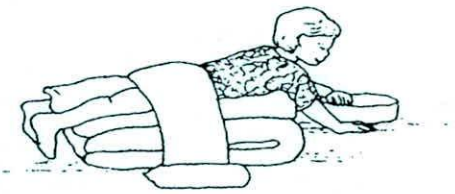
. This keeps his arms forward and helps him to lift his head.



. Hold floppy legs together with cushions or sandbags.

. Hold stiff legs apart with a roll.

. Straighten bent hips with two sandbags joined with a strip of material.



Side lying

. Keep both arms forward to bring his hands together.

. Bend one hip and knee. This stops his legs from pressing together and relaxes his body.

Lying on his back

. Bring his head and shoulders forward.

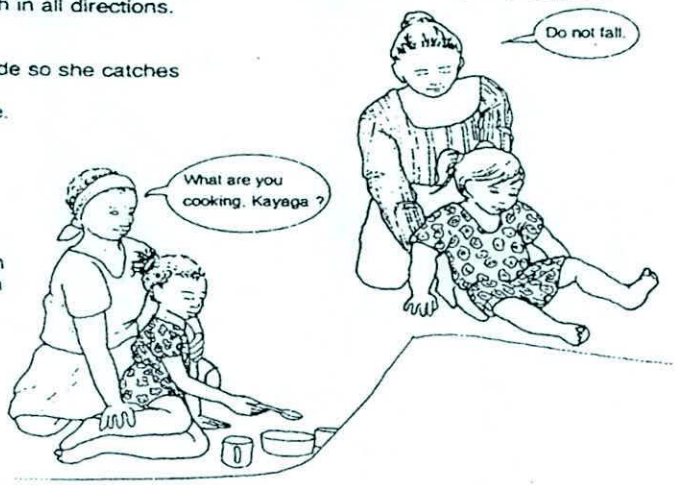
. Bend his hips and knees. This prevents his body from becoming stiff and straight.

- Sitting:- The child should be placed and supported in a comfortable position.

Push her forward and sideways so that she learns to catch herself. As the body balance improves she will be able to lift her hands and will not need to lean on them for support. Teach her to twist and reach in all directions.

. Hold her hips.
. Tilt her gently to one side so she catches herself.
. Tilt her to the other side.

. Sit her to one side.
. Encourage her to reach out in all directions with one hand.
. Hold her other arm straight so she can support herself.

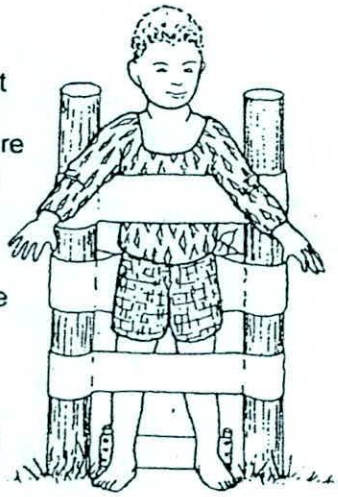


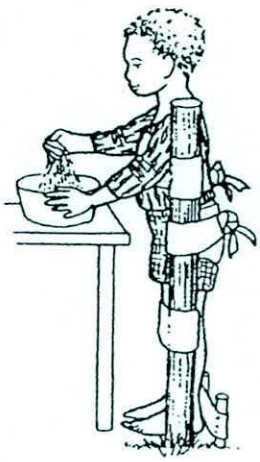
- Assistive appliances should be used where necessary
  e.g. Corner seat (see diagram)
  C.P chairs

- Standing:- The child should be supported in standing by caretaker or standing appliances e.g. standing frame, (see diagram)

If he needs less body support use an upright stander. Make sure the upright poles are pushed well into the ground or fix them to a large square base for use indoors.

Heel board





For children who lean back, bring the chest strap right around the body. Tie at the back.

Pull the ends of the bottom strap firmly to straighten the hips. Tie the ends securely over the bottom.

Note: The handling depends on the findings during assessment. A useful book is 'Promoting Development of Young Children with Cerebral Palsy' A guide Mid-level Rehabilitation workers WHO/RHB/93.1.

Diagrams of simple appliances

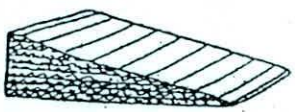
Prone Broad:

A 'wedge' or slanting support is often helpful. The height c
of the particular child.

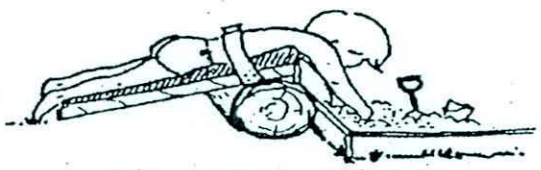
Diana manages best on a wedge high enough so that she can lift herself up a little at arms length. (Height is the length from wrist to armpit.)

Cassio does better on a lower wedge, so he can lift up on his elbows. (Height is slightly less than length from elbow to armpit.)

Wedges can be made with:



stiff foam plastic or layers of cardboard

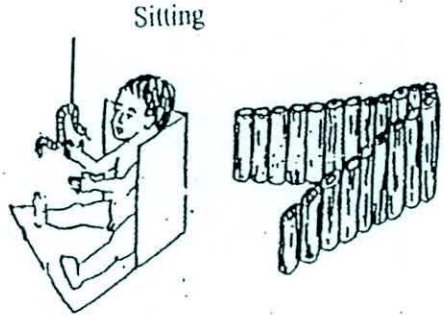


a log and a board with a soft foam cover

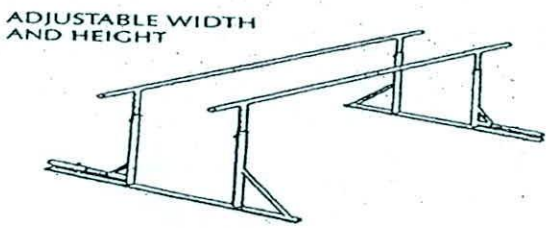
- Corner Seat

This chair can be made from wood, foam or cardboard.

Sitting

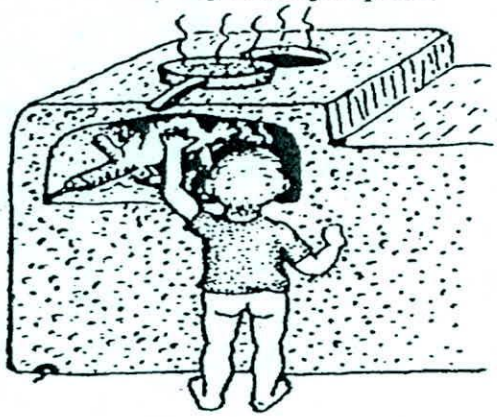


- Parallel Bar



a. Community - Prevent burns for example by using raised fire places.
b. Patient with burns – hygiene, passive and active movement, nutrition
c. Client with contractures: - continue to be active socially, care for the skin, cave money for incidentals and transport for surgery.

Picture of raised fire place



Turn handles of pans on stove so that the small child does not pull them.

TOPIC 8: LEPROSY

Objectives:

By the end of this topic, you will be able to:

1. **Define leprosy.**
2. **Outline the cause of leprosy.**
3. **Describe the signs and symptoms of leprosy.**
4. **Classify leprosy.**
5. **Describe the management of leprosy.**
6. **List the complications of leprosy.**
7. **Outline the management of these complications (emphasise rehabilitation).**

Introduction:

One of the commonest causes of **loss of sensation** (especially in the skin of hands and feet) is the disease **leprosy.** Leprosy has been categorised as one which leads to isolation of people affected by it, because of the stigma attached to the disease.

Cause:
Leprosy is an infectious disease caused by *Mycobacterium Leprae* or *Hansen's Bacilli.* These sources of infection are persons with the infectious forms of the disease who have not received proper treatment. The bacilli leaves such people's bodies mostly through the nose.

Leprosy bacilli once released into the air will enter other individuals through the nose and the skin. Most of the people in whom the bacilli enter do **not** develop leprosy. This is because most human beings have sufficient natural body resistance (immunity) to prevent the disease.

Signs and symptoms:

Leprosy is diagnosed by considering:
1. What the patient is complaining about (symptoms).
2. What the medical worker finds on examination(signs).

Symptoms:

Early: A small patch of recent origin either paler or redder than normal skin.
Numbness
Burning sensation in the skin
Slight weakness of the face, hands or feet

Late: More and larger patches
Painless injuries
Obvious nodules and/or thickened skin (infiltration)
More severe weakness or paralysis of the muscles of the face, hands or feet as shown by e.g. inability to hold things used daily, reduced strength in the hands.

Signs:

Leprosy should be suspected in individuals with any kind of skin patches or nodules. There are three *cardinal signs* of leprosy. Usually more than one of these signs is present, but if you are absolutely certain of only one of them this is sufficient to prove the diagnosis.

1. Diminished sensation to pin prick and/or cotton wool touch (light touch) in a patch on the skin.
2. Damage to peripheral nerves in specific sites resulting in loss of sensation in the skin and weakness of muscles supplied by the nerve. This is often accompanied by enlargement of the nerve trunk *(see annex 1)*.
3. The demonstration of the causative bacilli in skin smears examined under the microscope.

Classification of Leprosy:

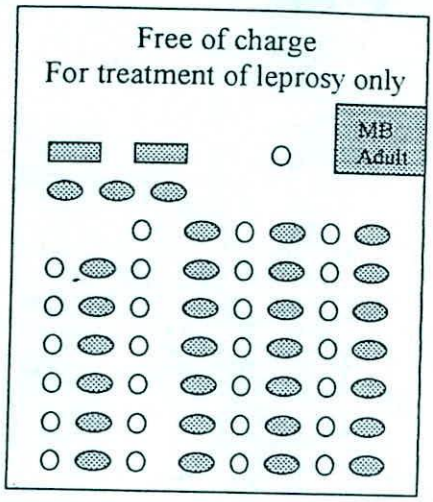
For the purpose of treatment, leprosy patients are grouped into 2 types:
Paucibacillary Leprosy (PB)
Multibacillary Leprosy (MB)
The classification is based on the number of skin lesions (patches) and the number of nerve trunks involved.

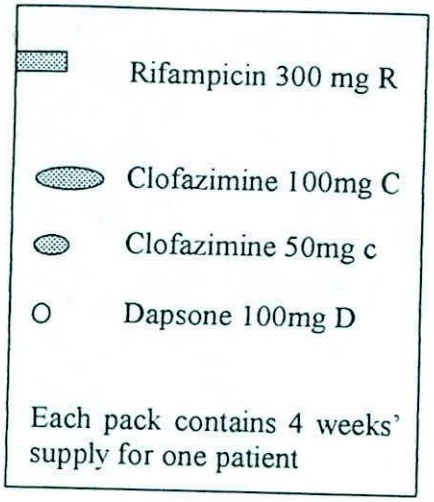
Characteristic	Paucibacillary (PB)	Multibacillary (MB)
Skin lesions	2-5 lesions	More than 5
Nerve damage	Only one nerve trunk	Many nerve trunks

Treatment:

Very effective anti-leprosy treatment called Multi-Drug Therapy (MDT) is available.
Leprosy is a curable disease.
It is essential that the patient takes the correct medicines, in the correct dosage, regularly and for a sufficient duration.
The treatment regimen is as follows:

Diagram I Blister Multi-Bacillary (MB) patients.





Dosage (Adult MB)

Monthly treatment: Day 1

Rifampicin 600mg
Clofazimine 300mg
Dapsone 100mg

Daily Treatment: Day 2-28
Clofazimine 50mg
Dapsone 100mg

Duration of treatment:
12 blister packs to be taken
Monthly within a maximum

Period of 18 months.

Dosage (Child MB 10-14 years)

Monthly treatment: Day 1

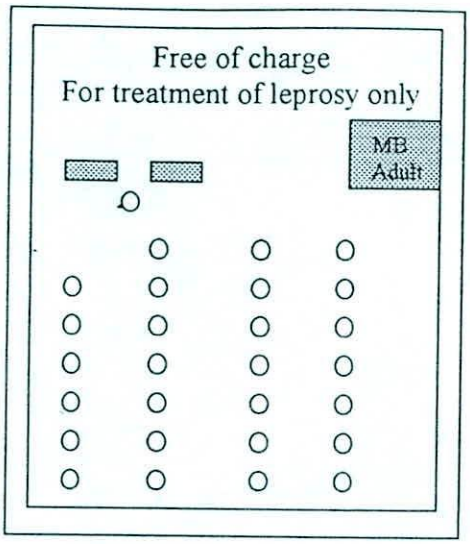
Rifampicin 450mg
Clofazimine 300mg
Dapsone 50mg

Daily Treatment: Day 2-28
Clofazimine 50mg every other day
Dapsone 50mg daily

Duration of treatment:
12 blister packs to be taken monthly
Within a maximum period of 18 months.

Blister Pack for Paucibacillary (PB) Patients

Front



MDT Drugs

Rifampicin 300mg R

Dapsone 100mg D

Each pack contains 4 weeks' supply for one patient

Dosage (Adult PB)

Monthly treatment: Day 1

Rifampicin 600 mg

Dapsone 100 mg

Daily Treatment: Days 2 – 28

Dapsone 100 mg

Duration of Treatment:
6 blister packs to be taken monthly within a maximum period of 9 months.

Dosage (Child PB 10-14 years)

Monthly treatment: Day 1

Rifampicin 450 mg

Dapsone 50 mg

Daily Treatment: Days 2 – 28

Dapsone 50 mg

Duration of Treatment:
6 blister packs to be taken monthly within a maximum period of 9 moths

For children below 10 years, the dose may be adjusted, for example, Rifampicin 300mg, and Dapsone 25mg.

If leprosy treatment is available at your clinic, the patients should be treated according to those guidelines; if it is not available, refer the patient to a health unit where the treatment is available or to the office of the Director of District Health Services (DDHS).

Complications:

1. **Leprosy reactions:**
   Leprosy reactions are episodes of sudden increase in the activity of the disease. This is thought to be due to an alteration in the immunological status of the patient. **Reactions are the major cause of nerve damage and disability in leprosy.** They should be detected early and treated promptly. Reactions commonly occur in the early part of the disease.

The most important type of reaction is known as **reversal reaction.**
It is characterised by the appearance of the following symptoms and signs of inflammation:

- Redness and swelling of skin lesions.
- Pain, tenderness and swelling of peripheral nerves.
- Signs of nerve damage like: loss of sensation and muscle weakness.
- Fever.
- Malaise (not feeling well)
- Sometimes hands and feet may be swollen.
- Rarely new lesions appears.

If there is nerve involvement, the reaction is severe.
Inflammation of nerves may lead to sudden paralysis, weakness, tenderness, new nerve swelling or new nerve damage.

1. **Possible out-comes of nerve involvement (in brackets are the nerves involved)**
   1. Weakness or inability to close the eyelids fully (facial)
   2. Loss of spontaneous blink (trigeminal)
   3. Dryness of the skin of the palms, **loss of feeling,** inability to grasp objects (ulnar and median).
   4. Walking with a *"foot drop"* (common peroneal)
   5. Dry, cracked soles of the feet with loss of feeling (Posterior tibial).

In the management of reactions it is important to identify the above out-comes. When corrective measures are taken early, they are all reversible, they should be routinely looked for at every contact with the patient e.g. whenever he goes to the clinic to collect a new supply of drugs.

All patients coming with early nerve damage or sensory loss should be referred immediately. In addition to treatment and referral, the patient should be told to rest the affected nerve until symptoms clear e.g. using an arm sling in the case of the nerve at the elbow (ulnar nerve).

2. **Complications resulting from nerve involvement:**
   - Permanent loss of feeling
   - Repeated ulceration of insensitive hands and feet that are not properly looked after.
   - Severe complications of the ulcers e.g. infection of the underlying bones (osteomyelitis) leading to bone loss.
   - Deformities.

3. **Other complications:**
   - Blindness
   - Nose deformity
   - Facial deformity
   - Segregation from society (especially with smelly wounds)
   - Self stigmatisation.

HEALTH EDUCATION:

- This should include:
- Causes of leprosy
- Effects of leprosy especially nerve damage

- The general beliefs about leprosy
- Availability of treatment
- Importance of completing treatment
- Importance of noting that reactions occur
- The disease can be cured
- Importance of measures to care for insensitive hands and feet
- Importance of early identification and management of leprosy.

COUNSELLING OF PATIENTS:

- Ask for new complaints and try to explain the cause.
- Counsel for informed acceptance of disease – this may involve a number of sessions.
- Counsel for self care so that a person affected by leprosy does not get further disabilities.
- Counsel for integration in family.
- Bring out the fact that the disease is curable.
- Probe about patient's thoughts, fears and feelings about the disease.
- Talk about the possibility of the condition causing life long complications.

REHABILITATION:

- Recommend where to obtain footwear or any other appliances and where they can be repaired if necessary.
- Check the status of the shoes or appliances in case of those people having them already.
- Those with wounds should have them dressed and be taught self care at home.
- Recommend work patterns which encourage resting of feet and hands.
- Patients with wounds that do not heal or get worse should seek medical attention as there could be complications needing surgical treatment.

Prevention of ulcers (especially foot ulcers)

- Deliberate inspection (looking) for insensitive hands and feet.
- Soaking at least 30 minutes daily in cold water and oiling (applying Vaseline) if they are dry.
- Resting: In built daily activities.
  Avoiding hot, sharp, rough objects
  Avoid excessive walking without rest.
- Protecting: Protecting hands if handling hot, sharp, rough objects.
  Protect tools.
  Protect feet by use of appropriate protective footwear e.g. microcellular rubber sandals.
- Use self care groups.

Care for small wounds:

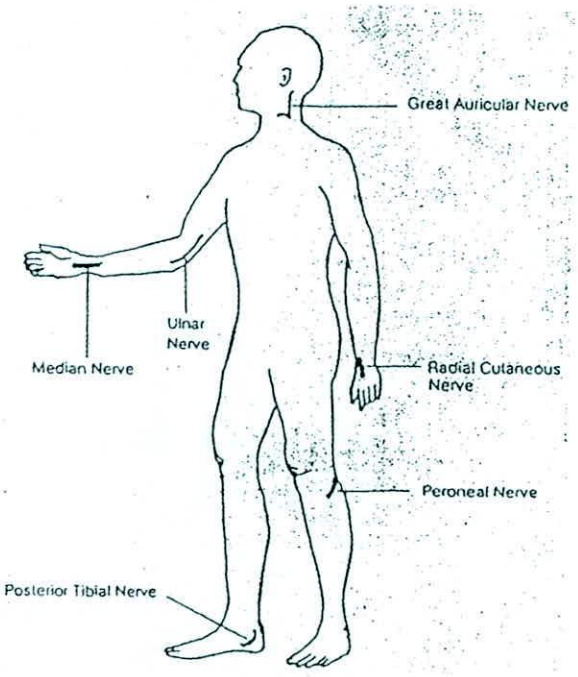
- Daily observation.
- Soaking.
- Washing regularly to keep wounds clean and covering (dressing) with a clean dressing.
- Resting the affected part.
- Using self care groups.
- If the wound is not healing or is getting worse, seek for medical attention.

- **The most effective way to prevent disabilities due to leprosy is early recognition and treatment of the disease.**
- **Persons with Multibacillary leprosy are no longer infectious from just a few days after starting treatment and will never be infectious again if they continue to take treatment regularly.**
- **Damage to nerves is the cause of most of the disabilities which people with leprosy develop.**
- **Early nerve damage can be reversed by medical measures.**
- **Permanent nerve damage raises a high risk of further disabilities**
- **Disabilities cannot be treated easily.**

Unit questions

1. List the signs and symptoms of leprosy.
2. What is a reaction?
3. List the common signs of early nerve damage.
4. How do you intervene when a patient has reactions?
5. What should a person with insensitive hands or feet do in order to prevent them from developing wounds?
6. What should a person with wounds on insensitive hands or feet do in order to encourage healing of the wounds?

Annex I *Places where nerves be felt*



TOPIC 9: ORTHOPAEDIC ASSISTIVE DEVICES (APPLIANCES AND AIDS *(8HRS)*

Objectives:

By the end of this topic, you will be able to:

1. **Define the term "assistive devices".**
2. **Outline the different types of assistive devices.**
3. **Identify faulty appliances.**
4. **Demonstrate the ability to utilize some of the appliances.**
5. **Refer clients who require new appliances or replacement.**

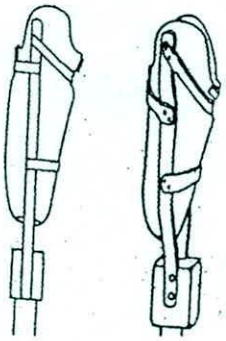
Definition:

These are devices which are used to improve performance of a person with an impairment.

Types of Assistive Devices:
There are those that are used to:

a) Replace lost limbs (artificial limbs or prosthesis),
b) Compensate for weakness in parts of the body (orthosis which include corsets, calipers, crutches, walking sticks and walking frames)
c) Correct deformities(shoes, corsets).

Pictures of Orthosis and Prostheses



Self-adjusting prosthesis

Wrist Hand Orthosis

Spinal Orthosis

Identification of faulty appliances and aids

Health worker should be able to identify the following faults:
1. Walking sticks, Crutches with cracks, worn out or missing tips.
2. Walking sticks and crutches that are too short or too high for the client.
3. Appliances with missing screws and nails.
4. Artificial limbs that are loose and cause pain, fatigue, wounds or are worn out or broken.
5. Shoes and boots that are worn out too big or too small.

REFERRAL

Children who have out grown their appliances and aids should be referred to the district / regional hospital for replacement. On average children and adolescent require two appliances in a year.

Adults who require appliances and aids should be referred to the district hospital for proper assessment and measurement. Adults who have worn out their appliances should also be referred.

Simple appliances such as walking sticks and crutches can be made or repaired by a local carpenter. Please remember that a person who requires a walking stick or crutch for the first time must be assessed by a rehabilitation health worker (occupational therapist, physiotherapist, orthopaedic officer, orthopaedic technician, surgeons and medical officers).

HEALTH EDUCATION

Utilization of Orthopaedic Appliances, Equipment's and Aids.

Health worker should inform PWDs, care takers and communities about facilities where they can get appliances and be taught on maintenance.

A) **Instructions for Users (which the health worker should give).**

Walking Sticks:

- Make sure the walking stick has a rubber tip, and is of the correct recommended height.
- Watch out for any cracks on the stick.
- Replace a cracked stick.

CRUTCHES

- Ensure that the crutches are of the correct size and have rubber tips.
- Observe any cracks, sharp edges and bends on the crutches.
- Watch out for any sticking nails and screws.
- Avoid leaning on crutches while standing/walking.
- Crutches should be placed three fingures distance from the arm pit (5cm).
- Use cushioned crutches for leprosy client .

FOOT WEAR

- Avoid tight fitting shoes.
- Avoid un-cushioned insole, closed foot wear.
- Detect and repair (immediately) any torn and worn out wear.
- Have foot wear with well cushioned insole, hard under soles and no nails or rough edges that would hurt your feet.
- Persons affected by Leprosy require special foot ware that has no nails and is made of a special material called celophane.

ARTIFICIAL LIMBS (PROSTHESIS)

Definition:

These are appliances which serve to replace the function and appearance of a missing limb.

- Prostheses are designed according to the level of Amputation.
- Above Knee
- Below Knee
- Through Knee
- Below Elbow
- Above Elbow
- Through Elbow

Maintenance, Referral and Utilization will be as for other supportive devices.

UNIT THREE: STRANGE BEHAVIOUR AND LEARNING DIFFICULTIES

SECTION A - MENTAL HEALTH CONDITIONS IN CHILDREN

Aim:

This section will enable you to recognise and manage common mental conditions in children. You will learn about :

1. Introduction to mental health conditions in children
2. Mental retardation (learning disability)
3. Hyper-active child
4. Conduct disorders
5. Emotional

TOPIC 1: INTRODUCTION TO MENTAL CONDITIONS IN CHILDREN

Objectives:

At the end of this topic, you will be able to:

1. **List the common mental conditions in children**
2. **Recognise signs and symptoms of mental conditions in children**
3. **Take history from all available sources**
4. **Manage and or refer**
5. **Follow up**

MENTAL CONDITIONS IN CHILDREN

Common mental disorders include:

- Introduction to mental health conditions in children.
- Mental retardation (learning disability).
- Hyper-active child.
- Conduct disorders.
- Emotional disorders.

Activity I: What are the signs and symptoms of mental conditions in children?

Abnormal behaviour in children

- Slow in development e.g. abnormal speech, delayed walking, toilet training.
- Restless, hyperactive, destructive.
- Easily aggressive.
- Bed wetting, loss of bowel control.
- Repetitive behaviour e.g. head banging.

- Does not relate to surrounding and people, has no social attachment to mother/other people
- Crying all the time
- Displays the behaviour of a much younger child

May have features of physical disability.

Activity II: Describe the causes of Mental illness in children

Causes of Mental Illness in children.

Before Birth

- Infections - Syphilis, German measles, Injury to mother, Attempted unsuccessful abortion and others.
- Poor feeding of the mother.
- Drugs – drinking alcohol, herbs.
- Hereditary causes.

During Delivery

- Prolonged labour.
- Complicated & difficult delivery.
- Assisted delivery – forceps, vacuum extraction.

After Delivery

- Repeated convulsions.
- Infections –Tetanus, Measles, Infections of the brain such as meningitis, encephalitis.

Environmental

- Violence in homes.
- Stress.
- Conflicts, civil strife.
- Sexual, physical, emotional abuse.
- Loss of parents.
- Poor nutrition especially at weaning.
- Mental illness of parent/principle care taker .

Activity III: General Management of Children with Mental Illness

Step 1:

1. Listen attentively to the parent/care taker or client/child
2. Let the client or care taker talk about the problem
3. Reassure both client and care taker
4. Refer to hospital where there is a trained mental health worker

Step 2: Follow up of old Cases/Clients

1. Obtain the information about the client problems from family members and involve them in caring for the client.

Questions that could be asked:-

a) How is the Child?
b) What changes have you noticed since the previous visit?
c) How does he behave?
d) Is the child on any medication?
e) What medication?
f) Do you still have the drugs?
g) How do you give the drugs?
h) Has the child received any other treatment for example Occupational Therapy, Physiotherapy, Speech Therapy and traditional treatment?
i) How is the child responding to this treatment?
j) Do you exercise or carry out prescribed activities with the child? How often? or why not?
k) What advise were you given?
l) Do you have any complaint with the therapies given?
m) Is there anything else you would like to tell me about the child?
n) What do you do to help him?
o) Is the child participating in family activities?
p) Is the child independent in ADL?
q) Is the child being tied?
r) When is your next visit?

2. Involve and supervise parents/clients in the treatment programme prescribed in the hospital such as Occupational therapy (O.T) and Physiotherapy (P.T) and Speech therapy (S.P).
3. Encourage parents/caretakers to restore regular habits (eating and sleeping habits)
4. Encourage and or refer the child to special needs education assessment.
5. Children who are able to learn should be taken to school.
6. Encourage integration of child in the family activities according to his ability.
7. Involve the probation officer and the L.C responsible for children

Step 3: Prevention of Mental Illness in Children

1. Carry out health education to the community encouraging:-
   - Immunization
   - Antenatal attendance
   - Deliver at a trained TBA's or midwife's unit.
2. Discourage alcohol and non prescribed drug use during pregnancy. If drugs are prescribed, the health worker should be made aware of the pregnancy.
3. Encourage good nutrition during pregnancy, infancy, and early child hood.
4. Encourage a caring/supporting environment without mental conflicts and alcohol abuse by parents.

TOPIC 2: MENTAL RETARDATION (LEARNING DISABILITY)

Objectives:

At the end of this topic, you will be able to :

1. **Define the term "mental retardation"**
2. **Recognise signs and symptoms of mental retardation**
3. **Assess the severity of mental retardation**
4. **Manage mentally retarded child**
5. **Follow up of child with mental retardation**

Activity I What is mental retardation?

Definition:

Mental retardation is a condition of arrested mental development occurring from birth or early childhood.

Activity II

1. Outline the signs and symptoms of a child with Mental Retardation
2. Compare the signs and symptoms with children of similar age using the following developmental milestones.

Age	Physical	Social
3 months	Finger gripping	• Smiling • Babbling • Recognizing mother
6 months	Sitting	• Attachment to care taker • Interested in toys and sounds
9 months	• Rolling over • Standing	• Beginning to feed self
1 year	• Walking • Run	• Drinking from cup • Saying Tata, Maama • Obeying simple instructions
3 years	• Walking on tip toe • Grasping fine objects	• Toilet trained • Making 2,3 word sentences
5 years	• Hopping on one foot • Throwing and catching a ball	• Helping with simple work • Bathing and dressing self • Longer sentences construction • More vocabulary

Activity III Classify mental retardation

Mild: Uniformly low performance in all kinds of intellectual tasks including learning, can go to school but perform poorly.
Normal language ability and social behaviour.

Moderate: Learn to communicate
Learn to care for themselves but with supervision

Severe: Can not look after themselves completely
Require to be cared for all the time,
ADL dependant

Activity IV Describe the Management of a Mentally Retarded Child

1. Early detection of mental retardation
2. The general approach is habilitative and educational rather than medical.
3. Encourage formation of parents/care takers' support group.
4. Liaise with other medical workers, special needs teachers and social workers.
5. Should they develop other disabilities like epilepsy, psychiatric disturbances, relevant guidelines should be followed.
6. Occupational therapy programmes in areas of self care e.g. toileting and feeding.
7. Activity of daily living (ADL) for example toileting, cooking, sweeping, washing.
8. Vocational activities/income generating such as mat making, carpentry.
9. Therapies that stimulates development. Examples are helping the child to stand using physiotherapy; speech therapists assist the child with language and speech development.
10. Encourage recreation activities such as games, story telling, music and drama.

Emphasise the Importance of

HEALTH EDUCATION AND COUNSELLING

1. Genetic Counseling:-
- Explaining to couples the possibility of having similar child if they have one already.
- Discourage women from giving birth before 20yrs and after 35 years of age.

2. Prenatal Care
- Advise mothers on the following:
- To avoid alcohol, cigarettes and non -prescribed medication.
- To eat a balanced diet.
- Get immunized.
- Check VDRL
- Attend antenatal care regularly

3. During Birth:-
- Deliver in hospitals, maternity centre or by a trained TBA.
- Report to hospital to ANC so that a big baby, small pelvis or other complications are detached early.

4. Post natal Prevention:
- Early diagnosis, proper treatment of child hood illnesses including malaria and fits.
- Ensure consumption of iodized salt.
- Vitamin A supplementation.
- Proper nutrition.

- Immunization of children.
- Encourage stimulation and play of children.

TOPIC 3: HYPERACTIVE CHILD (HYPERKINESIS)

Objectives:

By the end of this topic, you will be able to:

1. **Recognise signs & symptoms of hyperactive child.**
2. **Describe practical management of a Hyperactive child.**

Activity I What are the signs and symptoms of hyperactive child?

Signs and symptoms of hyperactive child

1. On set is between 1-5 years
2. Extreme and persistent restlessness
3. Sustained and prolonged motor activity
4. Difficulty in sustaining/maintaining purposeful activity
5. Prone to accidents
6. Poor concentration leads to learning difficulties
7. Minor forms of Anti-social behaviour such as disobedience, temper tantrums,, and aggression.

Activity II Describe Management of Hyperactive Child

Management of hyperactive child

1. Appreciate and reward the things they do well by praising them, hugging, giving tokens.
2. Gradual introduction of other activities to distract a child when he maintains one activity for a long time.
3. Encourage use of play house with toys instead of tying them.
4. Parents need support as it is difficult to change child's behaviour.

TOPIC 4: CONDUCT DISORDERS.

Objectives:

At the end of this topic, you will be able to:

1. **Describe presentation of conduct disorders**
2. **Describe the management of a child with conduct disorder**

Activity I: Describe Presentation of Conduct Disorders

Presentation of conduct disorders

1. They form the large single group of mental disorder in older children and young adolescents.

2. Repetitive, persistent pattern of behaviour which violets the basic social norms and rules.
3. Manifestation by aggression to people and animals, destruction of property, deceitfulness, theft and serious violations of rules for example truancy, running away from home, sexual, abuse of peers and others.

Activity II Describe the management of children with conduct disorders.

Management of children with conduct disorders

1. Mild disorders subside with no treatment, but for more severe disorders treatment includes case management by medical workers in the psychiatric department and follow up by social workers.
2. Collaborate with police and probation officers.
3. Rehabilitation schools could help in very difficult cases.
4. The difficult families to help are those:
   - where there is mental/emotional deprivation
   - chaotic Relationships in the family
   - poorly sensitised parents

TOPIC 5: EMOTIONAL DISORDERS

Objectives:

By the end of this topic, you will be able to:

1. **Define the term "emotional disorders".**
2. **Describe emotional Disorders.**
3. **Describe management of emotional disorders.**

Activity I What is Emotional Disorder?

Definition:

Emotional disorders are disturbances of feelings associated with different neurotic conditions such as anxiety and worry.

This is the second commonest disorder next to conduct disorder. Emotional disorders include selective anxiety, sibling rivalry, phobic states selective mutisms & school refusal. Emotional disorders could begin as separation anxiety. This includes inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached.

Presentation of emotional disorders include:

- Recurrent excessive distress.
- Reluctance to go to school.
- Persistent & reluctance to go to sleep.
- Repeated nightmares of separation from principle care taker.
- Physical symptoms e.g. Nausea, stomach-ache, headache, vomiting occurring on occasions of separation.

Classification of Mental Illness

Neurosis	Psychosis
• Mild form of mental illness	• Severe form of mental illness
• Patient does not lose touch with reality	• Patient loses touch with reality
• No abnormal thoughts/beliefs	• Patient has Abnormal thoughts
• No abnormal sensory experience	• Has abnormal sensory/experience

General Causes of Mental Illness

1. Organic Causes.
   Mental illness may be a result of an underlying physical illness. e.g. Cerebral malaria, Brain damage, Meningitis, Syphilis, Typhoid fever, HIV/AIDs, Alcohol Abuse, Marijuana/Bhangi. In case of a patient with mental illness, always exclude an organic cause first. Treatment involves treating underlying cause.
2. Genetic Factors.
3. Stress - Pressure of work, failure of exams e.t.c.
4. Social factors e.g. poverty, mental problems.
5. Environmental factors e.g. Living in slum areas.

In most cases mental illness is a result of combination of any of the above factors.

TOPIC 2: ACUTE ORGANIC PSYCHOSIS (DELIRIUM)

These are disorders in which there is underlying physical causes

Causes:

1. Cerebral malaria.
2. Typhoid fever.
3. Meningitis.
4. HIV/AIDs.
5. Alcohol Abuse.
6. Marijuana, Bhangi.
7. Head Injury.

Signs and Symptoms

- Fluctuating level of consciousness.
- Disorientation – in time, date, day, month, year, place, person.
- Impairment of memory.
- Poor concentration and attention.
- Misinterpretation of objects/things (illusion).
- Seeing things which are not there (Visual hallucination).
- Fear.
- Poor sleep.

There will be signs and symptoms of the underlying physical illness

Management

- Calm the patient.
- Establish and treat underlying physical illness.
- Control the behaviour with the drugs e.g. diazepam 5 –15 mg daily in divided doses.
- Health Education.
- Refer.
- .Follow up .

TOPIC 3 MANIA

Definition:

Mania is a syndrome characterised by **mood change** which may be towards elation or towards irritability over activity and self-important ideas. It is an affective disorder which can be classified as:

- mild
- moderate
- severe

Mania has a tendency to re-occur or is episodic. Whether treated or not, the patient will still improve. It has a good progronosis.

Early diagnosis and treatment shortens the duration, and prophylactic treatment prevents recurrence.

Clinical Effects:

- Mood may be euphoric or infectiously cheerful, but more often than not the patient is irritable, i.e. the mood is labile and unpredictable.
- Behaviour, talk and thought are characteristically accelerated.
- Sleep is often reduced. Patient wakes up early feeling lively and energetic. Appetite is increased.
- Appetite is increased but cannot settle down to eat.
- Sexual desires (libido) are increased.
- Patient may act impulsively with poor judgment.
- Thinking includes grandioze ideas.
- Disturbances of perception are not very common .
- Insight may be present or lacking.

Management:

1. Proper psychiatric and physical assessment
2. ***Short term management***

- Antipsychotic drugs such as chlorpromazine and haloperidol usually bring the symptoms of acute mania under rapid control, although sometimes very large doses are needed.
- In very severe cases Electro Convulsive Therapy (ECT) may be used.
- Carbamezapine has also been reported to have a controlling effect.

Long term management

- Prophylaxis treatment to prevent recurrence include carbamezapine, lithium carbonate.
- Treatment to prevent relapse should be continuous. The same drugs as above are used.
- Occupational therapy.
- Counselling.
- Health education.

Signs and Symptoms:

- A lot of plans associated with a lot of thoughts.
- Abnormal beliefs: The individual is special in some way, has special powers or has a lot of wealth.
- Lack of sleep. No time to eat.
- Irritable which can lead to aggression.
- Increased sexual desire.

TOPIC 4 DEPRESSION

Sign and Symptoms

- Feeling excessively sad for more than 2 weeks.
- Without or lack of interest in self and surroundings.
- Lack of energy.
- Blaming oneself for trivial things which occurred in the past.
- Worried of the past, present and future.
- Feelings of unworthiness.
- Ideas of committing suicide.
- Multiple vague body complaints (have no physical basis) e.g. Headache, body pains, constipation e.t.c.
- Disturbed sleep. Wakes up late at night and is unable to sleep again.
- Reduced appetite for food.
- Low sexual desire.

Causes

- Unknown but has genetic predisposition.
- Social stress e.g. life stress, failure in life, marital problems bereavements, poverty.

Management

- Reassure the patient.
- Health Education on:
  - illness.
  - Early signs of disease.
  - Chronic signs .
  - Management plan i.e. involve patient and caretaker in activities of daily living, patient nutrition, reaction, work and treatment compliance, prevention of suicide etc.
- Drug treatment
  - Imipramine 50mg – 100mg daily in divided doses.
  - Treatment is for 6 months.

- Refer if no improvement after 3 weeks.
- Follow up.

- Encourage a supportive environment
  - community support systems e.g. caring for patient, referral, placement of patients, support groups and establishing family relationships, etc.

TOPIC 5 ANXIETY

Definition:

It is a disorder in which the predominant features are those of anxiety and which are not secondary to another physical or mental illness.

Cause:

Unknown.

Signs and Symptoms

- Fear, apprehension, tension.
- Unable to relax, sits at the edge of the chair .
- Anxious mood but do not know why they are anxious.
- Palpitations.
- Trembling and shaking.
- Fear of dying, panic attacks.
- Reduced appetite for food.
- Multiple physical complaints especially headache without a demonstrable physical cause.
- Takes long to sleep. Sleep is interrupted from time to time and wakes up exhausted.

Management

- Calm down the patient.
- Re-assure and refer.
- Main stay of treatment is psychotherapy.
- Drugs play a minor role in management.

TOPIC 6: SCHIZOPHRENIA

It is one of the severe mental illnesses that usually starts early in life. The signs and symptoms have adverse effects on the patient, relatives and friends. It tends to run a down wards course. The individual never recovers fully to their original self.

Causes

- Unknown but has genetic predisposition. The illness can be passed on from parents to off springs.

TOPIC 7 SUBSTANCE AND ALCOHOL ABUSE

Objective:

By the end of this topic, you will be able to:

1. **Define the terms**
   - **Intoxication**
   - **Alcohol/drug dependence**
   - **Alcohol/drug abuse**
2. **Outline alcohol related disorders**
3. **Describe the general management for alcohol and substance abuse**
4. **List the psychoactive substances that cause dependence.**

Definitions:

Intoxication – This refers to psychological and physical changes brought about by a psychoactive substance, disappearing when that substance is eliminated from the body.

Alcohol/Drug Dependence – The term dependence describes the repeated intake of a physical substance resulting in a withdrawal state and a strong desire to take the drug.

Alcohol/Drug Abuse – This is a habitual alcohol consumption that is deemed excessive in amount resulting into damage to one's physical, mental and social well-being.

Psychoactive substances that lead to Dependence:

- Alcohol
- Amphetamine
- Cannabis
- Inhalers
- nicotine
- sedative
- amphiolytics
- opiodes

Alcohol Related Disorders

1. **Physical damage:**

   Alcohol can have direct toxic effects on certain organs such as the brain and liver. It is often accompanied by poor diet which may lead to deficiency of protein and vitamins. Alcohol increases the risks of accidents particularly head injury. It is accompanied by general neglect which can lead to increased susceptibility to infections.

2. **Damage to the foetus**

3. **Psychiatric disorders such as:**
   - withdrawal syndrome
   - delerium tremors
   - alcohol dementia
   - personality deterioration
   - alcohol hallucinosis

4. **Social damage including mental, land, and family tension, problems at work, road traffic accidents and crimes.**

Causes of Alcohol Abuse

The following factors may predispose an individual to alcohol abuse:

- sex – there are more male than female alcoholics
- Age – most drinkers are men in their later teens or early twenties
- Occupation – the risk of problem drinking is much increased among several occupational groups e.g. chefs, kitchen quarters, bar men, brewery workers, executive and salesmen, actors and entertainers, etc. Medical workers are another important group with an increased risk of problem drinking and other psychoactive drug dependence and abuse.
- Genetic factors – some excessive drinkers have a family history of excessive drinking and have a family history of developing dependence at an earlier age and more severely.

General Management of Alcohol and Substance Abuse:

Early treatment.

Treatment plan

- This should include assessment and appraisal of current medical, psychological and social problems.
- Involve spouses and or family members in the treatment plan.
- Additional information is very important.
- Develop specific goals with the patient or client and care taker. For patients with a dependency syndrome, withdrawal from alcohol is an important first stage in treatment, however, this should be carried out carefully.
- Sedative drugs are generally prescribed to reduce withdrawal sumptoms e.g chlorodiazepoxide is often used. N.B. Chlorodiazepoxide may not be given to patients who may continue to take alcohol since the combination may cause fatal respiratory depression.

Counselling of the patient – Information about the effects of heavy drinking is an important first stage in treatment. It is important to let the patient or client talk about his individual problems. Encourage the client to join the Alcoholics Anonymous (AA) groups.

UNIT FOUR: EPILEPSY

Aim: To equip health workers with sufficient knowledge, skills so as to manage persons with epilepsy.

Objectives:

By the end of this unite you will be able to:

1. Describe the signs and symptoms of Grand Mal Epilepsy.
2. Describe the emergency management of a patient having a fit.
3. Demonstrate ability to carry out health education to patients, care takers, teachers, relatives and the community.
4. Recognise when to refer a patient to the next level.
5. Keep records and utilise HMIS.
6. Follow up.

GRANDMAL EPILEPSY

Activity 1: What is grand mal epilepsy?

Definition: It is a 'falling sickness' which occurs suddenly, disappears spontaneously and has a tendency to recur. It is caused by abnormal electrical activity in the brain cells.
It is the most common type of epilepsy in Uganda.

Activity II: What are the causes of grandmal epilepsy?

1. In majority of cases, the cause is unknown.
2. Head injury including birth trauma
3. Tumours of the brain
4. Infections – cerebral malaria, meningitis, encephalitis
5. Alcohol and drug abuse

Activity III: What are the signs and symptoms of grandmal epilepsy?

Signs and Symptoms

1. There is sudden loss of consciousness followed by falling if standing or seated.
2. Stiffness of the whole body
3. Jerking movements of the whole body
4. There may be frothing at the mouth
5. There may be tongue biting
6. There may be passing of urine, feaces or both

7. After a fit, some may sleep, others may appear confused for some time.
8. Any attempt to restrain them may provoke violence and/ or aggression

Activity IV: Describe the emergency Management of a Patient with an Epileptic Fit

1. Keep calm.
2. Protect the patient from hurting him/herself by removing him/her from fire, water, traffic, or other dangers.
3. Protect the patient's head with some thing soft or your hands
4. Loosen tight clothing.
5. After the fit, turn the patient on his/her side (recovery position).
6. Stay with the person to comfort him/her (may be tired and may need rest)
7. After recovery, allow the patient to continue with what s/he was doing before.
8. In case the patient sustains cuts during the fit wash themwith soap and water and cover with clean cloth.

Do not:

1. **Try to put any thing in his/her mouth during the fit**
2. **Give her/him anything to eat or drink during the fit.**
3. **Try to stop the jerking movements.**
4. **Give any medication during a fit.**

Further Management

1. The caretaker should record the fit in a book as per annex 'A'
2. Encourage the person or caretaker to seek for medical attention from the nearest health facility
3. Encourage the person with epilepsy to take drugs as advised by the medical personnel.
4. The person on treatment should continue until advised by a medical worker.
5. A person with epilepsy should be followed up regularly.

Drug Treatment

Phenobarbitone is the drug of choice (It is cheap, effective and easily available)

Dose in 24 hrs	2-5yrs up to 15kg	6-10yrs 15-20kg	11-14yrs 25-30kg	15yrs 31kg
1st Dose Starting dose	15 mg	15-30mg	30-60mg	60-90mg
2nd maintenance dose	15 –30mg	30 –60mg	75mg	90m –120mg
3rd dose Maximum	45 – 60mg	75mg	120mg	180mg

It is advisable to start treatment at the minimum maintenance dose of phenobabitone. At the start of treatment, every patient should be reviewed every month.

At every visit, check for response to drugs, compliance and side effects. If at the next visit, there are no fits, that will be the maintenance dose.

Review progress after every 4 weeks. The maximum dose for each patient will depend on control of fits and tolerance of side effects of the drugs.

The frequency of giving Anti epileptic drugs depends on how often and when the fits occur.

- If fits are at night – give a doze once daily at night.
- If the fits occur during morning and evening give a doze twice daily dozes (morning and evening).
- If fits occur frequently throughout 24-hours, the doze is given three times a day (every 8 hours).

Epilepsy is a chronic disease. If a patient is on drugs regularly and does not fit for two years please refer them to a psychiatric clinical officer or physician or pediatrician who will tail off the drug over 6 months. In other words the doze will be reduced slowly over six months while observing the patient for fits.

When drugs are discontinued, 40% of those patients where seizures had stopped, suffer recurrences.

It is extremely dangerous to stop anti epileptic drugs suddenly. Rather than stoppind drugs suddenly it is better if the patient does not start at all.

The most common side effect of phenobarbitone are:

1. Drowsiness, Sleeplessness
2. Tiredness, dizziness
3. Poor balance

In most cases side effects of phenobarbitone wear off with time and some can be tolerated by the patient.

Treatment of Continuous fits

Children 10yrs or less give rectal diazepam according to National Treatment Guidelines.
If no response refer immediately
Adults

Rectal or intravenous Diazepam 20mg start. The IV doze should be given slowly over 10 minutes.
If no response, refer immediately

Referral Criteria:

1. Continuous fits (use rectal Diazepam and refer)
2. Patients less than 5 years of age
3. Patients who have fits in pregnancy only
4. Patients with fits occurring only in the presence of fever more than or at 38°C and impaired consciousness.
5. Failure to control fits especially if a patient gets more than three fits a day.
6. Patients on phenobarbitone who develop any of the following
   - vomiting for more than 48 hrs.
   - skin rash
   - Yellow colouration of eyes
   - Hyperactivity
   - Irritability
   - Red eyes
   - Sore throat

HEALTH EDUCATION

Correcting misconceptions:

1. Epilepsy is not infectious, one can not catch epilepsy from another person
2. Epilepsy is not caused by witchcraft or evil spirits.
3. Coming in contact with urine, feaces and saliva passed during a fit will not pass on the illness to you.
4. Flatus passed by the fitting person is not infectious
5. Sharing utensils with a person with epilepsy will not pass the illness to you.
6. Persons with epilepsy are not mad.

Further Information on Epilepsy:

1. Children of school age should be allowed to go to school.
2. Persons with epilepsy should participate in the normal community activities.
3. Persons with epilepsy should be discouraged from drinking alcohol.
4. Medication control fits but does not cure epilepsy.
5. Take drugs regularly. Patients should not change doses on their own
6. Make arrangements at home, at school or at work to keep the person from being hurt while having a fit.
7. A person with epilepsy should not go to the well alone and should not be allowed to swim alone.
8. Fire places, should be raised and protected.
9. Climbing trees and ladders should be discouraged
10. Driving vehicles, riding bicycles should be discouraged
11. Should not operate machines. Avoid going for fishing.
12. Epilepsy can be controlled with drugs

Basic Information:

1. Care of a person during and after a fit.(ie. Emergency care)
2. Encourage activities of daily living
3. Encourage economic activities in adults.

Topic 2: Petit Mal

Absence Seizures – Petit Mal

- It is generally a rare condition.
- It is more common in children.
- A child suddenly stops what he/she is doing. Passes a brief moment with empty stare.
- The child usually does not fall.
- He/she does not respond during the seizure.
- There is frequent unexplained dropping of things by the affected child.
- An individual may have 5 to more than 200 attacks in a day.

What to do:

Refer to the health facility.

TOPIC 3 TEMPORAL LOBE

Symptoms:

- It starts with an 'aura' of warning
- There is a sense of fear, stomach upset, odd smell or taste
- Hearing and seeing things which are not there
- He/she may exhibit abnormal behviour e.g. violence or aggression
- At the end of the seizure the person does not remember what happened.
  - many people with temporal lobe epilepsy have generalized-clonic seizures
  - in each individual the sequence of events in the attack is almost always the same.

Management

1. Advise the person to go away from dangerous situations at the onset of 'aura'
2. In case of strange behaviour the person should be restrained.
3. Encourage the person to seek medical attention.

UNIT FIVE: VISUAL IMPAIRMENT

Aim:

In this unit, you will learn about:
1. Anatomy and physiology,
2. Visual impairment and blindness,
3. Orientation and mobility

TOPIC 1 VISUAL IMPAIRMENT AND BLINDNESS

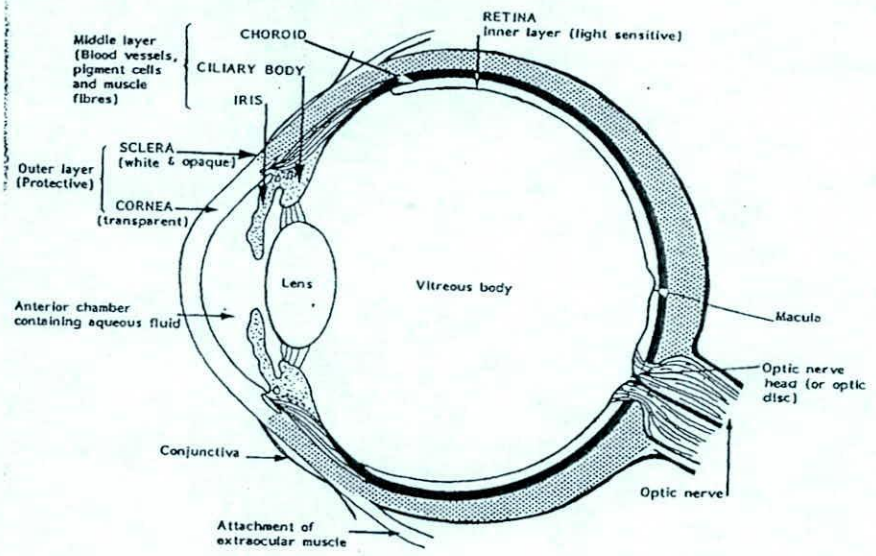
Objectives: By the end of the training the health worker should be able to:
1. Review the anatomy and physiology of the eye
2. Define visual impairment
3. Outline causes of not seeing well
4. Recognise some of the causes of visual impairment and blindness
5. Treat and prevent simple conditions and refer complicated ones to the next level.

CONTENT

Anatomy And Physiology of the Eye (How the Eye Works)

Refer to – Diagram showing cross section of the eye and/or eye model.

BASIC ANATOMY AND PHYSIOLOGY OF THE EYE



The ciliary body *(Figs. 2.1 and 2.2)* is a ring of smooth muscle around the eye. Numerous fine fibres called the suspensory ligament pass from the ciliary.

Identify the different parts of the eye including:

a. *Eye lids* : Protect the eye from injury and drying
b. *Eye lashes* : Stop foreign bodies from entering the eye

c. *Conjunctiva* : Lining of the eye ball and inner aspects of eye lids

d. *Sclera* : Strong coat which protects the eye ball contents

e. *Cornea* : Clear window through which light enters the eye. Helps to focus light rays on to the retina.

f. *Lens* : Adjustable focusing of the light rays on to the retina

g. *Retina* : Converts light energy into nerve impulses

h. *Optic nerve* : Transmits nerve impulse to the brain which interprets these into sight.

What Is Visual Impairment And Blindness:

a. When something goes wrong with the seeing process there will be visual impairment. When this is severe there is blindness.
b. When both eyes are blind the individual is referred to as blind.
c. Blindness in one eye only does not render somebody blind
d. We use different methods of assessing visual acuity to measure degree of visual impairment and blindness.
e. If one is not able to read a letter in the line marked 6/18 he has visual impairment (see visual acuity chart).
f. If one cannot count fingers at 3 meters in the better eye he is blind.

Common eye Conditions which may cause Visual Impairment and Blindness.

Anatomical Part	Causes	Mechanism
a) lens	Refractive errors	Improper focus of light rays on the retina
b) Lens opacity (Cataract)	• Congenital • Old age • Trauma • Diseases eg Diabetes	• Prevents light from reaching the retina
Corneal opacity	• Infections eg ophthalmic neonatorum • Traditional eye medicine • Entropion(in-turning of eyelid) from trachoma, leprosy • Vitamin A deficiency • Trauma • Onchocerciasis (River blindness)	• Causes corneal ulceration which heals but leaves opaque scars that prevent light from reaching the retina.
Retina and Optic Nerve damage	• Glaucoma and other diseases of optic nerve • Diseases of Retina	• Prevents impulses from reaching the brain

Assessment of a Patient with Eye Disease

History

When a patient complains of difficulty with seeing properly ask about the following:

a. For how long (days, weeks, months)?
b. How fast (Gradual, rapid or sudden)
c. Precipitating factors like: Trauma, burns, foreign body e.t.c.
d. Associated complaints like pain, discharge e.t.c.
e. Previous treatment (surgical, medical, traditional)
f. Is it in seeing small print or seeing distant objects?
g. Is vision affected?

CHECKING VISUAL ACUITY

a. Stand the patient 6 metres from the visual acuity chart in good light
b. Test one eye at a time beginning with the right eye by covering the other eye with a palm, not fingers.
c. Point to one letter at a time beginning with the largest letters to the smallest letters and note at which line the patient stops reading.
d. Ask the patient to indicate in which direction the letter is facing when using the E-chart.
e. Record the smallest line at which the patient can see clearly.

Examination With a Torch

Using a torch, look at eyelids and their margins for any discharge or swelling.

Eye Lashes	-	Are the eye lashes pointing away from the eye?
Cornea	-	Is the cornea clear and shinny?
Conjunctiva	-	Is the conjunctiva clear or is it red or brown? Are there any foreign body?
Pupil	-	Round and black or is there a white opacity behind it?

Eversion of Eye Lid:

i Ask the patient to look down without bending the neck.
ii. Grasp eye lashes of upper lid between thumb and index finger, and using thumbs finger of the other hand as a fulcrum turn the lid margin up to expose the Inner aspect of the lid.
iii. Look out for foreign bodies, follicles or papillae.

Management of Common Eye Conditions

Symptoms & Signs	Diagnosis	What to do
• Red eye • Pusy discharge But: Minimal pain (Gritty sensation) • Visual acuity is usually normal Incase of recurrent, chronic eye discharge with/without follicles (Follicles look like fine sand particles under the conjunctiva of the eyelid).	Conjunctivitis ? trachoma	• Wash eyes with clean water • Apply tetracycline eye ointment three times daily for one week. • Avoid steroids if no improvement after one week refer to eye clinic. Give health education apply tetracycline eye ointment 3 times a day for 6 weeks.
• Red eye • A lot of pain • Reduced vision (Below 6/18) • Excessive tearing • Photophobia	• Cornea ulcer • Iritis • Acute glaucoma foreign body	• Apply TEO • Pad the eye • Refer to eye clinic **immediately**
• Loose foreign body visible	• Superficial, foreign body	• Remove with cotton wool or clean cloth. • Then apply TEO three times daily for 3 days
• History of injury plus one or more of these signs and symptoms: - Bleeding from eye - Tear/laceration of eye lid or cornea - Blood behind cornea - Visual acuity less than 6/18 - Eye difficult to examine due to pain or swelling	• Severe eye damage	• <u>DO NOT</u> apply medicine to the eye • Pad the eye • Apply shield • Refer to eye clinic with Ophthalmologist **Immediately** • Pad of the eye discouraged by OCO • VA is not normal in refractive error
• Main problem is itching • Has lasted more than one month	• Allergic conjunctivitis	• Cold compress 3-4 times a day. • Refer to eye clinic
• History of night blindness, with or without Bitot's spots	• Xerophthalmia (vitamin A deficiency)	• Give 3 doses of vitamin A capsules as per schedules in table

		• Health educate caretaker about vitamin A rich foods.
• Eye lashes turned inwards so that they rub on eye ball	Entropion	• Refer to eye clinic for eye lid surgery
• Gradual painless loss of vision with a cloudy pupil.	Cataract	• Refer to OCO or eye clinic.
• Difficulty with reading small print or seeing near objects • Age over 40 years	Refractive error	• Reassure patient that this is a normal ageing process not likely to lead to blindness. • Refer to eye clinic for reading spectacles
• Visual acuity less than 6/18 in one or both eyes, with or without other signs	Visual impairment or Blindness from any cause	• Refer to eye clinic

Schedule for vitamin A Administration. In Xerophalmia

	6 – 11 MONTHS	1 YEAR TO ADULTS
Immediately on diagnosis	100 000 1U	200 0001U
Following day	100 000 1U	200 0001U
4 weeks later	100 0001U	200 0001U

Promotion of Eye Health

- Use every opportunity to give health education to patients and community members.
- Wash the face properly every morning with clean water
- Wash hands frequently
- Always use latrines
- Advise workers to use protective clothings like goggles for welders
- Sweep the compound
- Encourage use of car seat belts
- Put rubbish into rubbish pits
- Supervise children while they play
- Feed children with dark green leafy vegetables and yellow fruits
- Immunize all children on schedule
- Screening of school children
- Do not put medicine in the eye unless advised by a trained health worker
- Do not put urine or any other substance as in the eye.

Making of an eye shield (to be demonstrated)

TOPIC 2: ORIENTATION AND MOBILITY

Objectives:

By the end of this topic, you will be able to:

1. **Define orientation and mobility**
2. **Define how to help a person with visual impairment become independent in activities of daily living.**

Orientation and Mobility

Definition:

This is a process of helping a blind person know about the environment and be able to live independently.

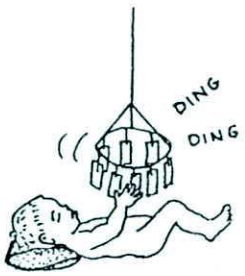
Helping a child become independent.

Early stimulation is important for child development. A child will have less stimulation and this can delay development. Teach the parents of a blind baby to do the following:

- Show extra love and care for the baby
- Use touch, sound, smell and taste to teach the baby parts of its body, members of the family and different textures.

Have him compare by touch and sound his own and other people's faces so that he begins to recognize different people.

At first you may need to place the toy in the child's hand, or guide his hand to it. Or hang different things near him so that when he moves his hands they touch them.



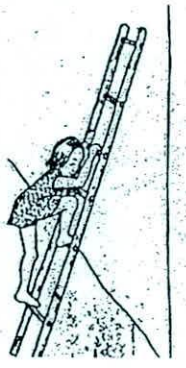
At each stage of the child's development, attract her attention with a noisy plaything. Have her reach for it and then try to move toward it.

Praise her when she does well or tries.

- Teach the baby to use the hands to eat by holding the hand to the plate and carrying it to the mouth.
- For bathing (old children) hold the sponge and guide the child's hand.
- Scatter different items in a room or safe compound for the crawling baby to move around and discover.
- When the baby starts walking keep items and furniture in the same in place to help them identify their position.
- Encourage the child to be adventurous and walk while feeling the way.
- Encourage the child to play with other children

Picture showing the proper length of a walking stick for a child with visual impartment

- Teach the child to use a stick to feel their way. The stick should be thin, light and tall enough so that it reaches half way between the child's waist and shoulders.



Help the child find his way by following walls and fences.

Move the stick from side to side, lightly touching the ground.

The width of the swing should be a little more than the width of his shoulders.

As the stick touches to one side, move the foot on the other side forward.

- Put a brick either side of the latrine hole to help the child position themselves.
- In school children may be taught how to read and write 'Braille'.

Helping an adult become Independent:

Adults are more difficult to help because they may be depressed. The adult blind person may be helped in the following ways:

Teach the adult to:

- Remember things that are in the home
- Describe various items in the home
- Describe items in the surrounding
- Recognise various sounds
- Encourage the adult to be positive and participate in family chores.

Rehabilitation workers in orientation and mobility:

Refer the blind child or adult to:

- A CBR worker
- The District Uganda National Association of the Blind (UNAB)
- Mobility instructors (these are in some districts)

TOPIC 2 FOREIGN BODY AND WAX IN THE EAR

Objectives:

By the end of this topic you will be able to:

Definition: Object in the external auditory meatus (canal)
History:
- Nature of Foreign body. Differentiate vegetative from non-vegetative or insect.
- Is there history of previous attempt at removal?
- History of Ear discharge?

Management

- Examination using ordinary Torch
- Attempt to syringe out if insect (dead or alive) or non-vegetative, (bead or stone)
- *Refer to hospital if:*
  1. There is history of ear discharge
  2. There is failure to remove by syringing
  3. Vegetable type of Foreign body
  4. The ear is severely inflamed or discharging
- Look into the ear using an Otoscope after removing the foreign body
- *If the canal is injured or infected/inflamed give:*
  1. Chloromphenicol ear drops and
  2. Refer to hospital
  3. If there is hearing impairment or ear discharge, do not syringe.

WAX IN THE EAR

Definition: Something in the ear
History :
Duration:
- When it was noticed
- Inquire into:
  - Hearing
  - Noise
  - history of discharging ear

Examination of the ear
- Examine ear using Ordinary torch or otoscope
- Apply drops of:
  - Cooking oil or
  - Sodium bicarbonate or
  - N/saline 2-3 times a day for 3/7

EAR SYRINGING
- Requirements

- Patients
- 2 large size kidney dishes
- Water at body temperature
- Higginson's or ordinary syringe
- A drape (piece of cloth or polythene sheet for protecting the patient from getting wet)
- Source of light – Natural or artificial
- Head mirror

How it is done

- Explain to the patient what you are going to do.
- Ear syringing may be uncomfortable but should *NEVER* be painful.
- Patient sits on the chair or ordinary stool
- Drape the patient
- Fill the syringe with water at body temperature with the back of your hand
- Pull the ear gently upwards and outwards to straighten the ear canal
- Direct the roof of the ear canal
- Push in the water gently until all the wax has come out.
- Look into the Ear canal after syringing to confirm removal
- Dry ear canal using cotton and cotton wool carrier
- If failed – Refer to hospital

Management

- Explain to the patient what you are planning to do before syringing.
- Never use instruments or sticks including cotton buds to remove F/B or extract wax from the ear canal.
- Never syringe forcefully or struggle with the patient
- Never syringe if there is H/O discharge

TOPIC 3: SPEECH DIFFICULTY

Objectives:

By the end of this topic, you will be able to:

Definition: Failure to develop speech at the expected age.

Speech Development

- Age 06 - 12 months – say first words; Maama, Papa e.t.c.
- Age 12 – 24 months – joins words e.g. see a dog e.t.c

- Age 18 – 36 months – joins sentences.

A person may have difficulty in speaking either because she/he cannot say words correctly. Speech difficulty may be present in the early childhood or may develop later in life.

Causes of Speech Difficulty

1. Hearing impairment/deafness
2. Receptive dysphasia
3. Disarticulation or expressive dysphasia
   - Problems in formation of words due to: - cleft palate, Tongue tie, Hypognathia

General and Local Examination

- Test Hearing Using various methods
  1. Siblant SSSS
  2. Bell
  3. Rattle
- If no response refer to hospital or unit for the deaf.
- If responding and is less than 3years wait and see after 3 months.
- If more than 3yrs and responding, refer to hospital or EARS (Education Assessment Resource Services).

Counselling Parents

- Don't cut tongue tie
- Advise parent to:
  - Love the child and try to communicate with him/her.
  - Talk to the child as much as possible even if the child cannot hear any sound.
  - Ensure the child is looking at the parent's face which should be in light so that the child can see the movements of the face.
  - Spend extra time with the child.
  - Involve other family members.
  - Learn sign language.
  - Consult/collaborate with CBR workers.

HEARING DIFFICULTY

Objectives:

Definition: Somebody cannot hear some words/sound easily.

Difference between Hearing Impairment and Deafness

1. Deafness is when you cannot hear any sounds at all.

Causes of Hearing Impairment (HI) and Deafness

- Congenital.
- Inflammatory.
- Traumatic.
- Neoplastic.
- Other cases e.g. Metabolic disorders.

Nature of Hearing Difficulty

- Progression.
- Intermittent.
- Persistent.

Associated Conditions e.g.

- Convulsions.
- Acute fever.
- Malaria.
- Measles.
- Meningitis.
- Medicines during pregnancy.
- Prolonged labour
- History of Birth trauma.
- Jaundice (Neonatal).
- E.T.C.

Hearing tests
See above

Counselling
See above

Referral
See above

UNIT 7: SPECIAL ISSUES ON DISABILITY AND HEALTH CARE

By the end of this unit, you will be able to learn:

1. The constraints disabled people find in accessing health services.
2. Solutions to these constraints.
3. The needs of disabled people at different ages.

TOPIC I ACCESSIBILITY TO SERVICES BY DISABLED PERSONS

People with impairment find health units in accessible. From two studies in Uganda [5,6] it was found that persons with impairments.

- Cannot climb the steps on our health facilities.
- Cannot use labour bed because these are high.
- Persons who cannot walk and are very dirty.

A person using a wheel chair will not be able to get the wheel chair into the latrine. If they chose to get off the wheel chair into the latrine, their hands, cloths, and lower limbs will be smeared with urine and faeces of previous users. Because of the problem of sanitation, many PWDs choose to fast if they have to visit the hospital or attend a meeting in the nearest administrative government unit.

What is the Solution?

Adjustments to buildings and furniture can help improve accessibility.

Examples are:

- Hand rails along corridors
- Ramps instead of steps (where steps are few). The gradient to enable a wheel chair user roll up should be minimum of 1:10.
- Adjustable maternity beds.
- Stance in latrine designed for disabled persons.

These adjustments need not only be made in the health unit but you could guide the family in making them at home. Improvement of the home is easier because the adjustment is for one or two people for example a box with a hole on both ends can be placed over a latrine to help an older person with arthritis who is not able to squat.

Exercise:

How can your health unit be made more accessible to persons with movement disabilities?
Who can help you design the improvement?
Where could funds come from to improve access?.

TOPIC 2: ATTITUDE OF HEALTH WORKERS

Objectives:

By the end of this topic you will be able to:

1. **Define the term attitude.**
2. **Develop positive attitudes towards people with impairment.**
3. **Appreciate potentials of people with impairments.**

ATTITUDE

Definition:

Attitude is what underlies behaviour. Attitude is basically a result of beliefs, values and experiences. Attitudes may be positive or negative according to the knowledge base, beliefs and experiences of an individual or society. Attitudes are largely reflected through our behaviour and response to situations. The situation of PWDs in developing countries is often reflective of strong negative attitudes:

Attitude affects behaviour.

What is the problem?

In the two studies on disability and the health service, persons with impairments reported that their main hindrance to accessing health services is the negative attitude of health workers. They reported that health workers:

- Treat them like beggars (and send them away because it is not Friday).
- Ridicule them if they come for issues related to their sexuality and reproductive health.
- Send them to the back of the line, especially the deaf.
- Are not able to communicate to health workers because of the language difference (for example using sign language) or because of the intimidating approach used by the health unit staff.
- Discuss you like you are a piece of furniture, they point, touch, then walk away leaving you without information.
- As person with impairment, find out more about their impairment they discover that health worker knowledge is lacking.

- Most important of all health workers do not provide adequate information to persons with impairments or their caretakers. The patient is not given answers to the 5 Ws and the prognosis. The lack of information is an important factor in self-referral to traditional healers.

What is the Solution?

As a health worker, it is important that your attitude to persons with impairment is positive.

- Have empathy for the PWD, and for parents who may be suffering rejection, blame, depression and in need of solutions especially for a rapid cure.
- Study more about disabilities because correct information influences behaviour.
- Interact with disabled people more often.
- Invite disabled people and parents of disabled children to facilitate on some of the CME sessions in your health unit. For example, complications of epilepsy or cerebral palsy can be discussed after a parent has presented the main concerns she has over her child.
- Take time to listen and explain. This is discussed in the IMCI HIV/AIDs manuals.

TOPIC 3: THE BEREAVEMENT CYCLE

Objectives:

In this topic, you will be able to:

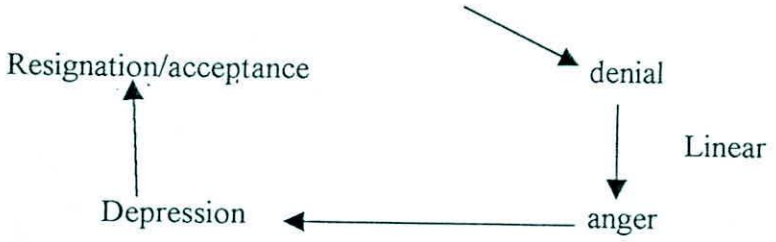
1. Define the term 'bereavement cycle'
2. Outline the stages of bereavement
3. Discuss the coping mechanism of bereavement

Definition:

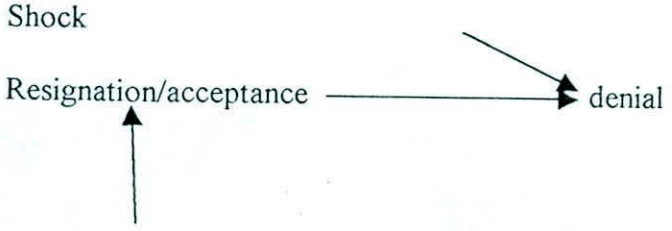
Bereavement is the emotional process animals including man go through after loosing something precious.

Bereavement became an important topic with the advent of the HIV/AID epidemic.
When a person dies, close relatives go through stages of bereavement

Shock



Depending on the personality and the environment, the bereavement process may take a few months to some years. Some people may linger in one stage and require help to go through it. In disability the bereavement process is a cycle.



The parent of a child with impairment or the adult with recent impairments will go through this cycle, several times in their life time.

Death is final but disability is not hence the different processes in bereavement. Many parents report that it takes up to 10years to finally accept the situation.

During denial, the parent will not accept their child is different. They may insist that it is the untrained nursery teacher, otherwise his child is normal or the doctor got the wrong diagnosis or the problem is not medical but spiritual.

During denial, parents and PWD often shop around for cures. Land is to be sold, goats slaughtered while searching for a cure from various specialists. The rich will even try Europe and South Africa.

It is important to understand this stage of shopping around and not to condemn the person during this stage for not taking your advice. Shopping around is a universal phenomenon and is done in developed and developing countries.

During the stage of anger, the PWD or parent may direct the anger to a spouse, children, the disabled child or the health worker who has given the bad news. Again it is important to understand what your client is going through and not to take the anger personally. Help them express themselves and help them come to a conclusion that the disabled child or the mother is not to blame.

Depression will not be discussed here please refer to Unit 3.

Resignation/acceptance is when the disability is accepted. Although the interventions start early, they are better accepted and easily followed. Resignation may lead to neglect or the person cutting themselves off society. It is important to encourage integration as this helps the PWD and increases awareness to the community.

Understanding the cycle of bereavement which may take up to 10years will help you approach persons affected by disabilities positively.

TOPIC : 4 LANGUAGE IN DISABILITY

Objectives:

By the end of this topic you will be able to:

1. **Apply appropriate language used in disability.**
2. **Identify inappropriate terms used in disability in your community.**

As mentioned in UNIT 1, the approach to disability was shifted from a medical modal to a social/human rights modal. The language used in disability issues has also shifted to reflect the new and positive trend. The new language has been coined by disabled persons. The person has no disabilities but has impairments.

Person with Disabilities is no longer the term to use because the affected persons have impairments that are organ specific. Although the person has impairments, he is not able to do various activities and participate in his community because of the 'disabling environment'.

Therefore the person is called (lately as of 2000) a disabled person. When referring to impairments or diagnosis, put the person first and the impairment is secondary.

Do not say:		**But say:**
Epileptic	-	Person with Epilepsy
Leper	-	Persons affected by leprosy
Polio victim	-	Persons affected by polio
Child with disabilities	-	Child with impairment or disabled child.
Mongol	-	Child with Down's syndrome
Imbecile	-	Person with severe mental retardation or learning disabilities.

Exercise:

In your local language, identify the negative derogatory terms and find more positive alternative terms. This is best done with disabled people in your area, but please make a start now.

TOPIC 5: LIFE CYCLE AND DISABILITY

Objectives:

By the end of this topic you will be able to:

1. **Define the term life cycle and disability.**
2. **Outline the stages of life cycle and disability**
3. **Discuss management of problems in each stage.**

As human beings grow from infancy to old age, their aspirations and needs change. This is due to the physiological and psychological changes as well as cultural expectations for different age groups.

1. Childhood and Disability

Throughout childhood (1-13) years there is rapid development of movement, social, language and cognitive skills.

The disabled child may not achieve the mile stones of other children for various reasons which you need to address as a health worker. Mile stones may not be achieved for the following reasons:

a. Impairment

The impairment may interupt with contact with the environment. This limits stimulation and development. There are various ways of helping a child with the impairment to develop. For example a blind-infant can be trained early in orientation and mobility.

b. Over Protective Parents/Careers

Over protection of children with impairments is understandable and is the biggest challenge to the development of a child. The parent protects the child from challenging situations thinking the child will be hurt.

For example, stopping the child from playing with sibs, not allowing the child to go to school, and limiting participation of health worker. There is need to look out for over protective parents to help them let the child face the challenging environment which will in turn foster development.

c. Child Abuse and Neglect

For various reasons, same parents hide their disabled child. Staying in a dark room with no stimulation retards the child and encourages negative habits such as self injurious behaviours like biting themselves or pocking the eyes. Some children are beaten, denied food and medical treatment to quicken death. Watch out for abusive parents and help them by explaining the potentials of the child if rehabilitated.

d. Helping the Caretaker

Parents or caretakers of disabled children or persons with multiple and severe impairments can be emotionally and physically exhausting. Encourage the caretaker to take time for themselves and leave some one else in charge for a few days each year. This will relieve tension and reduce abuse.

2. Adolescent with Impairment

Just like other adolescents, disabled adolescents are transforming into adults. They require information about the changes taking place in their bodies, sexuality and sexually transmitted diseases. Like other adolescents they need to be with peers. The impairment may bring confidence problems as they view themselves to be different. Girls with disability need special protection from sexual harassment and rape. Because of rapid growth during this period, appliances and aids are outgrown quickly.

When planning adolescent health services please remember the special needs of adolescents with impairment.

3. Adult with Impairment

Just like other human beings, adults with impairments require respect, gainful employment (self or employed), family and a home.

These needs should be respected. Health care workers should provide PWI with accessible and appropriate information on family planning sexually transmitted diseases, child-rearing practices etc.

4. Older person with Impairment

As we grow old, impairments tend to increase. For example, arthritis may limit movement, cataract may cause blindness, hypertension may cause stroke etc. It is important that the health care needs of older persons are addressed and not pushed aside as a normal process. Older persons in our community should be able to access all health services including rehabilitation. Accessibility in their homes should also be ensured.

UNIT 8: DISABILITY ASSESSMENT AND RECORD FORMS

Aim:

The aim of this unit is to enable the health worker assess and record the types and number of disabilities seen in the health facility or during outreach. The information and data collected is important for planning and evaluation of services provided. It will also help you monitor your intervention and assess whether the client is improving.

Objectives:

By the end of the training the health worker should be able to:

1. Complete disability form 01 and 02
2. Explain the purpose of the form.

TOPIC 1 DISABILITY FORM 01

The form has seven sections:
Section 1 is about client's general background
Section 2 is about the type of disability
Section 3 is about the cause of disability
Section 4 is the length of time a person has been disabled
Section 5 is about the severity of the disability
Section 6 is on the management plan and
Section 7 reports on follow up findings and treatment

Section 5 has 4 sub-section.
Sub-section a) should only be completed if you have identified hearing impairment in a client. Section b) should only be completed if the client has visual impairment. If the client has mental disability or multiple disabilities or a single type of disability that is severe, complete sub-section d). This may be completed in addition to sub-section a), b), or c).

Case Study 1

John is a 20 year old man who had polio. He moves by crawling.

John's disability form 01 may look like this: *(next page)*

DISABILITY FORM 01

(To be used by a Health Work from Health Centre III to Hospital)

District: *Katakwe* **Name of Health Facility** *Nakit Health Centre IV*

Health Facility Code No. *0469*

Identification

1. a. Name *John Bambo*
   b. Age *20 years*
   c. Sex *M*
   d. Place of resident village LC II (Parish), Sub-county, district *Ikiro*
   e. Tribe *Ganda*
   f. Religion *Protestant*
   g. Marital Status *Single*
   h. Next of kin _____

1. What is the type of Disability?

√	Mobility
	Hearing
	Speech
	Mental
	Vision
	Mental Retardation
	Epilepsy
	Spinal lesion
	Sensory
	Other (specify) .....

2. What was the cause of the Disability?

	Congenital
	Genetic
	Trauma at birth
	Other trauma
√	Disease
	Other (Specify)

3. How long has the client had this disability?

Less then 1yr	1-5yrs	Greater than 5 yrs √

4. Degree of Severity of the Disability

a. Hearing Assessment

- No reactions to cup & spoon - ☐ Severe
- Poor reactions to cup & spoon - ☐ Moderate
- Good reaction to cup & spoon. - ☐ Mild

b. Visual Assessment ***(For children 3 month to -3years)***

☐ Child's eyes follow candle/torch

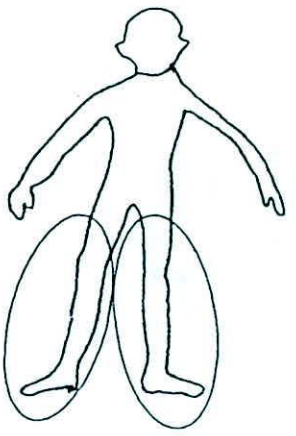
Greater than 3years

☐ Can see finger when standing 3m away in the better eye

c. Mobility physical Assessment

Mark part of body affected

√	Has contractures
	Spastic
√	Flaccid
√	Polio
	Spinal lesion
	Amputation
	No bowel control
	No bladder control
	Sensory loss
	Other



d. Mental and Independence Assessment for all disabilities.

i Feeds him/her self (including eating and drinking)

Alone ☐ with some help ☐ Not at all ☐

ii. Uses the latrine?

Alone ☐ with some help ☐ Not at all ☐

iii. Understanding simple instructions?

Alone ☐ with some help ☐ Not at all ☐

iv. For school going age
Goes to school Yes ☐ No ☐

v. For adults
Earns a living Yes ☐ No ☐

5. Management Plan

6. Follow-up

DISABILITY FORM 01

(To be used by a Health Work from Health Centre III to Hospital)

District: *Hoima* **Name of Health Facility** *Hoima Hospital*

Health Facility Code No. *0595*

Identification

1. a. Name *Fatuma Asiimwe*
   i. Age *3 years*
   j. Sex *F*
   k. Place of resident village LC II (Parish), Sub-county, district *Katibiti*
   l. Tribe *Nyoro*
   m. Religion *Moslem*
   n. Marital Status *Not applicable*
   o. Next of kin *Faridah Asiimwe*

2. What is the type of Disability?

√	Mobility
	Hearing
	Speech
	Mental
√	Vision
	Mental Retardation
	Epilepsy
	Spinal lesion
	Sensory
	Other (specify) .....

3. What was the cause of the Disability?

	Congenital
	Genetic
√	Injury at birth
	Other trauma
	Disease
	Other (Specify)

4. How long has the client had this disability?

Less then 1yr	1-5yrs √	Greater than 5 yrs

5. Degree of Severity of the Disability

a. Hearing Assessment

- No reactions to cup & spoon - ☐ Severe
- Poor reactions to cup & spoon - ☐ Moderate
- Good reaction to cup & spoon. - ☐ Mild

b. Visual Assessment ***(For children 3 month to -3years)***

☐ Child's eyes follow candle/torch

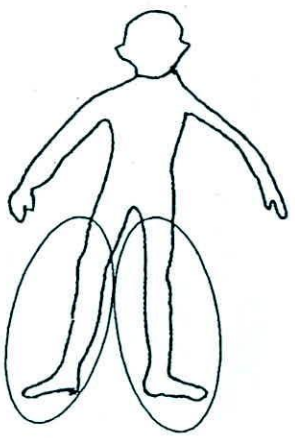
Greater than 3years

☐ Can see finger when standing 3m away in the better eye

c. Mobility physical Assessment

Mark part of body affected

	Has contractures
√	Spastic
	Flaccid
	Polio
	Spinal lesion
	Amputation
	No bowel control
	No bladder control
√	Sensory loss
	Other



d. Mental and Independence Assessment for all disabilities.

i Feeds him/her self (including eating and drinking)

Alone ☐ with some help ☐ Not at all ☐

vi. Uses the latrine?

Alone ☐ with some help ☐ Not at all ☐

vii. Understanding simple instructions?

Alone ☐ with some help ☐ Not at all ☐

viii. For school going age
Goes to school Yes ☐ No ☐

ix. For adults
Earns a living Yes ☐ No ☐

6. Management Plan

7. Follow-up

Group Work Exercises:

Complete the disability Form 01 for the following clients:

Case Study 1

Fasi was injured by a landmine and has an above knee amputation. He has a broken, worn out artificial leg.

Case Study 2

Mfabijo is a 70-year-old woman with cataracts in both eyes and severe arthritis. She is blind.

Case Study 3

Nkosi is 2 years old. He has weak legs and is not walking. He has a lump with a sore on her back. She is intelligent but has a large head. She dribbles urine.

Case Study 4

Bendi is a retired army man who is deaf after a bomb blast.

DISABILITY FORM 01

(To be used by a Health Work from Health Centre III to Hospital)

District.....Name of Health Facility .....

Health Facility Code No.....

Identification

1. a. Name .....

   b. Age .....

   c. Sex .....

   d. Place of resident village LC II (Parish), Sub-county, district .....

   e. Tribe .....

   f. Religion .....

   g. Marital Status .....

   h. Next of kin .....

2. What is the type of Disability?

☐	Mobility
☐	Hearing
☐	Speech
☐	Mental
☐	Vision
☐	Mental Retardation
☐	Epilepsy
☐	Spinal lesion
☐	Sensory
☐	Other (specify) .....

3. What was the cause of the Disability?

- ☐ Congenital
- ☐ Genetic
- ☐ Injury at birth
- ☐ Other trauma
- ☐ Disease
- ☐ Other (Specify)

4. How long has the client had this disability?

Less then 1yr	1-5yrs	Greater than 5 yrs

5. Degree of Severity of the Disability

a. Hearing Assessment

- No reactions to cup & spoon - ☐ Severe
- Poor reactions to cup & spoon - ☐ Moderate
- Good reaction to cup & spoon. - ☐ Mild

b. Visual Assessment ***(For children 3 month to -3years)***

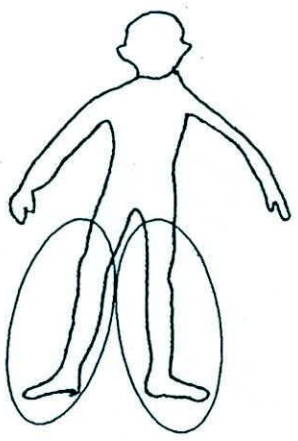
☐ Child's eyes follow candle/torch

Greater than 3years

☐ Can see finger when standing 3m away in the better eye

c. Mobility physical Assessment

Mark part of body affected



- ☐ Has contractures
- ☐ Spastic
- ☐ Flaccid
- ☐ Polio
- ☐ Spinal lesion
- ☐ Amputation
- ☐ No bowel control
- ☐ No bladder control
- ☐ Sensory loss
- ☐ Other

d. Mental and Independence Assessment for all disabilities.

i Feeds him/her self (including eating and drinking)

Alone ☐ with some help ☐ Not at all ☐

ii. Uses the latrine?

Alone ☐ with some help ☐ Not at all ☐

iii. Understanding simple instructions?

Alone ☐ with some help ☐ Not at all ☐

iv. For school going age

Goes to school Yes ☐ No ☐

v. For adults

Earns a living Yes ☐ No ☐

6. Management Plan

7. Follow-up

TOPIC 2 DISABILITY FORM 02

This is a form that is completed monthly and sent to the district focal person on disability. It should be completed at the end of each month.

An example of a completed form is given on the next page.

DISABILITY FORM 02

Health Facility Monthly Report

Health Facility *Kakeka HC IV* Code No. 0498

District *Rugiri* Health Sub-District *Ruyonda* Month *April* Year *2002*

Information compiled by:

Name *Sr. Sango* Signature .....

Number of Disabled Persons According to their disability

Types of Disabilities	Number in Need of Rehabilitation				
	Male	Female	0-4	5+	Total
Visual disability	4	9	1	12	13
Hearing/Speaking disability	1	0	0	1	1
Difficulty moving	12	8	6	14	20
Sensory loss (leprosy)	0	0	0	0	0
Mental illness	1	0	0	1	1
Mental retardation	2	1	2	1	3
Epilepsy	15	17	7	25	32
Other disabilities					
Has more than one disability	0	2	2	0	2
Total	**33**	**37**	**18**	**54**	**72**

2. Referrals Made

Reason for Referral	Number
Diagnosis/Assessment	7
Exercise therapy	10
Drugs	11
Corrective surgery	5
Vocational training	0
Home base care with CBR education (EARS)	8
Total	**41**

3. Rehabilitative treatment prescribed and received

Type	Number prescribed	Number received
Wheel Chair	1	
Crutches	2	
Calipers	1	
Spectacles	2	
Artificial limbs	0	
Surgical boots	0	
White cane	0	
Hearing aids	0	
CP chair	2	
Splints	1	
Exercises	10	
Drugs	32	
Others	-	

Comments/Suggestions Need to follow up on prescribed appliances and drugs
CME on disability carried out: Yes ☐ No ☐ If Yes, what's the topic? *Epilepsy*

Health Facility .....Code No. .....

District .....Health Sub-Districts.....Month.....Year.....

Information compiled by:

Name .....Signature .....

Number of Disabled Persons According to their disability

Types of Disabilities	Number in Need of Rehabilitation				
	Male	Female	0-4	5+	Total
Visual disability					
Hearing/Speaking disability					
Difficulty moving					
Sensory loss (leprosy)					
Mental illness					
Mental retardation					
Epilepsy					
Other disabilities					
Has more than one disability					
Total					

2. Referrals Made

Reason for Referral	Number
Diagnosis/Assessment	
Exercise therapy	
Drugs	
Corrective surgery	
Vocational training	
Home base care with CBR education (EARS)	
Total	

3. Rehabilitative treatment prescribed and received

Type	Number prescribed	Number received
Wheel Chair		
Crutches		
Calipers		
Spectacles		
Artificial limbs		
Surgical boots		
White cane		
Hearing aids		
CP chair		
Splints		
Exercises		
Drugs		
Others		

Comments/Suggestions Need to follow up on prescribed appliances and drugs
CME on disability carried out: Yes ☐ No ☐ If Yes, what's the topic?.....