SITUATION ANALYSIS OF MEDICAL REHABILITATION SERVICES IN THE DISTRICTS OF IGANGA, BUSHENYI & MBALE

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TABLE OF CONTENTS

ACKNOWLEDGEMENT 2

TABLE OF CONTENTS 3

LIST OF ABBREVIATIONS: 5

OPERATIONS DEFINITIONS: 6

EXECUTIVE SUMMARY: 7

CHAPTER ONE 8

INTRODUCTION 8
BACKGROUND: 8
JUSTIFICATION OF THE STUDY 9

CHAPTER TWO 11

OBJECTIVES OF THE STUDY 11
General Objectives: 11
Specific Objectives: 11

CHAPTER THREE 12

METHODOLOGY 12
Study variables: 12
Study population 12
Target Population: 12
Procedure of Data Collection: 13
Data Collection Methods: 14
hData collection instruments: 15
Data Analysis: 16
Quality Control 16
Ethical Issues 16
Dissemination of Information 17
Limitations of the Study: 17

CHAPTER FOUR 19

RESULTS 19
QUALITATIVE DATA 19
4.1.2 SOCIO -ECONOMIC PROBLEMS: 21
4.2 Definitions 22
4.2.2 DISABILITY. 22
Referral Systems for PWDs: 26
District level activities 27
Role of the Ministry of Health 28
Suggestion made by the PWD's to improve their plight: 29
RESULTS OF QUANTITATIVE DATA 31
5.4 Drugs available in health units 34
5.4.2 Drugs in Health centres. 35

DISCUSSION 36

HEALTH PROBLEMS 36

CONCLUSION 41

RECOMMENDATIONS: **42**

APPENDIX 1 .... **43**

LIST OF RESEARCHERS: 43

APPENDIX 2 .... **44**

TOOLS: 44

APPENDIX 3 .... **46**

LIST OF ABBREVIATIONS:

1.	A.R.I.	-	Acute Respiratory Infections
2.	AVSI	-	International Service Volunteer Association.
3.	B.P.M.	-	Blood Pressure Machine
4.	C.A.O.	-	Chief Administrative Officer
5.	C.B.R.	-	Community Based Rehabilitation
6.	C.P.	-	Cerebral Palsy
7.	D.M.O.	-	District Medical Officer
8.	D.E.O	-	District Education Officer
9.	DMU	-	Dispensary & Maternity Unit
10.	D.R.O	-	District Rehabilitation Officer
11.	EARS	-	Education Assessment Resource Service
12.	ENT	-	Ear Nose and Throat
13.	FGD	-	Focus Group Discussions
14.	HARC	-	Hearing Assessment Resource Centre
15.	HMIS	-	Health Management Information System
16.	KAP	-	Knowledge, Attitude and Practice
17.	KI	-	Key Informant
18.	MoGD	-	Ministry of Gender and Community Development.
19.	NUDIPU	-	National Union of Disabled Persons Uganda.
20.	MOE	-	Ministry of Education
21.	MOH	-	Ministry of Health
22.	POP	-	Plaster of Paris
23.	PWDs	-	People with Disabilities

OPERATIONS DEFINITIONS:

- **Medical Rehabilitation:**

  The sum total of medical Measures (treatment, operations appliances etc) aimed at managing a disability with a view of restoring to the original function are much as possible. (UN Standard rules No.22)

- **Quality Assurance:**

  Quality assurance is doing the right things at the right time. It also refers to Quality is a measure of how good something. This could be an object (like a drug or a service e.g. Medical Rehabilitation). Quality has also been defined as performance which meets or exceeds an expectation.

  Quality is dynamic in the sense that it relates to a set of standards and a form of expectations, or a statement of what is desired or considered ideal at the time. They are a formalised statement of what is expected to happen. The standards against which quality is judged may change with time. For example, a high quality radio that is 2 decades old is a poor quality radio today. The standards of surgical services today are different from those of 20 years age. Standards therefore have an important relation to the measurement of quality.

  Quality can therefore also be defined as performing to set standards. When the actual performance is less than expected then a quality gap is said to exist. Quality can also be said to be doing the right thing, in the right way, at the right time. Common to all these definitions is that quality must be measurable and comparable to a standard or expectation.

- **Out reach Services:**

  These are services offered out side the normal premises of the health facility. These are usually in the community, as near to the clients or consumers as possible.

- **Decentralisation:**

  The transfer of powers and authorities from central to Local Government.

EXECUTIVE SUMMARY:

PWDs usually face medical problems including those similar to the rest community and those due to and consequent to the individual disabilities. They also face social problems.

The social and Education problems have been fairly well addressed through the MoGCD and MOE. There has been very little and disjointed efforts to address their medical needs by MOH.

Aware of this therefore the MOH has developed a medical rehabilitation package to this effect.

They are doing this mindful of the process of decentralisation, quality assurance, integration and sustainability.

It was the main aim of this study to assess the medical Rehabilitation service for PWDs and their families through elucidating the KAP of PWDs and service Providers. Documenting the available resources/systems and services in the District was also done.

The study was carried out in the three districts of Mbale, Bushenyi and Iganga using a qualitative and quantitative methodology. The finding in this study show among others the following:

- PWDs face unique medical problems that require specific attention.
- The health workers who are to provide Medical Rehabilitation still lack correct knowledge and attitudes for managing disabilities.
- Services, personnel, drugs ad equipment are grossly deficient in the various levels of health facilities.

o PWDs opinions on the kind of services the would like to have

- There is also a general consensus on the importance of PWDs on some level of Health Care delivery in delivering health care services.

o The training needs of the various providers have also been identified.

Therefore all concerned should seriously consider training of health workers, developing positive attitudes towards serving PWDs, instituting in the various health facilities the equipment's, drugs, and staff so that the required services are offered and seriously consider involving PWDs in some level of health care delivery in accordance with the district rehabilitation package.

CHAPTER ONE

INTRODUCTION

Background:

The Disability and Rehabilitation section of the Ministry of Health (MOH) was established in March 1996. The purpose of the section is to develop and strengthen medical rehabilitation services for the following major groups of disabilities.

-visual
-hearing
-movement
-mental handicap
-non communicable diseases

The Ministry of Health hopes to develop the rehabilitation services using a 'District Rehabilitation Package'. This draft package is composed of required standards, technical guidelines and policies necessary for medical intervention in disability. It also includes a broad 5 year action plan, staffing and equipment recommendations. The district rehabilitation package was developed by 9 task forces composed of internees in disability at National, District and community level. the forces addressed the following areas of disability

-visual impairment
-hearing impairment
-epilepsy
-mental health
-children's mental health
-cerebral palsy
-polio and movement
-non communicable diseases
-orthopaedic appliances & aides

For the rehabilitation package to be effective and acceptable, it is important that it meets the needs of people with disabilities (PWDs) and their families and yet is within the resource capabilities of the districts and of the MOH. It is also vital that the package is implemented as a joint venture and not just a prescription from MOH. Other actors in this process besides the district and MOH are Ministry of Gender and Community Development (MG&CD),Ministry of Education, MOL and MOLG, persons with disabilities, the parents or caretakers of children with disabilities and service providers at various levels.

In order to fill up the gap in the draft package it was necessary to carry out a background situation analysis and needs assessment in the districts. Bushenyi, Iganga and Mbale were selected and this is where the study was carried out.

These districts were selected by the inter-ministerial committee composed of MG&CD, MOH, Ministry of Education MOE), and NUDIPU in its February 1996 meeting as areas of intense and exemplary collaboration between the implementers and users of various rehabilitation services.

The purpose of this study was to document what is going on as far as medical rehabilitation in the three districts is concerned.

This study therefore focused on these three districts in order that the health component which is the missing link can be adequately addressed in the district rehabilitation programme.

Although only three districts were studied, the results and conclusions here generated can reasonably be assumed to be similar in other districts.

Statement of the problem

Although the prevalence of disabilities has not yet been quantified in Uganda, based on the available information, there is reason to believe that it is a big problem, especially as a burden of disease to the PWDs and their families. Inspite of this however there has been little deliberate effort by the Ministry of Health to address the medical needs of PWDs. This little efforts by the Ministry of Health are disjointed and uncoordinated. They are carried out as separate services addressing individual disabilities. The problem therefore is that of inadequate and uncoordinated health services for PWDs. There is some efforts by the Ministry of Gender and Community Development (MoGCD) through the CBR programme and the MOE through the EARS programme to address the social and educational problems respectively.

Justification of the Study

There is now a deliberate effort by the MOH through the Rehabilitation section to address the missing link by using a medical rehabilitation package. This package is intended to be used in the district to address the medical needs of the PWDs. The Rehabilitation section is however faced with a problem of minimal information about the systems and services already available on the ground. The following reasons therefore, justify why this situation analysis was undertaken.

i) To get base line information for the MOH as to what is on the ground.

ii) Because the package will be implemented in the district, in the spirit of decentralisation, it was unecessary to find out what resources are available or can be mobilised in the District for medical rehabilitation.

iii) In line with the principles of quality assurance it was important to consult the PWDs on what kind of services they would like to have included in the package.

iv) All these lead to ensuring that sustainability is taken care of.

v) This study was necessary to provide information on which future evaluation will be based.

CHAPTER TWO

OBJECTIVES OF THE STUDY

General Objectives:

The overall objective of the study was to assess the medical rehabilitation services for PWDs and their families in the three districts of Mbale, Bushenyi and Iganga.

Specific Objectives:

- To assess KAP by the various service providers in the area of Medical Rehabilitation
- To assess KAP by the PWDs and care takers in the area of Medical Rehabilitation.
- To establish the available systems and resources for medical rehabilitation.
- To identify the gaps in the available services as compared to the recommended standards.
- To assess the available man power.
- To identify training requirements of health workers.

CHAPTER THREE

METHODOLOGY

Study variables:

- o Knowledge, attitudes and practices.
- o Policies, plans, budgets and resources allocated.
- o Services offered and referral systems available.
- o Man power available and training needs.
- o Drugs and equipment.

Study population

Target Population:

This included the following: PWDs, Parents with PWDs, Health Workers managing PWDs (Doctors, Clinical Officers, Nurses, Midwives, Paramedicals, Nursing Aides and others), District Rehabilitation Officers, Community Development Assistants, District Medical Officers, Chief Administrative Officers and District Education Officers.

Study Area.

The areas included in the study were the Districts of Iganga, Mbale and Bushenyi. The reasons for their selection have been mentioned in the introduction.

Methods of Data Collection

The following methods were used for the purpose of data collection:

- o Key informant interview.
- o Focus group discussions
- o Observation of the health facilities to assess the availability of the required facilities, equipment and man power.

Procedure of Data Collection:

In each district Data was collected at three different levels, namely:

(i) the District
(ii) the sub-county or health unit
(iii) and the individual PWDs and family

i) **At the District Level:**

Expected Out puts:

- o Knowledge, attitude and practices by top District Administrators towards medical rehabilitation.
- o Policies regarding Medical Rehabilitation.
- o Plans and budget for Medical Rehabilitation.
- o Activities being carried out.
- o District commitment towards Rehabilitation.
- o Reports

Target respondents were:

CAO, DMO, DEO, DHC, DRO,

Data collection:

Using a questionnaire that had closed and open ended questions the above officers were individually interviewed as key informants.

ii). **At the sub-county levels:**

a) Community Development Assistants:

Expected out puts:

- o Knowledge attitudes and practices in the area of medical rehabilitation.
- o Areas of possible involvement in service delivery.

Data collection method

:

CDA's in the district were randomly selected and participated in a FGD. A Standard guide was used to direct the FGD.

b) **Health workers.**

Expected out puts:

- o KAP of health workers in the area of Medical rehabilitation.
- o Inventory of staff, equipment and services offered.
- o Levels of training of the staff.
- o Training needs

Sampling:

Three Sub-counties were selected in each District.

The three sub-counties were selected using the following inclusion criteria. All Rural Sub-counties with a health unit at the level of a DMU were identified. Then out of these two were randomly selected. The second group included all Urban Sub-counties (i.e. Town Councils) with hospitals. Out of these urban sub-counties with a hospital only one was randomly selected. There was therefore a total of three Sub-counties namely: 1 Urban with a hospital and 2 Rural with DMUs. This enabled us to have a wider perspective of Rural versus Urban and hospital versus DMU health care provision.

Data Collection Methods:

- o Review of records
- o Observation using a check list.
- o Focus group discussion with 7 members of staff at the health unit.

iii) **The individual PWDs and Caretakers of PWDs.**

Expected out puts:

- o Where PWDs seek health services
- o What kind of services they need
- o How they participate in service delivery
- o What kind of reliable technical services can be provided for PWDs with communities.

Target Respondents:

PWDs and Caretakers of PWDs.

Sampling:

In each of the sub-counties selected for a health facility review, seven PWDs and caretakers of PWDs were randomly selected. The seven included four PWDs of different types of disabilities and three Caretakers.

Data Collection:

This group of seven people was engaged in a focus discussion using a discussion guide.

Data collection instruments:

Four kinds of Data collection instruments were employed.

i) Structured/Non Structured questionnaires. These were administered to DMO, CAO, DEO & DRO.

ii) Guidelines/ questions to the Focus group discussions for the health workers, PWDs & Care takers.

iii) Inspection check lists one for the hospital, another for DMU.

Interviewers:

In addition to the principle investigator, other researchers were recruited and trained in the basic methods of Data collection which were used. The researchers included 2 members from each of the five task forces of the Rehabilitation section of the MOH.

Training:

The core team of 9 members received a one day training in preparatory methods of information gathering, data processing, compiling and analysis.

Pre-test:

A pre-test and adjustments of the data collection instruments was carried out in Mukono District before the actual survey by the core team.

Data Management:

Triangulation:

All the data collected was triangulated during the analysis in order to complement and increase validity.

Data Analysis:

- 4 Key Informants in each of the three district were interviewed, thus a total of 12 respondents in all three districts.

- Three filled out inspection checklists (on services available, drugs and equipment) and staff lists were compiled per district in the selected three Sub-counties. This gives a total of nine.

- The following focus group discussions were carried out in each District:

(i)	CDAs	1
(ii)	Health Workers	3
(iii)	PWDs/Caretakers	3
	Total	7

The three Districts therefore had a total of 21 focus group discussions.

Because the amount of data collected in terms of numbers was small, most of the analysis was done manually.

Quality Control

Researchers were recruited and trained. There was continuous supervision during data collection. Debrief meetings were always held to harmonise the data collection each day. Study instruments were pre-tested and adjusted for the main field work. Data was cleaned before analysis.

Ethical Issues

The rehabilitation section of the MoH got the necessary clearances for the study. Letters of introduction to the District were given to the data collectors by the MoH. Prior to each interview and discussion informed consent was always sought from the respondent and all interviews were treated as anonymous and confidential.

- Collection of data was done simultaneously in the three districts by 3 teams, each with 3 members of the core team, and one district staff.

The logistical preparations were done by the Disability and Rehabilitation section of the MOH.

Data collection dates:

9th - 14th February'98 simultaneously in all the three districts.

CHAPTER FOUR

RESULTS

This chapter constitutes the presentation of results. There are two sections of this chapter. In order to meet the objectives, qualitative and quantitative data was collected.

The first section presents qualitative information on knowledge, attitudes and practices of PWDs and various providers of medical services. It also gives an insight in what various players and PWDs would like to see in the package and referral systems envisaged. The second section presents quantitative information on services, systems, resources and medical rehabilitation personnel available in the Districts.

QUALITATIVE DATA

General health status

The leading disease conditions in the three districts included: Malaria, ARI, Diarrhoea, Malnutrition and measles. In Male district cholera was also a problem. Other concerns included lack of funds, adequate clinical care and non availability of drugs.

It was pointed out by the various health managers and district officials that the information about the health status of the Pads in the district is scanty and in some cases not available as indicated below:

There is no information on Pads (DMO, Iganga)

The status is not very good (DMO, Mbale)

There is lack of statistics on PWDs (CAO, Mbale)

The situation is poor. Services are not available especially specialised services. This is worse with deep rural areas (DRO Bushenyi).

However, despite lack of information about PWDs, it was pointed out that they lack funds to pay for the services. Society has a negative attitude towards PWDs and often PWDs lack access to services.

Community Problems

A number of health problems were cited by PWDs. Most significant among them included being handicapped and therefore ability to earn a livelihood for themselves. This state affects the health care seeking behaviour because most of the PWDs are not mobile. Health units be are often physically distant. PWDs are reported to be too poor to cost afford cost sharing or to go to private clinics. Other problems mentioned included the design for public utilities. In particular, toilets and latrines were reported to be a problem as it exposes PWD's PWDs to the risk of other peoples' faeces or urine.

"Public utilities are not in place for PWD. To access a public urinal or toilet, a disabled may touch urine and faeces, you can imagine! These places are usually dirty. (PWD-Iganga).

Access to public health services e.g. immunisation was a problem identified. Some PWDs could not take their children to outreach immunisation centres due to mobility problems.

Other problems mentioned included mental illness, blindness (which causes paining eyes), sores in the hands (as a result of some of them walking with their hands), hearing impairment and poor nutrition were also highlighted.

"The blindness that I have is bad. I have problems with these eyes. Bad as they are, they remain painful and I am helpless. Even when I am referred by medical officers I have trouble in reaching this medical services". (PWD, Iganga FGD)

"Taking the child to hospital is a problem because the child can not tell you the illness and you also can not explain the condition properly to the health worker". (PWD, Mbale FGD)

Health workers also pointed out the most frequent medical conditions that affected PWDs and the disease pattern was not different although from the rest of the general population.

Almost all the focus group discussions mentioned malaria to be a big problem. Diarrhoeal diseases (7/9) and ARI (5/9) affected PWDs most.

"Broadly speaking, PWD's problems are both medical and surgical commonly, malaria, diarrhoea, respiratory infections, measles and meningitis, surgical problems included hernias, ectopic, (road traffic accidents).

Poor sanitation and hygiene related conditions, sexually transmitted infections and repeated outbreak of measles were pointed out by almost half of the group discussions. Least mentioned medical conditions included: Surgical problems like hernia, meningitis hook worms, malnutrition, anaemia, intestinal obstructions, amputations, mental Diseases, hypertension, TB and pregnancy complications."

"In this place, we have cholera which is now prevalent. We also have malaria and measles. Some people don't have latrines and therefore, there is poor hygiene" (health workers, Budadiri health centre Mbale).

Socio -Economic Problems:

A range of social issues arose from focus group discussion with PWD's. They included access to health care (physical and economic), attitudes (health workers, PWDs, and their families) and psychological problems of PWDs. Almost all the groups complained of poverty and inadequate income. PWD's lived in poor houses.

Over half of the groups of PWD's mentioned attitude related problems as their concern. PWDs said they are disregarded,(T6) feel useless (T6) and society (T6) has a negative attitude towards them. Often they are stressed by this. About half of the groups mentioned maginalisation and name calling among children as a problem. Some parents value children differently. Good schools are ear marked for children without disability as an endeavour to rationalise resources.

Access to health care was a big problem to the majority of PWD. Topographical (TQ) problems and distance were highlighted. For some who managed to reach health units, they get problems of social access due to bad attitudes of health workers. Some who fail to pay for services at times are denied services.

"People's attitudes towards us are negative. They view us as completely useless especially among fellow women. They even take away our husbands, who abandon us with children. Our parents also separate us from other children .Now with the new government policy towards PWD has awakened the PWD's plight "(PWD Iganga TC Iganga FGD).

"As for pregnant disabled mothers, health workers can't imagine that they can deliver properly, so, you are automatically referred to theatre even when it is not necessary "(PWD's Iganga TC, Iganga).

"Because I am semi literate, I find problems even to fit in the rest, they feel I am useless! Our parents disregarded us even in getting education, we were hidden behind houses". (PWD Bufulubi, Iganga).

"There are many hills and we do not have appliances to walk up hills so as to access health services", (PWD Rwengwe, Bushenyi).

"Health workers at hospitals are not eager to care for us. When PWD go to hospitals we are ignored, also, there are no drugs at hospitals " (PWD Ishaka Bushenyi)

"Sometimes, we feel that we inconvenience people. You want to got to bath,.... Some one has to take water there.... Don't you think they also get tired!!"(PWD) Mbale)

Definitions

The respondents were requested to define a few terms in order to gauge the knowledge levels.

Medical Rehabilitation.

The concept was understood by PWDs in medical and social terms. Sociologically it constituted, means and ways enabling PWDs to perform duties that they were not able to perform before. Rehabilitation also referred to mechanisms put into place to comfort PWD's so that they are more acceptable in society (counselling, facilities and "appliances" e.g. clutches/wheelchairs). More than half of the group discussions mentioned the above definitions. Some of them are indicated below.

"Rehabilitation may be in form of straightening my arm, so if this is done, then I would be able to work". (PWD Bukoma Iganga).

"Medical rehabilitation is a way of helping PWD e.g. in an accident. So this helps restore their lives. Medical personnel counsel us so that we don't lose hope. (PWD Iganga TC, Iganga.

"Medical definition involves, medical care, counselling services by medical personnel provided to the PWD's".

"I think it means helping people say children who cannot walk to walk or teach them how to eat" (PWD Namakwekwe, Mbale.)

Disability

It is apparent that also disability was defined using both medical and social definitions. Medically defined as the Inability of the individual body systems to function normally.
Definitions of medical rehabilitation by policy makers:

These officers also included social and medical aspects in the definition of medical rehabilitation. It was defined as a way of providing medical and social care for PWDs.

Almost all the groups (10/12) defined disability as persons whose body systems don't function properly or in one way or another. Examples given was blindness, physical fitness and dumbness (speech).

Socially defined as Inability of an individual to perform duties as per societal expectations.

About half of the groups mentioned that disability referred to individuals not being able to perform normally as per social expectations.

"Those who have had accidents, mental illness, stroke and actually can't perform their duties well' (Health workers Bugobero DMO Mbale).

For me, I could say people who are physically handicapped, often short legs, we have those with epilepsy, mental illness who can not do well their work. There also those who have abnormalities (Bugobero Health centre, Mbale.(FGD)

I think these are people with some accidents on their body e.g. lame, one part of their body not working properly say with one arm or leg and the deaf (health worker Budadiri, Mbale.

Types of disabilities identified:

A number of physical and mental disabilities were named by the participants in the various focus groups. The commonest type mentioned was blindness. Others included cerebral palsy, deafness, leprosy, epilepsy and cleft palate. The causes of the disabilities mentioned included, road traffic accidents, infections like measles, leprosy, syphilis, osteomyletis and polio others included, congenital abnormalities, infections and amputations.

"Visual disabilities are mainly due to measles, trachoma, & mental disability is due to dangerous diseases like syphilis" (CDA, IGANGA FGD).

"I have so many children with Fits, those who cannot talk, and understand". (CDA, Mbale FGD).

Gaps and constraints to health care for PWDs:

A number of gaps and constraints to service provision were noted by the respondents.

These included:

- Lack of equipment's, and appliances like crutches, hearing aids, optical equipment, special clinics in health units.
- Lack of services for PWD's in many health centres
- Lack of specialists for disabilities in many health units
- Delayed referral to health units.
- Negative attitude of health workers towards the disabled.
- Queuing at the health units.
- Long waiting time
- Lack of drugs in health units.

These were identified by all FGDs with PWDs and Health workers in all the districts.

"We had an ophthalmologic assistant who would draw a programme and move from village to village. Right now those programmes have stopped because the one we had died" (Health workers Bugobero FGD Mbale)/

"On reaching hospital I am not treated for my disabilities but malaria, backache. Even those with children with CWDs, Health workers or parents do not handle disabilities. Disabilities are not catered for ". (PWD, Bukoma, Iganga district)

"There are no specialist in disability issues. Health workers lack knowledge and therefore do not address disability issues". (PWD, Bitereko Bushenyi).

Health Care Sources:

Majority of people with disabilities seek care from hospitals either after being referred there by the community development assistants or by relatives. This is because of the availability of specialised services in the hospitals. Other sources of health care include sub dispensaries, dispensary maternity units (DMUs), traditional healers, private clinics drug shops and in homes.

"A new PWD case would be viewed at ritually or traditionally caused such that parents imagine it is has nothing to with health workers. They later find out when it's too late to recover. It is hospitals that later prove satisfactory since, they some times then reverse the trend of the disability" (P.W.D, Iganga Town Council FGD)

Available Specialised Medical Services:

Services available for people with disabilities were mainly identified by the health workers and community development assistants. The beneficiaries of these services didn't seem to know much about these services.

These services included, eye care, ENT surgery, physiotherapy, orthopaedic surgery, and orthopaedic workshops. These are offered in referral centres like, Iganga hospital in Iganga, Mbale regional hospital in Mbale and Ruharo eye centre in Mbarara.

It was also pointed out that there are some programmes like the HARK programme in Iganga. Community Based Rehabilitation programme in all 3 districts. There is a school for the deaf/dumb in Iganga and Mbale.

Specialised Staffs:

It was reported that there are few specialised staffs in health units and in the community to handle PWD's. Apart from the basic training in medicine, surgery, obstetrics and gynaecology, and basic sciences, majority of the health workers had never had specialised training. The staffs

who are specialised are mainly posted to referral hospitals. These include, psychiatric nurses, ophthalmic clinical officers, orthopaedic assistants, ENT surgeons, General surgeons, and at the community level there are community development assistants.

"Personnel in the district is very limited. There is one physiotherapist who is over loaded". (CDAs, Bushenyi FGD)

Perception of quality of care by PWDs:

The perception of good quality care by PWD's included good reception, history taking, and supply of drugs.

"When I go to the doctor, and he smiles at me I feel this is the most impressive".)PWD, Namakwekwe, FGD).

Attitudes of health workers in involving PWD'S and their Roles:

- All health workers were positive about the integration of PWD's in the implementation of health services.

The roles in which they think PWDs would be very instrumental are:

- Health education
- Treatment of the sick if given the basic training in drug use.
- Counselling.
- Providing outreach services.
- Identifying fellow PWD's
- Planning for health services.

It should also be mentioned here that some few PWDs, as result of negative attitude by health workers towards them, the recommended there be special services for them run by fellow PWDs health workers. This was however not the general feeling of the PWDs.

"It would be easy for the PWD to know what is going on in the health centre, especially now when PWD's talk bad about us medical personnel. They imagine that we do not give them facilities yet we don't have their facilities yet" (Health workers, Imanyiro Iganga FGD)

"There is a tendency to underrate PWDs and yet public opinion would change if they are involved in our health services". (Health workers Imanyiro, Iganga FGD).

"As a disabled you may bear a normal brain, so let us also be involved". (PWD, Bufulubi Iganga FGD).

Referral Systems for PWDs:

There are a number of referral centre in the districts. These include, hospitals, centres for the disabled.

Reasons for Referral:

The health workers noted that in majority of the cases patients are referred due to complications, mismanagement at home, lack of services at the health units, lack of equipment and skilled personnel.

Strengths:

The strength noted by the PWDs or respondents is that there is always skilled personnel at the referral centre.

Weakness in the Referral System:

-Missed opportunities at the referral centre

-Accessibility to the referral centres. This is in terms of geographical and physical access.

-Transport costs to these centres is often too high to be afforded by the PWDs.

-In some cases there is lack of communication between the referral centres.

- Often the patients are not provided with referral notes.

-There is sometimes lack of skilled personnel at the referral centres and equipment.

"The doctor in Mbale is the one who knows which doctor in Mulago to consult. Those two should have a way of communicating to ensure that the patients exchanged have reached") PWD's Namakwekwe, FGD Mbale.)

"Orthopaedic services are satisfactory like in Iganga hospitals it is properly catered for " (PWD, Iganga town council FGD)

Suggestions for Improving the Referral Systems:

Respondent suggested that:

- Ambulances should be availed at the sub-counties and health units to transport those people who have been referred.
- Skilled personnel should be posted to lower health units and mechanisms for these people to carry out outreaches be put in place by the district.
- Referral notes should always be provided to the patients who have been referred in order to improve on the communication between the patients and the specialist.
- The patients who have been referred should always pay a reduced cost to the health units where they have been referred.
- Drugs should always be availed at the referral centres.
- Out reaches should be organised by the district rehabilitation officers to cover all the sub-counties.

Respondent suggested that:

It is important to note that a number of activities are being carried out by the community development assistants especially in the areas of sensitisation, registration and referral to higher centres. There is very little provision of direct health care to the disabled. They also gather information about them and utilise it in planning services at district or local level.

"We send clients to Ruharo eye centre, physiotherapy at Kitagata, sensitising PWDs into forming associations and addressing their plight using LCs' (CDA, Bushenyi).

Social integration of services for people with disabilities:

- According to the CDAs, sensitisation of public, accessible transport, special training for teachers, use of ramps instead of stairs to permit interaction of disabled with the rest of society has either been limited or is lacking. This is linked with social stigma, lower coverage level of education and lack of voice by the PWDs in the planning process.

District level activities

At the district apart from the department of the DRO there are no planned activities for PWDs. The projects available in the District are not known by the district heads for example CDA's activities in Mbale are not known by the DMO's office therefore these activities are not appreciated.

District Policies

It was pointed out that there were no policies on medical rehabilitation on PWDs. The activities of the PWDs are not reflected in the work plan of 2/3 districts. In Bushenyi, however, it was indicated that there are some activities funded by the district rehabilitation office. However the budgetary allocations are too small to provide a comprehensive service. In Mbale, the Italian government through AVISI is providing support to the disabled the nominal value of which is not known by the district officials.

The major reasons given as to why there are no budgetary allocations is that the burden of disease for PWDs is not known to the district. officials.

Suggestions for improvement

The district officials recognise that there should be clear policies on PWDs. Sensitisation of the district leaders should be carried out. A committee on PWDs should be formed. The necessary equipment and trained personnel in the health units should be made available.

Package for PWDs

The district officials suggested that the package for improving services for PWDs should include carrying out prevalence studies, training staff on management of PWDs supply equipment and appliances to health units, advocating for PWDs, providing for operational costs for sustainability purposes and supplying drugs.

The role of the district in the Medical rehabilitation program:

The roles and activities by the district in service delivery for PWDs suggested included.

- Implementing the policies
- sensitising of local leaders down to the grassroot
- Increase awareness among the population on disabilities
- Political commitment and support during implementation.

Role of the Ministry of Health

It was suggested by the District heads that the Ministry of Health should provide technical guidance, sensitisation of the district leaders, staff training, support supervision, monitoring, evaluation and funding rehabilitation programmes in the districts.

Training Needs for Health Workers:

A number of training needs were suggested by the health workers. These included:

- Basic ophthalmology care
- Basic orthopaedic care and management
- Sign language
- Counselling
- Mental health
- Control of diarrhoea disease
- Physiotherapy
- Practical field experiences in the management of the disabled
- Caring for leprosy patients.
- Nursing care.
- Refresher courses in all aspects of care.
- Making wheel chairs.
- Social care for PWD's
- Health education

They think that all these components of training should be carried out in an integrated manner.

"We are interested in all these field since this area of disability is a new field", (health work FGD).

Training Needs for CDAs:

A number of training needs were suggested by the CDAs. These included:

- Basic medical care.
- Counselling techniques
- Sign language
- Basic eye care.
- Project designing and management.

Suggestion made by the PWD's to improve their plight:

Policy.

The PWD's should also be involved at all the levels of policy formulation.

Medical Care:

- Appliances for use by the disabled should be provided in all units.
- PWD's should be treated by fellow PWD's.
- Reduce the cost of services offered to PWD's
- The PWD's should also be elected on the health unit management committees.

Integration of Services:

The PWD's noted that if they are trained properly they can be involved in

-Social mobilisation of the communities for a specific task.
-They can also be involved at the implementation level of all community activities.

Structural design of health facilities:

-There is need to construct suitable toilets, stairs for PWD's.

Social economic status

- Special schools for PWD's should be constructed in each sub-county.
- Formation of groups at different levels in the sub-counties.
- Financial assistance from governments and NGO's in forms grants, credit schemes.
- Setting up income generating activities
- Sensitisation of PWD'S and the community on the plight of PWD's
- Seminars and workshops should be organised for PWD's including skills training.
- Paying school fees for PWD's children.

RESULTS OF QUANTITATIVE DATA

This section now presents quantitative data gathered using checklists on the situation of staffing, services available, equipment and drugs. This information was collected at two different levels namely the hospitals and the DMUs. Each of the different categories was being compared against a recommended standard.

Staffing Situation.

Hospitals

The following table shows availability of the recommended categories of staff who should be available in the hospitals.

Table 1: **Distribution of different categories of staff in the three hospitals.**

No. of category of staff available	No.	%
Types of staff available in all the three hospitals	7	25
Types of staff available in only 2 hospitals	12	43
Types of staff available in one hospital	5	18
Types of staff available in all the three hospitals	4	14
TOTAL	28	100

A total number of 28 categories of staff are recommended for each of the three hospitals. It is only 25% (7) of these categories that were available in all the three. 14% of the categories of staff were not available in the hospitals. The majority of categories of staff were either found in one hospital 18% (5) or in two hospitals 43% (12).

The types of staff universally available included: registered nurses, Clinical officer, Medical officer, Radiographer, Enrolled nurse, Dispenser and ad assistant health visitor. The staff that are absent in all hospitals include. Psychiatric clinical officer, occupational transport, psychiatric enrolled nurse and.

DMUs

The table below shows the of categories of the recommended staff available at the surveyed DMUs in all the three districts.

Table.2: **Number of categories of staff available at health Centre**

No. of categories of staff available	No.	%
No. of categories available in all the six health units	1	7
No. of categories available in only health units	4	31
No. of categories not avaialble at all	8	62
TOTAL	13	100

Only one category of staff (Nursing aide) that was universally available at all health units and 62% (8) are not available at all. These include Registered psychiatric nurses, Registered nurse, orthotic prosthetic artisan, Enrolled psychiatric rural nurses, comprehensive nurses, Registered midwives and laboratory assistants. The rest of staff 31% (4) are only available at some units.

Available Services:

Below are number of services that were found available at the hospitals and DMUs as compared with the recommended standard for services.

Services available at the hospitals:

The table below shows the number of categories of services that were found at the hospitals.

Table 3: **Number of services offered at different hospitals.**

No. of services offered	No	%
No. of services offered at all the three hospital	8	40
No. of services offered at one hospital	10	50
No. of services not available in all the three hospitals	2	10
TOTAL	20	100

40% (8) of all the recommended rehabilitation services are available at all three hospitals, while 10% (2) are not offered at all three hospitals The most universally available services are:

- Management of secondary disabilities and referred
- Referral of orthopaedic examination cases
- Appropriate examination room
- Referral of polio cases

- Maintenance of equipment
- Referral and follow up of cases of visual impairment

The services completely absent are:

- Presence of epilepsy case management guidelines and specific health education on disability.

Services available at health centres.

Table 4. **Number of services available at the health centre.**

No. of services	No.	%
No. of services available at all the health centres	3	12
No. of available at some health units	18	72
No. not available at all	4	16
TOTAL	25	100

Only 12% (3) of the services are universally available they include: space for examination, HMIS and referral of psychiatric cases. 16% (4) of the services is not available in all health units. They include follow up and counselling of epilepsy management guidelines for epilepsy, maintenance of orthopaedic appliances and recognition and management of psychiatric illnesses.

Equipment available at health facilities

5.3.1 **Equipment available at the hospitals.**

No. of equipment available	No.	%
No. of equipment available at all 3 hospitals	17	22
No. of equipment available at hospital	55	72
No. of equipment not available at all	4	6
TOTAL	76	100

25% of the different types of equipment is available at all three hospitals while 6% (4) of these different types are completely absent in all hospitals. The majority equipment are available in only some of the hospitals. The equipment universally available include: x rays, Laboratory, Pillows, toys, blankets, bed sheets, surgical equipment, linen, examination coaches, stethoscope, ear syringe, wax hook, kidney dishes, trolleys and sight source. Those completely unavailable are kits

5.3.2 **Equipment available at the health centre.**

Table 6. Equipment at the health centre.

No. of Equipment available	No.	%
No. of equipment available at six health centres	6	20
No. of equipment available at health centres	13	45
No. of equipment not available at all	10	35
TOTAL	29	100

20% of the types of equipment is available at all units. These include BP machines, stethoscope, bicycles, birth kits, and kidney dishes.

35% of the types of equipment needed is not available in all health units. Such equipment include: Flat wooden species, rolls, C.P charts, walking sticks, crutches, screening audio metre, warbler, autoscope and wax hook.

5.4 **Drugs available in health units.**

5.4.1 **Drugs in hospitals**

Table.7 Types of drugs in the hospital.

No. of types of Drugs	No.	%
No. of types of drugs at all the three hospitals	12	30
No. of types of drugs at some hospitals	19	48
No. of types of drugs not available at all	9	22
TOTAL	40	100

30% of the required types of drugs are available at all health units. The available drugs at all health units. The available drugs at all health units include rectal diazepam, chlorpromazine injection, and tabs, Plaster of Paris, Bronchiodilators, and hypotensive essential drugs, surgical sundries, Tetracycline eye ointment, Vit.A. 22% of the types required are not present in all health units. Those not available at all are: Ethosuccimide, Flublenazines injection, nasal drops, Teracortic, anti fungal, ear drops, Timohol, Flusomide strips.

5.4.2 **Drugs in Health centres.**

Table 8. **Types of drugs available at health centres.**

No. of types of Drugs	No.	%
No. of types of drugs at all six health centres	2	14
No. of types of drugs at some health units	7	50
No. of types of drugs not available at all	5	36
TOTAL	14	100

Of the 14 types of drugs recommended for health centre level only 2 are available in all health centres while 5 are not available at all.

The available ones include surgical sundries, Tetracycline eye ointment. The ones not available at all are: Chlorpromazine inj, imipramine tabs, Artane tabs, Nazal drops and ear drops.

DISCUSSION

Health Problems

PWDs, caretakers, key informants, CDAs and health workers mentioned a number of health and related problems that affect the PWDs. These were universally mentioned in all the three Districts, sometimes with a lot of emotions.

Among the problems mentioned are:-

- Being handicapped and unable to earn a living

- Inability to reach the required health facilities

- The design of public facilities which make them inaccessible to the stored health facilities or latrines that are soiled and make it risky for the PWDs to use them.

- They also particularly talked of inaccessibility of the few available facilities due to their almost universally poor mobility.

- Communication problems especially between the deaf and his care taker or health worker make it very hard for PWDs health problem to be properly identified and treated.

- They also have various problems that are peculiar to the individual disability.

- The other health problems and diseases are similar to or even worse than those of the general population.

Social Economic Problems that affect health of PWDs

The major problems mentioned are those of access to services or opportunities - both physical and economic. Poverty was the major culprit mentioned.

Attitudes of the health workers and parents was mentioned high among those problems that make it hard for PWDs to access health care. It is interesting to note that when health workers were asked how they feel about treating PWDs they all said they had no problems, on the contrary PWDs and caretakers unanimously said the health workers treat them as secondary patients for several reasons. Among them they are not people worthy treating and secondary they assume all PWDs do not have money and have come to beg not only for free treatment but also for money. In fact PWDs do not seem to be satisfied they sometimes think they are being treated with expired drugs, unsterile injections and non proper medicines.

They also raised as major health problems and health related problems although used all levels as opening remarks, are so important. They put forward important issues that need that need to be principally addressed by the programme early enough to build confidence in both the PWDs and health providers. They image on access and quality assurance. As seen earlier its so critical to build the confidence of the PWDs in our health system for instance some of them think when they are pregnant they are just operated on (caesarean section) without proper evaluation and when in their view they think they are able to deliver normally.

Policies and Resources for Medical Rehabilitation.

As shown in the results it was shown that there is almost no policy and planned activities in the *districts* in the area of medical rehabilitation. The programme therefore needs to quickly sensitise the district leadership in the importance of medical rehabilitation and the Ministry of Health policy regarding it in order to influence the district policy and planning process. This will greatly enhance greater resource allocation and activity implementation in this area. Short of that little will continue to be done by districts in the area of medical rehabilitation.

Knowledge, Attitudes and Practices about Medical Rehabilitation.

Medical Rehabilitation

On the whole PWDs seemed to have understood the meaning of medical rehabilitation. They however almost always linked it with social rehabilitation. Therefore there is need for proper education to ensure that medical rehabilitation (although not a clear cut), is not lost in other rehabilitation services. It should be noted however that in an attempt to translate the term "medical rehabilitation" PWDs answers could have been prompted.

On the other hand, surprisingly, who had an even more vague definition of medical rehabilitation. In fact in some case some people especially policy makers in fact have physical rehabilitation. This presents a gap in the knowledge of the consumers but more serious among the providers or assumed providers.

Disability

This was fairly well defined by all respondents PWDs and care takers alike. However when it came to listing examples only very few are mentioned mainly physical disability, hearing and visual impairment .Hardly any non communicable disease, mental illness and epilepsy were mentioned. Again this presents a knowledge gap which needs to be filled up.

Attitudes

As seen in the results there is a big problem of negative attitudes by health providers towards PWDs. This is evidenced by the perception of the PWDs. PWDs think that the health workers do not regard them like any other patient worth treating. On the other hand, many health workers said they treat PWDs like any other patient. This presents an area in which the programme needs to put emphasis while training the health workers to be sensitive to the PWD's needs. It is also important to sensitise the PWDs to be appreciative of the efforts by the health workers towards solving their problems especially in the prevailing conditions of the health care.

Sources of health care

As mentioned earlier in the results PWDs seek for health care services from established health centres and hospitals and private clinics. A few also seek treatment from traditional healers. There is therefore need to collaborate with the alternative providers of PWDs for health needs namely: private practitioners and traditional healers if we are to cover all PWDs.

Specialised medical services for PWDs

It is only in Mbale hospital and Bushenyi that there is some specialised PWDs medical rehabilitation services. Health workers and PWDs like feel these services should be decentralised to all levels of health care for easy access by PWDs. This therefore calls for deployment of specialists or training of the available staff in special skills.

Perception of quality of health care by PWDs.

When asked about what services and things they feel are criteria for a good service when they seek for health care, the PWDs said they are satisfied with the history tasking, good reception and supply of drugs. Therefore, if these are the things that satisfy the PWDs, any future programme and package for PWDs should ensure it taps on this strong base.

Gaps and constraints of health care for PWDs

A number of gaps in the health care delivery of PWDs were identified out namely:

- Lack of equipment and appliances
- Lack of services in the health centres
- Lack of specialists
- Lack of drugs
- Poor referral system
- Long waiting time
- Negative attitudes by health workers.

These problems identified by the PWDs are well collaborated by the quantitative information seen at the health facilities namely:

Only 25% of the required types of staff are available in all hospitals. While at health centres its only 7% of the required types of staff are available in all units.

Only 40% and 12% of the required services for PWDs are available in all the hospitals and health centres respectively.

Only 30% and 14% of the recommended types of drugs and supplies are available in all hospitals and health centres.

The following should be noted on those small proportions of universally available staff, services, equipment, drugs and supplies.

All of them were assumed to carry equal weights.

It is the staff, equipment, services and drugs which are basic for all health care not specific for disability that are universally available, for instance:

Staff - Nursing aides, Nurses, Clinical Officer

Services - Space for examination, HMIS

Drugs - Diazepam, chlorpromazine.

Equipment - X-ray, laboratory, beds, examination coach, thermometers.

As can be seen from the above, although these staff, services, equipment and drugs mentioned are part of the rehabilitation system, they are on the whole non specific to rehabilitation, they are generally supports. The more specific staff, services, equipment and drugs are generally not available. It is only in Mbale and Bushenyi hospitals that specific rehabilitation services and equipment are available for some disabilities otherwise for the majority of health units, little is present.

What this however shows is that there is some kind of system that can be used as base or starting point although it is greatly lacking in staff, services, equipment, drugs and supplies.

Possible areas of involvement of PWDs in health care delivery

When asked how best they could be involved in health care planning and delivery, the PWDs felt that that is the best thing that could be done for them. Among the roles they could play the following were mentioned.

Health Education
Identifying of fellow PWDs
Providing outreach services
Counselling
Limited involvement in management if given basic training.
Planning.

According to them, if involved this would build confidence among other PWDs to seek these services. It would also help raise public opinion and change attitudes of health workers towards PWDs.

When health workers were asked what roles PWDs could play in health care delivery, they also thought of the above roles. Their only problem was treatment since these people are not trained. Therefore, since it is cost effective and ensures quality involvement of PWDs in health care delivery at appropriate levels should be considered by the programme.

The referral system

PWDs, health workers and CDAs identified levels of referral from the smallest health unit through the hospital up to Mulago. The main strength they put forward was that there is a skilled personnel at the referral centre especially for orthopaedics. However a number of weaknesses in the referral system were mentioned like accessibility to the referral centre, transport, lack of proper referral documents, lack of skilled personnel and equipment at some referral centres and improper communication between the referring and the referral centre. They suggested improving the referral systems through having skilled personnel, providing an ambulance per sub-county and providing proper referral notes. They also suggested a reduced charges for the referred patient, improving in the availability of drugs to the referral centres and community outreach programmes to offer some service there. These are very critical issues as raised by the consumers and providers about the referral system especially the ambulance system, improvement of services at the referral centre and the community outreach services. If the referral system is improved it will greatly improve not only the management of PWDs health problems but also prevent disability by early referral and management of emergencies.

Training

Since there are a number of personnel in the District, it is important that they be trained in a number of skills which will enable them look after PWDs medical problems. A number of areas as evidenced in the results need to be addressed so that the health workers and CDAs can handle adequately medical problems of PWDs with minimum referral. The health workers strongly felt they needed additional training. This would therefore help them to integrate properly all the medical rehabilitation services in their day to day work. Since the staff available is generally non specific to rehabilitation, it is important to train all of them. Such staff including medical assistants, Nurses, Midwives and Nursing aides should be given appropriate on job training. This will certainly be more cost effective.

CONCLUSION

The objectives of the study were met namely: This study revealed and documents important issues that need to be considered by the programme and the districts as it is beginning to put together a package of medical rehabilitation.

- The main health problems and health related problems faced by PWDs include problems of access to health care (physical and economic), inappropriate health facilities and communication problems between the providers. One very perturbing problem is the attitudes of health workers towards PWDs.

- The knowledge of providers about medical Rehabilitation is still very low as exemplified by the poor definition of terms and limited number of disability categories mentioned by the providers.

- Although there is a structure and semblance of services, personnel, drugs and equipment in the districts, they are grossly lacking especially the specialised ones. The specific gaps in these are documented in the result chapter and annexes.

- The PWDs, care takers and providers have given their opinion on the kind of package they would like to see developed. The services according to them should be free and accessible with their participation.

- PWDs have also suggested a referral system with well equipped health facilities, an ambulance system and proper referral documents to enable them get the attention they require from the referral centres.

- There was a general feeling and quest for training of health workers, CDAs and some PWDs in some aspects of medical rehabilitation to enable them cope with the PWD's medical needs. The training should be for all available personnel now since it is very hard to have very many specialised personnel.

- The training need of health workers are mainly in the areas of specific management of PWDs medical problems and change of attitude.

RECOMMENDATIONS:

The following recommendations have been arrived at for consideration and implementation.

Training of Health Workers:

- In the spirit of integration of health services, Health workers should be oriented in various medical rehabilitation services so that the patient are adequate managed at smaller Health Units. We should consider training and important cadre mainly the nursing aides that are universally available and easily accessible.

Attitude of Health Workers:

- Even prior to the training immediate efforts should be made to orient and sensitise health workers in all units with an aim of creating the right attitude towards management of PWDs.
- The rehabilitation package should mention the positive attitude of health workers towards PWDs as a standard.

Services and Systems:

- Efforts should be made to equip all health units with the necessary staff, equipment and drugs so that they can offer the required services in accordance with the standards in an integrated manner.

Involvement of PWDs in Delivery of Services:

- Efforts should be made to involve the PWDs after necessary orientation in their health care delivery, especially in the areas of mobilisation, health education and home care.

Referral System:

- We should strengthen and streamline the referral system within the appropriate and available services.

APPENDIX 1

LIST OF RESEARCHERS:

NAME	DESIGNATION	STATION
1. Dr. G. Magumba (Principal Researcher)	DDMO Mukono	Mukono District
2. Dr. Alice B. Nganwa	Senior Medical Officer	Disability & Rehabilitation MOH
3. Dr. J. Walugembe	Pschiatrist	Butabika Hospital
4. Dr. S. N. Korongo	ENT Surgeon	Mbuya/Mulago Hospital
5 Mr. J. Bamuhiiga	Sen. Opth. Officer	Fort Portal
6. Mrs. M. Kabango	Sen Princ. Phisio	Disability & Rehabilitation MOH
7. Mr. S. Kiyuba	Social worker	Makerere University
8. Sr. L. Ofubo	SNO	Iganga Hospital
9. Ms. J. Nanyonjo	Occupational Therapist	Nakaseke Hospital

APPENDIX 2

TOOLS:

A) Guide line Questions for FGD for CDA:

1 What are your route duties?

2 Do you know what is meant by people with disabilities?

3 Are there some people with Disabilities in your area?

4 Do you know what is meant by medical rehabilitation?

5 In your schedule of work do you deal with people with disability?

6 What are their medical needs according to you?

7 How are they solving them?

8 What referral measures are available in your areas.

9. How best can these services and referral systems benefit PWD's.

10. What do you feel about being involved in the provision of these services.

11. How would best can you participate?

12. What specific training have you had to deal with PWDs?

13. What type of training do you need to perform better.

(B) Guideline questions for FGDs with Health workers.

1. What are you routine duties.

2. Do you know what is meant by PWDs.

3. Do you deal with any such case routinely

4. How do they come under your care

5. How do you deal with them in management and systems.

6 Do you manage all of them

7. How do you deal with those you are enable to manage.

8. Have you had any specific training to manage PWDs? What particular training have you had.

9 Is your basic training was their subjects of managing PWDs. Which particular areas.

10. Do you need any specific training to make you manage better.

11. What do you feel about being involved in a integrated programme of managing PWDs.

12. What particular role do you think you can play in this particular programme.

13. Do you think PWDs can be involved in provision of these Services at your health facility?

(C) Guidelines questions for FGDs of PWD/Care takers.

1. Do you know what is meant by Medical Rehabilitation of people with disabilities.

2. Where have been seeking for sick services including the referral system.

3. In which ways or which particular services have been satisfactory or nearby satisfactory.

4. Which particular services have been grossly lacking.

5. How best do you think these services can best be improved and offered.

6. In which particular area do you think our health worker can best be oriented to offer you these services.

7. Do you think you can be involved in development and offering of the services.

8. How do best would you be involved.

9. Are there any equipment and services that you could be involved in developing and offering with the community which ones?

10. How best could the referral system be implicated.

D) Questionnaire for IK - CAO, DHC, DMO, DRO

1) Do you know what is meant by medical rehabilitation PWDs.

2) Are there any policies by the district in your department regarding medical rehabilitation?

i) No
ii) Yes written policy seen
iii) Yes no written policy seen
iv) Not aware of any.

3) If policy is there what does it say?

4) Is there any plan for medical rehabilitation.

i) Yes seen
ii) Yes not seen
iii) No
iv) Not sure

5) What activities and provision were planned for?

6) Are there any budgetary provision in the current plan.

7) If yes how much and what % the whole budget is it.

8) What proportion of it was actually released in the last

financial year ------and this year-----------

9) Are you aware how serious the health problems PWDs are in your district state__________________

10) Are you giving the required resources as of the burden of these problems compared with all the problems?

11) If not why?

12) How could this be improved?

13) If one were to think of package to be implemented in the district how would you like to see this package?

14) What role should the district play in the implementation of this package.

15) What do you think should be the role of the centre.

APPENDIX 3

Training schedule of the interviewers:

1) Selection participants.

2) Venue:- Preferably in an area where pretest could be done.

3) Introduction of the study:

   - o Background
   - o Objectives
   - o Methodology
   - o Use of the data guaranteed.

4) Methodology
   - Theory on Data collection methods:
     1) Interview - KI
     2) FGD
     3) Inspection check list

   - Analysis

5) Introduction of the tools

6) Role play on KI/FGD

7) Defining of Roles - Centre
   - Facilitator
   - Interviewers
   - Core of three

8) Pre-testing

9) Time table for Data collection

10) Logistics.

Coverage:

In each district, 2 randomly selected counties and district headquarters will be visited.

o define medical rehabilitation needs

o The standard.

1. Researchers.

5 members of the task forces of the rehabilitation section of MOH. Each task force will be presented by one member.

2. One member of staff from Disability & Rehabilitation Section of OH. The 9 members will be divided equally over the three districts.

-One member from the DMO's office will join the two members from the national level team to form 3 data/information gathers at the district.

3. Facilitators: Disability & Rehabilitation Section of MOH.

4. Training: The core team will receive training in participatory methods of gathering information and recommendations through one day workshop.

- Data/Information Processing: The collection, compiling and analysis of data/Information and drawing of recommendations will be by the task force members. One of the members will write the report.

5. Preparation of Instrument: The following will be guides for discussions/interviews will be developed by the 5 task force members.

Interview guide for:

- DMOs
- District LCs and administrators including prominent CBR or CBHC organisation.
- CDAs
- OPL Staff
- Health Inspector/Health Educator
- PWDs/Parents of PWDs
- Observation check list

This will be done through a one day workshop.

6. The data/information will be collected by three teams from the three districts concurrently over a period of 5 days. The team will then gather for two days to compile analyse and draw recommendations.

7. And then... The report, together with the guidelines, standards, and policies will be the basis upon which the Disability & Rehabilitation Section will develop the district package.

8. Time Frame:

-Identify data/information collectors (by mail)	3 weeks
-Train and develop instruments	2 days
-Data/information collection	5 days
-Compiling/analysis/draw recommendations	2 days
-Report writing	3 weeks
-Report distribution	1 week