

Policies and Programmes for Disabled People in the Commonwealth

Report of a Survey



Commonwealth Secretariat

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by

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WHO IS DISABLED?

If you fail to see
the person
but only the disability,
then, who is blind?

If you cannot hear
your brother's
cry for justice,
who is deaf?

If you do not communicate with
your sister
but separate her from you,
who is disabled?

If your heart and your mind
do not reach out to
your neighbour,
who has the mental handicap?

If you do not stand up
for the rights of all
persons,
who is the cripple?

Your attitude towards
persons
with disabilities
may be our biggest handicap,
And yours too.

- TONY WONG, Executive Director "Combined Disabilities",
Jamaica, and World Council member, Disabled Peoples'
International.

INTRODUCTION

The International Year of Disabled Persons (IYDP), 1981, was proclaimed by resolution 31/123 adopted by the General Assembly of the United Nations on 16 December 1976, and was celebrated throughout the world with the theme "Full participation and equality". The Year had as its main objectives: "promoting all national and international efforts to provide disabled persons with proper assistance, training, care, and guidance to make available opportunities for suitable work and to ensure their full integration in society".

Objectives and organisation of the survey

2. As a contribution to the observance of the Year, the Commonwealth Secretariat commissioned this survey of the achievements of Commonwealth countries in relation to disabled people during 1981. The main purpose was to identify initiatives that might be sustained, especially in relation to the smaller and more remote countries, by technical co-operation between governments and through the activities of voluntary organisations. My terms of reference as the Secretariat's consultant are given in an appendix to this report.

3. In circular letter 38/81 of 4 August 1981, the Secretariat invited all Commonwealth governments to co-operate in the survey by sending copies of information prepared in connection with their observance of the International Year and, if possible, to nominate a correspondent to whom I could write direct. As almost every Commonwealth country had sent some particulars of its national IYDP co-ordinating committee to the United Nations Secretariat in Vienna, I was able to supplement this approach by writing to the chairman or secretary of most of the committees to solicit information. This in turn was supplemented by the selection of several countries in each major region of the Commonwealth for brief visits for discussion on the spot with government ministries, IYDP committees and the representatives of voluntary organisations active among disabled children and adults. The 22 countries visited are listed in an appendix to this report.

4. The response to these approaches was, predictably, uneven. Many governments and IYDP committees sent full accounts of their activities in relation to disabled people before and during the International Year, with their plans for the future. From others the information supplied was sparse; several did not respond at all. Countries visited included some in each category. I am therefore unable to arrive at a just assessment of the achievements in each and every Commonwealth country, and shall not attempt to do so. Instead, this report will review the general principles that emerged from the observance of the International Year, the main lessons learned and the possibilities for continuing effective action so that the stimulus of the Year will not be lost.

5. There is, of course, a very great difference between the steps taken to accede to the needs of disabled people in industrialised countries, which have sophisticated health and welfare services, and the limited choice of action that can be taken in small countries with enormous health and welfare problems still unresolved and very limited financial and manpower resources at their disposal. The provision of ramps and self-opening doors for wheelchairs may be a priority need in Australia, Canada or New Zealand. A prior need in Papua New Guinea, Fiji or St. Vincent may be a rehabilitation process that will enable people with spinal injuries to leave their beds in an orthopaedic ward and enjoy some mobility if wheelchairs can be made available. The intention of the report is to suggest a few ways in which the experience of some of the industrialised countries can be interpreted and made available to countries at a less advanced stage of development.

6. During the first country visits it became apparent that a practical way of approaching the subject of disablement was under four main heads: prevalence, prevention, provision and prospects.

Prevalence

7. Discussion of prevalence revealed the main categories of disabled people requiring assistance and the causes of their disabilities. Ideally, statistics would tell the story. One day, no doubt, they will. Many countries inaugurated disability surveys as a part of their IYDP programme of action. But very few results were in by the end of the Year. Meanwhile, we rely on the experience of government officials and voluntary organisations to indicate which categories of disabled people have come to notice: polio victims, amputees, the blind, the deaf, leprosy victims, the mentally retarded. Inevitably, there are two main distortions. First, their impressions are clearer for urban and more accessible rural areas than for remote villages. Second, voluntary societies usually specialise in one particular disability - blindness or leprosy, for example - and therefore tend to seek out adults and children who need help so that their existence becomes better known than that of people in other categories - cerebral palsy or tuberculosis, for example, and most noticeable of all, poliomyelitis.

Prevention

8. Discussion of prevention indicated the relative importance the health authorities gave to each category of disablement, conditioned of course by the availability and cost of effective immunisation or other prevention activity. There are four categories of preventive action:

- (a) those which governments have already built into their health care systems;
- (b) those which take the form of special interventions which governments are able to undertake with the backing of outside (or local voluntary) bodies, e.g. the World Health Organisation Expanded Programme of Immunisation, a Rotary-to-Rotary measles or polio campaign, or the Asian eye-camps sponsored by the Royal Commonwealth Society for the Blind - the hope is that interventions in category (b) will be promoted to category (a);
- (c) those which governments know are needed but which cannot be undertaken for lack of finance, trained personnel or accessibility;
- (d) research into causes of disability for which no effective preventive action is yet known.

Provision

9. Discussion of provision came under five main heads:

- (a) **Institutions for the disabled.** These include the old-fashioned schools for the deaf and blind, sheltered workshops and homes for the mentally retarded. IYDP policy is to spend less money on central institutions because they cost too much per head and because they tend to favour the disabled with relatively easy access to the major cities, neglecting the remoter rural areas. Also, they tend to segregate disabled people from society. Discussion shows whether it is utopian to suggest that the same amount of money, or more, could effectively be spent on realising the modern concept of family and community care for the disabled; and just what this would mean in the reality of remote rural areas.
- (b) **Prosthetics and orthotics.** The provision of artificial aids of all kinds involves first the detection of need; second, appropriate rehabilitation therapy; third, the production in quantity of appropriate aids; and fourth, fitting, training and maintenance. In the poorer developing countries, artificial limbs or hearing aids are not going to be available to those who need them if they have to be imported at great expense. A free gift of such aids from an overseas source is not very helpful if there is no local capacity to fit and service them. Local manufacture of appropriate aids presupposes an allocation of funds by a government hard pressed to maintain its basic services. Discussion showed the priority

government accords to the needs of the disabled: usually not very high because of the shortage of financial and staff resources. The priority sometimes depends upon the strength of representation made by pressure groups of the disabled themselves or of those who espouse their cause.

- (c) Vocational training. The use of the slogan "Remember our capabilities as well as our disabilities" brought out information about the extent to which governments are providing special education, whether in schools for the blind or deaf or in "open education" (by the provision of resource centres and specially trained staff), or by vocational training schemes devised to meet the special needs of disabled people so that they can use their capabilities to earn their way in life.
- (d) Employment opportunities. Some countries legislate for the employment of disabled people. In areas of high unemployment or under-employment such legislation is hardly to be expected, and would be difficult to enforce without a full official register of the disabled. Efforts are therefore concentrated on measures to assist disabled people who have a potential contribution to make to productive activity to find appropriate employment whether in sheltered or "open" conditions.
- (e) Human Rights. Questions about the human rights of disabled people, their access to public buildings, their full integration into the community - all of which form a large part of IYDP philosophy - resolve themselves in many developing countries into the simple question: "What special provision for the needs of disabled people is it fair and reasonable to expect your government to make in view of the many unsatisfied demands on your limited and hard-pressed financial and manpower resources?"

Prospects

10. Prospects for the future depend on the economic development of the country and on the priority accorded to the needs of disabled people. Without increased financial resources, or help from outside, governments will be unable to improve their primary health care or do much more than they do at present to meet specific needs. IYDP has focused attention on the fact that something like ten per cent of any population have some form of disability. Despite the real and severe financial constraints, there are provisions which can be made to enable many disabled people to lead a fuller life and to make their contribution to the economic and social well-being of the communities in which they live. Theory sometimes puts it the other way round: viz, to care for a disabled person, particularly if he is institutionalised, costs far more than to rehabilitate him so that his family can look after him or he can take care of himself. But governments cannot be expected, in their precarious financial state, to produce the money required now to include all desirable services to the disabled in their health or social welfare allocation merely in anticipation that they will be spared the expense later of caring for so many dependent disabled people. Nevertheless, it is worth reaffirming that where immunisation or other preventive measures can be introduced now, there is an undoubted saving in social welfare expenditure later.

11. Meanwhile, there are large numbers of irrevocably disabled people needing help. What is done for them is a matter of selection. Specific outside help is available government-to-government, through voluntary societies and through the UN Special Agencies. This help has been usefully focused and probably augmented by IYDP. The task now is to judge which of the IYDP initiatives in a developing country ought to be sustained permanently, and to enlist the support of outside agencies where their maintenance and development are beyond the means of the government and local voluntary societies. The tradition of Commonwealth cooperation, supplemented by the Commonwealth Fund for Technical Cooperation (CFTC), has a part to play here. Experience in one country can benefit another country by communication, by visits and by the offer of training facilities in conditions comparable to the home country of the trainee. This is already happening in many fields. The best I could hope for was to detect and portray specific areas in the whole disabilities field where assistance is most needed and might be forthcoming through the CFTC, and also through the Commonwealth Foundation; and conversely, to find possible sources of experience which might be tapped for the benefit of the poorer and more remote Commonwealth countries.

The verdict

12. In one sense, this report is being written a little too early. It is about national policies in relation to disabled persons; but very few national policies have yet been determined. It is about programmes for the handicapped; but in the countries with which the report is mostly concerned the programmes are still mainly in the hands of voluntary societies. The dialogue with governments continues; and a major purpose of IYDP was to coordinate and strengthen the advocacy of voluntary organisations for larger government grants and for the assumption by government of responsibility for the salaries of teachers of children with special needs, for better rehabilitation services and for placement in employment. Governments have not had time to respond to these representations; indeed some of them have not yet been presented to governments. In so far as they have been presented piecemeal during the course of the year, most governments of the smaller countries have been obliged to give very discouraging replies because of their financial plight (and that is not too strong a word). "Cuts wherever possible" is the order of the day in the present economic climate. And because of a world movement, strongly led by the United Nations IYDP Secretariat itself, to end the segregation of disabled people - adults or children - in institutions, pleas for larger government grants for schools for the blind and deaf, for sheltered workshops for handicapped people or for Homes for the most severely disabled children whose parents cannot cope, are not likely to find a ready response from hard-pressed governments.

13. Another world movement, led by WHO, to train the disabled in their own communities, is still in its infancy. It holds out the best hope, since it aims to reach the many millions of disabled people at present untouched by rehabilitation techniques. But it is too early to say how effectively it can deliver these techniques. The field-testing of WHO's manual on rehabilitation for developing countries is not much more than a year old. The preliminary results are encouraging, and this is the policy for the future. But discussions in many countries suggest that it may be embraced for the wrong reason: a saving of money. It is being assumed that great savings can be made on expenditure on institutions. The cost of training the very large numbers of village-level workers - community aides or whatever they are called - is not so far being taken into account. These essential people need not only training but also supervision; and it is the middle-level supervision that, in my view, is going to present the greatest difficulty, as well as costing a lot of money. Moreover, top-level professionals in rehabilitation and therapy will still be necessary and very few of the smaller countries have anything like the full team.

14. We have not yet reached the stage when we can make reliable estimates of the cost of switching from institutionalisation to care within the community. It is a great mistake to assume that it will cost less than the present meagre grants to institutions. It is an even greater mistake to plan on the assumption that institutions can be done away with altogether. A middle path will have to be found. By all means let us get away from the present limitation of medical and social rehabilitation to those within reach - geographically or financially - of services in urban areas. But these services will still be needed, whether they be orthopaedic wards and therapy specialists, training colleges for teachers of the deaf and blind or vocational training centres for open or sheltered employment. It is too soon to say just how the right balance is going to be found in the smaller countries.

15. In another sense, the report is timely. IYDP has focused world attention on the fact that something like 500 million people in the world - one in ten - suffer from some considerable disability. Ways have been thoroughly explored of easing their burden and accentuating their capabilities so that far more of them can become contributors to society instead of liabilities, which they do not want to be. All Commonwealth governments appointed national committees to observe the special Year and also, presumably, to guide them towards a national policy. In so far as these committees stressed public awareness of disabled people and their needs - and most of them regarded this as their major function - some measure of public demand has been created that there should be such a policy, and that it should be implemented. While this is fresh in the minds of politicians and administrators, it is appropriate to survey what was done in 1981 and to produce a view, however subjective, about the implications of working out a policy in countries with very limited financial and manpower resources.

16. There are, of course, no instant remedies. What is important is that the opportunity should not be lost of considering realistically what can be done in each country. A report on

Commonwealth IYDP experience generally, deliberately kept as short and uncluttered with detail as possible, may help each government to make up its own mind and get the problem of disabled people into some sort of perspective. It is also my hope that outside agencies, whose help the smaller countries so much need, will realise the immensity of the problem and concert with individual governments in selecting projects for assistance. This applies not only to major programmes of multilateral and bilateral technical cooperation, but also to the voluntary agencies on whose staff and money much of the work, particularly among handicapped children, must continue to rely for many years to come in many of the smaller Commonwealth countries.

Acknowledgements

17. My warmest thanks go to Professor Sir Kenneth Stuart, Medical Adviser to the Commonwealth Secretary-General, for inviting me to undertake this twelve-month survey; and to Mr. Keith Mather, Assistant Director in the Medical Division, for his unfailing support and encouragement. Many people in various ministries and voluntary societies in the countries visited put themselves out to be helpful, and I am only sorry that there are so many that I cannot list them all by name. Then there are the faithful correspondents who went to the trouble of sending me information by post. Of these, I think I should especially thank Botswana, Cyprus, Mauritius, St Lucia, Seychelles, Sri Lanka, Swaziland and Vanuatu, all of which I would have liked to visit if time and money had permitted.

SETTING THE SCENE

18. The assumption of the International Year was that one person in ten throughout the world suffered from some degree of disability. This assumption was based on a 1968 estimate by Rehabilitation International that the number of disabled people in the world was 450 million, increasing by some 3 million annually. While it is not possible to verify this figure, it is significant that it was not seriously challenged during the Year. When the General Assembly of the United Nations reviewed the Year on 7 and 8 December 1981, the figure of between 450 million and 500 million was still accepted as the best estimate of the number of disabled people in the world. The figure of course depends upon the criterion of disability. The definition of "disabled" implies an inability, because of some physical, sensory or mental impairment, to lead a full and satisfying life in the community.

Rehabilitation, social integration or prevention

19. The juxtaposition of the figure and the definition raises two questions: "What is being done to enable the individual to develop his capabilities so as to lead a fuller and more satisfying life?" and "What can society do to make life easier and more satisfying for the disabled person?". The answer to the first question lies in medical rehabilitation, special education, vocational training and employment opportunities. The answer to the second question lies in creating public awareness, changing traditional attitudes and inducing social action. It is the second of these questions that dominated the work of IYDP committees in most industrialised countries. In countries with fewer financial and manpower resources, attention tended to focus on the rehabilitation and employment aspects.

20. There is a third question: "How much of this disablement could be avoided in future by preventive action?". This received scant attention, except in some industrialised countries which emphasised the mounting toll of traffic accidents, and also in medical circles where the potential of the WHO Expanded Programme of Immunisation and other measures to reduce disablement dramatically in the next generation was already recognised and received some impetus from the International Year.

Who are the disabled?

21. This report will assess, in broad terms, the contributory elements which make up the totality of disablement, but specifically in smaller and more remote Commonwealth countries. To attempt to do so for major developed countries would be pretentious and self-defeating. But

much valuable material has been supplied by ministries of health and IYDP committees in the larger countries, and this enabled consideration to be given to the application of the experience of wealthier countries to the needs of those at a much less advanced stage of economic and social development. Much of it is not directly relevant. Those tackling the disabilities of affluence find it difficult to adjust to the diseases of deprivation. It was one of the tasks of the survey to bridge the enormous gulf between IYDP committees who were spending their time on access by wheelchairs to public buildings, because that was what their own environment dictated, and committees who realised that one good meal a day for the villagers in their country was perhaps a higher priority in health terms than begging even a few wheelchairs which would be doubtfully useful in mountainous and remote rural areas.

22. Countries varied widely in their practical interpretation of the term "disabled person". Meeting with some national IYDP committees, I formed the impression that their almost exclusive concern was with orthopaedically disabled adults. References to the profoundly deaf and the hard-of-hearing or to the blind and partially-sighted received the answer: "They have their own arrangements". Rather more contentious were the reactions to questions about the intellectually handicapped. With notable exceptions, the implication seemed to be that nothing much could be done for them anyway, and that it was better to leave them in the loving care of their families and communities.

23. These comments suggest that in many countries, perhaps the majority, not much attention had hitherto been paid to people with spinal injuries, residual polio paralysis, amputations and other mobility handicaps, and that these people were seizing their opportunity in IYDP to call attention to themselves. These are, of course, the "visible" handicaps and it is understandable that they should receive immediate attention in a year devoted to disabled people. One result will be that this report will emphasise the need for orthopaedic surgery, physiotherapy, occupational therapy and vocational retraining leading to employment, comprehensively referred to as "rehabilitation", for the many who are threatened with a life of total inactivity following car accidents, acts of violence or mishaps such as falling from trees. Much unnecessary suffering and frustration can be relieved by the development of appropriate facilities for such people. As they become more mobile, even if only in wheelchairs, society must listen to their plea for adaptation of their homes and for access to means of transport, public buildings, etc., which forms such a large part of the conclusions of many national IYDP committees.

24. But the "invisible" handicaps, particularly deafness and mental retardation, deserve better than the lack of attention they have received in some national programmes. The balance is redressed where there are strong associations of and for the deaf and where parents of intellectually handicapped children have successfully enlisted the support of others to create organisations to provide needed services and to solicit the support of governments in the supply of hearing aids, special schooling for handicapped children and other needs.

IYDP committee proposals or government programmes?

25. Few governments had programmes of action formulated specifically for disabled people. That was a reason for declaring a special Year. This consultancy was so timed that it was possible to find out what IYDP committees were planning to recommend; but that is not to say that their recommendations were necessarily going to be adopted by governments. There were three broad sets of circumstances. Where the deliberations of IYDP committees were very much under government control, the financial or manpower difficulties inhibited bold or impracticable suggestions. In these circumstances, it was the voluntary organisations that tended to get on with their own work, relying as before on public support by their own fund-raising efforts. At the other extreme, where the IYDP committee was detached from government, it was the ministerial representatives who tended to get impatient with the discussion of matters which did not directly concern them and to which, in many cases, they accorded little priority in the realities of government's financial resources. The third category was the IYDP committee which maintained active participation by the key ministries of government and by voluntary organisations, genuinely seeking to thrash out a policy which was both practicable and advantageous to disabled people.

26. Even in the third category of committee, there was a consciousness that limited and even shrinking government funds made the implementation of many of the proposals doubtful. In

several countries, discussion in government departments away from the IYDP scene showed all too clearly that very strong (and even unwelcome) ministerial directives would be necessary if some of the proposed projects were to be carried out. This was not due to any hostility to the cause of disabled people, but to jealously guarded departmental votes already considered too small for the long-term task in hand. Why should one ministry (usually Social Welfare) plan for larger share of the national cake, which was already too small anyway? Very rarely did an inter-ministerial approach to the whole question of disablement override these departmental considerations. By no means all national IYDP committees had formulated and submitted their proposals to governments by 31 March 1982; and it must necessarily take some time for governments to decide what action they are going to take on them.

27. It is for this reason that so much of this report describes the deliberations and aspirations of IYDP committees rather than the declared policies of governments: very few such declarations have yet been made. Where the implementation is clearly going to incur continuing annual liabilities, warning notes have already been sounded. If the gathering together of the real needs of disabled people for the first time in the reports of 1981 IYDP committees are not to be wasted effort - apart from the "public awareness" impact during the Year itself, which was often considerable - some continuing mechanism is essential: it will take much more than one year, or two, to influence the policies of the several departments involved in the direction of a co-ordinated effort. This report suggests what form such a continuing body might take. It exists already in several countries and is recommended by IYDP committees in others. The problem is to make it genuinely inter-ministerial and representative of voluntary effort at the same time.

28. It is, of course, theoretically possible to extract from the departmental records of each department of government those aspects of its work which have a bearing on disabilities and to make an inventory of them. The section of this report dealing with government policies for the disabled (paragraph 110 et seq) set out with the hope of being something of this sort. But it was soon realised that the report would run to several volumes and even then would be incomplete because the relevant information cannot be obtained in a short space of time. Where IYDP committees have prepared lists of services available to disabled people, these are a useful guide; but they rightly list large numbers of small voluntary associations and often overlook the main relevant government provision in hospitals, health centres and educational establishments which tend to be taken for granted or at least to be common knowledge. For the sake of brevity, if for nothing else, the section on government policies has become a mere shadow of its intended self. It merely gives a few significant facts from policies advocated by IYDP committees and programmes being carried out in a few countries to illustrate the problems of devising a national policy for disabled people. In that section, and throughout the report, the realities of economic possibilities in the smaller Commonwealth countries with few resources were kept very much in mind.

Country visits

29. It is dangerous to make judgements after visits to any country of no more than three or four days unless there is balancing documentation to support or justify impressions gained on the spot. I went to learn; unexpectedly, a main benefit of some country visits was the chance they gave to local IYDP committees to explain the reasons for their own activities, to discuss their difficulties and to hear what other countries were doing for their disabled. Ministries of health are accustomed to having representatives of WHO and UNICEF in their midst and to receiving visits from their consultants. Ministries of social affairs (social welfare, social development, social security), who had responsibility for IYDP arrangements in most countries, seldom receive international visitors. They received large doses of literature and encouragement from UN sources initially, but they had not hitherto been visited by someone whose exclusive concern was the whole range of disabled people. They found with relief that the visitor understood their problems and spoke their language: the Commonwealth mystique worked.

30. But "speaking their language" all too often meant the language of social welfare. There was everything from surprise to open disagreement when I suggested that there was a medical dimension to what they were doing. In their view, IYDP was a social welfare concern. It had been assigned to them and IYDP was a jealously-guarded social welfare preserve. Wherever possible, I tracked back from welfare to health. Discussions with health officials on the

preventive aspects of disablement were welcome and profitable; but in several countries the local view was that they had little or nothing to do with IYDP. After all, was not IYDP really about social integration and equal access to facilities? It was about people who were irremediably disabled. They deserved equal treatment and their rightful place in community life. Therefore it was a social welfare matter. The injection of the questions "Is everything possible being done to mitigate the disabilities of individual people?" and "Is all this disablement really necessary? How much of it could be avoided for the next generation? Is not WHO's Expanded Programme of Immunisation a vital part of IYDP, or at least of the Decade of the Disabled which follows it?" - either led to nothing or was referred to the ministry of health.

31. In one country my written and oral briefing by the Ministry of Social Welfare contained no mention of the admirable new rehabilitation institute and hospital for the disabled, opened by the President to mark the inauguration of the International Year. In another country the proposal of the IYDP committee was to create, on a fresh site, a centre for the disabled without incorporating or maintaining the existing rehabilitation machinery associated with the main hospital or the day centre for severely handicapped children. In a third, money raised by public subscription for the disabled was to be spent mainly on social welfare handouts to ease the way of life of disabled people and to subsidise their organisations.

32. In a fourth country, India, it is only fair to add, the central government budget for IYDP was controlled by the Social Welfare Ministry but spent on remedial, preventive or social objectives as need dictated. It proved possible and acceptable to discuss prevention and medical rehabilitation within the Social Welfare Ministry, which commanded the IYDP vote but recognised from the outset that the needs of the disabled had a large medical component. In concert with the Ministry of Health the Social Welfare Ministry was prepared to release money for physical rehabilitation and also for the prevention of disablement.

33. Much depended, of course, upon the medical representative on the national IYDP committee and the hearing he received in its deliberations. With notable exceptions, representation of the ministry of health in most countries appeared to be anything but compelling. This is perhaps not surprising as the committee was discussing matters far from medical professional concerns. This comment relates, of course, mostly to my "smaller and more remote" clients and particularly to committees which were firmly the responsibility of a government department. Where the committee was in effect a national council for the handicapped, operating at one remove from government, cooperation between Welfare and Health - and also with Education, Labour and Information - was more easily achieved.

Ministerial responsibility

34. Enough has been said already in this section of my report to show that policies and programmes for disabled people in the community cannot be the exclusive concern of any one ministry of government. Internationally, the stimulation and supervision of the International Year was assigned to the Centre for Social Development and Humanitarian Affairs in Vienna. Understandably, the Centre stressed the General Assembly's theme for the Year, which was "Full participation and equality", i.e. the second of the basic questions already posed in paragraphs 19-20 above. The goal was to integrate disabled persons into community life by removing barriers of all kinds, including unhelpful social attitudes. In accordance with this assignment at the international level, most Commonwealth governments designated their social affairs, social development or social security ministry as the responsible department of government. Just as the UN Centre for Social Development and Humanitarian Affairs had not only an international advisory committee but also inter-agency consultative machinery, so Commonwealth governments appointed national IYDP committees consisting of relevant government departments and voluntary societies working with and for disabled people. However, such is the nature of departmental responsibility within a government that a genuine inter-ministerial approach was all too often not achieved, and the social aspects tended to predominate.

35. Close cooperation with relevant voluntary organisations was the general rule; indeed, where governments had little or no money to spare, the Year's activities resolved themselves into attempts to coordinate and support their work. Perhaps the most surprising feature of the constitution and practice of many IYDP coordinating committees was a strange reluctance to admit into their councils the representatives of groups of disabled people themselves. This led in some countries to dissatisfaction with the traditional "service providers", whether government or voluntary, and some degree of militancy. The desire of disabled people to speak for themselves was reflected internationally by the creation of Disabled Peoples' International, which held its first Congress in Singapore in November 1981.

36. The first lesson to be learned from the experience of the Year is, therefore, that continuing work with and for the disabled should be on a genuine inter-ministerial basis, in the closest cooperation with voluntary agencies and with organisations of disabled people themselves. Where the social welfare aspect dominated, the impact tended to be intangible and possibly ephemeral. My first recommendation therefore is that the continuing national council for the handicapped, or whatever it is called, should be one stage removed from the confines of any one government department, be able to supplement official grants by raising more money from the public and be free to get on with its job, subject of course to independent audit. There are several models for such a permanent body in Commonwealth countries where these principles have been successfully applied. They will be mentioned in "Notes on some significant developments" below (see paragraph 132 et seq).

IYDP ACTIVITIES IN COMMONWEALTH COUNTRIES

Public awareness

37. Almost every national IYDP committee put public awareness of the existence and needs of disabled people at the head of its list of objectives. Presidential or ministerial statements opened the Year's proceedings. The press, radio and television were used to publicise the purposes of the Year and to present features about the achievements of disabled people as well as their needs. At least 17 Commonwealth postal authorities issued special postage stamps. There were sponsored essay competitions for schoolchildren and exhibitions of work done by disabled people. The widespread appearance of the IYDP symbol and slogans was impressive: on posters, on T-shirts, on car bumper stickers, on the covers of telephone directories. "Full participation and equality", the official theme, was supplemented by local slogans such as "Enable the disabled", "Disability is not inability" and "An equal chance is all they ask". Sports events for disabled people were doubly effective in publicising the special Year and giving great encouragement to the participants. The International Abilympics in Japan stimulated local skill contests - a stimulus to the disabled competitors and a public demonstration that "disability is not inability". A great deal of local ingenuity and the expenditure of a considerable amount of money left few members of the community unaware that 1981 was the Year of Disabled Persons.

Surveys

38. As many IYDP committees started their work by saying "We do not know who the disabled are nor how many there are in each category: therefore we must put in hand national surveys to establish the categories and figures as a basis for our planning", a recommendation to this effect appeared early in their proceedings. Some tentative results began to appear by the end of the Year. In Canada, for example, Health and Welfare "attempted to develop a picture of the extent of disability and estimated that in 1979 there were approximately 2.3 million disabled persons in Canada or 9.8 per cent of the Canadian population". This is remarkably close to the "One in ten" adopted by UNICEF. In many countries I was told either that the survey had been done but the results had not yet been collated, or that the survey was being put in hand but would take a long time, or that the manpower was not available and the projected survey had been deferred for the time being.

39. Even sample surveys cannot be conducted without a quite precise definition of "disability" which it is usually beyond the ability of, for example, a census enumerator to apply; and in many communities there is still a strong tendency to hide handicapped children as though they were a disgrace, an indication of wrongdoing on the part of the parents or a visitation from angry spirits. Health authorities in many countries took the view that to count disabled people, particularly children, without offering any remedy, was immoral. The way to ascertain their numbers and categories was to offer a service as, for example, in Indian eye camps where people come forward from considerable distances because treatment, including cataract surgery, is available. When such "camps" are multi-purpose, the records kept by the organisers are an invaluable and sometimes unique source of factual information about the numbers and categories of disabled people who are conscious of their need for help, or parents with children who need help.

40. Although figures were missing or deficient, IYDP committees realised that this was no excuse for deferring action. The broad categories of disabled people were already known through the activities of the ministry of health and of voluntary societies. IYDP publicity and activity brought more to notice. But reliance on these sources had the inevitable result that people with visible handicaps and those in urban areas tended to become the "disabled people" the Year was all about, not only in the public mind, but also in the attentions of IYDP committees. In smaller and more remote Commonwealth countries, with which this report is particularly concerned, the committees and the government authorities were all too aware of the numbers needing help, especially children severely handicapped by cerebral palsy or by mental retardation. Nevertheless, the establishment of better data remains a most desirable longer-term objective.

Handbooks

41. The preparation of statements about services already available for disabled people was a different matter. In some countries they had already been prepared by national councils of social service. In others their production was one of the most beneficial of IYDP activities. Their obvious and primary purpose is to let disabled people know what services exist and to encourage them to avail themselves of the help available. But they also provide a useful national stock-taking to help governments, voluntary agencies and the general public to measure the extent to which the needs of disabled people are being met. I suspect that even governments were surprised in some cases by the number and complexity of organisations and establishments attempting to provide for the needs of disabled people.

42. IYDP was a golden opportunity to review the provision as a whole, attempt some co-ordination (a difficult thing to do where voluntary bodies are concerned) and work towards a national policy. To achieve this would require a very powerful IYDP committee or council for the handicapped. Effective results could not be expected in one year, especially as several separate government departmental budgets would be involved. What matters now is that the IYDP initiative should not be lost but carried through by an inter-ministerial council or, better still, a statutory board with effective representation of government departments and voluntary agencies who can together thrash out a rational policy for the country as a whole in the years ahead. An inventory of existing services is an indispensable start.

Employment

43. Whether or not this word appeared prominently in the agenda of IYDP committees, the employment of disabled people, whether in competitive or sheltered conditions, was a major objective. It is the end result of every kind of rehabilitative provision and the key to "full participation and equality". "Employment is nature's best medicine and essential for human happiness", to quote the motto of Mona Rehabilitation Centre, Jamaica. One of the "barriers" IYDP committees attacked was the assumption by employers that handicapped people are more expensive to hire, train, place and support. Studies were undertaken to show that the productivity rate of disabled workers can be as good as, or better than, average; while their absentee record, time-keeping and devotion to the job tend to be better than average.

44. Several countries asked about Remploy, which gives sheltered employment in 89 factories in Britain to over 8,000 people whose disabilities are too severe for them to find "open" employment even under the quota system which was introduced under the 1944 Employment Act. This Act requires an employer of more than 20 people to take at least 3 per cent of his payroll from a register of disabled persons. India lays down that 3 per cent of all posts in its public service must be reserved for disabled people and I was told that in practice every 34th place goes to the blind, every 67th to the deaf and every 100th to the orthopaedically disabled. In Canada, the unemployment rate of disabled people runs between 50 and 90 per cent and many do not show in the official unemployment statistics because they are not engaged in the search for work. The Canadian advocacy groups tend to reject the quota system because they do not want to be the "statutory disabled employees" but to be employed for their own quality as workers.

45. A quota system presupposes a register. Although labour departments in the less developed countries are co-operating in finding employment for disabled people, few can contemplate

establishing or maintaining a complete register. A start has been made in Malawi (to take but one example). Inevitably reflecting the South and Central Regions rather than the less accessible North, a national register of handicapped persons shows 1,763 orthopaedically handicapped (70 per cent of them as a result of polio), 707 blind, 194 amputees, 120 deaf, 64 leprosy, 34 mentally handicapped and 213 unclassified. The response to the need for employment is impressive. A weaving factory opened by the President in 1976 as a Malawi initiative supported by the Royal Commonwealth Society for the Blind and the Christoffel Blinden Mission gives employment to blind, deaf and several physically disabled people, working on commercial lines and producing carpets and other woven articles. Also flourishing is the tie-dye centre in Lilongwe, where disabled people make a range of clothing of most attractive designs.

46. One thinks also of a workshop in Bangladesh, just outside Dacca, originally intended for blind people, which has a government monopoly on the production of school chalk (a messy business involving the grinding and moulding of gypsum), manufactures and repairs furniture for the armed services, and engages in power and hand-loom weaving of saris and surgical dressings.

47. I mention these enterprises because in subsequent visits where special employment centres for disabled people were still only paper recommendations of IYDP committees, I encouraged those concerned to believe that the realisation of their proposals was possible, given good management and the selection of products which would find a ready sale. These vocational training and production centres are replacing the old sheltered workshops which were tending to become dead-end dumping grounds. They show that it is possible to diversify production and to train together people with various disabilities, always hoping that outside employment will be possible after a period of training and experience, but recognising that many, because of the severity of their disability, may have to stay a very long time.

48. I have commented at some length on production workshops because works centres of one sort or another figure so largely in the recommendations of IYDP committees to their governments. But most of the countries with which this report is concerned are primarily agricultural and horticultural. Getting away from the IYDP committees based in capital cities, it is encouraging to find so many land settlement projects engaging the services of disabled people. The possibility of making blind farmers self-sufficient on the land was demonstrated in Uganda 25 years ago, and aided self-help schemes with this objective are now in existence in many Commonwealth countries. A ten-acre farm with hens, rabbits, heifers and goats and a ridge for growing coffee has just been added to the Mona Rehabilitation Centre in Jamaica. The Jairos Jiri movement in Zimbabwe, which has done so much for rehabilitation and vocational training, is adding an agricultural and horticultural dimension to its work.

49. In some of the smaller Commonwealth countries where unemployment, under-employment and economic stagnation are major problems, it may seem unrealistic to propose that either works centres or land resettlement schemes for disabled people are a practical proposition. But a lesson of the International Year is that anything at all that is attempted for the rehabilitation and social integration of disabled people must contain at least the hope of gainful employment, if only for purposes of self-respect.

Aids for the disabled

50. Very few IYDP committees concerned themselves with the production and fitting of artificial limbs, calipers, etc., or the local production of hearing aids. But where they did, they were able to encourage the use of local instead of imported materials and to arrange for the further training of technicians. Where this need was linked with the need for employment, it was gratifying to find disabled people working in, and even running, a prosthetic workshop.

51. This thought was commended to several other IYDP committees who were planning rehabilitation workshops of one sort or another. Particularly in the smaller countries, physically disabled people will not be able to benefit from the aids they need if these have to be imported at great expense in foreign exchange. Simplified aids, including artificial legs, have been developed in Eastern and Central Africa, and even more dramatically in India, using

locally available materials. Training in making such aids has already started but my hope is that it can be very much extended on a regional basis under a recommendation I make below (see paragraph 263).

Prevention

52 Most IYDP committees put the prevention of disablement prominently on their list of objectives. The most obvious area of prevention was road safety because hospital statistics show an alarming increase in car and motor-cycle accidents, resulting in spinal injuries and amputations. Nor were industrial and agricultural accidents forgotten, and committees called attention to the need to ordain and enforce regulations for greater safety at work. Statistics suggest that home accidents, particularly burns and falls, outnumber industrial and agricultural accidents - cooking while wearing a sari can present a serious fire hazard, for example - but this takes us into very far-reaching long-term social action.

53. Medical prevention, e.g. by immunisation, received remarkably little attention, although in five countries I was told that the incidence of deafness among children had been associated during IYDP with rubella epidemics and campaigns for rubella immunisation had been inaugurated. Special attention to this subject is recommended later in this report (see paragraphs 106-109). The successful extension of the cold chain to remote villages to ensure immunisation against polio was, of course, a main concern of the medical authorities but, surprisingly, rarely impinged on the consciousness of IYDP committees as part of their responsibility or interest. I discussed perinatal care and infant nutrition with medical authorities, who recognised them as essential prerequisites for the avoidance of unnecessary disability; but most IYDP committees regarded these subjects also as falling outside their purview.

SOME PRINCIPAL CAUSES OF DISABLEMENT

Childhood infections

54. IYDP committees concerned themselves mostly with people in the community who are already disabled and with preventing road and industrial accidents, rather than with action to reduce the number of avoidable disabilities in the next generation. Government health programmes, on the other hand, are giving increased attention to this aspect.

55. Deaths from diarrhoeal diseases and preventable infections like neonatal tetanus, measles, whooping cough and diphtheria - which could be described as the diseases of deprivation - are not the direct concern of this report. The survivors are. Recurrent infection coupled with malnutrition causes grave disabilities in later childhood and adult life; so any study of the disabled in the community must take account of them.

56. Most governments are as concerned now about maternity and child health services in rural areas as they are with the traditional emphasis on hospital care and the development of complex technology in prestigious institutions. Immunisation is recognised as an essential element in primary health care and governments are assisted by WHO, UNICEF, bilateral aid and voluntary societies in implementing the Expanded Programme of Immunisation. This covers the six major vaccine-preventable diseases of childhood; and some governments are able to add rubella, at least for girls at pre-pubertal age.

57. The extent of poliomyelitis epidemics in many developing countries over the last 25 years is only now being fully realised. After the introduction of the Salk vaccine (by injection) and the Sabin vaccine (by mouth) in 1958, industrialised countries lost no time in controlling their epidemics. Although finance and the organisation of delivery mechanisms deterred the extension to developing countries for some years, notable successes can now be recorded. But the damage has been done by the severe epidemics in many Commonwealth countries in the years immediately preceding the availability of the vaccines. Many victims died, but many remain alive with varying degrees of paralysis and they now form one of the most important groups for surgical, prosthetic and orthotic help. This is one of the reasons why so many of the IYDP

committees appeared to equate "disabled people" with the orthopaedically disabled and were so largely concerned with their mobility and access to all the amenities of normal life as full members of the community.

58. In 1979 the International Year of the Child focused attention throughout the world on maternal and child care. In 1980 UNICEF received from Rehabilitation International a detailed report on childhood disabilities which it has now incorporated into its regular programme. It recognises that most physical and mental impairments suffered by children result from inadequate nutrition of mother and baby, from faulty childbearing practices and from preventable diseases. In concert with governments, UNICEF will direct its main efforts towards better preventive measures through primary health care and basic services programmes. Recognising that most impairments that do occur need not necessarily develop into serious disabilities and handicaps, emphasis will also be placed on the detection and treatment of impairments, again through existing and improved health, education, nutrition and welfare services. UNICEF is working with WHO on the development of the manual for "Training the disabled in the community" which will involve a maximum stimulation of community participation in both prevention and rehabilitation. The manpower training requirements of such a programme are formidable, especially for countries with limited and hard-pressed resources, and are the subject of comment later in this report.

Blindness

59. The remark made in IYDP committees, already quoted in this report, that "the blind have their own arrangements" reflects the attention that has been given to the welfare of the blind for many years. A survey of the extent and causes of blindness over 30 years ago led to the formation of the Royal Commonwealth Society for the Blind (RCSB) in 1950. Since then, working with and through its partner organisations throughout the Commonwealth, the society has promoted education for blind children, vocational training and employment for blind adults, the treatment of blindness by mobile clinics and in eye camps, and major measures for the prevention of unnecessary blindness. It has founded national organisations for the blind in most Commonwealth countries, including many of the smallest, and has constantly supported and encouraged the concept that each country should make provision for its blind citizens within a national programme covering both rehabilitation and prevention.

60. These national societies have played a leading part in the creation of national councils for the handicapped, where they exist, and were represented on most IYDP committees, but not all. Indeed, the remark quoted above is an indication of a desire to seize the opportunity of the International Year to redress the balance in favour of the orthopaedically disabled, who regarded themselves as neglected by comparison, and also in favour of the mentally retarded for whom work is often of recent growth and somewhat an uphill struggle. Talks with organisations of the blind suggest that what they regard as the "wheelchair image" of IYDP in their country deprived them and the sensorially handicapped generally of the attention they merited.

61. While increasing support to national action for the education, employment and independent living of the irrevocably blind, the RCSB has led a vigorous attack on the causes of needless blindness. Fifteen million of the world's estimated 42 million blind people live in Commonwealth countries. The society's medical teams have restored sight to over one million blind people in Asian, African and Caribbean countries of the Commonwealth. Its research into onchocerciasis (river blindness) led to the major control campaign now mounted against this disease by international agencies working with nine West African governments. In 1974, on the invitation of the world organisations concerned with blindness and with ophthalmology, the society took the initiative in founding the International Agency for the Prevention of Blindness. This Agency, for which the society provides leadership and an administration, exists to mobilise interest and resources for a global effort for the prevention of blindness, which has now been recognised by the World Health Organisation as a priority of its global programme of technical co-operation. National programmes for the prevention of blindness are now in operation in many developing countries of the Commonwealth with the aim, over the next 20 years, of controlling four eye diseases - trachoma, onchocerciasis, xerophthalmia and cataract - which together account for two-thirds of the blindness in developing countries. The Commonwealth experience has proved to be an effective model for such international action which has been described by

the Director-General of the World Health Organisation as "one of the most cost-effective options in the whole contemporary range of world health policy".

62. Economic self-reliance for disabled people is an overriding aim of most IYDP committees. Sheltered workshops for the blind are tending to become either vocational training centres or commercially-run production centres giving employment to other disabled people in addition to the blind. I suggest below that this development, calling for improved techniques in management, marketing and design, is a direction in which an invaluable contribution might now be made by businessmen associated with the service clubs which do so much to provide buildings for sheltered workshops.

63. There has been a significant Commonwealth interaction in this field. Industrialised countries have contributed, and benefited from, a wider application of research, professional training and the development of sophisticated technology such as computerised and multilingual production of braille and talking books. Developing countries, with their experience of primary health care, mass low-cost surgery, rehabilitation for village life and the cheapened production of simple equipment, have influenced prevention and rehabilitation policies in industrialised countries.

64. The Royal Commonwealth Society for the Blind, in association with its partner organisations throughout the Commonwealth, has provided powerful stimulus for Commonwealth co-operation using philanthropic funds. It gives grounds for hope that similar action might now be taken for other groups of handicapped people, particularly if inter-governmental action for the disabled is recognised as an appropriate and cost-effective enterprise for Commonwealth co-operation.

Deafness

65. IYDP committees included representatives of societies for the deaf and those with impaired hearing. Statistically, such surveys as have been undertaken show that the prevalence of deafness is very high, one person per thousand being profoundly deaf (i.e. for whom amplification is of very limited or no value) and much greater numbers hard of hearing, the impairment ranging from serious handicap to genuine hindrance or social disadvantage. Yet the recommendations of national committees had little to say about the deaf in the community, apart from the need for early detection, special education arrangements and the provision of sign language on important public occasions and visible headlines for the television news. Their pleas for public awareness of disability of course included a realisation of the difficulties experienced by the deaf socially and in obtaining employment, but in general rather than specific terms. From the point of view of Commonwealth action, the concern must be for the education of deaf children, and also for effective research into the causes of preventable deafness.

66. In industrialised countries, children with impaired hearing are being helped, some by surgery, some by the devotion of parents and trained teachers, some by hearing aids. The profoundly deaf can go to special schools, where they can get almost individual attention, but this is probably the most expensive form of education in the world. In the developing countries, only a very tiny minority are at present within reach of any help. Generous gifts of hearing aids do little to remedy the situation. They break down all too quickly and the supply of batteries creates a problem, especially if foreign exchange is involved. Few batteries last more than a week or ten days. Often, the aids have to be left at school when the child returns home for holidays or on completion of a course: a measure of hearing has been restored, only to be taken away again. Nevertheless, a good deal has been achieved by voluntary societies in many developing countries. Their efforts need all possible support to increase the tiny proportion of deaf children at present receiving the special education they need.

67. Much of this support will have to come from outside. The Commonwealth Society for the Deaf was started in 1959 and continues to offer help and guidance; and Australia and New Zealand have for many years supplied technical assistance in the education of deaf children and their teachers in Papua New Guinea and the Pacific islands. The Ghana Government established a training college for teachers of the deaf in Mampong as long ago as 1964 and this is a main centre for training specialised teachers for other African countries, often with CFTC support.

68. The Commonwealth Society for the Deaf helped to develop an excellent teacher training complex in Malawi with the support of the Commonwealth Foundation. It has also fostered projects in Nigeria (where there is a strong local Society for the Deaf) and in The Gambia, where an audiologist from Australia has been supplied through the CFTC. The society sent a team of four to India early in 1982 to conduct short courses for teachers for the deaf in Madras, Calcutta and Bombay under the title "The modern educational treatment of deafness". But there is a great deal more for the society to do in conjunction with local organisations who need guidance, equipment, financial support and, above all, training for teachers of both the profoundly deaf and those with impaired hearing.

69. At present, in the less developed countries most deaf children pass through the primary school without any special provision for their difficulty in learning, or they do not go to school at all. With improved primary health care, and with more and more teachers on the look-out for learning difficulties, the profoundly deaf or children with impaired hearing are being brought to notice in greater numbers; and the waiting lists for government and private special schools for the deaf are growing far beyond the financial resources available to provide for them. The ideal, of course, is not to segregate handicapped children in special establishments but to educate them together with children without disabilities; but it can be argued that deafness is the greatest barrier to learning because of the high proportion of the normal schooling process the deaf child misses. Early detection is essential and special skills are necessary to enable him or her to communicate. Clearly, the day is far off when the village primary school can be equipped with either the skill or the apparatus to cater for the needs of children with impaired hearing, let alone the profoundly deaf who have not learned to speak. As these disabilities are detected, there must be special schools to which the children can be referred. The work of local voluntary bodies should therefore be encouraged and governments should see the necessity to assume responsibility for their educational work as circumstances permit.

70. This pessimistic but, I think, realistic assessment dramatises the urgent need for research into the prevention of unnecessary deafness. If it is true that in some communities as much as 70-80 per cent of hearing loss is due to genetic factors and consanguinous marriages are the custom, we can think only in terms of genetic evaluation and counselling. But elsewhere we are told that more than half the causative factors are potentially preventable. Otitis media is the most common cause of hearing loss in children, and this is often reversible by medical and surgical treatment, given early identification and early intervention. Already, the spread of the Expanded Programme of Immunisation is giving protection against measles and other diseases of childhood which can lead to hearing impairment.

71. A Commonwealth Society for the Deaf study in Ibadan, Nigeria, has shown that about two-thirds of the deaf children, where a cause was attributable, were deafened by measles, meningitis and rubella in about equal proportions. As noted later in this report, a consequence of the Leeds Castle seminar on the prevention of disablement is that rubella immunisation is being stepped up in many Commonwealth countries. With more concentrated attention to the causes of avoidable deafness, delivery mechanisms might well be devised which would reduce the incidence. Since there is so little we can realistically plan for the education and social well-being of the vast majority of the deaf and hearing-impaired in developing countries, a deliberate policy of prevention should be urgently explored and put into effect. Prevention is not only better than cure: it can turn out to be far, far cheaper.

Orthopaedic handicaps

72. Many IYDP committees gave the impression that their principal concern was with people in wheelchairs rather than the generality of disabled people. Their main drive was towards the removal of barriers, physical and social. Ramps (not always welcome to people with artificial legs) should replace steps. Curbs should be abolished where pedestrians cross at road intersections (not always acceptable to blind people). Doors should be wide enough to admit wheelchairs and they should open automatically whenever possible (hardly a high priority in third world countries). Washrooms in public places and at work should be adapted so that disabled people can use them. Reasonable solutions should be found for the transport of physically handicapped people on buses, aeroplanes and all forms of public transport. Housing standards should be developed which reflect the needs of disabled people, and government grants should be made available for adaptations. Sports and leisure facilities should cater for the needs of

disabled people. (My overseas tours ended at the Boston Marathon, where 22 "wheelies" completed the course, to the great delight of the one and half million spectators, two of them in a faster time than the course record for those running on two feet).

73. The use of the "access" symbol (a wheelchair in profile) in so many public places may well have been the greatest single means in some countries of creating public awareness of the disabled in their midst. It tended to reinforce the ideal that "disabled" means "wheelies", but it contributed to the removal of the other kind of barrier to which IYDP effort was calling attention: social attitudes which failed to recognise that wheelchair and other disabled people could function independently within society if they were accorded their right to "full participation and equality".

74. So the emphasis on the orthopaedically disabled served its purpose in countries where the main need was for public acceptance and recognition. There were echoes of this approach in less developed countries but the real priorities were utterly different. The ability to lead a full life in the community although confined to a wheelchair presupposes orthopaedic surgery and a rehabilitation process involving physiotherapy, occupational therapy and vocational retraining. These are available to a minute minority of the people of many of the smaller Commonwealth countries. One of the main purposes of this report will be to open up possibilities of bringing such help to more of those who need it.

75. Inevitably, there are regrets about the conduct of this survey. One of them is that I spent so much time with IYDP committees and the social welfare departments to whom they were responsible and so little time, comparatively speaking, with ministries of health, orthopaedic surgeons and rehabilitation technologists and technicians. It is true that ministries of health were represented, at least nominally, on IYDP committees. But hard-pressed medical officers concerned to improve and spread primary health care to remote villages can hardly be expected to spend time on committees discussing self-opening doors and wheelchair access to public lavatories. But I did see and hear enough to realise that, just as some IYDP committees paid a great deal of attention to the social needs of the orthopaedically handicapped, so this report should call attention to their surgical and rehabilitation needs in less developed countries.

76. In March 1970, the Commonwealth Foundation sent Professor Ronald Huckstep, then Professor of Orthopaedic Surgery at Makerere, Uganda, on a lecture tour of thirteen Commonwealth and four non-Commonwealth countries. It was much more than a lecture tour and its beneficial effects were still perceptible in several countries eleven and a half years later.

77. It started a process of considering how both developing and developed countries could tackle the vast problem of many thousands of untreated orthopaedically disabled people. Professor Huckstep's influence over the whole rehabilitation process, including the production of prosthetic and orthotic aids, had already been felt in Eastern and Central Africa. The next step was a symposium on orthopaedic training in developing countries, which took place at Oriel College, Oxford, in 1973, and a second symposium in 1976, also at Oriel College, on appropriate technology and delivery of health and welfare services for the disabled in developing countries. This series is now badly needed all over again: the inspirational and fact-finding visit, followed by joint consideration of the two vital subjects, appropriate technology and training at all levels. India was not included in the 1970 tour, although there was Indian participation in both Oriel College conferences. India has a great deal to offer, with centres covering the whole field of rehabilitation from orthopaedic surgery through therapy to vocational education and employment, with increasing production of simple prosthetic and orthotic devices made from local materials*. These they are now effectively taking to rural areas.

*A comprehensive review of these production facilities, as they were in 1979, by Mr. David N. Condie of Dundee, is available through the British Council.

78. Some continuing arrangement for Commonwealth consultation and action might have been expected to result from the Oriel College conferences, which were assisted by the Commonwealth Foundation. The nearest approach to such a Commonwealth organisation is World Orthopaedic Concern, a network of some 400 surgeons who keep in touch with each other and do all they can to improve the orthopaedic services in the most needy countries either by offering their own expertise or by organising training programmes in selected areas. Their activities are an inspiration to orthopaedic surgery and to the whole rehabilitation process, including the production of prosthetic and orthotic aids. They can advise and help governments towards the establishment of rehabilitation teams at professional level, which in turn will make possible the training of rehabilitation assistants, orthopaedic technicians and primary health care aides with a rudimentary knowledge of help to be given to the physically handicapped in their families and their community.

79. The regionalisation of their activities, which they are now contemplating, would facilitate the training of these rehabilitation teams on the job in their own countries, where they are needed, instead of running the risk that, as at present, a proportion of those sent away for training acquire disproportionately sophisticated skills and are reluctant to return home where more simple methods are appropriate.

80. While poliomyelitis immunisation is protecting the next generation in the developing world, the numbers of untreated paralytic polio cases have been grossly under-reported in West Africa, South Asia, the Pacific islands and probably elsewhere. Some may be content to crawl or to beg, but thousands need and deserve attention. In Papua New Guinea, the Solomon Islands and Fiji, there are people in bed for years on end after having fallen from trees, been injured in their ferocious game of rugby football or even kicked by cassowaries (three such were entered in the orthopaedic ward records at Lae Hospital). Add to this the growing concern in most countries about traffic accidents, seriously injuring at least 15 for every one they kill, and it will be seen that in communities covered by this survey, the real IYDP concern is not about access to buildings for wheelchairs but about people who cannot get into wheelchairs even if there were wheelchairs to put them in.

81. The Expanded Programme of Immunisation and better perinatal care are slowly but steadily attacking major causes of disability from birth mishaps and major childhood diseases which have a crippling effect, particularly polio and measles. But accidents to young people and adults will still occur, and a bedridden life with bedsores should not be the inevitable penalty. For the blind, for the deaf and for the mentally retarded, voluntary associations now exist almost everywhere. For the category of disabled people which IYDP seemed in some countries to be all about - the orthopaedically disabled - the Commonwealth initiative of 1970 to 1976 in this field needs to be resumed.

82. I have recommended accordingly later in this report (paragraphs 259-261). Since those recommendations were worded, they have been reinforced by reports from "Malawi against Polio" which might well be the pilot project for countries with large numbers of untreated poliomyelitis victims and other orthopaedically disabled people. While the Malawi Ministry of Health and the Save the Children Fund are carrying out a five-year immunisation programme against poliomyelitis, Rotary International has mounted, in conjunction with local service clubs, a major project to reach the untreated cases, which include over 17,000 children under 15 years of age. The project involves visits by orthopaedic surgeons with experience in the developing world and a considerable expansion of the local production of calipers and other supports. Professor Huckstep, who devised the project during his Commonwealth Foundation tours in 1970, 1978 and 1980, re-visited it in April 1982, just one year after the project started. His report will be a guide to other countries who decide to invite a strong external intervention of this kind to tackle the backlog of poliomyelitis victims and other orthopaedically handicapped people as a result of the programme I have recommended.

Mental retardation

83. Many IYDP committees did not include mentally handicapped adults or children in their purview. "As there is so little we can do for them, it would be cruel to remove them from the loving care of their family and community". "They cannot speak for themselves, and so lose out". "We do not want the public to think that the mentally retarded or the mentally disturbed are the sort of people we want them to think of when we draw attention to the needs of the disabled people in the community". These were typical of the reasons given for their exclusion.

84. Fortunately, if the mentally retarded cannot speak for themselves in committees, there are others to speak for them. Parents of mentally handicapped children in country after country have developed a pattern of action leading to the establishment of action groups, some of them now very strong, to influence the community and the government in favour of making at least some basic provision for children with intellectual handicaps. Concern for their own child leads to simple home-based activities, the inclusion of other children with similar needs, the seeking of professional help and the formation of associations to act as advocacy groups demanding the whole range of services: medical attention, schooling, vocational training and employment opportunities. Where this process is far advanced (New Zealand and St. Lucia come to mind, and there are many others) the groups concerned with intellectual handicap were in the IYDP process from the outset and played a major part in the Year's activities. They made sure, for example, that the mentally retarded were not excluded from Sports for the Disabled or from trips to Disneyland in the USA with groups of blind, deaf and orthopaedically handicapped children.

85. Special schools or day centres for the mentally retarded now exist in most Commonwealth countries. Many are of very recent growth. Inevitably, they tend to cater for children in urban areas or within bus-reach of towns. They rely heavily on voluntary assistance for funds and for staff. Governments are gradually assuming responsibility for the salaries of the few trained staff, and making small hard-won annual grants-in-aid; even, in a few cases, providing buildings. But this work is not given much priority and the current drives for economy in public spending give little hope of an early increase in government support. Meanwhile the dependence on voluntary help with the teaching and care of the children, including the wives of transient expatriates and short-term volunteer attachments, make the whole operation precarious. Fund raising does not get any easier, and although service clubs help a great deal, their contributions are usually once-for-all in the form of new buildings or the supply of equipment. Expansion of facilities cannot in most countries keep pace with increased demand; and few governments are at this stage able to contemplate taking a larger share in work of this kind.

86. In any case, fundamental questions are now being asked about the wisdom of expanding special institutions for the mentally handicapped. Governments are beginning to say that they will spend no more money on specialised institutions, without, in many cases, saying how the special needs of mentally handicapped children are to be met. The theory that these children should be cared for in the community and attend their local primary school is becoming accepted policy; but it presupposes that some of the teachers in primary schools should be trained or at least prepared to cope with slow learners; also that education ministries in even the smallest countries should have a special education division - or at least one officer - specialising in techniques and equipment for children with special needs. It is all too easy to say that more local people should be trained for this special work, to meet the growing need and to replace expatriate and local volunteers; but governments are often not only unwilling, but also financially unable, to increase the number of posts or to pay for the special training of staff.

87. Visits of qualified and experienced people under technical assistance arrangements seem to be the most acceptable answer; but they will bring permanent benefit only if the opportunity can be taken of in-service training for local people while the qualified practitioner is working in the country with a counterpart alongside to take over at the end of the technical assistance assignment. That again is easy to say, but it has been found difficult, if not impossible, in practice to provide local counterparts for expatriate volunteers, either because local candidates do not come forward or because adequate salaries or wages cannot be found (the second being probably the cause of the first). My recommendation therefore is that agencies of technical co-

operation, particularly those operating joint venture arrangements with voluntary organisations, should seek to supply experienced teachers of children with learning difficulties. Their presence would act as an inspiration to local people engaged in the work, improve their capabilities as teachers of the mentally retarded, introduce or improve local aids to learning, give new people in-service training and help both government and voluntary agencies to develop a long-term strategy.

88. Developments along these lines would be encouraged if there were a Commonwealth panel of consultants in mental retardation who would in turn create and inspire regional Commonwealth associations. On the recommendation of the New Zealand Society for the Intellectually Handicapped, I went to see Professor G. Allan Roeher of York University, Toronto, who in August 1982 becomes President of the International Association for the Scientific Study of Mental Deficiency at its Sixth International Congress. I discussed with him the possibility of asking the Commonwealth Foundation to help key people in this field to take part in the congress, which has as its theme "World-wide sharing", so that they could benefit from the discussions and the contacts. The thought was that, while they were there, individuals might be selected to serve as a panel of consultants and possibly as generators of regional institutes or associations to encourage and inspire local practitioners - medical and educational - in the field of mental retardation.

89. Professor Roeher has already done a good deal to stimulate and support the formation of local and regional institutes, not only in Canada but also in New Zealand, India (Trivandrum), Hong Kong and Australia (Queensland). He also fostered a Caribbean Institute on Mental Retardation and Developmental Disabilities with headquarters in Jamaica and a Caribbean-wide association stretching down to Trinidad and Guyana affiliated to it. Investigations on the spot suggested that although the institute in Jamaica appeared to have gone over very largely to the important narrower specialisation of early stimulation, the Eastern Caribbean unit of the association is effectively reaching the smaller islands with much-appreciated seminars and workshops on teaching mentally retarded children and on vocational rehabilitation generally. Similar work is done in the Pacific islands by the Asian and Pacific Action Committee of the New Zealand Society for the Intellectually Handicapped and a special education adviser provided under official Australian aid.

90. Because so many of those undertaking the care and education of mentally retarded children in the smaller and more remote islands have little prospect, for financial reasons, of formal teacher training and no other exposure to special education techniques, movements such as these, on a regional basis, are very much needed. There is already a move to form a Commonwealth Association for the Scientific Study of Mental Deficiency, following a successful First Asian and Commonwealth Congress on the subject, held in Bangalore, India, in May 1981. Although such an association might be expected to place its main emphasis on the important aspect of primary prevention, the Bangalore conference also stressed parent-professional partnership in the care, education, training and rehabilitation of mentally handicapped children and adults. Professor Roeher has invited the chief organiser of the Bangalore conference, Dr. V.R. Pandurangi, to promote the concept of a Commonwealth consultative panel during the Toronto Congress in August 1982.

91. The brief mention above of the importance of the concept of early stimulation provides an opportunity to emphasise the need for early detection and assessment. Every individual, however retarded, has a certain potential, and this will be reached only by maximum stimulation from babyhood within a secure family unit. That is easy to write but difficult to achieve. Many smaller countries are perforce having to wait until children get to school before attention is called to difficulties in learning, but improved perinatal services and the experiments now being conducted in some countries under WHO and UNICEF auspices raise hopes that access to children in need will become possible at an earlier age. I gather that a great deal more experience will be necessary before we are able to say that family-administered dietary treatment and additional mental stimulation can improve the capability of the retarded child to cope with self-care and a share in community living.

92. My comment from observation and discussion in many countries is that this is an area of research deserving a great deal of support. The process of bringing out, instead of hiding, mentally retarded children has started and we cannot pretend that the least developed countries have any prospect at present of multiplying (and ruralising) the meagre specialist services they now provide for their education.

93. In rural communities in developing countries, a considerable degree of mental retardation can easily pass unremarked and causes little social or economic handicap to the individual. The standard IQ tests are of little relevance here and a child may acquire a satisfactory degree of social competence in his own community, whereas in formal schooling or in a more sophisticated community he would be classified as mentally retarded; the mere labelling has an adverse effect on his prospects for development.

94. Maybe the IYDP committees were right in saying that for the time being there is so little they can do for mentally retarded children that it is kinder to leave them in the loving care of their families and communities. But better primary health care is not only keeping more of them alive; it is also tackling the problem of devising appropriate training for the child within the family and also for the family itself. This makes a great deal of sense, since the provision of special institutions is financially impossible, and is universally condemned anyway because segregation aggravates the handicap. It is too soon to judge the success of booklet BIII of the WHO manual on rehabilitation for developing countries ("For the training of persons who have difficulty with learning") but something of this nature must be attempted in many of the countries I have visited because there are long and growing waiting lists for existing institutions which are already struggling for existence for lack of finance and trained staff.

Leprosy

95. Although leprosy is still a major cause of disablement in many Commonwealth countries - because impairment from leprosy is still not being prevented by early detection and sustained treatment - very few IYDP committees mentioned people suffering from leprosy as beneficiaries of their activities. The numbers and facts are well-established: there are probably about 15 million people in the world suffering from leprosy, of whom about a quarter have some degree of disability attributable to the disease. Of the four-fifths who are still not being reached for treatment, something like a quarter - three million people - suffer from deformities of hands, feet and face and slow impairment of vision leading to blindness. These disabilities are in the main not part of the original infection but the consequences of neglect. They still give rise in many countries to ostracism and discrimination of all kinds - social, physical, religious and legal - and leprosy patients might therefore have been regarded as ranking high among the beneficiaries of a national programme aimed at "full participation and equality".

96. But only a few governments accord the priority to the control of leprosy or to the rehabilitation of those suffering from the disabilities associated with the disease that its prevalence and severity merit. Fortunately, there is a strong international Federation of Anti-Leprosy Associations active in this field; but they concentrate on early detection and sustained treatment rather than on the rehabilitation of impairments already caused by the untreated disease, in the knowledge that early diagnosis and adequate treatment could lead to a marked reduction in deformity and disability. Ideally, the early detection and treatment of leprosy should form an integral part of the growing primary health care provision of governments; but this will be slow to achieve in some countries where leprosy has long been regarded as a disease for "vertical" interventions and where community education and experience have not yet removed the age-old stigma attached to leprosy.

97. The first disability of leprosy is insensitivity; and it is a matter of health education to assist patients to live with it and not to aggravate their condition unnecessarily. Protection is necessary for the insensitive feet, and I was told in Malawi that ordinary "sneakers" were satisfactory. Where they are not available or are too expensive, special sandals can be devised using old car tyres. The need for these and other aids for leprosy patients should be borne in mind when governments are considering the expansion of their prosthetic and orthotic workshops. Farmers must guard against friction on their hands, and there are ways for women to protect their hands while cooking and doing housework.

98. The days of lazarettos and segregation villages are over. Occupational therapy and vocational training can make a leprosy patient a better farmer than before and enable him to compete successfully with his fellow men. For some established deformities, surgery, physiotherapy and prostheses can help and are needed. The point for this report is that people who have been disabled by leprosy should not be overlooked or snubbed in the rehabilitation and vocational training provision of governments.

PRIMARY PREVENTION OF DISABLEMENT

99. In the words of the WHO Expert Committee on Disability Prevention and Rehabilitation (February 1981), "No other single factor can contribute as much to diminishing the impact of disability as first-level prevention. Attempts to cure, restore or rehabilitate rarely give totally satisfactory results First level prevention should be the overriding priority for all national health authorities and for WHO".

The Leeds Castle seminar

100 Many of the activities mentioned in the preceding sections of this report could be classified technically as secondary or tertiary prevention. They prevent an impairment becoming a disability or a disability becoming a handicap. But in layman's terms, prevention means avoiding an impairment occurring in the first place. A major IYDP initiative was taken when the British Government invited leading world authorities on the principal disabling diseases - scientists, clinicians, health administrators and ministers of health - to pool their knowledge of the principal causes of disablement and to assess practical possibilities of primary prevention on a world scale. Their findings and recommendations offer a programme of action which follows logically from the International Year and the public concern it has stimulated.

101 Known as the Leeds Castle Declaration from the historic building in Kent where the international discussions took place, the programme of action calls attention to the number of disabled people in the world and to the fact that, unless decisive action is taken now, population growth and the increasing proportion of older people will greatly magnify the problem. Much of the underlying impairment is preventable. For example, by immunisation:

"World-wide expansion of a programme of immunisation could save five million children a year from disabilities caused by poliomyelitis, measles, tetanus, whooping cough, diphtheria and, to a limited extent, tuberculosis. This could come about in ten years at a unit cost of about three dollars per immunised child.

A world-wide expanded programme of immunisation would also facilitate production and effective use of vaccines against other diseases causing death or serious impairment. Among these is rubella, a prime cause of congenital blindness, deafness and mental impairment. The use of rubella vaccine should be promoted in all countries."

102. In the field of primary health care:

"Impairment arising from malnutrition, infection and neglect could be prevented by inexpensive improvement in primary health care. Collectively these conditions now disturb the lives and reduce the productivity of at least twenty million people each year.

For example, trachoma and vitamin A deficiency blind at least two million people annually; this can be controlled. Similarly, inexpensive and simple treatment can arrest impairment from leprosy (afflicting at least three million people), can restore sight to ten million people blinded by cataract, and can improve the hearing of ten million deaf people.

Particular attention should be paid to the nutrition of pregnant women to prevent malnutrition of the foetus and to encourage breast feeding of the baby."

103. The Leeds Castle Declaration continues with references to the need for the education of the public and the mobilising of political will:

"There are many opportunities for improvement in regard to other disabilities. These depend on more effective sharing of knowledge, especially with the public.

Many disabilities of later life can be postponed or averted. There are promising lines of research for the control of hereditary and degenerative conditions. Early identification and treatment of raised blood pressure can save millions from premature disability and death due to heart disease and stroke. The toll of accidents and addiction could be remarkably reduced.

Disability need not give rise to handicap. Failure to apply simple remedies very often increases disability, and the attitudes and institutional arrangements of society increase the chance of disability placing people at a disadvantage. Sustained education of the public and of professionals is urgently needed.

Avoidable disability is a prime cause of economic waste and human deprivation in all countries, industrialised and developing. This loss can be reduced rapidly.

The technology which will prevent or control most disablement is available and is improving. What is needed is commitment by society to overcome the problems. The priority of existing national and international health programmes must be shifted to ensure the dissemination of knowledge and technology. With proper use of modern communications this would involve modest costs and would bring great economic benefits. For instance, the world community is saving itself one billion dollars per year by the eradication of smallpox."

104. On scientific advance, the Declaration says:

"Although technology for preventive and remedial control of most disabilities exists, the remarkable recent progress in bio-medical research promises revolutionary new tools which could greatly strengthen all interventions. Both basic and applied research deserve support over the coming years".

105. The seminar welcomed the success of disabled people themselves in bringing their frustrations and their ambitions before the global community, and other achievements of the International Year. The participants regarded their programme of action as a logical and essential part of the follow-up, to ensure that the next generation does not suffer from the present degree of avoidable disablement. It has been adopted by the World Health Organisation and UNICEF, and has been written into the World Plan of Action for Disabled People, prepared by the Advisory Committee for IYDP for presentation to the UN General Assembly. Its implementation will be supported and co-ordinated by the United Nations Development Programme (UNDP). Government health ministries in Commonwealth countries will receive inspiration, guidance and help for their work of primary prevention as a consequence.

Rubella

106. Separate action has been taken to carry out the Leeds Castle injunction to promote vaccination against rubella. Health ministries and education authorities in most countries visited during this survey were all-too-conscious of the link between rubella epidemics and the number of deaf children in their schools at the corresponding later period. Even where vaccination against rubella had been introduced, the time-lag between the age of immunisation and the principal child-bearing age was causing fears of further epidemics before the purpose of the immunisation could become effective.

107. Rubella is often mild in its effect and sometimes passes almost unnoticed; but the effect on the unborn child if the mother contracts it in the early stage of pregnancy is devastating. Sir John Wilson, the principal instigator of the Leeds Castle consultation, has suggested for this reason that the name "rubella" is too mild; and during my visits I propagated his proposal that, for public education purposes its name might justifiably be changed to "baby blight", for it causes not only deafness but also mental handicap, blindness, heart defects, and often a horrifying combination of these impairments. I suspect, without statistical proof at the moment, that the reduction in incidence of rubella syndrome births in recent years in some industrialised countries is due not only to vaccination but also to increasing numbers of terminations of pregnancies when it is known that the baby is likely to be seriously deformed as a result of a pregnant mother's rubella. Some countries (e.g. Singapore) are following the

example of the United States by insisting on a rubella vaccination certificate for girls at high school age. In other countries, including Canada, New Zealand and the United Kingdom, rubella vaccination is the subject of periodical publicity campaigns but the cover is by no means 100 per cent.

108. In developing countries, rubella is not included in the "package" delivered under the Expanded Programme of Immunisation, partly because of the relatively high cost and partly because the congenital rubella syndrome is relatively infrequent, at least in comparison with measles, whooping cough, neonatal tetanus, polio and tuberculosis. There is also some failure to agree on delivery strategies, such as age at vaccination and whether both sexes should be included.

109. A multidisciplinary group, including representatives of WHO and UNICEF, met in London in March 1982 to consider these questions. The group concluded that an effective technology of control of rubella by vaccine is available, the limiting factor being take-up and delivery. A major collaborative effort will now be made to carry out the Leeds Castle injunction to promote vaccination against rubella. Under the leadership of the Royal Commonwealth Society for the Blind, voluntary organisations will seek, in conjunction with the health authorities, to achieve a decisive increase in the take-up of the vaccine (now estimated to be about 83 per cent overall) in the United Kingdom. In conjunction with UNICEF and the governments concerned, the Society has proposed an initial prevalence survey, followed by an immunisation programme, in Antigua, St Lucia, and in the Medak district of Andhra Pradesh, India, for which a questionnaire is being prepared for use as a part of a more general house-to-house survey. Enquiries have also been instituted with a view to similar action in The Gambia and Fiji.

GOVERNMENT POLICIES FOR THE DISABLED

Institutions or family care

110. The United Nations slogan "full participation and equality" accentuated the strong swing away from care in institutions to independent living in the family and in the community generally. Ministries of health and of social welfare, in large countries and small, insisted that resources were being diverted from the creation of new "disease palaces" (large hospitals in main centres of population) to primary health care nationwide; and from "dumping grounds" (residential homes for the disabled) to rehabilitation centres - better still to rehabilitation techniques at village level - with the objective of restoring mobility and sufficient well-being to enable disabled people to come and go in society on an equal basis with everybody else.

111. In accordance with this trend, the World Health Organisation has set its mind to find rehabilitation services which could be made available at family and community level at the lowest possible cost, with practicable methods of delivery. Where there is an infrastructure of community health workers providing basic services (immunisation, family planning, assistance over childbirth) under the supervision of medical advisers, it should be possible to introduce simple rehabilitation measures in the home or community which would materially improve the quality of life of disabled children and adults. A manual of these "appropriate technologies" was drafted in 1979 and was being field-tested in St. Lucia, Botswana, India, Sri Lanka, Nigeria and other countries during the IYDP. The community health aides who carry out this work are young people of the community who can get the confidence of their own people as no census enumerator or other outsider could. The WHO manual is being adapted so that they can use it to find the disabled people who can be helped, to identify their needs, to secure the involvement of the family and the community, to initiate the making of simple aids and supports, to arrange for referral where more sophisticated help is needed and to keep simple records of the numbers and categories of the disabled. All this is set out in the manual in the simplest (easily translatable) language: e.g. "people who have difficulty with hearing, speaking, seeing, moving and learning, or people who show strange behaviour".

112. By offering a simple service on the spot with referral of the more difficult cases, the true picture of the extent and nature of disablement in the community will gradually emerge. It

will provide a much sounder data base for future government policy in regard to disabled people than any form of census taking or sample surveying. Far more important is the fact that it will begin to meet some of the basic needs of disabled people hitherto unreached, while at the same time obtaining information about their numbers and categories.

The continuing need for professionals - and sub-professionals

113. But it will not do away with the need for intermediate and high-level professional services up the line of referral. For physical rehabilitation, some countries can afford the whole galaxy of professional orthopaedic surgeon, physiatrist, physical and occupational and speech therapist, prosthetist-orthotist, rehabilitation psychologist, social worker, vocational counsellor and employment placement officer. (WHO has recognised 14 separate professions in the relatively new science of rehabilitation). I had seen an array of this sort working together in Delhi, Jamaica, Ottawa, and knew of its existence in other large countries. The smaller countries could not aspire to such professional riches; intermediate countries find it difficult to field the whole team. Even where services exist at high professional level, the proportion of disabled people who receive help in many developing countries is minute, often confined to the environs of a major city or to wealthier people who can get access to them. While it is desirable that every country (or at least every region) should have the whole team as an "end-of-the-line" resource, an inspiration and a source of training, it will be necessary for much larger numbers of orthopaedic assistants or rehabilitation aides to be trained below the full professional level if the mass of the disabled people are to receive any benefit.

114. The swing away from high-cost care in major institutions will have to be paralleled by a swing to a rehabilitation capability in the district clinic assistant and the village-level worker. They must know how to cope with a wide range of problems arising under several of the rehabilitation disciplines in order to be able to educate parents and older children (the growing Child-to-Child movement is relevant here) to provide care and rehabilitation within the family. Without effective methods of training in the intermediate and lower levels, the vast majority of the people on whom the International Year has been focused will continue to be unreached and their numbers will increase as fast as the increase in population. It remains to be seen whether money is being effectively diverted from prestigious hospitals and "centres of excellence" to this nationwide extension of help for the disabled in the villages, requiring as it does the devising of delivery services and the selection and training of staff at several levels.

115. While it is obviously best for the village-level work to be done by recruits from the community who know the language, the customs and the susceptibilities of their own people, the task is so immense and so important that there is room for volunteers from other parts of the country or from outside to be attached to progressive village health programmes and work alongside those who are training the village-level worker. Here is a subject which might engage the attention of Commonwealth regional health agencies. They could not only lend their strong support to the organisation of this middle and lower-level training but encourage applications for temporary assistance from other Commonwealth countries to accelerate the process.

116. In the Caribbean, for example, the rather tenuous efforts towards the creation of an effective Association of Rehabilitation Therapists should receive support, perhaps through CARICOM. The deliberate aim, in my admittedly inexpert view, should be to encourage the all-too-few professional therapists, who already know the local problems, to spread both their professional and their local knowledge for the benefit of the smaller islands. Certainly this is preferable to raising sums of money from various sources to send new students to Jamaica for the full professional training, only to find on the completion of their course that there is no post at professional standard available for them in their own country. The Commonwealth Foundation is supporting clinical workshop programmes for physiotherapists in the Caribbean during 1982 and it is hoped that participants from the Eastern Caribbean, as well as Jamaica, may be able to attend. The strengthening of regional associations of rehabilitation therapists would both encourage the professionals in their work and provide a means for training orthopaedic assistants, rehabilitation aides, or whatever they may appropriately be called, as a part of the process of bringing help to the hitherto unreached disabled people in the smaller islands. There will be experience of this in St. Lucia and Jamaica after the recent field-testing of the WHO manual which included training courses for supervisors (physiotherapists and nurses) as well as primary health care workers.

117. Inter-country workshops to train for community-based rehabilitation activities are taking place in Botswana and in Kerala (India) in 1982, and WHO plans to extend the use of the manual, which is now available in several languages, with appropriate local illustrations. This will provide a stimulus to training at village, supervisory and professional levels.

The provision of aids

118. Whether physical rehabilitation is carried out in establishments in the capital city or at village level, a supply of calipers, braces and artificial limbs has to be organised, and people are required who can fit and check them. The growth of orthopaedic workshops using local materials has gained momentum in recent years, mainly through governments' own efforts, but with help and encouragement from the International Labour Organisation, the World Rehabilitation Fund of New York, OXFAM and others. I must repeat a reference here to the work of Professor Huckstep in relation particularly to the Commonwealth countries of East and Central Africa. In several countries I found that disabled people themselves were finding satisfying employment in new or expanded workshops of this kind. In the smallest countries the work is rudimentary or non-existent and there is scope for help in introducing the production of simple aids from local materials without requiring recourse to scarce foreign exchange for unnecessarily sophisticated imported parts.

119. Encouragement and help of this kind would form an important part of the proposal I have made in paragraphs 76-82 of the report in favour of the repetition of the 1970-76 series which started with an extensive Commonwealth tour by Professor Huckstep. India has a great deal to offer in this field with its development of the squatting leg and the Jaipur foot, the growth of ALIMCO and its National Institute of Prosthetic and Orthotic Training at Cuttack in Orissa State. Enquiries suggest that the Government of India and the establishments concerned would welcome proposals for co-operation in this field.

120. Wheelchairs were deliberately omitted from the preceding paragraph. The local manufacture of serviceable wheelchairs in a form to meet local needs is an obvious necessity. It is also obvious that this should be a consumer-led movement. There have been successes and there have been failures. I was shown many varieties of simplified "home-made" wheelchairs and heard strongly-felt arguments for and against each. (Are bicycle wheels a good idea or are they not? Pneumatic tyres are a nonsense, but what is the best substitute?). With the IYDP emphasis on wheelchairs, this is a field for concentrated research with the objective of finding models which suit local requirements and can be made relatively easily and inexpensively with a minimum recourse to imported parts. One centre that is just completing a special study of this subject with the help of Intermediate Technology and is about to produce an up-to-date handbook on the subject is AHRTAG (Appropriate Health Resources and Technologies Action Group Ltd) of 85 Marylebone High Street, London. AHRTAG are also prepared to be a clearing house for information and advice about prostheses generally and specific requests arising during this survey have been referred to them.

121. The growth of orthopaedic workshops, the need for sharing experience in the successful use of local materials, the training of technicians for this work and the need for research into the design and component parts for wheelchairs all point to Commonwealth co-operation on a regional basis. Visits are needed both ways. The successful technologist or technician should be encouraged and enabled to look into the needs of the least developed countries and devise possible lines of construction on the spot. Those attempting to meet these needs locally should be afforded inspirational visits to countries within their region where notable successes are being achieved. The whole subject should engage the attention of Commonwealth regional health agencies and the periodical meetings of ministers of health. The subject will become more and more important as WHO's policy of training the disabled in the community gradually gains momentum. Reliance on expensive imports could severely retard or even frustrate its progress.

Education of handicapped children

122. Ministries of education, as well as ministries of health, have an essential role in ensuring that the needs of the disabled are met, especially in the provision of special education for handicapped children. In the developing and industrialised countries alike (although on a

different time scale) the initiative in the education of deaf, blind and mentally retarded children came from voluntary associations, particularly religious orders in the first instance. Governments have assumed or are assuming responsibility, in varying degrees, as the years go by. A fairly normal pattern now in the smaller countries with which this report is primarily concerned is that the voluntary associations are still carrying the major responsibility for caring for the needs of handicapped children, providing buildings, equipment and teachers. They bring relentless pressure on governments to assume responsibility at least for staff salaries, but few national budgets stretch far enough to keep pace with the minimum acceptable demand. Staffing deficiencies are precariously made up by volunteers of all kinds. The least governments can do is to provide one specialist officer in their ministries of education to concentrate on the requirements of handicapped children, but this has still not been found possible in many of the smaller countries.

123. It does not help voluntary societies in their efforts to secure the partnership of governments that so much publicity is being given to the ideal of shifting away from special institutions for the handicapped to "open" or integrated education. The ideal is not in dispute; its achievement is much to be desired. But the realities of the situation in many of the smaller and more remote countries require the evolution to be very gradual. It will be sad if one of the results of the International Year is to deprive voluntary associations, local and international, of support in the form of money and volunteer service for the indispensable work they are doing, before an integrated education system can be devised with the resource centres and, above all, the trained staff to make it possible even to begin to dispense with special schools. Where the move is strongly away from residential "dumping grounds", more day centres are required where at least the totally deaf and the totally blind can be given basic schooling by skilled staff in the hope that they can proceed afterwards to classes in the state system of primary and secondary education.

124. Nobody wants to revert to the concept of an orphanage, least of all for the segregation of physically and mentally disabled children, but the realities of the situation are that parents do sometimes desert severely handicapped children and these children are the most difficult to lodge with foster-parents. The remarkable growth of Cheshire Homes in many countries in recent years is evidence of this need. Although their creation was stimulated by Leonard Cheshire and his international foundation, each Home is set up and maintained by local people to suit local needs. They are "homes" in a real sense, approaching as nearly as possible the atmosphere of a family. Many are for adults and the elderly. But in many countries, the local need has been recognised as for Homes for the severely disabled children whose parents cannot cope. Close contact is maintained with the parents and families wherever possible and the children mix with others in the normal system of education if they are capable of doing so.

125. As encouragement for their participation in a system of integrated education, there is plenty of evidence in all parts of the Commonwealth that handicapped children, especially the totally blind, equipped initially with the special preparation they need, can not only profit from secondary and higher education, but excel and walk off with some of the prizes, whether they be first class honours or being called to the Bar for a successful legal practice. It is only fair to say that much of this achievement is due to 30 years of persistent work by the Royal Commonwealth Society for the Blind and its associated local societies.

126. As the care and education of handicapped children is probably the major problem in the disabilities field confronting the governments and peoples of the smaller Commonwealth countries, the Education Division of the Commonwealth Secretariat could plan to update and reissue, preferably on a regional basis, the admirable 1972 publication, now out of print, entitled "Special education in the developing countries of the Commonwealth". It analyses the causes and effects of each disability affecting children, describes the provision being made for their education, including appropriate buildings and equipment, and suggests lines of development for special education in low-income countries. Much of the text is as valid and as valuable now as when it was written ten years ago. My one-man, one-year survey in 1981/82 covering other aspects besides the education of handicapped children could not hope to emulate the 1972 study. To set in hand now a revision of this document would focus the attention of governments on the progress made since 1972 and help them to judge the adequacy of their provision in the 1980s. I make a recommendation to this effect in paragraph 268 below.

Vocational training

127. The vocational training of juvenile and adult disabled people also owes a great deal to voluntary effort and, nowadays, practical support from service clubs such as the Lions, Rotary and Junior Chambers of Commerce. Sheltered workshops pioneered mainly for the blind in the 1950s and 1960s are now developing into vocational training establishments or commercial-type production centres which are becoming the concern of ministries of labour and/or social welfare with encouragement and advice from the International Labour Organisation. They are needed to provide skilled training and experience with the purpose of enabling handicapped people to live in the community, not in institutions, and to earn their living to the greatest possible extent. Sometimes it is necessary for them to be residential but possibilities are being developed of making them day centres with the trainees (better called employees) either living in groups or lodged with able-bodied people in the vicinity. It was the inevitability of permanent residence that caused these centres to be known as "dumping grounds". The test is whether it is assumed from the outset that the trainee is an "inmate", there for life, or whether the hope and expectation are preserved that after a period of training, he or she will be able to take a job in open employment.

128. Great efforts were made in the International Year to convince employers that even severely handicapped people are well worth taking on after appropriate training. This is borne out by reports on disabled workers which give evidence of productivity levels above average owing to greater diligence, special aptitudes and a high ability to concentrate. Both ILO and locally-made films were shown on television and to special meetings of employers in co-operation with chambers of commerce. Selective placement services for the disabled have been established in many countries with the assistance of ILO and are now an integral part of the national employment service. In many of the smaller countries this has not yet proved possible for lack of funds, but ministry of labour officials have undertaken to make the employment of disabled people a special concern. This work must be sustained, as open employment and independent living are the objective in all countries; and the case is proven that a far higher proportion of people with physical and mental handicaps can be employed than has been realised hitherto. This will be a main task for councils for the handicapped in conjunction with ministries of labour. It will be for each country to decide whether a quota system is desirable and enforceable in the local circumstances.

Works centres

129. Instead of the dead end of the sheltered workshop, vocationally trained or retrained disabled people now increasingly have the prospect of satisfying employment in works centres. The essential difference is that the emphasis is on the production of saleable articles of much wider variety and the employees include many categories of disabled people and some able-bodied as well. This pattern is evolving in several of the less developed countries, with advice and technical assistance from ILO, and is a main recommendation of IYDP committees in others. The trick is to find the saleable articles that disabled people can make, preferably from local or easily procurable materials, and then ensure that they have good management and marketing. Service clubs - Rotary, Lions, Jaycees, Apex and others - are helping here and it cannot be emphasised too strongly that this movement is, perhaps more than any other, the logical sequel to the IYDP effort in many of the smaller countries.

130. To quote again the Mona Rehabilitation Centre (Jamaica) motto, "Employment is nature's best medicine and essential to human happiness". School chalk and furniture production in Bangladesh, tie and dye production in Malawi, silkscreen and greeting card production in Papua New Guinea, and printing in Jamaica are a few examples. "Abilities Unlimited" in the Bahamas claim growing success with upholstery, coathangers, brooms and other domestic items which hold out a prospect of their workshop earning 75 per cent or more of its overheads and wages. Where necessary, representation is being made to government for import protection and also for the waiving of import duties on ingredients which cannot be produced locally. Financial self-support is too much to expect initially but it can always be an objective. It is particularly gratifying to find workshops with a high proportion of disabled employees producing the things their fellow-disabled need: artificial limbs, calipers, crutches and wheelchairs.

131. This development owes a great deal to voluntary societies and service clubs. Even if responsibility passes to a government department, its momentum needs the continued support of

these societies and of the disabled people themselves, through their own organisations, in a council for the handicapped. Reports which are coming in as this is being written show that this ideal is so far proving very hard to achieve in many countries because of the reluctance of governments to accept any additional commitments, usually because there is not yet an inter-ministerial approach to the needs of the disabled in the community.

NOTES ON SOME SIGNIFICANT DEVELOPMENTS

132. At this stage of the report, the consultant is in a dilemma. What reference should be made to individual countries? The opinions expressed and the conclusions reached in the preceding chapters are based on the perusal of voluminous details sent in by IYDP committees, together with notes and recollections of discussions in some 20 countries of different sizes and in very different stages of development. The material is available, indexed by subject and by country. A great deal of it is speculative, in that it rehearses plans and intentions for the observance of the International Year. In so far as achievements are recorded, they relate to public awareness rather than to success in influencing government policies and programmes in relation to disabled people. To reproduce such material at any length would make the report too long, too repetitive, and of somewhat ephemeral value.

133. Twelve Commonwealth countries reviewed their International Year in the United Nations General Assembly Debate on 7 and 8 December 1981. Edited versions of the delegates' speeches were prepared for reproduction as appendices to this report; but they, too, would make it too long, so only a few salient facts have been preserved and incorporated in the main text. To report as fully as possible on countries visited or on those which have sent in detailed reports would give a distorted picture. It would diverge from the primary purpose of the report, which is to present a critical appraisal of policies and practices in relation to disabled people, particularly for countries with very limited resources. At the same time, I was required to review the experience of all Commonwealth countries during the International Year and to identify initiatives that might be sustained after the Year is over. That I have done in general policy terms. How can it be done in detail for so many different countries?

134. Having been given a unique opportunity to find out how Commonwealth countries interpreted the International Year of Disabled Persons, and having acquired so much material, what I attempt in this chapter is to mention, in very condensed form, a few items from individual countries which may prove of general interest to all. The omission of some countries reflects either a shortage of space or a shortage of information. It in no way reflects upon their achievements, or lack of them. The selection has been made solely on the grounds of general interest and cross-fertilisation of ideas, in the hope that the items preserved and recorded may help to fulfil two of the purposes of the survey, namely, to sustain some of the initiatives of the special Year now that it is over and at the same time to provide ideas for inter-governmental co-operation in the years ahead. It is intended primarily for those in all Commonwealth countries who will have the continuing task of influencing or implementing government and voluntary agency policies in relation to disabled children and adults in their communities.

Australia

135. The impressive new premises in Canberra of the Australian Council for the Rehabilitation of the Disabled (ACROD) and the formidable list of its affiliated organisations nationwide illustrate the strength of the numerous voluntary societies of and for handicapped people in Australia. The national IYDP committee consisted entirely of non-governmental representatives, including one from each state, but it worked very closely with a specially-appointed governmental IYDP unit. On a permanent basis, the Government has a National Advisory Council for the Handicapped (NACH) and a Standing Inter-departmental Committee on Rehabilitation (SIDCOR).

136. In February-May 1981 the Bureau of Statistics carried out a survey of handicapped persons in Australia. The preliminary results show 13.2 per cent of the population as disabled (the criteria of severity are of course set out) of whom two-thirds are handicapped, 295,800 mildly,

253,700 moderately and 573,900 severely. The number in institutions was 111,000 (of whom 90 per cent were severely handicapped) and the number living in households was 1,153,600 (of whom 36 per cent were severely handicapped). Arthritis and back disorders headed the list of disabilities (290,600); deafness came second (130,300), heart disorders third (90,500) and blindness fourth (63,300). But, applying the severity test, total loss of sight (61,000) exceeded total loss of hearing (45,200). For mental retardation the number was 42,700, with an additional 23,300 "slow learners". Accident and trauma are presumably included in the figure of 37,600 for "musculoskeletal disorders".

137. A guide to rehabilitation services for handicapped people was produced by the Department of Social Security in July 1981. But the Australian production that impressed me most was "Towards prevention of permanent disability in Australia" prepared for the National Advisory Council for the Handicapped by Julia Richards. Few countries can claim to have such a concise, clear and authoritative statement of the disabilities suffered by their citizens and the measures that are being taken, or could be taken, to prevent them.

138. Official assistance to overseas countries is planned and administered by ADAB, the Australian Development Assistance Bureau within the Department of Foreign Affairs. The many voluntary aid organisations in Australia are stimulated and co-ordinated by ACFOA, the Australian Council for Overseas Aid, financed by its large number of constituent societies, many of which assist projects for the rehabilitation of the handicapped in Papua New Guinea, the Pacific islands, Asia and Africa. The Australian National Council of and for the Blind has recently formed an Overseas Aid and Prevention of Blindness Group under its former Chairman, General Paul Cullen. Particularly valuable in recent years has been the work of an adviser supplied by the Government of Australia to help with the education of children with special needs in Fiji and the smaller Pacific islands.

139. At the UN General Assembly debate in December 1981, the Australian delegate announced that over A\$1 million had been disbursed or programmed in the 1980/81 overseas aid budgets to help a multiplicity of projects designed to equip, train and in other ways assist disabled persons and organisations for the handicapped in developing countries.

The Bahamas

140. The International Labour Organisation drew attention to a new, enlarged workshop in the Bahamas which was intended to serve as a Caribbean regional training facility for staff engaged in the vocational rehabilitation of disabled people. Also emanating from the Bahamas was a proposal to form a Caribbean Association for the Rehabilitation of the Disabled (CARD). This organisation held an inaugural congress in Barbados in July 1981 with financial support from Goodwill Industries of America, the World Rehabilitation Fund and Catholic Aid for Overseas Development. Representatives of 15 countries attended and adopted a constitution. The intention was not to supersede other Caribbean organisations but to co-ordinate and, if possible, fund their activities. There would be an emphasis on vocational rehabilitation, small enterprise development and employment generally. Management training courses for vocational workshops are indeed on offer, at "Abilities Unlimited" in Nassau, and are expected to begin in September 1982.

141. In view of the fragmentation of effort and lack of any co-ordinating force in the smaller islands of the Eastern Caribbean, regional organisations offering facilities for training and co-operation are very much to be desired, provided that they can draw down external finance to overcome the perpetual difficulties of communication, especially the expense of air fares. There is no evidence at the moment that CARD will gain the allegiance of all the principal bodies concerned; but the workshop in Nassau apparently has a good deal to offer in the vocational education and employment fields if the problems of distance, fares and subsistence can be overcome.

Bangladesh

142. The Rehabilitation Institute and Hospital for the Disabled in Dacca was conceived and built as an orthopaedic hospital and a brace and limb centre, primarily for war victims immediately

after independence in 1971. It has developed into a major rehabilitation centre with continuous help from CARE (USA), the British Overseas Development Administration, World Orthopaedic Concern and other outside agencies. Its influence extends to all the medical colleges and district hospitals of Bangladesh. The souvenir volume of the ceremonial opening contains a useful round-up of the known facts about disabilities in Bangladesh and their main causes.

143. The IYDP committee under the chairmanship of the Director of Medical Services was superseded in July 1981 by a committee under the Ministry of Manpower Development and Social Welfare, the agenda of which emphasised social awareness, government provision for educational and vocational training for the deaf and blind and the grants given to voluntary agencies to pursue their work. Even so, my visits to both government and voluntary agencies institutions suggested that much still needs to be done to create a national policy which would bring them into closer association and particularly to ensure closer co-operation between the health, welfare and education ministries.

144. The voluntary work is impressive. From its headquarters at the Dacca Deaf and Dumb School, the Bangladesh National Federation of the Deaf runs three provincial schools and 20 voluntary units in various parts of the country. Two teachers have been trained in Calcutta with UNICEF help but a visit from a trainer is needed to give in-service training for teachers and also from a technician to teach them how to use and maintain hearing aids. They have therefore asked for help from the Government, which maintains official schools for the deaf.

145. The National Society for the Blind, long supported by the Royal Commonwealth Society for the Blind, now has seven branches, five of which operate eye hospitals, and eleven mobile units to assist its eye camp activities in which over 27,000 cataract operations, apart from other forms of treatment, were performed in 1981. Programmes of training for ophthalmic doctors and auxiliaries, sponsored by RCSB and the Australian Council of and for the Blind, have already added 35 doctors and 65 auxiliaries to the Bangladesh Society's staff. This programme will be greatly accelerated shortly because a new ophthalmic hospital and training institute is nearing completion at Chittagong with substantial help from Andheri Hilfe (West Germany) and a joint-funding project by the Royal Commonwealth Society for the Blind and the British Overseas Development Administration.

146. Assistance for Blind Children, established in 1978 with joint headquarters with the National Society for the Blind, runs an integrated education programme, providing hostels and other accommodation as well as braille kits for blind students and also rural self-employment projects for blind teenagers in animal and poultry husbandry. Elsewhere in the report I have described the vocational training centre just outside Dacca, originally a sheltered workshop for the blind but now becoming a commercial enterprise employing people with other disabilities also, which produces school chalk, furniture, surgical dressings and woven cloth. It is non-residential, but the employees/trainees can board with families nearby.

Barbados

147. "In Barbados", I was warned, "we have no tradition of central government taking responsibility for the handicapped: that has been the concern of the Vestries (the form of local government abolished in 1969) and of the community generally". My informant might have added "But we have a strong tradition of voluntary societies caring for particular groups of children with special needs: the Association for the Mentally Retarded Child, the Association for the Blind and Deaf, the Thelma Vaughn Memorial Home (now a Cheshire Home) for the Physically Handicapped, the Association for Correction of Learning Disabilities, the Council for the Handicapped, the Mental Health Association and the Association of Parents of the Handicapped".

148. Government has nevertheless taken over responsibility for the School for the Deaf and Blind and is promoting "open" education for handicapped children in ordinary schools. It also gives annual grants to some of the institutions for the handicapped. Its statutory Child Care Board is newly commissioned to include disabled children in its scope. ("The inclusion of the handicapped was a major change of policy and caused a complete reversal of negative attitudes towards them", I was told). The Ministry of Health has opened a Children's Development Centre jointly with the Association of Parents of the Handicapped as a day assessment centre.

An achievement attributable to IYDP is compulsory vaccination for girls against rubella; this is important as the prevalence of deafness appears to be unusually high. Barbados will be important for the Eastern Caribbean and for the PAHO/WHO regional project for training the disabled in the community if it is found possible to start the proposed middle-level course for rehabilitation assistants at the Community College.

149. On the last day of my visit, the IYDP committee recommended as its permanent successor a national council with eight main functions, including prevention, rehabilitation, fund-raising and advising government on policy and legislation concerning disabled people.

Botswana

150. In anticipation of the IYDP, Botswana's Commissioner for the Handicapped published in January 1980 a handbook describing the services available to disabled persons in the country. "If you have a disabled person in your family or know of any in your community or think that your child/relative has any problem with his physical or mental development, this booklet will guide you where to go to find help, professional advice and support". It describes what is being done for the orthopaedically disabled, physically and mentally handicapped children, the blind, the deaf and the mentally ill, and calls for support to the agencies which run them.

151. This flying start was due to the establishment in 1976 of a Special Services Unit for the Handicapped. This unit was charged with the duty of locating disabled people; counselling them; their parents and their families; co-ordinating the services of voluntary agencies and motivating the community to participate in their programmes; and formulating a policy to meet the needs of the handicapped and advising government on the development of a progressive programme for the disabled.

152. A National Commission for the International Year was set up under the chairmanship of the Permanent Secretary of the Ministry of Health. Its work was launched by President Masire with strong emphasis on prevention by immunisation, by particular care of pregnant mothers, babies and children, and by early detection and treatment. The President also stressed the need for rehabilitation to restore optimal function, early stimulation for normal development, special education for those who need it and incentives for employers to engage the services of disabled people. He concluded by saying "Don't ask what is being done for the disabled; ask what you yourself can do".

153. A National Council for the Handicapped was formed in 1980 which should "be the voice of the disabled, speak for them, help to get a better understanding of their problems and needs, and to obtain their rights". This national council will now carry on the activities initiated by the IYDP commission.

154. Within this helpful existing framework, WHO's manual "Caring for the disabled in the community" has been field-tested in Botswana but it is too early to attempt to summarise the results or the lessons learned.

Canada

155. In May 1980, Canada took the unique step of appointing an all-party committee of seven House of Commons members to hear the representations of advocacy groups of disabled people throughout the country, to study their proposals and their needs and to make recommendations to government. Their main report, a handsome illustrated volume of 190 pages entitled "Obstacles", lists 130 recommendations for action by government at all levels. They cover the achievement of adequate income and support for self-help efforts; the provision of technical aids, equal benefits and protection under the law; access to public buildings, facilities and programmes; equal access to opportunities in employment, housing, education, transport, recreation and information. Special stress is laid on community support services to reduce or eliminate the need for institutional care. "The message received loud and clear during the hearings was independent living for disabled persons. Get us out of the institutions and into the mainstream of life".

156. By the end of the Year, the Federal Government has responded positively to 56 of the recommendations and promised replies to many more. Some cannot be implemented immediately, but the report gives a programme of action which is known to be in accordance with the wishes of the disabled people of the country. They are well organised in the Coalition of Provincial Organisations of the Handicapped (COPOH) which has been growing in strength since its inauguration in 1974 to represent collectively the "advocacy agencies" of the disabled people themselves.

157. My own brief experience in Canada was valuable because it illuminated the IYDP theme of social integration, participation and equality - even the conscious swing away from the medical components of disablement. The "cripples" period in history regarded disabled people as pets, beggars, the inevitable percentage of lower-class citizens to be treated with contempt, pity or fear. There then grew up a movement of compassion which organised itself in the form of charities for crippled children, schools for the blind and the deaf, homes for the mentally retarded. Industrialised societies expected the wealthy to contribute to the well-being of the "unfortunates in our midst" with voluntary or paid service-providers to look after them, usually in residential institutions. In the third period, advances in medical science brought opportunities to improve the physical state of the disabled and created a range of new professions - orthopaedic surgeon, physiotherapist, artificial limb maker, wheelchair manufacturer - who were all doing things for the disabled to improve their mobility and ease their way of life - but as dependent citizens.

158. Now a fourth period has begun. Canada has provided leadership in a movement away from the medical (even rehabilitation) model, to the consumer model, in which handicapped people themselves examine their own potential, speak out for their own solutions and win the right to be treated as equal citizens. Public attitudes and public policies have hitherto classified handicapped people by their disabilities: henceforth they must be recognised for their abilities. With this experience, Canada was sympathetic to the movement stemming from the 1980 Winnipeg conference of Rehabilitation International which led to the first World Congress in Singapore in December 1981 of Disabled Peoples' International.

159. But this report is concerned mainly with the needs of disabled people in the smaller and more remote Commonwealth countries. Canada, through its International Development Agency (CIDA), through Canadian University Service Overseas (CUSO) and many other voluntary agencies and by mission-administered funds helping local voluntary effort for the disabled on the spot, is already making a major contribution to rehabilitation and education. My hope is that my discussions in Canada will help to direct attention to two great areas of need - deafness, through my discussions with the Canadian Hearing Society, and mental retardation, through my negotiations with the President-elect of the International Association for the Scientific Study of Mental Deficiency, Professor Allan Roeher of Toronto.

Cyprus

160. Cyprus responded promptly and fully to the announcement of this survey and it is a matter of great regret that I was not able to pay a visit, however brief. The IYDP committee drew up a plan of action which emphasised prevention as well as rehabilitation and had a Committee of Ministers (Labour and Social Insurance, Finance, Education, Health, Justice and Interior) to supervise its implementation. As it fully covers every aspect of the subject of this report from perinatal care to the elimination of curbs in main streets so that wheelchairs can pass, no summary here could do it justice. I include this brief paragraph only to call attention not so much to the comprehensiveness of the coverage as to the inter-ministerial approach both to planning and implementation.

Eastern Caribbean

161. In the bewildering fragmentation of effort in the smaller islands of the Eastern Caribbean, one looks for co-ordinating elements which can offer opportunities for training and the sharing of experience in meeting the needs of disabled people, especially children. In July 1981 an effort was made to start a Caribbean Association for the Rehabilitation of the Disabled (see under Bahamas), but it remains to be seen whether this will receive wide support in the

region. The Caribbean Council for the Blind successfully covers the whole area from its secretariat in Antigua and the Inter-Island Eye Service, run from Barbados, effectively draws down ophthalmological short-term assistance as required with the support of Operation Eyesight Universal (Canada) and the Royal Commonwealth Society for the Blind. It is now tackling the major problem of glaucoma in the islands with a preliminary conference early in 1983.

162. A Caribbean Association of Rehabilitation Therapists, inaugurated in the Bahamas in 1978 with UNICEF assistance, held its first conference in September 1981 in Guyana and has a membership covering the smaller islands, with its president in Guyana and its secretariat in St. Lucia. The Association seeks to make up the deficit in rehabilitation services in the Eastern Caribbean and is preparing a booklet on simplified equipment and techniques appropriate to the area. There are hopes for a course for rehabilitation therapy assistants in Barbados and an occupational therapy school in Trinidad. The Association has been commended to CARICOM and to the Commonwealth Foundation for further support. Its existence and growing strength are important in relation to the PAHO/WHO regional project for training the disabled in the community.

163. Also with its regional co-ordinator in St. Lucia is the Eastern Caribbean Unit of the Caribbean Institute on Mental Retardation and Developmental Disabilities. Supported by "Partners of America", it arranges much-appreciated workshops and consultative visits in the smaller islands, usefully covering other disabilities besides mental retardation. A Caribbean-oriented curriculum guide for teaching the moderately to severely retarded child is in course of preparation. Because of the cost of air fares, which bedevils all regional activity among the small islands, the unit is devising "video-seminars" which can be used in each country.

164. This attempt at a regional approach to the smaller islands of the Eastern Caribbean in no way reflects on the work being done by voluntary societies for the deaf, the blind and the intellectually handicapped in the individual islands or on the efforts of IYDP Committees to create more public support for them. They deserve all the support they can muster. The Canadian International Hearing Services of Weston, Ontario, an entirely voluntary organisation, helps the deaf in St. Vincent and Montserrat by visits of an audiologist, a teacher of the deaf and a technician, supplying hearing aids and other devices collected by Rotary Clubs. OXFAM has helped to build up Dunnottar House, St. Lucia, into a centre for the teaching and vocational training of mentally handicapped people. The Red Cross has long been active in Montserrat, Dominica, Antigua and St. Kitts, in schools for the deaf and workshops for the blind. By listing these that come to notice by correspondence or during visits, I am of course giving examples only.

165. It was suggested to me in the Caribbean that someone was needed for at least a year to give undivided attention to the development of regional organisations for the disabled in the smaller islands. This was one of the intentions of CARD (The Caribbean Association for the Rehabilitation of the Disabled). Whether this is realised or not, I hope that this work will now engage the attention of CARICOM.

Fiji and other Pacific island countries

166. The findings and recommendations of Fiji's IYDP national co-ordinating committee thoroughly review the provision by both government and voluntary societies for disabled children and adults. They conclude that there is so far no concerted plan for the development and provision of rehabilitation services and recommend the establishment of a central authority to assume overall responsibility. They emphasise primary prevention and early intervention, urging medical and paramedical services to play their part. Paying tribute to the work of voluntary societies in the education of handicapped children, they call upon the Ministry of Education to initiate a comprehensive programme for detecting and coping with children with special needs as a part of teacher training and the establishment of special education classes in ordinary schools. Stressing that rehabilitation calls for the combined use of medical, vocational and social measures, they ask for the Fiji Rehabilitation Council to be recognised and supported by the Government. There are also specific recommendations relating to access, transport and tax concessions. But the principal recommendation, as in this survey report, is for a statutory council or national committee to assume an overall co-ordinating function, to give effect to a national policy, including the use of government funds and overseas aid.

167. Fiji has a further special interest for this survey report. For many years, the smaller Pacific islands have benefited from training courses for teachers of deaf, blind and intellectually handicapped children in conditions and a culture not too unlike their own. These courses have now been adapted by the adviser supplied under technical assistance arrangements by the official Australian Development Assistance Bureau (ADAB). He runs six-month courses in Fiji with a heavy emphasis on practical experience with physically handicapped children at Suva Crippled Children's School, including the hearing-impaired, with mentally retarded children at the Intellectually Handicapped School and with blind and visually impaired children at Suva School for the Blind. The students also visit baby clinics to observe normal child development as well as early intervention programmes and spend a period at the rehabilitation workshops. The adviser visits the countries from which the trainees have come in order to give follow-up in-service training and to provide guidance to student teachers and nurses in the smaller islands and in Papua New Guinea.

168. The last intake for these courses is scheduled for July 1982, but there are hopes that the demand from Tonga, the Solomon Islands, Western Samoa, Vanuatu, Kiribati, Tuvalu and Papua New Guinea, as well as their obvious need for basic training of this kind, will ensure their continuation. Fiji would also be the obvious place for rather higher level courses as they become necessary: to send middle-level staffs to Australia and New Zealand for training in separate specialisation will not meet the needs of the smallest islands and would, in any case, be prohibitively expensive.

169. I reproduce below the press release given to the newspapers on my way to Suva airport on 8 February, because it is fairly typical of the kind of support I tried to give on the radio, on television or in the press during country visits.

"The Commonwealth Secretary-General, Mr. Shridath Ramphal, is taking a great interest in the work of IYDP committees in Commonwealth countries, and has sent me to some 19 countries so far, conferring with them about their achievements during this special year and their plans for the future. Here in Fiji I was able to visit a number of institutions for disabled people, to have talks with the Ministries of Health and Social Welfare and to meet members of the Fiji National Co-ordinating Committee for the International Year. I was particularly fortunate in that the committee has formulated its final recommendations; and I am glad to say that they are precisely in line with the policy the Commonwealth Secretary-General has commended to all governments.

They start with prevention and early detection which are most important. They then emphasise medical rehabilitation - a great deal more can be done to make disabled people mobile and to get them out of bed. Next, the right of every child to at least primary education, even if he has a serious impairment such as deafness, partial vision or intellectual retardation.

After that, vocational education is important; handicapped people can be useful, productive citizens when they are given the chance and the special training they need. Employment follows; if they can earn their living on the open market, well and good. If they cannot, then special arrangements can be made - and Fiji has its sheltered workshops so that they can be usefully employed and earn at least part of their keep. Access and transport are also important, so are sports and recreation for the disabled. The committee asked about legislation and I was able to say that the Commonwealth Secretariat has prepared a comparative study of laws affecting the disabled, which is available.

Finally, what of the future? The Fiji IYDP committee recommend - and I am in wholehearted agreement with them - a statutory national committee for the disabled with a Government-nominated chairman and representatives of all relevant ministries and voluntary societies. I emphasised that this committee should have power to get on with the job and to raise money from the public to supplement government grants and to be free from government procedures on estimates, etc., but of course subject to independent audit. This is the model that works well in countries that already have it.

For the sake of disabled people in Fiji, I hope that the proposed policies prevail and that the next generation will be spared preventable disability while those it has who are already disabled can be enabled to lead happier and more productive lives."

The Gambia

170. The IYDP national committee in The Gambia made an effective start in April 1981. An ILO-sponsored seminar on vocational training for the disabled, scheduled for Banjul in April, did not materialise so Gambia's IYDP committee convened a seminar on disability prevention and the rehabilitation of the disabled. The attendance included a wide range of government departments; voluntary associations for the deaf, the blind and family planning; Christian and Muslim missions; and Rotary. The only external representatives were UNDP and the Swedish "Emmaus Foundation Upsala - Banjul Handicapped Project".

171. The report starts with social integration, emphasising "measures to effect attitudinal changes towards disabled people" on the part of the general public. It then covers the whole IYDP spectrum in the following order: the mentally ill; prevention of disablement by improved sanitation and immunisation; polio victims (expressing concern that The Gambia has only two physiotherapists and two orthopaedic technicians, one of each provided very recently by Sweden's Emmaus Foundation); leprosy (expressing concern that the leprosy settlement should not be a dumping ground but a rehabilitation centre); the visually handicapped ("5000 blind"); the hearing-impaired (regretting the absence of research or statistics); the mentally disabled ("no trained psychiatrist, psychologist, social worker or occupational therapist attached to the mental hospital"). The report goes on to deal with the prevention of accidents (especially on the roads); vocational training for the disabled (the Lamin Technical Centre proposes to construct vocational centres in 60 key villages, integrating disabled with non-disabled); "special education" training to make possible the open education of deaf and blind (noting that at present high schools oppose the introduction of disabled pupils, claiming that they do not know how to deal with them); provision of mobility appliances to enable children to attend school; the mentally retarded ("acknowledging the fact that the mentally retarded have hitherto been ignored"); and finally the role of voluntary organisations ("noting with concern the lack of co-ordination and co-operation hitherto between government institutions and voluntary bodies") and of United Nations agencies. A resolution of the seminar proposed that legislation should be enacted to ensure that a percentage of disabled people were employed at all times.

172. Consideration by the Government of this formidable programme was interrupted by the political upheaval that occurred shortly after its submission. At the end of the special Year, however, the IYDP committee invited the Government to set up a permanent advisory board on disability with a full-time rehabilitation officer in the Department of Social Welfare to ensure continuity of attention to the programme. The Gambia already has a most efficient and effective health service and the hope is that the special attention given to the needs of disabled people will complement this on the social and educational side. It has also called attention to the need for orthopaedic and prosthetic help, which Sweden and Sudan are at present supplying. Meanwhile, the Commonwealth Society for Deaf has started an enquiry into the incidence and causes of deafness in The Gambia with an audiologist supplied by the CFTC and training in Britain for his Gambian successor financed by the Commonwealth Foundation. The Royal Commonwealth Society for the Blind continues to support the activities of the Gambian Society and enabled its secretary to attend the seminar in Malawi on the vocational rehabilitation and resettlement of the disabled.

India

173. To do justice to India's IYDP activities and its Government's continuing attack on the causes and alleviation of disablement in a few paragraphs is an impossibility.

174. Reporting the national plan of action to the General Assembly of the United Nations on 7 December 1981, the Indian delegate said that the specific objectives to be achieved in the light of present resources included evolving a national policy on the disabled which would encompass education, training, employment and measures to achieve full social integration and protection and guarantees under the law; preparing a prospective development plan for rehabilitation eventually to provide comprehensive rehabilitation services; initiating practical programmes for immediate and significant benefit for the disabled including their integration into the community; giving a positive rural bias to services to the handicapped; and developing and putting into operation a comprehensive and pragmatic national programme for the prevention of disabilities. The objectives also included providing for research and development through national

research institutions for the development of techniques and technologies for the rehabilitation of the disabled; developing a network of information and publicity services for the dissemination of information on new techniques and equipment programmes and of the creation of awareness of the potential of the disabled and to eradicate social prejudices; and collecting relevant data on the disabled in the country.

175. The focus would be on services for disabled children under 14 years of age, on extending employment opportunities for the disabled and on building a reliable national data base on disabilities. "It is our view that equal emphasis should be given to prevention and rehabilitation".

176. I will select some of the features brought to my notice which are directly relevant to the subject of this report. The deepest impressions left on me were the apparent ease of cooperation between the Ministries of Social Welfare, Health and Education; the great advances in orthopaedic and rehabilitation work; and the dramatic achievements in the prevention and alleviation of blindness which had been given a major priority. Mental retardation seemed to lag behind despite a strong Federation for the Welfare of the Mentally Retarded, for whom a major concern was the failure to amend the Lunacy Act of 1921; and social welfare officials expressed their concern at a lack of progress over both the mentally retarded and the mentally ill. Particularly impressive (as always in India) was the service given to the community by doctors and nurses, effectively supported by business men and service clubs.

177. Administratively, the Social Welfare Ministry was responsible for devising and implementing the IYDP programme for India but this did not inhibit an approach over the whole field of prevention, rehabilitation, education and employment. Four major commissions had not yet reported but IYDP work continues into 1982 with an increased budget. Some 9,000 scholarships for blind, deaf and orthopaedically handicapped students had already been taken up and the provision had been increased. Three per cent of all government posts are reserved for disabled people.

178. The departments of rehabilitation at Safdarjang Hospital and the neighbouring All-India Institute for Medical Sciences in Delhi provide surgical treatment; rehabilitation therapy, including the production and fitting of artificial limbs and other aids made from inexpensive, local materials; followed by mobility training, vocational guidance and even assistance with placement in employment. Visits to both centres would be an inspiration for anyone seeking to improve the rehabilitation provision in his own country. The All-India Institute centre is justly proud of artificial limbs which enable the wearer to squat; but I was told that I should have also gone to Jaipur to see the work of Doctor Sethi, who has developed the "Jaipur foot" which is a great boon to disabled farmers.

179. Inspirational visits to Delhi and Jaipur, perhaps in conjunction with the National Institute of Prosthetic and Orthotic training in Orissa and ALIMCO, the Artificial Limbs Manufacturing Corporation at Kanpur, would materially help the many smaller countries which are asking for advice about the production of home-made prostheses to replace prohibitively expensive imports: an oral proposal to this effect was welcomed by the Government of India. The visits could be extended to rural areas because the Indian Council of Medical Research has undertaken a study of polio disability prevention and rehabilitation among children throughout India and the All-India Institute is conducting a "valuation of the effectiveness of modern prosthetic hardware in rural conditions" in association with Mangalam, a private society formed in 1975, which has already held 14 rural camps attended by 4,000 orthopaedically disabled people, of whom 800 were supplied with artificial limbs and other aids.

180. To seek India's cooperation in this field will be pushing at an open door, for the Indian delegate told the UN General Assembly in December 1981:

"We attach great importance to international cooperation in solving problems relating to disability. In particular, I should mention the need for a greater flow of technology, technological information and know-how. Such a flow of information would be of particular help to developing countries and enable us to provide to the disabled the benefits of technology in the form of artificial limbs, aids, and so on".

181. The Central and State Governments of India are fully behind the massive campaign against unnecessary blindness, inaugurated 12 years ago by the Royal Commonwealth Society for the

Blind and actively supported by Lions Clubs, Rotary Clubs and other private organisations. In 1981 alone, 138,898 sight-restorative operations and a much larger number of treatments were carried out in these eye camps. This is made possible by the hospitality and personal service of village people and the dedicated, round-the-clock work of the Indian medical teams. After several years of practical study of the problem, the Royal Commonwealth Society for the Blind and its Indian associates inaugurated in 1981 a campaign against blinding malnutrition (xerophthalmia and keratomalacia), which irrevocably blinds some 250,000 children a year, merely because of a lack of vitamin A in their diet (a cup of green leafy vegetables a day would do the trick).

182. Government-administered centres for teachers of the blind at Delhi, Bombay, Calcutta and Madras are giving special training for 50 teachers a year and the States are encouraged to use them in "open" (integrated) education. Polio vaccinations have also been stepped up from 2.4 million children in 1981 to 3 million in 1982. The organisation of this work is facilitated by a system of 600 blocks of the "Integrated Child Development Service" for the pre-school child. Assistance has also been made available to leprosy programmes: the number of leprosy patients is estimated at 4 million of whom 25 per cent are disabled and 20 per cent still infectious. Endemic goitre, on the other hand, which affects 40 million people and is a major cause of mental and physical retardation, is so far evading control by the distribution of iodized salt.

183. My visit to India ended with a Colloquium at the International Centre in Delhi, attended by a representative group concerned with the welfare of the handicapped. What impressed me was the balance between rehabilitation, prevention and the vocational training needed by disabled people to find employment and self-reliance in the community. The field-testing of WHO's manual "Training the disabled in the community" has begun and will require training for multi-purpose rehabilitation workers in the 125 medical colleges and at primary health care level. Surveys are revealing a much higher residual paralytic polio problem in country areas than had been expected and this provides a stimulus both to polio immunisation and to the rural provision of rehabilitative services. There was agreement in the Colloquium that both mental illness and mental retardation were the main neglected areas. The first combined Asian and Commonwealth Congress for the Scientific Study of Mental Deficiency, held in Bangalore in May 1981, raises hopes that a Commonwealth association of people professionally concerned with this subject may come into being, perhaps during the sixth congress of the world body in Canada in August 1982.

Jamaica

184. Started after the severe 1954 polio epidemic, the Mona Rehabilitation Centre adjoining the University of the West Indies on the outskirts of Kingston, Jamaica, has developed from the provision of physical therapy and appliances for polio victims to all-purpose rehabilitation with the motto: "Employment is nature's best medicine and essential to human happiness". The large sums raised in 1954 to help 1000 children and 150 adults crippled by polio formed the basis of the Polio Foundation Trust which has been added to ever since by fund raising and by profitable enterprises such as the Monex Workshops and housing schemes.

185. The complex includes hospital wards, the University Hospital School of Physical Therapy, a wing for children with limited mobility, an appliance and prosthetic workshop, the Monex Workshops engaging commercially in woodwork, jewellery and printing (now become the University printing press) and an extensive housing project for severely handicapped people who work in the complex or outside in open employment. Near the front gate of the Rehabilitation Centre is a short road with ten identical houses on each side. This is the Cheshire Village, occupied by a mix of disabled and able-bodied people to make a community. Able-bodied people with outside jobs pay an economic rent; the most severely disabled have their rents subsidised. The tenants include physiotherapy students at the hospital, university undergraduates, a policeman and his family, the housemother of the Mentally Handicapped School, the muscular-dystrophy patient, an arrested leprosy patient and several semi- or paraplegics of various ages.

186. A school was started for the education of the polio victims and other severely disabled children (especially cerebral palsy) in 1954. It was soon realised that segregated education emphasised the disability; so instead of sending the children out to "open" education, a large primary school (750 pupils) was built within the Mona complex. Mentally retarded children were

included, and the retardation was often found to be more apparent than real: it was the early stimulation that had been missing. The large school was built in 1974 - the Polio Foundation Trust and the Government each paid half the cost. Physically and mentally handicapped are admitted as of right and ten per cent of the places are kept for children of parents who work at the University. The Ministry of Education allows a special teacher/pupil ratio so that the needs of the handicapped can be looked after, because the purpose is to integrate the handicapped into the normal primary education system as an experiment. Parent-teacher association relationship is stressed - the PTA has provided full kitchen equipment so that all children have a daily meal at nominal cost. The Friends of Hope Valley Experimental School concern themselves with the welfare of those children who lack adequate family support. There is a Special Education Block (1979) for physically handicapped children who missed starting school at the proper age so that they can catch up: they have a very high teacher/pupil ratio.

187. Newly added to the complex is a ten-acre farm inhabited by hens (3,000), rabbits, heifers and goats - all their droppings duly swept into the biogas unit. The whole operation is designed so that egg collection and marketing and animal husbandry can be carried out by even severely disabled people. Prime stock is used and can be sold to farmers for breeding purposes - the rabbits are sold as pets or for breeding, or end up in the meat patties sold by Monex Ltd as one of their cottage industries.

188. The Jamaica Paraplegic Association has its sports club at Mona and has sent teams all over the world, promoting the cause of sport for disabled people by the success of its athletes. It is doubtful whether any small country has come anywhere near Jamaica in the number of gold medals and world records it has accumulated. A Combined Disabilities Association has been formed by, for and of disabled people, with headquarters at Mona, as an advocacy group for all matters concerning the development and welfare of disabled persons in the society, including access, mobility and employment.

189. The activities of the IYDP committee in Jamaica included the organisation of a Telethon in December. This raised nearly a million dollars, which will be devoted mainly to a works centre for disabled people when a suitable site can be found in Kingston.

190. Jamaica has a Council for the Handicapped and the outgoing IYDP committee has proposed, as one of its principal recommendations, that its work should be strengthened by the appointment of a Director of Rehabilitation, on a par with the Directors of Public Assistance and National Insurance.

Kenya

191. Kenya was distinctive in that 1980 was declared a National Year of Disabled Persons, preceding the International Year in 1981. A National Rehabilitation Committee has been in existence since 1968, consisting of seven ministries, the National Council of Social Service, several of its constituent voluntary organisations, the Federation of Kenya Employers and the Central Organisation of Trade Unions. This committee was entrusted with the organisation of both the 1980 National Year of Disabled Persons and the IYDP in 1981.

192. Kenya is important in the African scene because of the quality of the work of its government and its voluntary agencies. The orthopaedic workshop at Kabete employs 23 artisans, most of whom are disabled, producing crutches, calipers, tricycles and special footwear at very low cost. It was the venue in 1976 for an African regional training course for prosthetic and orthotic technicians arranged by the World Rehabilitation Fund, jointly with WHO and the Government of Kenya, and might be so used again to help in meeting the great need for training in this work in many countries.

193. Reporting to the General Assembly of the United Nations in December 1981, the Kenya delegate said that research projects on the numbers of disabled persons and the categories of their disabilities had been put in hand by the Ministries of Economic Planning and of Culture and Social Service, in collaboration with the Institute for Development Studies of the University of Nairobi.

Malawi

194. Without apologies for the enthusiastic style, I feel that it will be useful if I reproduce in the following paragraphs an extract from the journal of my visit to Malawi from 20 to 25 October 1981. I do this because it describes in action so many of the activities proposed by IYDP committees in smaller countries for consideration by their governments and shows that they can be successfully accomplished.

195. The Ministries of Health, Education and Social Welfare all back the work of the Council for the Handicapped, established by Act of Parliament in 1974. The service clubs and other voluntary organisations also work together with it. So the people carrying out rehabilitation work day-to-day get recognition and support from both government departments and voluntary bodies. Second, the national policy covers every IYDP aspect, not with pious hopes but with consolidation and expansion of work already in progress, plus public relations campaigns to encourage the villagers to care for their disabled and to seek help from the appropriate medical or educational resource when necessary.

196. Recognising that the major cause of disability lies in the lack of maternal and early childhood care, exacerbated by childhood diseases and malnutrition, the Ministry of Health and voluntary agencies together extend maternal and child health clinics, increase the programmes of immunisation and devise more effective methods of early detection of treatable conditions. There is a great consciousness of prevention. The Council for the Handicapped ensures primary education of as many blind and deaf children as possible, working closely with the Ministry of Education, particularly to enable them to attend primary schools close to their homes and go on to secondary education if they show themselves capable of it. Since Malawi does not have universal free primary education, it is impressive that resource centres are set up so that the blind can benefit from primary and secondary education. Loving care is bestowed on deaf children to train them to speak and learn, and all school fees are waived for disabled children.

197. Montfort is a splendid complex of the School for the Deaf (mostly Commonwealth Foundation money), the School for the Blind (set up by the Royal Commonwealth Society for the Blind), and a teacher training college where special training is given in the teaching of the blind and deaf. It has for some time been used for training staff from Botswana, Lesotho and Swaziland, and recently from Tanzania; while in September 1981 it was the scene of an all-Africa seminar on teaching and rehabilitation of the disabled.

198. The employment field is particularly impressive. An RCSB initiative in setting up a weaving factory has blossomed with support from Christoffel Blinden Mission. It was opened by the President in 1976. In addition to some 33 blind men, it employs 13 deaf men and women and a number of severely disabled people who produce high quality carpets, wall hangings, place-mats, etc., of colourful design. But it is not a sheltered workshop. It works on commercial lines and some able-bodied are employed. Even more impressive, in a way, is the tie-dye centre in a disused operating theatre of the old hospital in Lilongwe. Very disabled people do the intricate work of binding the sheets of cotton into the curious shapes (they look like odd kinds of children's toys); others prepare the dyes at the right temperature. What emerges is a range of dresses, shirts, skirts, etc., of the most beautiful and colourful designs - all different. No wonder they sell well. (At a meeting in the Social Welfare Department, when I asked my usual concluding question "Is there anything that I can do for you?" they all agreed: "A new and larger building for the tie and dye". If somebody wanted to make a present to the disabled in Malawi, that would be it).

199. Rather different is the home economics centre for disabled girls in a relatively deserted spot at Magomere off the Blantyre-Lilongwe road in a reconditioned condemned building of a former school. The 14 girls were knitting and sewing - and sang unforgettably for my benefit. The nine-month course covers not only homecraft but also the production of knitted or crocheted items that find a ready use or sale back home. The girls (they all looked between 20 and 30 to me) have outings of interest in Malawi during the course and are given basic equipment to take home to help them towards being self-supporting. All are deaf, blind and deformed from spina bifida, polio or cerebral palsy. Despite cramped conditions and a rather remote location, a happy place. Just down the hill trees are being felled and land prepared for a larger building.

200. The Lions have built a prosthetics workshop south of Blantyre producing simple calipers with felt instead of plastic binders, and simple wooden shoes. Some were pathetically tiny (for small children), then all sizes up to full adult male. Most but not all of the workers are disabled. The Lions still run it in conjunction with the Council for the Handicapped.

201. Country-wide (and of course the figures are fuller for the South and Central Regions than for the much more inaccessible North), registered handicapped persons by the nature of their disability number as follows:

Orthopaedic (of 70 per cent polio)	1,763
Blind	707
Amputees	194
Leprosy	64
Mental	34
Deaf	120
Unclassified	213

3,095

This shows the overwhelming importance of polio and the high rate of blindness. Regarding mental retardation, here as in so many other countries: "It would be cruel and pointless to remove the severely mentally handicapped child from his home and community care". Nevertheless, schools do make an effort with late starters and slow learners.

202. Co-operating with the Health Ministry, LEPRO is not only delivering medication to leprosy patients but carrying out in the Northern Region an important study to indicate the types of persons susceptible to leprosy, so that they can be the first to receive treatment.

203. A 1979 survey showed that approximately 25,000 people were affected by polio, including some 17,000 under 15 years of age. The incidence of new cases was approximately 2,000 a year. The Ministry of Health, with the co-operation of the Save the Children Fund's STOP POLIO campaign, is carrying out mass immunisation and the incidence in the Southern Region has already dropped from 2,000 to 20. Malawi against Polio (MAP), with advice from Professor Huckstep and financial support from Rotary International and OXFAM, has been organised to bring medical assistance and a greatly increased supply of locally-made calipers, crutches and other physical aids to as many as possible of the 25,000 polio victims. Their social rehabilitation will be the responsibility of the Council for the Handicapped, whose weaving factory and tie and dye centre I have already described. These employ very handicapped people without institutionalising them. Their rural centre at Magomere will grow in its new buildings as a place where disabled women and girls earn homecraft and make little things (knitted and crochet) which they can sell to augment the family income. Far from being institutionalised, they are in regular touch with their families and in due course they return home and are replaced by others. The Council has successfully placed 45 men and 21 women, severely disabled, in jobs in 23 industrial and commercial concerns.

204. But most impressive of all are the Land Settlement Schemes, and the fact that so many blind farmers are settled among them, successfully cultivating 12-15 acres each and making a great success of it. The new good road from Salima to Zomba runs for 100 miles and more through well-cultivated lands, all tilled and prepared ready for the annual rains which start early in November. Some of the areas are planned settlements and among them are groups of blind farmers, each with a house, most of the houses provided by the Royal Commonwealth Society for the Blind. All were in immaculate condition. Many houses are steadily being added to, African style, with swept and garnished compounds. Some blind farmers have acquired bullocks - one had four - some are able to hire and pay for casual labour to assist them. Some acquire acres to add to their 12 to make them 15 or 20 or more. With no warning of our arrival, all were at home in their farmsteads. All grow maize, cotton and groundnuts; some tobacco, some cassava, some vegetables (cabbage etc.) for domestic consumption. Hens everywhere; but the eggs were for the family, I was told, not for the market.

205. Then to Macoha Training and Evaluation Estate (MACOHA = Malawi Council for the Handicapped). As the Ministry of Education has had open education for blind children (i.e.

they attend normal primary schools with resource centres and at least one teacher trained at Montfort), what was to happen to the growing numbers of blind children leaving school literate and numerate, but unable to find jobs? Industrial opportunities have been described above but Malawi is an agricultural country and the children come from rural areas and rural schools and farming families. They are mercifully not institutionalised, so what can they do on leaving school except return home and depend on the charity of the community, losing their literacy and numeracy? Now all take home Jubilee braille kits, which is a start, but as many as possible go to Mitongwe, the training and evaluation estate run by the Malawi Council for the Handicapped.

206. When I arrived, the eight unmarried blind trainees, the two married trainees and the two blind tenants had finished their course and gone. The fresh intake would be arriving in a few days. As in the West Indies, each house is three, one behind the other: residence, cookhouse and latrine in descending order of size. All were immaculately clean, as was the superintendent's office. The tobacco grading shed was in a dangerous state, but the Council's men were industriously building a new and larger one on a nearby site. The whole complex - tobacco drying sheds, plant nursery (protected by a splendid fence to keep out the goats), the little group of houses - is intended to create a realistic village atmosphere and provide no frills the trainees would miss later (but I did see a fine tractor and was told they had two). Capital support was provided by the Dutch Government plus Christoffel Blinden Mission, Oxfam and what the Council could raise itself in Malawi. Cultivation is of maize, tobacco and ground-nuts; some cassava. Local labour mingles well with the blind and the result is a resounding success. Nobody stays on after the course is finished. For this is vocational training for school leavers to enable them to earn their living on the land as soon as they marry. (Their families see to that.) Then they set up as tenant farmers on their own.

207. The next bit of vocational training for the handicapped will be tailoring. A building is being acquired at Luchenza and work will start before the end of the year. At present 120 are employed at weaving, 26 at the tie-and-dye, 58 on the land and 67 in open industry in competition with the able-bodied. Vocational training leads to employment.

Mauritius

208. Mauritius already had a National Council for the Rehabilitation of the Disabled, set up in 1977, which had designed a survey of prevalence and needs of disabled children, sampling 20,000 families (about 100,000 people). Its IYDP committee, with very much the same membership (all relevant government departments, including Economic Planning, plus major voluntary societies), expanded the work of the National Council by organising a series of special events, including sports and leisure activities for the disabled. It usefully broadened the usual concept of "access" to include access to education, transport, accommodation and employment, as well as community facilities and health services. It placed great emphasis on prevention, arguing that as government could not make funds available for costly projects, and as preventive measures are less costly than measures to alleviate disablement, the public should adopt preventive measures in the home, at work and on the roads.

209. An unusual feature was that, in addition to appointing its own sub-committees, it monitored the work of other ministries relevant to IYDP and had a finance coordination sub-committee to prepare cost estimates and to tap all available sources for funds. Whereas many other national committees referred in general terms to legislation, Mauritius IYDP usefully listed all legislation relating to disabled persons, covering invalidity pensions, public assistance relief, allowances for severely handicapped children, support for the Societies for the Welfare of the Deaf and of the Blind, etc. The Ministry of Health has a firm policy of employing physically handicapped people and sets an example of employing them in the national hospital, and in the orthopaedic and carpentry workshops. Finally, immunisation, maternity services and child health and school health services are all recognised as essential parts of the attack on disabilities.

210. Under CFTC arrangements, the Chief Physiotherapist of Mauritius has been lent to Seychelles to help them start up their new rehabilitation centre.

New Zealand

211. New Zealand anticipated IYDP by passing the Disabled Persons Community Welfare Act in 1975. This empowered the Government to develop services for disabled people. Nearly all its intentions have now been implemented, including grants for home alterations, allowances for persons caring for handicapped children living at home, provision of aids such as walking frames, and the payment of expenses for travel connected with treatment. More than 100 voluntary organisations provide services and facilities for disabled people. Those offering training, sheltered employment, or day care facilities can receive a 75 per cent salary subsidy for supervisory staff and an 80 per cent capital subsidy for buildings. In accordance with the policy that, wherever possible, care should be provided in the community rather than in institutions, the capital subsidy programme is giving way to salary subsidies for field workers engaged in work with disabled people living in the community. A capitation grant is payable to help with the running costs of residential accommodation for intellectually handicapped children. The Accident Compensation Commission not only pays financial compensation but assists with aids for daily living.

212. IYDP activities were structured to focus attention for two-month periods each on recreation and sport; access; accommodation and mobility; education and welfare; legislation and income; employment; prevention and rehabilitation. In the period when recreation was being highlighted, a marathon relay was organised involving all regions of the country and culminating in the presentation of a submission to Parliament by the participants. But the public success of the Year was a 24-hour-long Telethon appeal for the disabled which raised over \$6.25 million, against which there were bids for \$41 million. The money has to be disbursed within two years, and there are hopes that some of it will benefit disabled people overseas, especially in Commonwealth countries in the Pacific region, where much of New Zealand's technical and financial assistance has traditionally been concentrated.

213. The benefits of support through the years from the New Zealand Leprosy Trust Board and the New Zealand Society for the Intellectually Handicapped (IHC) are acknowledged in many Western Pacific islands. In preference to many organisations seeking to help separate groups of disability, the emphasis is now on the provision of services and facilities for all disabled children and adults to share resources, avoiding the duplication of services and the overlapping of fund-raising efforts. The principal beneficiaries so far are a centre in Nuku'alofa, Tonga, offering education and training to over 100 handicapped children and young adults; IHC's Centre in Western Samoa for intellectually handicapped and deaf children, shortly to have a new building for all handicaps; and a six-classroom school for 110 intellectually handicapped children in Suva, Fiji. The disabled in these and other Pacific islands have also long been helped by visits of medical specialists from New Zealand, which have now been extended to Vanuatu, Tuvalu and Kiribati at the request of the Governments of these island countries.

Papua New Guinea

214. A National Board for the Disabled, set up in Papua New Guinea in 1978, organised and supervised IYDP activities through a steering committee which included representatives of voluntary societies, service clubs and the media. The secretariat was provided by the Department of Community and Family Services. There was evident anxiety not to undermine traditional family structures by encouraging people with disabilities to leave home, and doubts were expressed about the "branding" terms "handicapped" and "disabled". The National Board had already inaugurated a local survey of disabled people in order to gain a better understanding of the scope of their work, but Papua New Guinea has many large, almost inaccessible areas and the steering committee was conscious of its lack of statistical information.

215. The committee listed the 12 centres in the country for work for disabled adults or children as the only government or voluntary society rehabilitation agencies in the country. Many of these I visited. Three stick in the mind. First, the complex of orthopaedic ward and workshop making wheelchairs, sandals for leprosy patients and other physical aids, 17 cottage homes, a sheltered workshop and school for handicapped children, at Lae, on the north shore. Second, the Cheshire Home for disabled children in Port Moresby. Third, a complex of orthopaedic ward, rehabilitation centre and commercially-run sheltered workshop at the general

hospital in Port Moresby, about to move into a new building recently completed by the Salvation Army vocational workshop. Until I visited the orthopaedic wards at Lae and Port Moresby, I had not appreciated the dangers of severe spinal injuries from "encounter games" (the local rugby football I suspect) and being "kicked by cassowaries".

216. In view of the duration of stay of some of the injured in hospital (over ten years in several cases), I was glad to find a rehabilitation association in process of formation to organise interim accommodation for physical, psychological and vocational rehabilitation, to be associated with Port Moresby General Hospital. While this report was being written, the President of World Orthopaedic Concern, Mr. J.W. Wilson, was paying a month's visit to Papua New Guinea under the auspices of the British Council.

217. The rapid localisation of voluntary services accentuates the need for trained Papua New Guinean staff to take over work done by expatriates. To arrange for too much of this training to take place out of the country (e.g. in Fiji or Australia) at this stage would aggravate the scarcity of staff still further. The great need, therefore, is for professional and volunteer staff to go to Papua New Guinea to train a range of local recruits for both rehabilitation and education work. Some of the conscious need for encouragement and guidance in these fields may be made when Rehabilitation International holds its regional conference in Papua New Guinea in September 1982. For the welfare and education of the blind, representatives of Christoffel Blinden Mission and the Royal Commonwealth Society for the Blind visited the country just before me and will no doubt propose a national policy for Papua New Guinea in association with them and with Helen Keller International.

St Vincent and the Grenadines

218. In temporary and very limited accommodation at the Red Cross headquarters in Kingstown, 24 deaf and hearing-impaired children, 24 mentally handicapped, 4 physically disabled and 3 slow learners form the School for Children with Special Needs run by the Association for the Handicapped. Government pays the three trained teachers, whose work is supplemented by US Peace Corps Volunteers, a Crossroader from Canada and local voluntary assistants, including parents of handicapped children. As it is non-residential and no vehicle is available to fetch children from afar, the school can serve the immediate Kingstown area only.

219. The IYDP committee has as its major project the rehousing of the school in more appropriate premises with residential accommodation so that children from the Grenadines and other parts of St. Vincent can attend; and also with a garden so that horticulture can be included in the curriculum. Application is being made through Britain's National Children's Homes to the European Community in Brussels for a building and equipment grant. At the same time, the committee is stressing the need to educate parents in the care of disabled children and in the prevention of disablement. A seminar was therefore held on early identification, prevention and rehabilitation with the theme "Disability is not inability".

220. The blind, as usual, "have their own arrangements", including a sheltered workshop rebuilt by the Lions Club. As a second priority after the re-siting of the School for Children with Special Needs, the IYDP committee see the need for a similar workshop for the rehabilitation and employment of other disabled adults.

Seychelles

221. The Seychelles IYDP committee reported that they had completed a 100 per cent survey of disabled people, compiled a disability register and called in all disabled people for screening at local clinics. The register listed 2,908 people (4.5 per cent of the population) of whom 20 per cent had disorders of slight, hearing and/or speech, 19 per cent had mental disorders, 16 per cent diseases of the nervous system, 12 per cent diseases of the respiratory tract, 11.3 per cent congenital abnormalities, 11.3 per cent disorders of the musculo-skeletal system and connective tissues and 7 per cent cardio-vascular disorders. Figures are also available for those of school age (6-18). Screening was immediately followed by an assessment of the medical, educational, social and employment rehabilitation needs of each individual. This whole operation was made possible by a joint Health/Labour & Social Security/Education/Information inter-ministerial approach and the co-operation of voluntary agencies including a newly-formed National Council for Handicapped Children.

222. For a new rehabilitation centre due to open in June 1982, Mauritius is lending its Chief Physiotherapist under CFTC arrangements to complete the final planning and start things off. The equipment is coming from France and the staff from Cuba.

223. The IYDP committee has completed its work and handed over to a permanent National Council for the Disabled with much the same multi-disciplinary membership.

Singapore

224. Singapore's IYDP literature was particularly impressive. A 100-page "Rights Issue" reproduced documents leading up to the special Year, analyses of the extent of disability, and Rehabilitation International's "Charter for the 80s" as well as a number of articles about Singapore itself. "Access Singapore" is a guidebook of accessible places for the physically disabled from arrival at Changi airport through hotels, shopping centres, government offices, libraries, theatres, sports facilities etc; it was published by the Council of Social Service with assistance from the Tourist Promotion Board, Handicaps Welfare Association, Society for Aid to the Paralysed, and the YMCA for the photographs. The Social Welfare Department produced a coloured pictorial booklet on "Work and the disabled person" with themes such as "An equal chance is all they ask", "Different disabilities but capable workers" and "Work - the road towards self-reliance", intended to "explode the myth that disabled persons are useless and cannot lead a meaningful and productive life". Pamphlets included "What do you do after the first Hello?" - "Befriend at least one disabled person this year". Over 10,000 taxi drivers received a pamphlet on how to help disabled passengers, several of them expressing surprise that it was so easy to fold a wheelchair and put it in the boot. These and many other publicity activities carried out the terms of reference of the IYDP committee which were to "formulate plans of action in disability rehabilitation and carry them through ...; reiterating that the disabled person is an integral part of the community with an equal right to health, education, housing and employment with his able-bodied counterpart".

225. Singapore had a chance to test its attitude to disabled people at the end of November, when it was host to the First Congress of Disabled Peoples International, attended by over 400 delegates from 53 countries, most of them disabled, some very severely. The implications of this congress are dealt with elsewhere in the report. Its motto "Vox nostra" might be interpreted: "We want to make our voices heard, please".

226. This emphasis on publicity and the welfare aspects is not meant to suggest that prevention, rehabilitation or schooling are neglected. The reverse is true. It is just because the medical services and the educational provision, by government and by voluntary associations, are so good that the main IYDP effort could concentrate on public awareness and co-operation. While requests for outside help for the blind (instructor for computer training), for the deaf (sophisticated hearing aids), for the mentally sick (contacts with mental health associations), for the slow learners (contacts with the Intellectually Handicapped Society in New Zealand), and for the training of teachers of all categories of handicapped children were made to me, Singapore readily agreed in return that they would listen to requests from less developed

countries for training and experience in the administration of social services and for supplies of a wide range of aids required in less developed countries.

227. Abilympics-Singapore organised a skills competition along the lines of the International Abilympics, the aim being to promote public awareness and recognition of disabled persons' abilities and to promote employment of the disabled. Among the main areas of competition were watch and clock repairing, dress-making, tailoring, cabinet-making, radio and television repairing and typing for the visually handicapped.

Solomon Islands

228. The IYDP committee in the Solomon Islands had as its main proposal for consideration by government the creation of a new national centre for the disabled on a site apparently already set aside for it near Honiara. The discussions I had with the chairman and secretary of the committee are perhaps best recorded in extracts from a letter I left with them on 4 february 1982:

"Rehabilitation centre is a better term than centre for the disabled because it emphasises the objective of restoring disabled people to as normal a life as possible. An essential point is that the new centre must evolve from existing work among the disabled, with the greatest possible continuity. This means that the council should interest itself in the work now being done for disabled adults at the hospital and in the Red Cross day centre for handicapped children, maintaining and strengthening their work until they can come together in a rehabilitation centre. Both have already trained staff (Solomon Islanders) who have been trained in Fiji and elsewhere, and have valuable experience on the job. The help of volunteers, especially with the children, will need to be continued and encouraged because of the lack of full-time staff. Apparatus and equipment essential for the new centre - the expensive equipment at the hospital work-shop and the speech trainers, hearing aids, etc, at the day centre - are already there and should be maintained, used and renewed without any break, for the sake of adults and children already being helped.

Work for the disabled in the Solomon Islands is at present supported by the Telethon Trust, the New Zealand Leprosy Trust Board, the Society for the Intellectually Handicapped of New Zealand, Rotary International, the British Red Cross and many other external voluntary societies. It is important to maintain their goodwill and support throughout, so that existing work does not suffer. Blind people, especially children, could be assisted by the Royal Commonwealth Society for the Blind, Heath Road, Haywards Heath, West Sussex, RH10 3AZ, England, and I suggest that you apply to them. It is doubtful whether any external sources will pay for bricks and mortar, so your own fund-raising efforts should aim to supply the building while you develop all possible internal and external sources of help with equipment, salaries, etc., especially local service clubs and the larger trading firms".

Sri Lanka

229. The IYDP committee, under the chairmanship of the Secretary to the Ministry of Social Services, published a national plan of action under seven heads, with an implementation programme and a list of implementing agencies under each. The awareness aspects received support from the media, service clubs and general public, stimulated by sports events for the disabled and the winning of 13 gold medals by the ten-member national team sent to the Abilympics in Japan in October. The integration aspects included the setting-up of additional special units in schools so that more disabled children could go to normal schools while living at home with their parents and the placing of disabled people in open employment. The prevention aspect - immunisation against disabling diseases and public education on disability prevention methods - figured prominently in the programme; and disability detection activities in rural areas were followed up by medical and social rehabilitation measures.

230. A survey of mentally retarded persons carried out under the IYDP committee complemented the 1981 census figures for people with other disabilities. The combined result

records 87,836 disabled people (0.60 per cent of the population) of whom 9,331 were recorded as totally blind, 9,341 as deaf and dumb, 30,027 mentally retarded and 39,137 orthopaedically disabled. (The very low percentage is no doubt due to the exclusion of the partially blind and partially deaf, together with the difficulty of conducting a disability survey by ordinary census enumeration methods).

231. The IYDP committee commissioned a directory of services and facilities available for disabled people in the country and a Sinhala translation of WHO's manual on "Training the disabled in the community". Preliminary field-testing of the manual was undertaken by the Sri Lanka School of Social Work.

232. The International Secretariat in Vienna has made a grant of US\$25,000 for the maintenance of an IYDP Secretariat in Sri Lanka, so that its work can continue into 1982.

233. A request for help in setting up small-scale appliance manufacturing centres, including visits to neighbouring countries to see them in operation, has been referred to AHRTAG, the appropriate health technology group in London, and will be pursued with World Orthopaedic Concern.

Swaziland

234. Information received from Swaziland was brief but to the point. A National Society for the Handicapped, an umbrella organisation for all activities for the disabled, had already been in existence for eleven years and had been largely responsible for the establishment of new services, many of them initiated by church organisations. There was a new impetus with the information at the end of 1980 of a national committee for the IYDP. Among its specific achievements have been the registration of 10,000 disabled persons in four disability groups; the setting-up of a vocational rehabilitation centre in collaboration with ILO and UNDP; assistance to individuals by providing prosthetic and orthotic aids; participation by two paraplegic representatives in the Abilympics in Japan; and the inauguration of a week-end market to sell items made by disabled people.

235. Emphasis on the provision of institutions is gradually moving towards family care with the introduction of rural health visitors, community development workers and primary health care, except perhaps for the mentally impaired. The extended programme of immunisation is covering most of the country, using mobile units where there are no clinics; but transport is a problem in some rural areas. Special needs are in training for teachers of the blind and deaf, the finding of less costly prosthetic and orthotic aids, and assistance for trainees from the vocational rehabilitation schools, in the form of housing for those who find open employment and protected workshops for those who need them.

Tanzania

236. At a rally attended by the President and Vice-President on 31 August 1981, the Minister responsible for IYDP, Mr Alfred Tandau (Labour and Social Welfare), estimated 572,000 disabled in Tanzania (3.25 per cent of the population) - 78,000 blind, 51,000 deaf, 136,000 orthopaedically disabled, 170,000 with leprosy and 136,000 severely mentally retarded. The voluntary societies for the blind and the deaf, which have existed for some time, are maintaining their work but are now being complemented by leagues of the blind, of the physically handicapped and of albinos; much of the money raised (target 12 million shillings) by the IYDP committee is intended for these new associations of disabled people to enable them to establish their secretariats, organise joint conferences of all handicapped people and provide the means (money, tools, materials, a hostel) whereby they can make their members more self-reliant.

237. Meanwhile, the far-reaching health services of the Government are achieving a high percentage of immunisation, regularly monitored by a Ministry of Health /DANIDA/WHO/UNICEF team. A report on leprosy in Tanzania by Jean Watson of the Leprosy Mission makes expert recommendations regarding both prevention and rehabilitation. Workshops for the employment of disabled people, the Yombo rehabilitation institute and the Masasi institute for the blind are being extended and improved.

238. A Swahili version of "Donde no hay doctor" ("Where there is no doctor" - David Werner's handbook for village health workers), with appropriate new local illustrations, was produced for use in Tanzania under Rotary auspices and a second, larger, order has had to be placed so that it can circulate widely in neighbouring countries as well. A Swahili version of WHO's manual "Training the disabled in the community" is also in hand.

Zambia

239. Inaugurating Zambia's Humanism Week on 18 October 1981, President Kaunda took as his theme "Enabling the disabled". Five hundred thousand disabled but rehabilitable people in Zambia were of employable age. Urbanisation and the breakdown of extended family care accentuated their needs. These were being met in various ways by both government and voluntary agencies; but their work needed to be co-ordinated, and that was what the IYDP committee should do. But it was not for one year only. "What is needed is a comprehensive policy aimed at tackling continuously the problems of disabled persons in our community."

240. Zambia has a Council and a Commissioner for the Handicapped established by Act of Parliament as long ago as 1968. It also has a Ministry of Education policy, declared in 1979, of "positive discrimination" in favour of children with special learning problems due to disabilities. To date, about half the blind, one in six of the deaf, scarcely any of the severely mentally handicapped and an unknown proportion of the orthopaedically handicapped receive formal education. The goal of public health policies is to reduce the impact of the various causes of disablement, but there must be a public concern for the large numbers of children who are handicapped for life. The aim in 1981 therefore was to plan the means for reaching out during 1982 through health and education services to contact as many disabled children as possible in order to ascertain their numbers and their needs and then to develop appropriate services.

241. A feasibility study for this campaign has already been conducted by Zambia's Educational Research Bureau with UNICEF support. Four screening instruments were field-tested for use by staff with limited training to ascertain children with visual and auditory impairments and children with severe physical and mental handicaps. Meanwhile, materials are being prepared for translation into seven Zambian languages which will focus on:

- how to identify a child with a handicap
- what can be done by the family and community
- what back-up services and resources are available.

242. Three Ministries (Health, Education and Culture, Labour and Social Services) are working together on the 1982 implementation programme with the co-operation of the University of Zambia and UNICEF. The objective is not just to count disabilities by categories but to supply prosthetic aids (spectacles, hearing aids, braces, crutches etc.) to those who need them. Increased production of orthopaedic aids is a major IYDP objective.

243. The adult disabled were encouraged to organise themselves for recreation purposes, for participation in the political life of the country and for technical and vocational training according to their needs. Parliament would be asked to introduce a quota system for the employment of disabled persons; but as many rehabilitated people as possible would be encouraged to return to their own districts of origin, where farm settlement schemes are run by the Council for the Handicapped.

THE MAIN CONCLUSIONS

244. The four major conclusions of this survey are now beginning to emerge. The first is that much of the paraphernalia of the relatively new science and practice of rehabilitation to be seen in industrialised countries is a long way out of the reach of smaller and more remote Commonwealth countries. Somehow, a means must be found to adapt these modern sophisticated technologies to the needs of disabled children and adults in the less developed countries - and not just in their urban areas.

245. The second is that brave efforts which are being made in the smaller countries to meet their educational needs are still largely in the hands of voluntary organisations. However well-disposed governments may be, they are very hard-pressed to maintain existing services of all kinds and have not the money to create new posts, let alone institutions, specifically for disabled people. Therefore, since IYDP has greatly increased the challenge to non-governmental organisations to redouble their efforts, they must be helped to find and support both paid and volunteer staff.

246. As there are limits to what amateurs or semi-trained staffs can do in many of these specialised fields, the third conclusion - and the strongest of all - relates to training. When this was discussed at length in various countries, it was pointed out that in one sense there was already too much training: some of the few nearly-indispensable people had the disconcerting habit of "going on courses", sometimes in faraway countries where economic and social conditions were so different as to be doubtfully relevant. When their quest was for a higher professional qualification recognised in the industrialised countries there was always a risk that the "indispensable" one might not return home but stay and practise where the emoluments were higher and the apparatus more sophisticated. Training must be more and more "on the spot". This means visits by professionals, sub-professionals and volunteers to the neediest countries to work alongside local people for a time. Of course, this is being done already, by VSO, by CUSO, by VSA, by World Orthopaedic Concern and by so many other organisations that it is invidious even to select those four for specific mention. But the need for training and the sharing of experience is paramount.

247. IYDP may have served a useful purpose if it directs the attention of voluntary organisations and governments with aid programmes to the specific needs of the large numbers of disabled people at present almost completely out of reach of the various forms of rehabilitation and educational techniques. They will say that they can only respond to requests. Many have learned the art of ventriloquising requests that they are able and willing to meet; but a major benefit of IYDP could be that the supply of outside assistance, which is desperately needed, could be conducted much more effectively and produce more beneficial results if it were based on a national policy for the disabled. My first recommendation, therefore, relates to the means of formulating such a national policy.

National councils for the handicapped

248. Only individual governments can decide what is appropriate and practicable in the circumstances of their own countries to sustain the momentum of interest and co-ordinated response to the needs of disabled people created by the activities of IYDP. I have read a vast amount of material about the work of IYDP committees and sat in discussion with some twenty of them. Their immediate 1981 objective may have been reached in many cases. The public may have become much more aware of handicapped people in their community, while disabled people themselves may have been encouraged to think that their voices will be heard with greater understanding in future. But the work does not end there. In the words of President Kaunda: "What is needed is a comprehensive policy aimed at tackling continuously the problems of disabled people in our community".

249. Here IYDP committees will have failed if they have not produced a co-ordinated programme of action and persuaded governments to adopt it; and I judge that most of them have not. One year is too short a time to alter government policies, especially when they are astride many departmental interests and many departmental votes. Where there were pre-existing councils for the handicapped, these have been strengthened for their task, with their objectives clarified and with enhanced government and public support. Where such councils do not exist, they need to be created.

250. The ideal is a statutory body with an independent chairman, respected in the community, listened to by government but enjoying the confidence of the major voluntary societies. IYDP experience strongly indicates that the selection of a serving civil servant, however senior, is inappropriate. He has his departmental duties and his departmental loyalties. He is liable for transfer to other duties. Only a very exceptional man could take an objective view of a subject which spreads deep into the concerns of other ministries.

251. The membership of a national council for the handicapped necessarily includes people who can speak for the ministries of health, education, social welfare and labour. Where there is a strong council for social services, its representatives on the council for the handicapped may cover a number of voluntary bodies, but those concerned with the blind, the deaf, the orthopaedically disabled and the intellectually handicapped need specific representation. It is particularly important that organisations of the disabled themselves should participate in the council's work.

252. If such a membership sounds large and unwieldy, it should be borne in mind that this report and this recommendation relate to smaller and less developed countries where the main problem is fragmented effort which needs to be drawn together into a combined government/voluntary agency policy. If the formulation of such a policy is left to government departments alone, it is doubtful whether much priority will be given to the needs of disabled children and adults; these are known much more intimately to the voluntary agencies who are seeking to meet them on a day-to-day basis. If the non-governmental organisations try to agree a national policy on their own (not an easy thing to do anywhere), the government departments concerned are not continuously (to use President Kaunda's word again) reminded of the needs of disabled people as they carry out their tasks and formulate their departmental votes.

253. Some countries are contemplating the appointment of a commissioner for the disabled. He and his department would provide a useful focus, but would still need not only a constant flow of advice from voluntary societies but also perpetual contact with the government ministries who could be expected to provide services for disabled children and adults. He would have to be equipped with something very much like a national council for the handicapped to do his work effectively.

254. Only when there is a national policy for the disabled will each of the small countries be in a position to formulate priority requests for the outside help that is most needed. In country after country, I was told that badly-needed items of technical assistance stood no chance of survival as formulated requests for foreign aid of any kind because, as they went through the necessary procedures, they would be stripped of all priority and finally fall off the bottom of the list. One sympathises with the dilemma of officials and ministers who have to decide such things, when the pressing need is for aid which will have some chance of promoting economic growth. A number of small, unco-ordinated requests for technical assistance that may benefit diverse groups of disabled people may understandably be relegated to the end of the queue. Proposals from a powerful co-ordinating body, able to represent itself as the custodian of a national policy thrashed out between the voluntary bodies that are doing most of the work and the government departments in whose general province the work falls, are much more likely to be heeded.

255. But everything will depend in the last resort on how seriously government - and that means the cabinet - takes the well-being of the disabled as a matter for official action. And, despite successful IYDP activities, it is doubtful whether many governments, with their increasingly severe financial constraints, accord to the disabled - one in ten though they may be - any very great priority. The work begun in 1981 therefore has to be sustained through the years ahead; and the disabled must speak through a national council. To borrow the title of the British report on the work of its IYDP committee, the International Year of Disabled People, 1981, was "a beginning, not an end".

Physical rehabilitation of the orthopaedically disabled

256. The articulateness of the wheelchair people, the use of the "access" symbol in so many public places, the growing success of paraplegic games, but particularly the visibility of orthopaedic handicaps led many members of the public to think - and many IYDP committees to act as though - the International Year concerned them in the main. Residual paralysis from poliomyelitis in many countries, increasing road and industrial accidents in all, the survival of many infants who earlier would have perished from their impairments, and the absence of strong voluntary movements such as those which have sought to help the blind, the deaf and the intellectually handicapped go some way towards explaining and justifying this attitude.

257. There have been great advances in the past few years in orthopaedic surgery, in various forms of therapy and in the production of prosthetic and orthotic aids from which thousands of

people in the wealthier countries have benefited, to become more mobile and to live much fuller lives in their communities. In the industrialised countries, the emphasis of IYDP was on carrying this social and economic integration to its logical completion: hence "full participation and equality" as the international slogan.

258. The task now is to bring as many as possible of these benefits to the millions who are quite untouched by them. It is beginning to happen. I saw it happening in India and in East and Central Africa. No doubt it is occurring in Nigeria and in many other countries as well. How do we accelerate its progress and reach the smaller and more remote Commonwealth communities?

259. Earlier in the report (see paragraph 77) I have commended the 1970-76 initiative which started with an extensive tour by Professor Ronald Huckstep, then of Uganda, followed by two Oriel College conferences organised by the National Fund for Research into Crippling Diseases and supported by the Commonwealth Foundation and the British Overseas Development Administration. The first of those conferences was on orthopaedic training and the second was on the very subject of this report, appropriate technology and delivery of health and welfare services for the disabled in developing countries. (Commonwealth Foundation Occasional Paper number XLI).

260. Now is the time to repeat that sequence. World Orthopaedic Concern are contemplating the appointment of a travelling emissary and also of regionalising their world-wide membership. They should be encouraged to do both. Many of their 400 members already have a great deal of experience of working for a time in the least developed countries. As this is being written, the President has returned for a month's work in Papua New Guinea and the Secretary has left via Madras for Dacca where, through the years, World Orthopaedic Concern has had a good deal to do with building up the National Rehabilitation Institute and Hospital for the Disabled, described in the notes on Bangladesh earlier in this report. Their registered office is in Singapore and their former Secretary is in Jamaica.

261. If an emissary could be chosen in consultation with them, the most needy countries could be selected for visits while preparations were being made for a symposium - or, perhaps better, three regional symposia. The agenda would spread from orthopaedic surgery through all rehabilitation techniques appropriate to the most impoverished countries and into the vital question of training community health aides for working with the disabled in the community. By the time these symposia could be mounted, the results of the initial field-testing of the WHO manual will have become known and the components of training for village-level workers and - perhaps more important - their supervisors will be much clearer than they are now. I recommend strongly that one of these symposia should take place in India, which has so much to offer.

Orthopaedic appliances

262. Although the symposia proposed in the preceding recommendation would produce fruitful ideas about the local production of rehabilitation aids of all kinds, both demand and supply are increasing so rapidly that this subject deserves separate attention. In the report, I have given a few glimpses of the development of local workshops, but accumulating evidence of activity (for example, the support of OXFAM for reviving the work in Uganda) renders any attempt at a comprehensive statement impossible at this stage. Many local booklets are being produced, some deriving from Professor Huckstep's standard 1975 work "Poliomyelitis: a guide for developing countries, including appliances and rehabilitation of the disabled". The evolution of simple aids made from local materials will be accelerated by the field-testing of booklet IV of WHO's manual "Training the disabled in the community".

263. My recommendation is that this subject should feature regularly in discussions at Commonwealth Regional Health Ministers' meetings so that the smaller and more remote countries can be helped to devise their own production of appropriate appliances. CFTC assistance should then be made available to enable successful experience to be shared by visits both ways: visits to neighbouring countries for short periods of inspiration and training and the loan of skilled technicians to train local people - including, whenever possible, people who are themselves disabled.

Education of handicapped children

264. Although, in deference to the consensus of IYDP opinion, priority in these recommendations has so far gone to the orthopaedically handicapped, my own principal concern, after reviewing a mass of material and reflecting on visits to over 20 countries, is with giving handicapped children a better chance in life. Crutches and calipers will help a great many; but what lives in the mind from these and earlier visits to schools in the most impoverished communities is the effort being made by largely untrained or semi-trained underpaid or unpaid staffs of voluntary societies to provide care and some kind of early stimulation and rudimentary education for children severely handicapped by deafness, blindness, cerebral palsy and mental retardation.

265. This scene was penetratingly reviewed by James Eedle in the Commonwealth Secretariat publication of 1972 "Special education in the developing countries of the Commonwealth", now out of print. Its merits have been briefly described in paragraph 126. Commonwealth education officials agreed at their 1979 meeting that, as 1981 was to be the Year of Disabled Persons, special education should appear on the agenda of the Eighth Commonwealth Education Conference in Sri Lanka in 1980. That conference recognised that the special education needs of children and adults who suffer from physical or mental disablement are of deep concern to education authorities in all Commonwealth countries. It noted (paragraph 138 of the conference report) that the Commonwealth Secretariat had carried out a number of surveys in the early 1970s leading to the publication of material on special education and welcomed the possibility of a renewal of Secretariat activity in this field. A study on low-cost equipment for use in special education has been carried out in accordance with a specific recommendation of the conference and a practical, illustrated handbook on easily-made aids for the disabled will shortly be available.

266. IYDP has aroused the expectations of the voluntary societies who still bear the main responsibility for the education of handicapped children in the less developed countries and has challenged governments to decide on a national policy. This suggests that consideration of special education will be more relevant and more important at the Ninth Commonwealth Education Conference in 1983 than it was at the Eighth, which took place before governments had set up their special committees to consider the needs of the disabled and received their recommendations. Education Ministers might well be asked to say in 1983 what conclusions emerge from the International Year and where their main difficulties lie in the field of the education of handicapped children. Such an exercise would both help to sustain the impetus of IYDP and provide a guide to future Commonwealth-wide or regional studies. It would also indicate where CFTC and Commonwealth Foundation support could most beneficially be applied.

267. In smaller and more remote countries, this work is still in the hands of largely untrained staff. Regional activities are attempting to share experience and provide at least some rudimentary training. Under Australian technical co-operation, short periods of practical experience in Fiji are provided for the smaller islands in educational work with both handicapped and normal children, together with follow-up visits to the countries from which the participants come. Similar courses are being attempted with very limited resources by the Eastern Caribbean Unit of the Institute on Mental Retardation and Developmental Difficulties, based on St. Lucia and reaching some of the smallest islands. Generic courses of this kind are needed in addition to the specialist, higher-level, courses for teachers of the blind, the deaf and the mentally retarded, especially if progress is going to be made with the WHO/UNICEF strategy for training the disabled in the community instead of in special institutions.

268. The ideal would be, as I have suggested in paragraph 126 of this report, to up-date through the 1980's the 1972 study of special education in the developing countries of the Commonwealth. This takes each disability in turn, authoritatively examines causes and prevalence, then describes the educational provision in countries which have very limited resources and many other claims on funds available for education. The basic facts about children's disabilities remain very much as they were in 1972 and an edited, summarised text would still be useful. The process of up-dating the statements about special education, perhaps on a regional basis, would be a logical sequence to IYDP activity which provided most countries with a stocktaking of their own educational provision and a better measure of the need.

269. The exercise would be particularly valuable to governments during the period when the trend away from special institutions to integrated education and training within the community

is gaining strength. In the realities of small, remote communities, we still do not know what this means. It must not be allowed to undermine prematurely the indispensable work of voluntary societies and expatriate volunteers who so largely maintain the special institutions and whose waiting lists grow as their fund-raising becomes more and difficult. In the aftermath of IYDP, there is an opportunity to realise a greater co-ordination of effort between governments and voluntary organisations and to define a joint national policy for the education of handicapped children. Discussion at the 1983 Education Conference and subsequent Secretariat activities should make sure the opportunity is not lost.

Deafness

270. Deafness is a major disability, not receiving the attention it deserves. The spread of vaccination against rubella could avert as much as ten or even twenty per cent of the incidence as well as preventing many other serious impairments. This is in hand (see paragraph 109). But the Leeds Castle Declaration also speaks of "inexpensive and simple treatment which could improve the hearing of ten million deaf people". It is tempting to think of mass delivery by adapting and using, for the deaf and hard of hearing, the technique of the eye camp which, under RCSB leadership, has been the means of restoring sight to cover one million people in Commonwealth countries over the last twelve years. This possibility is indeed being investigated. Deafness surgery would be more difficult in rural conditions than cataract surgery; but "eye-ear" camps would at least enable many people to receive treatment to safeguard them against the serious complications which follow common ear infections, especially otitis media.

271. This method has been rewardingly attempted under voluntary auspices in Thailand. The nearest approach in a Commonwealth country is the project recently started in The Gambia under the auspices of the Commonwealth Society for the Deaf, with an audiologist from Australia provided under CFTC arrangements. Much more of this kind of activity is needed. The extended use of booklet II of WHO's draft manual "Training the disabled in the community" during the early 1980s will tell us more about the prevalence and degree of deafness in rural areas. The booklet itself (community-based rehabilitation "for persons who have difficulty with hearing and/or speech") describes in detail how deaf children can be helped to learn to communicate and play a fuller part in community life. I suspect that its use will reveal a prevalence of deafness that will greatly increase the demand for medication and surgery.

272. In view of the manifest impossibility of providing, in the foreseeable future, trained teachers of the deaf for more than a tiny fraction of the deaf and hearing-impaired children over very large areas of the Commonwealth, both primary and secondary prevention of deafness deserve a great deal more attention than they are receiving. While I hope that both CFTC and the Commonwealth Foundation will continue to respond to requests for assistance to increase the training of teachers of the deaf - preferably in their own regions, e.g. in Ghana, Malawi, India, Jamaica or Fiji, rather than in countries where much more sophisticated apparatus and methods would be in use - I recommend that it should be at least paralleled on the investigation of the possibilities of prevention. Reviewing all IYDP activities and literature, I conclude that the deaf have benefited least from the attention directed upon the needs of handicapped people and I hope that this recommendation may help to redress the balance during the decade that follows.

Sport and leisure

273. I would not have expected to include a recommendation about sport and leisure, but contacts with groups of disabled people (National Games for the Disabled in Bangladesh, Combined Disabilities Association in Jamaica and others) and the stimulating effect of cultural events in the IYDP programmes of many countries made me realise their possibly unique potential in the rehabilitation of handicapped people. The International Stoke Mandeville Games Federation had already stimulated sports for paraplegics and the 1976 "Olympics for the disabled" in Toronto brought in young people with other disabilities. The encouraging effect of these international contacts cannot be overstated. Many Commonwealth countries which had no sporting events for the disabled organised them during 1981. The enthusiasm they generated should ensure their continuation. Apart from the therapeutic value of sport and leisure activities, the social and psychological effect of public achievements means a very great deal to the disabled in the community.

274. Apart from Stoke Mandeville and the International Sports Organisation for the Disabled, which can be relied upon to encourage the athletic activities, a new organisation with strong Commonwealth links is now organising a wider range of opportunities for handicapped young people to travel and to take part in recreational and cultural events in their own and other countries. With support from the Commonwealth Youth Programme, the Commonwealth Foundation, the British Council and Canadian sources, Mobility International, with headquarters in London, has in the last two years established projects for young disabled people in India, held a major event in Toronto, established effective contacts with Malta and Cyprus and is arranging for the British deaf cricket team to play in St. Vincent and Barbados. It is also in touch with organisations of young disabled people in Africa with a view to organising a 1983 cultural event. I recommend continued support so that Mobility International can become in time a valuable complement to the International Stoke Mandeville Games Federation in the field of culture, leisure pursuits and travel.

Mental retardation

275. In paragraph 88, I recommend the formation of a panel of consultants and/or a professional associations in the field of mental retardation. This is in hand. The Commonwealth Foundation has made it possible for additional delegates, from Bangladesh, Ghana, India, Jamaica, Kenya and Sri Lanka, to attend the "World-wide Sharing" Congress in Toronto in August 1982 and the incoming President of the International Association (Professor Roeher) has arranged with the organiser of the 1981 Bangalore Conference (Dr. V.R. Pandurangi) to promote both concepts. Whatever the outcome, both the prevention of mental handicap (a much neglected subject) and the training of teachers of the mentally retarded should receive more of the attention they deserve.

Rehabilitation assistants

276. In paragraphs 113-117, I call attention to the need for the training of rehabilitation workers in rural areas, and more particularly of their supervisors, at sub-professional level. Without such training, rehabilitation is going to remain the privilege of the very few as, in the words of the March 1982 WHO progress report, "it has developed into a highly complicated service delivered by a team of many highly-specialised professionals" and this makes it "unavailable to the great majority of the disabled, particularly in the developing world". The process of devising patterns of rehabilitation services requiring less advanced training and simpler facilities has only just started with the field-testing of the manual "Training the disabled in the community". The training and supervision of manpower is, to use the words of the WHO review, "the key issue". Two inter-country workshops have so far taken place, in Botswana (September 1981) and Kerala, India, (February 1982) attended by representatives from eight African and six Asian countries respectively. Work to date will be reviewed in Sri Lanka in July 1982.

277. It is too soon to make a specific recommendation, except to repeat that Commonwealth Ministers of Health will wish to watch this development very closely at their regional meetings and give it all the support they can in order that rehabilitation benefits may be brought to more of the unreached disabled people in rural areas.

278. For the Caribbean, I have already invited CARICOM and the Commonwealth Foundation to encourage the newly-formed Association of Rehabilitation Therapists whose secretariat is in St. Lucia where the WHO manual is being tested.

IMPLEMENTATION OF RECOMMENDATIONS

279. The implementation of these recommendations will require action at national, regional and Commonwealth Secretariat levels. In many aspects of the subject, the three are inter-dependent, so they will be dealt with together.

280. Only at the national level can the vital decision be taken and implemented. This is to sustain the initiatives of the International Year by appointing a national council for the

handicapped. Where these already exist, they are not always sufficiently removed from the control of one department of government to ensure effective inter-ministerial action in close co-operation with voluntary agencies, including associations of disabled people. A statutory national council can devise a national policy to make the best use of limited local resources and of technical co-operation with aid-giving agencies. If it is truly inter-ministerial, it can determine the priorities between primary prevention, physical rehabilitation, education and employment; and if it has a sufficient measure of independence, it can supplement government grants by arousing public support for specific projects within its programme. By the participation of voluntary agencies in its deliberations, it can seek the best solutions for the education and care of handicapped children by making their needs known to government and to aid-giving agencies as well as to the general public for their support.

281. But, with the smaller and more remote countries in mind, national councils and their constituent elements should be able to look to regional arrangements for the visits of inspiration and guidance and for the training of their staffs, whether for physical rehabilitation (including the local production of simple aids of all kinds) or for the education of children with special needs. There are success stories in these fields, but not enough sharing of experience. One way of doing this is to organise workshops, preferably in the smaller countries of the region in rotation; another is to support regional associations of therapists and of teachers of handicapped children. Particularly important is the regional sharing of experience in reaching the disabled in rural areas by the field-testing of the WHO/UNICEF manual "Training the disabled in the community".

282. The Commonwealth Secretariat, having sponsored this survey, will wish to support the initiatives outlined in the report for the prevention of avoidable disabilities and for the rehabilitation, education and employment of handicapped people, specifically:

- (a) by supporting the Expanded Programme of Immunisation, the attack on needless blindness and the special initiative which seeks to extend vaccination against rubella;
- (b) by encouraging World Orthopaedic Concern to regionalise its activities in adapting "western" technology, including the production of appropriate aids, to the needs of orthopaedically disabled people in the less developed countries;
- (c) by encouraging co-operation in the field-testing of the new WHO/UNICEF concept of "Training the disabled in the community";
- (d) by seeking to make up the deficit in research into preventable or reversible deafness;
- (e) by promoting the service of professionals and volunteers to augment and train the staff in smaller and more remote countries engaged in the education of children with special needs;
- (f) by inviting the Ninth Commonwealth Education Conference in 1983 to review the provision for the education of handicapped children in the light of experience during the International Year of Disabled Persons (1981);
- (g) by systematically updating during the 1980s its valuable comprehensive study (1972) of special education in developing countries;
- (h) by encouraging Commonwealth-wide, regional and local associations which are endeavouring to develop sub-professional or supervisory cadres in the broad fields of rehabilitation and the education and care of handicapped children;
- (i) by inviting both governments and the private sector (especially Rotary, Lions and other service clubs) to develop commercially-run works centres where disabled men and women can find gainful employment; and
- (j) by giving its support to the growing movement for sports, travel and leisure activities for disabled people.

283. Several of these activities are more appropriate to the Commonwealth Foundation, which is already active in the disabilities field, enabling professional people to work together in

orthopaedics, in the treatment and education of the deaf and in the study of mental retardation. I hope this report may assist the Trustees in discerning the aspects of disablement which are most likely to deserve their attention and assistance.

SOURCES OF ASSISTANCE

285. The Commonwealth Foundation has published three valuable Directories of Aid Agencies, one for the Caribbean (1978), one for Africa (1979) and one for Asia and the South Pacific (1981). They are comprehensive and detailed lists of international, Commonwealth and non-Commonwealth sources of aid and include many which are concerned with work among disabled people.

286. An attempt was made during this survey to keep an annotated list of such sources found to be active in the smaller Commonwealth countries. This would have included the United Nations Development Programme and the several Specialised Agencies, especially WHO, UNICEF, ILO and UNESCO; also Commonwealth and non-Commonwealth governments with bilateral aid programmes. These accounts alone would have been voluminous. But it was the multiplicity of non-governmental agencies that caused the attempt to be abandoned. New direct sources of assistance are still coming to light as this report is being written, showing how dangerous it would be to attempt a list when so many significant omissions would be inevitable. When one is visiting the receiving end, the sources of aid are not always disclosed. Although some 30 major voluntary societies were invited at the outset to give information about their overseas work, not all were able to list items specifically for work among disabled people; nor were many sources in Australia, Canada and New Zealand canvassed, and in many cases that is where effective help is coming from. To list individual sources because I happened to come across them by correspondence or during visits while conducting the survey would be unfair to the many whose work would go unacknowledged.

287. In the Commonwealth context, I found that most professional bodies concerned with disabled people were well aware of the assistance they might receive from the Commonwealth Foundation. On the other hand, the possibilities and procedures for assistance to governments through the Commonwealth Fund for Technical Co-operation were not very well known and doubts were expressed whether requests within the social development field would be entertained either by the national government agency or by the Committee of Management of the Fund. As the sharing of experience between developing countries in the rehabilitation and education of handicapped people is particularly important after the interest and initiative aroused by the International Year, I hope that more use will be made of both the General Technical Assistance Programme, and more especially the Education and Training Programme of CFTC.

288. At the International level, the Disabled Persons Unit of the Centre for Social Development and Humanitarian Affairs in Vienna will publish twice a year a "Disabled persons bulletin", starting in June 1982. This will include a summary of information about projects and activities in the field of disability prevention and the rehabilitation of disabled persons. There will be special emphasis on technical co-operation, covering the United Nations, the Specialised Agencies, inter-governmental organisations and voluntary societies. There will be a section on bilateral technical assistance projects of governments. The comprehensiveness of this bulletin, which will be sent to IYDP committees or their successor organisations, will atone in some degree for the incompleteness of this survey report in the matter of available sources of outside assistance.

APPENDIX A

SURVEY OF COMMONWEALTH POLICIES AND PROGRAMMES ON DISABILITIES

Terms of reference

In view of the fact that this is the International Year of the Disabled Persons and because the problems associated with disabilities are especially great in the small, remote countries of the developing world, a special study of disablement in Commonwealth countries will be undertaken. Information and evaluation of the services currently available in Commonwealth countries will be of value to those countries which wish to alleviate suffering from the major causes of disablement. The study will pay special attention to the needs of small, remote countries with limited resources.

The consultant will:

- (a) collect information about current national policies and practices in relation to disabled persons;
- (b) make a comparative evaluation of such policies and practices;
- (c) examine their applicability for countries in the developing world with special reference to the needs of smaller, remote countries;
- (d) assess delivery mechanisms and the motivation for behavioural change - including contributions to primary care and/or the need for special interventions;
- (e) include in his assessment the following disease categories: blindness, deafness, leprosy, poliomyelitis, accidents, rheumatic disorders, drug addiction, muscular dystrophy and mental handicap;
- (f) prepare a report:
 - (i) collating the information received under national and disease categories;
 - (ii) presenting a critical appraisal of the policies and practices identified and, in particular, their value and applicability in the smaller and remote countries of the developing world;
 - (iii) indicating the most critical needs of the disabled in such countries and sources of assistance;
 - (iv) recommending measures for assistance that might be taken at the national and regional levels and by the Commonwealth Secretariat and other agencies;
 - (v) in view of the expertise and resources already available in developing Commonwealth countries, particular attention will be paid to the assistance that they could give to smaller, poorer countries in their region.

APPENDIX B

COUNTRIES VISITED

1981

Austria (Vienna UNIDP Headquarters)	7 - 13 September
The Gambia	25 September - 5 October
Nigeria	6 - 9 October
Ethiopia (ECA and OAU)	10 - 12 October
Tanzania	13 - 17 October
Zambia	18 - 19 October
Malawi	20 - 24 October
Zimbabwe	25 - 28 October
Kenya	29 - 30 October

(Rapporteur at Leeds Castle Seminar on Prevention of Disablement
8 - 12 November)

1982

India	7 - 11 January
Bangladesh	12 - 17 January
Singapore	18 - 19 January
New Zealand	20 - 23 January
Australia	24 - 26 January
Papua New Guinea	27 - 30 January
Solomon Islands	31 January - 4 February
Fiji	5 - 8 February
Canada	14 - 17 March
Jamaica	18 - 23 March
Barbados	24 March - 7 April

(with one-day visits to IYDP committees in Trinidad and Tobago, St. Vincent and the Grenadines, and Antigua).

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