PD-AAV-517
ISN 49125

RURAL SERVICES FOR SPECIAL CHILDREN

PROJECT # 532-0094

END OF PROJECT REPORT

1987

Prepared By: PVO LIMITED

1. INTRODUCTION

I. Background

Private Individuals and Organizations have traditionally been the pioneers of caring for the handicapped and disabled in Jamaica.

In 1978 a group of these individuals held a series of discussions in an effort to develop programmes for providing better care and more equitable opportunities for disabled persons. Although they realized that it would be a monumental task, they resolved to conduct a survey to establish the degree of need throughout Jamaica paying special attention to the multiple disabled who were not able to obtain schooling.

In order to obtain financial assistance from US AID, the group formed a non-profit voluntary agency - The Private Voluntary Organizations Limited. The survey results published in 1980 (Children at Risk - Report on the needs of Handicapped Children and their families, 1978 to 1980) indicated that approximately ten percent of the population was disabled and only 2.6% were enrolled in Special Education programmes and these services were concentrated in Kingston. In practical terms for every one (1) child receiving services, thirty-eight (38) children were without service. (These results were confirmed by a separate survey conducted by the Ministry of Education).

The chief recommendation from the survey report was that services should be provided for disabled children in rural areas. The seven (7) member agencies recognized their individual limitations in addressing the needs of the rural disabled population. Subsequently, the project "Rural Services for Special Children" was designed, submitted and granted funding from US AID.

The "Rural Services Development for Special Children" envisaged as a Three (3) Year Project funded by US AID commenced in July, 1982, to provide services for approximately Six Hundred (600) children in the Twelve (12) rural parishes in Jamaica.

It was originally proposed that after three years, the components of the project would be transferred to capable agencies.

II. The Project

The heart of the project is a mobile unit equipped with an electric generator, hearing and vision instruments and a medical clinic. A Kingston based Mobile Team of Specialists including:

Psychologists;
Special Educators;

Audiologist;
Physiotherapist;
Nurse/Vision Screener; and
Occupational Therapist

conduct the services.

The specialist staff is comprised of full-time Peace Corps and Jamaican staff and part-time member agency staff. Administrative support to all components of the project is provided by the Kingston based Project Office under the direction of a Project Manager.

The services are provided on a parish basis.

The specialist staff visits health centres in each parish for clinic sessions. These sessions are arranged in conjunction with the parish health team. Publicity is carried out through churches, teachers, doctors, nurses or any other community member.

Vision screening, educational testing and placement in special schools or units, occupational and physiotherapy assessments, parent counselling and home based therapy and teaching sessions are among the services provided by the team of specialists. Community education is also conducted through films and classes covering topics such as proper nutrition, early detection of disability, improved antenatal and neonatal care, infant and child stimulation and simple behaviour and modification techniques. Participants are given the opportunity to explore their attitudes and feelings toward disabled persons.

Demonstrations and hand-outs suggest activities and games to stimulate the child through the senses, improve their potential for learning and cope with their disabilities. Toys and games are made at workshops, using scrap and local materials such as:

stones	shells	bamboo
cloth scraps	seed pods	tins
bottle stoppers	empty bottles	

Emphasis is placed on the parent being the most important person in shaping the child. Patience and encouragement in working with the disabled child is stressed.

Within one month of the clinic sessions, follow-up visits to the client's homes are performed. These visits serve to monitor home-based therapy programmes, proper nutrition and stimulation activities. Doctors' visits and other actions resulting from the clinics are discussed and further programmes taught.

The specialist team relies heavily on each community. The local dress-maker and furniture maker assist the occupational therapist and physiotherapist in the fabricating of Adaptive Aids such as:

Special Chairs;
Walking Frames;
Canes

for the children.

Support is given for the Special Education Units managed by the Ministry of Education. Intellectual, visual and audiological assessments are conducted for all children. Individualised programmes are designed, teacher and parent training workshops conducted and educational materials produced for the support of these programmes.

Training workshops are conducted for health personnel. Basic screening techniques are taught and experiences exchanged.

Special Workshops are conducted for students of Secondary, High and All-Age Schools, Community groups and the general public in all aspects of the Prevention of Disabilities.

III. Constraints

Several constraints were experienced during the period. The most severe are listed below, but not necessarily in order of severity:

1) The late arrival of the Mobile Unit, hence lack of time to accomplish all project requirements;

2) The present condition of the economy which affects the outlook of Jamaicans generally, thus impairing voluntary support;

3) The inability of individual agencies to extend their present facilities;

4) The overwhelming needs of the disabled and their families in in the rural Jamaica;

5) The dearth of trained persons to recognize and manage disabilities in children within their communities;

6) The total lack of facilities for severely and multiple disabled children;

7) The resulting handicapping conditions of the families of disabled children;

8) The current constraints in the society compounding the plight of the disabled.

Despite these constraints the project achieved a high level of success. The versatile and hardworking staff wore many "Caps" and continually developed new programmes in an effort to meet the needs of the beneficiaries of this project.

IV. Evaluation

The Mid-Point Evaluation of the project operations stated that the goals in most programme elements had been met and surpassed and the project had done an exemplary job in the areas of early detection of handicapping conditions, making timely and appropriate referrals, worked with a variety of programmes to achieve the goal of support for community based programmes, developed materials for use by teachers and parents, provided continuing support for unit classes and ascertained excellent medical care for disabled children.

The Report concluded that the various interviews with Government officials, school officials, direct service providers and parents, gave dramatic documentation to the conclusion that the Rural Services Project for Special Children has had and continues to make a significant impact on handicapped children, their families and a wide range of both Public and Private Agencies in Jamaica. These services, however, were conducted in only six (6) of the twelve (12) rural parishes.

V. Budget

The original project life was for a period of three (3) years, beginning March 1982; but project operations commenced in July 1982. Due to the aforementioned constraints (the most significant being the late arrival of the Mobile Unit), an amendment was granted by US AID to extend the project life to March 1986. The committed funds of US$500,000 remained unchanged.

The major item of expenditure was commodity costs and this included the cost of the Mobile Unit and project vehicles.

2. SERVICES

1. Prevention

The thrust on prevention of disabilities took two forms:

a) Prevention of disabilities in the unborn and normal children.

b) Prevention of further disabilities of the disabled.

a) Prevention of New Disabilities

PVO educated the general public on the prevention of disabilities for unborn children and children without disabilities.

This was accomplished in several ways including:

Workshops
Media - posters, radio, television, etc.
Information leaflets - personal contact directly imparting information in every forum possible.

Topics: included diet toxins, exercises, drug abuse, other medical factors and training. Audio visual presentations were made at each Health Centre visited, at key community locations eg. markets, libraries, post offices, service clubs, PTA meetings, community group meetings, etc.

b) Prevention for the disabled

PVO viewed the disabled child holistically, i.e. the child's disability is not independent of his other needs and should not be treated in isolation.

Those impinging areas which we saw as critical to the prevention of further disabilities which were addressed are:

1) Nutrition

Malnutrition was the most common factor observed in all our clients. It has a direct adverse effect on cognitive functioning which may become permanent. Nutritional counselling was provided for all disabled children and their families by PVO Specialist staff in conjunction with local health staff.

- PVO distributed seeds to families for kitchen gardens in an effort to improve the families diet.

2) Basic Health

PVO staff assessed each child's general Health to determine remedial needs as well as the need for adaptive aids. Such areas as skin condition, infections and oral hygiene were also addressed. In addition the PVO's staff gave advice on basic first aid and redemptive measures. However, more severe problems were referred directly to the appropriate health services. (These referrals were always followed through by the PVO staff.)

3) Immunizations

At the initial contact, PVO acquired immunization histories of all clients as it was a project policy that all clients should receive full immunization. Children in need of immunization were referred to the nearest health centre. The Health Centres were also informed independently to avoid parent delinquency.

4) Social Environment

PVO assessed the general social environment of the child to determine its compatibility with child development.

Action in this area varied and included training in positive interaction, parent counselling, referral to child services, agencies and family planning and re-uniting some parents and children in cases where children were abandoned.

II. TRAINING

A. Teacher Training

Teacher training as it related to the education of the disabled was a major function of the project.

This category was broken down into three components. The nature of the workshops varied based upon the professional training of the teachers and their needs.

a) Special Education Teachers

-- Their training was more specific and sophisticated than those of regular teachers. They were trained to conduct inservice training workshops for regular teachers at their school locations.

b) Regular Class Teachers

These teachers have received little or no training in teaching disabled children; therefore their training was more elementary than for the Special Education teachers. These workshops were usually conducted in zones in order to facilitate the participation of teachers from different schools in each zone. Here emphasis was placed on attitudes and guidelines on recognizing and managing disabled children in the regular classroom programme.

c) Basic School Teachers

Basic school teachers have unique training needs since they serve children below the age of 5 years. Many of these teachers had no formal training in education, therefore training was elementary. Workshops were conducted during their regular training programmes held regionally and at individual schools according to request. Here stimulation was stressed and toy making sessions were arranged.

Follow-ups visits were arranged to assess the impact of training sessions and to plan for future workshops.

B. Parent Training

The aim of conducting parent training is to enable the child to receive therapy on a consistent basis. The person most suitable for this job is someone with whom he comes in frequent contact - a parent. Parent here refers not necessarily to biological parents, but to primary care given who may be parents, grandparents, siblings, other relatives or neighbours.

Counselling was conducted on an individual basis beginning on initial contact with the Project Staff. In addition, training workshops on all aspects of disabilities were convened in communities and zones on a regular basis for all parents.

Focus was also placed on the parents of children who were not attending school for varying reasons - normally lack of school placement because of the severity of their disabilities. These parents were counselled in taking responsibility to ensure that their children were provided with whatever educational and Health service necessary and not to rely on the relevant authorities to make the initial step. Workshops for these parents were conducted on a monthly basis at key locations eg. Health Centres and Church Halls. Children accompanied parents to some workshops and the nature of these sessions varied according to the needs of the children/parents in attendance. Topics included behaviour modification, physiotherapy positioning, therapeutic games, causes of disabilities, stimulation, feeding, nutritional needs, diets , news on immunization and family workshops.

C. Community Health Staff

PVO Limited worked very closely and with considerable cooperation from the Community Health Staff. Topics at training workshops included direct care, screening for disabilities and adaptive skills training. From these sessions they were equipped with an understanding of the needs of disabled children and their family, the need for stimulation and adaptive skills for treatment of the disabled.

Health Staff were also provided with information on agencies serving the needs of disabled persons and an appropriate referral system (self addressed stamped referral cards from PVO Ltd. were left at key Health Centres).

D. Child Care Organizations

Workshops were conducted for child care staff attached to children's homes.

Topics included - causes and prevention of disabilities, stimulation, behaviour management and living skills. Follow-up visits were made to homes accommodating disabled children.

III. Referral

PVO staff worked relentlessly in establishing and coordinating formal links with key resources such as agencies or professionals to minimise obstructions and provide continuous and satisfactory care for the disabled.

Referrals were made in five categories (some children required a combination of referrals).

a) Medical

Whenever a child had a chronic or temporary health need, referrals were made to the nearest health facility capable of providing adequate care. Such referrals were for treatment of such things as:

Vision
Infections
Immunization
Malnutrition
Disease
Surgery (eg. orthopaedic or cosmetic)

A duel referral system was used with all health services whereby the parent/child is sent to the Health Care agent with a written referral using a standard referral form. A duplicate copy with a stamped self addressed detachable card was forwarded independently to the Agent to whom the referral was made. This enabled the staff to monitor all medical referrals.

b) Special Education Services

PVO made numerous successful referrals to existing Special education services including schools & units for Mentally Handicapped and deaf children, Ministry of Education Special Education Units attached to regular Primary Schools.

A written report of the child's functional assessment facility accompanied the child.

Whenever necessary, PVO staff met directly with key personnel and/or accompanied parents and children to interviews. Yearly contact are made to determine children's progress.

c) Regular Schools

Referrals to public school programmes were made for those children who could not access special education services and who were mobile enough to get to school and those children whose needs would best be served at regular school locations.

In some cases, mainstreaming in a Basic School was most appropriate with respect to their functional levels. (With transfers to regular schools when appropriate) For the other children, mainstreaming was effected in primary, or secondary schools.

In all cases, PVO Specialist Staff conducted preparatory exercises with Principal, Staff, Children and parents at each location prior to the admission of the children.

Follow-up visits were made to assist the class teachers and the child with adaptation (where necessary adaptive aids were fitted to facilitate the learning process eg. spectacles, hearing aids, special boots or walkers).

a) Related Services

PVO was successful in obtaining the services of numerous agencies such as:

i) Children Services Division - for foster care or family interview

ii) Poor relief - to obtain food stamps for the disabled

iii) Vocational training programmes to train disabled youths

iv) Service organizations - to obtain material or financial assistance for families.

Data on all disabled clients was sent to the Jamaica Council for the Handicapped and agencies serving the disabled were sent data on respective disability group.

PVO also accepted referrals from agencies and conducted specific services for agencies as requested - for example delivering medications, conducting therapy or transporting staff to locations to conduct interviews or assess needs.

IV Public Awareness

In order to reach as many children as possible it was necessary to spread the word regarding the availability of services offered by PVO. Additionally, it was necessary to inform the general public on disabilities in order to foster more humanistic attitudes and behaviour toward the disabled and to achieve acceptance.

a) Reaching the Disabled

Services were advertised in several different ways in addition to our referral system using:

i) Radio - eg. popular programmes
ii) T.V. - JIS
iii) Posters - located at central meeting places
iv) Leaflets - sent to schools, churches, etc.

b) General Public Education

PVO staff coordinated public education programmes covering a variety of related topics including:

i) Attitudes
ii) Causes & types of disabilities
iii) Needs of disabled persons
iv) Prevention of disabilities
v) Myths & facts on disabilities

Demonstrations took various forms including video and slides presentations, talks, radio & television presentations, distribution of leaflets and posters and visits to schools or work places.

Target audiences included:

i) Service organizations eg. Jaycees, Kiwanis
ii) Schools
iii) PTA's
iv) Church groups
v) Community groups

V Material Production

The Specialist Staff developed material to support all components of project activities as follows:

- educational materials for use in schools, tertiary institutions and home-based programmes
- materials for use in training programmes for professionals & para-professionals
- materials for public education
- audiovisual material for use in all training areas and for fundraising purposes.

All materials were carefully designed to meet the needs of the target groups eg. pictoral leaflets were designed for illiterate and semi-literate parents.

Materials were widely distributed at workshops and at key locations such as Health Centres, Libraries, General Practioners Offices and Poor Relief Offices.

VI Pre-School & School Age Services

a) Child Evaluation

Child evaluation was divided into two areas: screening and assessment.

i) Screening is the initial stage of identification where children who are disabled or who are potentially disabled are discriminated from those children who appear to be functioning normally. PVO depended primarily on the health services and schools to perform the initial screening of children.

ii) Assessment of the children with disabilities was conducted by the PVO Special Staff. This process is an indepth evaluation of a child's ability in various functional areas and served to:

i) positively identify children who have disabilities

ii) determine the level of functioning of each child

iii) determine the remedial needs of the disabled child and

iv) determine appropriate placement of the disabled child.

Assessments were conducted at regular clinics held at Health Centres, at schools or homes, to identify the following areas:

i) Psycho-Educational - to determine the cognitive and behavioural functioning levels of children in respect to their normal peers.

ii) Speech & language - to determine the level of communication abilities of children with respect to their culture & chronological age and identify structural or physical anomalies which inhibit speech.

iii) Audiology - to determine the hearing capacity of the children and their ability to function with adaptive aids.

iv) Motor - to identify muscular, neuromuscular and orthopaedic disabilities and determine the motor potential for the children.

v) Vision - to determine the visual acuity of the children.

b) Educational Services

Educational services refers to any intervention which leads to greater functional independence on the part of the disabled child and is based upon individual needs of the child. These services were conducted directly to the client and indirectly by training parents, professionals and para-professionals to implement services - Home-Based Programmes and by Placement in Special or Regular Schools.

i) Home-Based Programmes

Services were provided for those children awaiting placement in some existing programme or those who had to remain at home because of the nature and severity of their disability or some constraints eg. bus fares or lack of placement.

Each Specialist was responsible for the development of a plan of action for each child for whom PVO provided services. These plans were individually constructed based upon the development needs of the child and the practical contraints of the child's environment. These Home-based plans were implemented either independently or in collaboration with the other members of the PVO multi-disciplinary team, parents and health staff.

The areas covered included:

- self help skills such as dressing, toilet training,
- behaviour management
- stimulation
- speech & language development
- use & care of adaptive aids
- therapy for motor needs
- feeding

The PVO Specialist staff made regular home visits to assess the children's progress and revise programmes accordingly.

ii) Placement

Educational Placements were effected in Special Schools, Special Units and Regular Schools. Support was given as deemed necessary in locations as discussed in Training & Referrals.

c) Support for Ministry of Education Specialist Staff

The PVO Multi-disciplinary staff provided services to the four Ministry of Education Special Units at Duncans, Hazard, Catherine Hall and Ocho Rios Primary and All Age Schools in the following areas:

i) Assessments

All children received Multi-disciplinary assessment prior to admission in the Special Units and were re-assessed as necessary.

ii) Programme Planning

Assisted in the design of individual programmes for the children.

iii) Staff Training

Conducted inservice training sessions for teaching staff.

iv) Public Education

Public awareness programme prior to the opening of new Units.

v) Referral

Referred children medical treatment as appropriate.

vi) Parent Counselling

Assisted with Parent counselling.

VII Vocational/Job Placement

This area proved the most difficult task for the Project Staff. There are very few existing vocational programmes catering to disabled persons and these programmes are inaccessible to the more severely disabled youths. It was therefore necessary for the PVO Staff to revise the thrust to produce a more personalised programme which concentrated on the resources available in the individual's community.

Job Placement

PVO Staff acted as advocates in instances where the disabled could be employed if specialist counselling was available to the employer at his/her request.

Vocational Training

Some disabled youths were placed on an individual basis after personal contact with skilled persons in the local communities. This proved most successful.

Other disabled youths under the supervision of local farmers were given assistance in planting quick crops and rearing domestic animals individually or in conjunction with family members.

These programmes proved to the local community that disabled persons can become productive members of the society, at the same time the disabled persons develop stronger positive images of themselves.

Conclusion

The Private Voluntary Organizations Limited has made a significant impact on those children and their families who were serviced as evidenced by the following:

1. Rehabilitation

   With the establishment of new services, improved services and a comprehensive referral service, children were ensured school placements, home-based training and medical care (Please see appendix I).

2. Improved Attitudes Towards the Disabled

   This is evidenced by the increased new referrals to PVO Limited, the increased interest by community groups and the support of Special programmes such as Special Olympics, Horseback Riding for the disabled and the present training of an Equestrian Team for International Special Olympics by a Private Stable.

3. Establishment of Community Groups

   Volunteers and parent groups, teachers and other interested persons have come together to pool resources.

4. Research and Documentation

   The services available for disabled children and their families have been documented. In addition, audio-visual aids, printed materials and the design of a Jamaican Physo-Educational pre-academic and academic test for disabled children are now used in the PVO programmes. Data analysis was revealed that:

   i) the most significant Health problem of all the disabled children seen is malnutrition

      - the children's diets lacked protein, vitamins & iron

   ii) the most significant causes of visual disability are cataracts and glaucoma (the most significant health problem observed during vision screening was allergic reactions)

   iii) the most significant cause of deafness is rubella

   iv) the most significant health problem of the hearing impaired is Ottitis Media

   v) in most cases of Educational Development and Physical Disabilities the cause is Idiophathic. Most significant of the known causes are poor nutrition and trauma

vi) there is no established facility for training severely disabled children (see appendix II).

5. Improved Quality of Life for Disabled Children and their Families

This was accomplished by providing reliable, efficient services, increased school placements, improved medical care and surgical intervention, increased use of adaptive aids, improved attitudes of teachers, Health care staff and the communities.

6. Increased Self Image of Disabled Persons and their Families

This was evidenced by the increased number of parents and children attending workshops and social activities and the increased involvement of fathers in the development of their disabled children.

Based on the research carried out, the Private Voluntary Organizations Limited has prepared a Development Plan to:

i) provide services for disabled children and their families in the six rural parishes not receiving services at the present time

ii) decentralise Project Operations, by placing staff in regions to concretise community based services

iii) provide Agricultural Aid to families, thus improving the quality of the children's diets and providing an income for parents and disabled youths.

The impact on the lives of the disabled children and their families who are being serviced has awakened the consciousness of the Board and Specialist Staff to extend similar services for the remaining six parishes.

We are extremely grateful to the US AID for the interest shown in this project and for the financial support which has made it possible to bring hope into the lives of so many. We are committed to the task of servicing the entire island.

PRIVATE VOLUNTARY ORGANIZATIONS LTD.

REHABILITATION

Disability	Medical Referrals	Special Schools/ Units	Regular Schools	Home-Based Programmes	Vocational Programmes	Adaptive Aids
Hearing Speech 745 Language	206 27%	162 21%	432 57%	141 18%	10	Hearing Aids Shoes
Educational Developmental Physical 678	267 40%	97 14%	228 33%	334 49%	-	Spectacles
Vision 211	211 100%	12 5.7%	193 91%	6 2.8%	21	Shoes, Walkers Chairs, Braces Communication Board

Appendix I

PRIVATE VOLUNTARY ORGANIZATIONS LTD.

ASSESSMENT

Disability	No. of Children Assessed	No. of children with Disability	No. of children with Multiple Disability	Most Significant cause of Disability	Most Significant Health Problem
Hearing Speech Language	2320	745	71	Rubella	Ottitis Media
Educational/ Developmental Physical	920	678	322	Trauma Nutrition	Malnutrition
Vision	1367	211	54	Cataract Glaucoma	Allergies

Appendix II

Project Assistance Completion Report for the Rural Services for Special Children (532-0094).

Clearance:
OEHR:PLerner
OPDS:BCypser
OPEP:NHardy
CONT:LTarpeh-Doe
DDIR:JSchlotthauer