

THE REHABILITATION VILLAGE

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The rehabilitation village concept was started at Bindura Provincial hospital in 1985. This hospital has a bed capacity of 120 beds, but due to demand of its services, the hospital accommodates, on average, 220 patients. After 1980, the rehabilitation department had identified a large case load including patients with cerebral palsy and mental retardation. Many of these cases were coming from far away, therefore parents were unable to come for assistance in management of the child on a daily basis, neither could they be admitted nor lodged in the hospital because of the already over burdened inpatient bed situation. Hence, the concept of the rehabilitation village was born. The concept took into account the existing economic resources of the country and future extension of such a service, manpower resources. In line with the PHC concept, the rehabilitation village is affordable, effective and appropriate.

PHYSICAL STRUCTURE AND USE OF THE VILLAGE

The village is a residential training facility for clients built in such a way that it simulates a rural setting.

A full assessment and training recommendations are given in this environment where various skills are taught within the context of the daily programme. The villages consist of three to five living huts which serves as sleeping huts. They are built with brick and cement with thatched roofs.

An additional hut is built in such a way that the walls are only one metre high and the roof is supported by wooden pillars. This hut serves as a kitchen. It has a built-in bench and protected fire place. The ablution facilities consist of two toilets and a bathing area. Most villages in Zimbabwe are built at a district or provincial hospital, at clinics or at other community centres.

Training sessions are held for children who are divided into three major groups – those with cerebral palsy, mental retardation or communication problems. The carers can arrive a day before or on the morning the village is due to start. Each carer is required to bring their own bed clothes and candle. The programme runs for three days. During the first day, individual assessments take place and a review of the child is carried out with emphasis on progress, problems and difficulties. The second and third days have a programme set according to the group's needs. Individual sessions and activities of daily living are routine within the two days.

AIMS AND OBJECTIVES

- To provide a forum for teaching and facilitation on how to manage the children in order to promote their development and optimum level of functioning. The village provides basic teaching in:
 - * functional activities of daily living
 - * handling and positioning of patients
 - * promotion of functional communication
 - * promotion of effective socialisation and behaviour.
- To give knowledge and skills, and influence and promote a positive attitude in the mothers regarding the children's condition.
- To provide psychological support.
- To prevent further disability through education.
- To provide low cost appliances and other equipment where required and necessary, such as corner seats, proneboards, push-trolleys, educational toys, walking aids etc.

Once logistical arrangements have been looked into comprehensively, such as cooking and accommodation for facilitators

and clients, the rehabilitation village will run very smoothly and the objectives are easily met.

The majority of clients will find the money to come to the village three to four times per year. There are some who cannot manage this. Often if the mother institution where the village is held, ie the clinic or hospital, is willing, they will provide warrants for travel back home.

ADVANTAGES OF THE REHABILITATION VILLAGE

- Mothers and carers support and teach each other in a group.
- An average of twelve or more mothers can be seen at once with the cost of travel greatly reduced. Furthermore the time spent with a mother will allow for meaningful input and learning to take place because it gives time to do in-depth assessment and treatment planning with the child and carer during a functional day.
- Follow-up visits in the community will be more meaningful and the mother is much more aware of how to balance activities for the child with those around the home.
- The mother is much more in control and can teach other children and members of the family at home. The mother gets an in-depth education on the child's condition along with teaching on how to manage it.

DISADVANTAGES OF THE REHABILITATION VILLAGE

- When the child reaches school-going age, placing is difficult as the schools will find it problematic to cope with children with learning difficulties and mental retardation.
- The village itself, although resembling the home, is not the home.
- For it to be successful, it is staff intensive especially as the numbers of mothers increases.
- It is still very dependent on the professional.

THE VILLAGE IN MASHONALAND CENTRAL: ITS DEVELOPMENT AND EXPANSION

The various provinces are at different levels with this venture. In some provinces, the village has started to decentralise from provincial centres to districts. This is fully recommended so as to run villages as close to the community as possible. The following is an example of one province. This is the province which had the first village, in Zimbabwe, running in 1986.

In the past two years, Mashonaland Central has started to decentralise the rehabilitation villages. The Bindura rehabilitation village started in 1986. The programme was run and designed in Bindura and is continually adjusted and altered to suit the type of client attending.

YEAR	NO OF VILLAGES	NO OF CLIENTS PER SESSION	LOCATION
1986	4	5	Bindura
1987	17	8	Bindura
1988	18	9	Bindura
1989	17	8	Bindura
1990	26	9	Bindura, Centenary, Howard
1991	26	10	Bindura, Centenary, Howard, Mt Darwin
1992	32	12	Bindura, Centenary, Howard, Mt Darwin

Table I shows a steady increase in the number of villages over the past six years. Up to 1989, the villages were run only in Bindura. There was an increasing demand for the service. The majority of the clients were identified and referred through outreach and other community visits; others through the static serv-

ices such as the outpatient department and through screening of low apgar babies on the maternity ward.

Although the statistics showed an increasing demand and more referrals from the districts, the village had never been formally evaluated. The provincial therapist carried out a research project on the specific purpose and function of the village and sought to determine the effectiveness of the service with specific regard to the cerebral palsied child and mentally retarded child.

The findings were very encouraging and showed that the village is being used as a means of gaining full and comprehensive rehabilitation management. There were recommendations made from the evaluation and some of these have been implemented. A further study was carried out by G Mugoto to determine the effectiveness of the village.

The increasing demand and the positive results of the evaluation led to the province deciding to decentralise the rehabilitation villages from province to districts and, as the table illustrates, over two years, three districts have started their villages. In two of the districts, the villages attendance has been so high that they have already divided the clients and consequently are running two separate groups. Two of the district villages do not have the physical structure but utilise the concept effectively.

As a result of further expansion of the village, there is now a need to standardise the approach so as to ensure quality input especially as not all staff involved have a wide experience in paediatrics. The department has now obtained a kit (the START home programme) which gives some guidelines on treatment techniques. This has been identified and will be used in combination with the materials produced by L Mariga (A Teachers Guide for Children Having Individual Learning Disabilities) (1985), on mental retardation and communication materials by J Morris and H House.

Two more villages are targeted to open in another two districts but because of the Economic Structural Adjustment Programme (ESAP) and its effect on staffing levels, this development may have to be shelved. The projected number of villages for 1992 was 32. Provincial-based staff are facilitating all district villages as they have only one or two members of staff in the districts. The province however has the highest number of out and in-patients and a staff establishment of six Rehabilitation Technicians and three therapists.

CONCLUSION

Clients find the village effective for their immediate needs and the needs of the child. In both studies by Myezwa (1989) and Mugoto (1992), clients expressed support for the villages and found them effective for their individual needs. The village is certainly complementary to all community based activities. The mothers in the villages are already good teachers and we may look to having one day a bank of some of the mothers who can come as permanent facilitators for particular sessions.

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