

OXFAM  PUBLIC AFFAIRS UNIT



ONE IN TEN

DISABILITY AND THE VERY POOR by Adrian Moyes



OXFAM & PUBLIC AFFAIRS UNIT



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Disability is “difficulty in performing one or more of the activities that are generally accepted as the essential basic components of daily living such as self-care, social relations, working.” These activities vary with age, sex, country and social status.

Disability may be short-term, long-term, or permanent. This booklet is about long-term and permanent disability only.

The Third World is used in this booklet to describe the poorer countries — there are nearly 100 of them, containing over 3,000 million people.

There are further notes on these and other terms in the Yellow Pages reference section.

1 Introduction

About 340 million people in the Third World today are disabled. That's one in ten. The International Year of Disabled People is a good time to look at what causes that disability and what could be done about it. This booklet is designed to do that.

Oxfam is concerned with disabled people for two reasons. One of our aims is to alleviate suffering. In every society disabled people are among those who suffer most, not only physically through pain, incontinence, or immobility, but also mentally through dependence, rejection, or being treated as children. A second, equally important aim is to reduce the *causes* of suffering. A major cause of disability in the Third World is poverty. Oxfam's whole programme is devoted to reducing poverty.

This booklet describes the problems (sections 1–4) and suggests what could be done (sections 5–9) by governments (sections 10 and 11), by charities (sections 12–14) and by individuals (section 15). Each one-page section is faced by a 'case box' giving a real-life example, mostly from Oxfam's own experience.

The argument of the booklet (the left-hand pages) concentrates on what needs to be done. So read by itself it looks too negative. Most of the case boxes (right-hand pages) concentrate on some of the good things that are being done — so read by themselves they look too optimistic. Read together they provide a balance.

The Yellow Pages reference section in the centrefold gives details of major types and causes of disability together with definitions of common terms. The Appendix outlines Oxfam's back-up services for those who want to do more — slide-set, film, and Oxfam offices in Britain.

A booklet of this length (48 pages) covering a subject of this size (340 million people in 100 countries with dozens of different types of disability and a range of different causes) is bound to contain a lot of generalisations. It's worth remembering that they are no more than that. To each there are many exceptions.

Oxfam's aim in publishing this booklet is to alleviate suffering and reduce its causes by increasing understanding of what needs to be done and the probability that it will be. We rely on you, the reader, to help us reach this aim.

case box 1



The slums of Bangalore

India

This is how a group of disabled slum-dwellers in India describe their lives and the causes of their disability:

To be born a woman in a slum community itself is a curse but added to that if one is physically and mentally deficient it is too much. Where the whole family has to go out for work including the children if they have to keep the wolf from the door on a day-to-day basis, constant attention to a non-productive member of the family was a calamity.

Usha lay there abandoned in the dark and grovelled in the clothes which she dirtied and never cleaned up for days, reeking with foul smell and emitting animal sounds to which people around had grown accustomed and insensitive. "Oh, why won't the wretch die," was often the only cry of hope in the mouths of her parents.

She was unlike the girl in the next street, Muthylamma, whose mother, being worldly wise, took her and paraded her in the street junctions and earned the family's daily fare in cash and kind, enabling her father to spend his earnings on drink.

Totally left uncared for, many invariably became beggars, trading on their deformities. Some were used as stooges in the illicit liquor business and some ended up as pimps for the agents who controlled the flesh trade of the cheaper variety on the streets.

"My cart happened to pass over the tail of a monkey and that's the curse of Hanuman (the monkey god) that has given me a deformed child." "We polluted the bed when pox was next door and that's why Goddess Mariamma has cursed us with a monstrous female child." "It is our fate. No one can do anything." Superstitions help the poor rationalise away their miseries. There is utter resignation and the child forever would end up as a living curse, a burden to itself and a burden to others. "This child is given to me as a punishment for my sins." In the slums where the good things in life never trickle down, knowledge about preventive means, like polio vaccines, is mostly unknown, except for the sporadic campaigns by the municipal authorities now and then.

It is the slum which is the logical breeding ground for physical and mental handicaps, with malnutrition, vitamin deficiency, insanitation, ignorance, illiteracy, superstition the normal conditions of life and it is there they receive the least attention. No grand programme will ever reach them and the off and on charity programmes by well meaning people would only help further dehumanise them.

source: Report from the Physically Handicapped Slum People Development Association, Bangalore, India

2 A disease of poverty: the causes

The basic cause of disablement in the Third World is poverty. Poor people are the most likely to get disabled and the least likely to get treatment. Poor mothers can't afford to eat enough food during pregnancy and so they are more likely to give birth to physically or mentally stunted children. They don't have access to advice and care during pregnancy and birth, so many babies are damaged during birth.

Poor people are likely to do work which results in disablement, like climbing trees (and falling out of them), or carrying heavy loads on their heads, or wading in water that carries bilharzia, or working in factories or mines without proper safety equipment.

Poverty causes blindness. The very poor in India and Bangladesh have no land on which to grow vegetables and no money to buy them. So they don't get enough Vitamin A and may go blind as a result.

And poor people cannot get good advice or treatment, *advice* which might prevent the disease or accident in the first place and *early treatment* which might prevent a broken leg becoming a permanent limp or polio developing into crippling paralysis.

Disabled members of a family, whether children or adults, tend to get less food, less education and less medical care. Why spend money on a mad child, or one who cannot see, one who can never repay the investment by contributing to the family income, or looking after the parents when they are old? Disabled children get less attention too — less physical and mental stimulus — and that alone is enough to make a child disabled.

Much of the poverty is caused by the way communities and countries are arranged. The caste system in India makes sure that people who are born poor stay poor. The landlord system in Latin America enables the landowner to evict any tenant who improves his land. In India, the moneylenders fix the interest rate so that you can never pay back the loan.

But part of the poverty is caused by the way the world is arranged. Britain, with its extensive trade and its colonial history, has helped to shape, and now helps to maintain, this arrangement. The low price we pay for tin or tea or cotton comes out in low pay and poverty at the other end. We, too, are one of the causes of Third World poverty.

We don't need to riddle ourselves with guilt — we are not responsible for our past. We didn't make the history. But our people's part in the past and our acceptance of the present gives us a stimulus to change things now. We *will* have cause to feel guilty if, looking back from the future to today, we see that we knew what to do, could have done it and didn't.



One girl

India

In 1978 Taraben was about 18 years old. She looked 8 or 9. She lived in a very fertile part of Gujarat State in western India, where more and more of the irrigated land is coming under sugarcane. This crop is tended and processed mainly by labourers from distant parts of India who earn even less than the local farm labourers, like Tara's parents, Darshahhhai and Gangaben.

Tara's parents were landless and the only work available to them was as farm labourers on the property of a man belonging to the locally most powerful caste, which dominates not only agriculture but also politics in the area.

Darshahhhai and Gangaben had six well-spaced children of whom three were at school. None of them was yet earning and the parents together could only find 175 days' labouring work a year. The daily wage was 16 pence per worker. So the family's total income was £28 that year. The main filling food of the poor in that area is sorghum and it cost about 6 pence a kg. Each adult needs about three quarters of a kilo of cereal a day. So the parents' income was nowhere near sufficient to pay even for enough sorghum for all their household, let alone to pay for all the other items that people need.

Tara's family did not even have a home of their own. They lived in with her mother's brother's family. In these circumstances Darshahhhai and Gangaben badly needed their eldest child's earnings. They couldn't afford to have their eldest child a permanent invalid at home. But she could not and never had worked. She suffered from sickle cell anaemia and she had a haemoglobin count of 1.5 on a 14 point scale; she had a heart condition; an enzyme deficiency; and hookworm. Physically she was completely undeveloped. She had never seen a doctor.

This particular story had a happy ending. Tara's village happened to fall within an Oxfam-financed survey. The villager who interviewed her family insisted that she be brought to hospital and properly treated. Shortly afterwards he took her into his own home and nursed her. Eventually she was able to work as a farm labourer and continued to do so regularly.

source: Report from Suresh Kumar and Marieke Clarke.

3 The depth of the ocean: the scale

In a way it doesn't really matter how many disabled people there are. As Gandhi put it, "When there is an ocean of poverty, you don't need to measure its depth before doing something about it". Neither does it matter too much to each disabled person. It's only in the statistics that people are disabled by the million; in real life each one is alone.

But if we are to do anything about disablement, and particularly anything about prevention, it's useful to have at least an idea of the scale and the causes. Not that it can be much more than an idea.

In the Third World it is almost impossible to find out how many disabled people there are, even with a detailed survey in a small area. Sometimes people hide their children away, so that even neighbours are unaware of their existence.

But we can say something. The figures opposite give a rough world picture, and there are further details in the Yellow Pages in the centrefold. There are no separate figures for the Third World but the World Health Organisation (WHO) reckons that 7% to 10% of most countries' populations are disabled. That would mean about eight million in Bangladesh and Nigeria, 12 million in Brazil, 14 million in Indonesia and 64 million (more than the population of Britain) in India.

However many disabled there are now, there will probably be more in the future. WHO estimates an increase of about three million people a year (about three times the population of Birmingham) assuming, that is, no contribution from nuclear war.

In the rich countries, too, about one in ten is disabled but these disabilities are caused less by poverty and more by affluence — traffic, industry, old age, smoking, eating, etc. Third World countries are also becoming vulnerable from these while, at the same time, because of unequal economic and social development, substantial proportions of their populations remain very poor.

Third World countries have more old people in their populations as more people live longer — a particularly important point because so many disabilities are related to age. There is more road traffic, more people smoking cigarettes (especially high tar ones), more industrial machines and chemicals. In Brazil, one of the more industrialised Third World countries, there are over 5,000 industrial accidents a day affecting 8% of registered urban workers in a year.

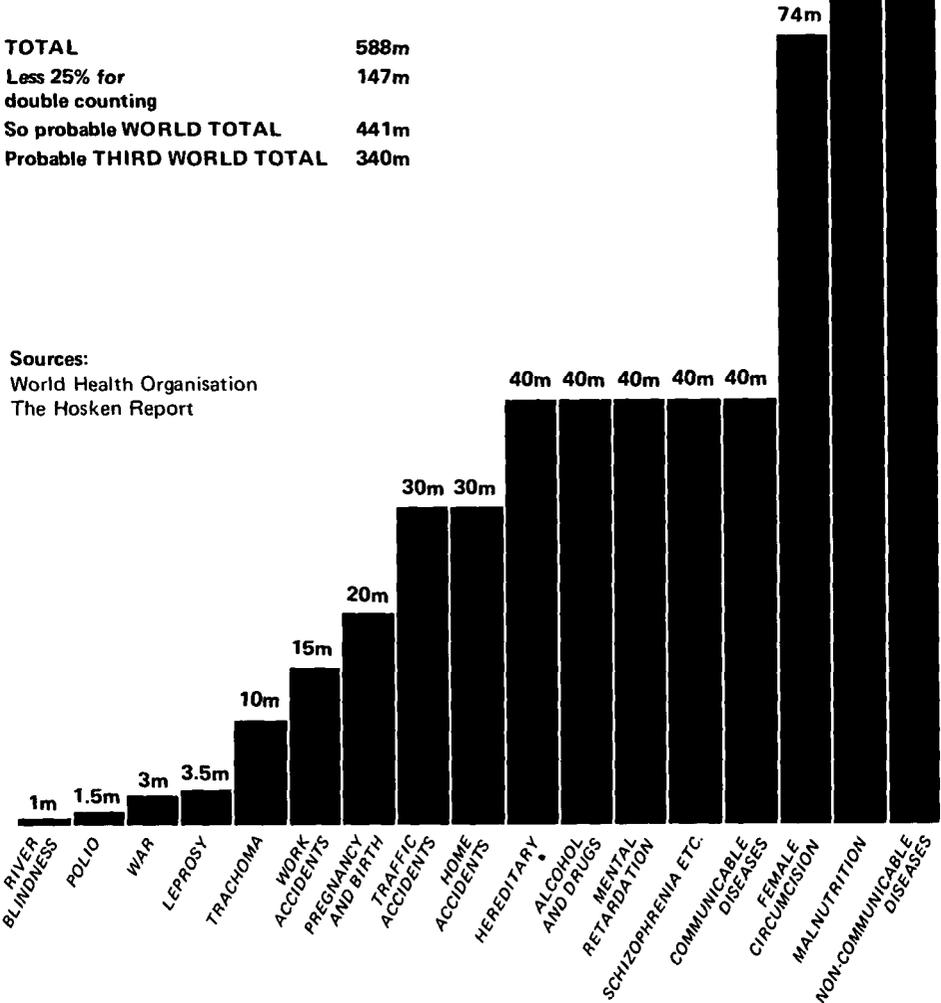
So the poor get the worst of both worlds. They are exposed both to disabilities caused by poverty and increasingly to those caused by affluence. It will be a hard task just to keep disablement in the Third World down to one in ten.

WORLD CAUSES OF DISABILITY

TOTAL	588m
Less 25% for double counting	147m
So probable WORLD TOTAL	441m
Probable THIRD WORLD TOTAL	340m

Sources:

World Health Organisation
The Hosken Report



All figures in millions

SCHIZOPHRENIA ETC. – i.e. functional psychiatric illnesses

HEREDITARY – blindness, deafness, muscular dystrophy, spina bifida

COMMUNICABLE DISEASES – malaria, T.B., V.D., bilharzia, sleeping sickness etc.

NON-COMMUNICABLE DISEASES – arthritis, back trouble, epilepsy, diabetes, cancer etc.

4 Our definition of your future: what it's like

Most of us have been at least temporarily disabled at some time during our lives in the sense of being unable to do what we normally do. 'Flu, a broken leg, even a cut foot, give us a glimpse of what it's like. But no more than a glimpse; long-term and permanently disabled people find the world is angled against them. In Britain, for instance, the people in wheelchairs find themselves barred from most restaurants, pubs, cinemas, theatres, social security booths and public telephone kiosks. "It's the environment that handicaps us," disabled people say.

Worse than physical barriers is the attitude of those who aren't disabled (or Temporarily Able-Bodied people — TABs — as the Canadians call them, to emphasise that it's "there but for fortune go you or go I"). TABs shout at the disabled, or pretend they aren't there (the "does he take sugar?" syndrome). They treat them as children unable to take decisions or responsibilities. They assume they have no sexual desires. Worst of all, they regard them as patients who really ought to be getting better even though their disability is not curable. Disabled people are forced to accept society's definition of their future.

Such attitudes are found worldwide and often they cause a bigger problem to the disabled than the disability itself.

In the Third World, disabled people are in some ways better off than they are in Britain. They are often well-accepted in their own societies. In villages in Mexico, a survey showed that nearly one third of the disabled people had come to terms with their disability and needed no further help. The story of one boy who came to terms with his disability is told in case box 4. In China, only one country but containing one third of the people in the Third World, disabled people are given jobs that fit their skills, from scaring birds off crops to machine-operating, from child-minding to stores-checking.

But in other ways it's much worse to be disabled in the Third World. Many disabled babies are killed or left to die at birth. Others die because there is no medical care to keep them alive. Those who survive may be castrated, or hidden away in the dark out of sight because their parents are ashamed, or fear that a curse has been put on them. Mentally disabled people may be chained to blocks of wood. In Indonesia some parents give false addresses to mental homes so that their children can never be returned to them even if they get better.

Finally, many people in the Third World are disabled because they lack what we in Britain would consider simple technological aids — most obviously hearing aids and glasses — without which a man or woman may not be able to hear enough to learn, or see enough to work.

case box 4



One boy

Bangladesh

It is easy, amid the talk of millions and statistics, to forget that the millions and the statistics are made up of individual people, each one a separate human being. Easy, too, in trying to absorb the scale of misery and suffering, to forget that lots of people, in the Third World as much as anywhere, do manage to make the most of their disability and to live quite reasonable lives. Here is the story of one boy to illustrate both points.

Madhab was 15 when he fell from a tree while trying to retrieve a ball and broke his neck. That was four years ago. Today he is paralysed from the neck down but he has been employed by a rehabilitation centre as a counsellor for other patients.

After his fall he was taken to a hospital in Dacca and put on traction. Before long, the poor introduction of catheters to enable him to pass urine, resulted in fistulae forming on his body - a series of wounds in his abdomen that oozed urine from the bladder.

He nearly died three times, first from a bout of food poisoning, next from cerebral malaria and a relapse, and finally, from tetanus. He was saved when someone found an old iron lung machine and arranged for him to be put into it.

Madhab moved to the Rehabilitation Centre for Paralysed Patients in Dacca, the capital of Bangladesh, about a year ago. He has no movement in his hands and an occupational therapist at the Centre designed a special splint to enable him to hold a pen. Now Madhab designs and draws beautiful illustrations for cards and the Centre has made a little rubber stamp for them to be marked before they are sold. He can also type.

Madhab enjoys reading. He loves listening to sport on his little transistor radio and he has recently learned to play chess. Occasionally he goes to the cinema.

His family are Hindus - now a minority in Bangladesh - and have just settled across the Indian border in Calcutta. Madhab did not want to go with them, because he knew that settling in a new place would be difficult enough for them without the problem of coping with his disability.

The staff at the Centre noticed how he talked to new patients, who are often depressed and confused when they arrive at the Centre. He would urge them to fight to beat their disability and to live as full a life as possible. All this, in spite of, or perhaps because of, what he had been through himself.

So when his parents announced their move, the staff at the Centre agreed to ask him to join them as a counsellor.

5 We need not beg: altering attitudes

Until recently, most disabled people have accepted the role that societies have allotted to them. They have accepted the low status and value that others have put on them, all the more easily in that it's hard to be proud of disability.

But in the last few years, especially in North America and Scandinavia, groups of disabled people have begun to work actively to change the attitudes of non-disabled people and thus the status of the disabled. They argue that the community should be accessible to all its members, that disability is a normal part of every society, that the disabled have rights like everyone else and shouldn't be treated as children or permanent patients. They want people to accept their own description of themselves, which is very far from the charity image of sexless cripples.

They aim for *independence*; they want to have, as nearly as possible, the same control of their day-to-day lives as non-disabled people do. They also aim for what they call *integration*; they want to be able to mix in with what everybody else does as much as their disability allows, to use the same services (buses, telephones, schools, etc) as everyone else, to attend the same political meetings, to go into the same pubs. To achieve these aims, they work to get laws changed — or existing laws enforced — as well as altering attitudes.

There are now over 2,500 such “consumer” groups (as they are called) in the USA. In Britain, too, similar groups are emerging.

Internationally, a newly-formed World Coalition of Persons with Disabilities has been set up “to unite handicapped people and their organisations to more effectively press their demands” in the Third World as well as in the rich countries. In the Third World, a few organisations are taking the same line; one in India is described in case box 5. Its members, disabled slum-dwellers, say, “We have rights. We need not beg”.

Much of this sort of thing is not welcomed by conventional mainline organisations which provide services to disabled people. Some of them don't know much about changing laws, or pressing for rights, and they feel threatened by the new groups and their aims. It makes them less helpful than they could be.

This is a pity; changing attitudes worldwide is vital if the disabled are to have a better deal. All the miracle drugs, all the wonders of technology, all the loving care in the world won't be enough if the disabled are still thought of as subnormal nuisances.

case box 5



A local pressure group

India

The essence of local pressure groups is that they do things for themselves. Here is a report written by members of the Physically Handicapped Slum People Development Association of Bangalore (India).

In the slums of Bangalore, a modest attempt is being made with the help of the handicapped themselves to bring hope and self respect into their blighted lives through their own efforts to claim their right to equal participation as citizens rather than mere recipients of someone else's charity.

Krishna, a cripple from the slums, supported by the Centre for Concern for People Development, whose effort is to help 're-people de-peopled people', went from house to house, spotting out the handicapped, talking to them of the suffering of other people like them, and of their ignorance of preventive drugs that are available, and the need to unite and organise in order to realise the benefits from the Government which was their right.

"The deformity is in our bodies, not in our spirits." "Not charity, but equal rights." "We have the right to live - and to live like others." The crippled, the blind, the halt, the mentally handicapped gathered slowly and began to share their misery. "Doctors extort money for giving certificates, agents want money to bribe officials to get us pensions, postmen want money to deliver orders, and where do we go for money?"

It is the women who suffered most indignity and exploitation and they became vocal in these meetings. When they realised their need to organise and unite, in subsequent meetings, they discussed in detail clause by clause the memorandum of their society that would take shape to fight for their grievances and to build fraternity among them. Right from the beginning their participation was ensured and a management committee of men and women was elected from among themselves. The Physically Handicapped Slum People Development Association was born.

Area volunteers visit their respective areas and share their problems in a common meeting. Area public meetings are called, when the literate handicapped of the area help write pension forms, and enable people to get official documents for the poor by passing the middlemen sharks.

Very soon, a big procession would wend its way to the State capital, explaining the plight of the poor handicapped to the Government authorities and would demand facilities that would alleviate their suffering and help them emerge as equal citizens.

source: Report from the Physically Handicapped Slum People Development Association, Bangalore, India

6 Better than cure: prevention

About one half of the disabled people in the Third World don't need to be disabled. We already know how to remove the causes, or how to stop the development of disability.

Removing the causes

In theory we know how to remove or reduce many of the causes of disability. The elimination of malnutrition alone would knock 100 million off the total. Higher living standards would, as they have in Britain, dramatically reduce leprosy and TB. Vaccination can eliminate the paralysing strain of the polio virus. Better sanitation can eradicate bilharzia. Existing knowledge and techniques could cut blindness by 80% and cerebral palsy (spastics) by 40%.

In practice, it's difficult to apply the knowledge we have. The poor, who are the large majority in the Third World, have little control over such things as land reform which would enable them to grow more food, over government spending on health and water services, or over employers who cut costs on safety measures.

Stopping the effects

Once someone has got a disease or a condition which might produce a disability, it is often possible to prevent the disability from developing or at least to reduce its effect. The key in most cases is early identification and treatment. Case box 6 describes two small-scale examples of this in villages in Mexico and the Philippines.

Minimising the consequences

Once disability is established, it is still possible to do a lot to minimise its consequences. There are many no-cost or low-cost techniques, exercises and aids to stimulate muscles or minds, to increase mobility, balance, or reach.

If village health workers could be given training in such methods, both the number of disabled people and the seriousness of their disabilities could be greatly reduced.

Prevention or treatment

As human beings, we tend to give priority to the treatment; we can see the visible effects of disability, whereas people who may get disabled in the future (even including ourselves) do not excite our sympathies so much. But cost-effectively, it is prevention that pays. It is cheaper to vaccinate 100 children against polio than to provide services for one disabled child; it pays to provide safety measures to prevent home and agricultural accidents rather than institutions to care for the victims. Of course, in real life, societies have to cater for people already disabled — they cannot abandon them in favour of prevention. But the emphasis should be on prevention — it costs less, and, in human terms, it achieves more.

case box 6



Finding and helping

Mexico/Philippines

If disabilities are to be nipped in the bud, and their subsequent effects minimised, it's necessary to identify the people with disabilities. Then simple techniques, many of them costing nothing or little, can be used to prevent, reduce, or sometimes reverse a disability.

In rural Mexico, the Pan American Health Organisation is running an experiment in village disability identification. The people working on the experiment go first to the village authorities (some of whom are elected and some appointed) to ask for their help. They stress that they can't promise to help everyone that is found, at least not at first, but they hope to be able to help some.

If the village authority agrees, a team of about twenty people is selected - sometimes school-children, sometimes local health groups and sometimes just ordinary villagers who volunteer.

The first task is to paint numbers on all the houses so that they can be sure of not missing any. Then they go round to each house asking if there is or is not anyone disabled in it. If there is, the surveyor fills in another form with a few more details.

Then the local health worker sees each disabled person (with the surveyor) to discuss what can be done, to teach how to do it, to involve the family and the community and to leave behind one or more of the fifteen "instruction sheets" available. These cover such subjects as play activities, learning, movement, work, speech, sight, and so on. Not everyone can read but enough can to make the sheets useful as a reminder.

In one sense the experiment is ahead of its time in that the back-up facilities to help the disabled are not yet adequate. But that matters less than might be thought. The survey has found that only one third of the disabled people needed professional help from doctors or hospitals. The rest had either come to terms with their disability (29%) or needed only help available in their own community (41%).

In another experiment in the Philippines, two outside surveyors worked with the villagers to identify disabled children under six. They found that 21% of the 568 children they covered suffered from one or more disabilities. After only a few months of help and advice on such things as diet (breast-feeding, Vitamin A to reverse oncoming blindness, etc) and no-cost methods of stimulation to improve the condition of children with mental and muscle movement difficulties, nearly half of the children have shown improvement.

Both these experiments suggest that if villagers can be involved in identifying and helping their disabled, significant improvements can be made - at very low cost. If this sort of experiment can be refined and adapted for use as part of national health services, many millions of disabled people would benefit.

sources: Pan American Health Organisation
UNICEF.

7 Beyond the home: rehabilitation

Even with much more prevention, there would still be many millions of disabled people in the Third World. How can they best be helped?

One answer, indeed the main one so far, has been to set up institutions, mostly on Euro-American lines. These certainly have their advantages. For short-term treatment they are often the only solution — and for many people faced with long distances and bad transport, they are the most convenient one. Even institutions where people stay for a long time (often years) can act as an extension of the family, taking the burden of disablement from the very poor. There is a space too for institutions where people can stay for the most of their lives because they need care which could not be provided in their home village or slum. But there are also disadvantages.

For one thing institutions cost a lot — from £200—£1,500 per person per year, depending on local costs and the amount of voluntary help they get. At present they cater for perhaps 2% of the disabled in the Third World. If we somehow doubled that number, they would still cater for only 4%. It's been calculated, for one African country, that if the entire health budget were devoted to institutional care, it would take 200 years to reach every-one disabled.

Even if the money was available, institutions still wouldn't be the answer. They concentrate on the disability whereas disabled people possess a lot of other things besides their disability. Institutions don't change attitudes. Indeed, they reinforce the way the public sees disabled people (as suitable to be shut away in "homes") and also how disabled people too often see themselves (dependent "patients"). Finally, institutions seldom take advantage of the help that families can give.

Unfortunately, many civil servants and medical workers in the Third World insist that Euro-American style institutions are the proper answer and that anything else is humiliatingly second-rate.

The most important asset for anyone trying to help someone disabled to make the most of their life is their family. What's needed is help for the family members to overcome their fears and superstitions, to enable them to help their disabled relative and to get whatever outside help is available. Work at this level keeps the disabled person within his own family and village or neighbourhood setting; it can do a lot to maintain him or her as an ordinary human being. An example of how the family can be involved is given in case box 7. Case box 12 describes a different approach — do-it-yourself manuals.

If we are to do more than help a tiny fraction of disabled people then we must go beyond the institutional home. We must take the service to the people (all the more so in that so many of them cannot easily move) and help those who can be most helpful to disabled people — their own family.

Yellow Pages
facts for reference

ACCIDENTS

WHO estimates that some 75 million people worldwide are affected by accidents. The three main types are traffic, work and home accidents.

Traffic accidents are probably less widespread in the Third World because of the number of people who live in the countryside where roads and vehicles are still rare. But transport networks and urbanisation are increasing. Accident rates are likely to be high where, as in much of the Third World, vehicles, cycles, animals and people share the same carriageway.

Work accidents affect about 15 million people worldwide. In the Third World, the majority are caused by agricultural work (cut limbs, falls, etc) because that is the work the majority do. But those in industrial work are at risk through low safety standards, lack of training and absent or inadequate protective equipment.

Home accidents involve about 30 million people worldwide. Babies and small children are particularly at risk from open cooking fires on the floor.

ALCOHOL AND DRUGS

In some countries alcoholism and drug abuse are major causes of disability but they are often hidden behind a more respectable diagnosis and often, indeed, remain unmeasured altogether. In Chile, 5% of the population over 15 are alcoholics though the rate is lower in most countries. In Iran, 1–2% are dependent on drugs and in Thailand 1–4%. WHO estimates that about 40 million people worldwide are disabled in that they "have difficulty in performing one or more of the activities that are generally accepted as essential basic components of daily living" through alcoholism or drug abuse.

BILHARZIA (schistosomiasis)

People affected – About 850 million worldwide, mostly in the Third World. In some countries, rates are very high; in Egypt, for instance, 50% of the population are affected.

Symptoms – A short fever, followed, several weeks later, by mild but relentless inflammation of the liver, intestinal veins, lungs,

bladder, etc. In many cases this leads to general weakness and debility, making it difficult to work. Only severe cases are classified as causing disability.

Cause – The worms of a small fluke or flat-worm live as parasites in human veins. Their eggs, each armed with a small spike, set up an irritation in the affected organ. In time, the normal structures are replaced by scar tissue which becomes rigid and shrunken, leading especially to bladder and liver trouble.

The eggs leave the body in urine or stools. They hatch in water (streams, ponds, canals, etc) and develop as parasites in snails. After incubation, they leave the snails as larvae and it is these which can penetrate the skin of any human in the water. Inside the human they hatch into worms.

Cure – It is possible to cure bilharzia with drugs, though most have unpleasant side-effects. But people get rapidly reinfected if they enter the water. Bilharzia can be prevented either by destroying all the snails (massive anti-snail campaigns have been held in China) and/or by sanitation to prevent the water from being reinfected.

BLINDNESS

About 42 million people worldwide are blind or partly blind. The three main causes are nutritional, degenerative and infectious.

Nutritional

Vitamin-A deficiency is the chief cause of two diseases which both damage the cornea (the transparent covering on the front of the eye which helps to focus light on the retina). It particularly affects children under 6. Probably about half those affected die because of malnutrition.

Degenerative

The main cause is cataracts – a cloudiness in the normally clear lens of the eye. Cataracts are associated with ageing. About 17 million people worldwide are severely affected by cataracts and many more are affected to some extent; in India alone, for instance, about 30 million people have cataracts. Glaucoma is another condition associated with ageing.

Because people die younger in the Third World than they do in Britain (typical life expectancy at birth is 40–50 years, compared to over 70 in Britain), there are many fewer old people. Consequently, the partial sightedness and blindness associated with old age is much less common than it is in Britain.

Infectious

The two main causes are:

Trachoma

People affected — Probably the most widespread infectious disease in the world. About 500 million people are affected, of whom 2 million are totally blind and another 8 million "economically blind" (that is, their ability to carry out useful work is reduced).

Symptoms — Inflammation of the clear membrane covering the eye (the conjunctiva).

Cause — A virus transmitted by direct contact with infective material. Flies, lack of clean water, inadequate sanitation and overcrowding contribute to its spread.

Cure — Trachoma can be cured by sustained treatment or by antibiotics, and the inverted eyelid treated by surgery. There is no effective vaccine.

River blindness (onchocerciasis)

People affected — About 20 million, mostly in the Volta river basin in West Africa and in Central and South America. About 500,000 are totally blind and the same number partially sighted.

Cause — Filarial roundworms are transmitted as larvae by a small gnat, the blackfly. The worms, up to 4 inches long, live for many years and regularly produce larvae. There may be 40–50 million in the blood at any one time. Blindness results when the worms invade the eye.

Cure — A drug called *Banocide* kills the larvae but not the worms. Prevention is through controlling the environment so as to discourage the blackfly.

DISABILITY

Technically, disability is the second of a three-part series of terms but it is often used loosely to cover them all and that is how it is used in this booklet. The three-part series goes like this:

Impairment

the actual loss or abnormality that affects the body or mind; for instance, the loss of a limb or other organ, a defective mechanism (such as diabetes or paralysis), disturbed perception, disfigurement or mental retardation.

Disability

the physical or mental result of the impairment; the partial or total inability to perform mental or physical functions in the way that humans can normally perform them, functions such as walking, lifting loads, counting, taking an interest in and making contact with surroundings, eating, etc. Disability may be short-term, long-term or permanent.

Handicap

the resulting difficulty in performing one or more of the activities that are generally accepted as the essential basic components of daily living, such as looking after yourself, social relations and working. These activities vary with age, sex, country and social status.

Handicapped people are thus those with a physical, sensory or mental handicap of sufficient impact to prevent them from functioning fully as people of their age and sex are expected to do in their societies.

The term 'disability' has been criticised (along with other terms like 'handicap', 'impairment' and 'limitation') for reflecting a negative view of people. It has been suggested that it would be better instead to focus on 'abilities' or 'activities'. But this becomes complicated in use and WHO concludes that, despite its negative cast, the term 'disability' is known and accepted worldwide.

Note, however, that it is best not to refer to 'the disabled'. Disabled people feel that this de-humanises them (rather like 'the African', 'the house-wife', etc). They prefer 'disabled people' or (better though longer) 'people with disabilities'.

FEMALE CIRCUMCISION

Mutilation of the female genital organs is common in Africa, where it is estimated that about 74 million girls and women are affected. Circumcision is, in fact, only one of three forms of mutilation, the most severe of which involves not only the excision of the clitoris and the labia (both *minora* and *majora*) but also the sewing up of the vulva leaving only a small hole.

After even the mildest form, orgasm is impossible and this in itself could be considered a disability. Genital mutilation can lead to the growth of cysts, neuroma (making the whole area unbearably sensitive to the

touch), sterility, incontinence and birth injuries, both to the mother's reproductive organs and to the baby who often suffers brain damage due to long and obstructed labour.

The extent and consequences of genital mutilation have only recently become widely known and most disability statistics do not include it. In its milder form it is possible to avoid classifying it as a disability in that orgasm may not be generally accepted as normal in the countries where circumcision is practised. But in its commoner, more severe, forms it is not only a disability itself but can also lead to others.

Some African women are beginning to work for change but they caution well-meaning outsiders from rushing in to try to stop a long-standing and deep-rooted practice, which, ironically, is carried out by and at the request of women.

HANDICAP

Originally a sporting term, used to describe the means that are taken to reduce the advantage of a superior performer (human, horse, dog, etc) over other competitors. In the health field, handicap is widely used to mean disadvantage. But it is also used to describe impairment, functional limitation and disability.

In a recent survey (*New Society*, December, 1980) people tended to use 'handicap' to describe a mental condition, or something you are born with, and 'disability' for something physical caused by an accident or disease. To avoid confusion, the term 'handicap' is not used in this booklet.

INCIDENCE

The number of *new* cases (of a disease, illness or disability), over a given period of time, usually annually. In the Third World many severely ill or disabled babies die or are killed, so the incidence is usually much higher than the *prevalence*, which measures the *total number* of cases existing on any given day. Incidence is often double prevalence, so it is worth checking which any given figure refers to.

IYDP

The United Nations adopted the Resolution designating 1981 as the International Year of Disabled People (IYDP) in 1979, though preliminary work and lobbying had been

going on for several years before that. In setting up these Years (or sometimes Decades) the UN aims to focus attention on a subject (Refugees, Women, The Child, International Co-operation, Tourists, Youth, Films, The Elderly, Pure Water) and to encourage people and governments to do something. The Years have come in for a certain amount of criticism on the grounds that they produce little more than paper and co-ordinating committees but it is significant that disabled people were very keen to have their own Year, and some of them lobbied hard to get it.

IYDP's theme is "full participation and equality of disabled people in all aspects of society and greater public awareness of the needs of disabled people".

Its aims are to:

- 1) help disabled people in their physical and psychological adjustments to society,
- 2) promote efforts to provide disabled people with proper help, care, training and guidance, make jobs available for them and integrate them fully into society,
- 3) encourage research into things that will help disabled people take part in ordinary life, such as access to transport and buildings,
- 4) educate the public on the rights of disabled people to take part in and contribute to economic, social and political life, and
- 5) promote prevention and rehabilitation.

LEPROSY

People affected — About 20 million, nearly two thirds of them in Asia, and most of the rest in Africa. Tends to occur in poor families with overcrowded housing.

Symptoms — Depigmentation of the skin and a loss of nerve sensation. This makes it hard to avoid accidents (for instance, through burning) and ulcers. The lack of sensation remains after the disease has gone, leaving what are known as 'burnt-out cases'.

Cause — A bacillus closely related to the TB bacillus. It is not hereditary. There is a spectrum running from non-contagious to mildly contagious. 80–90% of people with leprosy in most countries are non-contagious.

Cure — A drug called *Dapsone* is an effective cure, though it takes 2–4 years, may produce dangerous reactions and is beginning to produce a resistant strain of micro-organisms.

In almost all countries there is a strong social stigma against lepers. It is sometimes called *Hansen's disease* (for instance, in Brazil) in an attempt to avoid the stigma. It is very difficult to discover it early or to persuade people to take treatment. Oxfam is strongly against segregation into special institutions ('leprosaria' or 'leper colonies' as they are sometimes called) as this encourages people to conceal the fact that they have (or may have) leprosy and is, in any case, unnecessary.

MALARIA

People affected — About 200 million. Widespread in the Third World. It is estimated to kill one million people a year in Africa.

Symptoms — Recurrent attacks of fever. There are four types of malaria, the most dangerous being cerebral malaria which can easily damage the brain.

Cause — Four species of parasite carried from person to person by the *anopheles* mosquito. The female must suck blood for her eggs to mature and as she does so the parasites are passed on.

Cure — Drugs based on quinine can both prevent and cure. But real prevention lies in the eradication of the *anopheles* mosquito. In 1955 WHO started an eradication programme based on the pesticide DDT. For a while it made good progress but the mosquitoes soon built up a resistance and malaria is now rapidly returning to areas once free of it. Meanwhile, the parasite itself is developing resistance to the quinine-based drugs.

MALNUTRITION

People affected — About 500 million people are affected. The long-term effects are particularly harmful to children and WHO estimates that about 100 million of them are impaired or disabled as a result. Many people with malnutrition-based disabilities also appear under other headings, as with endemic goitre, or blindness caused by Vitamin A deficiency. Two particular dangers for small children are over-diluted artificial milk (instead of breast-milk) and weaning (they are not given enough food to supplement milk).

Symptoms — Lack of energy, stunted growth and vulnerability to disease. The two worst manifestations are *marasmus* and *kwashiorkor* which affect very young children, who need twice as much food in relation to their bodyweight as adults.

Cause — Not enough food. It is poor people who do not have enough food; malnutrition is a disease of poverty and ignorance.

Cure — Enough food. At the moment there is enough food produced in the world to avoid malnutrition entirely. It is a question of ensuring that everyone has access to it.

MENTAL DISABILITY

Severe mental disorders (for instance, schizophrenia and phobic states) form one of the highest categories of disability. WHO estimates that "at a given time, at least 1% of any geographically defined population suffers from severe mental disorders and that at least 10% will be thus incapacitated at some period in their lives. The prevalence for less severe mental disorders is much higher". About 40 million people in the Third World suffer from severe mental disorders. WHO also estimates that a further 40 million suffer from mental retardation (not reaching human development 'milestones' on time, or at all). Mental disability is thought by many to be the largest and fastest growing category of disability in most countries.

Major causes are *congenital* (hereditary and damage during pregnancy or birth), *infectious* (brain damage resulting from, especially, measles, meningitis and cerebral malaria) and *stress*. This last includes stress arising from daily living (bad harvest, illness, debt, etc), from political fear (especially, in the last few years, in Chile, Kampuchea, Uganda and Guatemala) and even from development projects (lost jobs due to technical innovations, repayment of credit needed to take advantage of new seeds, etc).

ORTHOTICS

Artificial attachments or fittings designed to strengthen parts of the body; for instance, calipers, braces and clogs. Most of the crippled people in the Third World could be helped with such devices if they were available at low cost, though not everybody *wants* to be helped in this way. They are more mobile on knees, bottoms, hands, etc. Boots and clogs are important to people who have lost sensation in their feet through leprosy.

Locally available materials should be used to make simple and strong fittings. Local materials make for cheap appliances more susceptible to emergency repairs. Low cost appliances are particularly important for children, who need frequent replacements.

POLIO (poliomyelitis or infantile paralysis)

People affected — About 1½ million people — mostly in the Third World.

Symptoms — A mild, feverish illness, like 'flu. About one person in 100 of those who get the fever goes on to develop paralysis. Complete recovery is possible but some degree of permanent paralysis usually results. About 5–10% of those paralysed die, or are 'neglected to death'.

Cause — The polio virus. It enters the body through the intestine wall cells when someone swallows a bit of human faeces. In 9 out of 10 people it is overcome by the body's defences and gives lifelong immunity. About 10% contract mild fever and about 1% of these develop paralysis, when the virus invades the nerve cells in the base of the brain or those in the spinal cord which control muscle movement. The older you are when you get it, the more likely you are to develop paralysis.

Cure — Once contracted, polio cannot be cured. Prevention is through immunisation. At present it costs about 90p to immunise one person in the Third World. Unfortunately, polio cannot be eradicated as smallpox has been but the 'wild' virus (which causes paralysis) can be replaced with a 'vaccine' virus (which doesn't). This is called clinical eradication.

PREGNANCY AND BIRTH

About 20 million people worldwide are disabled because something happened to them during pregnancy or at birth. Most of them are in the Third World, where about 80 million births occur each year, with a risk that is several times higher than in the rich countries.

There are three main causes:

- *malnutrition and severe anaemia during pregnancy,*
- *disease during pregnancy, such as German measles, 'flu or syphilis, and*
- *damage during actual birth, often caused by low-quality midwifery.*

PROSTHETICS

Artificial substitutes for a part of the body — for instance, wooden legs, false teeth and glass eyes. Artificial legs are the main form in the Third World; artificial arms are not much used. Not all people who have lost a limb want an artificial one; sometimes, as in India, the acquisition of a leg would mean the loss of livelihood as a beggar. In Jamaica it has been found that not everyone uses the limbs provided. Because of this, it is often best to make a very small charge for artificial limbs, so as to force people to decide whether they really want them.

Wooden legs often need to cope with wet and muddy conditions and the solid ankle cushion heel is better at this than more complicated and expensive metal ones. They are best made by local carpenters and shoemakers from local materials, so that they can be accurately fitted and easily repaired.

REHABILITATION

Rehabilitation is the last phase of a three-stage series, the first two being *prevention* and *curative care*. It is defined as "the combined and co-ordinated use of medical, social, educational and vocational measures for training or retraining the individual to the highest possible level of functional ability". It deals with not only physical disabilities but also a whole range of health problems including psychiatric disturbance, drug dependence and mental retardation.

Rehabilitation measures include medical care and treatment, therapeutic measures, training in self-care activities (such as mobility, communication, body care), technical aids (crutches, hearing aids), education, social counselling and assistance, and vocational training and placement designed to enable someone disabled to find suitable employment.

Rehabilitation is based on the philosophy that what a person is capable of doing is of greater importance than what he or she can't do. It aims to make the maximum use of all the abilities that each disabled person possesses.

Rehabilitation relates mainly to actions aimed at the individual and it neglects those aimed at changing things in his or her immediate surroundings or in society at large. Concentration on rehabilitation is sometimes criticised because of this.

The term rehabilitation should not be used to describe long-term care needed by severely disabled people in institutions where this is not aimed at bringing about a change in their condition. The term "care of the disabled" is used here.

SPASTICS

A term used to describe someone with cerebral palsy (also known as Little's Disease) where, due to brain damage, the muscles are kept permanently taut.

This is called spastic paralysis; where they are limp it is called flaccid paralysis. The paralysis is due to failure of groups of nerve cells in the brain; it can be caused by jaundice at or soon after birth, or physical injury, or shortage of oxygen during birth.

SUICIDES

Unsuccessful suicide attempts affect about 2½ million people each year. Methods include the use of firearms, explosives, poisons, gas and burning, many of which may result in future disability. In the Third World pesticides are commonly used.

THIRD WORLD

The term used to describe the 100 or so poorest countries in the world, containing about three quarters of the world's people. About one third of these 3,000 million people live in China.

It is not a very satisfactory term but nor is any other. The countries of the world form a spectrum running from the very rich to the very poor. And many poor people live in countries that are relatively rich as conventionally measured (for instance, by average income per head), so there is no easy way of describing the countries with a lot of poor people in them. 'Under-developed countries', 'less-developed countries' and 'developing countries' have been used. The term Third World does reflect the diversity of the countries it describes and it is short. The terms First and Second Worlds are not much used; they refer to the Soviet Union and Eastern Europe on the one hand, and to North America, Western Europe, Japan and Australia on the other. The division is political, not economic, and it is the user's political standpoint which determines which group of countries is called First and which Second.

TUBERCULOSIS (TB)

People affected — About 50 million, mostly in the Third World (it has virtually disappeared from rich countries).

Symptoms — Fever, cough and loss of weight.

Cause — The tubercle bacillus, which is transmitted through droplets expelled by coughing. Malnourished and diseased children, especially in overcrowded housing, are particularly likely to catch it.

Cure — Recent research shows that immunisation gives little protection for chest TB, though it may be effective for meningitis and bone infections. A mixture of drugs can cure most cases. In the long run, the first line of prevention is better nutrition and housing conditions. These were the factors which have all but wiped out TB in the rich countries in the course of the last few decades. But there is no need to wait for these conditions; it is possible to reduce TB dramatically by finding and treating people with the disease and tracing contacts.

WAR

In view of the high number of wars in the world (roughly one every 6 weeks since 1945), the number of war-disabled is surprisingly small. WHO estimates that about 3 million people worldwide are disabled through war, cyclones, earthquakes, floods and sport.

One reason why numbers are not higher may be that in the Third World people severely disabled in wars die; they cannot be got to treatment centres in time. Certainly in Oxfam's experience most surviving war-disabled people are only mildly disabled. War-disabled people tend also to be young and male, since most fighting involves proportionately more of them, though of course bombing (as in Kampuchea and Vietnam) affects the whole population of the area bombed.



A child development aide (left) visits a mother in her home. Maxwell, UNICEF

Rehabilitation at home

Jamaica

Disabled children are often neglected. Their families think they will grow into dependent, non-productive adults. It is assumed (not only by their families) that their education requires a team of highly qualified specialists, perhaps with expensive equipment, working on a one-to-one basis, and is, therefore, bound to be very expensive. UNICEF's Early Stimulation Project in Jamaica is designed to disprove both these ideas.

It is based on the idea that a significant proportion of the disability is caused by depriving the child of information, usually through ignorance and poverty, but sometimes through deliberate neglect. Mothers don't space their children and so have little time for each; the style of upbringing in Jamaica involves punishment as a means of discipline and learning, with the result that the child becomes programmed to react to threat.

The Project aims to provide continuous very local help, especially to the mother (or grandmother or other relative if the mother goes out to work). So it has recruited and trained Child Development Aides, teachers who help the mother to train her child and to develop his or her skills and capacities. These Aides are women who don't have much education but who do have a mature and understanding personality. They are given some training (and more at regular intervals) and they visit an average of 12 children's families a week. There are back-up facilities in the form of regular medical assessments and checks in schools. The Aides are adept at making use of local materials - for instance, simple toys which the parents help to make from recycled waste materials.

The first analysis of the results covered 36 children whose development was compared with normal children. The results showed that the mildly and moderately disabled children did almost as well as the normal children. The more severely disabled didn't, of course, but even they gained twice as many skills as would have been expected with no stimulation at all.

The cost was about £60 per child per year - a lot if you multiply it by the number of disabled children in any given country but considerably less than the sort of high-level institutional care that many people still think is the only alternative to doing nothing.

This is an example of the many small-scale experiments around the world which produce encouraging results. But it's important to remember that they are only experiments, that the people who run them are highly motivated enthusiasts and that everyone involved is likely to become excited in some degree by the novelty of the approach. The difficult task is to translate one-off, successful experiments into a widespread routine service that's part of regular education and health programmes.

8 Keep it local: technology

Technology can do a lot to reduce the effects of disablement. Millions of people in the rich world aren't disabled because their hearing aids and spectacles enable them to act as if they weren't. In the Third World the main problems are knowledge, cost and distribution. The more that people can learn how to make things locally out of local materials (which are usually free or very cheap), the more disabled people will be able to benefit.

Some aids cost nothing, or almost nothing. A simple wooden frame enables a blind Indian farmer to sow in straight lines. A shawl, held at each end and looped under a child's stomach, can help her to learn to walk. A table-top can be re-shaped so that a child can stand within it, supported by his elbows, and help with household work. A simple frame of branches can support a child learning to walk, or getting up from squatting at the toilet.

Some aids cost more but they needn't cost much — calipers, for instance, to support the legs of paralysed people, mainly those who have had polio. The types made in Europe and America are not suitable in the Third World; they cost too much and their complicated design makes them harder and costlier to mend. Calipers designed in Uganda are manufactured by virtually unskilled workers without the use of screws, welding or heating. They cost one fiftieth of the imported calipers.

Sometimes maintenance is the problem. Hearing aids, for instance, must have regular maintenance or they become useless. Many technical aids are, in fact, unsuitable for use by rural people. Standard artificial legs, for instance, are unsuitable for people who have to work in water-covered paddy-fields, planting or tending rice. They do better with a wooden peg-leg; it is easier to balance and less likely to rust or go wrong.

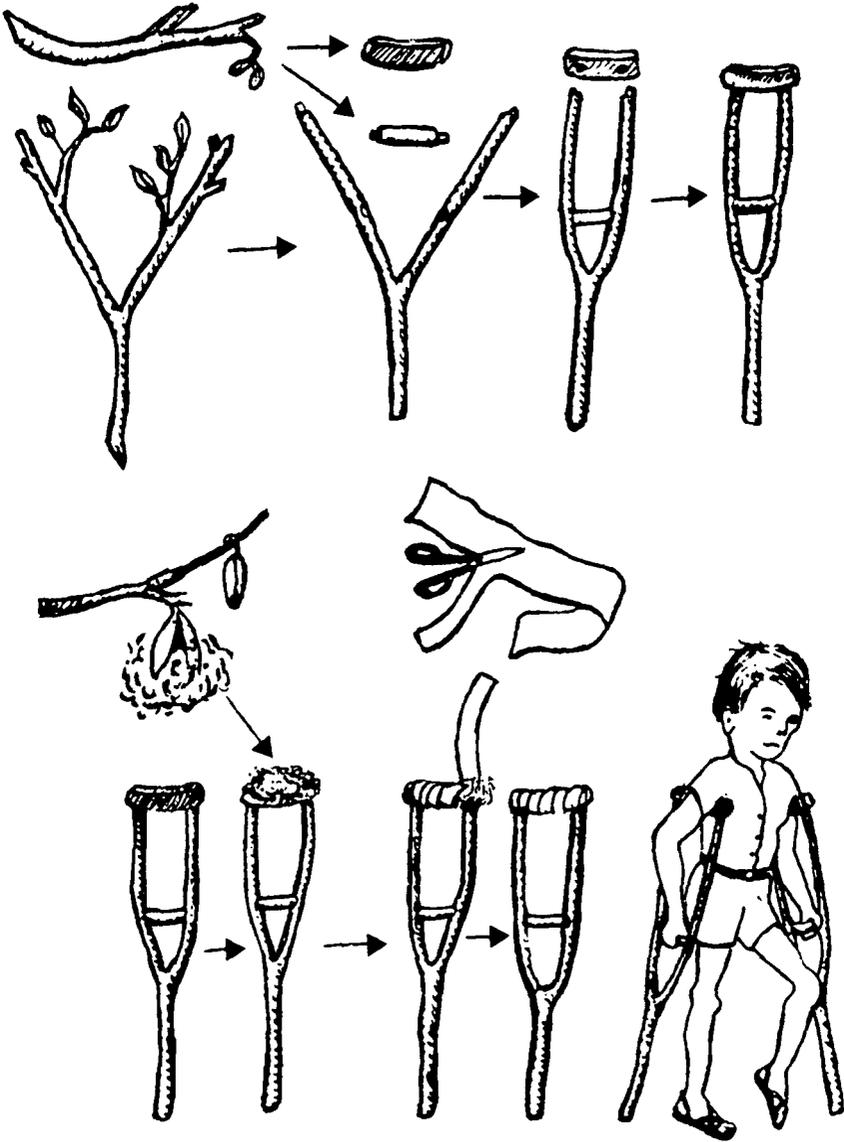
The trouble is that almost all the technical work has been done by and for people who live in towns. In the rich world most people live in towns and in the Third World most of the institutions and technical and manufacturing centres are in the towns. So there is relatively little understanding of how technology can be used to help people in a rural setting.

It is tempting to think that we in Britain may be able to put our technological ability to work on behalf of the disabled in the Third World. But experience seems to suggest that, on the whole, design is best done in the place where it's needed and if possible with the help of the people who need it.

case box 8

Locally made aids

Here is a diagram showing how a common aid can be made locally. The crutches illustrated require very little skill or equipment.



source: David Werner, Where There Is No Doctor, Macmillan and Co., London

9 If no bird sang but the best: employment

Everyone has the right to contribute to their family or their society — to have a job. Maybe disabled people have a slightly stronger right; they need the boost of self-reliance and independence that a job can give more than people who aren't disabled. But in fact they don't ask for a stronger right, merely an equal one. They don't ask for charity, merely equality of opportunity. The woods would be silent, they say, if no birds sang except those that sang best.

If they had equality of opportunity, many disabled people would be in a very strong position to get jobs. Blind people, for instance, are often good at massage, operating telephone switchboards, or sexing day-old chicks. Deaf people can work in noisy surroundings. Some mentally disabled people can be happy doing simple, monotonous jobs. According to the UN's International Labour Office (ILO), disabled workers tend to have higher productivity because they are diligent, they concentrate better, and they take more pride in doing their work. Perhaps, too, they are more frightened of losing their job.

Unemployment is even higher in the Third World than it is in Britain. With no social security, people are desperate to get work, even part-time work, in order to stay alive. Why should anyone worry about employing the disabled? Most don't, but surprisingly some do. In India, for instance, employers are supposed to employ 3% disabled people, and they get a small tax advantage for doing so. But that's mostly in the towns of course; in the countryside, in India, as elsewhere, the employment scene is one of despair. What can be done?

The standard answer is a sheltered workshop, where the disabled work under supervision and sheltered from full commercial pressures. But there are several disadvantages to this approach in the Third World; the workshops can only handle a few people, and they rely on charity for support; the workers compete with other workers; and the goods produced are often shoddy.

One alternative is agricultural work. This has many advantages. Disabled people can grow food for survival without relying on charity, they can avoid competing with other job-seekers and the cost of training and equipping them is low. A scheme of this kind in Malawi is described in case box 9. But even this approach has its limits; in some parts, in India and Bangladesh, for instance, there isn't enough land even for small-scale horticulture by disabled people because richer people own the land.

Employment is a tough issue. It's not only the disabled who need employment, though their need and right is at least as great as anyone's. They are already penalised by their disablement — we should try to see to it that they are not penalised any more.



Blind farmers

Malawi

It's surprising to most sighted people that blind people can do a lot of farm work. In Malawi there are two large Government-run agricultural schemes where new land is being opened up for cultivation. In each, a small number of blind people are included. The scheme is run with the help of the Royal Commonwealth Society for the Blind.

All the farmers grow cotton, groundnuts, rice and maize, and all have access to advice on better farming methods, credit, fertilisers and pesticides. The blind people get extra help in the form of special teaching and supervision but they are treated very much as ordinary settlers, with access to the same facilities, the same scope for rewards in the form of good crops and the same penalties if they don't work.

Many of the sighted settlers lack the stamina to continue and so pull out. So do some of the blind farmers. And some fail to make the grade; one has been sacked for persistently refusing to work and another for selling fertiliser and pesticide obtained on credit in order to buy drink. There's a price for being treated like everyone else.

The area is a hot one, with malaria and irregular rainfall. Some years the crops do well; when they don't it's hard, sometimes impossible, to repay credit. But on the whole the scheme is doing well - and the blind farmers with it.

An Oxfam Field Director wrote: "It is to me an incredible sight to watch a completely blind man spraying his rows of cotton at a smart walk, and managing to do so without losing the row or walking into the bush at the end of the row. Periodically he also trails his hand to feel that the spray nozzles are not blocked.... I was very impressed by the way that the farmers managed to weed comparatively large areas of young cotton without even once damaging the crop the fact that they did as well as the average sighted farmer last season proves that they are capable of supporting themselves and must give back to them the dignity that many had previously lost."

But the blind people are, to some extent, dependent on their sighted wives and families; it is much more difficult if both husband and wife are blind.

An encouraging aspect has been a change in the attitude of the sighted people towards the blind ones. There is increasing co-operation between the blind and the sighted settlers - for instance, help in spraying cotton, gifts of food to people who are short, financial help at times of illness, etc.

This is an example of a rather successful scheme which treats disabled people, as much as possible, like others, setting them the same targets and providing them with the same facilities. It also illustrates the importance of families and the possibility of changing public attitudes.

10 The end of poverty?: targets

Targets are tempting — especially in IYDP. There's a lot to be done to prevent, maybe, half the disabilities in the world and delay or alleviate many of the remainder. Why not set ourselves a target, a deadline by which we will have reduced by so much each disability — blindness, polio, leprosy, etc ?

There are two types of problem; one has a single correct and checkable solution, like the answer to a sum or a crossword puzzle. The other has many partly correct solutions, but it's not possible to check which is the most correct. There's no single correct checkable solution to a marriage relationship, for instance, or to running a village co-operative.

Disablement includes some of each type. The reduction of disabling diseases, for instance, is the first type. Smallpox has already been wiped out; other diseases could be drastically reduced. In some cases the solution isn't yet clear — but it's still possible to set a target for, for instance, the development of a vaccine, or of a cheap effective treatment. Such targets are worth setting, even though they may be difficult to meet. And there are many difficulties; one is that drug companies are often not interested in cures or vaccines for the diseases of poverty — the poor are too poor to buy them.

The World Health Organisation (WHO) has set a target of making immunisation available to all the children in the world for polio, TB, diphtheria, tetanus, whooping cough, and measles by 1990. The Save the Children Fund is working with them on the polio campaign. The UN has set a target of making clean water available to everyone by the same date.

But disablement includes the second type of problem to which there is no single, correct solution. The most obvious example is our attitude towards disabled people which cannot be changed by money and technology. In these cases it is not possible to set specific targets and there are only rather general ones, such as Oxfam's (fewer disabled, and a better life for those who are) or Rehabilitation International's detailed (44-point) *Charter for the '80s*, calling for such things as the reduction of malnutrition and the involvement of Trade Unionists in reducing accidents.

There is a danger that targets can divert attention from the real problems. It is easier to go for a target of water-pipes or taps instead of clean water, for measurable targets like the reduction of a disease, instead of intangible ones like changing attitudes.

But targets can be useful, provided that we see their limitations. And provided that we remember that the basic cause of disablement is poverty, and our main target is to end it.

case box 10

The British Government's aid

The British Government doesn't really have a 'programme' of aid to disabled people in the Third World; indeed, even during IYDP, it finds it hard to put a figure on how much it is spending on schemes which are designed to benefit them. Much of its programme is designed to reduce poverty, though, and so it should reduce disablement too.

The British Government's normal policy with its aid programme is to respond to requests from Third World governments. There is, of course, a certain amount of room for negotiation within this policy both positively (why don't you ask for this or that?) and negatively (we don't finance that sort of thing). But disablement comes so low in the priorities of most Third World countries that funds are very seldom requested for it. If they were, the Overseas Development Administration (ODA) claims, Britain would respond by devoting a higher proportion of its aid budget to preventing or treating disablement. The present Minister for Overseas Development, Neil Marten, has been Vice-president of the Disabled Drivers' Association and so he may be assumed to be personally sympathetic to the needs of disabled people.

So it's primarily up to the Third World governments to ask for more aid for disablement if they want it, although, given the state of Britain's aid programme, it is hardly likely to be extra money, only funds diverted from an alternative use. But funds for disablement are very likely to benefit the poor, disablement being primarily a disease of poverty, so it could be argued (at least by those who think that more aid should go to the poorest) that Britain ought to stimulate more requests for it. This could easily be done through the use of visiting advisers or ODA staff in the Third World.

Britain's aid for disablement falls into three main parts:

Research. During colonial times, Britain built up a worldwide reputation for research into diseases common in the Third World. This work, perhaps more useful to the very poor than anything else in the aid programme, continues today. In 1979 the ODA was financing projects costing £1.5m. Most of the work was being done in Britain. The two main subjects were leprosy and malaria.

International organisations (primarily WHO but also UNICEF and others). In 1980/1 the ODA contributed £7m to WHO. Part of this went to finance projects specifically designed to reduce or prevent disabilities - eg the river blindness campaign in West Africa (the ODA has spent £3m on this in the five years up to 1980) and the Expanded Programme of Immunisation, an international campaign to immunise all children under the age of five by 1990. In addition, WHO runs many schemes to prevent disabilities and part of the ODA's contribution goes towards them. The same is true of the ODA's contribution to UNICEF - nearly £6m in 1980/1.

Voluntary agencies. The ODA contributes up to 50% of the cost of projects funded or run by voluntary agencies, such as the Royal Commonwealth Society for the Blind, the Save the Children Fund, or Oxfam.

sources: Correspondence with the ODA;
Report on Research and Development, 1979, HMSO, London, 1980

11 The price of a leg: motives

None of the targets are likely to be set, let alone met, unless the countries of the Third World set them and decide to meet them. What would be their motives for doing so? Disabled people are usually a low priority — should they be the higher one?

There are two possible motives for doing more about the disabled — the financial and the humanitarian.

The idea that helping the disabled could have *financial* benefits seems to have grown up in the '40s and '50s. It was given a boost by the discovery that a rehabilitation service in Guatemala had in three years reduced the average period of treatment for injured workers from 203 days to 37. Since then, people have put forward the financial benefits of getting someone disabled back to work, or of reducing the cost of treatment, pensions, etc.

The main financial benefit is more productive capacity. But the people most likely to give a “return” on money “invested” in their future are rather special disabled people — most obviously the young, educated (or capable of being educated), male, inhabitants of industrial areas. So a policy based on financial benefits is unlikely to do much for most of the disabled people in the Third World.

In the *humanitarian* approach the benefits are seen from the point of view of each individual and his or her family. They include physical and mental improvements, less suffering and pain, less dependency on others, higher social status and acceptability and less work for the family in looking after the disabled person.

But estimating the cost of all this is difficult. These benefits don't have measurable values, and so it's not possible to say how much should be spent to achieve them. If we set the value high enough, more than the whole health budget of most Third World countries could be spent on the disabled. A Tanzanian attempt to achieve the benefits at low cost is described in case box 11.

So a balance has to be found. WHO suggests that quantity (helping as many people as possible) should be the priority, rather than quality (helping a few people a lot). As Halfdan Mahler, the Director-General of WHO, puts it, “Planners should not be asking to how many people can we give good health care? But, given these resources, how do we use them to provide health care to everyone?” Probably the best balance, as usual, is to give prevention the priority treatment.

If the countries of the Third World are to give disabled people a higher priority, it must be in the name of a just society, a society not prepared to write off 10% of its population, nor prepared to tolerate misery because it can't be measured.



Ndugu Dhavaba outside his house with some of his crops

Village integration

Tanzania

Tanzania has high aspirations of setting up a just society, providing as full a life as possible for all its members. Yet, it has very little money to spend on disabled people. Its solution is to make sure that everybody possible lives with and is cared for by their families, leaving only those for whom institutional care is essential and those whose families cannot be traced. Most of the latter are elderly people who left home long ago to work on sisal, tea, cotton or coffee plantations (crops which are mostly exported to Britain).

For them, the Tanzanian Government is experimenting with village integration. The idea is for groups of 36 to live in the middle of ordinary villages, contributing what they can with their own labour and skill, using a minimum of Government money and services and relying on the villagers for the rest.

In Salame, a village in northern Tanzania, the first of those experiments has started. The disabled people were able to move into some disused huts left over from a colonial tse-tse fly research station. The villagers gave them seven acres of land. The disabled people help to sow and weed and harvest but the villagers give their labour to help. There was also a plan for a chicken unit but this seems to have gone awry.

The initial disused huts were only intended as temporary accommodation. New ones are being built to a slightly higher standard than the villagers'; the disabled people are all adults and need more privacy than ordinary families, for instance, while some of them are incontinent and need concrete floors.

The villagers have been contributing labour; each section of the village contributes one man each day (often a different man) to make up a 6-man team. Half of the team are paid in food from the Government and the other half work for free. The villagers seem to take this free labour for granted; "Of course we help," they say, "the disabled people can't build for themselves".

But although it's a start, it's only a shaky one. The village is a particularly poor one and can barely feed itself (it can't in a bad year). How can it be expected to help feed a further 36 people? And the villagers weren't properly consulted about the scheme; it was thought up by the Regional and District authorities. Also the new houses cause resentment. The villagers, too, are living in temporary accommodation (most of them only moved into Salame in the past five years) and though they will eventually build themselves better houses, for the moment they resent the contrast.

So things haven't gone too well yet but well enough to make people (including Oxfam) think that the idea could work at a second attempt, if the lessons learnt in the first are taken into account.

12 Suffering long: charities

The main motives are humanitarian. So it's not surprising that charities are widely involved in helping disabled people both in the rich and in the poor countries. Many of the charities in the Third World are branches of those in the rich countries, or are closely modelled on them. They were set up in the charitable tradition of Western Europe to "bind up the wounds of society" as Britain's Charity Commissioners have it.

Over the years, these charities have done a lot for a small proportion of the disabled people in the Third World and they have amassed an impressive body of expert knowledge and experience. It seems self-evident that what they do is valuable and helpful. A closer look, however, reveals some disadvantages.

Charities have to raise funds from the public, so they publicise the most emotional pictures of disabled people — often children. Thus, they confirm most people's idea of disabled people as child-like, passive, dependent, sexless and irresponsible. They dramatise "the unthinkable tragedy" of disablement, reinforcing people's fear of disabled people and their desire to avoid them (usually by putting them into institutions). In this way they perpetuate the attitudes they need to change if they are to benefit disabled people.

Some of the worst examples of this come from the Third World, but charities in Britain sometimes use this kind of publicity. In a slightly different setting, Oxfam has been criticised for promoting the "starving child" picture of the Third World poverty, creating negative attitudes about people in the poor countries. The aim is to use emotional response as a starting point on a road that leads to greater understanding — what Oxfam calls the "educated £". But the danger remains and charities need to be wary of confirming the attitudes they are trying to change, of building up the barriers they should be breaking down.

Many religions and cultures see giving to the poor as a way of gaining merit or pleasing the gods, or ensuring a better reincarnation. That's fine for the givers but it does nothing for the self-respect of the receivers. They are encouraged to go on existing by begging rather than doing something for themselves.

True charity of course is not like this at all. It springs from goodwill, generosity and understanding. Over most of the world, under one name or another, it is recognised as a virtue.

True charity in disablement lies in accepting and understanding the needs, limitations and capabilities of disabled people. It also lies in disabled people understanding the limitations of those who haven't experienced disablement themselves. If this kind of charity were more widespread, then attitudes would be different and many of the problems that disabled people face would be reduced.

case box 12

Do-it-yourself manuals

WHO believes that families and communities can play a major role in reducing disablement. So it has prepared a series of easy-to-follow booklets, designed to make use of all the things that can be done by the family and local community to help someone disabled. There are booklets for people who have difficulties in moving, seeing, hearing and learning, and one for "people who show strange behaviour" (fits). There are also booklets for local supervisors, school-teachers and community leaders, as well as one for senior planners and policy-makers. The booklets are being user-tested at present (Oxfam is helping to test them); a revised version should be ready for wider use in 1982.

Here is part of one page from the booklet for community leaders.



- They should also participate in festivals and religious meetings and other community meetings and activities.



- You should make it possible for the disabled to participate in community elections. You should also give them the opportunity to take responsibility in village councils, religious committees and school committees, etc.



- There may be a need in your community for an advisory group for the disabled. This group can take the responsibility of seeing to the welfare of the disabled, such as equal opportunity for jobs, housing, transport, supply of water, economic support, etc.

This group could consist of community members who are interested in the disabled, and others with different kinds of disabilities.

source: Training the Disabled in the Community, an experimental manual on rehabilitation and disability prevention for developing countries, WHO, Geneva, 1980.

13 Where the need is greatest: development agencies

Organisations which specialise in working with disabled people are often criticised for giving too much attention to the actual disability — blindness or leprosy or paralysis — to the exclusion of everything else in a disabled person's life. General development agencies — UN agencies, government aid programmes, and voluntary agencies — have the opportunity of avoiding this. They can include the disabled in the ordinary development schemes they finance in the Third World by making special allowances, avoiding hardship, or creating employment opportunities. How do they take advantage of these opportunities?

In 1979 some 30 development agencies (mainly from the USA) met to try to answer this question. They were rather self-critical. They found that,

- many people who work on the staff of these agencies have hardly ever worked or lived with disabled people, nor do they know much about the special attitudes towards disabled people that exist in each country in the Third World.
- there is a big lack of information and a big surplus of misinformation, superstition, and fear.
- the agencies continue to finance, and thus strengthen, protectionist, paternalist institutions, modelled on Euro-American lines, which separate the disabled from their families and communities and which, in any case, can only handle a tiny fraction of the number of disabled.
- the staff of development agencies tend to be foreigners in the Third World and they have a strong tendency to work with those who speak their language and understand their motives and aims. Many of these people hope to copy European and American methods in their own countries, however inappropriate they are. They confirm the outsider's view of disablement, and the outsiders reinforce theirs.

General development agencies obviously shouldn't concentrate too much on the disabled (or any other group); if they did, they would lose the advantage of helping communities as a whole. But since their aim is to work "where the need is greatest", they should surely take disabled people into account. To do this they need staff who are sensitive to the needs of disabled people and who can see clearly the links between disablement, poverty and development. If development projects are designed, as most are supposed to be, to help the poorest, they must surely include the disabled.



Torture and terror

Chile

Some disablement is caused on purpose. Beggars may mutilate their children in order to attract the sympathy of passers-by; about 74 million women in Africa are genitally mutilated; and about 3 million people worldwide are disabled as a result of war. And some people are disabled through torture and terror.

In Chile, for instance, one of the main instruments used to put pressure on people whose beliefs differ from those of the Government is the use of periodic acts of repression, designed to produce an atmosphere of tension and anguish. One or both parents of a family may "disappear" - be imprisoned without charge or trace, leaving the children as temporary and terrified orphans. Many people in prison are tortured, so that even if they are let out, they are mentally or physically disabled.

The atmosphere of fear and tension is increased by carefully designed campaigns in the pro-Government press and radio. Even those not directly affected share some of the terror.

In Santiago, the capital city of Chile, a programme works to help people who have been politically imprisoned, and their families. FASIC (Fundacion de Ayuda Social las Inglesias Christianas) runs group sessions, provides medical help and trains people to do self-employed work. They have to be self-employed because these ex-detainees are barred from ordinary work by Government decree.

Most of its "clients" are young people. Chico can scarcely go out in the street. He won't enter any kind of vehicle. He believes the police follow him everywhere. Maria is frightened of crowds and noise. Torture damaged her hearing and her sense of balance. She can only work at a job which requires very little movement of the head. She is learning to make jewellery and paint miniatures.

FASIC workers find that the families of the people imprisoned are affected almost as badly as those imprisoned. Children have nightmares, suffer fits of crying, can't cope with school, or get violent.

FASIC is also studying the characteristics shown by people in this sort of situation. It exchanges the information it collects with other centres around the world concerned with trauma resulting from political repression. It is also advising the new Nicaraguan Government on how to handle psychiatric rehabilitation of people imprisoned and tortured under the Somoza Government.

Counting the immediate family members, there are about 5,000 people in Chile disabled through political repression. Not many, perhaps, in terms of the 340 million disabled people in the Third World. But IYDP is about them, too, and about societies which disable people on purpose.

source: Oxfam file TASC 03

14 Expert counsel: the disabled as consultants

When it comes to helping disabled people in the Third World, disabled people in Britain are at an advantage. Not only do many of them possess useful skills covering a very wide variety of trades, professions and experiences, but — much more important — they share the experience of being disabled.

This shared experience crosses cultural, language and national barriers, as disabled people from the rich world who have visited the poor countries confirm. The experience of being rejected, or put in a “home”, of being treated like a child, of relating to one’s parents, of making (or not making) love — all these are so strong that they make for close and useful links with disabled people in the Third World.

In the belief that disabled people from the rich countries can be useful in the Third World, a few groups, mainly in the USA, are beginning to work out a system for putting them to use. On the invitation of a Third World group run by disabled people, they send a team of three people, at least two of whom are disabled people, expert in whatever has been asked for. They can arrange for training, for example, or counselling, or help in setting up businesses.

In the USA, the visiting teams are financed by groups of disabled people. There is no central funding agency or big finance from the Government, industry or foundations. Some of the groups are nationwide and some quite local. They have grown up largely by chance, cashing in on members’ links with the Third World or interests in it.

Not many of the disabled can actually make a visit, of course, but those who stay at home can also help. They can put pressure on general development agencies to take the disabled into account when they give money to development schemes in the Third World. They can also do such things as translate into local languages (some have the time, skill and energy to learn them), put documents and books into braille, find out what suitable equipment is available, or help handicraft groups get their goods through customs and onto the market.

The work of these groups is only just beginning in the USA and hardly occurs at all elsewhere. And it has only been tried in Latin America and not yet in Africa or Asia where the cultural barriers may be greater. Such groups have only a limited role of course; they can only visit existing institutions, most of which are in towns, whereas the greatest need is out in the countryside where there aren’t any organisations that could invite foreigners. There is a danger, too, that the invitations might come from the sort of institution which modelled itself most closely on Euro-American examples and which would, therefore, be least useful to the very poor. But the apparent success of the American groups suggests that it might be worth experimenting with similar groups from Britain.



The fear of leprosy

Brazil

Perhaps more than any other disease, leprosy still evokes fear and horror over much of the world. "Unclean, unclean" is still the cry and there is still pressure to isolate people suffering from leprosy in "colonies". The Brazilians call leprosy "Hansen's disease", in an attempt to lessen the fear and stigma, but the traditional attitudes remain as this story from Manaus dramatically demonstrates.

Manaus is a major town about 1,000 miles up the Amazon. On January 1, 1979, the State Government closed the Antonio Aleixo Leper Colony, about 15 miles outside the city. In its heyday, in 1975, it handled 1,800 residents but by 1978 this was down to 600. Largely in order to save money, the State Government decided to give the residents some land and transform the Colony into a suburb, complete with post office, school, medical post, etc.

Opposition politicians alleged that by closing down the Colony the Government was releasing a flood of people with contagious leprosy onto the streets. Their fears were supported by local traders, who feared loss of business, and by many of the townspeople who did not know that only some forms of leprosy are contagious and even they are only mildly so. Something close to panic spread over Manaus, with angry recriminations on press and television and allegations that the Colony's funds had been mismanaged as well.

As it happened, there was an influx of people with leprosy onto the streets but not for the reason the politicians supposed. While the Colony was open, large numbers of people with leprosy thought it best to hide away out of sight - on river islands and small slum areas - for fear of being incarcerated in the Colony. When there was no longer any danger of this, they decided to show themselves. Since they had minimal resources, they took to begging. And the people of Manaus reacted in standard horror-struck fashion. The people and the politicians thought that the beggars were former inhabitants of the Colony. In fact the scale of leprosy in Manaus was revealed for the first time.

The story ends rather happily. A clinic in the town now handles 9,000 out-patients (compared to 7,000 handled by the Colony). People are much less inhibited about going there, partly because it is not near the homes of most of them, so they are unlikely to be recognised by friends and neighbours, and partly because besides leprosy, it treats all sorts of skin ailments and VD. There is, thus, nothing to identify anyone attending as someone having leprosy. As a result, new cases were identified in 1979 at the rate of five a day.

Meanwhile, back at the Colony, there is now a suburb of 3,000 people, complete with shop, market place and its own local government and mayor. A small hospital caters for about one hundred very severe cases.

This is an unusually vivid example of the fear that leprosy still generates. In this case, perhaps also unusually, the people with leprosy benefited because the Government refused to give way to the panic and reverse its decision to close the Colony. It also points to the advantages of out-patient clinics over institutions for detection and continuing treatment.

15 What we can do: ideas for action

The main causes of disability are rooted in poverty. We can work to reduce that poverty, either by sending money to fight it locally in the Third World, or by working to change Britain's continuing part in the world poverty system that helps to keep the poor poor. Some development agencies, such as the Save the Children Fund, concentrate on tackling it in the Third World; some, like Oxfam, Christian Aid and War on Want, tackle it both in the Third World and in Britain; some, like the World Development Movement, the New Internationalist and the Brandt Commission, concentrate on the rich countries' part in the poverty system. Support (in work or money) for this sort of organisation is a good way of reducing disablement, not directly, it is true, but, once you see the connection between poverty and disability, effectively.

What can we do more directly? Here the disabled have the advantage; the experience they share with the disabled in the Third World makes them very useful. They can work to set up or support the sort of groups described on page 27.

But there are things that everyone can do. Here are some of them.

Changing attitudes

Wrong attitudes the world over are one of the biggest obstacles that disabled people have to face. We need to get our own individual attitudes right first, and then work on our society's. Since poor countries tend to copy rich ones, some of that should rub off onto the Third World. It sounds a bit nebulous and remote but unless we get our own and our society's attitudes right, we're never going to be much help to disabled people in the Third World.

British Third World disablement agencies

Many British agencies spend all or part of their funds on financing work for disabled people in the Third World. Examples are the Royal Commonwealth Society for the Blind, LEPRO (the British Leprosy Relief Association), the Commonwealth Society for the Deaf, and so on. These agencies rely on money from individual members of the public, so if you support them it is worth checking that they are spending the money on the things which really are the most useful to disabled people. Many of them are; if so, your enquiries will give them support in developing new and more valuable programmes. The key points we've covered in this booklet are:

good attitudes to the disabled (page 9). Charities should not put out images of the disabled which strengthen the attitudes they should be trying to change.

prevention (page 11). It's easier to collect money for helping people with disabilities than it is for preventing the causes of future disabilities. Obviously we can't ignore the people whose disabilities can't now be prevented. But prevention is vital too. Some agencies specialise in prevention, some in treatment and rehabilitation, and some do both. You may want to spread your support, so that at least some of it goes to prevention.

beyond the institutions (page 13). Many British agencies support institutions in the Third World; that's what they have done in the past and they continue partly because many of them do good work and partly because it's difficult to cut off support from an institution without causing a lot of hardship. But the only way to reach more than a few disabled people is to go beyond the institutional home and develop new ways of helping the mass of disabled people. You could support agencies which are trying to expand this side of their work.

General development agencies

General development agencies (such as Christian Aid and Oxfam) support a lot of work that is specifically for disabled people in the Third World. They have greater freedom in allocating their funds than charities which are tied to one type of disability or to one institution and so they should find it easier to follow the priorities listed above. You could support those which do so.

In addition, they should take the disabled into account in their ordinary work — finding out, for instance, how an irrigation scheme might affect disabled people and whether it will produce any jobs for them. They can also back organisations run by disabled people in the Third World which are trying to change local attitudes. Again, your enquiries and support could boost these policies.

The Government

The British Government doesn't really have a 'programme' for the disabled (see case box 10) — it responds to requests from the Third World. Since aid for disablement is more likely than most aid to reach the poor and needy, it would be good if the Government did more to stimulate such requests, as it could easily do. You could write to, or see, your MP about this, or write direct to the Minister for Overseas Development (Overseas Development Administration, Eland House, Stag Place, London SW1E 5DH).

British companies

Some British companies have subsidiaries or local branches in the Third World. Some of these are fairly independent of their British owners but a lot can be controlled or influenced from Britain. So it is possible to ask them to

ideas for action contd.

make sure that proper safety precautions are taken in any factory, office, mine, plantation or engineering works that they operate or control. This should include training, notices and labels that are understandable by the local workforce, safety guards on machinery, ventilation and filtering, protective clothing and masks, and so on. British companies should surely not take advantage of lax local laws and high unemployment to operate plants likely to cause disabilities.

Another approach is to ask that British companies employ either the legal minimum quota of disabled people, or, where there isn't one, at least 3% of their workforce. Note that this approach does not involve more jobs — merely a fairer distribution of those that exist.

You could write to British companies with overseas interests and ask for information and let them know if you think their replies are inadequate. Your voice carries more weight if you are a shareholder in the company. Groups of disabled people may like to buy shares. If the company's policy on employing disabled people in the Third World is unsatisfactory you can then raise questions about it at the Annual General Meeting.

IYDP

During IYDP many organisations will be holding 'events' such as talks, slide-shows, conferences, etc, about disablement in general. The events will be held both by disablement agencies and others such as Women's Institutes, Scouts, Rotary, Church groups, schools, etc. For the most part they are likely to be concerned with disablement in Britain but they may jump at the chance of learning something about it in the Third World. Oxfam's slide set with speaker's notes offers an easy way of doing this. There is no need to be an expert; the notes that go with each slide can be read out word for word by someone who knows nothing of the subject and can at least provide the basis for discussion. Alternatively, you could ask one of the agencies involved to send a speaker. (Oxfam local offices are listed in the Appendix.)

Any of this involves a bit of effort — finding things out, writing letters, giving talks, even sending money. But disabled people in the Third World really are close to rock bottom. From Britain we can only do a little about them but it would surely be worth something if our collective actions prevented only a million people out of the 170 million "preventables" from becoming disabled, or gave a slightly better life to only a million out of the 340 million Third World disabled. Only a million? It's a lot if you're one of them.

Appendix Oxfam back-up services

Slide set

A set of slides illustrating this booklet is available from Oxfam offices. Speaker's notes provide full information about the slides and are designed to be read out by a group member without a detailed knowledge of the subject. The text is also available on tape as a tape/slide set.

Education packs

From autumn 1981 Oxfam Trading is marketing a box of toys made by disabled people in Britain and the Third World. A pack of back-up materials will also be available for teachers, youth leaders, etc, describing the people who produce the toys.

Another education pack — this one for 9—14-year olds — goes with the film *Who Cares?* It includes a poster describing the children's day and a booklet with suggestions on how to get involved in Britain.

Both packs available from Oxfam Education Department, 274 Banbury Road, Oxford, OX2 7DZ.

Oxfam film

“WHO CARES?”

16 mm Colour Film
Running time: 21 mins.

This film sensitively portrays the handicap from which many of the world's poor people — especially the women — suffer: an inability to fend for themselves or play a useful role in their society. By following the story of Rathna, a 19 year-old Indian girl, it shows how she was enabled to overcome her feeling of inferiority and hopelessness by the loving care and practical help of those around her, and by being given the chance to realise her abilities whilst living with a community of children suffering severe physical handicaps.

The film tells the story of how Rathna became completely paralysed at the age of 16, but was cured inside a year by an old man in the next village who practised herbal medicine. However, Rathna was left too weak to help her poor parents in the fields. Worse, she knew that marriage would be impossible, for no man in this part of rural South India could afford an unproductive wife. She travelled to Mysore, a city 30 miles from her village, to search for some suitable work but, undernourished and sickly as she was, no-one would employ her as a servant and anything more ambitious was ruled out because she had never completed her basic education. She returned home, apparently without any hope.

There in her village a young disabled man, who had been helped to become a tailor, encouraged her to go to the organisation which had trained him and which could educate her; so she took the bus to Melkote, where the people of the Janapada Seva Trust welcomed her and, following Mahatma Gandhi's principles of self-sufficiency, provided Rathna with the environment in which she found confidence and successfully completed her studies.

With other underprivileged women she shared the tasks of the institution's daily life, helping to cultivate the adjoining valley and work the printing press which was provided, like the institution's water-pump, by Oxfam. The press carries out work for the surrounding district and is now self-supporting. Alongside the women the Trust provides a basic education for about 20 severely handicapped children whose high spirits — well observed in the film — helped Rathna to see her own less obvious disadvantages in better perspective.

Rathna returns to her village a different young woman, equipped and able to become a primary school teacher, thanks to all who cared enough to help and encourage her.

This film, which includes some very moving sequences, serves to remind audiences that there are many people whose lives are less obviously disadvantaged than those with a physical disability, and they need help just as much.

The film is available from Oxfam offices or Concord Films Council Ltd, 201 Felixstowe Road, Ipswich, Suffolk IP3 9BJ. Tel. Ipswich 76012.

Oxfam Offices in Britain

ABERDEEN 14a Queen's Road. Tel. 0224 573374
St. ALBANS 161 Hatfield Road. Tel. 0727 66520
BARNSELY 18 New Street, S70 1SA. Tel. 0226 89587
BELFAST 164 Ormeau Road, BT7 2ED. Tel. 0232 30220
BLACKBURN 14 Preston New Road, BB2 1AW. Tel. 0254 661297
BRISTOL 62 Cotham Hill, BS6 5JX. Tel. 0272 34335
CAMBRIDGE 110 Regent Street, CB2 1DP. Tel. 0223 358758
CARDIFF 33 Whitchurch Road, CF4 3JN. Tel. 0222 20030
CHESTER 47 City Road, CH1 3AE. Tel. 0244 45543
CUMBRIA First Floor, Cumberland House, Scotch St., Whitehaven
CA28 7NG. Tel. 0946 61059
DARLINGTON 94 Bondgate. Tel. 0325 59849
EDINBURGH 5 Union Street, EH1 3LT. Tel. 031 556 2148/9
EXETER 121 Fore Street, EX4 3JQ. Tel. 0392 55007
GLASGOW 1 Lynedoch Place, G3 6AB. Tel. 041 332 6566
GUILDFORD 23 Woodbridge Hill, GU2 6AA. Tel. 0483 76451
HOVE 31 Western Road, BN3 1AF. Tel. 0273 777338
ILKESTON 138/140 Bath Street, DE7 8FF. Tel. 0602 328123
LEAMINGTON SPA 30/32A Bath Street. Tel. 0926 26476
LINCOLN 15 St. Mary's Street, LN5 7EQ. Tel. Lincoln 39392
LIVERPOOL 162 Aigburth Road, L17 7BR. Tel. 051 728 7257
LLANELLI 48 Stepney Street, Dyfed, SA15 3TR. Tel. 05542 59898
LONDON 4 Replingham Road, Southfields, SW18. Tel. 01 874 9324/7335
LONDON 333 Upper Richmond Road West, SW14 8QR. Tel. 01 876
3599/3399
LUTON 11a King Street, LU1 2DW. Tel. 0582 37285/36713
MALDON 183 High Street, CM9 7BS. Tel. 0621 55837
MANCHESTER 494 Wilbraham Road, Chorlton-cum-Hardy, M21 1BB.
Tel. 061 861 9731/2
NEWCASTLE 80 High Street East, Wallsend, Tyne & Wear, NE28 7JH.
Tel. 0632 629499
NORTHAMPTON 192 Wellingborough Road, NN1 4EB. Tel. 0604 37724
NORWICH 19 Magdalen Street, NR3 1LE. Tel. 0603 26007
NOTTINGHAM 72 Lower Parliament Street. Tel. 0602 583755
READING 373 Oxford Road, RG3 1HA. Tel. 0734 52299
REPUBLIC OF IRELAND 53 South Kings Street, Dublin. Tel. 710308
SALISBURY 12/14 Catherine Street, SP1 2PN. Tel. 0722 29256
SEVENOAKS 95 High Street, TN13 1LH. Tel. 0732 51873
SHIPLEY 31 Westgate, W. Yorks. BD18 3QX. Tel. 0274 595216
SOUTHAMPTON 206 Shirley Road, SO1 3FL. Tel. 0703 25847
WORCESTER Nash House, 8 New Street, WR1 2DN. Tel. 0905 29159
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