SUMMARY

The world Health Assembly in 1977 decided that 'The main target of governments and W.H.O. in the coming decades should be the attainment by all the citizens of the world, by the year 2000 of a level of health that will permit them to lead a socially and economically productive life'.

A W.H.O. expert committee in connection with the above aims, reported that 'Rehabilitation included all measures aimed at reducing the impact of disabling and handicapping conditions' and that the quality of life of the disabled in general was lower than that of the able-bodied.

The same committee has also estimated that the population of disabled children in developing countries may rise to 135 to 150 million by the year 2000. With this as the back drop, the stage seemed set for the launching of definitive rehabilitation programmes. The object of all of them clearly was to bridge the gap between the vast number of disabled children and their needs and the minimal services available. Conduction of rural camps for diagnostic and therapeutic purposes was selected as one of the answers for identifying the possibilities of providing an improved quality of life to the rural disabled children who had seldom heretofore been approached.

The aim was to examine, advise, wherever possible operate and provide orthotic and rehabilitative appliances in their own environments in villages or small towns. The orthopaedic teams with para-medical staff reached the disabled children rather than the patient and parents travelling all the way to orthopaedic and rehabilitation centres available in a few select urban areas or cities like Bombay, Pune and Nagpur.
Seventy-five camps were held in various districts of Maharashtra from June 1976 to October 1981, and during their conduction their utility in various other districts also came to light. Thus, it was seen that various patterns of disability could be identified and the extent of the workload at different levels of health services could be estimated. Rehabilitation services could also be planned for educational and counselling services for the beneficiaries and their parents. Training could be rendered to general practitioners who maximally come in contact with disabled rural children via the medium of mass diagnostic rural camps. Finally, an additional benefit to the communities where such camps were held was the fostering of an increased sense of integration between the rural people and various local charitable social organisations.

As has already been dealt with in detail, a large number of observations were made during the study which covered 23 of the 30 districts of Maharashtra. The salient features recorded from the tabulated statistics are as follows:

1. Males are more commonly affected by childhood disabilities, than females. Almost 30 percent of the disabilities were seen in the children less than five years of age.

2. Infective diseases and polio had caused 55.50 percent of the childhood disabilities seen. Cerebral palsy came next as the causative factor in 14.46 percent. The etiological pattern of physical disabilities in rural Maharashtra followed a definite pattern.
3. Unilateral lower limb affection was seen in 44.5 percent of cases while unilateral upper limb involvement was only seen in 7.76 percent. 12.43 percent of cases had bilateral upper or lower limb affection.

4. 95.05 percent of cases of infective childhood disabilities were caused by poliomyelitis, of these 42.44 percent showed mild affection. 35.92 percent showed moderate deformities and 21.64 percent presented with severe deformities.

5. Many factors aggravate the disabilities of the orthopaedically handicapped children. Some of them were investigated in 13,264 patients.

   (a) 90.25 percent of the patients had a family with a monthly income less than Rs.69/-.

   (b) 57.83 percent of the patients had consulted an allopathic general practitioner for their disability. 24.84 percent of the patients saw the doctor for the first time at the camp.

   From the experience of the rural camps it was considered worthwhile developing and propagating the idea of making special training available for various categories of medical personnel in order to improve diagnostic and rehabilitative services.

   (c) 85.1 percent of the parents of disabled children stated that they were worried about the child's future. Only 1.7 percent of them expressed congenial attitudes.
(d) Some had wrong treatment by unqualified personnel accepted as village bone setters or wisemen. A large number of patients were subjected to some traumatic therapeutic measure during the acute phase of polio. The most common trauma inflicted was in the form of injections (66.5%) or massage (29.6%).

(e) Rural children were faced with physical barriers like uneven floors (82.16%) and lack of toilet facilities in their homes and huts.

Patients were then categorised depending on the therapeutic measures they required. The clinical demographic and environmental observations made, also helped to influence the planning of therapeutic management. Thus, 32.64 percent of the patients were expected to benefit from surgery, for 18.7 percent only orthotics, were thought necessary.

The various categories of patients were called to the specialist centre to receive the benefit of the treatment planned for them at the camp. Here, they were given appropriate therapy and asked to come for follow up regularly so that their rehabilitation could proceed under careful supervision.

Rural disabled children had to overcome special physical barriers in their environment and their life style. Therefore, some conventional methods of treatment had to be modified to suit their purposes. It was thus that innovations like the calipers with knee joints allowing 135° of flexion in 20 children, groin to toe cast following hip and knee release in
93 children, cane calipers for 20 patients and the shoulder capsule in
20 cases were designed and implemented.

In short, a considerable section of Maharashtra's rural people were
approached, the problems of their disabled children were identified and the
strategy of planning their rehabilitation was thoroughly explored. Such a
large scale study with a rural bias, encompassing the demographic, clinical
and environmental profiles of childhood physical disabilities, would stimulate
others it was hoped, to undertake surgical intervention work based on
appraisal of environmental settings.

The etiological pattern of the disabilities showed that a large number
of factors were preventable e.g. nutritional, infectious and polio etc.. If
preventive and therapeutic services were undertaken at a national level,
we could hope that the rate of increase of the population of disabled children
would slow down considerably.

This study has been useful in that besides diagnosis and treatment
of disabled children in these camps the following has been attained as a
collateral benefit.

(a) It has educated social workers, well wishers and rural population
that orthopaedically handicapped children can be rehabilitated
to lead useful and productive lives.

(b) It has educated the masses in the villages that the disabled
children should be taken to rehabilitation centres early and
not made to suffer and go through a psychological and physi­
cally traumatising childhood.
This study has pointed out the possibility of using existing infrastructural resources to enhance health care delivery. If diagnostic camps were made a routine activity of the Primary Health Centre, the vast number of rural disabled children yet unapproached could be allowed to enjoy the benefits of modern rehabilitative techniques. At the same time it would be possible to record changes in the morbidity pattern of the etiological factors.

Primary Health Centres could undertake prevention of poliomyelitis by improving the sanitary conditions and availability and administration of polio vaccine.

Conduction of normal deliveries in the village by trained midwives and by trained dais could be emphasised to minimise cerebral palsy and its after math.

Disease detection camps at Primary Health Centre level for various morbid conditions would ensure optimum utilisation of infrastructure and finance.

The nation as a whole would benefit from the boost of useful manpower in its rural areas if more and more states adopted the idea of raising the lot of their handicapped people. The goal of health for all by 2000 emphasised by the W.H.O. could be implemented in rendering of primary health care.
The modest aims of this study have, we trust, been achieved. However, they can be considered to have been exceeded if this work starts a chain reaction in the nation leading not to an explosion but towards a greater awareness of the need to take active measures for improving the lives of our disabled children.