Current needs and practices of rehabilitation in Fiji and Pakistan

Anjum Masood

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CURRENT NEEDS AND PRACTICES OF REHABILITATION IN FIJI AND PAKISTAN

A Project

Presented to the

Faculty of

California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Rehabilitation Counseling

by
Anjum Masood

September 1993
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FIJI AND PAKISTAN

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September 1993

Approved by:

Dr. Margaret Cooney, Chair, Rehabilitation Counseling

Dr. Louise Fulton, Special Education

9/17/93
ABSTRACT

This project explores the current status of rehabilitation needs and practices in two countries, Fiji and Pakistan. The cultures of Fiji and Pakistan are explored and the reasons why these countries do not have comprehensive medical or rehabilitation program are discussed.

An evaluation of current practices indicate both countries have strong needs to develop comprehensive rehabilitation centers. A model for comprehensive rehabilitation centers to be organized in Fiji and Pakistan is presented. Special emphasis is placed on the development of vocational rehabilitation services in order to enable people with disabilities to be independent and employable.
ACKNOWLEDGEMENTS

I wish to express sincere appreciation to the following persons for their invaluable assistance in the preparation of this project: Dr. Margaret Cooney for organizing my thoughts and in instilling confidence in me. Dr. Louise Fulton for her insight into the needs of persons with disabilities.

My family for their strong and continuous support, both emotional and financial. Their concerns have been my inspiration.

My fiancee, Sohail Hasanjee for his words of encouragement, enthusiasm, understanding and cooperation. I would also like to acknowledge my friends in believing in me.
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CHAPTER I

INTRODUCTION

This project will explore current rehabilitation needs and practices in the following two countries: Fiji and Pakistan. It is important to evaluate rehabilitation needs in these developing countries as they enter the 21st century. In addition, this project will explore the rehabilitation practices of the above two countries and offer recommendations to expand services to persons with disabilities.

Rehabilitation requires considerations because many countries have launched new specialized training, placement and employment programs or built up existing ones. Fiji and Pakistan have implemented initial stage of providing pilot services for people with disabilities in their societies and have been active in developing basic rehabilitation centers and workshops, many of which are in rural areas.

One year and a half ago this author came to the United States from Pakistan to study Rehabilitation Counseling at California State
University San Bernardino (CSUSB). Two main objectives of studying rehabilitation counseling was to develop an understanding of rehabilitation practices and rehabilitation competencies in order to be able to return to Pakistan and help professionals develop and implement rehabilitation programs. The Rehabilitation Counseling faculty have provided me with new insights and competencies into the diversified field of rehabilitation counseling.

In 1992, this author decided to do research into the needs of rehabilitation in Fiji and Pakistan and explore characteristics of comprehensive rehabilitation centers. These research findings are presented in the third chapter of this project. The author has the background from her experiences in Pakistan and graduate work at CSUSB to help others develop needed rehabilitation programs.

The provision of rehabilitation knowledge is important to the countries of Fiji and Pakistan because existing information concerning the current practices and needs in these two countries is very limited. This author hopes this project will prove useful to rehabilitation professionals, professors, students, governments and non-governmental organizations, in their efforts to offer needs
services and improve the lives of persons with disabilities.

Unlike developed countries, Pakistan lacks advanced computer technology. This project discusses the important relationship of computer technology and rehabilitation. Computer technology can translate braille input to regular output, for persons with visual disabilities and transform voices of dumb people into real words. Although these soft wares are very expensive, they can be invaluable tools for rehabilitation professionals and clients.

Limitations

This study was limited by the lack of literature on current rehabilitation needs and practices in Fiji and Pakistan. Searches for relevant materials were conducted at California State University, San Bernardino, The University of California, at Riverside, and Loma Linda University in Loma Linda, California.

Methodology

The methodology for this project consisted of conducting four structured interviews with persons from Fiji and Pakistan and
reviewing the literature. The questions used for the structured interview can be found in Appendix A. Persons participating in the interviews were: Mohammed Irshad Ali, a foreign graduate student from Fiji in the rehabilitation program; Dr. Talat Khan, a physician from Pakistan; Sushma Lal, a foreign graduate student in the rehabilitation counseling program; and Dr. Madan Kandu, Professor of Rehabilitation Counseling at Southern University in Louisiana.

The findings of these interviews, an intense review of literature, and rehabilitation graduate work at CSUSB helped formulate the proposed comprehensive model.

**Definition of Rehabilitation**

Rehabilitation is a facilitative process which enables a person with a disability to attain usefulness and satisfaction in life. The individual’s disability may result from any type of disabling conditions including physical, psychological, mental, emotional, or from various diseases or accidents. People may also be disabled by cultural disadvantage as a result of social, financial, or educational deprivation. Whenever any of these conditions causes
handicaps in life adjustments, the person is disabled. Rehabilitation then equalizes opportunity for life attainment as a human right and an obligation of society.

One key goal of rehabilitation is to have people be as independent as possible. To help persons overcome handicapping conditions. Rehabilitation provides individualized services to persons such as assessment, counseling, medical care, or occupational training, financial assistance, occupational evaluation and job placement. In various countries such as the United States these services are eligible to people through a system of public and private agencies.

A substantial portion of the world's population is disabled and their number grows each year. While this data varies geographically, even the most advanced nations have their problems providing services to persons with disabilities. In 1975, there were more than 6 million disabled children in North America, more than 11 million in Europe, 13 million in Latin America, 18 million in Africa, and 88 million in Asia. Persons with disabilities in any country need rehabilitation services to achieve their potential for
independence and productivity. Disability usually limits only selected functions, usually allowing people to be able to work. Often the greatest barrier towards disabled persons stems from ignorance, stereotyping, and prejudice by able bodied persons.

Rehabilitation program success depends upon the availability of public and private funds and facilities, technological development and dissemination, the supply and qualifications of professional rehabilitation workers, and the nature of the societal environment: public attitudes, work incentives, physical accommodations, and the economy.

More than anything else, rehabilitation is intended to assist persons with disabilities to be able to help themselves and to be independent. The role of the rehabilitation counselor is to work with the disabled person to be independent and if possible, employable. And the process is enhanced by the rehabilitation counselor working with a team of specialists.

Rehabilitation simply means helping a disabled individual to live rewardingly. The process of total rehabilitation includes both independent living as well as vocational services referred to
collectively as "rehabilitation."

Over the years rehabilitation has been defined in a number of ways. The classical definition of rehabilitation, adopted internationally, came from a May 25, 1942 symposium in New York of the National Council on Rehabilitation [1944]: "restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable." John McGowan [1960] used essentially the same definition in his first orientation manual for state rehabilitation employees.

There are three fundamental courses of action available when a disability imposes limitations on an individual: (1) Remedation of the cause of the person's handicaps, (2) compensate for the disability by enhancing other strengths of the person, or (3) change the environmental circumstances so that the impact of the disability is minimized. The best foundation for rehabilitation incorporates all of these approaches, utilizing and developing all needed resources of the community and embracing all professions that can contribute to the process. This is total rehabilitation.

Total rehabilitation includes physical, mental, economic,
familial, social, comprehensive process of rehabilitation. In practice, however, it is found that environmental, personal, and vocational goals in life as part of the improvement in the ability to work and to live independently bring about concurrent adjustment in other areas of an individual’s life.

Despite the type of disability or service provided, the goal of rehabilitation should be to help each person achieve whatever life adjustment that person is capable of attaining. Belief in the right of independence and productivity is deeply ingrained in the philosophy of rehabilitation. An extension of this concept of self-sufficiency is the right of people to be themselves, to work out their own problems, and to make personal decisions. Rehabilitation, then, can be viewed as a method through which disabled people are enabled to mobilize their own resources, decide what they are able to be, and achieve goals through their own efforts in collaboration with Rehabilitation Counselors.

Cultural and Demographic Characteristics of Fiji and Pakistan

Fiji and Pakistan cultures began over a thousand years ago.
The two countries have a rich history of collaboration. They have learned from each other, interacted with each other, and influenced each other. Their languages have mixed to produce new and rich developments in music, poetry, painting and architecture. And however Fiji and Pakistan have remained independent an emphasizing their individuality.

The Country of Fiji

Fiji is made of about 332 islands, which vary in size from 10,000 square kilometers to tiny islets a few meters in circumference. The Fiji Islands are scattered over about 95,000 square miles of South Pacific, between the meridians 177 degree east and 178 degree west and between the parallels 16 degree and 21 degree south. The land area of the group is 7,055 square miles, or less than one-thirteenth of the sea area. Six-sevenths of the land area is in the two larger islands, Viti Levu and Vanua Levu, and more than three fourths of the people live on them.
History

More than one hundred years after Magellan's wonderful voyage across the Pacific, in 1643, the governor of the Dutch colony of Batavia, on the island of Java in the East Indies, sent Abel Jans Tasman out from that port on a voyage of discovery. Abel Jans Tasman sailed past Australia and discovered the lands which are now called Tasmania and New Zealand. Abel Jans Tasman passed through the Tonga, or Friendly islands and discovered the Fiji islands.

Captain Cook in 1774 was the next navigator to explore Fiji. Fifteen years later, in 1789, Captain Bligh, in the launch of the "Bounty," passed through the islands without making a landing. In 1797 Captain Wilson of the London Missionary Society's ship "Duff" landed missionary passengers at Tahiti, Tonga, and the Marquesas. Setting a course for Canton, China, for a cargo of tea, he was brought into touch with Fiji group (Coulter, 1942).

By 1820 Fiji was regularly visited by whaling vessels and other ships in search of cargoes of sandalwood. The main islands, especially the sandalwood areas, became well known.
In the 19th century Fiji had a stable political, and economic society of their own—one little understood by missionaries and other Europeans who visited their shores or came to reside in their islands. Many Fijians believe Western contact especially in the late 19th century had a negative influence on the country.

The Fijian natives have been characterized as cruel, but their bloody practices can be understood only within the framework of their social order. The Fijians were a religious people; they had their gods, their priests, their witch doctors, and their temples. The priests and witch doctors often practiced deception and regularly exploited their long-suffering people. The temples were the scenes of rites and ceremonies which we term barbaric, heathen, and indescribably cruel. Many of the old native beliefs and taboos, however, were securing sanitation and moral and physical cleanliness. The sacred beliefs and practices of the people were a function of their whole economic and social organization.

When Europeans first came to Fiji, the natives were divided among several powerful confederacies. As British, American, and French ships of war visited Fiji their captains made it quite clear to
the chiefs that their governments did not look with favor on savagery and fighting.

In 1874 Fiji was offered to the British Crown. The queen's representative, Sir Hercules Robinson, informed Thakombau that all lands which could be shown to have been fairly and honestly acquired by the whites would be secured by them; all lands which were then in the actual use or occupation of any tribe would be set apart for them; and that all the residue of the land would go to the government (Coulter, 1942).

Thus, after a period of three hundred years, a new day had dawned for Fiji and the Fijians, with commerce, trade, and contacts with the representatives of other civilizations. Vessels began to visit the islands regularly to trade in coconut oil, tortoise shell, and dried sea slugs, good for food.

The Civil war in the United States caused a shortage in the world's cotton market. It was found that the climate and soil of Fiji were excellent for raising the crop. A cotton boom developed in the islands which resulted in a rapid increase in the number of European cotton-planters.
The demand for laborers was proportionate to the increase in European planters. For various reasons native Fijian labor was unsatisfactory. Between 1860 and 1877 about eighty-five hundred laborers were introduced into Fiji from the Solomon Islands, the Line Islands, and the New Hebrides for the cotton plantations. The natives were badly treated. This method of dealing with a labor shortage was found unsatisfactory, and the majority had been returned to their homes by 1877 (Coulter 1942).

During the American Civil War a considerable quantity of Sea Island cotton of excellent quality was produced. Subsequent years, however, showed that the crop which the most productive was sugar cane, and the extension of its cultivation rapidly took place, while the growing of the cotton receded to an insignificant position.

The raising of the sugar cane began in the early seventies near where Suva, the capital of Fiji now stands. Plantations were soon established in other places in the islands.

The Colonial Sugar Refining Company which became the most prominent sugar cane producer established by encouraging immigrant Indian labor, which was to have a profound effect on the future of
Fiji. In 1877 the agent-general of immigration in Fiji went to India, and the next year a system was adopted, in cooperation with Great Britain, India, and Fiji, in which indentured laborers were brought from India to Fiji under strict supervision and a guaranty of repatriation. For the next thirty-eight years the system continued, ships taking away the repatriates and bringing back new groups of laborers. But only about one in every two introduced elected to be repatriated; the remainder preferred to settle down in Fiji as small farmers or to seize other opportunities which were afforded by the economic development of the islands. In addition, a few free Hindus arrived from Mauritius, British Guiana, and Trinidad and took up land.

The Indians found in Fiji, in the biblical sense, “a land flowing with milk and honey,” in happy contrast to the continual want and poverty of the country of their birth (Scarr, 1984). In 1914 the Colonial Sugar Refining Company started a scheme for the settlement on ready-made farms of Indians serving the last year under indenture and for their occupation when their indentures had expired. At its mill centers large areas were set apart in which
fields were subdivided into plots varying from two and a half to four acres.

In 1916 the colonial sugar refining Company offered to provide up to 100,000 dollars for the establishment of Indian settlements in district adjacent to their mills. This offer was to assist the government in meeting demands of the Indians for land in Fiji. In that year the company had its first experience in leasing land directly to the Indians.

In 1921 a serious strike occurred, and sugar-cane operation were completely paralyzed. After the strike was broken the Indians resumed work, the labor difficulties were overcome by the wholesale establishment of the Indians on land as lessees, the company paying its tenants for the amount and quality of the sugar cane produced.

By 1926 the Colonial Sugar Refining Company had become the sole sugar operative in the colony. It has developed into the biggest business concern in the islands. The system of Indian tenant farmers which it initiated has been continued down to the present time (Kanwal, 1980).
During the long years of Indian immigration and settlement in Fiji, little attention was given to the condition of the indigenous people by the government. They had plenty of land, their essential resource, and they farmed it in the traditional way. There was a small movement to ports and urban centers where Fijians earned wages for a while and then returned to their villages.

Missionary influence, would, changed the Fijian religion. Other contacts with the West modified Fijian social system. There were breakdowns of ideas and attempts at reconstruction which were accompanied by considerable bewilderment and by social and personal disorganization.

Currently Fiji diversifies into small-scale industries, the economy is strengthened and revenues provide for expanded public works, medical services and education. The country's central position in the region has been strengthened by recent developments in sea and air communications. Today, Fiji plays a major role in regional affairs and is recognized as the focal point of the South Pacific. Fiji gained independence in 1970 and adopted a democratic constitutional form of Government based on the British
Westminister system.

The Country of Pakistan

An understanding of Pakistan today requires an understanding of its complicated past. Its history is that of territorial disputes among the Muslims of South Asia. Intellectual and political developments elsewhere in the Islamic world often have a direct impact. While in some respects, its history, is deeply rooted both in the traumatic circumstances of its creation, the civil war of 1971, and continuing political instability have meant that the relevance of the past has not always been clear. Today Pakistan faces a crises of poverty and underdevelopment which eludes simple solutions. For example, only 25% of the Pakistani population have college degrees. There are many illiterate persons in Pakistan. In addition, there are countless people who cannot afford health care.

The Islamic Republic of Pakistan has existed within its present borders, in the north-western part of the Indian subcontinent, only since 1971. For the first twenty-four years after independence in 1947 from India the majority of the country's
population lived in the East Bengal, but after a bloody civil war this broke away from the dominant western wing and became the independent state of Bangladesh. The year 1947 itself had also seen horrendous violence and transfers of population within the newly partitioned British Indian empire. Fifteen to twenty per cent of the population of Pakistan immediately after independence were refugees from India, taking the place of Hindus and Sikhs who had fled in the opposite direction (Aziz, 1967).

It was only after the First World War and the eventual formulation of the demand for a homeland for South Asia's Muslims by the Muslim League and its principal leader Mohammed Ali Jinnah, the founder of Pakistan, that attention became focused on a specific territory as well as on the political demands of the whole community. When suddenly Pakistan achieved independence as modern territorial state in 1947. At this time a whole range of political questions demanded answers that the leadership was not in a position to provide. Since independence, efforts have been made to solve them by placing greater emphasis on the idea of an Islamic state, but this too has been problematic, with several sharply
contrasted models on offer. Meanwhile, questions of class and region have become ever more acute, while the international environment in the aftermath of the Afghan crisis of 1979 has been a demanding one (Qureshi, 1965).

History

The earliest archaeological evidence for human habitation in South Asia in fact comes from Pakistan, and the first urban civilization in the subcontinent had its center in the Indus valley. The two cities of Harappa (in the Punjab) and Mohenjodaro (in Sindh) together with Kalibangan and Lothal in India are the most important known centers of a distinctive culture which flourished from around 2500 BC and declined during the course of the second millennium BC.

The first contact South Asia had with Islam was when Muhammad bin Qasim, the Arab governor of Basra, invaded Sindh in the 8th century and established a brief sway over the lower Indus valley. In the 11th century the Ghaznavid rulers, Turks who had established themselves in Afghanistan, succeeded in dominating much of what is now Pakistan. In 1206 a center of Muslim power
was established within South Asia. This was the Delhi sultanate, which dominated northern India for the next three centuries. It was not, however, a stable regime and had to contend with domestic rebellion, intra dynastic feuding and constant pressure from outside Muslim groups, notably the Mongols of central Asia. It was a Mongol dynasty, the Mughals, who from the 16th to the 18th centuries pushed Muslim dynastic control to its widest limits in South Asia. They also established an administrative and fiscal system that allowed the development of the most distinguished intellectual and artistic achievements of South Asian Islam in the Pre- modern period (Ahmed, 1973).

During the whole period from the founding of the Delhi sultanate to the decline of the Mughal empire many individuals entered India from outside, mostly to serve as soldiers, officials and artists. The rulers did not staff their administrations exclusively with Muslims, however, nor did they make any concerted efforts to convert their indigenous subjects by force. By the 19th century Muslims formed no more than about a fifth of the population of India, concentrated disproportionately in East Bengal,
the north-west and the towns and cities of North India. Most of the Muslims were converted members of the indigenous population. The process had been a gradual one and had taken place largely under the influence of Muslim holy men belonging to the mystical sufi orders. Settling in various parts of India, they had gradually drawn some sections of the population to a religious identity as Muslims that did not demand too drastic a break with traditional beliefs and practices.

By the 18th century the Mughal empire was in decline and was gradually replaced first by regional rulers and then by the colonial power of the British East India Company. In 1858, following the revolt of the previous year the British government assumed direct control of India and abolished both the East India Company and the last shadow of the Mughal empire. The mid-19th century also marked the beginning of the construction of the infrastructure of a modern state and economy (Kausar, 1977). For some of the Muslims of South Asia the impact of the British meant in a direct way the loss of political and cultural dominance, and it was among these groups in North India that new movements sprang up in the later part
of the 19th century. Two small towns near Delhi became associated with divergent positions on how to respond to the political and cultural challenge of the British. The first was Deoband, where a group of ulama (learned men) settled after the 1857 defeat. Drawing on the work of earlier reformers, notably that of Shah Wali Allah in the 18th century, they set out to purify Islam of and to be orthodox to the traditions of Prophet Mohammed.

The Muslim League, founded in 1906, was a pressure group for the protection of Muslim interests. The British responded favorably by creating what were known as separate electorates for Muslim voters in the new legislative councils that were being established. It soon became clear, however, that other possibilities existed for the expression of Muslim elite interests besides cooperation with the British. Ideas of pan-Islamic solidarity became important. One episode in this period is of special importance. This was an agreement reached with the Congress in 1916, the Lucknow Pact, which confirmed the Muslim demands for recognition as a separate political unit with legitimate demands such as reservation of seats in legislative institutions.
By the early 1930s the rapid pace of political development, in particular the ability of the Congress to challenge British power, meant a refining and limiting of the political options open to the Muslim population and to its elite leadership.

From 1940 to 1947 events moved rapidly under the impetus first of the Second World War and then of the desire of the postwar government in Britain to grant independence.

Pakistani society of the early 1980s remained ethnically diverse yet overwhelmingly Muslim. It was largely yet beset by the problems of hyperurbanization in which the vast majority lived in poverty while narrow stratum of elite families enjoyed great wealth.

Rural overpopulation and the continued high rate of population increase have fueled massive urban expansion. Cities have grown at an extremely fast rate. This expansion has been accompanied by problems in being able to provide social services and employment for hundreds of thousands of new inhabitants.
Definitions

Adjustment - to settle rightly.

Belief - conviction that certain things are true, religious faith.

Blindness - visual acuity for distance vision of 20/200 or less in the better eye with the best possible correctional field vision of no greater than 20 degree.

Braille - the tactile language system used by individuals with blindness.

Civil war - war between different factions of the same nation.

Counselor - an adviser.

Culture - the skills, arts, etc of a given people in a given period.

Disabled - unfit, to make unable.

Drug abuse - drug abuse is learned deviant behavior resulting primarily from environmental influences.

Fiji - country on a group of islands in the South West Pacific, north of New Zealand.

Foreign - situated outside one's own country, or having to do with other countries.

Handicap - the actual obstacles the person encounters in the
pursuit of goals in real life, no matter what their source.

**Handicapped** - persons who have functional limitations from a disability.

**International** - between or among nations.

**Island** - a land mass smaller than a continent and surrounded by water.

**Language** - human speech, any means of communication or the written symbols for speech.

**Leprosy** - a disfiguring skin disorder which can cause handicaps.

**Native** - belonging to a locality or country by birth, production, or growth.

**Missionary** - of religious mission.

**Muslim** - a believer of Islam.

**Pakistan** - country in South Asia, at the head of the Arabian Sea.

**Poliomyelitis** - Polio is an acute virus infection of the spinal cord often followed by residual paralysis of muscles.

**Population** - all the people in a country.

**Refugee** - one who flees from his home or country to seek refuge elsewhere.
Rehabilitation - to bring or restore to a state of health or constructive activity.

Stress - an important emphasis or a mental or physical tension.

Tribe - a group of persons descended from a common ancestor and living under leader or chief.

Underdeveloped - inadequately developed, especially economically and industrially.

United States - country including 50 states in North America.

Values - individual needs and satisfaction associated with work and lifestyle.

Visual disability - any reduction in central vision, binocular vision, color vision, peripheral vision, or the visual accommodation due to malformation, disease, or injury to the eye.

Vocational Skills - the skills an individual needs for the performance of an occupation.

Vocational Training - the specific training required for a person to acquire the knowledge and skills of a particular occupation.

Work - activity that is carried out for which payment is received.
CHAPTER II

REVIEW OF LITERATURE

The review of literature for this project will consist of two major components. First, society's reactions to persons with disabilities in Fiji and Pakistan will be discussed. Secondly, a discussion of current rehabilitation needs and rehabilitation practices in Fiji and Pakistan will be provided.

Society's Reactions to Persons with Disabilities in Fiji

From the early Egyptian, Greek, and Chinese civilizations to the present day, negative attitudes toward disabled persons have prevailed (Altman, 1981; Bowe, 1978, 1980; Deutsch, 1949; Hahn, 1982, 1983, 1985a). These negative attitudes reflected in various forms of communication and media from the Bible to current comic books (Gartner, 1982; Koaska, 1984, Woodward, & Tyler, 1984; Kriegel, 1982; Nunnally, 1961), and they have existed within most cultures and nations (Albrecht, 1981; Bhatt, 1963; Rosenbaum & Katz, 1980; Safilios-Rothschild, 1981). Bowe
(1978, 1980), Dejong and Lifchez (1983), Hahn, (1982, 1983, 1985a), and Szasz (1977) consider the less than optimal treatment of disabled persons in the United States to be primarily due to negative societal attitudes and belief about such persons. Individuals must realize the attitude of the public and how it negates the adjustment process.

A review of current literature reveals the universal concern among rehabilitation professionals and educators with the visually disabled person's difficulty in managing with the negative attitudes of the general public (Goffman, 1974 and Scott 1969). Roberts' (1973) view of the effects of attitudes is typical "There is the commonly held view of blind people being helpless, resigned, melancholy, sexually sterile, etc." (p. 52). He goes on to describe the "strong tendency" of most blind people to comply with social stereotyping.

Tuttle (1984) observed the impact of visual disabilities and the attitude of the general public. He maintained that:

A blind person's self-esteem is also affected by the recognition that he is not totally self-sufficient,
that he is dependent on the sighted to meet some of his needs even with the best adaptive behaviors and coping skills. The dependency needs of the blind are more visible than the dependency needs of the sighted, and as a result, most members of society tend to share the opinion that person with visual disabilities are more dependent and less worthy (p. 19).

Individuals who have been thoroughly trained, learn to reduce the effects of the handicapping conditions. However, it may still be necessary to convince people that a person with a visual disability has become an independent, capable person. This difficulty arises because of cultural beliefs which regard blindness in particular as an incapacitating disability. The complex nature of the customs and traditions of various ethnic groups in Fiji further negates the adjustment process.

To prove one's identity and overcome the fears and apprehensions of one's society, an individual needs to master the many chores of surviving in a competitive world. An important key therefore, is the mastery of skills and techniques, and the awareness of the
forces that govern our multi-cultural society.

An amplification of this belief was made by Harrington (1982), in his book, *Handbook of Career Planning for Special Needs Students*:

In considering the impact of legal blindness on the adolescent and the young adult, the factors of education, social and recreational influences, and the attitudes of the family must undergo a certain degree of scrutiny. With the approach of adulthood these factors take on a greater significance for the visually impaired concerning the future (p. 133).

Social events not only provide means for interaction, but also recognition within the cultural structure of Fiji's various ethnic groups. Developing good public relations and communicating effectively may help people realize that a person with a disabilities are the same as other people. Significance participation in social and cultural gatherings is an important aspect of Fijian culture. In many ways visual disabilities may interfere with recreation and social activities. Recognizing this fact, some thought should be
given to how disadvantages can be compensated for if needed.

Society's Reactions to Persons with Disabilities in Pakistan

Societal responses toward disabled persons are determined in part by the cause of the disability. However, what society perceives to be the cause of disability has a greater influence on its responses toward disabled persons than the actual cause of the disability (Rubin & Roessler, 1987).

Perceived causes of disabilities have been shaped at different times by different forces such as religious beliefs and advances in medicine. Whatever the perceived cause is, it has influenced the attitudes and responses of societies toward disabled persons.

The earliest recorded explanation of a disability was demon possession. Historically, while this cause has been most often applied to mental disorders, it has also been associated with diseases like epilepsy, mainly because of the early perceptions of epilepsy as mental illness (Rubin & Roessler 1987). Therefore, mentally ill persons were therefore treated by religious clerics such as Mullahs and Pirs rather than by physicians. Cruel methods of
treatment such as starving and whipping were more typically applied to make the mentally ill person's body a very pleasant place for self-respecting devil to reside. In modern times the belief that mental illness resulted from devil possession began to be replaced by the belief that the mentally ill were sick people. As a result, mentally ill persons were more likely sent to asylums.

Unfortunately, treatment in early asylums was often far from therapeutic. It was not unusual for patients to be found chained to the wall in dark cells. Education and training for retarded persons during this period were precluded by society's view of mental retardation as inherited and, therefore, incurable. There was almost total absence of reference to mentally retarded persons in the medical literature during this period. Sensory disabilities such as blindness and deafness, too, were thought to be caused by evil spirits, demon possession as a causal explanation of mental illness often like exorcism, sometimes benign but mostly brutal or callous isolation of mentally ill persons.

As in any other country the Pakistani population is representative of various disabling conditions. However there are
three disabilities which are of major concern: Leprosy, polio, and drug addiction. This author will discuss the disabling conditions of leprosy to illustrate the negative attitudes of able bodied persons towards persons with disabilities in Pakistan. Throughout recorded history, whether in Europe, Asia, Africa, or America, leprosy victims have been feared, shunned, and in a very real sense discarded by the societies in which they live (Dols, 1983, p. 891). Such behaviors are often rooted in a belief that the disease is a punishment from God, with strong associated implications that only the most heinous sins, such as unspeakable sexual excesses, would have earned so fearful punishment (Waxler, 1981, p. 169-194). Thus, in antiquity, people who contracted leprosy were forcibly caste out from home and family and castigated as a threat to the rest of society (Richards, 1978). In the depths of the hysteria in medieval Europe, accused lepers were executed by burning, drowning, or live burial (Dharmendrs, 1967).

Lepers were also rejected by their neighbors, were unable to get married, and had difficulty in obtaining proper medical care. Furthermore leprosy victims usually faced difficulty in obtaining
and keeping a job. Confronted by such devastating difficulties two people had attempted suicide. One, a young man from Bangladesh, related how his own mother had asked him to leave home and never come back. He had attempted to kill himself by drinking chemical fertilizer but was resuscitated at a local hospital.

Those patients whose spouses had left them had also suffered severely. In a culture in which marriage and children, especially sons, are highly prized, being without a husband or wife is a very serious matter indeed). In one isolated case a divorced woman with leprosy was only able to find a second husband among fellow leprosy patients. But in most cases divorced leper women remain single.

Despite the harsh treatment accorded by society, few people die from the direct effects of the Leprosy itself. Today, in fact, the prognosis is excellent for most patients, given an early diagnosis and reasonable adherence to a regime of medication.
CURRENT REHABILITATION NEEDS AND REHABILITATION PRACTICES IN FIJI

Vocational Institutions and Employment Agencies

In most districts there are private and government vocational institutions which offer a number of services which students may wish to pursue with the assistance of their teachers. Government institutions often recruit students for their training programs toward the end of the school year. The schools provide career counselling for students, however they do not offer job placement services. Teachers must take the initiative to invite personnel from these institutions such as the Fiji Institute of Technology, the Fiji National Training Council, and colleges in various districts. Personnel from these institutions are aware of the academic and practical requirements of their occupations. Discussions on a first hand basis provides students with an opportunity to evaluate their skills, aptitudes and interests for occupations. Most districts in Fiji have private vocational schools which are licensed by the government. They hire their own staff and operate on their fees they collect through providing training. A number of private schools
offer job placement services.

There are also private employment agencies in most towns and cities which offer job placement services. Many agencies have contracts with employers, and their services are paid for by employers. These agencies usually advertise in newspapers and elsewhere to locate their clientele. A student needs to be willing to contact such agencies and explore their services.

Over the years, the attitudes of employment and training institution personnel towards individuals with disabilities has improved considerably. However, applications from disabled individuals are usually discouraged, since hiring a person with a disability is seen as a definite risk factor.

Often, students with disabilities are referred to a placement counselor at the Fiji Rehabilitation Center. Counselors are trained in the best methods of how to serve people with disabilities. They spend their time in contacting employers, and training institutions for the purpose of providing rehabilitation services for students with disabilities.
Religious and Charitable Organizations

In most districts in Fiji there are religious and charitable organizations which offer services that may be of help to those planning a career. These organizations are usually listed in the telephone directory under the heading of Social Service Organizations. The Young Men’s Christian Organization (YMCA), and the Young Women’s Christian Association (YWCA) offer assistance in job seeking skills, securing employment, and have social and recreational activities. Apart from assisting people in need, the Salvation Army, and the various religious organizations assist people in locating particular services they need. These organizations offer career counselling and employment opportunities for young people.

Family and Friends

The family is an important component of Fijian society. It is common for people to seek assistance from family members and friends in Fiji. People with disabilities do not feel reluctant to discuss the subject of job-search with family members and friends.
People with disabilities must approach people who they think may be in a good position to introduce them to employers or suitable positions. Almost everyone can think of personal contacts such as teachers, fellow church members, friends, or those who take particular interest in the progress of individuals.

CURRENT REHABILITATION NEEDS AND REHABILITATION PRACTICES IN PAKISTAN

A major disabling condition in Pakistan is leprosy. Marie Adelaide Leprosy Center (MALC), the only agency devoted to diagnosis and treatment of leprosy in the Karachi area, began in 1954 in little more than a packing box shelter (Wyatt, 1984). For the most part, the inpatients at Manghopir and at MALC are tragically deformed and disabled. Most of the leper patients are resigned to spending their remaining years in what amounts to protective custody where they are shielded by the hospital from the harsh, rejecting world outside its walls.

In addition, in both institutions there are patients who as children were recognized as leprosy-infected in their communities.
and were treated as outcasts (Anonymous, 1987). These people, particularly those born in Afghanistan, tell of total rejection by their families, of consignment to animal quarters, even of outright expulsion from their native villages. Except for the fortunate few who were identified by MALC outreach teams and transported to the Karachi facility, most of the survivors of such treatment have been left severely deformed and unable to fend for themselves. Rejected by the outside world, they now exist only as hospital residents.

Another group of leprosy victims are the wives whose husbands deserted or divorced them when they developed symptoms of the disease. In Karachi and in Pakistan as a whole, these women and their children often join the ranks of the beggar population. The more fortunate among them are rescued by MALC and provided with some degree of training in a ‘cottage industry’-type occupation, such as making beaded and mirrored objects for sale to tourists. However, ordinarily the objects produced by them are not identified as having been made by leprosy patients when they are sold.

Recognizing the many adjustments required for life outside the hospital, institutions such as MALC devote significant portions of
their budgets and technical expertise to providing social and economic aid to patients whose disease has been brought under control. These institutions take particular cognizance of the crucial role played by economic forces. At MALC, for example, the hospitalized patient is not only taught new, marketable skills. Occasionally he/she is also given an interest-free loan to help him establish a household and/or means of earning a livelihood (Pfau, 1980). This expanded, realistic involvement with the whole person, not just with his disease, is aimed at reducing the number of treatment defaulters.

Further, the MALC leprosy program includes a crucial education component aimed at the public in general. A major goal of this outreach effort is to remove, or at least reduce, the mass of fear and superstition surrounding leprosy that has been bequeathed by centuries of ignorance and prejudice. This program, too, given the cooperation of today's mass media, offers the promise of long-lasting returns. Finally, MALC trains paramedical workers--'leprosy technicians' who are sent to difficult terrain such as the remote desert regions of Baluchistan as well as to hostile areas.
such as Afghanistan in order to discover patients and enroll them in treatment programs.

Throughout much of the disease of leprosy unique's history, aid to victims and their families has depended upon charitable and religious organizations. Another issue to leprosy control is that of missed diagnoses. In the present study, patient’s histories showed that because of inadequate knowledge on the part of the physicians, cases were mismanaged and years of potentially management therapy were lost. It seems clear that in this part of the world, medical schools need to pay more attention to diagnostic function. Education of traditional healers in Pakistan as well as some level of interaction with scientifically trained physicians will make an additional vital impact, particularly because such healers will offer patients the comfort of a familiar cultural input to augment the unfamiliar daily medication regimen (Mull, 1988, p. 260-393). At present, the diverisive barriers that exist between physicians and traditional healers act to the detriment of leprosy patients as well as many other people.

Recent research elsewhere in South Asia indicates that
photographs of leprosy victims, pictures of the causative organism, and photographs of the same people after treatment with medication might be effectively used in conjunction with each other to educate patients about the cause and proper management of the disease (Berreman, 1984, p. 853-864). Information disseminated on television has helped millions of parents to protect the health of their children.

Campaigns in favor of immunization against polio, another major disease in Pakistan, has received mixed reactions by the public. In Pakistan, polio vaccination is promoted on television by showing a disabled person who never received the polio vaccine. When questioned, a majority of viewers from different social strata said they considered that the film motivated parents and thus led to improved inoculations. On the other hand, some viewers thought that the image of a disabled child could have an adverse effect on children who had been affected in this way. The parents of such victims, especially if uneducated, often carried an immense burden of guilt for not having had their children vaccinated. Furthermore, the children eventually tended to bear resentment against their
parents for not having taken the trouble to ensure that vaccination was performed in time.

It seems clear that the film should be modified so as to extend a helping hand to polio-disabled children. The media needs to induce awareness, but not at the cost of causing psychological harm. The aim should be to build positive attitudes in the community. The government of Pakistan perhaps could pay special attention to the improvement of the film. Rather than creating confusion and doubt in the minds of polio sufferers and their families, an effort should be made to establish mutual trust. For example, a description of rehabilitation to help disabled children to develop their full potential could be included in the film.

The third major disorder which is providing a challenge to Pakistan is drug abuse. At the turn of the century Pakistan is now facing the threat of drugs in such a magnitude that the future of the country may be determined by the success or failure to handle this problem. The government of Pakistan has placed emphasis on how drugs chemically alter the brain function leading to loss of control on emotion, paranoia, loss of inhibition and unprovoked anger.
Drug abuse usually starts in the early teens reaching a peak around twenties and decline at the late twenties (Grossman, 1985, p. 47-49). General delinquency, behavior disorder, unusual parental life style (e.g., heavy drinking), poor parental relation with mental instability in the parents, parental disharmony, separation or loss of either parent are the common aetiological factors. Over ambitious adolescent, having low academic aspiration, and motivation or poor performance at school are the very important aetiological factors. Usually drug addicts are from upper class. In a study conducted by Indian Institute of Social Welfare and Management in 1979 it was revealed that medical students who resided in hostels were more prone to drug addiction and most of them were from higher income group (Nag, 1987, p. 131).

Drug abuse is no longer a problem in the Pakistan urban class but it has spread into the Pakistan rural agricultural belts and in low socio-economic status. With the changing life style society frustration, depression, anxiety in adolescents lead them towards addiction--ganja, charas, heroin in some form or other are commonly used.
The mental sequelae following prolonged drug abuse are schizophrenia like symptoms, manic and hypomanic state, depression and withdrawal convulsion while physical effects are hypertension, cardiac dysrhythmia, impotency, loss of memory, impairment of immune system. Heart attack, stroke, sudden death may occur following even first use of some drugs eg, cocaine (Nag, 1982).

The social problems created by drug taking is not always confined to the drug or the individual who takes the drug but by the prevailing attitude of the particular society. If a particular drug is disapproved by a society, often just arbitrarily, then the person using the drug finds himself being regarded as a person, rather unusual to the society, and an object of distrust and disbelief to the society. As for example, in Western society alcohol has a recognized place in social life though everyone is aware of its adverse effects following chronic use (Willis, 1985, p. 1-3).

The Pakistani society needs to be educated about the ill effects of drug abuse through different social organizations, mass media, school health program and even through religious organization.
Summary

Overall, the review of the literature indicated that able bodied persons in the countries of Fiji and Pakistan have negative attitudes towards persons with disabilities. The literature review discussed particularly negative stereotypes and attitudes towards persons with disabilities in Pakistan. It appears that this prejudice stems from illiteracy and a fundamental approach to religion which often views disabilities as a punishment from God.

In comparison, able bodied persons in Fiji view persons with disabilities as helpless and in constant need of family support and dominance. Finally, the literature review showed a need for rehabilitation services across all aspects of societies in Fiji and Pakistan.
CHAPTER III

A REHABILITATION MODEL PROVIDING COMPREHENSIVE
REHABILITATION SERVICES IN FIJI AND PAKISTAN

After completing the interviews with people from Fiji and Pakistan I have come to the conclusion that the greatest setback to rehabilitation services in both countries have been the negative attitude towards persons with disabilities. The general attitudes of the public towards the disabled are those of callousness, indifference, pity, and dislike. Even parents of disabled children usually do not have a positive or encouraging attitude. Rather their attitude are of shame and fear of social scorn and stigmatization, as well as an almost religious or superstitious view of disability as a manifestation of the Will of God. And in some instances, they view disability as the wrath of God for their own prior sins.

Fijians and Pakistanis regard disabilities as so incapacitating that it negates the rehabilitation process as a consequence of cultural beliefs. Disabled individuals are retained within the family in both countries therefore, being deprived of the opportunity to
develop their skills to the fullest potentials. The sympathetic response of the community, and the lack of attention by the governments of Fiji and Pakistan negates the rehabilitation training process. Although a number of volunteer organizations have developed programs and institutions for persons with disabilities, the concept of rehabilitation and independence for such individuals is largely misunderstood by the community.

This portion of the project will discuss a proposed comprehensive rehabilitation model which will provide rehabilitation services to persons with disabilities. This model can be employed in both countries of Fiji and Pakistan. The model was developed as a result of a review of the literature, the completion of four comprehensive interviews conducted with persons from Fiji and Pakistan, and new insights gained from completing course work in rehabilitation counseling at CSUSB. This proposed model is proposed by the official report, "National Policy for Rehabilitation of the Disabled" published by the government of Pakistan. This document strongly recommends the development of rehabilitation services for persons with disabilities. This report can be obtained by writing to
Directorate General of Special Education, government of Pakistan, Islamabad.

This rehabilitation model will be governed and funded by the state governments of Fiji and Pakistan. It will be comprehensive in order to meet the needs of persons with varying disabilities. The responsibility for comprehensive rehabilitation needs to be shared by the state, county boroughs and municipalities as well as private organizations and societies. The governments will or may be encouraged to provide special grants for rehabilitation organizations.

This proposed rehabilitation model will be comprised of a variety of services for persons with disabilities. Services will be provided on both an in-patient and out-patient basis. The main rehabilitation headquarters will probably be located in Suva which is the capital of Fiji and Karachi which is a major industrial city in Pakistan. Due to the rural geographical characteristics of both countries it will be necessary to have satellite centers located in strategic rural areas.

The director for the rehabilitation center will either be a physiatrist or a professionally trained person who has an extensive
background in rehabilitation. The center will have to employ a wide range of trained rehabilitation professionals in order to carry out the objectives of the model. Persons with disabilities will come to the center for the following services: medical, psychological, general rehabilitation modalities such as physical therapy and speech therapy, vocational evaluation and training, and placement into either employment or independent living. Services for rehabilitation clients range from medical restoration to work adjustment and vocational training. Often, the rehabilitation counselor will need to secure medical and psychological adjustment services from independent specialists in the community. In other cases, the counselor can secure these services for a client from a number of different public and private facilities.

The vocational component of the model will assist clients in becoming independent and/or obtaining employment. Effective vocational planning requires a special relationship between the rehabilitation counselor and the client characterized by rapport and trust. The counselor must have collected sufficient information during the evaluation phase of the rehabilitation process for
assessing the appropriateness of vocational objectives. Assessment of appropriateness of vocational objectives involves both a complete vocational analysis based on data collected through interviews with the client and the consideration of all necessary medical, psychological, and work evaluation techniques. The vocational analysis process initially done by the counselor must involve the client regarding his/her vocational choice. In addition, the counselor may have to work with the client to help him or her accept their disability. The counselor will also include counseling with the family of the client. Education will be encouraged to change stereotypes and stigmas attached to disabling conditions by religious and cultural beliefs.

This chapter will now describe rehabilitation facilities and various medical and vocational support services that rehabilitation counselors will need to use to enhance the rehabilitation of disabled persons in both Fiji and Pakistan.

Comprehensive Rehabilitation Centers

A comprehensive rehabilitation center is a facility that provides
for the management of clients with chronic disabilities. These institutions are usually associated with general hospitals, but they may be 'free standing.' Most of the centers that have the capacity to handle patients with severe disabilities also have inpatient facilities for 24-hour-a-day intensive treatment. They also may include outpatient facilities and services for clients.

Highly specialized or comprehensive rehabilitation centers include those offering services for blindness, deafness, severe mental retardation, or alcoholism. All rehabilitation centers have a certain commonality. Their staffs all include full-time physicians with special interest and training in disability and expertise in rehabilitation treatment. They also have full-time staffs of allied health professionals representing those disciplines necessary for the rehabilitation treatment of the type of patient they serve. Most offer vocational rehabilitation services provided by vocational rehabilitation counselors.

The hallmark of all rehabilitation centers with regard to any patient being admitted is an initial evaluation to identify the full range of disability problems. Evaluation invariably involves
participation by all of the relevant professionals for the individual patient. After the evaluation, the rehabilitation team, together with the patient, develops a treatment plan for treatment of the disability and removal of the handicapping problems. For each problem, goals are established which characterize the objectives of the rehabilitation plan. Formulation of goals and a treatment plan, ensures that all professionals are working with the patient toward a common end.

During the course of treatment, the rehabilitation team will meet frequently to assess progress, modify goals, and alter treatment programs, as indicated by the patient's progress. Efforts are directed towards minimizing the handicaps of the disability, maximizing residual capacity, establishing suitable interfaces between the patient and the environment, and modifying the environment to secure an adequate match between what the patient may be able to achieve and what is his/her environmental circumstances may demand. Special emphasis will be placed on working with the client and his/her family. Many services that clients need to complete their rehabilitation programs are provided
within rehabilitation facilities, but many services are found outside of rehabilitation facility. Therefore, the rehabilitation counselor need to use other resources in the community.

**Professional Services**

Many highly trained professionals play a vital role in the rehabilitation process. Some of these individuals may provide medically oriented services such as physical medicine, rehabilitation nursing, physical therapy, occupational therapy, and speech, hearing, and language therapy. Others may contribute allied services such as rehabilitation engineering, therapeutic recreation, and creative arts therapy (art, music, acting, and dancing) (Goldenson, 1978). A description of the key service providers that the rehabilitation counselor may have to work with are as follows:

**Physical Medicine**

Physical medicine is a recognized specialty dealing with the treatment and rehabilitation of disabled individuals. The physician specializing in physical medicine is referred to as a physiatrist.
The physiatrist must establish realistic goals for maximum recovery of the individual and manage a variety of services such as rehabilitation nursing, physical therapy, occupational therapy, speech therapy, and audiology care in order to accomplish the goals of the rehabilitation plan (Goldfine, 1977).

**Physical Therapy**

Physical therapy has been defined as the "art and science dealing with the prevention, correction and alleviation of disease and injury by employing manual and physical means and devices according to the prescription of a qualified physician" (Hickey, 1957, p. 481).

Based on the results of a careful evaluation (muscle, sensory, and range of motion tests), the physical therapists select among a variety of treatment modes including "heat, cold, light, water, massage, ultrasound, exercise, and functional training" (Latimer, 1977, p.279).

**Speech, Hearing, and Language Therapy**

Rehabilitation services are also provided by speech, hearing, and
language pathologists who use a variety of techniques for “developing, correcting, or restimulating speech and language patterns so that individuals can successfully communicate with each other” (Hoffnung, 1977, p. 387). According to Hoffnung (1977), speech and hearing services may be found in hospitals, rehabilitation centers, schools, universities, and a variety of other types of public and private rehabilitation programs.

Occupational Therapy

Spackman and Willard (1957, p. 439) describe occupational therapy as the use of “manual, creative, recreational, educational, prevocational industrial and self help activities under medical prescription to gain from the patient the desired physical/or mental response.” The goals of such services include rehabilitation of functional deficits, development of new functional abilities, and the maintenance of both over time (Lansing & Carlsen, 1977; Lindberg, 1976). Occupational therapy is prescribed for a variety of needs—for example, improving the client’s muscle strength, range of motion, coordination, endurance, sensory function, working
capacity, cognitive functions, social relatedness, personal habits, time management, and role functioning (Ad Hoc Committee of the Commission on Practice, 1980).

Rehabilitation Engineering

Reswick (1980) defined rehabilitation engineering as a combination of engineering and scientific technology with medicine to improve the lives of the people with disabilities. These improvements may require restructuring of the environment or equipping the person with needed prosthetics, orthotics, or aids (Parsons & Rapport, 1981).

Reswick (1980) noted several important qualities of rehabilitation engineers. For example, they must be competent professionals in their own field of specialization, that is, "mechanical, electrical, systems, chemical, materials engineering, and orthotics/prosthetics" (p. 74). They must be capable of working as part of a multidisciplinary health professional team devoted to developing the most effective devices, therapy modes, and/or environmental modifications possibilities. Of
course, development of innovations are only part of their role. They also must have understanding of marketing, manufacturing, and distributing.

**Therapeutic Recreation**

Therapeutic recreation stresses the activities such as hobbies, sports, and other leisure time pursuits which can contribute to the recovery and or well being of individuals with disabilities. It enables the individual to engage in positive relationships while at the same time building functional skills contributing to both independent living and vocational potential.

**Rehabilitation Nursing**

The rehabilitation nurse assist the physiatrist and other ancillary medical specialists such as the physical or occupational therapist who treats the rehabilitation client (Ince, 1974). The rehabilitation nurse plays a central role in working with both client, family, and the rehabilitation team. Nurses spend an extended period of time with clients therefore becoming coordinators of the rehabilitation
team efforts during the medical phase (Morrissey, 1957, p. 428).

**Rehabilitation Counselor**

Role and function in rehabilitation counseling suggests that counselors do, in fact, play a multifaceted role. In addition, they must operate as very "sophisticated professionals" in each aspect of their job role (Roessler & Rubin, 1982). For example, to fulfill the responsibilities of their job role, rehabilitation counselors must carry out: (a) case finding, (b) intake, (c) diagnosis, (d) eligibility determination, (e) plan development and completion, (f) service provision, (g) placement and follow-up, and (h) post-employment services. That job role calls for multiple rehabilitation counselor knowledge and skills related to affective counseling, vocational assessment, vocational counseling, case management, job development, and placement counseling (Garner, 1985; Rubin et al., 1984).

**Summary**

This chapter has discussed a model for a comprehensive
rehabilitation center to be developed in the countries of Fiji and Pakistan. At the present time there is a paucity of rehabilitation in both of the above developing countries. Thus there is a strong need for trained professionals to develop comprehensive rehabilitation centers which will meet the needs of persons of various ages, ethnic backgrounds, and disabilities.

The comprehensive model will provide a wide range of rehabilitation modalities. Special emphasis will be on providing needed vocational rehabilitation services to persons who need help with independence and employment. In addition training will be provided at the center to enable persons with disabilities to become literate, employable, and independent.

The rehabilitation center will develop the following services for both residential clients and those clients who come to the centers from surrounding communities.

1. Medical, psychological, educational, and vocational evaluation.
2. Medical services such as nursing care, prosthetic fitting, physical therapy, occupational therapy, and speech therapy.
3. Social services such as social work, family support group
counseling, and liaison services with other community service organizations.

4. Vocational evaluation and rehabilitation vocational counseling.

5. Work adjustment training and counseling.

6. Evaluation of transportation capabilities and needs.

7. Evaluation of technological needs.

8. Provision of rehabilitation engineering services.


10. Placement to vocational training centers or competitive employment.

11. Provision of follow-up services.
CHAPTER IV

RECOMMENDATIONS

1. Community awareness programs need to be developed in Fiji and Pakistan in order to change the negative attitudes towards persons with disabilities.

2. It will be important for government, industry, and education to share the responsibilities for training persons with disabilities in Fiji and Pakistan.

3. Services need to be coordinated between medical and rehabilitation personnel in Fiji and Pakistan.

4. Resources and facilities need to be identified for higher quality of educational and technical services in Fiji and Pakistan.

5. Comprehensive rehabilitation centers need to be established in Fiji and Pakistan.

6. Schools need to develop work experience programs for persons with disabilities in Fiji and Pakistan.

7. Rehabilitation services need to be developed to assess and meet the needs of persons with disabilities who live in rural areas in
Fiji and Pakistan.

8. Additional research is needed in major areas of rehabilitation in Fiji and Pakistan.
Appendix A

Questionnaire Regarding Rehabilitation in Two Culturally Related Countries

1) Demographic Information
Name:
Address:
Phone:
Native City and Native Country:
Age:
Sex:
Marital Status:
Number of Dependents:

2) Educational History
a) State the college or university from which you received your Bachelor's degree and the location of the institution?

b) What was your undergraduate major? What was your undergraduate minor?

c) State the college or university from which you received your Master's degree and the location of the institution?

d) In what area was your Master's work?

e) NA:
3) Occupational Information

a) What is your current occupation?

b) What occupations have you been engaged in the past?

4) Personal Experience with Rehabilitation

a) Discuss your personal experiences in the field of rehabilitation?

b) In your country what are the societies' attitudes towards persons with disabilities?

c) Discuss your work experiences in the field of rehabilitation?

d) Discuss current rehabilitation practices in your country?

e) What do you feel are major needs of persons with disabilities in your country?

f) Describe existing government and private services to persons with disabilities in your country?

g) What future services are needed in your country to meet the needs of people with disabilities?

h) Do you have any further insights into the area of rehabilitation in your country which you would like to discuss with me?
References


Roessler, R., & S. E. (1982). *Case management and rehabilitation counseling*. Austin, TX: PRO-ED.


