A CASE STUDY OF THE COMMUNITY BASED REHABILITATION PROGRAMME IN MONGOLIA

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ABSTRACT

This paper presents a case study of the status of the community based rehabilitation programme in Mongolia. The case study is based on participatory dialogue conducted in the summer of 2000 with key personnel associated with the programme. The country has tried to implement a different model for the implementation of a CBR programme and must be one of the rare examples where such a huge geographical coverage has been achieved. At the same time, the difficulties in monitoring make it difficult to assess the real coverage in terms of access, acceptability and impact on the lives of disabled persons in the rural areas.

INTRODUCTION

Mongolia is among the poorest nations in the world with a per capita GNP of $400 (1). Geographically, it is a large landlocked country with a total area of 1.56 million square km but with a population of only 2.6 million people, giving the country a population density of merely 15 persons per hectare (2). The country is located in central Asia, bordering with Russia in the north, the People's Republic of China on the east and south and marginally with Kazakhstan on the west. The average altitude of the country is 1,580 m above sea level, characterised by undulating steppes covering about 45% of the country, mountains with dense forests in the north and the Gobi desert in the south that cover about 35% of the country (3). About a third of the population lives in the capital city of Ulaan Bataar, another third in 21 towns or Aimag (Province) centres, and another third in isolated hamlets or as nomads floating from one place to another.

Politically, the country, became the world's second communist country in 1924 and experienced decades of Stalinism under the local leadership of Choibalsan until the fifties. The fifties witnessed the regime of Tsedenbal that saw a stronger influence of Soviet and Chinese governments. In the sixties, with the Sino-Soviet split, Mongolia sided with Soviet Union. During this time the Mongolian script was changed to Cyrillic script. Throughout the seventies, the Soviet influence continued, along with the influence of several countries of the East-European Bloc - East Germany, Poland, Czechoslovakia and Hungary. In 1984, Batmonkh succeeded Tsedenbal and embarked upon economic reforms known as *il tod*, the Mongolian counterpart of perestroika and glasnost. The period also saw enhanced relations with China. However, in 1990, large pro-democracy protests erupted in Ulaan Bataar, leading to amendment of the constitution to hold multi-party elections that paved way for the establishment of democracy. The nineties witnessed several teething problems as are common to the evolution of a new democracy undergoing rapid economic changes. Adding to the teething problems, the constraints to Mongolian economy have been Mongolia's severe climate, scattered population, wide areas of unproductive land, and primary base in agriculture, livestock breeding, and mining-based economy. Some of the salient problems that the country has been struggling with in recent times have been frequent government changes, repeated restructuring, high inflation rates, high level of poverty (about 40% of the population lives below the poverty line), budget cuts for education and health sectors (as high as 40-50% since 1990), soaring of school drop-outs and non-enrolments (as high as 20-25% since 1990), rising unemployment, growth in the number of street children in the capital city, and a deteriorating quality of the environment (4). In such a situation it is easy to imagine that the needs of persons with disability can easily be neglected.

DISABILITY IN MONGOLIA

Accurate data about disability in Mongolia are lacking. However, according to some estimates and survey by the Office of Mongolian National Statistics, in 1999 there were 45,000 persons with disability (1.73%) in the country, of whom 15% had vision difficulties, 20% had speech and hearing difficulties, 35% had mental handicap, and 30% were classified in other categories (5). Furthermore, 34,000 (75%) out of these persons with disability are children in the school-going age.

PURPOSE AND METHOD FOR THIS CASE STUDY

The purpose of this case study is to summarise the status of the community based rehabilitation programme in Mongolia. The case study is based on participatory dialogue conducted in the summer of 2000 with key

personnel associated with the programme. In gathering information for this case study discussions were held with the following stakeholders:

- Key personnel in the Policy and Co-ordination Department at the Ministry of Health and Social Welfare, Government of Mongolia, who are closely working with the present project (n=3)
- Key personnel at the National Rehabilitation and Vocational Training Centre for the Disabled (NRVTC), Government of Mongolia, which has been identified by the Government as the key implementation agency for all rehabilitation related work (n=6)
- Key personnel of the present project implementation team including the AIFO representative, designated country project co-ordinator, and designated senior trainer (n=3)
- Sample of functionaries of the CBR committee (n=7) at one sample aimag (Bayankhongar) of the present project including personnel at the vocational training centre (n=3)
- Sample of persons with disability and their family members at one sample aimag (Bayankhongar) of the present project (n=8)
- Key members of a new emerging non-governmental organisation (NGO*), "Tegsh Duuren*" (n=5)
- Key representatives of existing local non-governmental organisations (NGOs) of disabled persons including the federating organisation (n=12)
- Sample representatives of Buddhist religious organisational orders (n=2)

COMMUNITY BASED REHABILITATION PROGRAMME ACTIVITIES IN MONGOLIA

In 1991, the Government of Mongolia solicited the assistance of World Health Organisation (WHO) for initiating community-based rehabilitation (CBR) services for its disabled population. In August 1991, the Rehabilitation Unit (RU) of WHO and Associazione Italiana Amici di Raoul Follareu (AIFO), an Italian non-governmental development organisation, conducted a joint feasibility assessment (6). Given the geographical, climatic and logistical peculiarities of the country, it was decided to follow a 'top-down cascade' approach for implementation of a CBR programme and it started by identification and training of a four-member national CBR team. According to this plan each level would have trained the following lower level, starting with the national team of CBR, through the Aimag doctors at provincial level, the somon (district) doctors and family doctors, and finally the health workers (feldschers) at the village (Bag) level. Thus it was hoped that through the community level health workers, community involvement and ownership of the CBR programme would be achieved.

Initial activities focused primarily on training national and intermediate level health personnel for rehabilitation related work. Between 1992 to 1996, training and capacity building of the national personnel working with the Ministry of Health was undertaken along with organisation of district level training courses with the assistance of expatriate consultants. In 1997, an extensive three-year plan (1998-2000) was formulated to systematically expand the implementation of the community based rehabilitation programme in Mongolia to almost 56% of the national territory, with the assistance of funding from the European Union (EU) and AIFO (7). The two primary activities that were identified for implementation in collaboration with the Ministry of Health were:

1. Training of health personnel at intermediate and peripheral level, namely, family doctors (for urban areas), Aimag (province) doctors, somon (district) doctors, feldshers (rural health workers), in techniques of medical rehabilitation and making of simple appliances. Each training programme was planned for three weeks with ten-day refresher courses and also included translating and distributing the WHO Manual and other teaching materials in Mongolian. The trained personnel were to transfer the information and skills to persons with disability and their families in the communities. Eleven aimags (provinces) in the western part of the country and six districts in Ulaan Bataar were selected for implementing the training.

2. Support for production of orthopaedic appliances through improvement of a national orthopaedic workshop at Ulaan Bataar and creation of two regional orthopaedic workshops in Zavkhan and South Gobi.

In addition to the above, two primary activities, the plan included components for collaboration with other Ministries, national and international NGOs, strengthening of organisations of persons with disabilities, promotion of inclusive education for disabled children, micro projects for vocational training, and promotion of economic self-sufficiency of persons with disability through rotating credit funds.

ACCOMPLISHMENTS OF THE CBR PROGRAMME IN MONGOLIA

The most visible accomplishment of the national CBR programme has been the training of intermediate level functionaries using the WHO manual. By the end of 2000, close to 5,336 intermediate level functionaries, village workers and community volunteers had been trained. Among them, seventy two percent were women.

The training programme has mainly focussed on community level workers as 27% of all persons trained by the programme were community volunteers, 18% were village health workers (feldschers) and another 18% were other community workers. Thus 63% of all the persons trained by the programme were going to work at the community level. Many of these community workers had had no other opportunities for participating in any training courses for the past many years. Further workshops for making simple rehabilitation aids have also been organised. As a result six orthopaedic workshops have been set up at Aimag (Province) level. Also, ten senior level personnel at the national level have been trained in rehabilitation related planning and management.

The data collected by the CBR programme seems to be very different from the data provided by the National Statistics Office. Between 1992 and 2000, the project has covered 6 districts of Ulaan Baatar city and 11 provinces, and in a total population of 1,427,608 population it has identified a total of 47,050 persons with disability (3.3%). Out of these persons with disability, 13% are children below 5 years and another 12% are children of 6-15 years, while 75% of disabled persons are adults. Similarly the percentages of persons with different disabilities emerging from the data collected by the CBR programme, seem to be very different from the national data provided by Statistics office, especially for persons with intellectual impairment. Among the disabled persons identified by the CBR programme, 24 % have visual impairments, 15% have hearing and speech impairments, 15% have impairments related to movement, 6% have convulsions, 4% have mental illness, 10% have intellectual impairment and 26% have multiple disabilities. Forty nine percent of the disabled persons identified by the programme are women and 51% are men. Such differences in data can be partly explained by differences in survey methodology and definitions of different disabilities used during the surveys.

The activities of the CBR programme at the village level included home visits, making of simple mobility aids, referral services, training for starting rotating savings and credit funds, parent training, vocational training courses, support for strengthening of organisations of disabled persons and so on.

In the nine years since the programme has been launched, there also have been some national level accomplishments. Two of the significant achievements of the national rehabilitation effort in Mongolia are firstly, the development of a National Programme on “Improving the quality of life of people with disabilities” in 1998 and secondly, the creation of a National Rehabilitation and Vocational Training Centre for the Disabled (NRVTC), in November 1999. The first development is significant in terms of the national commitment and political will to work for the cause of persons with disability. The creation of NRVTC is a step toward national capacity building. The centre consists of three units, namely, vocational training department, orthopaedic workshop, and rehabilitative therapy unit.

At the national level, another accomplishment has been the establishment of a central rehabilitation management and training team. In the summer of 2000, this team consisted of the Director General of the Department of policy and co-ordination at the Ministry of Health and Social Welfare, Director of NRVTC, project co-ordinator of the CBR programme, the Director General of the Department of policy and co-ordination at the Ministry of Enlightenment (Education), and the Director of Social Welfare at the Ministry

of Health and Social Welfare. The existence of such a team is vital for sustaining and directing efforts for activities that look at the totality of rehabilitation needs and are multi-sectoral.

As far as non-governmental organisations (NGOs) in the country are concerned, many of them emerged in Mongolia after the establishment of democracy. NGOs can serve as important partners for rehabilitation related work where either they can deliver small projects or they can serve as "watchdogs" for monitoring the activities. For the CBR programme, the organisations of disabled persons have had special importance. A national level federation of organisations of disabled persons has been created, partly also due to efforts of the CBR programme. The Buddhist organisations are also gaining re-emergence in the country and some monks have participated in the training courses. Their participation in the CBR programme can play an important role in promoting community awareness and involvement.

CHALLENGES FOR THE COMMUNITY BASED REHABILITATION PROGRAMME IN MONGOLIA

While the Mongolia CBR programme has made significant progress in increasing the coverage to almost 56% of the population, all the activities have been concentrated in the western half of the country. For the national authorities as well for provincial administrations in the eastern half of the country, it is important to extend the programme activities to the uncovered areas. For those unfamiliar with the country, the organisation of any services at the village (Bag) level, where a few houses and a small population may be spread over a large geographical area, would seem a daunting task. However, the role of community health workers (feldscher), often women, is closely integrated in the social and cultural life of these villages and may enjoy an important social position and prestige, even if the salaries may be very low. Sometimes they may travel on horses for days, travelling up to 80 km to reach a sick person, and often stay with the sick person for a period, before coming back to their homes (tents). In addition, they visit all the families of their village, at least twice every year. Theoretically, such prolonged home visits would provide an ideal opportunity to interact with disabled persons and their families for transfer of information and skills. Whether this is happening in practice and whether the training provided to them answers the needs of the communities, still needs to be evaluated.

The main difficulty for implementing the CBR approach in Mongolia's rural areas is the sparse, nomadic population. 'Community' has a totally different meaning in the Mongolian context where one family is separated from another by 20-40 kilometres and families move their living place several times during the year to find newer pastures for their animals. Communication and transportation between the provincial centre and districts, and between districts and Bags (villages), is difficult due to lack of basic infrastructure. Thus, it is difficult to organise any supervision and referral support to the community health workers. This lack of accessibility is further compounded by an extreme continental climate of only 100 frost-free days a year. All these factors make it very difficult for persons of the same village to come together, and organising meetings of persons from different villages even more daunting.

Thus, communication and sharing of knowledge and experiences between different communities is much more difficult, which hinders a wide base of community based movement. This is a big challenge for the CBR programme in Mongolia. It also affects the quality of data collected from the different provinces about the CBR activities.

Frequent transfers and high turnover of higher and intermediate level functionaries of Ministry of Health trained by the programme is another challenge for the programme. Involvement of the ministries of infrastructure, finance, agriculture, and education is vital. The first two can serve as important resources in strengthening local sustainability of the programme, while the third will be helpful in planning for rotating credit funds, as many of the micro projects are agriculture related activities. Representatives from Aimag levels are completely missing in the core planning team. Also missing are the representatives from emerging and existing NGOs. While the present capacity of some of these players might be weak, it will not be helpful to neglect these partners completely and to deprive them of building their potentials for future.

The other challenge pertains to improvement in training. The training content and process also need further refinement and updating. At present all the major training activities are planned and supervised by the central training team. However, with the extension of the programme coverage it is under strain. Incentives for trainers remain a challenge as also the issue of "burn out".

The programme needs to decide if it should focus on extension of activities of the remaining uncovered parts in the eastern half of the country or if it should further consolidate its activities in the covered areas. In any case, the programme needs to evaluate its impact at the most peripheral level.

CONCLUSION

Mongolia presents a unique situation for community based rehabilitation programming. Over the past decade, the country has been able to identify and devote significant political will towards improving the situation of disabled persons in some parts of the country. However, the lack of infrastructure, scattered nomadic population, severe climate, frequent governmental changes, and repeated restructuring make planning and management of rehabilitation particularly difficult. The country has tried to implement a different model for the implementation of CBR programme and must be one of rare examples where such a huge geographical coverage has been achieved. Even if the programme has been implemented through the existing governmental structures, the specific role of village health workers (feldschers) in Mongolia can provide a bridge between these structures and community involvement. At the same time, the difficulties in monitoring make it difficult to assess the real coverage in terms of access, acceptability and impact on the lives of disabled persons in the rural areas.

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