Establishment of services for pre-school handicapped children

by Marigold J. Thorburn

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ESTABLISHMENT OF SERVICES FOR PRE-SCHOOL HANDICAPPED CHILDREN

by Marigold J. Thorburn

Report prepared for the Government of the Syrian Arab Republic by the United Nations Educational, Scientific and Cultural Organization (Unesco)
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I. INTRODUCTION

1. The mission described in the present report was carried out from 10 to 29 March 1986 at the request of the Government of the Syrian Arab Republic and was funded by Unesco under its Participation Programme for 1984-85 for the following purpose:

(a) to advise the Directorate of Social Services, Ministry of Labour and Social Affairs on the initiation and establishment of early assessment, intervention and pre-school services for young handicapped children,

(b) to advise the Directorate of Social Services (D.S.S.) on the planning of programmes for pre-school handicapped children and the establishment of relevant centres.

In February 1986, prior to the mission, draft guidelines for pre-school educational services were submitted by the consultant to the Syrian authorities.

2. After the consultant's arrival in Syria, the terms of reference were further clarified with the Director of Social Services, Mr Ahmed Sabbagh, as follows:

- A centre (or one of several possible buildings) has been designated for the pre-school programme. The main intention is to provide kindergarten-type services to children aged 3-6 years.

- All services will be free.

- New staff will be recruited from graduates of the social work training programme.

- The budget will be agreed upon after decisions have been made on what kind of services will be provided.

- Mr Subhi Maya, the Director of the Institution for Juvenile Delinquents, has been given the responsibility of the programme.

3. The Syrian Government has accepted the goals of the International Year of Disabled Persons of full participation and equality for handicapped persons. They are implementing these goals by:

(a) integrating children in their own homes (not increasing residential institutions)

(b) providing educational services

(c) helping adults to find jobs

4. The burden and constraints of the Ministry of Education has prevented that Ministry from assuming the responsibility of special education, so the latter has been given to the Ministry of Social Services. The plan for full integration is for the distant future.
5. Concerning the pre-school services:
   - They do not know the full extent of the problem.
   - Regular kindergartens only serve 15 per cent of the pre-school population. A previous effort at integrating a unit for the deaf into one of the kindergartens was a failure.
   - The Ministry of Health has responsibility for children under 3 years.

6. With the co-operation of the staff in the D.S.S. the consultant was able to visit several institutions for handicapped children, key personnel in the Ministry of Health, and the Women's General Union (see Appendix 1). In addition, two short seminars on early intervention for staff and parents were held.

7. Discussions were also held with the Representative of UNICEF, the UNDP Deputy Resident Representative, and by telephone with the Director of the Syrian National Commission for Unesco.

II. MAIN FINDINGS AND CONCLUSIONS

A. Situation analysis of pre-school children of risk for disabilities

8. There are no accurate figures on the prevalence of disability in Syrian children. In the 1970 census, questions on disability were posed and from the responses, figures were abstracted and advanced to obtain estimates of the numbers of handicapped children for this decade. These were as follows:

<table>
<thead>
<tr>
<th></th>
<th>0 - 4</th>
<th>5 - 14</th>
<th>14 - 25</th>
</tr>
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<tbody>
<tr>
<td>Deaf</td>
<td>620</td>
<td>3,990</td>
<td>2,487</td>
</tr>
<tr>
<td>Blind</td>
<td>368</td>
<td>2,282</td>
<td>4,294</td>
</tr>
<tr>
<td>Physically handicapped (amputees only)</td>
<td>140</td>
<td>670</td>
<td>8,082</td>
</tr>
<tr>
<td>Mentally retarded</td>
<td>325</td>
<td>3,161</td>
<td>3,763</td>
</tr>
<tr>
<td>Others</td>
<td>1,309</td>
<td>3,940</td>
<td>2,193</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2,762</td>
<td>14,046</td>
<td>13,629</td>
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These figures are certainly serious under-estimates.

Background health information contributing to the childhood disability problem

9. The UNICEF report indicated that approximately 19 per cent of the population are under 5 years of age, giving a total of 1,874,000, of which 54 per cent live in rural, and 46 per cent in urban areas. Approximately 3.7 per cent, or 363,000, are under one year old.
10. The infant mortality rate for the period 1976-1979 was estimated as 63/1000 for males, and 51/1000 for females. The current estimate is 59/1000. A study in Damascus in 1971 indicated that the perinatal mortality rate was 31/1000. (Perinatal mortality is the number of stillbirths and deaths in the first week of life for every 1,000 births).

11. Regarding morbidity, the specific conditions likely to lead to childhood disability in Syria would include:

- measles
- poliomyelitis
- middle ear infections
- infectious diseases and meningitis
- cerebral palsy due to perinatal damage
- chromosomal defects
- genetic mental retardation, deafness and eye defects resulting from consanguinity.

The consultant was informed that polio is now only sporadic, and that chronic middle ear infections are uncommon.

12. Malnutrition is estimated to occur in about 45 per cent of children of which half is mild and about 19 per cent is moderate.

13. On the above basis it can be speculated that the childhood disability prevalence (depending on the criteria used for disability) is not more than 6 per cent, giving:

- 60,000 children in rural areas
- 52,000 children in urban areas

or, based on the annual birth rate of 360,000, approximately 22,000 new disabled children each year.

14. If in fact polio is no longer a major cause of disability, the most common types in the pre-school age group will be:

- mental retardation
- cerebral palsy (multiple disability)
- seizure disorders
- deafness and hearing impairment.

The needs of pre-school children with disabilities

15. The problem of disability not only encompasses the whole life-span of the person, it also involves the family.

16. No handicapped child should be left to his own devices during the pre-school period. This is the most formative period. Since only 15 per cent of Syrian children receive pre-school services away from the home, the norm for the pre-school children is to be reared in the family environment.
17. This means that the primary function of pre-school services for handicapped children should be to give support and advice to the family. Appropriate intervention during this period will have a significant effect on the family's ability to accept, care for, cope with and train the child with a disability. The most important needs of this group are:

- The early detection and diagnosis of the problem
- The evaluation of the nature, type and severity of the disability
- The provision of medical treatment, if appropriate
- Counselling and emotional support for the family in their adjustment to the crisis of having a handicapped child
- Advice and relevant facts and information on appropriate resources and services needed for parents
- Training of the mother/child dyad in specific developmental skills and general management of behaviour to promote maximum development
- Preparation for school

18. It is also important to remember that while childhood disability can occur in any family, it will be more frequent in poorer families. Since the largest section of a population falls into that socio-economic category, the needs of poorer families and their inability or lack of motivation to make use of inconvenient services must receive priority attention.

19. Finally, there is often a tendency for parents of children with difficult problems to want to place the child in a residential facility. In the child's interest this is probably the worst thing that can happen.

Existing services for pre-school handicapped children

20. Specialized and specific services for this group of children as outlined in the previous section, are almost non-existent in Syria.

There are two facilities offering kindergarten type schooling:

i. The kindergarten school for the deaf which caters for 40 children, 3 - 6 years of age.

ii. The school for cerebral-palsied children which caters for children from 3 - 20 years.

Both these schools have a voluntary association to which they are affiliated, though the main financial and supervisory support comes from the D.S.S. Both schools also offer medical assessment services, and the second also provides home visiting by parents and physiotherapy and adaptive aids.

21. There are no developmental or medical assessment services in the hospitals. In fact, doctors seem to be poorly informed and ill-equipped to assist the family
in a positive fashion. This aspect came out very strongly in the three parents' meetings. In the first, a small meeting of approximately 8 - 10 mothers of C.P. children, all except one had been given no or poor information. In the two large meetings, each attended by over 100 parents, the questions asked, after the main talk, went on for over an hour and were mostly on the medical aspects of the various disabilities. There is obviously a tremendous need for appropriate information for parents, which must be provided early and on a continuing basis, as the parents are still expecting and seeking cures and medical miracles, even for teenagers.

Existing resources for normal children

22. The Ministry of Health has a Maternal and Child Health (MCH) care programme which incorporates prevention and early detection of disability. This is not linked in any way with the services provided by the D.S.S.

23. The MCH programme provides coverage for about 16 per cent of the population, and is being expanded to 35 per cent in this next two years. It incorporates an antenatal package of eleven clinic visits with medical examinations, midwife checks and laboratory tests. The child welfare component provides eleven clinical visits, including two monthly weight checks in the first year, medical checks at 2, 6, 12, 18, 24, 36 and 60 months, E.P.I., including measles vaccination and growth monitoring, hearing and vision screening.

24. The Women's General Union, a body politically affiliated with the Arab Ba'ath Party, runs day-care centres and kindergartens for normal children of working women.

25. There are 160 kindergartens and 30 day-care centres throughout Syria. They are not allowed to take handicapped children. Their programme is partially (20 per cent) staffed by teachers, and is supervised and partly supported by the Ministry of Education. The mother pays a portion of her salary as a fee. More details are provided in Appendix 1.

B. Programming issues

26. Before making recommendations on the initiation and development of pre-school services, certain principles and issues need to be emphasized.

i. The philosophy and goals of full participation and equality need to be kept foremost in mind. These principles should not be sacrificed for expediency.

ii. The initial programme that is established will set the tone and the pattern for the future. It is very difficult to undo what has been started, especially if buildings are involved. The programme should, therefore, start small and be flexible and replicable.

iii. The pre-school child cannot be seen in isolation from his family, nor can he be split into two neat parts, 0 - 3 and 3 - 6. What is the optimum for each child should be provided on a continuing basis.
iv. The purpose of intervention in the pre-school period includes:

- promoting maximum development
- strengthening parent-child bonding and relationships
- dispelling negative parental attitudes towards disability
- preventing further handicaps or behaviour problems
- preparing the child for the most integrated school situation possible.

Success in these issues will assist in preventing institutionalisation.

v. Intervention will need to combine:

1) various professional skills
2) involvement of the family
3) close linkages with the health and educational systems
4) continuity of care from as early as possible
5) the most feasible and cost-effective approaches
6) accessibility to families, especially poor ones.

vi. The consultant strongly supports recommendations II to VI of the Unesco Special Education Report No.2 of Mr Henning Sletved, 1983. These are all relevant to the existing programme.

vii. Since the programme will eventually have to reach all children in Syria, it will need to be cost effective and replicable using Syrian resources.

Justification for a service for assessment and early intervention

27. There are probably approximately 50-60,000 handicapped children of pre-school age in the Syrian Arab Republic, and there are at present virtually no services meeting the needs of this group. A service for assessment and early intervention for handicapped children is justified because:

- training and education of Syrian handicapped children does not begin until school age
- there are no formal assessment procedures in place for the purposes of placement or individual programme planning for either pre-school or school age children with learning, motor, speech or neurological disabilities
- only a small proportion of disabled children are in school
- it is probable that some children at present in segregated special schools do not need to be in such settings
- there is a lack of assessment materials, tests and relevant information based on Syrian customs and culture
there is a lack of family support services to give advice and appropriate information to parents, resulting in much misinformation and highly unrealistic expectations for disabled children.

III. RECOMMENDATIONS

A developmental service for assessment and early intervention

Target population:

28. Families with
   (a) children 0 - 6 years with any type of disability and/or developmental delay
   (b) possibly also children aged 6 - 18 years.

Organized on a geographical basis

Programme:

29. It is suggested that the service provide six functions -
   a) Assessment of children
   b) Parent guidance and training
   c) Training of pre-school children with disabilities
   d) In-service training
   e) A Resource Centre for materials
   f) Advocacy and public awareness for the integration of disabled children into normal programmes

Assessment

30. Children could be referred to the programme in one of several possible ways:
   a) From doctors in hospitals or offices
   b) From health (M.C.H.) clinics
   c) From public awareness programmes
   d) From schools

31. The function of the assessment component of the programme will be -
   a) to assess all children referred for type, nature and severity of disability
   b) to make a medical diagnosis and provide basic treatment, if relevant
   c) to design an Individual Programme Plan (I.P.P.) for the child
   d) to inform and counsel the family in appropriate aspects and management
   e) to refer the child to other services when/if needed (medical, educational, etc.)
32. The volume and scope of the programme and its geographical distribution will depend on whether the service deals with pre-school children only or all children. If the latter is decided, the volume and turnover can be expected to be at least three times what it would be if only pre-school children are accepted for assessment.

Guidance of parents

33. This aspect can serve at least three functions:

a) Providing training for parents
b) Putting parents in touch with each other through meetings or home visits
c) Providing resource materials (books, educational toys, etc.)

Training for pre-school children with disabilities

34. This aspect will be dependent on and follow the assessment. The programme should consider the following models of training, the choice of which will be partly dependent on the family, the age of the child and the severity of the disability:

a) Individual instruction of mother/child dyad in the centre
b) Group instructions of parents with children
c) Home instruction of parents with children
d) Kindergarten classes.

The last should be carefully considered and provided only when other approaches do not meet the needs of the family, e.g. where mother is at work or child has severe problems. Efforts should be made to provide integrated placements, if at all possible, either in Day Care Centres (D.C.C.), kindergartens, or community relief centres in rural areas.

In-service training

35. The programme can provide short-term training courses for various types of personnel working in the field, e.g. health workers, teachers, doctors, etc.

Resources of materials

36. This aspect can include:

a) information about disability
b) books, manuals, leaflets for parents, workers
c) toys
d) adaptive aids and equipment
e) A.V. materials (films, slides, etc.)
37. Fundamental to the success of the programme will be the establishment of strong links between the medical and health programmes for early detection (see paragraph 56).

38. Since several types of services will be provided the administrative structure of the programme will have to be carefully organized and procedural manuals will probably be required (see paragraph 53).

39. Criteria will need to be established for entry and discharge.

Facilities and scope of programme:

40. Initially the programme should operate out of one centre in Damascus. It is suggested that the building next to the elementary school for mentally retarded children at Mazze and previously occupied by the school for the deaf, would be eminently suitable after repairing and renovation. It has twelve rooms on each of the two floors, some of which could be joined together to make a larger room for training and meetings. The total of approximately twenty rooms would be ample to commence the programme as suggested in paragraph 29.

41. Later on it will be necessary to establish similar centres in Aleppo, Homs, etc. and smaller satellite centres will be soon required in Damascus. The important point of the buildings is that they must be easily accessible by public transport for the families.

42. It is probable that the centre will receive at least 500 new cases per year and should estimate to carry continuing intervention programmes for at least 200 pre-school children.

43. As the demands on the service grow, which they will, as it becomes known what resources and services are being provided, it will be more desirable to establish satellite offices or centres than keep the programme centralised. These centres should be small. It would be better for administrative, accessibility and visibility purposes to remain small and functional.

44. The facilities of the initial centre will need to comprise -

- rooms for professional assessment
- physiotherapy (downstairs)
- play areas (inside and outside)
- audiometry
- an adaptive aids workshop (downstairs)
- library and display area
- storeroom
- waiting area (downstairs)
- small classrooms (upstairs)
- rooms large enough for training courses and meetings
- rest rooms, bathrooms and kitchen
- a coffee or refreshment shop (downstairs)
- a room for a computer
Personnel:

45. At present there are very few Syrian professionals trained in the special education, developmental assessment, educational evaluation field. However, this should not be an obstacle to the development of a programme. A basic core of personnel that will be required will include the staff to provide services to children and families (1-4).

a) A professional clinical director (see paragraph 62).

b) A basic assessment team including,

   i. a paediatrician part-time*
   ii. a well qualified and experienced special education teacher*
   iii. a social worker
   iv. a developmental screening technician

   This basic team will perform the initial assessments on all the children. They will decide whether the child needs more specialised assessment.

c) They can be backed up by a specialised team of

   i. physiotherapist*
   ii. speech therapist*
   iii. audiologist (part-time)*
   iv. special education or early childhood education teachers; 3-4, for the classes
   v. behavioural psychologist* (optional)

d) A home visiting team of 10-16 social work graduates or parents or community workers.

e) Resource staff may include

   - librarian/resource centre documentalist
   - computer programmer
   - audio-visual technician
   - records officer

f) Administrative personnel, typists, etc., will also be required.

46. All the staff providing clinical and educational services will require training (see paragraph 50). All, except those marked *, can be graduates of the social work programme.

For item 45 (d) it will also be helpful to develop a special category of staff (assistants or auxiliaries), developmental screening technicians or home teachers who will need a total of approximately 2-3 months of training to carry out the major services directly to the children of: screening; teaching in the home; assisting teachers in the classrooms.
47. Research and experience in Canada and in many other countries has shown that it is not necessary to have only professional staff. Approximately 70 per cent of direct services to clients can be provided by non-professionals (e.g. baccalureate or even lower education).

48. N.B.: The credibility of the service with doctors referring both with children and with parents, will be greatly facilitated by having a paediatrician on the staff, especially if it is possible to find one with training in developmental paediatrics.

Materials:

49. A wide variety of materials will be required. These will initially have to be imported and adapted from abroad, but efforts should be made as early as possible to develop indigenous and appropriate items. The materials required include:

   Testing, screening and evaluation materials, questionnaires, record forms, etc. A variety of basic ones can be suggested to perform specific functions.

   Training packages and information booklets and leaflets. These can be used by staff as guides and/or given to parents to help them understand problems and give guidance on what to do.

   Toys and teaching aids. A wide variety of these will be needed but they should be directly related to learning objectives and should be locally made as far as possible. Many can be made by staff and parents.
Audio-visual materials. Slide sets, videos and films are very useful for training purposes both for parents and staff.

Adaptive aids. Certain disabilities will require specific adaptive aids or appliances such as braille machines, hearing aids, adaptive and orthotic aids, walkers, wheelchairs, etc.

Training:

50. Since the D.S.S. may not/do not apparently have any professionals with training and experience in the area of early intervention (with the exception of physiotherapists, and these are not usually experienced with children) an extensive amount of in-service training will be required. As the programme develops, and the needs for the various services and the skills required become clearer, it should be possible to build some of the areas of knowledge and skills into existing or new pre-service training programmes. (For example, both the W.G.U. and Dr. Mardini in M.C.H. stressed the need for the training of personnel in day care with background in health services, education and nursing. If such a programme were to be developed it would be an ideal opportunity to incorporate a programme of training in childhood disability).

51. It is probable that all the staff will require training. However, their needs will be different according to

i. their background and their skills already acquired

ii. their new responsibilities and tasks

An analysis of the job descriptions and tasks of all the staff would be needed and a flexible training programme can then be designed to provide the necessary knowledge and skills. This would be an early step in implementing the new programme. The training, however, can be planned to take place over a period of time and be interspersed with periods of service to gain experience. A sample of a hypothetical training programme is given in Figure 1.

52. It is probably advisable to commence the programme using relatively simple procedures and allowing the ingenuity and creativity of the staff to identify or select more complex and sophisticated procedures as the needs arise and are uncovered by experience.

Administration:

53. The existing schools and programmes of the D.S.S. are administered in a decentralized way at present in that each unit is allocated a budget, and that budget is disbursed in the school. Staff appointments are made by the Ministry.

54. The administration of this programme could also be carried out in the same fashion. A suggested administrative structure for the service could be as follows:
55. The full complement of services outlined in paragraph 29 above would not be available at all centres established, as this would be too costly. Most centres of the system would probably have only one-quarter of the staff envisaged above.

**Linkages and co-ordination**

56. A programme for pre-school children is of necessity multidisciplinary and multisectoral, involving health, educational and social welfare components. The 'Developmental Service' should, therefore, operate in close co-ordination with other children's services. This service will need -

i. Referrals from health programmes as early as possible to facilitate early detection and early intervention,

ii. Referrals to specialised medical facilities for consultations on neurological, genetic, orthopaedic, ENT, and ophthalmic problems,

iii. Links with 'normal' pre-school services, e.g. regular day care, kindergartens, and health centres,

iv. Links with the regular school system and special schools.

In all these there will be a beneficial two-way exchange of services. The Developmental Service will need to seek these co-operative arrangements. Fortunately, some channels are already established. Dr Mardini, Director of M.C.H., is very interested and anxious to co-operate both in services and in training.

57. The established centre may need to develop mutually acceptable referral and reporting procedures.

58. Seminars and workshops to orientate these agencies will also be very useful. Training courses for, e.g., day-care centre staff, could facilitate the acceptance of mildly handicapped children into regular day care.

59. To facilitate referral of children from medical clinics, the D.S.S. could place some of their clinical assistants (see paragraph 45) in clinics to do screening of suspected handicapped children.
Resources to assist in programme development

60. The following were suggested in the final discussion with staff of the D.S.S.:
   - Formulating a detailed implementation and management plan
   - Preparing an operational manual of procedures
   - Training - short-term and long-term
   - Materials development
   - Technical personnel

   The D.S.S. requested the consultant to provide an outline implementation plan and training plan. He agreed that assistance would be needed in training and materials development; also in curriculum. The consultant offered a curriculum for pre-school children (the Jamaican adaptation of the Portage Model). Concerning items 3 and 4 these could be obtained through multilateral and/or bilateral aid.

61. The consultant understands that a programme for training professionals in cerebral palsy and severe childhood disability is being developed by Cerebral Palsy Overseas in co-operation with the Ministry of Health. The D.S.S. could avail themselves of such opportunities for training professional staff.

Short-term training of personnel for developmental service

62. In this section short-term training only is considered, to prepare the personnel to initiate and develop the programme. For the overall long-term plan, reference is made to Table 1, a training matrix which summarizes the skills and knowledge required.

63. All personnel (including administrative and ministry staff) will require some of the courses (the Core orientation); some will require all. The para-professionals will require most of it, while others will require parts, according to their skills and tasks.

64. The more senior professionals should be involved in the training of the lower level staff. This will help in the understanding of the roles and skills of the different groups and will give the senior staff responsibility for the effectiveness and capability of the junior staff.

65. Where training needs are common to all groups, they should be taught together. Group discussion and skill training with strategic distribution of more competent persons will facilitate the learning of slower people. The training should be as practical as possible initially. Theoretical and academic material can be given later when the participants see the relevance and application of these more difficult aspects.

66. General purposes of training
   a) to familiarize the staff with the goals and operation of the programme (Core course);
b) to familiarize the staff with current philosophical principles relating to disability, new trends in management and basic knowledge of causes, types and prevention of disability in children (Core course);

c) to train staff in the various tasks and skills which will be required by the programme;

d) to facilitate teamwork and co-operation within the programme;

e) to facilitate co-operation and interagency referral and reporting.

67. Before detailed training objectives for different groups of staff can be suggested, there needs to be full discussion of the roles, functions and tasks of the various personnel. These can be seen in outline in the screening system suggested in Table 2.

Roles of personnel in developmental service for assessment and early intervention

68. Decisions will need to be reached early as to whether the Assessment Team of the D.S. will provide assessments only for pre-school children, or also include assessments of school-age children. If the latter are included, the size and volume of the programme will be increased considerably, as eventually there will be at least twice, and maybe three times, as many school-age children as pre-school children.

69. An alternative to centralizing in the D.S. the assessment of all children, would be to establish an assessment capability in all the schools, and only refer the more difficult and complex cases to the D.S. The existing schools would then act as a screening system to 'filter out' the less complex cases and only pass the more difficult ones to the D.S. These decisions will be critical in the long run to the successful and effective functioning of the D.S., for if they are not resolved early, the D.S. will find itself having to cope with an increasing load and waiting list of referrals. A system of screening, therefore, is very important; so that the more highly trained staff will not spend unnecessary time in tasks that could be done by people with less sophisticated skills. (See Figure 2).

70. If it is agreed that this system be implemented then the tasks of the various personnel will be easier to understand and clarify, and training courses can be designed to help them perform these tasks. The critical decisions which will help to keep the waiting list of referrals manageable will be made between points b. and c. Adequate procedures and proper training for the D.S. technicians will enable the designated professional to decide on which cases to accept. At the same time, clear criteria for acceptance into the programme will need to be established.

Recruitment of personnel

71. The most critical person in the initiation and establishment of the programme will be the Director. His/her personality and qualifications will also influence the maintenance and quality of the programme and motivation of the staff. It is therefore essential that this person have qualities of leadership
and dedication to the programme and the needs of the clientele (the families of handicapped children) as their primary concerns. In this instance it may not be possible to find a person who has both these personality qualities and the necessary technical and professional skills and experience. It is more important to have the former qualities and provide training for the person. To facilitate the development of the programme, if the above is the case, it has been found helpful to import a professional from overseas to work for two years with the Director as counterpart, to provide professional guidance and training.

72. Since virtually all the staff will need training in the technical aspects of assessment, special efforts can be made to recruit staff who have the right background, experience in their own fields or adequate training, an empathetic personality, and willingness to learn. An agreed upon and articulated philosophy of service, as the underpinning of policy statements, will be an important bond and common cause to generate staff motivation and team work. The Director must be able to elicit respect and recognition from staff and clients.

Suggested training objectives for each group of personnel

a) Professional assessment team

73. Assuming that the professionals with the backgrounds suggested in paragraph 45 can be recruited, they will bring to their jobs their own particular skills of clinical assessment, teaching skills, therapeutic procedures, counselling etc.

74. The responsibilities of the team members will include making decisions on the diagnosis, treatment, referral, placement and family counselling, and intervention necessary in each case referred to them. These may be made individually or in case conferences. A second area will be follow-up of progress of specific cases assigned. A third will be the supervision of para-professionals in the implementation of intervention programmes. Others will include organizing parent training, in-service training, workshops and seminars, and liaison with other facilities. These responsibilities should not be considered to be confined to the Centre but should equally be field work.

75. In addition to their own specific professional assessments, all the team members should be able to undertake basic screening and assessment tests, e.g. the Denver Developmental Screening Test, history taking and the Portage Guide for Early Education for pre-school children or other selected assessment scales for older children. Training objectives, therefore, will include the professional team members being familiar with -

i. the goals and philosophies of rehabilitation
ii. a brief situation analysis for Syria
iii. problem analysis and priority determination
iv. rehabilitation policy
v. aspects of prevention

Note: For the above, Modules 1 to 3 and 10 of the WHO Manual 'Managing Community Based Rehabilitation' by Dr. Einar Helander will be very useful.

vi. the purposes of assessment.
Training course for the child assessment team

76. In preparation for this course, to save and avoid 'classroom' instruction time, it is strongly recommended that members of the team read -

'Childhood Disability: Its prevention and intervention at the community level' - A manual prepared by UNICEF

'Detection of Developmental Problems in Children' by Krajicek and Tomlinson, University Park Press

'Medical Aspects of Developmental Disabilities in Children, birth to 3'. A resource for special service priorities by James Blackman.

77. The training objectives of the course will enable:

a) team members to

- do the Denver Developmental Screening Test
- take full histories of children
- understand the physical examination
- determine the priority problems
- develop individual educational or treatment plans
- use the Portage Guide to Early Education
- work together as a team
- counsel and advise parents
- keep accurate records and understand teaching system
- assist in training lower level personnel in the basic skills described in earlier modules. This should be after gaining experience in the programme and would apply for subsequent training programmes.

b) the nurse to do -

- hearing and vision screening tests
- Global Assessment Scale
- The Bayley Scales of Infant Development

c) the educator to do -

- The Jamaica Portage Checklist
- The McCarthy Scale
- The Global Assessment Scale
- The Bayley Scales of Infant Development

d) the doctor will do the physical examinations.

78. This course will require practice under supervision, of the D.D.S.T., the Bayley Scales, the Global Assessment Scale and the Portage Guide. The whole
course will probably require two weeks of training, using children on which to practise. The use of the McCarthy or other tests of intellectual and adaptive skills could be taught separately.


Note: Points i. - iii. available from the Caribbean Institute on Mental Retardation

80. Further sessions on special subjects should be held at intervals on -
- Behaviour management
- Physical disabilities, cerebral palsy
- Communication problems
- Mental retardation
- Autism

b) Training of para-professionals

81. A sample of course outlines for screening technicians and home teachers is given in Appendix 2. In addition, these staff should be taught to use the Portage Guide to Early Education. This would take 1 - 2 weeks, depending on the level of education of the trainees. A total of approximately 8 weeks will be required. This training programme should also be conducted in practical settings with much exposure to and practice with children.
BIBLIOGRAPHY


Situation Analysis of Mothers and Children in Syria (1985) - a UNICEF Report

Present Status of Child Health in Syria by Dr Mardini

Political and Socio-Economic Trends Affecting Children (UNICEF)


Syria - A report of a professional visit by Cerebral Palsy Overseas
Institutions Visited

SCHOOL FOR CHILDREN WITH CEREBRAL PALSY

Director: Mrs Shaza Jundi el Wareh

Opened: January 1985

45 children, 3-20 years

Mrs Jundi is the mother of a girl of 8 years with cerebral palsy. She started the Syrian Society for Cerebral Palsy and persuaded the Ministry of Social Services to commence the Centre which operates a school. The Society has more than 500 members of which approximately half are Palestinian.

A mothers' group (of children not in the Centre) meets weekly to discuss their problems.

The majority of members are from poor families. Some of the more experienced mothers do home visits. They are planning a training course for 20 mothers from outside Damascus on how to manage their children. They hold a weekly clinic with a paediatrician. They also have volunteer specialists in ENT, Ophthalmology, and Orthopaedic Surgery.

Approximately 4-6 children are seen weekly.

Main Plans for 1986

1. Training for parents to do home visits

2. A toy library

3. A prevention campaign will be the major project, with posters and leaflets for hospitals and doctors and leaflets for school children. There will be a weekly 10-minutes radio programme.

4. A seminar on early detection for doctors.

The Centre consists of the first floor of a 3-storey building. It has a fair quantity of equipment but the rooms are small and cramped for the number of children and amount of equipment. There is a team of physiotherapists, of which one was trained in Germany. There is really insufficient space for them to function adequately.

The motivation of parents and staff is very high.

The Society organized a seminar with an eight person team from Cerebral Palsy Overseas in 1985. Further training and an outreach programme in rural areas is planned with Cerebral Palsy Overseas and the Syrian Government.

Women's General Union

I visited this programme because it appears to be the only resource for pre-school children other than the M.C.H. programme (see Appendix 2).
The Women's General Union is a popular organization connected with the regional leadership of the Ba'ath Arab Party (the ruling political party).

Goals

It was started in 1976 to serve the working women.

1. To increase access to work opportunities
2. To improve women's education
3. To improve health of women
4. To increase involvement of women in national development.

The Syrian constitution provides for equal rights of women.

The main effort of the Women's General Union has been directed at developing facilities for pre-school children of working women. They operate -

1. Day-Care Centres for age group 0 - 3 years
2. Kindergartens for age group 3 - 6 years

The centres come under the supervision of the Ministry of Education. The directors and teaching staff are paid by that Ministry and the rest of the staff by Women's General Union.

There are 190 centres throughout the country, 160 kindergartens and 30 day care centres, ranging in size from 30 - 200 children.

There are problems in

1. transportation (access to centres)
2. lack of equipment
3. insufficient centres
4. poorly trained staff. (Only 20 per cent of the 1,000 staff are trained).

The staff who have received training have the baccalaureate plus one year of training in the Ministry of Education which qualifies them for teaching 3-12 year olds. The day care centre supervisors have a different background but the nature of this was not clear.

The Women's General Union is trying to establish a better training programme within the Ministry of Education.
TICHREN KINDERGARTEN was purposely built in a residential area four years ago.

The Director has a psychology degree.

The parents pay Ls100.00 per month and Ls65.00 for transport.

Hours are 7.30 - 2.30.

There are 325 children - 200 in the day care section and 125 in the kindergarten.

Staff: 12 supervisors in the day care section 3 in the kindergarten.

Only children of working women may attend. No handicapped children are allowed.

A health report and immunisation certificate are required.

Programme

Children are divided into rooms and classes by age group.

7.30 - 8.30 Arrivals
8.30 Meal from UNICEF (Milk and cheese sandwich)
9.00 - 9.30 Break
9.30 -10.00 Language
10.30 -11.15 Meal
11.50 -12.30 Organized free play
12.30 - 1.00 Music
1.00 on Sleep

There are 10 minute lessons in Science, Arts, and Language.

A doctor comes twice weekly to check children. There are no growth or development monitoring procedures.

Maternal and Child Health Care Programme

I obtained the following information from Dr Khalid Mardini, Director of M.C.H. and from a visit to an M.C.H. clinic in the centre of Damascus.

The programme was established relatively recently.

Antenatal Care provides a package of 11 antenatal visits and includes medical examinations, routine blood, dental and urine tests and tetanus toxoid.

Child welfare includes a programme of 10-11 visits with 7 full medical examinations including vision and hearing checkups.
The clinic visits are scheduled at approximately 6 weeks, 6 months, 12 months, 18, 24, 36 months and 5 years, and include immunisations, growth monitoring, dental checkups and stool examination. Weights are checked every 2 months for the first year.

The coverage is about 16 per cent.

Personnel include doctors, regular nurses and midwives.

Since 1983 an assistant public health nurse - midwife, has been trained for M.C.H. duties. This is a two-year training course and 80 graduates each year.

With the increase in staffing from this programme they hope to double their coverage in the next 2 - 3 years.

Dr. Mardini feels that there should be a basic training programme in health sciences that could form a core course for workers in health services, in day care, and in services for handicapped children.
APPENDIX 2

MANUAL

This is the Manual for the training programme for three groups of workers who are para-professionals employed in Early Stimulation and Child Development. These three groups are:

1. Child Development Aides:

   The overall goal for these workers (who are recruited from the Special Employment Programme) is to produce a person who can work with a mother and child as a team in the home, in promoting developmental progress in children with developmental delays. The Aide acts as a home teacher and instructs the mother who then carries out the training of her child herself. The objectives of training therefore indicate the need for the following skills:

   A. to be able to go into a home and establish a relationship with the mother. Obtain the necessary information.

   B. To establish a friendly relationship with the child. To pre-test the child. To undertake and demonstrate prescribed activities.

   C. To promote behavioural approach.

   D. To report accurately and regularly.

   E. To visit regularly.

   F. To ensure mother's co-operation in the project.

   G. To consult with supervisor and accept direction on problems, goal setting and implementation of activities.

2. The Developmental Screening Technicians:

   The goal for these workers who are recruited from National Youth Service, is to be able to administer, score and report accurately the Denver Developmental Screening Test. The objectives of training include the following:

   A. To be able to go into the clinic or home.

   B. To establish a relationship with the mother of the child.

   C. To observe and assess the general readiness of the child for the test situation.

   D. To undertake the prescribed following activities:

      1. Prepare test sheet;
      2. administer test;
      3. record data;
      4. report test;
5. complete data card;
6. inform mother of result;
7. report results to supervisor.

3. Residential Child Development Aides:

The goal for these workers is for them to be able to work in a residential setting, under supervision, in a team training and supervising children, on an individual basis and in groups in social, self-help, general development and recreational skills.

Objectives of Training:

A. To enable workers to work in a residential home.
B. To work in a team in a co-operative manner.
C. To work under supervision.
D. To work with handicapped children in a positive and encouraging way.
E. To instruct and promote children:
   1. individually
   2. in groups
   
   in the following:
   
   self-help and independent skills
   social skills, compliance
   developmental skills
   recreational activities.

F. To report to supervisor.

The training programme of these three groups of workers will be combined courses for areas of general and common knowledge, attitudes, etc. but will be split up to give detailed specialised training in the practical skills required by each group.

The curriculum of the training programme is divided up into modules as follows:

MODULE NUMBER
II. Working with children.
III. Human relations
IV. Teaching skills
V. Normal developments
VI. Behaviour
VII. The Handicapped child
VIII. Community - culture, social practices and attitudes
IX. Services in Syria
X. Operation of project
XI. Nutrition
XII. Making toys
XIII Working with children in groups.

Most of this will be covered during the six weeks, but further sessions may be necessary later as in-service training.

TIME TABLE

Daily sessions will run from 8.40 a.m. - 4.00 p.m. There will be a lunch break at 12.30 - 1.30.

Time-Table Week 1 for All Workers

Monday
8.30 - 9.00 a.m. Registration of trainees
9.00 a.m. - 10.30 Orientation and introduction
10.30 Break
11.00 a.m. Official Opening Ceremony
12.30 Lunch break
1.30 p.m. First Session: Working with mothers and children

Tuesday
8.30 a.m. Normalization - principles and implications:
1.30 p.m. How do I see myself?

Wednesday
8.30 a.m.
1.30 p.m. Co-operation
Thursday
8.30 a.m.  Instructions
1.30 p.m.  Attitudes about self and colleagues

Friday
8.30 a.m.  Instruction
1.30 p.m.  Evaluation
3.30 p.m.  Community questionnaire

Weekend assignment  Carry out community questionnaire

Time-Table Week II

SPECIAL TRAINING PROGRAMME FOR CHILD DEVELOPMENT AIDES WORKING IN COMMUNITY

Monday
8.30 a.m.  Compiling results of survey
1.30 p.m.  Special session

Tuesday:
8.30 a.m.  Working with mothers
1.30 p.m.  Working with children individually (PR)
            This session to be shared with residential child development aides
3.30 p.m.  Basic human needs

Wednesday
8.30 a.m.  Normal development including film 'A Growing Responsibility' (JB, CM and PR)
1.30 p.m.  Skill training and instruction

Thursday
8.30 a.m.  Skill training and instruction

Friday
8.30 a.m.  Skill training
1.30 p.m.  Orientation to the operation of ESP
3.30  Evaluation of course

Weekend assignment  To find new children for working with
<table>
<thead>
<tr>
<th>Time-Table Week III</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday</strong></td>
<td></td>
</tr>
<tr>
<td>8.30 a.m.</td>
<td>'The Handicapped Child'</td>
</tr>
<tr>
<td>10.30 a.m.</td>
<td>'They can be helped', a film</td>
</tr>
<tr>
<td>1.30 p.m.</td>
<td>Attitudes to the Handicapped</td>
</tr>
<tr>
<td><strong>Tuesday</strong></td>
<td></td>
</tr>
<tr>
<td>8.30 a.m.</td>
<td>Normal development</td>
</tr>
<tr>
<td></td>
<td>Films, 'Terrible 2's and Trusting 3's', etc.</td>
</tr>
<tr>
<td>2.30 p.m.</td>
<td>TESTS</td>
</tr>
<tr>
<td><strong>Wednesday</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skill practice</td>
</tr>
<tr>
<td><strong>Thursday</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skill practice</td>
</tr>
<tr>
<td><strong>Friday</strong></td>
<td></td>
</tr>
<tr>
<td>8.30 a.m.</td>
<td>Behaviour modification</td>
</tr>
<tr>
<td>1.30 p.m.</td>
<td>Evaluation</td>
</tr>
<tr>
<td><strong>Weekend assignment</strong></td>
<td>To make behaviour observations.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time-Table Week IV</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday</strong></td>
<td></td>
</tr>
<tr>
<td>8.30 a.m.</td>
<td>Problem solving</td>
</tr>
<tr>
<td>1.30 p.m.</td>
<td>Report back on behaviour observation</td>
</tr>
<tr>
<td><strong>Tuesday to Thursday (inclusive)</strong></td>
<td>Skill practice under supervision</td>
</tr>
<tr>
<td><strong>Friday</strong></td>
<td></td>
</tr>
<tr>
<td>8.30 a.m.</td>
<td>Special session on nutrition</td>
</tr>
<tr>
<td>1.30 p.m.</td>
<td>Attitudes about colleagues:</td>
</tr>
<tr>
<td></td>
<td>General discussion and evaluation of course.</td>
</tr>
</tbody>
</table>
Time-Table Week V

**Monday**
8.30 a.m.  Skill practice under supervision

**Tuesday**
1.30 p.m.  Field Trips
           Discussion

**Wednesday**
Practice sessions under supervision

**Thursday**
Field trips

**Friday**
8.30 a.m.  Community and culture
           Exploring attitudes about society.

**Week-end assignment**
To take children from home.

Time-Table Week VI

**Monday**
Field trip

**Tuesday**
Teaching aid and toy making

**Wednesday**
Field trips

**Thursday**
Problem solving
           General discussion of project

**Friday**
Tests and evaluation

2.30 p.m.  Graduation: termination of course
APPENDIX 3

List of services consulted during the mission

Mr Ahmed Sabbagh, Director of Social Services; Mr Misbah el Kari and Mr Subhi Maya of the Directorate.

Dr Khalid Mardini, Director of Maternal and Child Health, Ministry of Health

Deputy Director of the Women's General Union

Mr Abdel Aziz Chouaib, Director of Association for the Deaf

Mrs Barea Merestani, Director of Elementary School for the Mentally Retarded.

Mrs Shaza Jundi, Director of the Syrian Society for Cerebral Palsy and the School for Cerebral Palsied Children.

Dr Basema Jaber, paediatrician.

Dr Mohammed Nabeel Yamis, ENT specialist.

The Director of Quadisaya Institution for the Mentally Retarded, and staff.

Three meetings with parent groups.

Director of M.C.H. Clinic in the Centre of Damascus.

Institutions visited

The Institute for the Blind and Deaf

The building of the previous school for the deaf

A kindergarten and day care centre

An M.C.H. clinic operated in the centre of Damascus for child welfare and health by the Ministry of Health
Implementation Plan for the Establishment of Early Assessment, Intervention and Pre-school services for young Handicapped Children

Engage consultant
Appoint professional director and secretary
Organize and plan rooms of building
Engage architect to design alterations
Commence alterations to building
Order materials, books, tests
Collect names of clients
Make decisions on remaining team members
Recruit professional team
Recruit clientele, set up appointments
Orientate and train staff
Orientate user agencies and other professionals
Commence clinics to assess children
Plan para-professional training
Recruit para-professionals
Train para-professionals
Commence home visiting
Make decisions on programmes for children
Set up records department
Review records and protocols format
Establish materials and resource centre
Conduct workshops in early detection for Ministry of Health
Begin parent training
# APPENDIX 5

## TABLE 1 - TRAINING MATRIX

<table>
<thead>
<tr>
<th>Subjects/Modules</th>
<th>PROFESSIONALS</th>
<th>PARA-PROFESSIONALS</th>
<th>ALL OTHER STAFF IN SERVICE</th>
<th>DOCTOR AND NURSES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PROFESSIONAL ASSESSMENT TEAM</td>
<td>CLASSROOM TEACHERS</td>
<td>SCREENING TECHNICIANS</td>
<td>HOME-TEACHERS</td>
</tr>
<tr>
<td>1. CORE ORIENTATION</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>2. Basic screening devices</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
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<tr>
<td>3. Use of DDST</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
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<tr>
<td>4. Individualised Assessment</td>
<td>+</td>
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<tr>
<td>5. Designing an IPP</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
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<tr>
<td>6. Teaching:</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>a) Individual</td>
<td>+</td>
<td>+</td>
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<td></td>
</tr>
<tr>
<td>b) Group</td>
<td>+</td>
<td>+</td>
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<tr>
<td><strong>Special Problems</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>7. Mental retardation</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Behaviour management</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>8. Cerebral palsy</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Adaptive equipment</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Polio</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Adaptive equipment</td>
<td>Some</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Speech/Hearing</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Methods of communication</td>
<td>Some</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>11. The blind child</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Mobility training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Other medical problems</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Working with parents</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Record keeping</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>
# TABLE 2 - FLOW CHART AND SCREENING SYSTEM

<table>
<thead>
<tr>
<th>Stages</th>
<th>WHO WILL</th>
<th>DO WHAT</th>
<th>TO WHO</th>
<th>WHERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Nurses, doctors</td>
<td>Simple developmental screening tests</td>
<td>Children at high risk or suspect disabled</td>
<td>Clinics, hospitals, offices community</td>
</tr>
<tr>
<td>2.</td>
<td>Screening Technicians</td>
<td>DDST, vision and hearing screening, questionnaires</td>
<td>If abnormal</td>
<td>Developmental Service Centre</td>
</tr>
<tr>
<td>3.</td>
<td>A professional</td>
<td>Review all cases in point 2 and approve appointments for</td>
<td>Children who meet criteria for acceptance</td>
<td>D.S./Special School</td>
</tr>
<tr>
<td>4.</td>
<td>Basic professional team</td>
<td>Examine all cases excepted, using questionnaires tests, according to age. Prepare I.P.P.</td>
<td>&quot;</td>
<td>D.S./Special School</td>
</tr>
<tr>
<td>5.</td>
<td>Specialised professional team members</td>
<td>Use specialised assessments. Prepare I.P.P.</td>
<td>On children referred by point 4</td>
<td>D.S.</td>
</tr>
<tr>
<td>6.</td>
<td>Some professional or home teacher(s) or kindergarten teacher</td>
<td>Implement intervention/treatment/teaching programme</td>
<td>Children needing intervention</td>
<td>D.S., School, kinder-D.C.C., home</td>
</tr>
<tr>
<td>7.</td>
<td>Professional team members responsible for case</td>
<td>Review progress, re-test, re-design I.P.P., refer, etc.</td>
<td>Children on intervention or follow-up</td>
<td>Home, school D.S.</td>
</tr>
</tbody>
</table>