IN THE NAME OF GOD

Performance of Community- Based Rehabilitation planning (CBR) In Rural Areas of Iran

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Introduction :

The situation of people with disabilities in the developing countries should be a matter of great concern. there are today close to 250 million severely and moderately disabled persons in these countries; the annual increase is 10 million. Most of them are poor , dependent ,abused, neglected, excluded from education ,training and jobs ;They die early and have no power while alive. Between 15 and 20 per cent of all people now living below the poverty level have a disability.

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The majority of them have no share in community development programs and are virtually excluded from the public services they need to be prepared for a life in the community. Their human rights are not well protected.

It is clear that in this situation an effort should be made to improve the quality of life of persons with disabilities.

Countries acting to assist disabled people are motivated by a belief in equality and by the desire to limit the severity of disability and the hardship it imposes on individuals and families, as well as to limit the loss that occurs when a sector of the population is economically unproductive. All people have the right to health. In order to ensure that right for all of its citizens, a nation provides opportunities for disabled people to develop and use their physical and mental abilities.

The world health organization is striving to realizes Health for All . In 1978, the International conference on Primary Health Care, held in Alma-Ata, declared that primary health care would address the main health problems in the community and thus promote Health for All through the provision of promotive, preventive, curative, and rehabilitative services. Following the declaration , WHO developed the strategy of community-based rehabilitation (CBR) as a means of integrating rehabilitation with health and development activities at the community level.

The community-based rehabilitation system has in a very short time been introduced into about 90 developing countries.

Major strategies for rehabilitation:

- **Institution-based rehabilitation services** may be provided in a residential setting ,or in a hospital where disabled people receive special treatment or short-term intensive therapy. The institution-based approach focuses on the person's disability and gives little attention to the person's family and community, or to other relevant social factors.The major shortcomings of institution-based care are its high cost and its location ,usually in urban centers , making it inaccessible to those living in outlying areas. In addition, specialized institutions often lack qualified personnel. Competent institution-based care, however, is an important part of the rehabilitation referral system for special assessments, surgical interventions, other skilled treatment, and specialized equipment.

- **Outreach rehabilitation services** are typically provided by health care personnel based in institutions. Such a program provides for visit by rehabilitation personnel to the homes of people with disabilities. The focus is on the disabled person, and perhaps the person's family. Education and vocational training are generally not included. Community involvement in these services is usually limited, with the result that they evoke little social change. The cost per person treated is high. Outreach services can be a valid part of the referral system , however , when used in special situations , such as the delivery of services to extremely remote areas.

- **Community-based rehabilitation (CBR)** is characterized by the active role of people with disabilities, their families, and the community in the rehabilitation process. In CBR knowledge and skills for the basic training of disabled people are transferred to disabled adults themselves, to their families, and to community members. A community committee promotes the removal of physical and attitudinal barriers and ensures opportunities for people with disabilities to participate in school , work , leisure , social , and political activities within the community. A person is available in the community to work with disabled people and their families in rehabilitation activities. Disabled children attend the local school. Community members provide local job training for disabled adults. Community groups assist the families of disabled people by providing care for their disabled children or adults , transportation , or loans to initiate income-generating activities. Community resources are supported by referral services within the health , education , labour , and social service system. Personnel skilled in rehabilitation technology train and support community workers , and provide skilled intervention , as necessary.

Community-based rehabilitation (CBR) is a common-sense strategy for enhancing the quality of life of people with disabilities by improving service delivery in order to reach all in need by , providing more equitable opportunities and promoting and protecting their rights.

The goal of CBR is to bring about a change; to develop a system capable of reaching all disabled people in need and to educate and involve governments and the public. CBR should be sustained in each country by using a level of resources that is realistic and maintainable.

- **Rehabilitation in Iran :**

In Iran responsible of giving rehabilitation services to disabled people is Welfare Organization, which is an independent department of Ministry of Health & Medical Education.
The organization is also responsible for early childhood education and development. It is made up of **3** departments: prevention , social affairs and rehabilitation.

Rehabilitation in Iran began during the **1920**s. At the beginning all the activities were charitable , but later on they were supported by government budget.
After the Islamic Revolution in **1979** all the activities were united under a national government body the Welfare Organization.

By year **2000** the population of I.R.Iran was close to **68** million, during the next 25 years the population is expected to grow by about **40** percent to about **94** million.

On the basis of census in **1996** , about **479590** households out of **12398235** have disabled people. It is **3.9** percent of above households which is calculated **3.4** percent in urban areas and **4.7** percent in rural areas.
The prevalence of moderate and severe disability in the I.R.Iran is- using international standard calculations for the year **2000** estimated at about **4.2** per cent., corresponding to **5.7** per cent, or some **5.3** million person , an increase of about **90** per cent. As the country recently went through a period of war, leaving behind it a large number of disabled veterans, so the above numbers may underestimate the prevalence.
The annual incident rate using international standard calculations should be about **0.5** per cent of the population. This excludes short-term (expected to last less than three months) disability and that occurring during the terminal phase of a disease.

In addition to the Welfare Organization of Iran which is responsible for offering different services such as :
rehabilitation , medicine , vocational , social , educational and processional services
The Exceptional Education Organization also have the responsibility of the public education of the disabled people in primary school , guidance-school and high school...

At the present time more than 80 thousands exceptional students are studying in specialized schools of this organization. The state Welfare Organization in the medical rehabilitation services department is offering services to the disabled people in different centers of

physiotherapy , occupational therapy , audiometry , speech therapy , optometry and technical orthopedics.

There is especial emphasis on different disorders such as spinal cord injuries , C.P , mental retards blind and deaf in every section.

Every year a considerable number of hearing aids , wheel chairs , various kind of walking stickstype writers for the blind , cassette recorders , tape cassettes and medical aid equipments are purchased and distributed among the disabled without any charge.

Conforming the residential area and cities to be used by the disabled is one of the important measures which have been taken by the deputy of social rehabilitation with the help of different organizations such as the ministry of Housing and Municipality.

Holding educational courses for the blind and the deaf , publishing books and publications in Braille and cassettes.

For mentally retarded people , some of them participate in daily educational and training classes and some are looked after in the caring centers. In addition those elderly people who can not be hold at home or do not have a guardianship are sent to special sanitariums.

From the vocational point of view , mentally retarded people pass training course in more than 100 vocational rehabilitation centers and it has been tried to find them a suitable job after training and in this regard with the help of ministry of labor and other organizations , every year we provide some work opportunities for the disabled , although it is not enough.

Special budgets , establishing the co-operatives for disabled persons and paying their insurance premiums are of high priorities in job-placement of handicapped people.
Over 10,000 individuals are trained annually.

- **Contributors to and categories of disability :**

It is not possible to precisely account for the specific contributors to and categories of disability in Iran without a proper scientific study . Below follows some indicative numbers , built on international data :
a)congenital conditions and other disabilities appearing during infancy and childhood,congenital malformations (for instance, club foot , hip dislocation ,spina bifida)and inborn errors of metabolism, about **1-3/1000** ,moderate to severe mental handicaps about **10-15/1000** ,cerebral palsy about **1-2/1000**.
Consanguineous marriage may concentrate the incidence of hereditary diseases in the families, but appear to have less impact on the total disability incidence. Malnutrition is not common in

Iran,but might specifically affect persons with disability.(for maternity care and childbirth there are special maternity homes, some **85** per cent of all births take place in these homes or in hospitals are assisted by professional midwifes. These are important ,as they contribute to prevention of prenatal and maternal disability).
b) Vision impairment is in most countries assessed to affect about **10/1000**,most of it caused by cataract, glaucoma and eye infections, congenital blindness is very rare.
c)hearing and speech disorders: congenital deafness is usually rare about **1-2/10000**,aquired moderate to severe hearing impairment appears to affect about **10/1000** of all populations, mostly among the elderly. Speech disorders are common ,but most of them are slight, severe speech disorders are often associated with hearing impairment ,cerebral palsy and stroke.
d) Non-communicable somatic disease is the main cause of disability after the age of **50** , among these osteoarthrosis and arthritis (rheumatic diseases), including back disorders is the most important group , followed by cardiovascular disease , stroke,cancer,asthema and chronic bronchitis,diabetes,and others.
Chronic neurological disorders such as multiple sclorosis,parkinson`s disease and muscular dystrophy appear to affect only small groups of people in Iran. Epilepsy is in most countries relatively common, about **10** per cent of all persons have at least one attack but most is transitory.
e) Mental disease, especially senile dementia and Alzheimer's disease are important causes of disability among those aged **70** and above , a population group on the increase in Iran.
Chronic mental disease such as schizophrenia and manic-depressive disease should have a prevalence of **1-2/1000.**
Conditions caused by traumatic events of the recent war such as neurotic stress syndrome and depression are no doubt common.
Alcohol appears to affect few people in Iran , the official estimate for drug abusers is two million.
f)accidents/trauma concern a very large group of war victims in Iran , as well as those who has accidents at home , at work and in the traffic. There are some **4,000** persons with spinal cord injury.
g) Communicable diseases do not appear to be a major disability-causing factors in Iran, the immunization programs for polio,tuberculosis,diphteria-pertussis-tetanus,measles and hepatitis are at saturation point. Malaria and AIDS are cause of concern in Iran, but there is no leprosy. Future consideration could be given to meningitis and rubella immunization to reduce certain specific causes of disability.

The above numbers may be compared with the categories of the resulting disabilities according to the national statistics for participants in the CBR program during year **2000** (multiple disability mostly refers to persons with cerebral palsy and among them it is common to see a combination of moving and learning difficulties).

Categories of disabilities in Iran (on the base of CBR `s studies) :

Category of Disability	Percentage

Visual	14.2
Hearing and speech	16.7
Moving	28.3
Mental	11.3
Fits	7.5
Psychotic	6.6
Multiple disabilities	15.4

Based of the above numbers and of a wide experience it is estimated that a program for active rehabilitation including follow –up ,needs to include at any one time some **1%** to **1.5%** of the population. In Iran this would imply a delivery system capable of presently (**year 2001**) serving between **700,000** and **1,000,000** persons , by the year **2025** at least between **950,000** and **1,400,000**.

- **CBR in Islamic Republic of Iran :**

CBR project began in **1990**. At the moment it is implemented through PHC in rural areas of **60** cities (**28** provinces) and about **2,663,269** individuals are observed.
There are **37000** handicapped people over **80** percent out of above disabled persons are referred to higher levels to receive some allowances.

CBR in Iran began after the WHO manuals (*Training in the community for people with disabilities)* were translated and adopted to Islamic culture. Evidently the technologies described in the training packages appear to be adequate and the functional results of excellent quality.
The first training workshop was held for physicians , PHC managers from MOH and senior therapist from Welfare Organization with assistance from WHO, in Semnan province , where the first pilot project began in **2** districts Miami and Shahrod city. This was followed by a cascade model training , for other six cities.

The physiotherapists and occupational therapists in welfare organization were trained in Tehran and other cities. Then they were involved in training CBR personnel in other cities with the guidance of the Welfare Organization main office in Tehran.

Now **28** provinces in Iran are implementing CBR. this is a national program running under the aegis of Welfare Organization, but within the primary health care (PHC) referral framework.

PHC is organized as a four-level referral system , from the health house or unit , rural health centre , district to provincial centre (figure 1). 1)
Health workers staff the health units and centers. There are now **16,000** health houses in Iran(now **1921** health houses are involved in CBR programme) , each serving a population of **1,500** and staffed by one or two health workers(behvarze) who are trained for two years and

receives **2** weeks training in CBR. These are also key workers in CBR , identifying , functional training , referring and supporting disabled person. In most communities , CBR is implemented through a rehabilitation committee with representatives from disabled persons , their families , health workers and CBR advisers. Advisers are specialists in therapies , community and social work.
2) Rural health center: these normally cover **5-6** health houses. These staff includes a generalist doctor and middle level workers (kardans) who have undergone **2** years of training ,including **1**week in CBR .
3) District center: in which there is specialized personnel. For the rehabilitation sector there are the,,experts,, :a doctor , phisyo- and occupational therapists , social workers and psychologists .
4) Provincial and national levels: there are other specialized services , such as hospitals , clinics and orthopedic workshops .

Health & CBR workers liaise with health centers , schools and employment agencies to facilitate assessment , treatment , surgery , physio and occupational therapy , fitting of prothesis , referral , educational and work placement. Health and /or CBR workers are also involved in prevention work including genetic counseling, health education and promotion. They select a member of families of disabled people and give them translated WHO manuals about each type of disability and try by using them provide effective rehabilitation services for disabled persons.
Therefore family training and community participation are very important in Iran's CBR program.

Role of WHO in development of CBR in Iran:

Community Based Rehabilitation Program in Iran started with complete coordination with WHO. Planners of this program used scientific resources that were published from WHO about principles of CBR and experiences of other countries, which are involved in CBR.
One of the most important services in Iran's CBR is family training which is in the base of the WHO`s manuals. These manuals were translated at the first and modified for Iranian culture and now they are used as reference for training of disabled persons, their families, staffs, teachers, community committees and other persons or components of CBR.
WHO office in Iran was very interested to implementing of this program and tried for providing scientific and financial supports for it.
They invited some international advisors who had very useful roles in guidance and training of managers for setting good program and planning for it's sustainability and evaluation. For this reason Dr. Zinken ,Mr. Hariharan , Dr. Populin , Dr. Helander, Dr.Mendis, Dr.McConkey have traveled to Iran and after visiting from fields presented their reports and participated in workshops.

And also some managers and experts took part in International courses with supports of WHO,In countries like India , Vietnam , Lebanon , France , Portugal and were trained about principles of management and evaluation.
Some regional and national workshops about CBR have been organized with scientific and financial supports of WHO representative office.
In the meantime WHO has provided some equipment such as audiovisual material for CBR department.
CBR department in Iran is hopeful these supports to be continued in future, There are many Ideas for promotion and developing of this program which needs to be supported from WHO .
Some planning for future are: 1- setting courses about CBR for training in the university for Physiotherapists, occupational therapists, social workers, speech therapists, psychologists and nurses. 2- Providing training curriculum for mid- level staffs with coordination of University of Rehabilitation and Social Sciences 3- planning for urban CBR 4 – Development of CBR in National level 5- coordination with Ministry of Labor for Inclusive Education 6- Making Iran's CBR special website.

Strategies in CBR :

- Using from existing PHC network to perform and expand the CBR program
- Provide accessibility to the rehabilitation services for rural population
- Decrease the cost of rehabilitation program
- Provide a help for social development
- Complete the PHC network with adding CBR as the third level of prevention

- **Approaches in CBR :**

- Training in the house (using WHO manual)
  Training out of the home (kindergarten, schools…..)
- Short-term vocational training
- Ability training
- Increase public awareness and change attitude

Conclusion regarding service delivery:

The service delivery system has been set up in agreement between the Welfare Organization and the Ministry of Health and Medical Education. The CBR program is now part of the PHC delivery system.
During this initial period the ,,experts,, working at district and provincial levels have evidently to a larger or smaller extent delivered services directly at the homes of disabled persons , in some cases this delivery has been done by the local health workers.
No doubt this participation by the experts,, at the grassroots has given them a valuable experiences of the realities to cope with.
However it will now be necessary to re-structure the CBR service delivery into a proper multi level system. This has already been done with the PHC system.
The tasks carried out by the ,,experts,, should because of the high costs be reserved for the tertiary and quaternary levels. The primary level work by the behvarze (primary health worker) can be increased to include all the primary ,direct contacts with the disabled person and the families : choosing and motivating the family trainers ,provide instructions and hand-on guidance on how to use the training packages ,fill out the assessment and evaluation forms etc.
What now appears to be missing is the secondary level represented by the health center and the kardan(middle level worker).
The re-structuring of the service delivery system will be necessary , as the CBR grows to become a nation-wide system , caring for a very large number of PWDs.
To use the PHC system does not imply that all primary and middle level workers have to be trained. It will at the beginning be enough to train one primary health care worker at each health house and one middle level worker at each health center.

Different levels in Iran`s CBR :

District centers (common between health and welfare systems) :
-Functions :
Planning and coordinating the covered rural PHC centers
Examining and prescribing the rehabilitation aid equipment needed by the referred disabled
Providing the financial support and employment
Providing the inter sectional relationships
Referring the disabled to higher levels
Formulating the statistical forms

-Staff :
Rehabilitation expertise (PT,OT,Psychologist,…)
Health expertise

Rural PHC centers :
-Functions :
Monitoring the health workers functions
The medical examination and referring to the higher levels if necessary

The intervention on the environment adaptation and the social affairs
Formulating the statically forms and records
-Staff :
Physician
Middle level worker(kardan)

Health house :

Functions :
Identifying the disabled persons
The preliminary testing and referring to the higher levels
Selection of a person from family for training disabled person in home
The intervention in social affairs of disabled persons
Organizing the rural CBR committiees
Formulating and submitting the statistical reports
Communicating with schools to accept the disabled person
Staff :
Two health workers (male and female)

Training of staffs in CBR :

-The PHC staff training:

Health workers	2 weeks
Middle level workers	1 week
Physicians	2 days

-The welfare expert training:

PHC training	1 month
CBR training	1 week

The management system :

a) local level

There is already now an involvement in the management of CBR at the community level through the community rehabilitation committees (CRCs). There is no doubt that when that system works well , the local ,,ownership,, of the CBR program can be ,,transferred,, to them. The CRCs can then be participating and taking responsibility for

i) local planning such as proposing new initiatives to the authorities
ii) seeking and managing local funds for CBR
iii) taking an active part in the reporting ,monitoring and evaluation processes
iv) assisting the change among non-disabled citizens in improving attitudes and behavior towards PWDs.

b) records and reporting systems

There is already now a system with records of all PWDs, who participate in CBR. The records are however very time-consuming to read. It is not easy to find out the results, unless records with a standardized form are introduced.

c) monitoring and evaluation

At present the monitoring is not quite complete, it only measures the quantity of PWDs and numbers of services which they were received but does not measure the quality of results.

d) cost control

Cost control is a measure of the efficiency of the resurces used. Although there are at the level of the province and headquarters level of the Iran Welfare Organization indications of the alternative costs of various rehabilitation services, the managerial system needs more development to insure a more rigorous approach to spending and accounting.

Now Welfare Organization in the base of excellent results from perfurmance of CBR in Iran decided to develop this program within a 5 years period to 140cities of 28 provinces (rural area).

Role of each person or section in CBR program :

- **Family member :**

-Recognize symptoms related to disability
-Learning and studying WHO manual books
-Verbal report of result to PHWs
-Improve physical environment of the home
-Increase acceptance of disabled person

- **PHWs(local facilitators)** :

-Locate and identify a person with disability
-Report identify of disabled person to community committee and MLHWs
-Identify and motivate trainer from disable person's family
-Giving manual books to trainer
-Supervise and check trainer

-Identify disabled children of schoolage who do not attend school , and report to the community committee and MLHWs
-Discuss with local school for fort schooling of those identified children
-Identify disabled adult who do not work
-Assess their interest, motivation and capacity to work
Identify a job with the family that the disabled person can do
-Arrange training for that job , and assess the outcome
-Provide special technical tools needed for that job
-Monitor the work attendance and help to solve any practical problems
-Report to community committee problems of disabled people about human rights &etc.

- **LHWs(middle rehabilitation workers) :**

-Confirm identification of disabled people
-Refer person with unclear disability to district level
-Supervise PHWs
-Check results and keep records
-Refer disabled people to higher level to services
-Provide functional training not feasible to carry out at lower levels
-Supervise and adapt training carried out at community level
-Liaise between referral services and community
-Analysis educational needs and possibilities for schooling among referred disabled children
-Analysis possibilities for higher education and arrange for such education
-Refer children for whom regular ,local schooling does not seem feasible
-Undertake training for local school teachers who receive disabled children in their classes
-Training of PHCWs
-Planning of district services and information for interested committees
Technical supervision of PHCWs

- **Community committee :**

-Assess capacity , motivation and interests of the disabled adults referred for a vocational program
-Identify training needs and arrange for appropriate mainstream training
-Give adequate assistance such as loans to disabled people with capacity for self employment
-Refer those with unclear situation or those who could participate in more extensive program
-Reduce physical barriers in the community
-Increase acceptance of the disabled person by community members
-Make all community services accessible to as many disabled persons as possible
-Take actions in respect of the above referenced problems
-Arrange for representation of disabled people in all community committees concerned

-Report to referral levels all problems calling for the attention of the authorities
-Decision on the setting up of a community program
-Planning and management of community program
-Other economic inputs as decided (e.g. subvention to appliances , special consultations , schooling , apprentice ships , revolving fund for self employment
-Monitoring and evaluation

- **Teachers :**
  In community and district level :
  -Include disabled children , if feasible , in the local school
  -Make all community services accessible to as many disabled persons as possible

  In provincial level :
  -Analyze educational needs and interventions for referred children
  -Provide special education , if possible as a preparation for a regular school

  In national level :
  -Design educational approaches to be tested in the local school for those who cannot have special education
  -Include appropriate train9ing programs for teachers , so all of them have an adequate knowledge of educational needs of , and measures for , disabled children

- **Physician with help of MLHWs :**
  First referral level :
  -Identify disabilities in unclear cases by using diagnostic methods available at lower levels
  -Provide medical treatment not available

- **Physician or other provincial specialists :**
  Second referral level :
  -Identify disabilities in unclear cases by using diagnostic methods not available at lower levels
  -Provide medical treatment not available at lower level
- **Physician and other national specialists :**
  Third referral level (provincial) :
  -Identify disabilities in unclear cases by using diagnostic methods not available at lower levels
  -Provide medical treatment not available at lower level

- **Specialist :**
  Second referral level :
  -Provide specialized functional training not available to Cary out at lower levels
  -Analyze educational needs and interventions for referred children

Third referral level :
-Design functional training program to be applied at home for people who fail to respond to standardized training , and supervise its application
-Provide special education , if possible as a preparation for disabled children in a regular school
-Design educational approaches to be tested in the local school

- **Vocational specialist :**

-Assess capacity , motivation and interests of those being referred
-Design a vocational program for those returning home
-Choose disabled adults with capacity for more extensive training and refer them to the appropriate program.

- **Societies (government and agencies , ministries , NGOs , ...) :**
Referral levels :
-Implement changes in building codes to remove and prevent physical barriers
-Improve access to public , buildings and their roads
-Improve access to transportation (e.g. buses, trains, etc)
-Improve curricula for teachers to include teaching of better attitudes toward disabled people
-Increase public awareness and concern for disabled people

- **Ministry (ministries , national rehabilitation , coordination committee) :**
National level :
-Analyze legal questions and problems of representation
-Propose solution that are in conformity with existing legislation
-Propose and adapt new legislation to improve the situation
-Training of other professionals in the rehabilitation field

- **National rehabilitation coordinator :**
-Orientation, information and training of all relevant of groups of personnel
-Training of MLHWs
-Management and administrative support services
-Planning and providing all resources for the training of MLHWs and all other personnel in the educational , health , social and vocational fields
-Technical and management supervision of MLHWs
-Monitoring and evaluation

- **District and provincial authorities :**
-Take and action possible regarding legal problems that can be solved at these levels
-Report unsolved problems to the national levels
-National and provincial planning

Problems and suggestions :

- The middle level workers should be specially trained on the CBR field
- Strong coordination between the ministry of health and the welfare organization is essential
- The need of health workers to more training (but CBR does not interact in the training program which is provided by the ministry of health)
- The people's needs and demands are more than the program potentiality (the literacy level has gone up higher than before ,the health conditions has been promoted , mass media system have spread and etc.)
- The CBR has not gotten its status as a part of the rural development program
- The integrated and inclusive education has should be accepted in the programs of education ministry
- The sporadic and dispersion of the villages and their low rate population :1979 Rural area 65 % , Urban area 35 %2000 Rural area 30 % , Urban area 70 %
- The governmental centered planning and lack of the people's participation is the decision-making by NGO
- The integration between CBR and PHC has not happened and some resistance exist

Table.1- Population & Centers under CBR Coverage (2002)

lth houses	Rural health centers	Population under coverage	Identified disabled people	Percentage of disabled people	Under coverage disabled people	Percentage of coverage
1910	**467**	**2695262**	**49576**	**1.8**	**28518**	**57.5**

Table.2- Staffs of CBR (2002)

ommunity workers	Middle level workers	Physicians	Experts		Managers		Other
			Welfare Org	Health network	Welfare Org	Health network	
3597	**635**	**527**	**306**	**117**	**114**	**78**	**44**

Table.3- Numbers & types of identified disabled people (2002)

pes of ability	Visual	Hearing & speech	Physical & moving	Mental retardation	Psychotic	Fits	Multiple	total
umber	**7011**	**8293**	**14014**	**5554**	**3288**	**3758**	**7658**	**49576**
centage	**14.2**	**16.7**	**28.3**	**11.3**	**6.6**	**7.5**	**15.4**	**100**

Table.4 – CBR program's rehabilitation services to disabled people**(2002)**

Types of services	Need to services	Performed services	Total cost	**Cost unit**	Percentage of services
Training in the family	**21959**	**14507**	**768871**	**53**	**66**

Outside the family training	**8615**	**5533**	**713508**	**128.9**	**64.2**
Referral services	**23302**	**18731**	**817061**	**43.6**	**80.3**
Rehabilitation equipments	**14021**	**8417**	**2805322**	**333**	**60**
Employment	**4606**	**1183**	**2938601**	**2484**	**25.6**
Financial support	**18312**	**11238**	**4961216**	**441**	**61.3**
Total number	**90815**	**59609**	**13004579**	**218**	**65.6**

- **General population under coverage: 2695262**
- **Identified disabled people : 49576**
- **Identified disabled people who are under coverage: 28518**

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