CHRISTIAN SERVICE UNIVERSITY COLLEGE

BENEFITS AND CHALLENGES OF A REHABILITATION CENTRE

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DECLARATION

We declare that this project is our own work undertaken during the Bachelor of Science Nursing program at Christian Service University College, under the supervision of Dr. Kwabena Nsiah. References cited have all been duly acknowledged.

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SUPERVISOR'S DECLARATION

I hereby declare that the preparation and presentation of this dissertation was supervised in accordance with the guidelines on supervision laid down by Christian Service University College.

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ABSTRACT

Congenital abnormalities have been one of the major causes of infant and childhood deaths. Some of the children who survive also suffer from chronic illness and disabilities. This calls for training to help these children live normal lives. The importance of social rehabilitation in such children or persons must not be overlooked, since this is one of the major ways to help them cope, adjust to activities of daily living (ADLs) and turn them into successful individuals. The study was conducted at the Edwenase Rehabilitation Centre. The data collection instrument was a questionnaire structured in English and made up of both open and closed-ended questions. The main objectives of the questionnaire were to find out about the benefits and challenges of the rehabilitation centre and how the trained disabled individuals can become an asset to the human resource of the country, through social rehabilitation. The collected data was analyzed with SPSS 17-0 and presented using frequency and bar charts. The research revealed that disabled individuals can be trained to live a more independent life if they go through successful social rehabilitation. The research also revealed that the rehabilitation centre had a major challenge with financial support from the government and had inadequate tools and equipment to allow a free course of the training. In addition, the research showed that individuals disabled due to a congenital cause were mostly abandoned and had less support from family than those who acquired their disability through other factors that occur later in their lives.

DEDICATION

We dedicate this work to our families and our lecturers for the support throughout our journey in our education.

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All glory and honor to the Almighty, the most High for His guidance, protection and knowledge given us all through this project. We would like to all extend our gratitude to our supervisor, Dr. K. Nsiah, for his patience and tutelage throughout the course of this project.

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CHAPTER ONE

INTRODUCTION

1.1 Background

During the past years, there have been interest on the study of child birth defects or congenital diseases. In the time of pregnancy and the time of delivery, the foetus is exposed to profound physical and emotional changes. There could also be mental disorders. These conditions are caused by developmental processes affected by genetic factors, chromosomal aberrations, environmental factors, multi-factorial heredity and some factors which are currently unknown (DeSilva, 2016).

There are several genes whose mutations are associated with selected congenital anomalies (Mendelian inheritance in man [MIMI]). There could be polygenic inheritance in which more than one gene affect the selected phenotypic trait. There could also be the occurrence of multifactorial inheritance which is not only genetic factors but also environmental factors that affect selected trait.

Also, improper lifestyle of the mother during pregnancy such as alcoholism, smoking, craving for harmful substances such as clay, chalk, raw and excessive starch, not going for clinical check-up and improper dietary habits can also cause abnormalities in the foetus. Emotional and mental instability are also factors that can cause the condition if the mother's system is disturbed. There are some environmental factors that cause congenital abnormalities and they are known as teratogens which have their effects dependent on the genetics. The genotype can modify the teratogenic effect. WHO estimates that some 260,000 deaths world-wide (about 7% of neonatal death) were caused by congenital abnormalities in 2004. They are most prominent as a cause of death in settings where overall mortality rates are lower.

For example, in Europe region, as many as 25% of the neonatal deaths are due to congenital abnormalities. It resulted in about 623,000 deaths per year in 2013 down from 751,000 in 1990. The type with the greatest death are congenital heart diseases (323, 000), followed by neural tube defect (69, 000).

People with congenital conditions have been treated differently from others. In our country Ghana, Dr. Kwame Nkrumah, with the help of the Commonwealth, through Dr. Brown from Britain, gathered facts concerning the treatment of individuals with congenital diseases. The following are some of the facts that were gathered;

i. They discovered that children were killed as infants. Those who escaped this cruelty were isolated and given less attention. Some were known by the communities as children born of evil. Most people stayed away from them with the misconception that their condition was transferable or contagious.
ii. Adults on the other hand, were locked up and ostracized. They were fed less and less taken care of by their families till they died.

This raised an awareness to the government, and rehabilitation was provided to protect and train these individuals.

There are two main forms of rehabilitation presently. These are medical rehabilitation and social rehabilitation. Medical rehabilitation focuses on the treatment of the disease by surgical or medical means. An example is a surgery of the eye for a blind man. On the other hand, social rehabilitation focuses on training the residual parts of the body which may be less damaged or fully functioning. It also focuses on building the psychological, emotional, and social aspects of the individual to help the person live a normal life. Social rehabilitation is achieved by two main processes. That is,

training for ADL (activities of daily living) and general education and vocational training. Training and general education are achieved by the following processes;

i. Engagement in needs assessment.

ii. Socialization

iii. Mobility training.

iv. Attainment of proficiency for ADLs.

v. Emotional and mental stabilization.

1.2 Problem Statement

Individuals with congenital diseases find it difficult to cope with life if medical rehabilitation fails to achieve the expected results. Some lose hope of a better life, some commit suicide, some hide from the society because of the shame they feel that they carry due to their condition. Others are abandoned and neglected by both their family and the society. On the other hand, physically and mentally impaired individuals who have been in that state from child birth grow up not being able to acquire a vocation that can provide income. They become a burden to their families who have to cater for them for life. Parents with such children are not able to have a better life due to expenditure from the disease condition. They are limited sometimes in the jobs they acquire since they need more time to be with their disabled relative. These individuals are not able to grow into the various responsibilities the society requires such as being a parent, and a resourceful personality to the family and the society itself.

Various individuals have researched on people with disabilities but much has not been done about the situation to bring most of these individuals into the educational setting

and the working class. Shelters have been provided for them but most of them still lack trainees to help them learn how to live by themselves and perform activities of daily living. (Principal of Edwenase Rehabilitation Centre, 2017).

1.3 Objectives of the Study

1. To find out about the challenges and benefits of the rehabilitation centre.
2. To find out how individuals with congenital diseases cope with the pressures from the society.
3. To find out how being in a rehabilitation centre helps inmates in adjusting to the society.
4. To find out about the challenges faced by the individuals in the centre.
5. To find out what can be done to aid the institution.

1.4 Research Questions

1. What have you learnt from this institution?
2. Are the trainees able to meet their purpose of coming to this centre?
3. What are the major challenges of this centre?
4. What has been the greatest challenge as a trainer in this institution?

1.5 Significance of the Study

This study looks at the role played by social rehabilitation centres in the lives of individuals with congenital diseases. In most developing countries such as Ghana, disabled persons form part of an impoverished group of people such as paupers, street beggars with lack of access to institutions such as schools, work places and even hospitals. They are regarded as unproductive and incapable of contributing to the

country. This perception undermines their abilities and potential which as a result turns them into a burden onto the society.

These problems at hand require the attention of the nation. If these individuals are able to make a better life for themselves with help from the government and the society as a whole, to provide income earning jobs and a better self-esteem, they would serve as an addition to the human resource of the nation. Their work can add revenue to the country. Some of these individuals have good and high intelligent quotient (IQ) and can develop ideas that can help in the development of the nation. Others are very creative and talented. Some can also go as far as teaching others. They can be helped to develop their abilities to add up to the richness of the nation's resources.

1.6 Operational Definition of Terms

Congenital disorder: also known as congenital disease, deformity, birth defect or anomaly, is a condition existing at or before birth, regardless of the cause of these diseases. They are characterized by structural deformities.

Rehabilitation: this is a treatment or treatments designed to facilitate the process of recovery from injury, illness or disease to a condition as normal as possible.

Social rehabilitation: is a service meant for all individuals with disabilities and partial or complete incapacity for work who require help in dealing with problems in their daily life arising from their disabilities or special needs.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews previous studies related to this research. Previous studies were reviewed from articles, journals and books. The literature was reviewed under the following headings:

- Benefits of social rehabilitation in developed countries.
- The progress of social rehabilitation in Ghana.
- Challenges faced by social rehabilitation centres in Ghana.
- Ways of solving challenges faced by rehabilitation centres in Ghana.

2.1 BENEFITS OF SOCIAL REHABILITATION IN DEVELOPED COUNTRIES

This research is focused the benefit of social rehabilitation serving as a coping measure for congenital diseases and some of the challenges the rehabilitation centres in Ghana faces. Social rehabilitation is a service meant for all individuals with disabilities and partial and complete incapacity for work, who require help in dealing with problems in their daily life arising from their disabilities or special needs.

The main objective of this research is to help such individuals cope with their condition and experience improvement on every aspect of life. These include, psychological, emotional, physiological, social and most importantly, financial aspects of life.

Previous researches in the past have proven that most individuals disabled from birth are disregarded in all walks of life and receive less privilege meant for humanity.

Agencies all over the world, especially in developed countries have put systems to accomplish this vision to a point. An example is an agency known as Life Networks which provides a home and training for individuals who have experienced congenital anomalies since child birth. According to (Andrew, 2016), Life Networks, social and vocational programs are put in place to help these individuals build a better life for themselves. An example of such social programs is the three (3) to four (4) man cells formed among disabled individuals. The essence of this cell is to create a bond among the individuals, to serve as a support group and to make provision for friendship with a co-dependent environment. This cell encourages its members through sharing of experiences, concerning successful individuals with similar abilities or disabilities. They share the burden of undesirable experiences to help lift the burden of their challenges off their shoulders.

This experience provides psychological well-being and repairs emotional damage which was formed from societal rejection and loneliness. It provides an exciting environment seeing former worried parents and families who can finally see their disabled relatives enjoy the company of friends. Other social programs include fun activities such as racing competitions and “the best buddies” system which assists in pairing individuals with similar interests among the disabled with another individual (abled or disabled). The goal of this system is to provide their clients with an opportunity to socialize with others with no disability and to provide someone they can go out and have fun with outside the facility.

On the other hand, there are training programs to help them improve upon their residual abilities to generate income opportunities. An example is the theatre troupe. This program trains their skills on acting, composing, music, intelligent thinking, dancing, singing, puppeteering and puppet making, and painting. The individual is

allowed to acquire and improve more than one skill as many as possible. There are opportunities to acquire skills on fine arts as well such as photography and cooking.

The best part of this is the provision of employment support system which involves experts who help assess an individual's skills and help them find a corresponding income earning job to provide financial support with the aim of achieving independency.

2.2 THE PROGRESS OF SOCIAL REHABILITATION IN GHANA

In Ghana there are ten main rehabilitation centres set up by the government. Nine of these were built by Dr. Kwame Nkrumah, according to the current Principal of Edwenease Rehabilitation Centre. These centres have few tutors and trainers. The equipment at these centres are inadequate in number and lack modern technology to facilitate rehabilitation. Some of the buildings are also in need of renovation to suit its supposed purpose since the facilities were built to serve mainly as a refugee for the disabled. Presently, the idea of rehabilitation has greatly evolved from the idea of a refuge and provision of social bonds to training for skills and provision of therapeutic health service.

According to Belova (2017),"Socialized medicine often cannot offer full-fledged medical examination and treatment of such children, due to the nature of work of medical institutions, which is based on narrow specialization of doctors". This shows that the government alone cannot create several high class rehabilitation facilities to improve the life for individuals with congenital anomalies.

According to Gyamfi (2014), the most prevalent form of disability in Ghana is the visual or sight impairments with 40.1 per cent of the total population having some

form of disability. This is followed by persons with physical disabilities, other than visual impairment of 25.4 per cent; then by persons with psychosocial disabilities with 18.6 per cent, people with intellectual disabilities with 15.2 percent and then other forms of disability with 10.4 percent.

As opined by Botchway (2015). According to the Ghana Federation of Persons with Disabilities, “People with disabilities in Ghana are often regarded as unproductive and incapable of contributing in a positive way to society, and rather seen as constituting an economic burden on the family and the society at large, which leaves them in a vicious cycle of poverty.” The Federation says “In developing countries, there are rarely strong disability movements actively working to improve the living conditions of people living with disabilities. Disabled persons are often only weakly represented in civil society and Ghana is no exception.”

According to the United Nations, “evidence and experience show that when barriers to [people with disabilities] are removed and persons with disabilities are empowered to participate fully in societal life, their entire community benefits. Barriers faced by persons with disabilities are therefore a detriment to society as a whole, and accessibility is necessary to achieve progress and development for all.”

This was a conclusion drawn by Botchway (2015), who indicated that compared to developed countries, Ghana has a long way to go, concerning social rehabilitation for those suffering from body and psychological impairment.

If one should take a look at our society, one would realize that there is little information concerning social treatment of such individuals. Most people, who are privileged to have been born with all parts of their being intact, are not well enlightened, concerning persons with disabilities in our society and shun them. There

are instances in our schools where children tease their colleagues who have congenital impairments. In the work places, the physically challenged are sometimes denied jobs which could meet their skills. The reason given is that there are people who can do the job better or that there are no training programs to help develop their skill to meet the working standard.

2.3 CHALLENGES FACED BY SOCIAL REHABILITATION CENTRES IN GHANA

2.3.1 Irregular Follow-Up Due To Financial Problems

Most of the patients coming into government institutions in the developing countries are from lower socio-economic strata and most of them are daily wage earners. They are living hand to mouth existence. Even the patients from "well to do families" face financial problems when a member in the families develops mental illness and when income earning members of family develop illness, the problem becomes more acute. Even after these individuals and their families are offered treatment, a third of them continue in their untreated state.

The processes of rehabilitation start with medication, but due to lack of money they cannot come for regular follow-up. Sometimes, the illness of an income-earning member of families means that the family does not even have money to eat, let alone to get the bus-fare, so the patient cannot come for medication regularly. The medicines cannot be purchased from outside because cost of medicines is high. These medicines have to be used for a long time or in some cases for the lifetime. This leads to frequent relapses of illness.

2.3.2 Difficulties in a Vocational Rehabilitation

Sometimes, the patients want to come to day care center for vocational training, but due to lack of money, they are unable to do so. Even governments in the developing countries cannot arrange for transport because of the lack of funds, so the patients cannot come regularly.

Sometimes, patients may manage to get bus fare for attending daycare activities, but the centres may not have the materials for the daycare activities; e.g. patients may be doing tailoring work but sometimes there is no stock of materials for making the clothes.

Some private day care centers are there but cost is prohibitive. There are no buyers for the materials produced in rehabilitation center, because most of the time the materials produced by the patients are not as good as the materials produced by professionals. The only buyer is the government, but the governments in the developing countries have limited requirements and limited purchasing capacity.

2.3.3 Lack of Job Opportunities

In developing countries with a limited job opportunities and burgeoning population (e.g. population of India is more than one billion), even educated people do not get jobs, so it is very difficult for the mentally ill patients to get jobs. Unemployment and underachievement are threats to their social status.

In Ghana, people with mental illness are not yet eligible for any welfare services. Employment provides not only a monetary recompense but also ‘latent’ benefits — non-financial gains to the worker which include social identity and status; social contacts and support; a means of structuring and occupying time; activity and

involvement; and a sense of personal achievement (Botchway ,2015). People with mental illness are sensitive to the negative effects of unemployment and the loss of structure, purpose and identity, which it brings (Rowland & Perkins, 1988).

2.3.4 Rehabilitation Centres as Shelter

In developing countries, where poverty is widespread, most of the relatives of the patients do not want to take discharged patients, even when patients have recovered completely. The reason for not taking back discharged patients is that they cannot be assured of having food, shelter or job. Some relatives are reluctant to take discharged patients because they fear that the patients may relapse at home and they again have to borrow money to return patients to the institute. All these things may interfere with rehabilitation, treatment and improvement of patients.

2.3.5 Rehabilitation as a Dumping Site

Many relatives of the patients are not interested in the treatment or rehabilitation of the patients. The main aim is to get patient admitted in institute and get rid of him/her. Families that do this may are not at all at fault, because treatment and rehabilitation of psychiatric patients is always difficult due to frequent exacerbations and relapses of the illness. So to get rid of a patient they may give wrong addresses of homes or even change their home after patient is admitted in the institute.

Sometimes they give the wrong history and the wrong symptoms, which are not what are observed when patient is subsequently admitted in the institute.

The reasons why they want to dump patients are many. First, some families' economic conditions are poor, so they cannot feed the patient. Second, many families' live in small houses, which have no room for the patient. Third, many patients, though

recover to quite an extent, they are still unable to find a job, so they have to stay at home throughout the day. The fourth reason is the social stigma attached to the mental illness. Family members fear that their sons, daughters, sisters and brothers may not be able to get good spouses because almost everybody knows the fact that mental illness is inheritable and no one wants to see illness in their off springs. Besides, newly-wed spouse may be unwilling to stay with a mentally ill patient in the same house.

2.3.6 Societal Insensitivity

Many patients when returned to the society, face insults. The society keeps overt as well as covert discrimination against them. They do not admit them in their friendship circles and other activities. So the patient becomes lonely and isolated. Mansouri & Dowell (1989) report that stigma is a significant source of distress in, for example, people with severe enduring mental illness in a community-support programme, where it correlates with self-esteem. In cinema and television, mental illness is the substrate for comedy, more usually laughing at than laughing with the characters (Byrne, 1997). Negative attitude towards people with mental illness starts at playschool and continues into early adulthood (Byrne, 1997).

2.3.7 Burn-Out of Hospital Staff

Rehabilitation involves labor-intensive processes. The results are slow to come and relapses are frequent. The term burn-out has been used to conceptualize the long-term negative effect of stress and includes emotional exhaustion, tendency to develop cynical and negative attitudes towards others and negative self-evaluation, especially regarding personal accomplishment at work (Maslach & Jackson, 1986). The daily

work of continual confrontation of illness, sadness, suffering, fear and pain makes staff insensitive towards patients. Power relationships between patients living together in intimate and anxiety-provoking circumstances have the potential to lead inmates into sexual relationships, mostly unhealthy, which in turn affects the staff. The staff find it particularly challenging to handle these difficulties with sensitivity; they can contribute to poor outcome, characterized by treatment dropouts, lack of meaningful therapeutic relationships and acting-out behavior (Maslach & Jackson, 1986). Sometimes, the staff stop correcting the unacceptable behavior of patient, as slowly, insensitivity creeps in their behavior, without their own knowledge. This leads to rapid turnover of staff engaged in the rehabilitation. New staffs have to be trained again. (Patrick W.Corrigan, 1995)(Christina Malach Professor of Psychology, 1971-1978).

2.3.8 Lack of Staff and Overburdened Staff

The staff of the rehabilitation centres are woefully overburdened in the developing countries. The ratio of staff to patients is rarely in accordance with law and requirement. The beds are grossly inadequate, in comparison to number of patients and population. Along with managing the inmates they also have to do the administration work and management of staff. Along with this work sometimes, there is deputation of psychiatrist at the remote places (Edwenase Principal, 2017).

Therefore, very little time is left for rehabilitation work and its supervision. The low salary, in comparison to private practice makes government job unattractive, so the work of rehabilitation remains in a sorry state.

2.3.9 The Bureaucratic Hurdles

The delay due to bureaucratic hurdles may slow the processes of rehabilitation; example is that sometimes demand of seeds for plantation work is put before the monsoon but sometimes seeds arrived after the completion of monsoon. Sometimes due to procedural delay there is delay in procurement of medicines. Sometimes the task is so frustrating that one feels that the processes of rehabilitation, rehabilitates no one except those involved in the work of rehabilitation (Edwenase Principal, 2017).

2.4 WAYS OF SOLVING CHALLENGES FACED BY SOCIAL REHABILITATION CENTRES IN GHANA

Rehabilitation serves as a means of rebuilding one in terms of emotional needs, physical challenges, and psychologically. One must try and pay attention and aid the rehabilitation centres as much as possible.

Due to challenges faced by these facilities, it becomes quite difficult for the trainers to offer the needed assistance to the inmates.

Most of the major concerns of the trainers had to do with food, lack of equipment, and financing. Also the trainers pointed out the institution being seen as a dumping site for their wards is a demerit for what the institution stands for and what their duty as trainers are.

In order for the institution to function as it was structured for, more awareness must be created for the general public to understand the institution and what it stands for.

The government should also be prompted on the challenges faced by the institution and then aid should be appropriately given to them. The government should also see

to it that the trainers are paid on time and handsomely rewarded for their contribution to society and the inmates as a whole.

NGOs must be alerted as well, to aid these institutions with whatever help they can render to them. Exchange programs must be structured to encourage socialization between the inmates and those outside the institution.

The institution, as a facility, should make it a point to not push away people from the outside who want to know more about the facility and its benefits to the inmates (GhanaNewsAgency, 2012)

Also, families who bring their wards over to the facility should be made to provide home address and even designate welfare personnel to do impromptu follow- ups on them at the given address to prevent them from totally abandoning their wards.

CHAPTER THREE

METHODS

3.1 Introduction

This phase of the project deals with the type of research method, setting used in the research and population sampling technique. This chapter helps describe the method of data collection used and shows the validity, reliability, ethical consideration and limitations of the study.

3.2 Study Design

A quantitative descriptive method of study was used. The design of the research produced a platform to find out how social rehabilitation has been helpful to individuals with disabilities, especially those caused by congenital diseases. It helped in revealing that most disabilities were congenitally acquired. In the process of data collection, the study revealed major challenges faced by the social rehabilitation centre and benefits that the centre brings into the lives of these individuals as well as to the development of the country as a whole in its small way.

3.3 Research Setting

This study was conducted at Edwenase Rehabilitation Centre which is located in Edwenase, Kumasi. The rehabilitation centre was founded by the late Dr. Kwame Nkrumah in 1958 with the help of the British Commonwealth at the time.

The study took place on the compound of the rehabilitation centre, using various departments of vocational training. These departments include the shoe making department, dressmaking and tailoring departments, crafts and leather work department, beads and needle work department and the music department.

3.4 Target Population

The population for the study included the administrator, the assistant administrator, a tutor each from the various departments and a selected group of the trainees/inmates from each department to represent the whole population of inmates.

3.5 Sample Size and Sampling Technique

A probability sampling method of stratified sampling was used in narrowing the total population size of 91 members of both staff and inmates to 19 representatives. These include one (1) administrator, nine (9) trainers /vocational tutors and nine (9) Inmates/trainees. This method was useful because there were different groups of disabilities, hence, various groups of abilities to be used in training, difference in challenges and perspectives. This brought about the need to group the individuals. There was a need to select a representative from each department due to the inability for some of the inmates to give needed information, understanding and willingness to participate in giving needed information.

3.6 Tools and Methods of Data Collection

A questionnaire-based survey was done in the form of interview for the data collection. The questions which were used were open and closed-ended forms. The questionnaire was in three (3) parts. These included questions for administrative staff, questions for trainers/tutors and questions for trainees/inmates.

3.7 Data Analysis

Data collected was analyzed and summarized using Statistical Package for Social Sciences (SPSS 16.0) and the parameters measured were presented by using tables and bar graphs.

3.8 Validity and Reliability

The questionnaires were scrutinized by our supervisor for necessary corrections and amendments to be made in order to make the questions valid, reliable and suitable for the participants of our research. The questions were then reviewed by the Department of Nursing of Christian Service University College before it was approved to be used. In addition, the questions were reviewed by the administrator of the rehabilitation centre and tested for its clarity before permission was granted to us to use the questions for the interview of the staff and inmates. Also, the participants were delighted to be a part of the study in the hope to help create a public awareness which could help develop the centre and make them more acceptable in the society. With this in mind, they freely gave the needed information as detailed as they could.

3.9 Ethical Consideration and Data Collection

A letter of introduction and purpose was received by the researchers from the Head of Christian Service University College, Department of Nursing to obtain permission from the Head of Edwenase Rehabilitation Centre to conduct this study.

3.10 Limitations of the Study

We encountered challenges with combining classroom activities with the collection of data and we had to choose specific individuals among the inmates who had the ability to understand and communicate with us. This narrowed down our sample size.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter deals with the data analysis and presentation of the results of the study. The findings were presented in the form of tables and bar charts.

TABLE 1: Type of physical challenges

Type of physical challenge	Frequency	Percentage %
Visually impaired	2	22.2
Leg Deformity	4	44.5
Learning Difficulty	1	11.1
Hydrocephalous	1	11.1
Hearing Impaired	1	11.1
Total	**9**	**100.0**

From Table 1 above, out of the respondents 4 (44.5%) had leg deformities, which was the most common, followed by 22.2% who were visually impaired.

TABLE 2: Benefits of Rehabilitation

BENEFITS OF SOCIAL REHABILIATION	FREQUENCY	PERCENTAGE%
Acceptance (Feeling at home)	9	75.0
Successful graduates	3	25.0
Skills for daily activities	8	66.6
Confidence and spiritual uplifting.	9	75.0
Vocational Training	9	75.00
Total Number of Respondents	**12**	**100.0**

With respect to Table 2, there were 12 respondents in all. Nine (9) of them were inmates and the others were three (3) staff members. All the inmates who were interviewed said that they felt at home and accepted at the rehabilitation centre. Three of the staff testified they were graduates of successful social rehabilitation. Majority of the respondents (88.9%) said they had acquired skills and techniques that will enable them earn an income on daily basis outside the centre.

TABLE 3: Main Challenges Faced By the Facility

CHALLENGES OF THE FACILITY	FREQUENCY	PERCENTAGE%
Equipment	8	88.9
Finances	1	11.1
Total	**9**	**100.0**

Table 3 focuses on the challenges faced by the facility, where 8 of the respondents (88.9%) being the trainers of the facility answered in favor of equipment and one respondent said finances.

TABLE 4: Vocations taught at centre

SPECIFIC VOCATION TAUGHT	FREQUENCY	PERCENTAGE%
Hairdressing	1	11.1
Bead making	2	22.2
Tailoring	1	11.1
Shoe making	3	33.4
Weaving	2	22.2
Total	**9**	**100.0**

According to Table 4, 3 (33.4%) of the respondents were undergoing shoemaking training, while 2 (22.2%) were taught bead making and 2 (22.2%) were also taught weaving.

TABLE 5: Educational Background of Trainers

EDUCATIONAL BAKGROUND OF TRAINERS	FREQUENCY	PERCENTAGE%
NVTI	1	11.1
Degree	4	44.5
HND	3	33.3
None	1	11.1
Total	**9**	**100.0**

Table 5 shows that majority, 4 (44.5%) of the respondents (trainers) were degree holders and 3 (33.3%) had an HND.

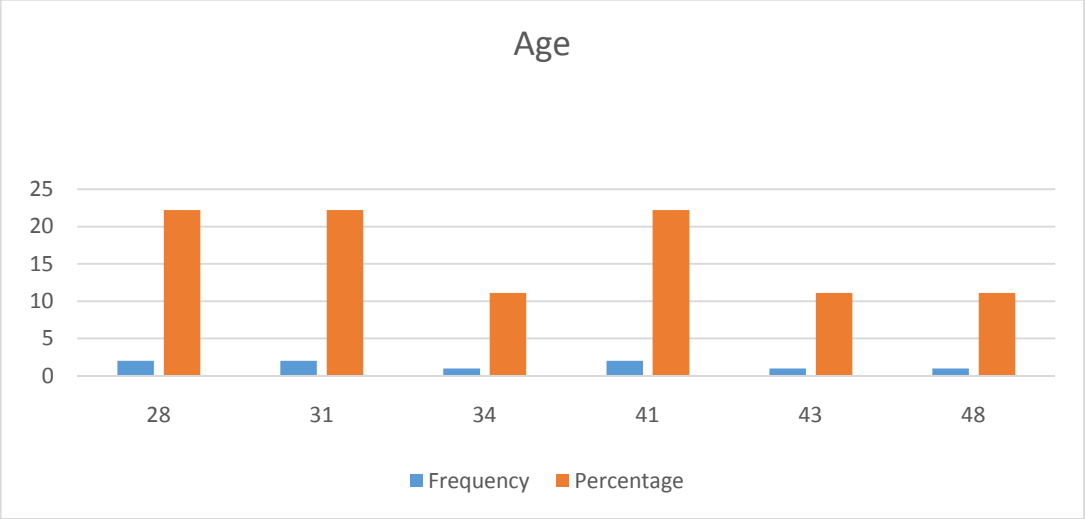

FIGURE 1: Age of Trainers

In figure one, it shows that majority of the trainers were between the ages of 28-41.

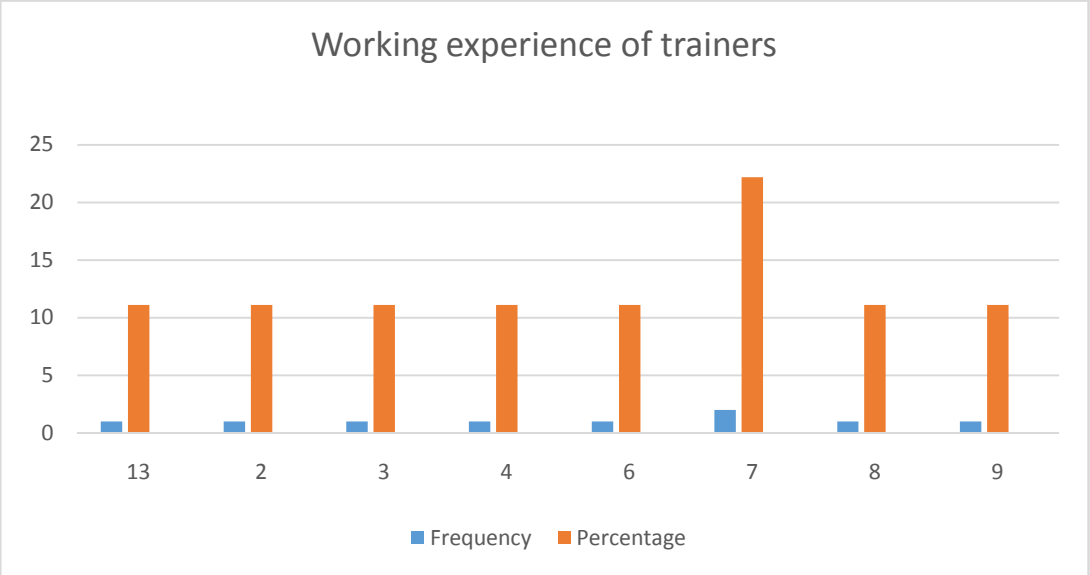

FIGURE 2:Years of Work Experience of Trainers

Figure 2 shows that most of trainers had 7 years of working experience.

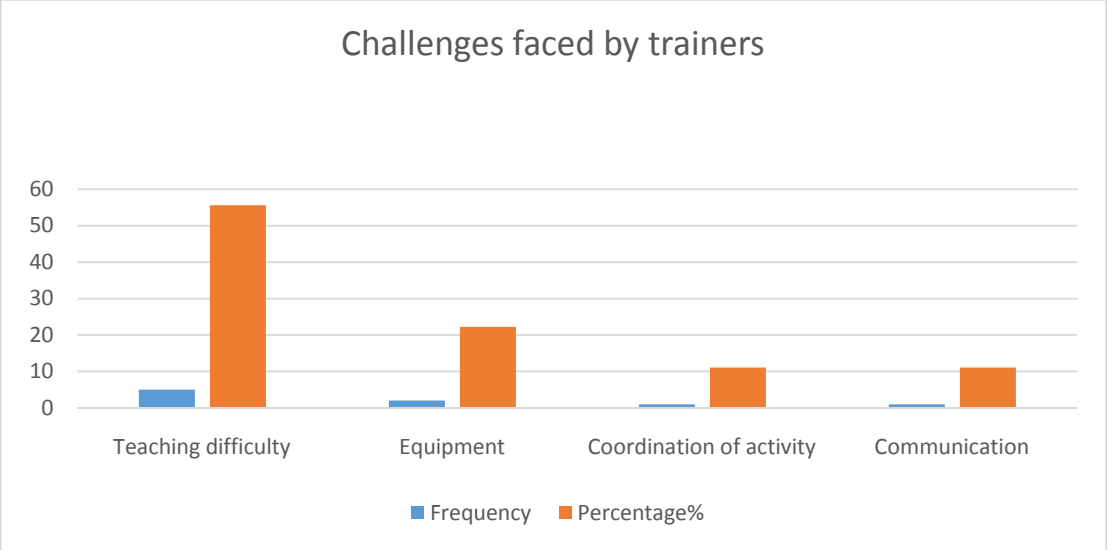

FIGURE 3: Challenges Faced By Trainers

Figure 3 shows that 5 (55.6%) of the respondents had difficulty in teaching the inmates and the others complained about lack of equipment being their challenge.

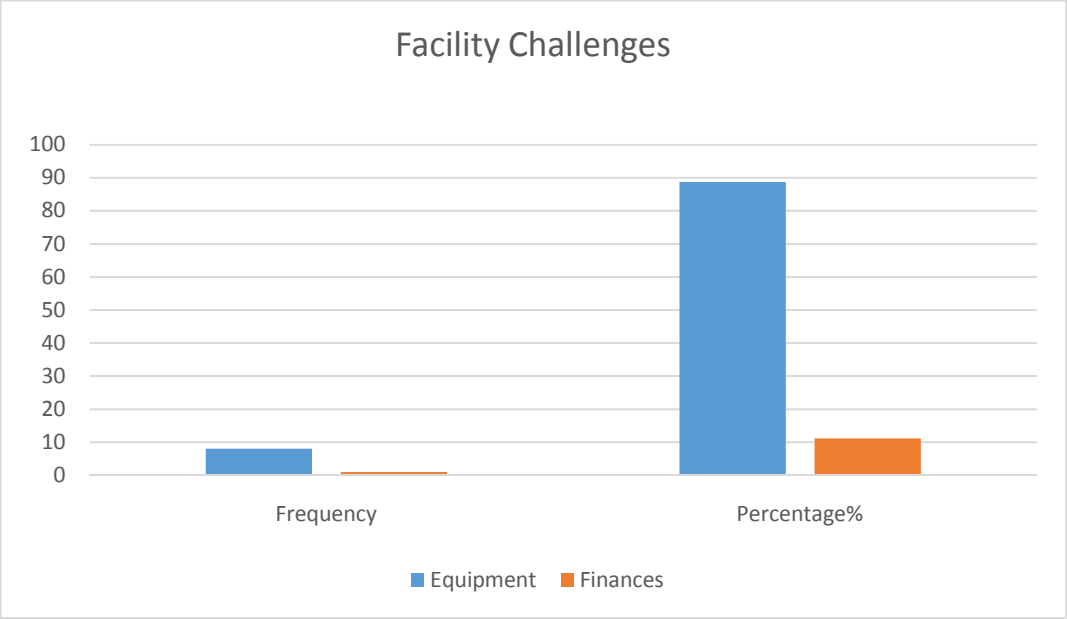

FIGURE 4: Facility Challenges

Most of the trainers and inmates sampled complained about financial challenges. One or 11.1% of trainers and students complained of lack of financial support from the families of the inmates and from the government, while 89.1% complained of the lack of equipment which makes teaching and other forms of training very difficult.

CHAPTER FIVE

DISCUSSION

5.0 Introduction

This chapter focuses on the discussion, interpretation of the findings. The chapter examines benefits and challenges of social rehabilitation. The aim is to help examine if the objectives of the study were met.

5.1 HOW THE INDIVIDUALS WITH CONGENITAL DISEASES COPE WITH PRESSURES FROM THE SOCIETY

5.1.1 Type of Physical Challenges

According to Table 1, at Edwenase Rehabilitation Centre, there are individuals with various categories of disabilities. These are the visually impaired, those with leg deformity, those suffering from learning difficulty, those with hydrocephalus condition and those with hearing impairment.

These physically challenged persons are further grouped into various vocational departments. The training of the residual abilities must be done using these vocational departments. This has not been very successful at the centre due to challenges faced by the institution.

5.1.2 Benefits of the Rehabilitation Centre

Table 2 is a representation of the major benefits that the rehabilitation centre has had on the disabled. The respondents in Table 2 are nine inmates and three staff members. All of the inmates interviewed testified that they felt at home at the

rehabilitation centre and that is was a place where the inmates saw themselves as co-equals. Some of the inmates and the principal explained that the inmates are treated as inferior outside the walls of the institution. They felt different from their siblings, parents and supposed friends. They testified that in the facility, they have formed real bonds to support each other emotionally and psychologically. Researchers witnessed friends among the inmates talking to each other and playing together.

Also, the principal and two staff members spoke of successful graduates who are still in touch as clear examples. The study revealed that ninety percent (90%) of the inmates successfully graduated being able to perform daily activities on their own and lived a consistently income earning life outside the institution.

Eight of the eligible inmates who were interviewed from various departments of the institution spoke of how they have acquired skills to perform activities of daily living, through training from their tutors. It was noticed that visually impaired individuals walked without any external help but with the aid of their trained ears and other senses without bumping into objects. This served as evidence that the inmates had received training.

All the inmates who were interviewed said that they have been able to build up confidence and had received spiritual uplifting since their stay at the training centre. This had built in them the will power to face the society and push to be successful, in spite of the discrimination found outside the walls of the institution. Moreover, the inmates showed excitement concerning the various income earning vocations they had learnt and hoped to do better in the vocation. This training was the most prioritized benefit to them, besides the training they had received to perform daily activities.

5.2 THE CHALLENGES OF THE REHABILITATION CENTRE

5.2.1 Main Challenges Faced By the Facility

The facility faces a great financial need and lack of equipment to make training successful as standard requires when compared with the example cited in the literature review. From Table 3 (also shown in figure 4), eight students spoke of the lack of equipment such as needed cloth to learn tailoring, or leather for leather work. They attributed it to lack of finances. The principal of Edwenase Rehabilitation Centre stressed on the financial need, according to Table 3, being a great limitation for standard training. Irrespective of these challenges, both staff and inmates work hard to provide materials for their stay at the centre. For instance, there are inmates who have been trained to work with their trainers in various crafts, which produce income earning goods. Some of these goods are shoes, doormats and bead ornaments. These goods are sold with the help of their tutors and the money is used to promote teaching among the inmates. (Table 3 and Figure 4)

5.3 HOW BEING IN A REHABILITATION CENTRE HELPS INMATES IN ADJUSTING TO THE SOCIETY

5.3.1 Vocations Taught At the Centre

There are 5 main vocations taught at the centre. These various vocations form the departments in the rehabilitation centre. These include hair-dressing, bead making, tailoring, shoe making and weaving. Each department consists of the various categories of disabilities as shown in Table 1. Ideally, this is not the best as shown in the literature review and was confirmed by the principal of Edwenase Rehabilitation Centre. The reason for this form of integration is improper ratio of tutors to trainees and lack of teaching materials due to lack of funds. This makes training difficult for

both trainers and inmates. Nevertheless, having a vocation boosts the confidence of the inmates. Most of them believed that having a vocation, being able to perform daily activities and having support from the centre will make people in society respect them in their respective communities.

5.4 WHAT CAN BE DONE TO AID THE INSTITUTION

5.4.1 Educational Background of Trainees

In the process of gathering data to find out the quality of training received, there was a need to enquire about the qualification of the trainers to make comparison with the standard set by rehabilitation centres in developing countries as the example cited in the literature review, using Life-Networks Rehabilitation Centre. Most of the trainers interviewed including the assistant administrator, were degree holders. Three had HND, while others who had no qualification in formal education had been well trained in the area of crafts to teach a vocation to the inmates. Such trainers may not have been trained in orthodox schools in the country, but were good at their crafts and had good working experience (this is represented in Figure 2). An example was the shoe-making trainer. This is represented in Table 5. Yet, Table 5 depicts that there are no health workers such as psychologists, doctors and nurses to help assess the progress of the inmates; especially, that of emotional, psychological, psychosocial and cognitive wellbeing. Therefore, the facility would benefit greatly if these personnel were sent to work at the centre. Also, training programmes can be held for the trainers to improve their teaching skills.

5.4.2 Age of Trainers

Figure 1 shows that the trainers with ages between 28 to 41 years form the majority, while ages of 34 and 43 to 48 years were the least. This implies that all of the trainers were adults with life experiences which were used as a tool to counsel and motivate the inmates about the success they could strive for if they worked hard. The inmates need more of such role models to help them believe in a better future.

5.4.3 Years of Work Experience of Trainers

Figure 2 shows the working experiences of the trainers, based on the number of years they had worked with the rehabilitation Centre. Most ranged from 10 to 20 years and the least were between 5 to 10 years. The respondents from the staff did not have a working experience less than five years. This made them the best respondents to give the information being sought for by the study. Most of them gave similar answers to the same questions during their interview, even though they were all interviewed separately and privately. This showed that the answers they gave about the centre were valid. The trainers need more motivation through various supports from the community to help make their work at the facility easier. This can be done by resolving the challenges they face at work.

5.5 CHALLENGES FACED BY INDIVIDUALS AT THE CENTRE

5.5.1 Challenges Faced By Trainers

Fig 3 shows the challenges faced by most trainers in the rehabilitation Centre. Most were teaching difficulty, followed by lack of equipment, with poor coordination of activity and poor communication being the least challenge.

5.5.2 Teaching Difficulty

This was as a result of needed materials and the integration of students. For instance, a classroom consisting of the visually impaired, those with Down's-syndrome (causing low cognitive ability and delay in physical growth), individuals with leg disabilities but have good cognitive function demand various methods of teaching and different lengths of time to be able to successfully train them in a vocation. In order to teach effectively, there is the need for a lower number of students to a trainer. Unfortunately, the trainers do not have this privilege at the centre.

5.5.3 Lack of Equipment

Besides the improper integration of students, the trainers are faced with the challenge of lack of teaching materials and other equipment that make social rehabilitation easier. For instance, in the literature review, the inmates in Life Networks had computers to help them form social bonds outside the centre and to learn other ways to be useful in the society by learning different forms of computer programmes. They also had psychologists, nurses and doctors and other health workers in the institution to help trainers monitor the progress of the inmates. They had various hospital equipment such as exercising machines to help the inmates learn how to perform daily activities by training and reshaping their residual abilities. The rehabilitation centre currently here in this part of Ghana and other regions do not have these materials.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

From the survey, rehabilitation centers are built to help the disabled people in the society, in terms of performing their ADLs, improving on their communication and it serves as a link between the government and the people. If challenges such as lack of equipment and inadequate finances are addressed by the government it will be able to go a long way to help in the performance of the rehabilitation centre and the society as a whole.

The society can also play a major role in helping the disabled, especially those having had this experience from birth. The society must learn to accept them because social rehabilitation does not end within the walls of the rehabilitation centre. Rather, emotional and psychological rehabilitation continues to develop or retard, based on how one feels accepted in one's own community.

6.2 RECOMMENDATIONS

Researchers recommend this study to upcoming final year students to take up this research and add to the information that has been obtained by the group. Researchers recommend that upcoming students should focus on aspects of this study that were not focused on or tackled at all. Some of these aspects are as follows;

This study focused on the disabilities that were congenitally acquired with lesser attention being given to disabilities that were caused by other factors such as accidents or illness acquired later in the life of such individuals.

The researchers also did not focus on the financial aspect of the training, advanced technology that can be used to train the inmates of the rehabilitation centre and the importance of personnel such as professionals of social welfare who can help graduates from the rehabilitation centre to get their lives back on track and ensure proper care and proper treatment of these individuals from their families and the society. Upcoming students can make the effort to visit or base their research on other centres in the country.

It is also recommended to the university authorities to take up this research and forward it to a higher authority to support the rehabilitation centre in any manner possible. The Department of Applied Science can help to train health personnel in order to help the disabled cope with their situation at the clinical institution, especially those that are caused by congenital factors.

Researchers recommend to the society to treat the disabled as they would treat normal individuals. Everyone must play a part to support this disadvantaged group of the society to make Ghana a better place to live.

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