A

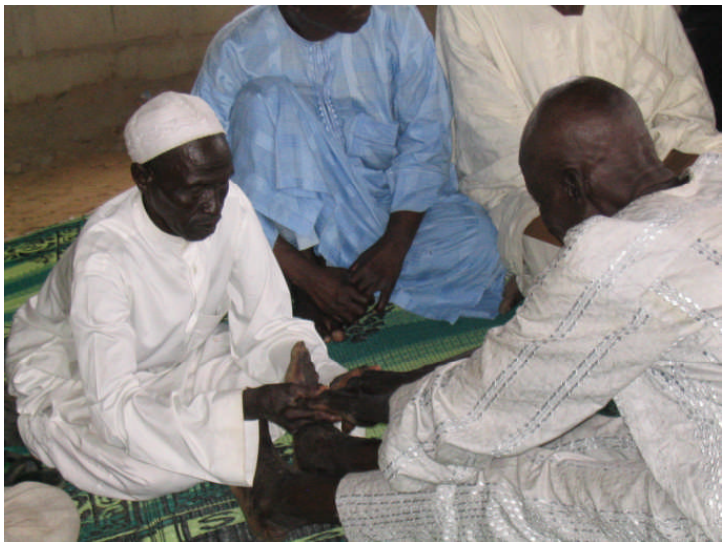
MANUAL

FOR LEPROSY CONTROL PROGRAMS IN NIGERIA

ON ESTABLISHING

AND RUNNING

SELF CARE GROUPS



Preface

The National Tuberculosis and Leprosy Control Programme (NTBLCP) in Nigeria was launched in 1991.

With the assistance of the ILEP member organizations working in Nigeria, Damien Foundation of Belgium (DFB), German Leprosy and TB Relief Association (GLRA), Netherlands Leprosy Relief (NLR) and The Leprosy Mission International (TLMI), the NTBLCP has been able to cure 111,788 leprosy patients since the start of the programme.

At present about 5,000 new patients are placed on treatment every year and this figure is steady for some years now.

However, there is a huge number of cured leprosy patients who are still suffering from the effects of the disease. These persons, who lost the sensation of feeling in eyes, hands and feet or have disabilities, are daily confronted with problems.

Rehabilitation of these former leprosy patients is one of the main activities contained in the Leprosy Strategic Plan 2007 – 2011.

The Self Care Group (SCG) has an important role to play in rehabilitation. Through these groups, persons affected by leprosy are encouraged to take responsibility for their own body.

During evaluation of existing groups, it became clear that the group members are able to reduce the number of ulcers, improve on their hygiene and show more self esteem. They look cleaner and are better accepted by the communities.

Therefore the NTBLCP considers the SCGs an important part of Leprosy Control in Nigeria and highly recommends the use of this Manual to all State TBL Control Programmes, Partners and Stakeholders as a guide in the setting up of SCGs.

We wish you success in your entire leprosy control effort.

Ben. C. Nwobi
National Coordinator, NTBLCP

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- Ms. Catherine Benbow, former TLMI Occupational Therapist
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- Mr. Henk Plomp, NLR Representative in Nigeria
- Mr. Malam Modu Waziri, physiotherapist Molai General Hospital, Maiduguri

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Rayfield, Plateau State
Dr. Tahir Dahiru, NLR Medical Adviser
Mrs. Ellie Plomp – de Ligny, NLR Training Adviser

Acronyms

ALERT	- All Africa Leprosy, TB, Rehabilitation, Research and Training Center
DFB	- Damien Foundation Belgium
DPO	- Disabled Peoples' Organisation
GLRA	- German Leprosy and TB Relief Association
ILEP	- International Federation of Anti-Leprosy Organisations
LGA	- Local Government Area
LGATBLS	- Local Government Area TB and Leprosy Supervisor
MA	- Medical Adviser
MO	- Medical Officer
NGOs	- Non Governmental Organisations
NLR	- Netherlands Leprosy Relief
NTBLCP	- National Tuberculosis and Leprosy Control Programme
POD	- Prevention Of Disabilities
RFT	- Released From Treatment
SCG	- Self Care Group
SER	- Socio-Economic Rehabilitation
STBLCO	- State TB and Leprosy Control Officer
TBL	- Tuberculosis and Leprosy
TLMI	- The Leprosy Mission International

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Introduction

For a long time health staff working in the leprosy control programme in Nigeria have been trying to solve the problem of patients with recurrent ulcers.

Those patients were regular guests in the leprosy referral hospitals. Some of them returned so often that they were sometimes referred to as "professional patients".
Still, all these patients received extensive health education. Even daily in some hospitals. Dr. Tahir Dahiru, who was in charge of Yadakunya Hospital in Kano for 15 years, personally interviewed all patients about to be discharged. He said: *They know even better than my staff what they should and what they should not do. Why then are they returning soon with big and ugly ulcers?*
It seemed that the health education was not effective at all.

In 1999 the Netherlands Leprosy Relief (NLR) Training Adviser in Nigeria, Ellie Plomp – de Ligny and the NLR Representative in Nigeria, Henk Plomp, visited All Africa Leprosy, TB, Rehabilitation, Research and Training Centre (ALERT) in Ethiopia. During their stay they visited some Self Care Groups, which were set up by Catherine Benbow, at the time The Leprosy Mission International (TMNI) Occupational Therapist and her staff. Her enthusiasm was infectious and back in Nigeria the idea was discussed with a number of doctors of NLR supported hospitals.

In April 2001 the first meeting was held with the doctors and the Prevention of Disabilities (POD) staff (physiotherapists and POD-assistants) of 8 leprosy referral hospitals in the NLR supported states. For the pilot project, hospitals were chosen as it was certain that enough potential group members would be living around the hospitals.
Meetings were held 2 times per year during which progress and problems were discussed. Furthermore training of facilitators and group leaders was conducted.
In April 2006 two more hospitals and eight state TBL control programmes joined.
As at November 2007, there are 69 functioning groups with 830 members in the NLR supported states.

The evaluation visits have shown that the number of recurrent ulcers among the group members has reduced considerably and so has the number of admissions.
In circumstances where health education has been less effective, the SCGs have made a huge impact, with such outcome as less ulcers, improved hygiene, higher self esteem, better contacts with the community and solutions to many problems.

The staff from TLMI and German Leprosy Relief Association (GLRA) were invited to the November 2006 meeting after which these ILEP member organisations agreed with the concept of SCGs. This has resulted in the establishment of SCGs or the initiation of the process in areas supported by these organisations.

I. Concept:

1. Definition

A Self Care Group (SCG) is a medico-social association of people with similar problems who are empowered to take care of their own problems through group support.

2. Objectives

General:

- To assist people affected by leprosy to find methods to improve their physical and social situation.
- To bring down the high number of ulcer referrals to the hospitals.
- To change the attitude of persons affected by leprosy towards their problems.

Specific:

- To reduce the occurrence of new and recurrent ulcers among people affected by leprosy.
- To improve the appearance of group members in such a way that their self esteem and self confidence increase, which leads to better acceptance and participation within the community.
- To improve the use of appropriate protective wears.
- To identify and discuss common problems in order to propose solutions to these problems.
- To support and/or refer group members with special problems.

II. Stakeholders

The following describes the responsibilities of the various stakeholders at different levels in the process of establishing Self Care Groups.

Stakeholders in SCGs near hospitals:

- **MO in charge of hospital:** Monitoring the functioning of the SCGs
- **Coordinator:** Physiotherapist, POD-assistant or other health staff: Baseline disability assessment; supervision of groups by regular attendance of meetings; monitoring of group functioning and assisting groups with solving of problems.
- **Facilitator:** Ward orderly, community member or a person affected by leprosy: Assists the group in finding solutions to their specific problems.
- **Group leader:** A group member who is chosen by the group: Organizing group meetings; keeping record of attendance; leading the group meetings; stimulating active participation; encouraging individual group members.
- **Group members:** Participate actively in the meeting; are willing to give and take advice; are willing to show eyes, hands, feet and if applicable amputation stumps.

Stakeholders in SCGs in the field:

- **STBLCO in charge of State TBL Control:** Monitoring the functioning of the SCGs
- **Coordinator:** State TBL Supervisor: Baseline disability assessment; monitoring of group functioning and discuss problems encountered with the facilitators.
- **Facilitator:** LGATBL supervisor, community member or a person affected by leprosy: Assists group in finding solutions to their specific problems.
- **Group leader:** A group member who is chosen by the group: Organizing group meetings; keeping record of attendance; leading the group meetings; stimulating active participation; encouraging individual group members.
- **Group members:** Participate actively in the meeting; are willing to give and take advice; are willing to show eyes, hands, feet and if applicable amputation stumps.

Stakeholders in all SCG activities:

- **National Tuberculosis and Leprosy Control Programme (NTBLCP):** Policy formulation on rehabilitation of people affected by leprosy; strategic planning; monitoring and evaluation during routine field visits.
- **Local Governments (LGAs):** In some cases the LGAs provide a venue for the SCGs.
- **ILEP member organizations:** Training of staff, facilitators and group leaders; monitoring and evaluation.

III. Setting up Self Care Groups.

In this chapter we will give guidelines for the formation of new Self Care Groups. One has to realize however, that these guidelines are not the law. There can be situations that ask for another approach.

For instance, the formation of a new group in an environment where SCGs already exist, will be different from the formation of a group in an area where no SCGs are functioning.

1. Group formation

Group formation might be a lengthy process, taking up to 2 – 4 months. It is better to move slowly and establish a good foundation rather than race ahead and soon collapse.
The following steps could be followed:

- Introduction of the idea of SCGs during discussions with potential group members. Involve local health staff, community leaders and members, religious leaders and the Chief of persons affected by leprosy or leaders of leprosy settlements, where applicable.
- Make sure that the philosophy of SCGs is clearly explained. It is important that potential members are aware from the beginning what their responsibilities will be and that no financial incentives will be given.
- Screening of potential group members according to the criteria should be carried out by the coordinator and the facilitator. A list of those who fulfil the criteria should be made.
- As the membership is strictly voluntarily, only those who wish to join will be invited for the first meeting.
- During the first meeting the members have to choose a group leader.
- The group will decide on the venue of the meeting, the frequency of meetings and all other organizational matters.
- The facilitator should attend all meetings during the initial period, but should reduce to once a month when the group is well established.
- The facilitator will provide the necessary support and report on developments/additional assistance needed to the coordinator.

2. Criteria for group membership

The following criteria could be used:

- Persons affected by leprosy.
- Permanent sensory loss in either hands or feet.
- Persons with disabilities due to other causes than leprosy, who wish to join such a group to support one another.

3. Group size

The group sizes may vary depending on the locality;

- The ideal group size is 8 – 12 members.
- In "leprosy villages", near leprosy referral centres and in some urban areas the groups might be somewhat bigger.
- The coordinator should establish new groups, if existing groups are growing too large. In large groups the procedures take too much time and members may start becoming bored.
- In rural areas the groups might be smaller than the ideal size. If distances are challenging, a group of people living close to each other can have the size of 3 – 5.

4. Meeting venue

- The group decides on the meeting venue. There are however some criteria. The facilitator and the coordinator should make sure the venue decided upon is meeting those criteria.
- The meeting venue should be big enough for the group to sit in a circle with sufficient space in the centre for a member to sit for inspection by the group members.
- The venue should have some privacy to enable the members to discuss freely.
- The venue should have some shade for the hot season and some cover for the rainy season.
- The venue should preferably not be in the hospital premises or at a clinic.
- In the field programme, the venue should be in a place easily accessible to all members.

5. Timing of meetings

- The group has to decide on the most appropriate meeting time and the duration.
- Meeting times can vary with the season: In the farming season people want to go to the farm in the early morning, so meetings should be better planned in the evening. In the hot season meetings might be better planned in the morning.
- It is important that there is consensus on timing within the group as irregular attendance will be the result if there is not.

6. Content of the meeting

- The group leader briefly checks attendance.
- The group leader goes into the centre.
- His eyes, hands, feet, footwear, appearance and where applicable amputation stumps are inspected by all members.
- Problems identified are discussed e.g. causes and reasons for the occurrence of problems, etc.
- Advice on how to take care of identified problems given.
- Thereafter members sequentially go into the centre and the same procedure is followed.
- Sometimes pressing family or social issues are discussed at the end of the meeting.
- Follow up of previous advice and recommendations are also discussed.

7. Management of financial contribution

A lot of groups decide to start a system of financial contribution by the members. These contributions are meant for activities decided upon by the group. The group can decide to assist a member in need. Marriages, funerals, accidents and other mishaps can be reasons for the group to support a member.

The facilitator and the coordinator can assist with the safekeeping of the money, but should not be involved in decisions about the use.

Warning: The system of financial contributions is a tricky issue. It can trigger big fights and should be treated with utmost care by the facilitator and the coordinator.

IV. The functions of the group leader and the facilitator

The group leader and the facilitator are both crucial to the success of the group. It is very important that they are not dominating the discussions and taking the decisions, but rather facilitate the group process.

The group leader:

- Is part of the group and part of the circle.
- Starts and closes the meeting, in Nigeria often with a prayer.
- Keeps record of attendance.
- Inspection of eyes, hands, feet and footwear starts with the group leader.
- Makes sure all group members are inspected and are actively involved in the inspection of other members.
- Leads the discussions and makes sure that all members take part.
- Carries out the decisions of the group.
- Represents the group in contacts with authorities and NGOs.

The facilitator:

- Is not part of the group and sits outside the circle.
- Comes in only when the group process is not followed or when the group invites him/her to.
- Can give suggestions and propose direction during discussions by asking thought provoking questions about particular issues or wrong advises given by group members.
- Is the contact for the group with the leprosy programme.
- Can give advice to the group on medical and/or social issues.
- Needs to advise individual group members on referral if the group fails to do that.

As already mentioned in chapter II the group leader is chosen by the group members during one of the first meetings. It is important for the members to know that they should choose a mature person who is respected by all and has proven to be a wise person. It is good that the group members are aware of the function of the group leader before they elect one.

The choice of the facilitator will be done by the project leader (hospital doctor/ control officer) together with the coordinator. It is important to choose someone who knows a lot about leprosy, but it is not necessary to appoint a physiotherapist or a health educator. Ex-leprosy patients or ward orderlies have a lot of knowledge and are not seen as health staff. If a person affected by leprosy is chosen he/she should not have serious leprosy related disabilities.

Community volunteers could be used after proper training in facilitating SCGs and wound management.

V. Training

1. Training of facilitators

Steps in training:

- Training by the coordinator and the project leader. Content: Role and responsibility of the facilitator, wound management knowledge, facilitation skills and the functioning of SCGs.
- On the job training by the coordinator on facilitation skills.
- Central training in facilitation: Functioning of SCGs, role and responsibilities of the facilitators, ulcer management and the use of appropriate footwear, problems encountered and proposed solutions. Methods used: Presentation of pictures by evaluators, discussions, group work, presentations by participants, role plays.

2. Training of Self Care Group leaders

The training of the group leaders is done in the first instance by the facilitators and the coordinators. They concentrate on the attitude of the group leader: Is he/she not dominant? Does he/she give attention to all members and makes sure all members do participate in the discussions?

After some time a central meeting of group leaders (old and new) and coordinators is held during which the following topics are discussed:

- Responsibilities of the group leader
- How to run a group.
- Weaknesses and successes.
- Plans for the future.

Methods used during the meeting are: Presentation of pictures by evaluators and discussions, group discussions, presentations by participants, role plays.

Training of facilitators and group leaders can be repeated if the need arises.

VI. Monitoring and evaluation of SCGs

1. Monitoring

Data gathering should be kept to a minimum. As the aim is to let the groups function independently, too much data gathering would not be sustainable.

The monitoring should be done by the facilitator, the coordinator and the project leader (hospital doctor/control officer).
The facilitator visits the group twice a month or monthly. The coordinator visits at least once per quarter and the project leader visits all groups at least once a year.

The following data for monitoring are used:
Quantitative data:

- Group size, age and gender mix.
- Meeting place and frequency of meetings with or without facilitator.
- Data on the number of ulcers, old and new.
- New disabilities
- Footwear
- Assistive devices: Glasses, walking sticks, crutches, prostheses, etc.

Qualitative data:

- Membership attitude towards wound healing.
- Participation within society including the family.
- Group maturity – support and function.
- Changes in perception in self worth/dignity.
- Suggestions for future development of the group.
- Utilization of footwear

The project leaders and coordinators should meet twice a year to discuss progress, challenges and problems using the reporting format. (See ANNEX III) They should present the data for their groups, problems encountered, conclusions and plans of the groups for the next six months.

2. Evaluation

Regular evaluation is necessary to assist the project leaders and coordinators. These evaluations can be done during the routine visits by Medical Advisers or during an evaluation tour of evaluators to a number of projects.

The evaluation should be geared towards support, assistance and encouragement rather than fault finding.

In programmes supported by other ILEP members, this could be done by Medical Advisers and/or specialized rehabilitation staff.

The evaluation should concentrate mainly on:

- Number of ulcers healed and new ulcers seen
- Number of patients referred by the group to a health facility
- Socio-economic activities carried out
- Opinions of SCG members on the importance of the group for their daily life
- Group maturity
- Role and effectiveness of the group leader
- Skills and role of the facilitator
- Stage of group development

The evaluators should use a checklist. (See ANNEX IV)

VII. Special topics

1. Budget

For the running of Self Care Groups around the hospitals a budget is not needed. The meetings don't attract any costs, the facilitator is close by and so is the coordinator.

Things like footwear, sunglasses, prostheses, etc are under the hospital budget and do not need extra funding.

For groups in the field it might be that some money is needed. The facilitator might have to travel some distance. This has to be looked at per group. The coordinator can plan his/her visit as part of his/her routine supervisory visits.
The control budget is again responsible for footwear and so on.

Activities that need money and are budgeted for:

- Half yearly meeting of project leaders and coordinators (2 x 2 days)
- Training of facilitators (one day)
- Training of group leaders (one day)
- Evaluation visits by MA and/or other staff

2. Footwear

All members of the SCGs with loss of sensation on the feet are entitled to receive standard footwear.

As is the rule with others, everyone gets 2 pair per year free of charge.
If group members prefer to use their own shoes, the facilitator should make sure that those shoes meet the criteria for protective footwear.

Those who are in need of special footwear, can receive those at the hospital as usual.

It is important that footwear is inspected during the group meetings. Therefore the shoes should be placed in front of the group members while sitting in a circle.

3. Referral

Referral by the group of individual group members with signs of reaction, complicated/malignant ulcers and other condition needing hospital attention, should be encouraged.

The facilitators have to advise the groups on this and have to assist individual group members who are referred.

4. Socio- Economic Rehabilitation

Mature SCGs move towards activities that change their financial and social status. The number of ulcers has been reduced, the members look cleaner and healthier and their self esteem has increased.

The next logical step is to look for means to sustain oneself and the family in a way that does not cause damage to the insensitive hands and feet.

There are a number of activities that can be mentioned:

- Vocational therapy; training in a new profession.
- Micro credit; interest-free loans for setting up small scale businesses.
- Income generating projects.

For the moment there is no national policy on this in Nigeria. It is expected that this policy will be developed in the coming years.

At present, SCGs that want to move towards SER are advised to organize themselves officially as Disabled Peoples' Organizations (DPOs) and to get in contact with Government organizations and NGOs and/or DPOs active in rehabilitation.

VIII. Common problems

Every group will encounter problems and challenges during the development. It is important that the coordinator and the facilitator are aware of this and take appropriate action.

To mention some of the problems:

- Expectation of financial incentives
- Other competing needs or demands
- Safekeeping of money contributed by members
- Deciding on how to use the money
- Late coming/ irregular attendance
- Meetings during raining season
- Meetings during harvesting season
- How to replace income from begging
- How to set up SCGs in highly mobile groups of people
- Splitting of large groups
- Power hungry members may threaten the existence of the SCGs
- Dominant members might move the group away from the concept of SCGs

The above problems could be discussed extensively during the half yearly meetings and solutions agreed upon. The outcome of the interventions can be discussed during subsequent meetings.

Annex I

References

- Paper presented to the Brazil 16th International Leprosy Congress, August 2002, by Catherine Benbow.
- A manual for leprosy control programmes for SCGs in Indonesia – Dr. Marion Steentjes and Kerstin Beise.
- Wound Care for People affected by Leprosy – A Guide for Low Resource Situations; Hugh Cross, American Leprosy Mission.

Annex II

Reporting format

Reporting format Self Care Groups: …… Project

Date: …..……..

Groups	Group size *June '07* *Nov '07*				Category Nov '07		Meeting frequency	Description of Venue	People with ulcers		New ulcers	New Disabilities
	M	F	M	F	L	NL			June 2007	Nov 2007		
Total												

Note: L = Leprosy
NL = Non Leprosy

Note: **Please fill this form for each group separately**.

Positive outcome of the group:
Social components to be included.

Problems encountered: (June 2007)

Solutions:

Group plans for the next 6 months: (June – November 2007)
Group:

****

Problems encountered: (November 2007)
Group:

Coordinator:

Conclusions:
Group:

Coordinator:

Group plans for the next 6 months: (November 2007 – June 2008)
Group:

Annex III

Evaluators checklist

Self Care Groups

Checklist

State:

Date:

Venue:

In-charge:
- Name:
- Function:

Coordinator:
- Name:
- Function:

Group:
- Name:
- Male/Female/Mixed: Male: Female:
- Number of members:
- Number of members present:

Remarks: ……..……

…….

…….

……..

Frequency of meetings:
With/without facilitators:

Age categories: **<40**
>40

New members in 2007:

Facilitator:

- Name:
- Function:
- Male/female:
- Age:
- Since:
- Workshop Rayfield, Nov. 2005 (facilitators) attended: | Yes/No |

Group Leader:

- Name:
- Male/Female:
- Age:
- Since:
- Meeting Bukuru, Oct. 2003 (group leaders): attended: |Yes/No |

Observation:

Venue:

- Adequate/Inadequate

Remarks: ……

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.. ……

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Group setting:

- Good/Bad

Remarks: ……

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.. ……

Group Leader:

- understands his/her role/does not understand his/her role
- give direction/does not give direction

Remarks: ……...

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Facilitator:

- understands his/her role/does not understand his/her role
- dominant/not dominant
- gives guidance/does not give guidance

Remarks: ……..

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Group dynamics:

- Are members interested:
  …….
  …….
  …….
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- Are members participating:
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  …….
  …….
  …….

- Are members willing to take advice:
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  ……....

- Are members giving advice:
  ……
  ……
  ……
  ……

- Are members willing to show their eyes, hands and feet:
  ……
  ……
  ……
  ……

- Is footwear inspected:
  ……
  ……
  ……
  ……

- Where applicable, are amputation stumps inspected:
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  ……
  ……
  ……

- How many members should have been referred, but were not referred:
  ……
  ……

- How many ulcers did not heal since the beginning of the group:
  ……
  ……

- How many new ulcers:
  ……
  ……

General remarks:

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Problems identified:

1. Facilitator: …….
   …….
   …….
2. Group leader: ……..
   …….
   …….
3. Others: …….
   …….
   …….

Recommendations:

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Discussion with Coordinator, Facilitator, Group leader and Group members:

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Annex IV

Additional information

Group development

There are 4 stages in the development of a group and it is essential that the facilitator understands these stages so that he/she is able to 'direct' and 'manage' the different situations as they arise appropriately.

The four main stages of group development are:

FORMING – Starting

1. group is just a number of individuals
2. each person is stressing his/her independence
3. participation is limited
4. experience is being gained and group rules being established.

STORMING – Conflict / fighting

1. may be conflict between members – hostility or silence
2. disappointment concerning the group function – they had other agendas – other expectations
3. rejection
4. leadership conflict

VERY CAREFUL handling of the groups by facilitator is required at this stage.

NORMING – Sorting out

1. tensions are overcome
2. group members accept one another
3. active participation begins
4. group spirit begins to develop – acceptance of one another

PERFORMING – Producing

1. roles are relaxed and functional
2. the purpose of the group is now taking place – group participation and support.
3. new insights and solutions are developed

Groups do not progress from one stage to another in sequence but may jump backwards and forwards particularly during the storming and norming stages. This is a normal process and is to be expected.

Group leadership / facilitation

1. The functions of a group leader or facilitator

Leaders or facilitators are responsible for development and maintenance of the group – not dominance and control.

Leaders or facilitators develop groups in the first state by:

- introducing self
- providing a means of group members to introduce themselves
- making others feel comfortable in the group
- working with the group to create group aims and objectives or determine them for the group.

Leaders or facilitators maintain and develop groups by:

- bringing the group together – a warm introduction involving all members.
- developing and assisting the group to work together
- ensuring safety of the group
- facilitating content and achievement of objectives
- encouraging members to participate and take responsibility for themselves
- summarizing and closing the group in a positive manner.

2. Shared or joint leadership or facilitation:

There are positive and negative factors in shared leadership:

Positive factors in shared leadership are:

- members have two leaders from whom to learn and relate to
- the group has the strengths of two leaders within the one group
- if one of the leaders is having difficulty or missing the point, then the other leader can assist
- if one of the leaders is having conflict with a group member, then the other can facilitate resolution.

Negative factors are:

- takes more time
- leaders may not work well together which may affect group dynamics
- leaders may use only their strengths and may not work on their weaknesses as leaders.

Steps to take when running a group:

1. Before each group session starts the leaders or facilitators should meet and check the following:
   a. how they want to work together
   b. what type of leadership / facilitation will be taken
   c. what weakness need to be worked upon
   d. session content.

2. During group session the leaders should sit across from each other so they can see and have eye contact with each other. This 'body language' helps the leaders to work together more effectively.

3. After each session, the leaders should evaluate the session together:
   a. was the session helpful to the group members – which outcomes were achieved, which were not?
   b. did all group members participate? Was the participation balanced and appropriate?
   c. was the meeting place and length of meeting appropriate?
   d. were there any unexpected interactions – were they handled well or could have been guided differently?
   e. was the joint leadership effective? What could have been improved upon or changed?
   f. What changes need to be made for the next session?

4. Prepare for the next meeting.

Wound management knowledge of the facilitator

It is essential that the facilitators understand the objectives of the programme and to know how to work towards those objectives. From the outset the facilitator should know what the programme will and will not provide. (**Note:** it is harder to withdraw items after supplying them for a season than not to supply in the first place!) Training and supervision / encouragement of the facilitator are essential.

Examples of knowledge, experience, supplies, etc, include:

Footwear
Is commercially made footwear available? What are the safety points to consider when buying commercial footwear?
Is some or all footwear made in an orthopaedic workshop?
Is the footwear free of charge or purchased? What payment policy is operational?
Are orthoses used ? Who makes them?

Wound dressing materials
Does the programme supply any materials or do the people have to provide their own?
What examples of home based or traditional medicine are possibly available?
Alternatives to white gauze bandages are: clean strips of old cloth or bed sheets; cellulose strips from plants such as the false banana.
Traditional wound healing materials include: papaya leaf or fruit pulp, aloe vera, honey, etc.

Soaking containers
Does the programme provide buckets or bowls or do people have to find their own container?
What are the examples of containers used in your programme area?
Examples may include: discarded cooking pots/vessels, a hole in the ground that is lined with clay or plastic, a plastic bag …

Soaking: Do you soak ulcers or not? My experience is yes. It does not affect the healing rate.

Water
What do you do when clean water is in short supply? How clean is clean? Water that has been used for bathing or washing may be used. Coconut water!
Has anyone used animal urine? If it has been left in direct sunlight for more than ½ hour all possible bacteria will have been killed.

Scraping tools
Traditionally pumice stone has been advocated as a good 'scraper'. However, pumice is not widely available so what can be used instead? A smooth stone, a long finger nail, the core of a maize cob, a green pan cleaner, rough grass?

Oils
Traditionally programmes have provided Vaseline, but what are the alternative oils available?
Examples include: maize oil, oilseed rape, olive oil, palm oil but not butter (the rats are attracted to butter).
Does anyone have any experience of using 'neem' oil to make the oil bitter to discourage rats?

Trimming:
To what extent is dead tissue trimmed and who does the trimming? What tools are used for trimming?

Rest:
What does the word 'rest' mean in reality?
Define this in different situations in your programme, for example: Does rest mean the whole body or only the affected part? How can you rest if you need to collect water, plant corn or take produce to market? Taking a break during an activity for a few minutes or half an hour. Only working half a day. Changing activities during the day thus working patterns. Use of a stick or crutch to reduce weight bearing. The importance of elevation when at rest.

What happens if someone cannot rest a particular time? This is a reality and needs to be accepted if there is no alternative … the person's reasons should be understood <u>not</u> condemned.

Walking aids
What walking aids are acceptable to the local people? Which walking aids are available? Which aids can be made locally? How you decide upon the design?

Protective hand pads
What effective hand pads to protect from heat, pressure or friction are used locally? Is the design effective? How could they be improved?

Referral
Knowledge of when to refer people for additional interventions such as surgery should be well understood by the facilitators and procedural mechanisms in place for referral.

Annex V

Meeting venue on the road, not sitting in a circle. NOT GOOD.

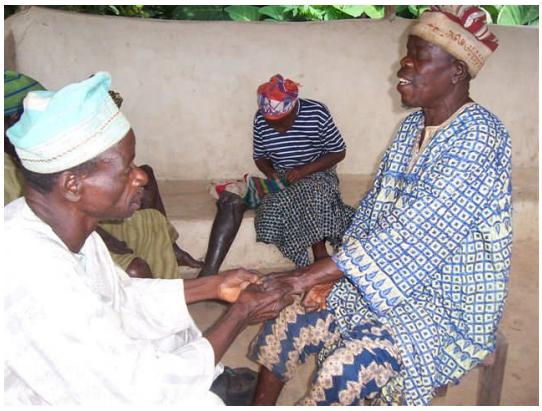
In a circle, shoes in front, a perfect setting.

Meeting venue too small, no space for inspection of eyes, hands and feet

A good venue for a small group

GOOD: The facilitator is present, but not in the circle.

GOOD: The group leader is the first to be inspected



Inspection of hands

Inspection of feet

SELF CARE IS FUN