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The Quality of Life of Trainees with Physical Disabilities at Vocational Rehabilitation Institutions: A Study of Ithuseng Vocational Rehabilitation Centre

Maneo A. Rakotsoane* and Pius T. Tanga**

**Baylor College of Medicine, Children's Foundation, Lesotho, PMB A191 Maseru, Lesotho*
E-mail: mrakotsoane@yahoo.co.uk
***Department of Social Anthropology/Sociology/Social Work, National University of Lesotho, P. O. Roma 180, Lesotho*
E-mail: tanga8_2000@yahoo.co.uk

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ABSTRACT This paper is based on the findings of a study that focuses on material, social, psychological and physical wellbeing of trainees with physical disabilities at Ithuseng Vocational Rehabilitation Centre (IVRC) in Maseru, their access to infrastructure and other services around the centre, and choice within the centre. The effects of institutionalization on their quality of life were also explored. The study sample consisted of ten (10) trainees with physical disabilities. Data was collected through qualitative interviews with the respondents, and analyzed qualitatively. The findings of the study reveal that trainees at IVRC are provided with basic needs that include shelter, food and clothing. Furthermore, their psychosocial and physical wellbeing have improved since they enrolled at IVRC. However, the study also reveals some dissatisfaction about the way the trainees are treated by some members of IVRC staff, highlighting lack of privacy, being controlled, and not having choice and a say on the things that concern them as the main causes of dissatisfaction. The findings also reveal that being in a vocational rehabilitation institution has both positive and negative impacts on the quality of life of those being institutionalized.

1. INTRODUCTION

Explanations of disability indicate that most people with disabilities are amongst the poorest of the poor, living lives of disadvantage and deprivation. Disability is defined by the World Health Organization (1980) as any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being. Elwan (1999) on the other hand indicates that disability is a relative term (restriction of the ability to perform a normal human activity), and its measurement is beset with problems, including the lack of reliability and validity of the instruments, most of which are poorly standardized and produce non-comparable estimates.

A survey was conducted by the World Health Organization (WHO) in 1981 on the occasion of International Year of Disabled Persons organized by the United Nations and revealed that there were 500 million people with disabilities in the world (United Nations Department of Public Information 1984: 14). However, Onasanya (n.d.) opines that the United Nations Population Information Network estimates that there are almost 800 million people living in Africa, and 50 million of them have some disability.

The Lesotho Bureau of Statistics (2004) indicates that Lesotho has a population of 2.2 million of which 10% is estimated to be people with disabilities. The 2001 Lesotho demographic survey shows that approximately 4.2 percent of Lesotho population in 2001 was reported as having one form of disability or another (Lesotho Demographic Survey 2001: 291). The survey also shows that the dominating form of disability in Lesotho is physical disability which comprises of amputations, lameness and paralysis. The sources of disability in Lesotho are attributed to a number of factors. They include mine and roads accidents, no clinical attendance by expectant mothers, illness, domestic accidents and fights, and drug abuse. It is believed that the majority of people with disabilities in Lesotho live in circumstances of isolation, stigma, poverty, disadvantage and powerlessness. Too often, the

Correspondence to:
Dr. Pius T. Tanga, *Ph. D.*
Telephone: +266 2221 3946
Fax: +266 2213 4000
E-mail: tanga8_2000@yahoo.co.uk

lives of such people are handicapped by physical and social barriers in society, which hamper their full participation in the affairs of their society.

Nirje (1976) as cited by Marfo et al. (1986) points out that a person with some disability has three handicaps. The first is the impairment of functions with which that person is afflicted. The second is the lack of opportunity and the restrictions placed on that person by society which does not regard him/her as a producer. The third is the lack of self-esteem which eventually occurs when the person with some disability begins to realize that he or she is regarded as a second class citizen. In order to change the situation of people with disabilities mentioned earlier, vocational rehabilitation was introduced in many countries, Lesotho included, where people with disabilities are equipped with usable vocational skills that could improve their quality of life.

One of the vocational rehabilitation centres in Lesotho is Ithuseng Vocational Rehabilitaiton Centre (IVRC) which is a government owned centre, operating under the Ministry of Health and Social Welfare. It is situated in Maseru, the capital city. It offers vocational training to physically disabled men and women from 18 years and above. The duration of the training is two years after which the trainees are expected to have acquired the necessary skills in order to establish their own businesses.

1.1 Statement of the Problem

People with disabilities have a right to live as independently as possible and as active members of their communities. They must have necessary skills that will help them live independently both socially and economically. It is believed that the quality of life of people with disabilities can positively be impacted through rehabilitation services such as vocational skills. However, Johnston et al. (1997) indicate that up to now, rehabilitation services for persons with disabilities have mainly been focusing on vocational rehabilitation services. In many such rehabilitation institutions, the quality of life of those institutionalized is neglected. They are not well taken care of in the areas of health and fitness. Their mental health with regard to their personal adjustment and their spiritual wellbeing are also not considered. There is poor personal relationships and social contacts with the outside world. They have limited choices of what to do and less freedom on frequency of visits by friends and relatives, and other related matters. Therefore, this paper examines these aspects of life at Ithuseng Vocational Rehabilitation Centre (IVRC) which are important in improving the quality of life of people with physical disabilities.

1.2 The Concept of Quality Of Life

The term “quality of life” was coined in the United States in 1956 as a political slogan. Within a decade it had swept around the globe. Within two decades it had been largely preempted by the healthcare field and related disciplines of human service. The term did not exist in the 1920s when rehabilitation came into being. However, enhancing the quality of life of people whose lives had been saved but who would have permanently disabling residuals was the root and reason for developing it as a distinct field (Kane n.d). Kemp (2000) points out that quality of life is difficult to define especially in rehabilitation because there is no agreement as to whether it should be measured objectively, such as by employment status, marital status or home ownership, or whether it should be measured subjectively, such as by people’s opinions of their lives. He further argues that another issue complicating the understanding of quality of life on a personal level is that most people think of quality of life only in its positive aspects, such as a high quality of life or high life satisfaction. However, quality of life can also be negative. Low quality of life could entail not having what one wants, or it could exist in the form of despair, stress or depression if it was very negative.

Quality of life is a general term used to describe the perceived well-being of people (Murphy and Williams 1999). The broad definitions of quality of life tend to address freedom of action, sense of purpose for one’s life, achievement regarding work, family or social/ recreational life, self preservation of esteem and integrity, and physical and material well being (Felce and Perry 1996). Regardless of method used to assess quality of life, quality of life assessment often focuses on the perceived well-being of the individual in physical, psychological, social and material areas. Felce and Perry (1996) show that physical well-being addresses basic life domains such as physical health and fitness.

Psychological well-being typically addresses mental health in regard to personal adjustment (Stewart and Ware 1992). Social well-being typically focuses on the extent and quality of personal relationships, spiritual fulfillment, community involvement and extent of involvement in active and participatory recreational activities. Material wellbeing tends to focus on financial and quality of environmental factors (Murphy and Williams 1999).

Diener (1994) indicates that subjectively measured, good quality of life could be seen as synonymous with positive sense of well-being. That is, a high positive self-appraisal of one's self and one's circumstances. Poor quality of life could be seen as synonymous with a negative sense of well-being, which is, a negative self-appraisal of one's self and circumstances. Kane (n.d.) argues that good quality of life is a summary of everything we care about. Every aspect of human capacity (functional abilities, psychological and intellectual abilities, physical health, pain and discomfort) are determinants of one's quality of life. She further says that to develop a meaningful concept of quality of care, focus should be on the psychological and social aspects of quality of life. Dignity, privacy, a sense of identity, continuity with one's previous life, a sense of meaning, fulfilment, meaningful relationships and social participation, the chance to make a contribution, spiritual wellbeing, control and choice over one's life are all important and should be considered in dealing with one's quality of life (Fabian 1991).

2. METHODOLOGY

The findings presented in this paper are based on a study conducted in Maseru with inmates or trainees of IVRC. Being a qualitative study, the sample consisted of ten (10) trainees with physical disabilities. The centre's administrator and guidance and counselling officers were used as key informants. Data was collected through in-depth interviews with the respondents, and it was analyzed qualitatively in order to find the quality of life of trainees with physical disabilities at IVRC. An interview guide was designed and was translated into Sesotho, the local language which was used in conducting the interviews.

3. RESULTS AND DISCUSSION

Quality of life is difficult to define as Kemp (2000) maintained. However, the findings of this study were therefore based on the trainees' opinions of their lives at the centre. The findings are mainly on trainees' material wellbeing which include accommodation and living arrangement, food, clothing, cosmetics and toiletry, and medical expenses; social wellbeing; physical wellbeing; and psychological wellbeing. All of these provided a picture of the environment within which trainees with physical disabilities were living at IVRC. Based on that, their quality of life was clearly detected.

3.1 Material Wellbeing

The findings on material wellbeing revealed that at IVRC the trainees were provided with basic needs which included food, shelter/accommodation, and clothing.

3.1.1 Accommodation and Living Arrangements: The centre provided the trainees with accommodation where the trainees were expected to share rooms from two up to five. The number of occupants depended on the type of physical disability the occupants had. For instance one respondent pointed out that they were two in a room and he believed it was because his roommate used a wheelchair, therefore, they needed more space. If there were more people, it would not be easy for him to move around. Another respondent said that they were five in a room. He pointed out that initially they were three but they accommodated the other two because the heater in their room was not functioning properly. When asked whether or not they were comfortable with the living arrangements (sharing) one of them said:

There is no privacy in here, as you can see we are three in a room, we are overcrowded, if we were two it would be better. But there is nothing we can do because it is the way the centre arranges for our accommodation.

This statement clearly shows that the respondent was not satisfied with the living arrangements, i.e. sharing the room, since there was no privacy. What was said above seemed to be in agreement with what the UN Report on Human Rights and Disabled Persons (2003-2004) says. According to this report, one typical aspect

of life within institutions is the virtually total loss of privacy for the 'inmates' as they usually have to share their accommodation with one or more others. Anderson and Gottfried (1991) also described the environment in institutions as one of the limited privacy. Another respondent who was dissatisfied about the living arrangements also said:

I do not like it when we are many in the room because we end up having conflicts sometimes. But because it is the way we have to live, I have to accept the situation as it is.

This shows that the respondent was not satisfied with having to share the room with other trainees. However, she further mentioned that she had to accept the situation as it was. From this it can be argued that though the respondent was uncomfortable with the living arrangement, it was not easy for her to raise her concern and she had to accept the situation as it was. Therefore, there was no freedom of choice, and freedom to raise concern on accommodation issues at the centre. Another respondent (four in a room) said that he was comfortable and happy with the arrangement because he did not get bored because as roommates, they were able to communicate and discuss important issues. He mentioned that they sometimes talked until late at night. This shows that though Shearer (1981) highlighted risks of institutionalization as boredom and loneliness, for some it is not always the case, just like with this respondent who has roommates to talk to.

From the responses concerning the living arrangements, it can be concluded that most trainees (seven) were comfortable about living arrangements. That is, they did not mind sharing rooms. However, there were some who showed dissatisfaction and gave reasons. Such reasons included lack of privacy and the possibility of conflicts among the roommates.

3.1.2 Food: On the issue of food, the respondents were asked if they were provided with food at the centre and whether or not it was balanced diet and well-prepared. The findings revealed that the trainees were provided with food at the centre, three meals a day and some tea in-between. A satisfied respondent joyously said:

Food here is very good, we eat meat everyday, in the morning we have soft porridge, sausages, bread and sometimes eggs. During tea break we have tea and *polony* or cheese sandwiches. So I am really satisfied with the food provided at the centre.

However, there was one respondent who was not satisfied with the food that was provided at the centre. She said:

Food is not satisfactory here; the menu is the same so one can easily predict what will be eaten on every meal. Moreover, when they give us *russians* (sausages) and *polony*, they always go for cheaper brands and we end up not knowing what we are eating, even their rice is like 'mealy-rice'.

The findings revealed that there were some respondents who did not have problems with food provided at the centre. The reason could possibly be that such respondents were from very poor families which could not afford even the kind of food offered at the centre. In other words, food provided at the centre was better compared to what they could afford at home. However, there were very few who seemed not satisfied with the food provided. The reason for this could possibly be that, back at home they had better food compared to what the centre was offering.

3.1.3 Clothing: The respondents indicated that they were sometimes provided with clothing, but priority was always given to those who were poorer based on home assessments conducted before the trainees could be admitted at IVRC. When asked about the source of clothes, the trainees indicated that they were donated by volunteers. The issue of donations by volunteers was confirmed by the centre's administrator who pointed out that local clothing shops and individuals give out clothes to the centre and those clothes are distributed to the trainees. According to her, first priority is given to those who are more destitute than others. The only problem with the donated clothes was that summer clothing was sometimes donated in the middle of winter, or winter clothing in the middle of summer. She also asserted that, at the centre they did not provide trainees with clothing except for blankets and linen that the trainees used.

3.1.4 Cosmetics and Toiletry: All of the respondents revealed that they were expected to buy their own toiletry and cosmetics. But for those who were really needy, they were provided with toiletries and cosmetics. This was confirmed by the Centre's Rules and Regulations (no.2) guiding the trainees which clearly state that: "All trainees are expected to bring their own cosmetics and toiletry including bathing soap, washing soap, toothbrush and toothpaste".

3.1.5 Medical Expenses: Most respondents asserted that they incurred their own medical expenses at the centre. However, since the centre is situated very far from clinics and hospitals, the responded revealed that they were sometimes provided with transport by the centre. There is a vehicle at the centre which is also used for administrative purposes, and it is sometimes used for transportation of trainees to the hospital. When inquired about where they got money to see the doctor, one respondent indicated that he borrowed it from friends if he did not have. In his own words he said:

If you get sick, it is your own business, but the centre always provides transport to take you to the clinic or hospital. If I do not have money, I borrow from friends at the centre. There is no money put aside by the centre for doctors' consultations.

From the above response and other responses given by the trainees, one learns that at the centre, the trainees' medical health is not as well-taken care of as the rest of their other needs. However, there were some exceptional cases. For instance, two respondents pointed out that they normally produce letters given by the Department of Social Welfare in their own districts to the medical centres they go to. Such letters enable them to get free health and medical services at any government-owned health centre they go to. Trainees at IVRC are therefore provided for materially, that is, they are provided with basic needs which include food, shelter and clothing.

3.2 Social Wellbeing

Social wellbeing covers personal and social relationships, and social contacts with the 'outside world'. The respondents were asked whether they had regular contacts with their families and friends. They responded that they visit their families once a month; they go shopping once a month; and go to church every Sunday, each to his/her denomination (church). They however stated that they were often expected to be back on stipulated times. For instance, one respondent indicated that when they go home they are expected to be back by 6: 30 p.m. IVRC rules and regulations clearly indicate that every trainee should go home once a month (preferably month end) and go out for shopping once a month, but should be back by 6: 30 p.m. while on Sundays they should be back by 1: 00 p.m.

Another important finding related to what is said above is that in order for the trainees to go out of the centre, regardless of where they were going, they must have a written permission from the centre's management. Without such written permission, the security guard at the gate cannot allow them to go out. The respondents pointed out that their families and friends were allowed to visit them but during tea break, lunch and after classes. They further mentioned that they received them in the dining hall since they are not allowed to go into their rooms. One respondent who was apparently not happy about this kind of arrangement said:

Visitors are not allowed into our rooms but only in the dining hall even if it is one's wife. It is not easy to show affection, that is; kiss her, since there are always many people in the hall. Furthermore those people who are visiting are also disgusted by this kind of arrangement. If you take your visitors into your room, you will be acting against the rules and regulations of the centre, and you can be suspended.

What is said above could be understood in the light of what Koso- Thomas (1987: 38) says about African sense of sexuality. He maintains that love and appreciation of both man and woman exist in Africa but are suppressed in public. It is considered unafrican to display one's feelings in public because this is disapproves of. It is believed that emotional feeling between spouses is a private matter.

Some respondents mentioned that even though they were not allowed to visit their friends outside the centre, they could visit each other in the centre. But one respondent indicated that sometimes they had to sneak out (especially if it is in the evenings) in order to have time with their girlfriends. But they did that discreetly because if they get caught, they would be in trouble. The above findings on social wellbeing showed that the trainees did not have much freedom to associate with the outside world at the centre. Moreover, if their families and friends visit them, they were not given privacy as they received them in the dining hall. Since the dining hall is a communal area, they are precluded to show any natural display of affection which is necessary for people when they meet their loved ones. Furthermore, they might not comfortably and openly talk with their loved ones because of lack of privacy. Mature people are used to

freedom of how to live their lives and perform their daily activities, however, being at IVRC means that the trainees are restricted from exercising that freedom as they have to follow rules and regulations.

3.3 Physical Wellbeing

When inquired about their physical health, the respondents indicated that their health is much better compared to when they were back at their homes. Some even reported that ever since they arrived at the centre, their lives had improved so much that they no longer had to see doctors as frequently as they used to do at home. The following is an excerpt extracted from what one of them said:

Since arriving at the centre my health has improved a lot, I eat three times a day; I do not have to worry about what I will eat for the next meal because everything is provided for here. At home there are always financial constraints so it is not easy to have three meals a day. I have even gained a lot of weight since arriving here.

At the centre cleanliness is encouraged. As indicated in the laws and regulations of the centre, every trainee has to go to the workshops (classes) tidy everyday. This seems to have been what has made the respondent here to change the habit of sometimes not taking a bath for a week. Six respondents reported that they participated in sporting activities like table tennis. They also mentioned that there is also a gymnastic room at the centre, though not well-equipped, which they use for exercising. Therefore, they regard themselves as healthy and fit. One respondent who was using crutches indicated that since his arrival at the centre his physical health has improved a lot because he can easily see the physiotherapist for consultation. This is his account:

My health has improved a lot since arriving here. Once in two weeks I go and see the physiotherapist to help me with my feet. I already feel the difference. At home I could not afford to see the physiotherapist because there was none at the nearby hospital. So it was not easy for me to come to Maseru because I could not afford the fare for taxi.

Based on the information provided by the respondents on their physical health and fitness, it is evident that their physical health has improved a lot since arriving at the centre. This is probably because of the balanced diet they are given daily coupled with physical exercises in which they engage. Kappel (1995) and Thomas (1996) have argued that within institutions, an emphasis is placed more on the physical health. This holds at IVRC where the trainees indicated that their physical wellbeing is well taken care of.

3.4 Psychological Wellbeing

On psychological wellbeing the findings revealed that some participants were mentally and emotionally satisfied at the centre. The following are some of the statements made by some of the respondents showing their psychological satisfaction. One of them had the following to say:

Before arriving at IVRC, I used to be very shy, I could not speak to people without thinking that they will pity me. I could not even make friends or even propose love to girls. This is because non-disabled people did not take me seriously and were discriminating. But now I have confidence, I do not hesitate to approach girls if they are good-looking. Moreover, even when I visit home, there are people who come to my place and ask me how I am doing and how Maseru is. I think people are starting to be friendly which was not happening before I enrolled at IVRC.

The implication from this respondent's account is that he has gained confidence now unlike before enrolling at IVRC. As a result he is able to make friends and also approach women for intimate relationships. It is important for people with physical disabilities to have confidence. This is because people tend to avoid contact and relationships with people with disabilities, and by so doing it becomes difficult or impossible for them to have close and intimate relationships. Therefore, having confidence in oneself can help overcome such difficulty. This account shows that the respondents have gained self-esteem and confidence and regard themselves as part of their community as they now also take part in community gatherings where developmental and political issues are discussed. Another man pointed out that he is psychologically satisfied because at the centre he has found people with similar disability with whom he can share his experiences. However, some individuals expressed their concern about

the emotional abuse they experience at the centre. They reported that there were some of the instructors that really did not talk to them like they were talking to the adults who deserve respect. They indicated that this lowers their self-esteem, and affects them a lot because there was nothing they could do to change the situation.

Enrolling with IVRC has helped some of the respondents to regain their self-esteem and confidence. This is because they have access to counselling services when the need arises. Moreover, they had good emotional support from other trainees because they too had physical disabilities and were able to share their experiences. Therefore, they were psychologically satisfied. However, there were some incidences where some reported that they were not satisfied because some staff members did not respect them, and even treated them like young children.

3.5 Choice and Control within the Centre

On choice and control within the centre, the respondents were asked whether or not they had choice and control over their daily activities and other activities that concerned them at the centre. The findings revealed that things are not always done democratically at the centre. The trainees had very limited choice. The findings on this aspect are supported by MacNeil and Teague (1987) who had described the present system of institutions as closed environments characterized among others by limited opportunities for choice and limited availability of options. The respondents indicated that on arrival at the centre they were not given the chance to choose who should be their roommates. One respondent puts it thus:

When I arrived here I was told that I would share a room with some individuals whom I did not know. I was not given chance to choose them. I then had to abide by that because if I did not I would be regarded as non-respectful.

Moreover, it was found out that the trainees at the centre did not have any say on the food menu and meal times. They followed the food schedule which was drawn in their absence. They mentioned that the private company did the catering, therefore, they had no say on the menu. One angry respondent when showing his dissatisfaction on the way things were done concerning food said:

Those people at the kitchen are very rude, they do not understand or care about our needs. If one tells them that he does not like certain food that is being served and asks for substitution, they do not listen, they say they want the proof from the doctors that one is not supposed to have certain foods. For instance, I do not like rice because even after eating it I feel like I have not yet eaten, so when I ask them if I can have 'pap' instead of rice, they say that cannot be done. They even refuse to give us leftovers if we are not full.

Many trainees were satisfied with the food they were provided with at IVRC. However, some of them said their problem was that they were used to freedom of choice concerning what food to eat back at home and when, but at the centre there was no such freedom. The other thing that the respondents highlighted is that, they were supposed to wake up very early in the morning to be ready for the day's work. At a specified time (7.00a.m) they had to go for breakfast. They further indicated that they were not allowed to take their meals into their rooms in order that they could eat them later at their own convenient time.

The respondents indicated that they raised their concerns and grievances through their prefects. When they first arrived at the centre they were asked to select their prefects through whom they could forward their concerns and grievances to the administration. These prefects were the ones that could directly meet with the relevant authorities at the centre. For instance, if there were concerns about food provided, the prefects would deal with that, not individual trainees. On the contrary, one respondent mentioned that even though they had the prefects that represented them, their concerns were not dealt with sufficiently. That is, in most cases they did not get positive results concerning their grievances and sometimes it took long before their grievances could be dealt with.

The other issue that was highlighted by the respondents was that they were denied the right to exercise their sexuality. That is, to have intimate relationships at the centre. The following is what one of them said:

We are treated like young children in this centre who are not expected to openly display their sexual feelings in this centre. We are not allowed to have sexual relationships with our girlfriends. If by mistake one is caught engaging in sexual activities, that person is immediately suspended.

From the preceding account, it shows that at the centre, one had to put aside family matters like bearing children. This is so probably because being pregnant may prevent the trainee from effectively performing everyday activities. To the centre, the child would be a burden as it is not designed to accommodate young children. On the issue of choice and control within the centre, it is evident that there was no democratic practice at the centre. The trainees had to abide by the rules and regulations of the centre, they were not supposed to question any activity imposed on them by those in authority.

On the daily activities, they had to follow the daily routine. For instance, if it is time to wake up they have to do so, if it is time for breakfast they have to go there at the same time. This happens for the rest of the day with other activities that follow. This goes in line with what Goffman (1961) observed when he noted that in institutions, each member's daily activities are carried on in the immediate company of a large batch of others, all of whom are treated alike, and are required to do the same thing together. Moreover, he indicated that all phases of the day's activities are tightly scheduled, with one activity leading to a prearranged time into the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials.

3.6 Infrastructural Accessibility

The respondents were asked if the buildings and other services were easily accessible to the trainees because of their disabilities. One respondent who was using crutches to ease mobility indicated that even though he was using crutches he could move around the centre. His disability did not prevent him from moving around. He mentioned that the buildings were in such a way that people with physical disabilities could easily access them. The other respondent confirmed that the buildings were easily accessible in the centre. In his words:

In this centre, buildings and facilities are in such a way that we (people with physical disabilities) can easily use them. For instance; I easily use the showers here. I can reach them because they are made in such a way that even very short people like me can use them.

Another respondent who used a wheelchair indicated that he did not have a problem moving around the centre because where there were stairs, there was also another entrance specifically designed for people using wheelchairs. He further pointed out that there were other facilities like toilets and bathrooms which had specifically been designed in such a way that people using wheelchairs could have no problem using them. This shows that infrastructure such as buildings and other services are easily accessible to the trainees. The buildings are designed in such a way that they can easily be accessed by the trainees regardless of their physical disabilities.

3. 7 Effects of Institutionalization on the Quality of Life

The findings of this study on the effects of institutionalization on quality of life of trainees with physical disabilities revealed that being in an institution has both positive and negative impacts on their quality of life. The respondents highlighted that they were provided with basic needs which included shelter, food, and clothing. This greatly impacts positively on their quality of life especially their physical well-being. Moreover, being in an institution has helped some of the trainees to adjust and feel comfortable about their disability. One of the respondents mentioned that before arriving at IVRC, she was not aware that there were many people with physical disabilities. Therefore, seeing many people with physical disabilities gave her courage to be proud and accept her disability.

It was also found out that being in a vocational institution helps the people with disabilities to be busy. When busy they are unlikely to engage in non-acceptable behaviours like using marijuana. One respondent mentioned that since arriving at the centre he was well focused and did not engage in bad behaviour like using marijuana which is what he used to do at home. He pointed out that he was using 'dagga' because he was hopeless, useless and lonely as he did not have friends who he could talk to. According to him, using 'dagga' was the only way he used to reduce his frustrations because at his village no one was wishing to befriend a person with disability of his nature. Some respondents stated that they could easily make friends at the centre as the trainees really understood what it is like to have some disability because they too had disabilities. One mentioned that she was com-

fortable when they stayed together in the same place because they understood and accepted one another unlike in their villages where they were always teased because of their physical appearance. MacNeil and Teague (1987) have argued that institutions are characterized by restricted opportunities for information among others. This is not the case with IVRC where the trainees indicated that they have access to information, so they are well-informed on issues that concern them. There are sometimes workshops and seminars at the centre that are held for the trainees. In such activities, the trainees are provided with necessary information dealing with various aspects of life.

The respondents also mentioned that at IVRC there are people who are willing to help them when they are having some personal problems. These people include some of the instructors and guidance and counselling officers. They help them in the areas of personal and social adjustment and career development ensuring that the trainees become productive and well-adjusted to their disabilities. It was found out that there was also some negative impacts institutionalization had on the quality of life of the trainees. As mentioned by the respondents, these include lack of privacy, loss of control of their lives and daily activities, and lack of choice within the centre. The respondents pointed out that at IVRC they have totally lost their privacy as they have to share their rooms. Moreover, they are controlled on when to eat, how to spend their spare time, when to go out of the centre and be back, and even when to sleep. One respondent mentioned that they have to switch off the lights at 9: 00 p.m. every weekday and on weekends at 11: 00 p.m. They are controlled verbally by the staff and also there are written rules and regulations that the trainees are provided with when they arrive at the centre. They have to abide by such rules and regulations. Otherwise they get suspended or dismissed from the centre. They also can not object to the unfair treatment due to the type of rules and regulations.

With this type of control, their life is negatively affected. They do not gather enough self-esteem and confidence both of which are vital components to face life's challenges. This being the case, they may find themselves being overly dependent and in a state of powerlessness. They may also be convinced that there is no way they can get their life to be as normal as possible regardless of their physical disabilities. With all this happening, the trainees may end up engaging in negative behaviours like alcohol and drug abuse.

4. TRAINING

Although the main objective of this paper was to assess the quality of life of inmates in the IVRC, training provided to them was also examined. The goal of the centre is to provide vocational training to the inmates, so that they become self-reliance and stop the begging syndrome which is usually associated with disabled people. It was found out that the trainees were provided with vocational skills which include dressmaking and fashion design, carpentry, leather and metal work. Each trainee had a trade in which he or she was being trained under an instructor. All of them were very happy with the training they were receiving and hoped that on return, they will establish their own workshops and help employ the many jobless youths roaming the streets.

5. CONCLUSION

Some conclusions have been drawn from the findings and include the following: First, apart from vocational and physical health rehabilitation of the trainees at IVRC, other aspects of quality of life like their material wellbeing, psychological wellbeing, and social wellbeing are also well-taken care of unlike as found by Kappel (1995); Thomas (1996); and Johnston et al. (1997). Although much has been said about the negative aspects of institutionalisation, there are many positive benefits institutionalization has on the quality of life of people with physical disabilities. Finally, despite some dissatisfaction expressed by some trainees, quality of life of the trainees at IVRC is generally better compared to when they were back at their original places. Therefore, when it comes to vocational rehabilitation, institutionalization is still the best option for people with physical disabilities in developing countries like Lesotho.

6. RECOMMENDATIONS

The following are recommended so as to improve the quality of those with disabilities in institutions: first, trainees-staff relationship

should be strengthened so that the trainees could be as comfortable as possible throughout the training. By so doing the trainees could regain their confidence and therefore work hard towards improving their lives. Secondly, there is a need to minimise the control as most of them are adults and need some freedom to enjoy social life. Similarly, it would be useful if the trainees are consulted when decisions concerning them are taken. For instance, they could decide with whom to share their rooms, and how they should spend their spare time. Again, those in authority should also open up communication channels to allow the flow of exchange of views from both ways.

REFERENCES

Anderson M, Gottfried CG 1991. Nursing Home Care: factors influencing the quality of life in a restricted life situation. *Aging,* 3: 229-239.

Diener E 1994. Assessing subjective well being: Progress and opportunities. *Social Indicators Research***,** 31: 103-157.

Elwan A 1999. Poverty and Disability; A survey of the literature. *Social Protection Discussion Paper Series.* New York: Human Development Network, World Bank.

Fabian E 1991. Using quality of life indicators in rehabilitation program evaluation. *Rehabilitation Counselling Bulletin***,** 34: 344-356.

Felce D, Perry J 1996. Exploring current conceptions of quality of life. In: R Renwick, I Brown, M Nagler (Eds): *Quality of Life in Health Promotion and Rehabilitation*. Thousand Oaks, CA: Sage Publications, pp.51-62.

Goffman E 1961. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York: Doubleday, Garden City.

Ithuseng Vocational Rehabilitation Centre's Rules and Regulations, No. 2, 2004.

Johnston MV, Stineman M, Velozo C 1997. Outcomes research in medical rehabilitation: Foundations from the past and directions for the future. In: MJ Fuhrer (Ed.): *Assessing Medical Rehabilitation Practices: The Promise of Outcome Research*. Baltimore, MD: Paul H. Brookes Publishing Co., pp.1-41.

Kappel B 1995. Making the impossible possible: Reflections on individualized approaches with a focus on Ontario. *Journal of Leisurability***,** 22 (4): 3-13.

Kane R n.d. Ask the residents about Quality. Official Home Page of Aging 2006. From <http: / www.asaging.org/am/cia2/nursinghome.html> (Retrieved June 20, 2006).

Kemp B 2000. Quality of life while aging with a disability. From<http:/www.jik.com/qolkemp.html> (Retrieved July 18, 2006).

Lesotho Bureau of Statistics 2004. Lesotho Population. Government of Lesotho Home Page 2006. From <http: /www.bos.gov.ls> (Retrieved September 19, 2006.

Lesotho Demographic Survey 2001. Analytical Report, Vol. 1. Bureau of Statistics. Government of Lesotho Home Page 2006. From <http: /www.bos.gov.ls/ population/Disability.pdf> (Retrieved May 25, 2006).

Koso-Thomas O 1987. *The Circumcision of Women: A Strategy for Eradication*. London: Zed Books Ltd.

MacNeil R, Teague M 1987. *Aging and Leisure: Vitality in Later Life***.** Englewood Cliffs: Prentice-Hall.

Marfo K, Walker S, Charles B (Eds.) 1986. *Childhood Disability in Developing Countries: Issues in Habilitation and Special Education***.** New York: Praeger Publishers.

Murphy O, Williams J 1999. *Assessment of Rehabilitative and Quality of Life Issues in Litigation***.** Boca Raton, FL: CRC Press.

Onasanya A n.d. Disabilities in Africa. Official Home Page of Pearls of Africa 2006. From <http: / www.pearlsofafrica.org/htmlDIAhtml> (Retrieved June 20, 2006).

Shearer A 1981. *Disability- Whose Handicap?* Oxford: Blackwell.

Stewart AL, Ware Jr. JE 1992. *Measuring Functioning and Well-Being: The Medical Outcomes Study Approach***.** Durham: Duke University Press.

Thomas WH 1996. *Life Worth Living: The Eden Alternative in Action***.** Acton: VanderWyk and Burnham.

United Nations 2003-2004. Human Rights and Disabled persons. United Nations Offical Home Page 2006. From http: /www.un.org/esa/socdev/enable/ dispaperdes3.htm (Retrieved December 12, 2006).

United Nations Department of Public Information 1984. *World Programme of Action Concerning Disabled Persons 1983-1992*. New York: United Nations.

World Health Organisation 1980. *International Classification of Impairments, Disability and Handicaps (ICIDH)*. Geneva: WHO.