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ROLE OF SOCIAL WORKERS FOR DISABILITY IN UTILIZING TOOLS FOR SUPPORTING ACTIVITIES

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Abstract

The provision of assistance to persons with disabilities at the Social Rehabilitation Center for Physical and Sensory Disabilities aims to improve the ability of persons with disabilities to fulfill basic rights. This research was conducted using descriptive evaluation research with quantitative approach models that are supported by qualitative data. Evaluation models using the countenance stake evaluation model are models that prioritize decryption evaluation and assessment. Based on an analysis of the results of research conducted at 10 disability centers in Indonesia, the overall evaluation of the use of tools for the effective service disability category with an average score of 80.00%. Plan the provision of tools for physical and sensory disability services (blind, hearing impaired and speech impaired) in the appropriate category (83.02%), but need to pay attention to the provision of assistance standards for persons with disabilities (physical and sensory) preceded by assessors and interviews . Recommendations on the results of research on the provision of aids for people with disabilities need to be accompanied by social workers and experts making tools that are carried out on an ongoing basis. Social workers are involved in considering standards for assistive devices for people with physical and sensory disabilities which begin with assessments and interviews in collaboration with professionals in the environment. Assistance for social workers in assisting disability in the provision of assistive devices is provided through medical examinations, provision of assistive devices, through measurement, assistive devices according to type, size, level of disability, and good quality, assistive devices receiving routine care, receiving information about care for Device. both beneficiaries and families.

Keywords: Social Workers, Disability, Aid, utilization.

Introduction

In Indonesia, as many as 23 million Indonesians experience disabilities, they are very large, so they need facilities, transportation, sidewalks, toilets, and friendly buildings. In fact the new 1 to 3 friendly city is a disability (Tempo, 2018). The rights of disability are contained in the Law No. 19 of 2011 or the United Nations Convention for Rights of Persons who have ratified Indonesia in November 2011. In addition to the law No. 8 of 2016 on the disabled who was passed on 15 April 2016 and entered into force from 15 April 2016. The Convention on the Rights of Persons with Disabilities (CRPD) defines disability as a result of the interaction between the unwillingness with the barriers of environmental attitudes and

barriers that impede their participation in a full and effective manner with Others in society on the basis of equality (Eta Yuni Lestari, 2017).

The role of social workers in the use of aids for the services of people with disabilities in 10 locations in indonesia, with samples of 600 auxiliary recipients and 50 social workers. From all the accessible disability centers there are three specialized disability centers s dealing with sensory disabilities, 3 of the speech deaf-and-mortar disability centers s, 2 physically-cdisability centers enged disability centers s and 2 disability centers with disabilities (physical, sensory and deaf speech). Chart of evaluation location based on region allocation and distribution of assistive devices for disabled services can be presented on a chart. 2 as follows.

Chart 1. Location of research 10 rehabilitation disability rehabilitation center for disability

Location/City		Number of respondents
Palembang	BRSPDF "Budi Perkasa" Palembang	(60 beneficiaries and 5 social workers)
Kendari	LRSPDSRW Kendari	(60 beneficiaries and 5 social workers)
Jakarta	BRSPDSRW Melati	(60 beneficiaries and 5 social workers)
Bandung	BRSPDSN Wyata Guna	(60 beneficiaries and 5 social workers)
Makassar	BRSBDF BRSPDSN "Tumou Tou"	(60 beneficiaries and 5 social workers)
Denpasar	BRSPDSN Mahatmiya	(60 beneficiaries and 5 social workers)
Bogor	BBRVPD Cibinong	(60 beneficiaries and 5 social workers)
Bantul	BRTPD Bantul	(60 beneficiaries and 5 social workers)
Kupang	BRSPDSRW Kupang	(60 beneficiaries and 5 social workers)
Manado	BRSPDSN Tumou Tou Manado	(60 beneficiaries and 5 social workers)
10 ocation		**600 beneficiaries and 60 social workers**

The use of aids for a disability requires accessibility as a facility provided for the disabled to give a common chance. Disabilities require the assistance of accommodation worthy of modification and appropriate adjustments. It is necessary to ensure physical disability is capable of carrying out the functioning of a part of human rights and fundamental freedoms based on equality. The universal design concept that can be applied to product design, environment, building, public space, programs on computer and services that can be used by all user groups, to the fullest extent possible, without the need for special adaptation or design.

Public attitudes and government policies to accommodate the principles of non-discrimination, equality and equal opportunity acknowledge the limitations that can be overcome. The provision of infrastructure for physical accessibility disabilities is an important factor in addressing a condition called "disability". Increased public awareness and State responsibility to address disability is an important task of a community of nations in the world irrespective of the type and severity of impairment owned by being able to enjoy the rights of those Most essential.

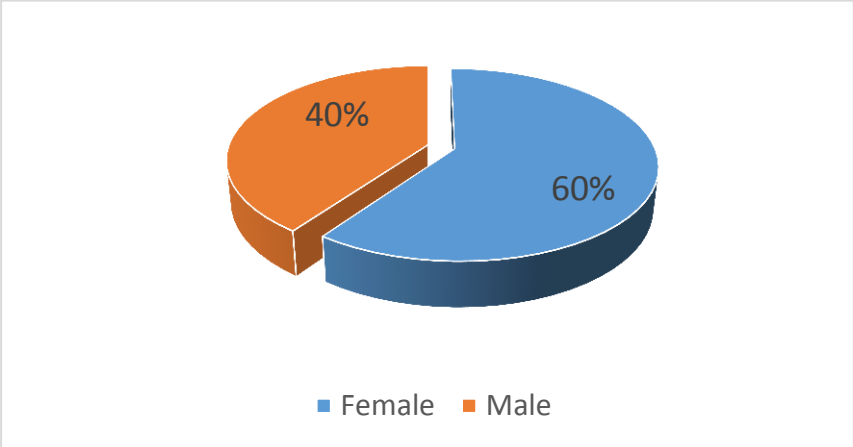
Activity evaluation of the use of aids for this disability service refers to law no. 8 of 2016 about the disabled. The evaluation activities for this disability service are focused on: types of mobility aids available and benefit and how to use, the suitability of tools with disability needs and the benefits of hearing aids by the disabled and contributions to the use of tools for the service of the disability to a prosperous, independent life and without discrimination.

This study sought to know the role of social workers in the utilization of aids for the service of physical and sensory disabilities reviewed from the aspect of preparation (antecedents) procedures, legality, and operational standards of procedures . The role of social workers is not separated from the use of aids for the service of physical and sensory disabilities reviewed from the implementation aspect of the program (the suitability of aids to the needs of the disability). The role of social workers in assisting the utilization of aids for the service of physical and sensory disabilities is reviewed from the outcome aspects of the program.

Research and discussion results

This research aims to determine the role of social workers in assisting the utilization of aids for the service of physical and sensory disabilities, can be seen from the characteristics of the respondents based on gender as follows: characteristics of respondents in this research researchers for the eight characters, namely based on age, sex, last education, occupation, marital status, description of the research characteristic of researchers described below:

Chart 2. Gender Social workers

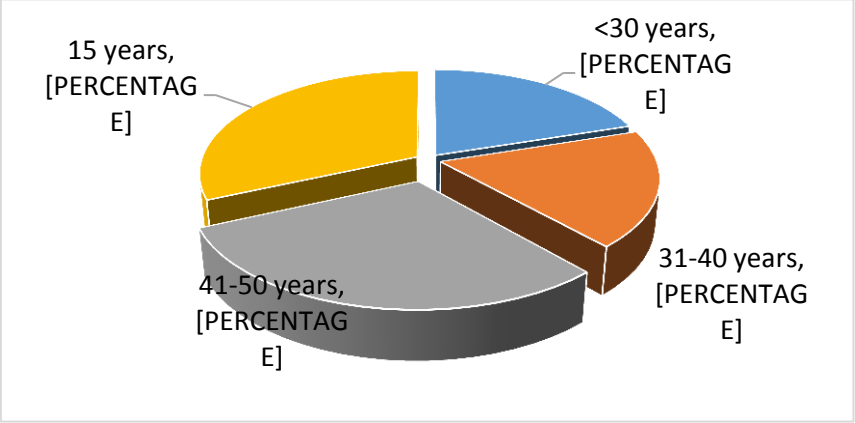


Source: Primary Data, n = 60

The number of social workers across the disability centers with 60% of female disability and male genital is as much as 30% more female social workers than male gender social workers. From

the data obtained information that the social workers in the ten disability centers s are evaluated dominated by women.

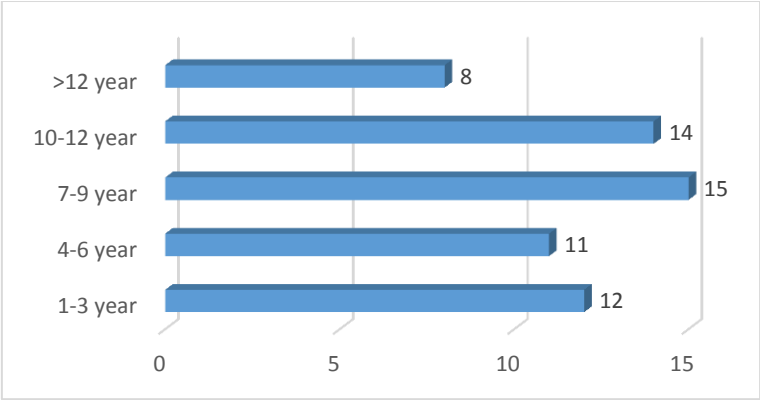
Chart 3 Age of Social workers



Source: Primary Data, n = 60

Charts 3. The age of social workers who are in 10 disability centers s in Indonesia most older than 51 years old is 32, second in the age range of 41-50 years which is 30, the third in the age range above 30 years is 18% and the least is aged between 31-4 0 years 18.

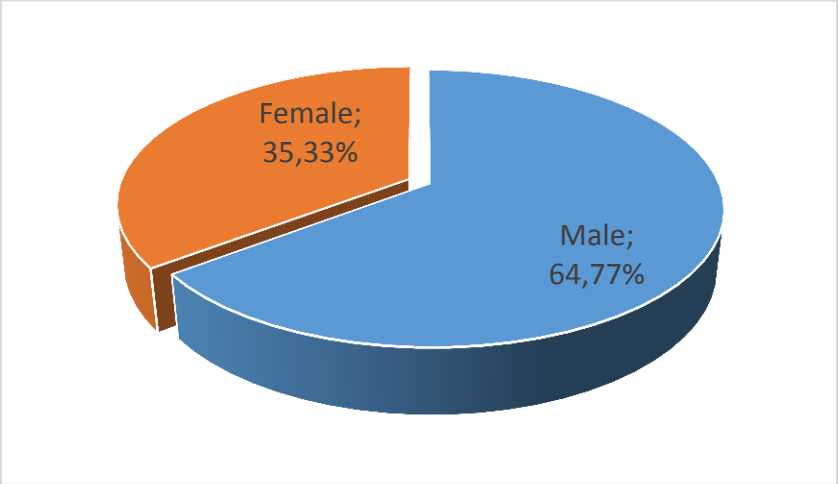
Chart 4. Long Time Serving as Social workers



Source: Primary Data, n = 60

Chart 4. Long working as functional social workers who are in 10 disability centers s in Indonesia at most 15 people 25% worked for 7-9 year. Social workers who work for 10 -12 years as much as 14 people 23.3%. While working as social workers who have worked less than 12 years 8 people or 13.3%. Social workers are expected to combine working in partnership with ensuring that the focus remains on the child's needs and protection. To date, most research in this area has relied on retrospective accounts from parents or workers. Overall, social workers tended to use a very confrontational and at times aggressive communication style. This was so consistently observed that it is likely to be a systemic issue. In conclusion, it is argued that at the levels of research, theory and official guidance, insufficient attention has been give to the micro-skills involved in safeguarding children and that this is an urgent priority for further work.(Forrester et al., 2008)

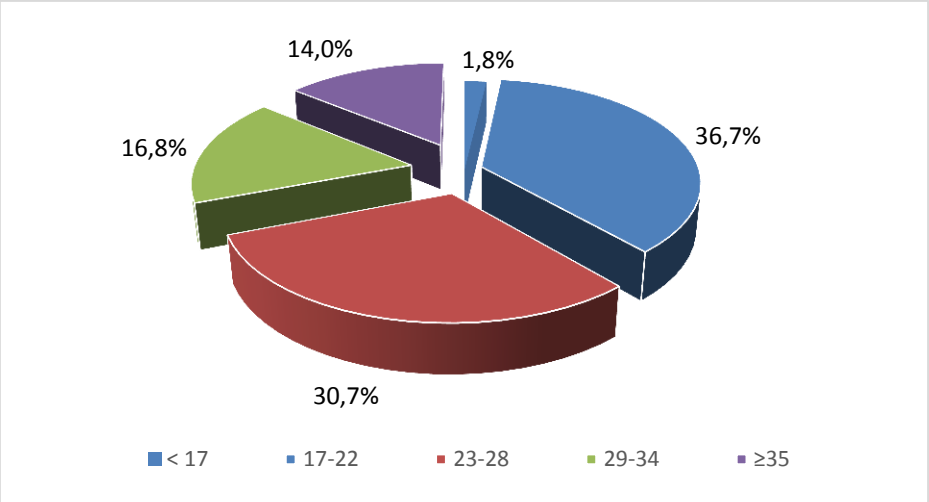
Chart 5. Gender beneficiaries



Source: Primary Data, n = 600

Chart 5. The number of clients, which are male and male disability, is 64.67% more than the female gender, 35.33%. From the data obtained information that the clients in the ten disability centers s were evaluated dominated by male.

Chart 6. Client Age

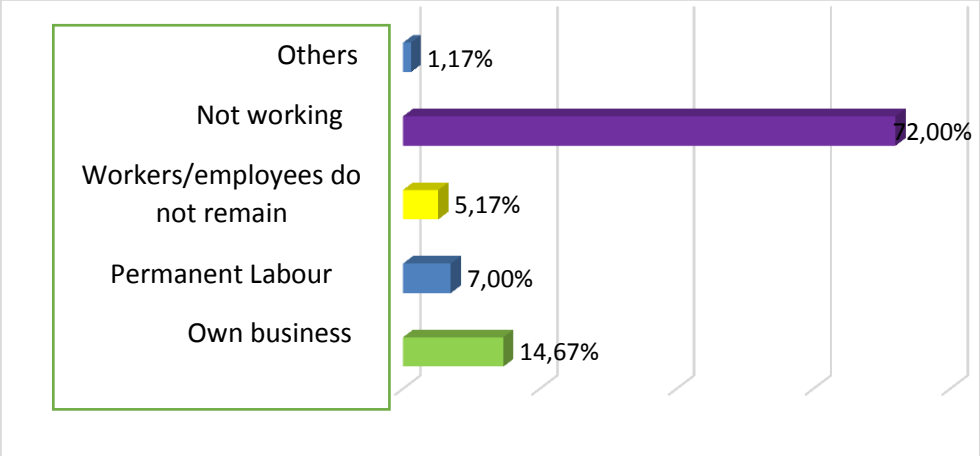


Source: Primary Data, n = 600

Chart 6 The age of clients who are in 10 disability centers s in Indonesia is dominated by 17-22-year-old as much as 36.7%, second in the age range of 23-28 years which is 30.7%, third in the age range of 29-34 year ie 16.8%. For that outside of the productive age, either under the < 17 Year or > 35 years there are as many as 15.8%. Disability-free life expectancy and life expectancy with disability were found to depend strongly on the indicator of disability, but the patterns of differences both between genders and between educational categories were largely independent of the indicators used. Life expectancy as well as disability-free life expectancy showed a systematic relationship with level of education: the higher the level of education, the higher the life expectancy and disability-free life expectancy. The differences between educational categories in disability-free life expectancy were markedly larger than in total life expectancy. Life expectancy with disability was shortest among the more educated and longest among the less educated. Due to the higher life expectancy and the higher prevalence of disability among women, life expectancy with disability was longer among women than men according to all indicators (Valkonen et al., 1997).

Explaining that the level of education of 10 disability centers in Indonesia is dominated by the level of education of high school/equivalent of 34.33%, both elementary school level/equal to 24.83%, third in junior High School category/equal to 17.33%, no school 16%, did not finish elementary school 6.17% and last Diploma IV/bachelor 1.33%.

Chart 7. Client's Disability work before at rehabilitation centers



Source: Primary Data, n = 600

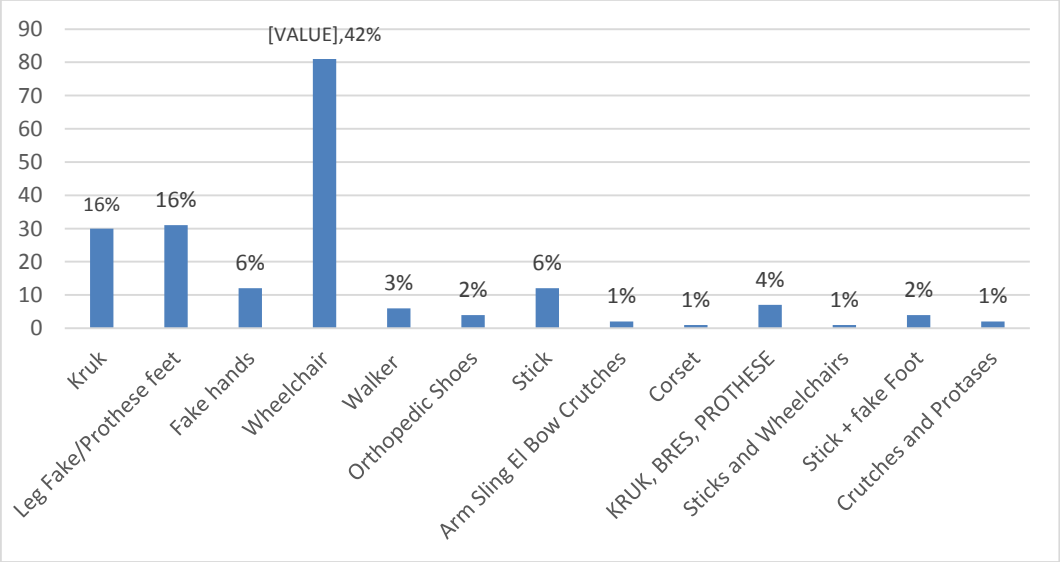
Chart 7. Presenting information on the work of the 10 disability centers s in Indonesia, amounting to 72% of clients have a job, 14.67% in its business category (a vocational graduates), 7% of workers/permanent employees, 5.17% of workers or employees are not fixed and other jobs as much as 1.17%. The subjects who did not have manual jobs and who had an amputation of only one or two fingers were able to keep the same job more easily after the amputation. Only a few subjects found their silicone prosthesis useful at work. Conclusion It can be concluded that a partial hand amputation may present a great problem in keeping the same job after amputation. An aesthetic (cosmetic) silicone prosthesis is helpful especially for subjects with higher education whose work involves personal contacts and for whom aesthetics is important. They use the prosthesis for certain activities, such as typing (Burger et al., 2007).

Information about the marital status of most of the beneficiaries of 10 disability centers s in Indonesia in the status of unmarried is 85.83%, both marital status is 12.33%, third divorce status as much as 1.67% and divorced 0.17%. The noninstitutional population is considered first: divorced and separated people have the worst health status, with highest rates of acute conditions, of chronic conditions which limit social activity, and of disability for health problems. Widowed people rank second for health status, followed by single people. Married people appear healthiest, having low rates of chronic limitation and disability. Their rates of restricted activity and medical care are intermediate, but hospital stays tend to be short. Considering the institutional population, rates of residence in health institutions are highest for single people and lowest for married ones.(Verbrugge, 1979)

Types of aids received by the beneficiaries of 10 disability centers s in Indonesia, the type of assistive devices are grouped by the type of disabilities. The type of sensory aids given from the disability centers is Riglet + pen by 2%, glasses 0.5%, stick + Riglet + pen amounting to 73.5%, stick + hour talk of 3%, stick + hour Talk + Reglet + pen by 6%, stick of 14%, and goggles + 1% stick. The most help is the stick + Riglet + pen given by the disability centers to the beneficiaries. The type

of assistive devices received by the sensory disability of the speech is hearing aid/hearing aids of 100%. When someone looses one type of sensory input, s/he may compensate by using the sensory information conveyed by other senses. To verify whether loosing a sense or two has consequences on a spared sensory modality, namely touch, and whether these consequences depend on the type of sensory loss, we investigated the effects of deafness and blindness on temporal and spatial tactile tasks in deaf, blind and deaf-blind people. Deaf and deaf-blind people performed the spatial tactile task better than the temporal one, while blind and controls showed the opposite pattern. Deaf and deaf-blind participants were impaired in temporal discrimination as compared to controls, while deaf-blind individuals outperformed blind participants in the spatial tactile task. We speculate that discriminative touch is not so relevant in humans, while social touch is. Probably, more complex tactile tasks would have revealed an increased performance in sensory-deprived people (Papagno et al., 2016).

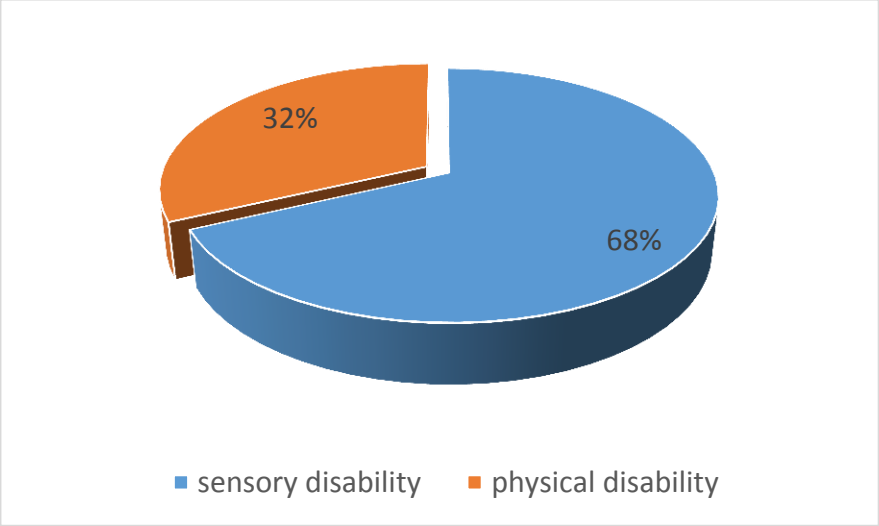
Chart 8. Types of physical Aids



Source: Primary Data, n = 600

Based on chart 8. Type of assistive device for physically disability centers enged by 16%, fake leg 16%, fake hand 6%, 42% wheel chair, Walker by 3%, orthopedic shoes by 2%, stick of 6%, hand carrying of 1%, corset at 1%, Kruk + bress + Protese of 4%, stick + wheelchair of 1%, stick + fake foot by 2%, and Kruk + protase of 1%. From the data obtained, the most widely accepted assistance is a wheelchair of 81 pieces (42%). Assistive devices are a key aspect in wearable systems for biomedical applications, as they represent potential aids for people with physical and sensory disabilities that might lead to improvements in the quality of life. This chapter focuses on wearable assistive devices for the blind. It intends to review the most significant work done in this area, to present the latest approaches for assisting this population and to understand universal design concepts for the development of wearable assistive devices and systems for the blind (Velázquez, 2010).

Chart 9. Disability Type

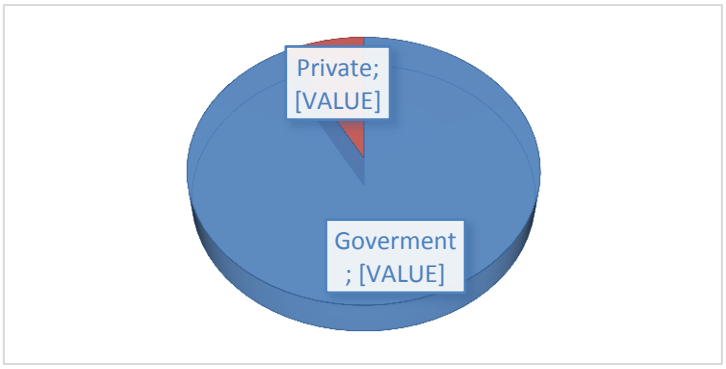


Source: Primary Data, n = 600

Chart 9. The results of 10 research locations showed that two types of disabilities studied showed 5% of clients were those with sensory disabilities and 32% physical disabilities.

Clients with the most physical disabilities are crippled or stiff 51.8%, due to cerebral palsy or movement disorders, muscles, or posture caused by injury or abnormal development in the brain 21.8%. Paraplegia or motor decline or sensory function of gestures 11.1%, the lowest physical client disability due to 1% stroke. To access what demographic and clinical factors are related to the provision of assistive technology (AT) devices in low-income countries. The type of AT equipment provided is highly dependent ($p < 0.001$) based on the client's diagnosis, changes, number, and socio-economic strata, whether the client requires care, the geographical zone in which the client lives, the year the AT provisions are, and the total amount of AT transferred. In contrast, the sex of the client ($p > 0.05$) and the type of health services affiliated with the client are not supported. In addition, the age of the client, the socio-economic strata of the client, the number of AT devices provided to the client, and the type of data associated with the level of association that is most strong with the type of AT equipment provided. Prioritize the second person who suits the highest level, and maybe the person with the budget. Supposedly, the socioeconomic strata are low, young people and the elderly, and the provision of at least one AT device. Application for Rehabilitation The provision of AT supports the same opportunities for social participation of protected people. Also, persons with disabilities have the right to access AT regardless of the type of restriction, gender, race, age or region in which they live. Research on AT in developing countries is still scarce; thus, there is a need to do a studio in such situations. This study provides scientific evidence to support the development of models, finding and providing strategies in low-income countries where resources for rehabilitation are scarce (Rios et al., 2014).

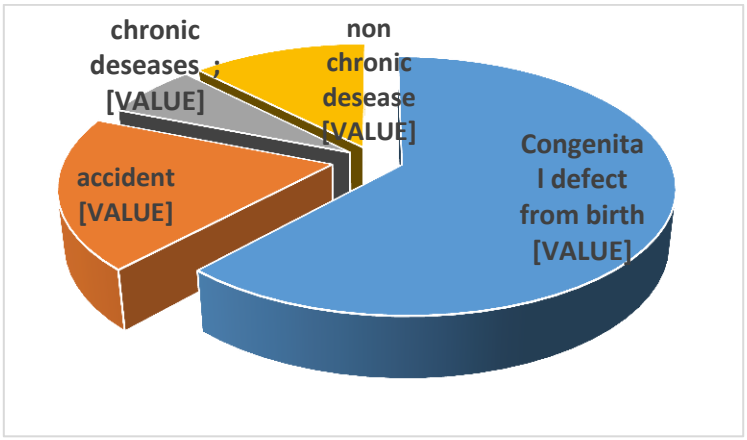
Chart 10. Resources for Disability Aid Fund



Source: Primary Data

Chart 10. Obtained information that the tools of 10 disability centers s in Indonesia are from the government of 92%, this value includes the provision of tools from the local government, Balai, and social ministries. The remaining 8% is derived from the private foundation of the Shadu Vaswani Center, the foundation of the Rumah Diah Pitaloka, the foundation of the International Truth.

Chart 11. Factors causing client disability

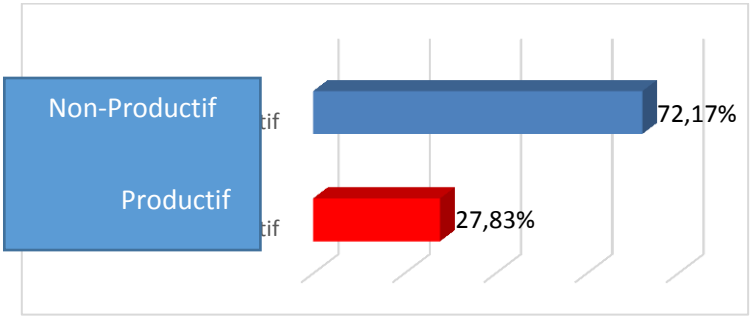


Source: Primary Data n = 600

Graph 11. Above presents information that the factors causing clients disability from 10 disability centers s in Indonesia are mostly by congenital birth (62%), the second caused by accident (19%), from the information obtained on the field clientele with Disabilities Accidents are experienced by most workers working in companies or factories. non-chronic diseases (high heat, glaucoma) (12%), and lastly caused by chronic diseases (over-dosing of the drug, and over-dosing of drugs) by 7%. A consistent and comparative description of the burden of diseases and injuries, and the risk factors that cause them, is an important input to health decision-making and planning processes. Information that is available on mortality and health in populations in all regions of the world is fragmentary and sometimes inconsistent. Thus, a framework for integrating, validating, analyzing and disseminating such information is needed to assess the comparative importance of diseases and injuries in causing premature death, loss of health and disability in different populations. The first Global Burden of

Disease (GBD) Study quantified the health effects of more than 100 diseases and injuries for eight regions of the world in 1990 (1-3). It generates comprehensive and internally consistent estimates of mortality and morbidity by age, sex and region (4). The study also introduced a new metric - the disability-adjusted life year (DALY) - as a single measure to quantify the burden of diseases, injuries and risk factors (5). The DALY is based on years of life lost from premature death and years of life lived in less than full health (Report produced by the Department of Health Statistics and Information in the Information, Evidence and Research Cluster of WHO) (WHO, 2008).

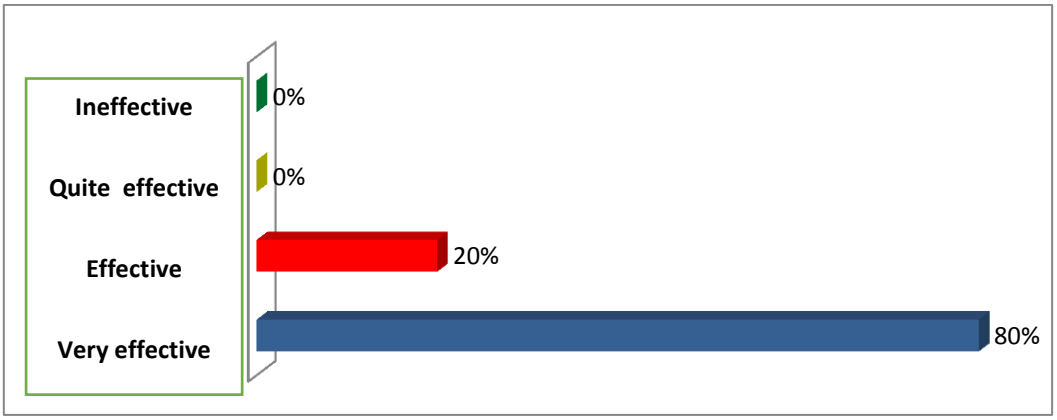
Chart 12. Beneficiary Category



Source: Primary Data n = 600

Chart 12. Above, that the clients who are at 10 disability centers s in Indonesia are an unproductive independent category client of 72.17%, this data is backed by most of the work data or by 72% has no job and productive self-reliant of 27.83%. Youth who are blind or visually impaired (BVI) and youth who are deaf or hard of hearing (DHH) often have low participation in sports and regular physical activity. Financial situations and budget cuts have forced many states to combine residential schools for low incidence disabilities such as BVI & DHH. Deductive content analysis reveals a number of meaningful themes in each category for both disability groups. Findings suggest that both hearing and visually impaired youth enjoyed physical activity and valued health benefits. However, this desire did not translate into being physically active. Youth suggested barriers for this including low parental encouragement for sports and physical activity and some social exclusion from non-disabled peers in game settings (Ward et al., 2012).

Chart 13. Standard Operational Procedures Tools For Disability Service



Sumber: Data primer, n= 600

The results of the research on the utilization of tools and the alignment used by the client is very effective 80%, meaning that the tools provided are suitable and beneficial for the disabled with a maximum meaning other than beneficial and appropriate tools These aids can sustain daily life, while 20% of respondents feel effective according to the benefits and suitability, meaning it can be used for daily activities but felt not maximally.

The components that can be evaluated on the antecedent are The following presented countenance matrix antecedent components as below.

Grafik 14 . *Countenance Matrix* component *Antecedent*

Description Matrix		*Judgment Matrix*	
Intens	Survey	Standar	*Judgment*
Standard operational procedure Provision of disabled aids (physical and sensory) through accessories and interviews, provision of assistive devices through social workers referral, tools through medical checkup, provision of aids, through measurement, aids by the type, size, level of disability, and good quality, the tools get regular maintenance, get the socialization of assistive equipment care for family clients.	Actualization Operational standards of procedures achievement as much as 80% in the category is appropriate, but not all aspects of the standars procedures is implemented by the criteria set.	Provision of tools is provided beforehand through interviews, assessment, and referral of social workers. The disability gets the aid of the apparatus through his medical examination. The provision of tools, through measurement, aids by the type, size, level of defects, and good quality. Post-awarding aid to receive periodic maintenance. Assistance is given to beneficiaries per the disability. Complaints of equipment breakdowns soon followed, the Disability centers has a standard of service, the region has a law or regional regulations about the utilization of assistive devices.	Some standard use of tools for the service of physical and sensory disabilities of 10 disability centers s in Indonesia has not been by the prescribed procedures.

Based on the chart above, the operational standards of procedures that is in the disability centers at 10 research locations is included in the category very suitable. If referring to the assessment category in the analysis using the percentage calculation value (%), ≤ 40: Very ineffective, 41-55: ineffective, 56-7: Moderately effective, 71-85: Effective, 86 – 100: Very effective. The percentage value of 80% for operational standards of procedures providing aids for clients in the disability centers at 10 research locations in the effective category.

Intense conformity with surveys, in matrix descriptions, found no suitability between the operational standards of procedures made disability centers made by researchers, especially on components of providing AIDS through measurements, tools that are given quality Well, there is no routine maintenance, aids that are given not in accordance with the aesthetic of the beneficiaries. Based on the results of the interview with the speaker, it is explained that standards procedures utilization of the tools provided by the Disability centers in the following procedures or factory standards (so). This causes the tools for some users not according to the size of the posture, there is a week and there is a prolonged (short body), also informed that the tools given are easily broken and less quality (blind). Riglet and pen are considered to still less good because sometimes easily broken and the pen sometimes too taper and too, making it difficult for users to enjoy the benefits of the tool. As such, the disability centers needs to expand the network to deepen the relevant sensory-specific tools, in order to obtain accurate information and experience in the provision of good tools. Likewise, in the deaf of speech, it is not preceded by the assessment of beneficiaries. So that the use of hearing aid aids is not maximal, the maximum socialization of the treatment of tools for clients and families. Cases on the physically cdisability centers enged, the wheelchairs still found are not in accordance with the beneficiaries ' posture, so it causes another complaint to the beneficiaries.

The actualization of the achievement of the use of tools for services with physical and sensory disabilities (blind, deaf, deaf speech) in 10 indonesian disability centers s in the category is very suitable (58.50%). When referring to the assessment category in the analysis by using the percentage calculation value (%), ≤ 40: very ineffective, 41-55: ineffective, 56-7: moderately effective, 71-85: effective, 86 – 100: very effective. The percentage value of 58.50% for the actualization of the achievement of implementation of aids in 10 research locations in the category is appropriate. The results of the interview with a client that the stick and riglet (those blind sensory disabilities) received from the disability centers is not made of strong materials and does not fit the needs of the client this stick does not fit the posture of the body so that some of the sticks are not used. With impaired deaf and speech impaired, in the use of aids, there is still a problem in the care and size of the hearing aid users. Physically disabled, on the use of wheelchairs, fake hands, prosthetic feet, and other assistive devices still need measurement, the treatment that is appropriate to the condition of the apparatus received.

The evaluation component at the transaction stage is the implementation of mentoring by the social worker in utilizing tools for services of sensory blind, deaf, speech deaf and physical disabilities in 10 Balai Indonesia which is reviewed from the aspect of conformity. It can be presented face Matrix transaction component on the chart below.

Sensory assessment procedures - based primarily on residual capacities - are appraised. Consequences for everyday life are described briefly. Non-sensory, alternative classificatory schemes and procedures are presented and the results from behavior modification procedures used for correcting maladaptive behaviors are summarized. Methods for communicating tactilely are described and evaluated. Attention is also drawn to some suggestions regarding learning of alphabetic codes and sign acquisition. Finally, suggestions for future research are proposed.(Rönnberg & Borg, 2001)

Chart 15. The role of social workers Companion in the use of assistive devices for the disabled (Countenance Matrix component Transaction)

Description Matrix		*Judgment Matrix*	
Intens	Observasi	Standar	*Judgment*
Implementation of mentoring by social workers in utilizing physical and sensory disability aids done per the standards.	The ability to actualize the implementation of tools for services with physical and sensory disabilities (blind, deaf and deaf speech) is 58.50% in the category quite appropriate. Not all standard operational procedures are implemented by the Disability centers in the utilization of AIDS.	Implementation of tools utilization include: Aspects of conformity consisting of: -Safety indicators -Amenity Indicator -Usability indicators -Self-reliance indicators	The implementation of each indicator that starts from the safety indicator in its execution in the category is very appropriate 52.00%. The easy indicator reaches 85.00% in categories very easily. The tool usability indicator on 7.83% with a category is very suitable. Self-reliance indicators are 76.00% in highly independent categories. For suitability, the utilization of the tools reviewed from the four indicators is in a very suitable category. Although the safety indicators are still in small numbers this is due to the discovery of the tools received by the beneficiaries that do not match the posture and condition of need.

According to the community of the disabled, for the condition outside the disability centers , family, the community environment from the interview to the family and explained that the client is still less active in social roles in a residential environment due to lack of confidence in the conditions experienced. Research results on the usefulness of aids for physical and sensory disability services in 10 research locations. The role of a social worker as a disabled companion, among other things, listens to complaints when socializing with friends in the Disability centers through effective communication, explaining the attitudes and feelings and explaining the choice.

The evaluation component of the role of social workers is seen from the usefulness of aids provided for the service of physical and artistic disabilities (blind, deaf, Deaf speech) in 10 disability centers of Indonesia. The following are presented countenance matrix component outcomes. It can be presented in the following chart.

16. Countenance Matrix Component Outcomes

Description Matrix		*Judgment Matrix*	
Intens	Observasi	Standar	*Judgment*
The role of social workers in helping people with disabilities is seen from the usefulness of aids.	The actualization of the utilization of assistive aids is 51.50% in unusable categories. However, some clients use aids in both physical and sensory disabilities (blind, deaf, and deaf) when activities in the disability centers and the neighborhood, because they feel embarrassed and lacking confidence.	The role of the social worker tool utilization should be 100% utilized by the disability.	The results of data collection in 10 locations of disability rehabilitation centers in Indonesia, both physical and sensory defects (deaf, deaf, deaf), the tools provided have not been utilized maximally. Those with disabilities still lack the use of sticks (blind) because of lack of confidence. Low vision clients do not need a stick when in a disability center environment because they are familiar with the location of buildings and facilities and infrastructure at the disability rehabilitation center. The role of social workers has not been maximally helped people with disabilities carry out daily activities, due to lack of education and training, increased ability and knowledge about disability and improved handling skills for persons with disabilities by the changing times.

The tools provided by the disability rehabilitation center are not all clients use or utilize assistive devices. For physically handicapped aids in the form of wheelchairs, sticks,

crutches, feet, and fake hands, walkers, orthopedic shoes are still not utilized in the disability centers environment. It is said that the accepted aids still does not conform to the beneficiary's posture. Inconsistency is the reason clients are reluctant to use tools obtained from the Disability centers. Likewise, in the case of impaired deaf speech with the tools of hearing aid, most of the sensory disabilities are reluctant to use hearing aid aids in both the disability centers environment, shelter and outside the disability centers /home environment.

Persons with disabilities are not comfortable with the tools that are worn because it does not match the equipment and condition of the disability. People with sensory disabilities require the help of sticks, Riglet pens, but Riglet sticks and pens are easily found and cannot be used. for low vision clients the use of sticks is needed outside the disability rehabilitation center, but inside the disability rehabilitation center is not needed because it can still do activities without using tools such as sticks. Some male clients prefer not to use a stick when traveling because the stick makes them lack of confidence, feeling ashamed of uncomfortable and outdated tools.

A. Conclusion

Conclusion of research on the role of social workers for the disabled in the use of tools to support the daily activities are as follows:

1. Planning for the provision of tools for the services of physical and sensory disabilities (blind, deaf and deafness speech) in the appropriate category (80%), but need to pay attention to the provision of aids for the disabled (physical and sensory) starting with assessment and interviews, providing tools through the referral of social workers. Provision of aids through health screening, and thorough measurements, according to the type, size, level of disability, and quality. Need socialization on routine care aids for clients and families.
2. The role of social workers in the application of assistive devices for appropriate categories of clients (58.50%). The role of the social worker has not yet received the client's expectations, because it does not match the client's needs regarding posture. For the sense of disability, the low vision stick category that is given is useless because it is already a very familiar environment.
3. The use of assistive devices by persons with disabilities who can make maximum use of 51.50%. The role of social workers has not been maximized in assisting disability in institutions, so it is necessary to increase the capacity of social workers. The capacity building needed for social workers in rehabilitation centers is through education, training, and social work practices for persons with disabilities to carry out service tasks and handling disabilities

B. Recommendations

Based on the analysis of congruences and contingency, recommended as follows.

1. First, the role of social workers in the planning of providing aids for services with physical and sensory disabilities (blind, deaf and deaf speech) in the disability centers should consider the provision of aids for the disability (physical and sensory) beginning with the assessment and interviewing, providing assistive tools through social workers ' referral, aids thorough medical checkup, provision of aids, through measurements, aids by the type, size, level of disability, and good quality, tools get regular maintenance, get socialization about assistive treatments both in the family.
2. Social workers at the social rehabilitation disability centers are expanding the network to acquire knowledge and experience regarding the procurement of aids for physical and sensory disabilities (blind, deaf, deaf speech) so that the utilization of aids can be social welfare for themselves and their families.
3. The role of social workers as a companion in the implementation of assistive aids should refer to the operational standards of procedures that is adapted to the law and local regulations that exist in the respective region. Utilization of tools should be used to help clients reach the mobility that is in the disability centers , environment and outside the disability centers .
4. Social workers can improve social rehabilitation efforts for the disabled by establishing and building rapport, forming contracts, providing support and encouragement to the disabled, creating and building cooperation with other social workers who support other professions.
5. Social workers in the disability rehabilitation center are expected to cooperate with the local government to know and motivate the client to accept their limitations and encourage more confidently.

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