Sida Evaluation 98/15

Community-based Rehabilitation Programme in Zimbabwe

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F O R E W O R D TO THE EVALUATION REPORT

by the Health Division, Sida

Community-based Rehabilitation(CBR) in Zimbabwe.

According to the United Nations there are more than 300 million persons with disabilities throughout the world. Out of this number around 200 million live in developing countries and only a small fraction has access to services and rehabilitation. In Zimbabwe the number of persons with disabilities(PWDs) is estimated at around 800.000.

CBR is a strategy to reach the majority of PWDs. Experience show that it is possible to meet 60-70% of the rehabilitation needs through the locally implemented CBR.

The World Action Programme for PWDs was approved by the United Nations in 1982, and Sida has worked ever since to integrate rehabilitation issues into its development cooperation. Sweden has also actively supported the elaboration of the United Nations Standard Rules on the Equalization of Opportunities for PWDs, which were adopted by the member states in 1993.

One of the most active repsonses to these ideas in the bilateral development cooperation has come from the Government of Zimbabwe. It was one of the first Governments in Africa to recognize the problem and the need to tackle it. Since Independence in 1980 Zimbabwe has pursued a policy of "Equity in Health" and adopted the Primary Health Care concept to provide basic health services including a comprehensive rehabilitation programme for the disabled.In 1992 a Disabled Persons Act was enacted. The law recognizes the right for all PWDs in Zimbabwe to have access to care and rehabilitation. The law also emphasizes equity concerning rights, opportunities and participation in society, especially as regards education, health care services and social welfare.

The bilateral Health Sector Support Programme between Zimbabwe and Sweden will come to an end in 1999. Since its inception it is estimated that around 34 million SEK have been used from Sida funds, mainly for training and education of relevant staff att district and village levels. During the collaboration period 42 CBR-projects have been established in 31 out of totally 57 districts. Ca 315 Rehabilitation Technicians and 130 Physioterapeuts have been trained.

ACKNOWLEDGEMENTS

The Rehabilitation Unit, MoH&CW, is very grateful to all Provincial Medical Directors, and District Health Executives for allowing the study to be carried out in the selected districts. Gratitude is extended to the Secretary for Health and Child Welfare for permission and support to carry out the evaluation.

The evaluation was supported by a grant from SIDA without which it would have been impossible to carry out any activities. Sincere gratitude is extended to the Swedish International Development Agency (SIDA) for supporting the Ministry of Health and Child Welfare's rehabilitation activities and the Community Based Rehabilitation programme since 1981. Appreciation is extended to all the evaluators who were able to collect all the data over a period of 2 weeks, sometimes under very difficult circumstances. The partnership that the MoH&CW has enjoyed through co-operation with NGOs and other sectors of Government in the evaluation as well as programme implementation has been greatly appreciated.

Special thanks to all people with disabilities and their relatives for willingly giving up their other important duties to participate in the evaluation. Lastly but not least sincere gratitude is extended to all the Local Facilitators without whom there would have been no programme to evaluate where it not for their freely given time and heart.

CONTENTS

APPENDICES :

Abbreviations

CBR	-	Community Based Rehabilitation
EHT	-	Environmental Health Technician
FGD	-	Focus Group Discussion
LF	-	Local Facilitator
MoH&CW	-	Ministry of Health and Child Welfare
MoPSL&SW	-	Ministry of Public Service, Labour and Social Welfare
NGO	-	Non-Governmental Organization
OT	-	Occupational Therapy
PT	-	Physiotherapy
PWD	-	Person with Disability
RHC	-	Rural Health Centre
RT	-	Rehabilitation Technician
ST	-	Speech Therapist
SIDA	-	Swedish International Development Agency
UNESCO	-	United Nations Education, Scientific and Cultural Organization
UNICEF	-	United Nations International Children's Emergency Fund
VCW	-	Village Community Worker
VIDCO	-	Village Development Committee
ZRCS	-	Zimbabwe Red Cross Society
WHO	-	World Health Organization

EXECUTIVE SUMMARY

Community Based Rehabilitation (CBR) was first introduced in Zimbabwe in 1982 when the Zimbabwe Red Cross Society established its first project in Mutoko District, Mashonaland East Province. The Ministry of Health and Child Welfare (MoH&CW) adopted the CBR concept in 1988 when 8 pilot projects were established in each of the 8 provinces. These projects were gradually expanded to more districts and some high density areas in Harare, Chitungwiza and Bulawayo. To date CBR has been established in 31 (54.4%) of the 57 administrative districts in Zimbabwe, covering approximately 47.8% of the total population of Zimbabwe. Some NGOs in Zimbabwe are also running CBR projects.

The evaluation was carried out in 9 CBR districts in Zimbabwe. The main aim of the evaluation was to assess the impact of the programme and its benefits to people with disabilities and their families; and to assess the districts' and communities' capacity to sustain the programme in view of human, material and financial resources.

Quantitative and qualitative data was collected using semi-structured questionnaires for interviews and checklists for focus group discussions and records reviews. All questionnaires were administered by the evaluators who also conducted focus group discussions.

Planning for the evaluation including development and pre-testing of the tools commenced in July 1995 and field activities were effected from 22 April to 3rd May 1996.

Results

A total of 36 focus group discussions and 1 234 interviews were conducted. 801 (64.9%) interviewees were people with disabilities (PWDs) and carers; 232 (18.8%) were local facilitators (CBR volunteers); 99 (8%) Rural Health Centre staff; the rest were policy makers (6.3%), and rehabilitation technicians and therapists (2%). Respondents were interviewed individually and focus groups discussions held with various randomly selected community groups which included community leaders, carers of PWDs, local facilitators and general community members.

The results show that the CBR programme in Zimbabwe has improved the knowledge base of the community in disability issues. 69.7% of PWDs and their families were knowledgeable about their disabilities. 88% had knowledge and understanding about CBR. Most of the local facilitators and RHC staff had knowledge and understanding about CBR (97.4% and 78.8% respectively).

The results also show that CBR has improved service provision to disabled people, their families and the community. 54% of people with disabilities indicated that they had benefitted from the programme by receiving appliances, referral to specialist services and receiving instruction on how to cope with their disability.

47.2% of disabled people reported positive changes in their lives while 42.4% reported changes in the community attitudes towards disabled people as a result of the CBR programme.

63% of the local facilitators expressed increased support from the community, an indication that most communities were supporting the programme. This was also evident from the results of FGDs with community leaders and the community in general.

The evaluation established that :-

1) The referral system was being utilised; the majority of Local Facilitators (ie. 96.1%) reported use of the existing referral structures.

2) Women play the biggest role in looking after disabled people at home and also in the running of the programme in the community. Over 70% of carers were women.

3) Many children with disabilities had reduced schooling opportunities due to mobility problems, long distances to schools, inadequate facilities and poverty.

4) poverty was a major factor within the recipient communities. This had direct implications on the smooth running of the programme.

Although some people with disabilities and their families had acquired knowledge about their disabilities and were benefitting from the programme, the evaluation also identified some weaknesses in training, record-keeping and programme monitoring. Recommendations are made for improvement in the weak areas.

Glossary of Terms

1.	Assistive devices	-	Aids and appliances used by people with disabilities to improve function.
2.	Care-giver	-	The person who has the main responsibility for looking after the person with a disability.
3.	CBR	-	Provision of affordable and accessible rehabilitation services within the community utilizing available community resources. Emphasis is on empowering PWDs and their families with active participation of the families and communities.
4.	Local Facilitator	-	Community worker who implements CBR programme at community level eg. Village Community Worker, Red Cross Volunteer, Community Volunteer. Their role is training families of PWDs.
5.	Person with a disability	-	A person who has a moving, hearing, seeing, learning, feeling or mental disorder which restricts function.
6.	Intermediate Supervisor	-	Refers to nurses at RHC, EHTs, Teachers, Nutrition Co-ordinators, Community Based Distributors.
7.	Project Co-ordinator/Manager		RT or Therapist co-ordinating the CBR programme.

LIST OF TABLES

21. Has the programme been beneficial to you?

22. Have you been provided with an assistive device?

23. Have you ever been referred to any other service?

24. Have you received any instruction on how to deal with your disability?

25. Since the programme started has there been any changes in the lives of PWDs, community's attitudes towards PWDs and community facilities for accessibility?

26. Are you able to move around without difficulty?

27. Do you know of any associations of PWDS?

28. Are you involved in any IGP or club?

29. PWDs/Carers' expectations from the CBR programme

30. What support are you getting from the community in the programme?

31. What support is given by the community towards the programme?

32. What do you do for clients you cannot help in the community?

33a. Did you receive any training in CBR?

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1. INTRODUCTION

1.1 Zimbabwe is a landlocked country within Southern Africa. It shares borders with Botswana on the west, Mozambique on the east, South Africa on the south and Zambia in the north. Although Zimbabwe is mainly agricultural based, there is also mining, manufacturing, construction and tourism. The 1992 population census put Zimbabwe's population at 10.4 million with an annual growth rate of 3.13 percent. The same results show that more than 70 percent of Zimbabwe's population lives in the communal and commercial farming areas.

Zimbabwe is divided into nine administrative provinces which are further sub-divided into fifty-seven districts.(See Fig. 1). The districts are divided into wards and further sub-divided into villages. The administrative and political structures operating in the communal areas are closely interlinked. The health sector has developed along these local governmental structures and has developed services at primary level (Rural Health Centre), secondary (District Hospital), tertiary (Provincial Hospital) and quaternary level (Central Hospitals/Institutions). A two way referral system has been set up as a link of the different levels.

1.2 Health Services

Since Independence in 1980, the Government of Zimbabwe has pursued a policy of "Equity in Health" and adopted the Primary Health Care concept as the desirable method to execute that policy. As part of the government's effort in providing basic health services which are affordable, accessible and acceptable; rehabilitation services have been established at all the four levels of health care. A comprehensive rehabilitation programme which encompasses institutional based care, outreach and community based rehabilitation activities has been adopted. A network of rehabilitation facilities has been set up at district and provincial levels to achieve the goal of health for all by the year 2000.

As part of the decentralisation and expansion of services by the Ministry of Health and Child Welfare a training programme for Rehabilitation Assistants (now Rehabilitation Technicians) was started in 1981. To date, 313 Rehabilitation Technicians have been trained for the Ministry and Non-Governmental Organisations. In 1987, Physiotherapy and Occupational Therapy training was commenced at the University of Zimbabwe in order to further develop the services. 108 therapists (79 Physiotherapists, 29 Occupational Therapists) have been trained to date. Speech Therapists continue to be trained outside the country. To date only 4 Zimbabweans have been trained in Speech Therapy for the Ministry of Health and Child Welfare.Thirty Orthopaedic Technologists and Orthopaedic Assistants have also been trained.

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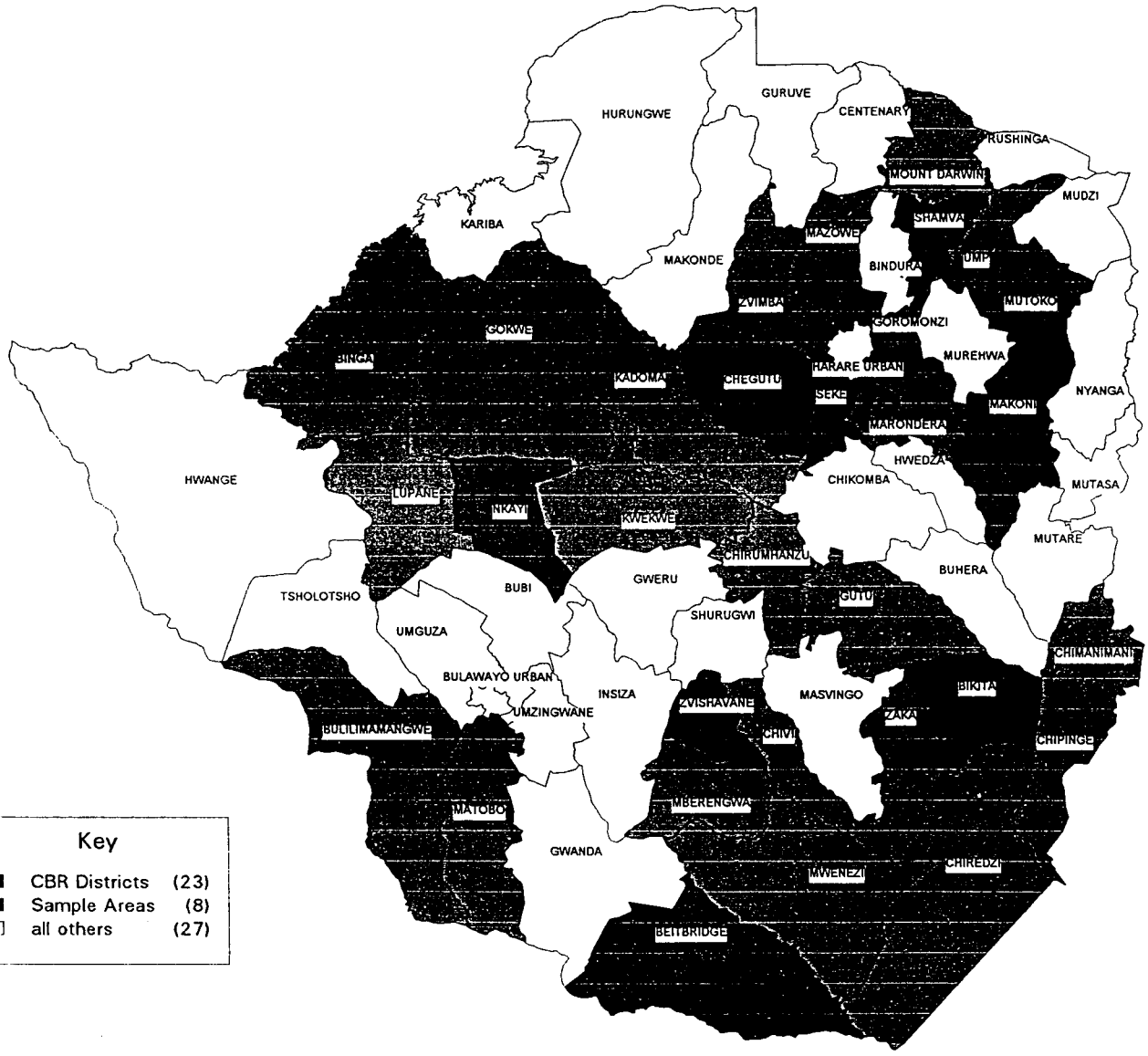
April - May 1996



Note: CBR Districts, districts to which the programme has been introduced to date.

EDC-NHIS Unit, Harare

Although the Ministry of Health and Child Welfare has trained all the various cadres for the rehabilitation services, there has been an unprecedented manpower drain to neighbouring countries and abroad. Effectively the Ministry of Health and Child Welfare has 64 Therapists, 149 Rehabilitation Technicians, 20 Orthopaedic Technologists in its various institutions.

1.3 Disability Survey and Community Based Rehabilitation

In 1981, the Ministry of Labour, Manpower Planning and Social Welfare in conjunction with the Ministry of Health and UNICEF conducted a disability survey to determine the number of people with disabilities in Zimbabwe. The survey revealed from the samples studied that there were 276 000 disabled persons in the 23 out of 55 selected districts of the country. Of the 276 000 people identified by the survey, 3.7% needed rehabilitation services. This figure is also comparable to the figure of 3% which is estimated by the World Health Organization as the number of people needing rehabilitation services in any given population. The population of Zimbabwe at the time stood at 8 million. The survey indicated that visual, lower-limb, upper-limb, mental, hearing and speech problems were the most common in Zimbabwe. The age group most affected was the 16 to 25 years and disease was the main causative factor. There was therefore a strong indication from the survey that appropriate and early interventions, in terms of service provision, were required in order to provide assistance to people with disabilities. To this effect CBR was chosen as the appropriate strategy to address the situation.

1.4 Definition of Community Based Rehabilitation (CBR)

There are several definitions of CBR and the one that has been adopted in Zimbabwe is described in a joint position paper (1994) by International Labour Organisation (ILO), UNESCO and World Health Organization. This states CBR "as a strategy within community development for the rehabilitation, equalisation of opportunities and social integration of all people with disabilities".

Einar Helander described CBR as "a strategy for enhancing the quality of life of disabled people by improving service delivery, by providing more equitable opportunities and by promoting and protecting their human rights".

At community level CBR is an integral part of community development and relies, as a result, on mobilization of local resources and focus on the family of the disabled as the most important resource.

1.5 CBR in Zimbabwe

The first CBR projects in zimbabwe were initiated by the Zimbabwe Red Cross Society in 1982 (Mutoko district) and in 1986 (Gutu district) and later handed over to the Ministry of Health and Child Welfare. In 1987 a CBR project was established by the Ministry in Zimuto in Masvingo province on a small scale. The concept of CBR in Zimbabwe was then adopted by the Ministry of Health and Child welfare on a national scale in 1988. The first phase was the implementation of 8 pilot projects in each of the 8 provinces. The programme then gradually expanded to more districts within the provinces.

The setting up of the 8 pilot projects ran over a four-week period following the format shown in Table 1 below. This format was later used as a guideline for all subsequent projects.

Table 1 Format for Launching CBR

Week 1	Introduction of the programme to the community and community leaders: raising awareness through training workshops
Week 2	Training of local facilitators to identify and train disabled people
Week 3	House-to-house survey by the local facilitators to identify people with disabilities
Week 4	Screening of people with disabilities by a rehabilitation/medical team

After screening, the programme continued in the form of home visits, rehabilitation villages, follow-up, further referral and continued development of community participation in the programme encompassing income generating projects. All this has been achieved through co-ordination and networking with different agencies.

In 1990, The CBR Monitoring Committee comprising of therapists and rehabilitation Technicians involved in CBR carried out a rapid assessment of the 8 pilot projects. The rapid assessment revealed positive results of the programme in aspects of early identification and referral and increased awareness about disability and rehabilitation within the recipient communities. Recommendations for further expansion were made from this study.

In 1991, an external evaluation, jointly commissioned by the Swedish International Development Agency (SIDA) and the Ministry of Health and Child Welfare (Zimbabwe) was done on the Ministry's rehabilitation services. The evaluation concluded that CBR was an acceptable and suitable method of service delivery in Zimbabwe. It was also recommended from this evaluation that SIDA should continue to support the implementation of CBR projects in Zimbabwe.

1.6 CBR Coverage

CBR coverage in this report is described in terms of the geographical areas and the populations in which the programme has been established to date. CBR has been introduced in 31 (54.4%) of the total (57) districts in rural Zimbabwe (See Fig 1). Three urban programmes have also been established in Harare and Bulawayo. Coverage in terms of population benefitting from the programme is 5 514 729 (47.84%) of the total population (11 256 258) of Zimbabwe. If expansion continues at the present rate, the goal of the Rehabilitation Unit (MOH&CW) to have introduced the programme in every district in the country by the year 2005 will be achieved.

1.7 Funding for CBR

Funding for the initial launching of the programme has been provided by SIDA and the Ministry of Health and Child welfare. The specific areas of assistance from SIDA have been:-

- Provision of facilities for rehabilitation; rehabilitation villages, rehabilitation departments and staff houses.
- Funds for training activities in the community and capacity building.
- Provision of aids and appliances for clients to facilitate integration and independent living.
- Transport during the implementation period.
- Funds for income generating projects for the benefit of clients in the CBR area.
- Adaptations in the home and school.

The recurrent expenditure, mainly in funding follow-up activities and staff salaries and allowances has remained the responsibility of the MOH&CW. Once launched, the programme becomes absorbed into the other district activities.

2. PURPOSE OF THE EVALUATION

To establish how the CBR programmes in Zimbabwe are running and to use the results in the planning and management of future programmes.

2.1 General Objective

To evaluate the **impact** and **sustainability** of the CBR programme and its **benefits** to people with disabilities.

2.2 Specific Objectives

2.2.1 To establish whether CBR has facilitated the empowerment of people with disabilities in social integration, equalization of opportunities and self actualization.

2.2.2 To assess the knowledge and perception of the community, client, care giver, family on CBR.

2.2.3 To determine the accessibility of the community environment to people with disabilities.

2.2.4 To assess provision and utilization of assistive devices and appliances and their effects on functional ability.

2.2.5 To determine the CBR coverage in relation to population and geographical areas.

2.2.6 To ascertain community participation in the CBR programme.

2.2.7 To determine whether the MOH&CW CBR programme operates in co-ordination and partnership with other government sectors, non-governmental organizations and community structures.

2.2.8 To establish tools used in the monitoring and evaluation of the CBR programmes.

3.2.9 To establish whether the programme can be sustained at all levels in terms of: training, resources, commitment and utilization of the referral system.

2.2.10 To make recommendations for future interventions.

3. LITERATURE REVIEW

Various studies and evaluations of Community Based Rehabilitation have been conducted in Zimbabwe by both local and foreign people. (See Appendix 2). Other countries in Africa such as Swaziland, Botswana, Lesotho, Kenya (to name a few) have also introduced the Community Based Rehabilitation strategy as a method to reach the majority of people with disabilities. They too have conducted evaluations/studies of their programmes but there is very little exchange of information in this respect.

The information below summarises four (4) studies and evaluations that have been conducted on CBR in Zimbabwe.

3.1 A Report on Eight Community Based Rehabilitation Projects

This study was done in 1990 by the CBR Monitoring Committee within the MOH&CW Rehabilitation Unit six months after the implementation of the first 8 pilot projects. The study focused on the format and utilization of resources in the implementation of the new projects.

Various community members and health workers in the project areas were interviewed.

The results and findings of this study indicated that:

- the majority of people with disabilities identified by the projects had not had any previous contact with rehabilitation services. Many needed assistive devices.
- the community had some commitment in the programme

3.2 Community Based Rehabilitation Evaluation Report: Zimbabwe Red Cross Society

This study was done over a 3 week period in 1993 by a six (6) member team from MOH&CW, Ministry of Public Service, Labour and Social Welfare, WHO, Norwegian Red Cross and International Committee of the Red Cross.

The evaluation focused on ascertaining the degree of community involvement, commitment and participation in the Red Cross run CBR programmes at various levels.

Three projects were evaluated in three different districts in Masvingo, Mashonaland East and Matabeleland South.

From the interviews carried out the evaluation established that:
- most volunteers were young and short lived in the programmes
- problems of market, resources and lack of skills were experienced in implementing income generating activities
- the community had gained understanding about disability

The evaluation recommended expansion of CBR to more areas.

3.3 The Impact of Community Based Rehabilitation in Zimbabwe : "The Clients' Point of View"

This study was conducted in 1993 by H Myezwa in Shamva and Mount Darwin districts of Mashonaland Central. The objective of this evaluation was to look at the impact of CBR from the clients' point of view. The areas of concern in the evaluation focused on:-

- the number of people with disabilities identified in CBR.
- the view of client towards the service.
- the sustainability of the programme by the community.

Focus Group Discussions and structured interviews using a questionnaire were used to collect qualitative and quantitative data. The evaluation established that:

- CBR had a positive impact on the communities studied
- Knowledge and skills gained positively influenced the communities' attitudes towards disabled people.
- there was need to do more for strange behaviour and learning disabilities.
- inadequate knowledge by local facilitators and community leaders adversely affected community participation.

3.4 A Survey of Follow-up of Clients and the Functioning of Home Based Programmes

This study was carried out by two students from Holland. Focus was on analysing follow up procedures for CBR clients and the functioning of the home-based programmes through interviews with Rehabilitation Technicians, Local Facilitators and care-givers. Records were reviewed using a structured form.

430 children in the age-group (5 - 14 years) constituted the sample.

The major findings of the study were that :-

- Rehabilitation staff were unable to follow-up all the clients identified.

- Those clients who had been followed up had few repeat visits in districts where the total number of identified clients was large.

- The record keeping at community level by the Local Supervisors was insufficient.

This study recommended that there was a need for more training about the CBR programme for the Local Supervisors.

This study had its own limitations in that interpreters were used to conduct the interviews and the responses may not have been accurate.

Conclusion

All four studies conducted identified some weaknesses and made recommendations on how to improve the different CBR programmes. However, the studies were done on a small scale and focused mainly on the benefits of the programme to PWDs and aspects related to the follow up of the clients.

4. JUSTIFICATION

The above studies/evaluations have looked at service delivery and the views of the clients on the CBR programme. There was however a need to evaluate the programme in terms of :-

- the adequacy of CBR in addressing the needs of people with disabilities.
- the equalization of the rights and opportunities of people with disabilities.
- level of co-ordination and partnerships with other agencies involved in CBR.
- level of community involvement

It was also within the initial plans of CBR, to evaluate the programme periodically in view of future operations and sustainability.

5. PROCEDURE AND METHODOLOGY

Methodology

The evaluation was carried out in stages as follows:

5.1 Planning

Three planning meetings involving representatives of rehabilitation personnel from the eight provinces and central hospitals were held between July and October 1995. The purpose of the meetings was to introduce the proposed evaluation to get views of all involved people before concluding terms of reference and objectives of the proposed evaluation.

At the third meeting a Core Group was appointed with the following terms of reference:

a. Developing the evaluation tools and finalising proposal
b. Act as moderators during data collection
c. Analysis of data and writing the evaluation report

The core group, under the chairmanship of the Chief Therapist, met for one week in December 1995 to develop the tools and finalise the evaluation proposal. The team met again in March to develop the training programme for evaluators and guidelines for field activities.

5.2 Selection and Training of Evaluators

9 teams of 5 people each selected from the following departments and organisations in each province, formed the evaluation team:

NGO for or of disabled people x 1
Department of Social Welfare or Ministry of Education x 1
MOH&CW Rehabilitation department x 2
MOH&CW Health Information department x 1

Each team had a vehicle and a driver for the data collection period. Each team evaluated the programme in its own province. (This was done to reduce logistical problems)

A one day workshop was held to train the evaluators. The purpose was :

a. To give a briefing on CBR in Zimbabwe
b. To discuss Terms of Reference and Objectives of the evaluation.
c. To go through all the instruments and guides.
d. To translate the questionnaire contents into Shona and Ndebele for easy reference.

5.3 Evaluation Sample and Population

Random sampling of project districts was not possible due to logistical problems. (Evaluation coincided with the malaria season). Districts were selected using the following criteria:

a. CBR programme had been in existence for 2 years or more.
b. Logistics in the district were favourable for completion of data collection.

Final composition of sample was 8 rural districts in each of the 8 provinces and one urban programme in Harare.

Sampling and Sample Size

Based on existing CBR reports and the above-mentioned criteria, each team was expected to identify and interview respondents from the entire CBR catchment area as follows:

- 100 people with disabilities randomly selected from the district hospital disability register
- All available Local Facilitators
- All available Intermediate Supervisors
- All available Policy Makers
- Community members randomly selected

Each team was instructed to conduct 4 Focus Group Discussions (FGDs) from the following categories of respondents:

- Community leaders
- Local Facilitators
- Parents/carers of PWDs
- Community at Large

5.4 Data Collection Techniques and Tools

Data collected was both qualitative and quantitative using the following tools:

	Technique	Tool
1.	Focus group discussion	checklist
2.	Interviews	questionnaire
3.	Review of records	checklist
4.	Observation	checklist

A total of 3 semi-structured questionnaires and 3 interview guides were used in the evaluation.

5.5 Data Collection

Procedures

District Health Executives (DHEs) in the selected districts were informed of the intended evaluation and its objectives in advance.

On the first day in the field meetings were held with the local facilitators and community leaders to inform them of the purpose of the evaluation and the procedures that were to be followed for client/carer interviews and focus group discussions. The working programme for the 12 days data collection period was developed from these meetings.

Interviews were carried out at pre-arranged meeting points and respondents' homes. Criteria for home interviews was based on either convenience to the evaluation team or the respondent.

Focus Group Discussions (FGDs) were conducted at meeting points. One person was appointed to take notes during FGDs. Data collection lasted 12 days.

5.6 Data Handling and Analysis

In the field, team leaders, (Provincial Therapists) were responsible for the safety and upkeep of data.

The team leaders met for 2 weeks for merging, post coding and data analysis. Two Health Information Clerks were engaged for the same period for data entry and analysis.

EPI INFO was used in analysing data from questionnaires. Responses from FGDs and other interviews were manually analyzed and summarised.

5.7 Limitations

1. The scattered settlement pattern in most villages made it logistically impossible to interview all respondents in their homes. Most respondents had to be brought to a central point and this posed problems if respondents did not bring hospital cards and other information to the point.

2. Timing : Data collection coincided with malaria season hence sample areas had to be conveniently selected.

3. Enumerators without adequate rehabilitation knowledge had limitations during the interview process.

6. FINDINGS AND DISCUSSION

Presentation of findings is according to the evaluation's broad objectives of impact, benefits and sustainability.

6.1 Summary of Sample Areas

The sample areas were 8 districts; one in each of the 8 provinces and one urban district as in Table 2 below. Fig. 1 illustrates their location.

Table 2 Evaluation Sample Areas

PROVINCE	DISTRICT	TOTAL No. OF WARDS EVALUATED
Matabeleland North	Nkayi	3
Matabeleland South	Beitbridge	25 (entire District)
Masvingo	Bikita	3
Mashonaland West	Sanyati	3
Mashonaland East	Seke	8
Mashonaland Central	Shamva	2
Manicaland	Nyamidzi	2
Midlands	Zvishavane	18
Chitungwiza	Chitungwiza	4
TOTAL	9	68

6.2 Summary of Respondents by Province

In the 68 wards that the evaluation was carried out, a total of 1234 people were interviewed. This number excludes participants in Focus Group Discussions (these were not individually enumerated). (1 093) 89.2% of the respondents were from the rural areas. Table 3 below shows the distribution of respondents.

Table 3 Respondents by Province

PROVINCE	No of Wards Covered	PWDs/ Carers	Local Facilitators	Intermediate Supervisors	Program Manager	No. of Policy Makers
Mat North	3	97	44	3	2	11
Mat South	25	50	6	8	1	12
Masvingo	3	95	47	10	1	7
Mash West	3	68	26	29	2	16
Mash East	8	100	27	24	2	8
Mash Central	2	103	13	2	1	3
Chitungwiza	4	95	22	7	4	5
Manicaland	2	100	18	7	2	10
Midlands	18	93	29	9	9	6
TOTAL	68	801	232	99	24	78

20 of the programme managers were Rehabilitation Technicians (RTs) and 4 were Therapists. Intermediate supervisors included Environmental Health Technicians, nurses, teachers and nutrition co-ordinators. The 78 policy makers were interviewed at district and provincial levels. These included representatives from Government departments and NGOs dealing with disability (see Appendix 4). Focus group discussions were carried out with different community groups as detailed in Appendix 4.

6.3 Characteristics of Respondents (PWDs/Carers)

6.3.1 Table 4 Respondents by Category

TYPE OF PERSON	FREQUENCY	%
Person With a Disability	431	53.8%
Care Giver/Family Member	369	46.1%
Other xx	1	0.1%
Total	801	100%

Fig.2

xx VCW looking after person with disability

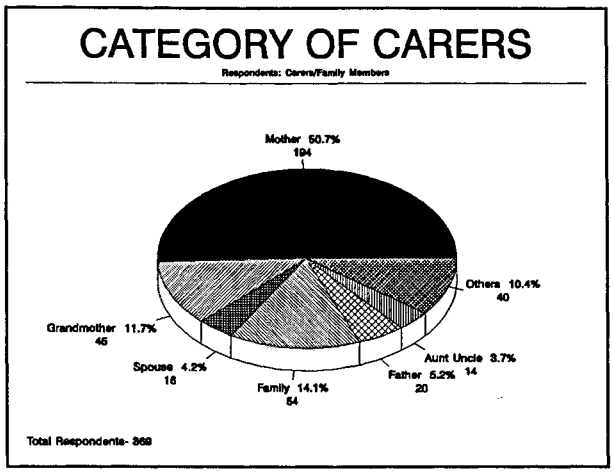


Fig. 2 shows the category of respondents.

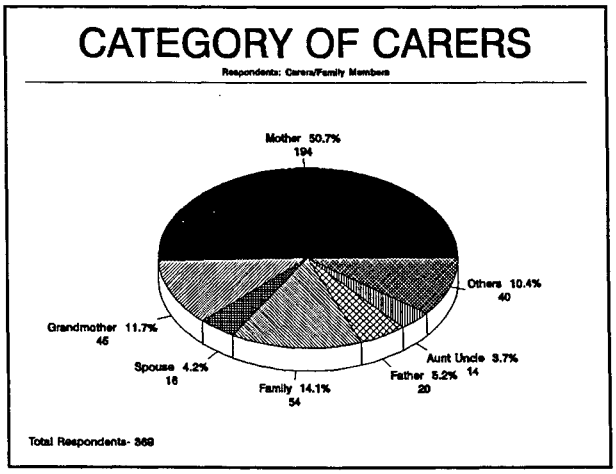
In the PWD/Carer group the majority 431 (53.8%) of the total respondents were PWDs and 369(46.1%) were carers. One respondent was a VCW looking after a PWD from her community (Table 4).

Table 5 Carers by Category

CATEGORY OF CARER	FREQUENCY	%
Mother	194	52.6%
Grandmother	45	12.2%
Spouse	16	4.4%
Father	20	5.4%
Family Member **	54	14.6%
Others	40	10.8%
Total	369	100%

** Member of immediate family (brother, sister, son, daughter)

Fig.3



In the carer category, the mothers 194 (52.6%) of the total (369) played the biggest role in caring for PWDs followed by other family members (14.6%) and grandmothers (12.2%).

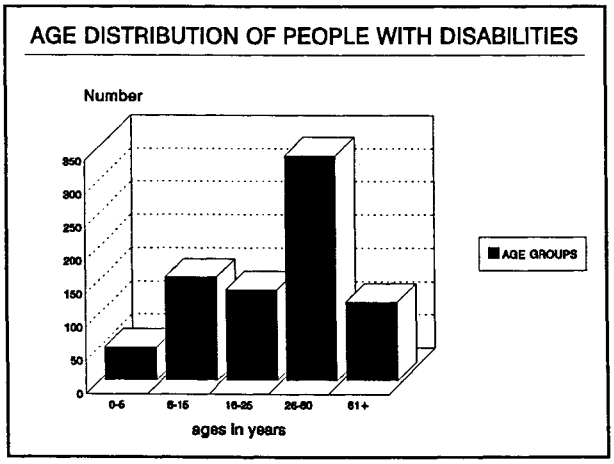
Where a spouse was the main carer, the majority (13) were wives looking after husbands. It is evident from the results that women have the responsibility of taking care of PWDs. This is in line with cultural expectations (about a woman's role) in the Zimbabwean society. Other people like uncles, aunts and in-laws also took care of PWDs. This is not surprising because in Zimbabwe the extended family is expected to look after relatives. However the result points to the need for the programme to focus on women's needs . 20 fathers were caring for a PWD (spouse or son in most cases). (See Fig 3).

6.3.2 Table 6 Age Distribution of People with Disabilities

AGE IN YEARS	FREQUENCY	%
0 - 5	49	6.2%
6 - 15	155	19.5%
16 - 25	136	17.1%
26 - 60	338	42.4%
61 Years and Above	118	14.8%
Total	796	100%

Age was not specified for 5 respondents.

Fig.4



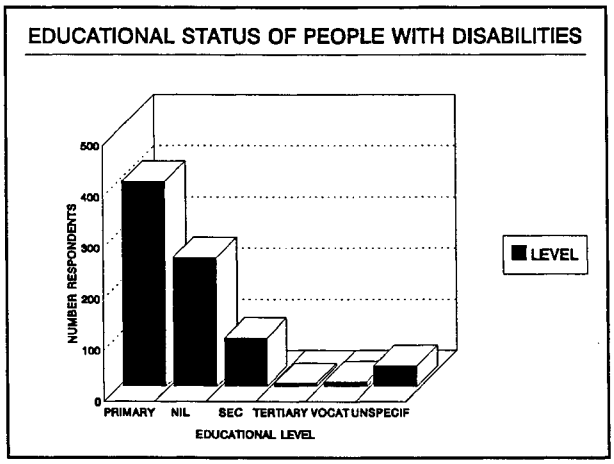
The majority 338 (42.4%) were in the 26 - 60 years (active working age group), followed by the schooling (6-15) age group (19.5%) and vocational training (16-25) age group (17.1%). (See Fig 4).

6.3.3 Table 7 Educational Status of PWDs

EDUCATIONAL STATUS	FREQUENCY	%
No Education at All	251	33.0%
Primary Education	401	52.7%
Secondary Education	94	12.3%
Tertiary Education	6	0.8%
Vocational Training	9	1.2%
Total	761	100%

The majority of PWDs (52.7%) had done primary education only, with many having done two to four years of primary education. Many children were not attending school due to financial problems. 251 (33%) had no education at all, 94 (12.3%) had secondary education and only 6 (0.8%) and 9 (1.2%) had done higher education or vocational training respectively. (See Fig 5).

Fig.5



It is evident that the majority of PWDs have limited schooling opportunities and those who have had the opportunity have only attained primary education. Apart from financial problems some of the major reasons for not attending school were:-

1. mobility related problems in moving disabilities
2. distances to schools in the community
3. teachers failing to cope with certain disabilities, eg. learning disabilities, seeing and hearing/speech disabilities.

6.3.4 Table 8 Marital Status of PWDs

MARITAL STATUS	FREQUENCY	%
Divorced	39	5.1%
Married	251	32.6%
Single	406	52.7% ***
Widowed	74	9.6%
Total	770	100%

*** The figures are inclusive of all age groups.
The evaluation did not seek to establish relationships between disability and marital status.

6.3.5 Table 9 Economic Status of PWDs

ECONOMIC STATUS	FREQUENCY	%
Destitute	577	72%
Not Destitute	195	24.4%
Not Indicated **	29	3.6%
Total	801	100%

** It was difficult to establish destitution in some households in urban centres (Chitungwiza).

577 (72%) were found to be destitute. For the purpose of the evaluation 'destitution" was defined as any household situation which was dependent on Social Welfare Assistance or well wishers for basic survival. For those who were described as 'not destitute', 195 (24.4%), they earned their living through; formal employment (few), peasant farming (majority) or were being supported by their employed grown up children.

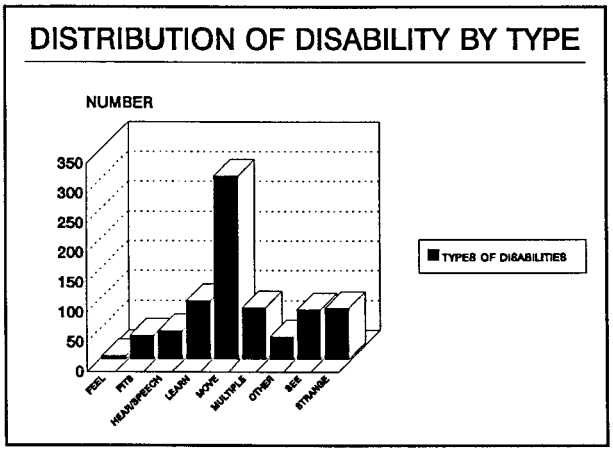
The evaluation established that poverty was a major factor within the recipient communities. This has direct implications on the smooth running of the programme because if one's basic needs are not fulfilled they may not prioritise on their rehabilitation needs.

In relation to this, the major expectations expressed by respondents in all disability categories were mainly basic needs such as food, clothing and money.

6.3.6 Table 10 Distribution of Disability by Type

Disability Type	Frequency	%
Lack of Feeling in (Hands&Feet)	6	0.8%
Fits	40	5.0%
Hearing and Speech	48	6.0%
Learning	99	12.4%
Moving	308	38.7%
Seeing	84	10.6%
Strange Behaviour	86	10.8%
Multiple	87	10.9%
Other	38	4.8%
Total	796	100%

Fig.6



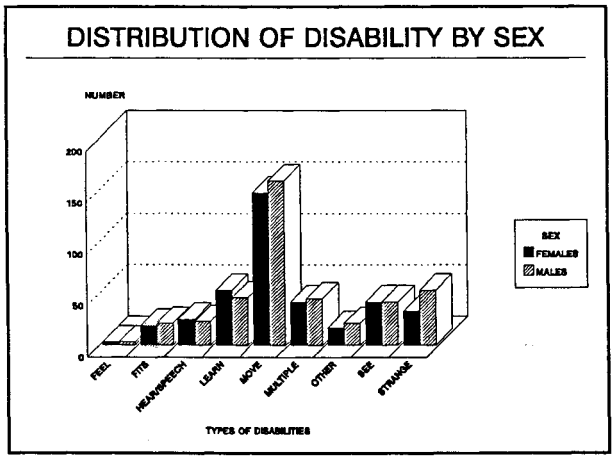
Categorising of disabilities was based on the WHO guideline in the Manual "Training the Disabled in the Community" and all the 8 anticipated types of disabilities were identified during the evaluation. As shown in Table 10 the commonest type of disability was moving difficulty 308(38.7%) of the total (796) followed by learning (12.4%), multiple (10.9%), strange behaviour(10.8%) and seeing (10.6%). The most common conditions in Moving Disabilities were amputations, clubfeet, polio and old fractures.The least common disability was lack of feeling (0.8%). The low incidence in this category could be an indication of the success of the Leprosy Programme in Zimbabwe. (See Fig 6).

6.3.7 Table 11 Distribution of Disability by Sex

TYPE OF DISABILITY	FEMALE	MALE	TOTAL
Lack of Feeling	3	3	6
Fits	19	21	40
Hearing and Speech	25	23	48
Learning	53	46	99
Moving	148	160	308
Multiple	42	45	87
Other	17	21	38
See	42	42	84
Strange Behaviour	33	53	86
Total	382	414	796

The sex distribution was almost equal for all disabilities except in the strange behaviour category in which males 53(61.6%) were more than female 33(38.4%). (See Fig 7).

Fig.7



6.3.8. Table 12 Distribution of Disability by Age

Type of Disability	0-5 Yrs	6-15 Yrs	16-25 Yrs	26-60 Yrs	61+ Yrs	Total
Lack of Feeling	0	0	1	5	0	6
Fits	0	9	9	20	1	40
Hearing/Speech	6	16	15	11	0	48
Learning	10	26	27	34	2	99
Moving	18	51	47	140	52	308
Multiple	11	22	15	28	11	87
See	1	8	6	27	36	84
Strange Behaviour	0	12	7	63	4	86
Other	3	11	9	10	5	38
	49	155	136	338	118	796

For analysis respondents' ages were grouped in the following categories:

0-5 yrs Pre-school Age
6-15 yrs School going Age
16-25 yrs Vocational Training Age
26-60 yrs Working Age group
61+ Old age

This kind of grouping is useful for the Rehabilitation Unit to come up with relevant intervention strategies.

In the pre-school age group some disabilities may not have been identified at this stage and may only be discovered when the child starts school when learning and emotional problems become prominent. This is the time when parents/carers seek assistance. Within CBR special emphasis is put on children because for them the disability means a life long problem (Helander, 1981). Similarly the CBR programme in Zimbabwe places special emphasis on the rehabilitation of children below 5 years and those of school going age (5-14yrs) in order to increase their future prospects.

The highest number of respondents is in the working age group. This may be because this group is able to make its own decisions and will seek assistance pertaining to their disability.

6.4 CHARACTERISTICS OF RESPONDENTS (LOCAL FACILITATORS)

6.4.1 Table 13 Type of Worker and Sex

TYPE OF WORKER	F	M	FREQ	%
Red Cross Volunteer	21	0	21	9.1%
VCW	158	7	165	71.1%
Other Volunteer	41	5	46	19.8%
TOTAL	220	12	232	100.0%

232 Local Facilitators participated in the evaluation. The majority 220 (94.8%) were female. This is in line with women's role in the Zimbabwean society. It is much easier for a woman to enter and be welcomed into people's homes than it is for a man. There were only 12 (5.2%) men.

The majority 165(71.1%) were Village Community Workers(VCWs) who receive an allowance of Z$70 (US$7) per month from Government. These workers are already responsible for community development activities under the Ministry of National Affairs, Employment Creation and Co-operatives. Their main role is community mobilization, motivation and caring for ill/disabled people in the community. All Government Departments and NGOs who have community programmes involve the VCW. This result has positive implications on the sustainability of the CBR programme in Zimbabwe . The programme relies heavily on this cadre and experiences to date have shown that VCWs are a more reliable worker than other unpaid workers whose drop out rate is very high.

46 (19.8%) were other volunteers and these included people selected by the community such as faith healers, general community members, traditional midwives, council workers. Red Cross Volunteers constituted 9.1% of the Local Facilitators.

6.4.2 Table 14 Age of Local Facilitators

AGES	No. OF RESPONDENTS	PERCENTAGE
20-35 yrs	52	22%
36-50 yrs	137	59%
51 yrs and above	36	16%
Age not specified	7	3%
TOTAL	232	100%

The highest number of local facilitators were in the 36-50 years age group. This is not a surprising finding because local facilitators are selected by the community on the basis of their motivation, innovation and leadership qualities in community activities. Most people in this age group will have already been established in their communities and shown their abilities to the community leaders.

6.4.3 Table 15 Economic Status of Local Facilitators

ECONOMIC STATUS	FREQUENCY	PERCENT
Paid	175	75.4%
Unpaid	57	24.6%
TOTAL	232	100.0%

Of the 175 (75.4%) who responded that they were being paid, 165 were VCWs receiving an allowance from Government and the remaining 10 were being paid by some NGOs involved in CBR. The rest (24.6%) were not receiving any allowance at all.

6.4.4 Table 16 Educational Status of Local Facilitators

EDUCATIONAL STATUS	FREQUENCY	%
Primary	174	75.7%
Secondary	55	23.9%
Other	1	0.4%
Total	230	100%

Educational Status was not stated for 2 respondents.

Of the 230 respondents, the majority 174 (75.7%) had primary education and 55 (23.9%) had secondary education. One of the pre-requisites to be selected as a VCW or Home Educator is the ability to read and write in vernacular and/or English. Local Facilitators are expected to keep a register and write regular reports on community activities that they are involved in. This also is important for monitoring and evaluation of the programme.

All Local Facilitators contacted had basic reading and writing skills.

6.4.5 Table 17 Length of Time in CBR Programme (Local Facilitators)

LENGTH OF TIME IN PROGRAMME	FREQUENCY	%
Under 1 year (3-12 months)	31	13.4%
1 - 2 years (13-24 months)	79	34%
2 - 3 years (25-36 months)	41	17.7%
3+ years (37-99 months)	81	34.9%
Total	232	100%

The local facilitators had been in the programme for periods ranging from 3 months to 99 months. The majority 201 (86.6%) had been in the programme for more than 1 year.

6.5 IMPACT

To assess impact, the Questionnaires covered the following areas:-

- Knowledge and understanding about disability;
- Respondents' perceptions of CBR;
- Role and contribution to the programme and;
- benefits gained from the programme.

Knowledge and Understanding about Disability

PWDs/carers were asked to comment on whether they had knowledge and understanding about their 'disability'. Those who responded positively were further asked to comment on the type of knowledge they had acquired. The results are summarised in Tables 18a and 18b below.

6.5.1 Table 18a Knowledge and Understanding About Own Disability

RESPONSES	No. OF RESPONDENTS	%
Yes	558	69.7
No	209	26.1
No response	34	4.2
Total	801	100

209 (26.1%) of the respondents said that they had not gained any knowledge about their disabilities, the majority (69.7%) knew about their disability. On 34 (4.2%) of the questionnaires, no response was indicated. Those who knew mentioned several areas in which they had gained knowledge concerning their disability.

Table 18b Type of Knowledge Gained About Disability

TYPE OF KNOWLEDGE	No OF RESPONSES
Cause of disability	203
Signs and symptoms	83
Treatment	114
Prevention of disability	7
Prognosis	85
Other	92

As shown in Table 18b above, the prominent areas were ; Causes of Disability (203), Signs and Symptoms (83), Treatment (114) and Prognosis (85). Very few people (7) mentioned Prevention of Disability. The reason could be that most conditions were non degenerative and hence this aspect of the rehabilitation process did not apply. It is also possible that only 'Primary Prevention' and not 'secondary or tertiary' prevention were emphasised.

The results indicate that most people in the programme are knowledgeable about their disabilities. This has positive implications on the involvement/participation of CBR clients in the programme. The results also point to a need to place emphasis on disability prevention during awareness training activities.

6.5.2 Knowledge About CBR

CBR clients (PWDs and Carers), Local Facilitators and Intermediate Supervisors were asked to explain what they know about CBR. Responses from clients and local facilitators were classified into 7 areas as given in Table 19 by category. Perceptions of the Intermediate Supervisors are summarised separately.

6.5.2.1 Table 19 Respondents' Perceptions of CBR

CATEGORY OF RESPONSE	FREQUENCY BY	
	PDWs/CARERS	LOCAL FACILITATORS
1. Do not know/understand	96 (12%)	6 (2.6%)
2. Assistance for PWDs in Community/Home	190 (23.7%)	125(53.9%)
3. Community involvement in caring for PWDs	33 (4.1%)	21 (9.1
4. Follow-up by rehabilitation staff	23	7
5. Integration of PWDs in society	13	28
6. Helping PWDs to be self-reliant/independent	66	42
7. Provision of appliances to PWDs	15	20
8. Referral of PWDs to other services	-	11

96 (12%) of the respondents in the PWD/Carer category and 6 (2.6%) of the local facilitators did not know or understand about CBR. The 6 local facilitators who said they did not understand about CBR might have joined the programme at a later stage and did not receive any training. This may indicate some shortcoming in the programme in the area of training. The majority of the respondents in both categories however had knowledge and understanding about CBR as shown by the range of responses in Table 19. The three most significant areas were:

1. Assistance for PWDs in community/home
2. Helping PWDs to be self-reliant and independent (Community Education and self-promotion)
3. Community involvement in caring for PWDs.

6.5.2.2 Perceptions of CBR by Intermediate Supervisors

78 (78.8%) of the total (99) intermediate supervisors indicated that they knew about the existence of the CBR programme and that they understood the concept of the programme. 21 (21.2%) said they had no knowledge about CBR. For the majority who indicated knowledge about CBR, the prominent responses were;

a) provision of disability services at the community level
b) referral of PWDs to higher institutions
c) the family play a key role in the rehabilitation process
d) Training of PWDs in various projects.
e) counselling and support to mothers and care givers of PWDs
f) programme helping PWDs to be independent
g) encourage PWDs in community activities
h) programme that integrates PWDs into the community and promotes IGPs
i) provision of aids and appliances
j) adaptations of public facilities for accessibility
k) encourage schooling for young disabled
l) identified disabled people in the community are treated by rehabilitation
people
m) helping disabled in the community without referring them to national institutions.

Most of the responses focused on provision of services in the community, referral of PWDs and family involvement. It should be noted from the above responses that although the majority said they knew about CBR a high proportion of the explanations indicated good knowledge on the rehabilitation processes but were not specific to CBR.

6.5.3 Role and Contribution in CBR

PWDs, their carers and Local Facilitators were asked to comment on what they understood to be their role in the CBR programme. The responses were categorised into 6 areas as shown in Tables 20a and 20b below.

6.5.3.1 Table 20a Perceptions of PWDs/Carers of their Role in CBR

TYPE OF ROLE/CONTRIBUTION	NO. OF RESPONSES
1. No Role/Contribution	287 *
2. Assisting/involvement in IGP	60
3. Identifying and referring PWDs to services	18
4. Recipient of rehabilitation services	60 *
5. Family trainer	151
6. Other	77

287 (35.8%) of PWDs/Carers said they had no role or contribution in the programme. 60 (7.5%) perceived their role as that of 'Recipient of Services'.

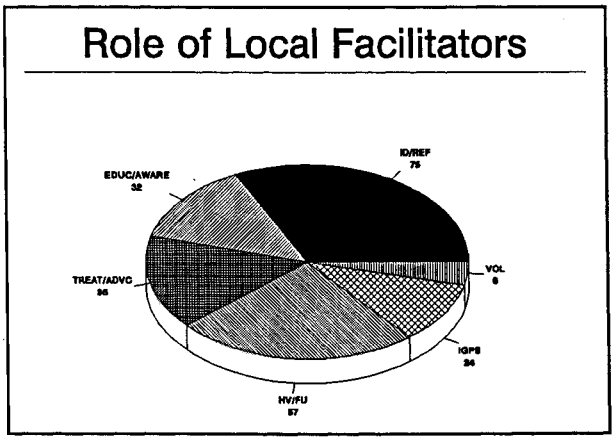
The other roles mentioned in descending order of frequency were 'Family Trainer'(18.9%); Other Roles (9.6%); Assisting in IGPs (7.5%). Identification and Referral was the least mentioned (only 2.2%). These results indicate that a high proportion of PWDs and their carers did not see themselves as having an active role in the overall programme. However the mention of roles of 'Family Trainer' and 'Involvement in IGPs' by others show that involvement in the programme is limited to assisting the individual in the family with little or no participation in community activities. This could be indicative of the fact that PWDs and their families are still marginalised and therefore not always involved in the planning and decision making processes in the community.

6.5.3.2 Table 20b Perceptions by Local Facilitators of Their Role in CBR

ROLE/CONTRIBUTION		RESPONSES
1.	Identification and referral	75 (32.3%)
2.	Education and awareness raising	32 (13.8%)
3.	Treatment and advice	36 (15.5%)
4.	Home visits/follow-up	57 (24.6)
5.	Organizing and monitoring IGPs	24 (10.3%)
6.	Co-ordinator/volunteer	9 (3.9%)

The most stated role by the local facilitators was that of identification and referral (32.3%). The next most stated role was that of home visits/follow-up (24.6%). The least mentioned role was that of Co-ordinator/Volunteer(3.9%). (See Fig 8).

Fig.8



These results reflect the way the programme has been running in Zimbabwe where the emphasis has been to use local facilitators in identification and referral of PWDs rather than in training and advice.

6.5.4 Benefits of the Programme

PWDs and carers were asked to indicate whether the CBR programme had been beneficial to them.

6.5.4.1 Table 21 Has the Programme Been Beneficial to You?

RESPONSE	FREQUENCY	%
YES	433	54%
NO	207	26%
NO RESPONSE INDICATED	161	20%
TOTAL	801	100

54% of the respondents indicated that they had benefitted from CBR. Benefit was directly related to tangible benefits such as : people got assistive devices (26.8%) and materials for IGPs; improved mobility of child, placement of child in a school. 26% of the respondents reported that they had not benefitted at all from the programme. Details of some of the perceived benefits are detailed below :-

6.5.4.2 Provision of Assistive Devices

Table 22 Have you been provided with an Assistive Device?

	FREQUENCY	%
YES	215	26.8%
NO	409	51.1%
NOT APPLICABLE	177	22.1%

TYPE OF APPLIANCE	FREQUENCY (%)
Wheelchairs	68 (32%)
Spectacles	18 (8.3)
Boots and Callipers	36 (16.7%)
Prosthesis	16 (7.4%)
Crutches	51 (23.7%)
Walking Sticks	5 (2%)
Orthoses	4 (2%)
Corner Seats	5 (2%)
Hearing Aids	4 (2%)
Other	8 (4%)
TOTAL	215

215 (26.8%) of PWDs had received aids and appliances through the programme. The majority 51.1% had not received any appliances. The main reasons being unavailability of funds. The type of appliances provided through the programme were: wheelchairs, spectacles, boots & callipers, prostheses, crutches, walking sticks and orthoses.

6.5.4.3 Referral To Other Services

Table 23 Have you ever been referred to any other service?

YES	305
NO	314
NOT APPLICABLE	182
TOTAL	801

TYPE OF SERVICE	FREQUENCY
Orthopaedic Centre	39
Social Welfare	62
Schooling	16
Vocational Training	5
Medical Care	153
NGOs	27
Other	3
TOTAL	305

The most utilised referral service was medical care, followed by social services and orthopaedic and prosthetic services. The high incidence of referral to medical care is an indication of the vital role of the programme in 'primary prevention'. The above results show that there is utilisation of the referral system in the CBR programme.

6.5.4.4 Practical Instruction on how to deal with Disability

Table 24 Have you received any instruction on how to deal with your disability?

YES	522	65.2%
NO	249	31.1%
NO RESPONSE INDICATED	30	3.7
TOTAL	801	100%

TYPE OF INSTRUCTION	FREQUENCY
Activities of Daily Living	31
Schooling	1
Advice	92
Referral	37
Communication Therapy Skills	2
Exercise	98
Treatment (not specified)	203
Other	32

522 (65.2%) PWDs and Carers had received instruction on how to deal with their disability. 32% had not received any instruction at all. The most mentioned types of instruction were treatment, exercises and advice. The result show that the CBR programme had benefitted many people by providing instruction on how to cope/manage their disability.

6.5.4.5 Benefits of the CBR programme as perceived by the community

The results from FGDs on benefits of the programme were categorised in two areas; those relating to the 'Life of PWDs' and those relating to 'Community Development'
The responses are a summary of perceptions from the community in general, community leaders, care givers and policy makers.

a) Benefits in relation to PWDs

- PWDs were now receiving drought relief and public assistance
- PWDs were given materials and livestock for projects
- PWDs were sent for vocational training
- PWDs were given soap and clothing
- Some PWDs received aids and appliances
- Some children with disabilities were placed in school or institution
- status of disabled had improved
- improvement in function for PWDs
- care givers received instruction on how to manage PWDs
- PWDs are visited regularly by VCWs
- some PWDs have gained functional independence
- some people have gained knowledge about disability and rehabilitation
- some people are now benefitting from IGPs
- mentally ill people have been encouraged to take medication
- the community is now involved in identifying disabled people and referring them for rehabilitation
- community has knowledge for detecting disabilities early

b) Benefits in relation to Community Development (all groups)

- some projects have been beneficial eg. meat became readily available through IGPs resulting in good nutrition of community members (chicken and goat projects).
- the programme has fostered better communication between disabled and able bodied
- people are more aware of disability and now accept and involve disabled people in community activities
- local supervisors helping disabled in their homes
- the programme looked at the whole family situation and not PWD only

Respondents in all categories identified 6 major areas of benefit:-

a) schooling and training;
b) material support to meet basic needs;
c) provision of aids and appliances;
d) functional independence of PWDs;
e) training of family and community on rehabilitation skills and
f) referral to services.

The results show that CBR is benefitting some PWDs, their families and the community in general. However 26% had not realised any benefits and 20% did not comment. The majority of these were in the 'learning disabilities' or 'mental illness' categories. The reasons could be that their own expectations were not met or they were not aware of the limitations of the programme. There is need for intensified community education on the rehabilitation process and the CBR concept.

6.5.5 Changes in Lives of PWDs, Community Attitudes and Community Facilities for PWDs

PWDs and carers were asked to comment on whether as a result of the programme any changes had been noticed in lives of PWDs, community attitudes and facilities.

Table 25 Since the programme started has there been any changes in the lives of PWDs, community's attitudes towards PWDs and Community facilities for accessibility.

	YES	NO	NR	TOTAL
Change in life	378	309	114	801
Change in attitudes	340	295	166	801
Change in facilities	202	401	198	801

378 (47.2%) expressed greatest change in the lives of disabled persons. This ties well with the fact that changes in the community attitudes is the second highest change noted.(42.4%). 25.2% said they had noticed changes in community facilities.

6.5.6 Access to Community Facilities

Table 26 Are you able to move around without difficulty?

	YES	NO	TOTAL
Home	606	104	710
Church	531	139	670
School	395	116	511
Transport	510	170	680

The number of respondents differs to the question on accessibility to each of home, church, school and transport. In all categories, the percentages of people with disabilities who did not have problems with accessibility ranged from 75% (public transport) to 85% (home environment). Although these results are pleasing, all they tell us is that PWDs are coping (mobility wise) in the indicated environments. It should be noted that majority of homes and buildings in the rural areas are simple structures and do not have barriers to access/mobility as in the urban situation. More detail is required to get a true picture of the type of problems experienced by PWDs in these situations.

6.5.7 Knowledge of any association of PWDs

Table 27 Do you know of any Association of People With Disabilities?

Yes	135	16.9%
No	610	76.1%
No responses	56	7.0%
TOTAL	801	100%

From the Table above, it is clear that a high number of PWDs (76.1%) are not aware of associations of PWDs. A very small number (16.9%) expressed that they knew of associations of PWDs. The Jairos Jiri Association for Rehabilitation of Disabled People was mentioned by a number of respondents, especially those who had undergone vocational training at Jairos Jiri centres.

6.5.8 Involvement in IGP/club for PWDs

Table 28 Are you involved in any IGP or Club?

Yes	191	23.8%
No	422	52.7%
No responses	188	23.5%
TOTAL	801	100%

TYPE OF IGP/CLUB	FREQUENCY	%
Sewing and knitting	41	21.5%
Livestock rearing	23	12%
Gardening	48	25%
Poultry	37	19.4%
Other	42	22%
TOTAL	191	99.9%

191 (23.8%) of the respondents said that they were involved in some IGP projects or clubs. 52.7% were not involved and no response was indicated on 188 questionnaires. Three main types of IGPs were mentioned: crafts (sewing and knitting); livestock/chicken rearing and gardening. The results show that many PWDs and their families are not involved in IGPs. In view of the fact that the majority of the respondents were destitute, there is need for the programme to strengthen this aspect of the programme in order for the service to be more meaningful to the recipients.

6.5.9 PWDs/Carers Expectations from the CBR Programme

PWDs and their carers were asked to comment on their expectations from the programme. 197 (24.6%) gave no comment at all. 604 (75.4%) of the total respondents (801) expressed their expectations. The responses were categorised in 10 areas as shown in Table below:

Table 29 PWDs/Carers Expectations from the CBR Programme

EXPECTATION	NO. RESPONSES	%
Food, Clothing and Money	126	15.7
Aids and Appliances	44	5.5
Income Generating Projects	87	10.9
Employment/Schooling	40	5
Improvement in Function (Self Reliance)	24	3
Treatment and Advice about Disability	69	8.6
Training/Knowledge about Disability	2	0.2
Child/Relative to go to a Special Institution	16	2
Don't Know/We expect you to provide everything	59	7.4
Other	143	17.9
No response/No comment at all	197	24.6

The results show that the respondents' expectations were directly related to basic needs and availability of opportunities for PWDs in education, employment, functional independence and self-reliance.

7.4% expressed that they 'Did not know ' and gave the following reasons:-

- 'I don't know what the programme offers, I don't want to expect and then get nothing'.
- I am suffering, I don't think anything can be done'.
- 'I got all that I needed'.
- 'We can't say anything, we look towards whatever you do or bring us...'

3% expressed that they expected their/their relative's condition to improve coupled with improved functional ability. "To see my child walk"

16 people expressed that they wanted their children/relatives to go into a special institution. (A view contrary to the concept of CBR)

Under the category 'Other' some of the responses were:-
- "I want to be given a tractor to plough my fields"
- "I want a training centre for PWDs to be built into the community"
- "I want the programme to help the poor disabled"

From the above results it can be deduced that the CBR programme to a certain extent was meeting the expectations of PWDs and their families. Benefits expressed match expectations.

However some of the expectations expressed ; 'I want a tractor to plough my fields' or 'I expect my child to walk' or 'I expect anything, I don't know what the programme offers' points to a need to strengthen training in CBR concept and objectives so that PWDs, families and communities have realistic expectations.

Summary (Impact)

The results in this section of the report show that CBR programme in Zimbabwe has had some impact in the following areas:

- Improving the knowledge base of the community in disability issues as shown by the positive responses on knowledge about own disability and the CBR concept; and the community's involvement in identifying disability and referring for assistance.
- Providing CBR services to disabled people, their families and the community as shown by the perceived benefits detailed in the report.
- Winning the participation of PWDs, families and community in the rehabilitation process.

However the results also indicate that the programme needs to strengthen its efforts in 'disability and rehabilitation awareness' training with focus on disability prevention and transfer of CBR knowledge and ability in order to create realistic expectations from the programme.

6.6 SUSTAINABILITY

This aspect of the programme was assessed by asking questions related to the current support and contribution by the community; the training of Local Facilitators and involvement of other sectors in the running of the programme.

6.6.1 Support from Community for PWD and Family

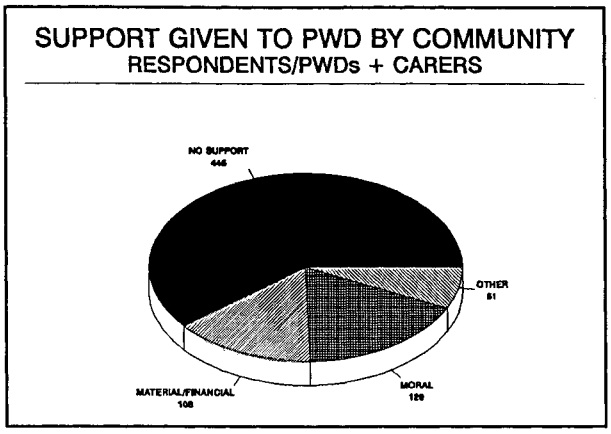
PWDs/carers were asked to mention the type of support they were getting from the community. 103 (12.8%) of the respondents gave no respond, 698 responded. Of those who responded 445 (55.6%) said they were not getting any support and only 253 (31.6%) were getting support. The responses were categorised into 4 areas as shown Table 30 below.

6.6.1.1 Table 30 What support are you getting from the community in the programme?

TYPE OF SUPPORT	PWDS/CARER	L. F.s
No support	445	(55.6%)
Financial/ material	108	(13.5%)
Moral	129	(16.1%)
Other	51	(6.4%)

The most mentioned type of support was financial, material and moral. (See Fig 9).

Fig.9



Those who said they had no support expressed that the programme was still new to realise the support, had not much knowledge about the programme or only got support from local facilitators and kraal heads.

The material support mostly mentioned was food, clothing, soap and mealie meal.
Moral support was in the form of prayers, congratulations from neighbours when there is obvious improvement on a pwd's condition and support in efforts of A pwd ; one respondent said 'people bring their clothes to me for mending and pay me money'.

'Other' forms of support mentioned were; people were supporting by assisting PWD in the fields, fetching firewood and water, maintaining accommodation eg. reroofing, making bricks, etc. Other forms of assistance were pushing wheelchair, accompanying child of a disabled person to school or reminding PWDs about taking medication and review dates.

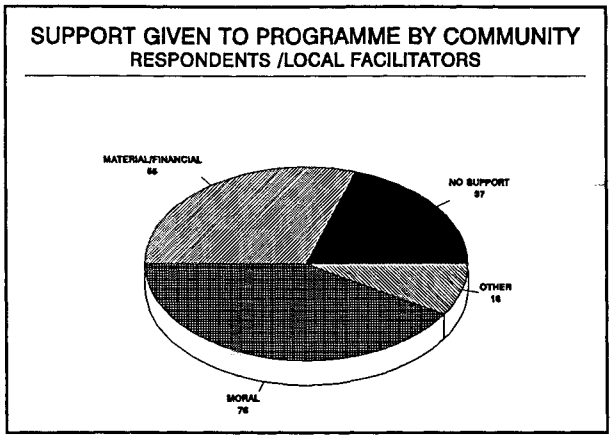
6.6.1.2 Local Facilitators' perception of support given by community

Table 31 What Support is given by the community towards the programme?

TYPE OF SUPPORT	FREQ.RESPs.	%
No Support	37	15.9%
Financial/material	55	23.7%
Moral	76	32.8%
Other	16	6.9%

190 (82.3%) of the local facilitators responded, 17.7% did not comment. 37 said the community was giving no support at all. Where support was given the most mentioned was moral and other forms of support, a view similar to that of the pwds and their families. (See Fig 10).

Fig.10



The results in Tables 30 and 31 show that the community has the capacity to contribute to the programme. Although material, moral and physical (in the fields etc) support emerge as the common forms of contribution by the community towards the programme, with improved knowledge and skill of CBR more can be expected from the community in view of community development and participation. PWDs, families and the community at large need more education and encouragement to actively participate in CBR.

6.6.2 Referral by Local Facilitators

Local facilitators were asked to indicate where they refer pwds who they cannot help within the community. Their responses were categorised into 4 areas as shown in Table 32.

Table 32 What do you do for clients you cannot help in the community?

PLACE OF REFERRAL	FREQ. RESPS	%
Nothing	10	3.9%
Clinic or Hospital	125	49.4%
Rehabilitation	69	27.3%
Other Sources	49	19.4%

These results show that local facilitators contacted were utilising the referral system. Only a small proportion (3.9%) were not sure of what to do.

6.6.3 Training in CBR for Local Facilitators

Table 33a Did you receive any training in CBR?

YES	208	89.7%
NO	24	10.3%
TOTAL	232	100

The majority, 89.7%, said they had been trained in CBR. They indicated the topics in which they had been trained as given in Table .

Table 33b Topics Covered During Training

TOPIC LEARNED	FREQ. RESPs.	%
Type and Causes of Disability	51	17%
Identification and Referral	51	17%
Management of Disability	97	32%
Equalisation of Opportunities	42	14%
Other	59	20%

When asked what other topics they would have liked to learn, the result was as in Table 33c.

Table 33c Other Topics Preferred

Prevention, causes and disability	43	(19.4%)
Management of disability	67	(30.2%)
IGP skills training	28	(12.6%)
Empowerment of PWDs	9	(4%)
Nothing	26	(12%)
Other	49	(22.1%)

A high proportion (30.2%) wanted training in 'Management of Disability' and (19.4%) in 'Prevention and causes of disability'. Also mentioned were training in 'IGPs', and empowerment of PWDs.

6.6.4 Support in CBR Work

Local Facilitators were asked to mention the people who were supporting them in their CBR work. Their responses are given in Table.

Table 34 Who Supports you in your CBR Work?

PERSON SUPPORTING	FREQUENCY	%
Community/Community Leader	40	15.9%
RHC Staff (EHT, Nurse)	49	19.5%
Rehabilitation Technician	132	52.5%
NGO/Church	9	3.6%
Other	14	5.6%
Nobody	7	2.8%

The majority (52.5%) mentioned the R.T. as their main supporter. The next highly ranked were Rural Health Centre Staff (19.5%) and Community/Community leaders (15.9%). This result confirms the results on utilisation of the referral system and also points out 'who' are the key players in CBR. However the result also point to the need for the programme to put more emphasis in involving PWDs and their families in the promotion of CBR with emphasis on improving their role/participation.

6.6.5 Community Involvement in CBR

Community members and community leaders expressed that they were appreciative of the assistance provided by the CBR programme to PWDs in the community and also recognised that the community had a role to play. The same view was expressed by Local facilitators and intermediate supervisors.

Regarding 'Improving Community Involvement' the common views expressed were:

- Centres should be set up to co-ordinate efforts by the community to assist PWDs
- Community to be supported financially in projects
- Increased community education about CBR
- Establishment of rehabilitation committees at Community level in order to formalise community's role
- Encourage formation of support groups of PWDs

6.6.6 Means of Sustaining CBR Programme

Respondents in all categories were asked to give their views on means of sustaining the CBR programme. The following is a summary of the respondents' views:

6.6.6.1 Community Involvement and Participation

The community involvement and participation in CBR as expressed by all groups in the FGDs covered mainly material and financial support.

How Community is currently Involved

- material and financial support
- assisting in running IGPs
- identifying and referring PWDs
- moral support
- motivating of the community by local leaders
- setting up of community centres for self-help activities

6.6.6.2 Suggestions to Improve Community Involvement and participation in CBR

Respondents' view on how to improve community involvement and participation in CBR.

Community members and leaders expressed that they were appreciative of the assistance provided by the CBR programme to PWDs in the community and also recognised that the community had a role to play. The same view was expressed by the Local Facilitators and intermediate supervisors.

Regarding "How Community Involvement and Participation in CBR can be improved", the common views expressed were:-

- community should be fully educated on disability and their role in the programme
- rehabilitation communities should be formed at ward level to formalise community's role
- centres should be set up to co-ordinate community's efforts to assist PWDs
- headmasters and teachers in CBR areas should be fully educated on the programme and their role
- community should be given full responsibility of running the programme
- community should be supported financially in projects
- PWDs should be trained in projects to become trainers of other PWDs

6.6.6.3 Resource Requirements to Sustain CBR Programme

In terms of resources required to sustain the programme, respondents' views in all FGDs covered the following areas of need:-

- Government should increase funding of the programme in the areas of aids and appliances and transport
- More rehabilitation personnel should be working in the community
- Districts and RHCs should be provided with adequate facilities and equipment to support the programme.

6.6.6.4 Intersectoral Collaboration

The question on intersectoral collaboration was directed to policy makers. The responses indicate that multisectoral co-operation exists. Areas of co-operation mentioned were:

- training
- community/home visits
- income generating projects

However, the need for more networking was highlighted in order to take full advantage of the available resources. Respondents stressed the need for a multi-sectoral approach in the implementation of CBR.

6.6.6.5 Community Concerns about the Programme

- community wanted more information and meetings on the running of the programme
- community does not know where to source funds to support or initiate projects
- community felt that IGPs must be done within PWDs' home
- parents were concerned about sexual abuse of disabled children, they wanted to know how to prevent this

- parents/caregivers were concerned about the survival of the PWD in the event of the death of parent/caregiver
- lack of transport money by PWDs to reach services
- Allowances for Local Supervisors too little
- no adequate schools for children with disabilities
- PWDs are indigent
- inconsistent support from the district rehabilitation team
- lack of schooling and employment opportunities for PWDs
- barriers to social integration eg. negative community attitudes, long distances to buses, schools, shops, etc.

Current Community Initiatives to Solve Their Problems

- material support through church organisations and community leaders
- problem solving meetings being held in the communities
- some respondents said that the community had nothing to offer towards solving the problems affecting the CBR programme.

6.6.7 Suggestions to Improve the Programme

PWDs and their families, community and policy makers were asked to suggest ways to improve the programme. Their views were:-

- establishment of vocational and rehabilitation centres within the community for improved access by PWDs
- expansion of the programme to cover more areas
- community leaders felt that long-term family planning methods should be made accessible to PWDs
- rehabilitation staff should attend Rural District Council meetings
- support groups for disabled people should be formed in the community
- local authorities should have a budget for PWDs in their areas of jurisdiction
- full-time rehabilitation worker needed in the community
- provision of transport to RTs to facilitate community support visits
- Government must supply travel warrants to assist PWDs in accessing medical and rehabilitation services
- increase education opportunities for young PWDs
- provide RHC staff with adequate knowledge, skills and equipment to enable them to support the programme at grassroot level.
- increased disability awareness training to the community
- the programme needs to address the needs of mentally ill people

- communication between the district hospital, RHC and the community should be enhanced
- incentives for Local Facilitators to encourage active participation in CBR
- more funds should be made available for the procurement of assistive devices for PWDs
- disability, rehabilitation and CBR should be included in all medico-social training programmes
- Local Facilitators should be given bicycles to facilitate their community activities
- community felt that IGPs should be done within PWD's home

Summary and Comments on Sustainability of CBR)

The evaluation considered the aspects listed below to determine sustainability:-

- community involvement and participation;
- training for local facilitators;
- resources required to sustain the programme;
- inter-sectoral collaboration.

Findings of the the evaluation indicate that communities are supporting people with disabilities and their families morally and financially. However there is need to increase the scope of support by increasing community participation through social mobilisation and education.

The formation of community rehabilitation committees will formalise the role of the communities in the community based rehabilitation and shift the decision making and monitoring to the community. Identification of local resources and their uttilization in CBR will be a responsibility of the community rehabilitation committee. This approach is going to change the belief that external resources from government or non-governmental organizations are needed to sustain the programme.

Most local facilitators have received training on some aspect of disability and community based rehabilitation. A training curriculum that is uniform and applicable to the whole country needs to be developed. Training has to be designed in such a way that continuity is ensured at local level. Knowledge on disability and rehabilitation should be updated regularly.

Inter-sectoral collaboration is needed if resources are to be utilised maximally for the benefit of community based rehabilitation programmes. The role of NGOs including churches needs to be strengthened in CBR.

7. RECORDS ON THE CBR PROGRAMME

The evaluation sought to establish records that are kept at different levels in CBR work. General observations and checklist were used to determine these records.

At Community Level

Local supervisors kept records pertaining to their CBR work. These records were :-

i) register for all people needing help in the area including disabled people.
ii) separate register for disabled people.
iii) individual project records.

The records kept at RHC differs from area to area but the MoH&CW common records observed during the evaluation were :-

- "At Risk" register
- Disability register
- chronic diseases register
- domiciliary visit register

At District Level

All records pertaining to CBR were kept in the Rehabilitation Department. These were the major records observed :-

- CBR register for clients
- in- and out-patients register in which CBR clients are indicated (general register)
- treatment cards for clients
- appliances and special equipment register
- IGP register
- CBR periodic statistics (quarterly, monthly and annual)
- quarterly and annual reports specifically on CBR
- reports on specific activities effected in the CBR area like workshops, meetings, visits.

Observation

The evaluation established that tools for monitoring CBR activities exist at all levels. However, there is lack of uniformity in the types and format of the records kept. This poses problems when collating programme information at national level.

8. CONCLUSIONS

8.1 The MoH&CW CBR programme has to date been introduced in 31 out of the 57 administrative districts in Zimbabwe. If the expansion continues at this rate the ministry's goal of having introduced CBR in the entire country by the year 2005 will be achieved. However the evaluation noted that in some cases CBR is a 'programme' covering the whole district and in others 'projects' covering a few wards within a district. The evaluation did not establish coverage in terms of numbers of disabled people actively involved in the programme to date. The coverage reflected is that of communities benefitting from the establishment of the programme in their localities.

8.2 The evaluation established that women in the community play the biggest role both in looking after people at home and also in the running of the programme in the community.

8.3 It was established that many children with disabilities had reduced schooling opportunities and the highly expressed reasons were mobility problems, long distances to nearest schools, financial problems, lack of facilities and inability by teachers to cope with a disabled child in the regular classroom situation.

8.4 Local Facilitators had received education in CBR work, however they expressed that they needed more training to enable them to adequately manage people with disabilities within the community.

8.5 Although some people with disabilities, their families and the community had acquired knowledge about disability and rehabilitation, others were not at all knowledgeable and those who said they had knowledge further questioning revealed that more training was needed to ensure they had adequate knowledge to fully participate in the programme.

9. FINAL RECOMMENDATIONS

9.1 Training

9.1.1 The intermediate supervisors (RHC, nurses, EHTs, Pre-school and school teachers, etc) who are the 1st line supervisors for local facilitators should be given adequate training on CBR to enable them to competently support the CBR facilitators.

9.1.2 A national standardised syllabus should be developed for the training of Local Facilitators to ensure :-

a) transfer of technology to local facilitators (role : identification and referral: home visits and follow-up).

b) Standardised reporting system at all levels (To facilitate programme monitoring and evaluation)

9.1.3 Training of women especially mothers and grandmothers (main carers of disabled children and adults) should be enforced to ensure sustainability of programme at the community level.

9.1.4 The community education/awareness programme should be intensified in order to ensure sustainability of the programme and to assist the community to understand their role in the programme.

9.1.5 The subject of 'Disability/Rehabilitation' should be included as a component in the curricula of all medical courses (nurses, doctors, environmental health technicians, etc.) With an increased level of knowledge these cadres will have a better appreciation of rehabilitation to enable them to effectively support the CBR programme.

9.2 Referral

9.2.1 There is need to strengthen the referral system to ensure people with disabilities receive prescribed services and to reduce the waiting period for the provision of appliances and other services.

9.2.2 Whilst the referral system is being utilised, problems are experienced by PWDs in reaching the referral centres or obtaining the prescribed services eg. appliances, etc. due to lack of funds. More co-ordination should be enforced with the Department of Social Welfare and donor organisations in order to meet the needs of the PWDs.

9.2.3 There is need to put a mechanism in place to ensure feedback of information from one referral source to the other.

9.3 Co-ordination and Partnership

9.3.1 National NGOs (eg. NCDPZ, Zimbabwe National League of the Blind) are not known at the community level. The MOH&CW should liaise and support these organisations to make people aware of their existence. Awareness raising activities should be done together. More involvement by these organisations of PWDs will have implications on the empowerment of PWDs.

9.3.2 Income Generating and other projects need better planning in terms of feasibility studies into proposed products and services to ensure their viability. IGPs also need regular monitoring. There should be a concerted effort between MOH&CW and other relevant agencies in implementing IGPs.

9.3.3 From the findings and observations of the evaluation it appears a significant number of children (school going age) and young adults with disabilities are extremely disadvantaged with regard to opportunities for schooling. The programme need to place more emphasis on increasing schooling opportunities through :-

a) timely referral for education assessment;
b) early identification of children with learning disabilities in the community;
c) reduction of physical barriers to mobility,etc.
d) disability awareness programmes in schools for teachers, pupils and parents.

9.3.4 The MOH&CW in conjunction with other relevant ministries and agencies should pursue strategies that will increase schooling and employment opportunities for PWDs.

9.4 Programme Records

9.4.1 Better systems of recording, monitoring and evaluating CBR activities and IGPs should be developed to improve clarity, intend and result measurement and to enable corrective action to be taken in good time.

9.4.2 Standardized data collection tools need to be put in place for use by local facilitators and intermediate supervisors. This will facilitate monitoring of data collection at the community level.

9.4.3 Disability registers should be established at all Rural Health Centres to facilitate monitoring of activities at the community level. RHC staff should be given appropriate training to assume responsibility for updating the registers.

9.5 Expansion of CBR

9.5.1 Rehabilitation staff should spend more time at grassroot level aimed at encouraging community involvement in needs assessment and decision-making and should avoid the risks of an outreach-oriented prescriptive approach to service development.

9.5.2 Expansion of CBR into new districts should be encouraged. However Province and Central Hospitals should ensure current services are satisfactory and comprehensive. Further expansion should also be related to availability of adequate rehabilitation staff and other resources at the district level.

9.5.3 CBR should continue with emphasis on community education and training in order for the MOH&CW to fully realise its mission.

10. LIST OF REFERENCES

. Chiviru J H ; Munandi J R; Mudombi D P; (1992). An Evaluation of Jairos Jiri Community Based Rehabilitation (CBR) programme in Chivi District. [unpublished]

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APPENDIX 1

TERMS OF REFERENCE

1. To evaluate the benefits of the Ministry of Health and Child Welfare CBR programme to people with disabilities.

2. To review progress of the CBR programme in relation to stated objectives and targets.

3. To assess impact and effectiveness of the CBR programme.

4. To assess the extent of co-ordination of CBR between Ministry of Health and Child Welfare and Non-Governmental Organization programmes.

5. To assess the present coverage of the CBR programme in Zimbabwe.

6. To assess the adequacy of the training of VCWs and Volunteers.

7. To review the CBR component in the RT and PT/OT training (ie. meeting the demands of CBR programme).

8. To find out whether the CBR programme is discussed at various development committees.

9. To find out if rehabilitation is part of the health plans at all levels.

10. To assess the sustainability of CBR programme.

11. To assess the referral system from community to central and vice versa.

12. To assess monitoring methods ie. records reports.

APPENDIX 2

LITERATURE REVIEW

TITLE OF STUDY	NAME OF AUTHOR(S)	YEAR
The Impact of Community Based Rehabilitation Services in Zimbabwe : The Client's Point of View	H Myezwa	1993
A Report on Eight Community Based Rehabilitation (CBR) Pilot Projects	Rehabilitation Unit, Ministry of Health	1990
Evaluation of Rehabilitation Services in Zimbabwe	L Njini A Geordt J Hanekom B Lagerkvist	1991
Evaluation of Community Based Rehabilitation, Chivi District (Jairos Jiri Association)	J Chiviru J Munandi D Mudombi	1992
Evaluation of the Zimbabwe Red Cross Project	S Chidyausiku A geordt	1993
Community Based Rehabilitation in Zimbabwe. "A Survey of Follow-up Clients and the Functioning of the Home Based Programme"	R Broer M Rottier	1992

APPENDIX 3

EVALUATION TEAM

TASK FORCE

Mrs S Chidyausiku (Co-ordinator)

Core Group
Mrs C Nleya
Mrs J Munandi
Mr M Marasha
Mr D Mbadzo
Mr F Mhuri

EVALUATION TEAM PER PROVINCE

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Mr Z Fakero	(RT)
Mrs W Mukudu	(RT)
Mr T Gate	(NCDPZ representative)
Mr L Tsodzo	(Health Information Clerk)
Mr Chiunye	(Driver)

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Mr E Koffie	(RT)
Mr S Chitambire	(RT)
W Shamuyarira	
Mr C Muchira	

Mashonaland West :

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Mr T Manyanga	(RT)
Mr N Tsoto	(NCDPZ)
Mrs J Tsoto	(RT)
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Mr K Mandizvidza	(Health Information Officer)
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Mr T Machingura	(OT)
Mr A Musavengana	(JJ)
Mr P Jira	(Health Information Officer)

Manicaland :

Mr W Pfumo	(Co-ordinator)
Mr T Dadirayi	(RT)
Mr I Matewa	
Mr J S Mutanguro	(NCDPZ)
Mr T Chadura	

Chitungwiza :

Ms S Matora	(Co-ordinator)
Mr R Tarasana	(OT)
Ms M Sakonda	(RT)
Mrs M Mabvuta	(ZPHCA)
Mrs P Chingono	(RT)

APPENDIX 4

LIST OF PEOPLE INTERVIEWED

(RHC/Rural Hospital)		Number
Nurses	-	45
EHTs	-	13
Nurse	-	5
Nutrition Co-ordinators	-	2
Community Based Distributors		1
Teachers	-	33

District Level

Health

DHEO	-	5
DNO	-	7
Matron	-	5
DMO	-	3
SIC Community	-	3
DHSA	-	4
Pharmacy Technicians	-	1
ZNFPC Managers	-	3
Health Education Officers	-	1

Social Welfare

District Social Welfare Officers		6

Education

District Education Officers		5
District Remedial Tutors	-	4

Local Government

DA	-	5
A/DA	-	2
Chief Executive Officers (District Council)		1

Ministry of Construction

DMO	-	2

LIST OF PEOPLE CONTACTED IN EVALUATION

Chiefs	-	4
Councillors	-	13
Ward Co-ordinators	-	2
Kraal Heads	-	89
VIDCO Chairpersons	-	17
Village Committee members		35
Agritex Officials	-	4
Businessmen	-	8
Traditional/Faith Healers	-	4
Traditional Midwives	-	8

APPENDIX 5

EVALUATION TOOLS A1

NATIONAL COMMUNITY BASED REHABILITATION EVALUATION

Interview Questionnaire for a Person with a Disability or Caregiver

me of interviewer: ..... Study No. ☐☐

te of interview:.../.../... Team No. ☐

ovince:.....

strict:.....

a\Ward:.....

pondent is: Person with a Disability ☐

Carer/family member ☐ specify.....

Other ☐ specify.....

: I

).O.B.: ☐☐☐☐☐☐ 2. SEX M ☐ F ☐

Marital Status: 4. Educational Status

M	☐	Primary	☐	specify
S	☐	Secondary	☐	specify
D	☐	Tertiary	☐	specify
W	☐	Vocational training	☐	specify
		Other	☐	specify

ocial status: Destitute ☐ If not destitute then source of income

Not destitute ☐ .....

pe of disability: *(tick and specify condition)*

eing difficulty	☐	.....
ving difficulty	☐	.....
range behaviour	☐	.....
fficulty in hearing / speech	☐	.....
fficulty in feeling	☐	.....
fficulty in learning	☐	.....
s	☐	.....
er type of disability	☐	

cify .....

ve you gained knowledge and understanding about disability ?

☐ YES ☐ NO

knowledge?.....

b) Have you gained knowledge and understanding about your disability?

YES ☐ NO ☐

What knowledge?.....

c) Have you received any instruction on how to deal with your disability?

YES ☐ NO ☐

i) If yes, by who?.....

i) What instruction?.....

Can you explain what you know about Community Based rehabilitation?

.....

.....

What is your role in the programme ?

.....

.....

Vhat is your contribution to the programme ?

.....

.....

as the programme been beneficial to you ?

ES ☐ NO ☐

omment:.....

)What are your expectations from the programme?.....

.....

Are you satisfied with the way the programme is running?

YES ☐ NO ☐

Comment:.....

What are your suggestions for improving the programme?.....

.....

.....

it do you think is most difficult for a person with a disability in

.s community?.....

.....

ce the programme started has there been any changes in the:-

lives of persons with disabilities ?

YES ☐ NO ☐

What ?.....

community's attitudes towards people with disabilities?

YES ☐ NO ☐

What ?.....

community facilities for accessibility?

YES ☐ NO ☐

Comment:.....

What support are you getting from the community in the programme?

.....

.....

II To be filled in for Person with a Disability

e you able to move around without difficulty within the community:
ome, church, school, public transport)?

	Yes	No	N/A
me	☐	☐	☐
urch	☐	☐	☐
hool	☐	☐	☐
blic transport	☐	☐	☐

comment :.....

.....

e you been provided with an assistive device?

☐ NO ☐

es,

hat type?.....

id you contribute towards the payment?

☐ NO ☐

you find the device/appliance useful?

☐ NO ☐ Not very useful ☐

you use the device in your everyday activities?

s ☐ Sometimes ☐ Never ☐

u know of any association of people with disabilities?

☐ NO ☐

If yes are you a member?

YES ☐ NO ☐

a) If yes, do you hold any position in the association?

YES ☐ NO ☐

If yes, what position?

b) Are you involved in any IGP or club?

YES ☐ NO ☐

Information on club/IGP.....

.....

Have you ever been referred to other services?

YES ☐ NO ☐

c) If yes, to what service?

d) Were you satisfied with the service?

YES ☐ NO ☐

comment why?.....

.....

hat do you consider to be your main problems?.....

.....

.....

III For the Caregiver

you face any problems in taking care of the person with a disability?

☐ NO ☐

yes, what problems.....

.....

do you think these problems can be solved?.....

.....

t do you think is most difficult for your relative?.....

.....

have any questions or general comments on the programme?

NATIONAL COMMUNITY BASED REHABILITATION EVALUATION

Questionnaire for Local Supervisors
(To be administered by the Evaluator)

Case No. ☐☐

ame of interviewer:..... Province:.....

ate of interview:.../.../... District:.....

Area/Ward:.....

pe of worker:

W ☐

d Cross ☐

her Volunteer ☐ specify:.....

Economic Status

Paid ☐ Age ☐

Unpaid ☐ Sex ☐

ıcational Status

☐

mary ☐ specify.....

ondary ☐ specify.....

tiary ☐ specify.....

er ☐ specify.....

---

low long have been involved in the programme?.....

What is your role in the programme?.....

n you tell us what you know about Community Based Rehabilitation?

.....

.....

Did you receive any training in Community Based Rehabilitation?

es ☐ No ☐

Who did the training?.....

w long was the training?.....

at did you learn about rehabilitation?

.....

.....

at else would you have liked to learn?.....

.....

What other training have you received besides training in Rehabilitation?.....

What is your opinion about the running of the programme?

Well ☐

Not so well ☐

Not well at all ☐

Comment:.....

Do have you any information on rehabilitation at home?

Yes ☐ No ☐

Vhat type of written information do you have?.....

.....

/hat type of records do you keep about the programme?

eports ☐

ecord book/register ☐

ther ☐ specify.....

hat do you do with the records?.....

Who supports you in your CBR work?.....

How often do you meet with the person?.....

Do you find the meetings useful?

es ☐ No ☐ Sometimes ☐

at other community responsibilities do you have?.....

.....

at support is given by the community towards the programme?.....

.....

.....

t do you do for clients whom you cannot help within the community?

.....

ave you referred clients to other services?

☐ No ☐

f yes, specify.....

Did you get feedback?

Always

Sometimes

Never

Do you have any suggestions to improve the running of the programme?

.....

.....

Final Evaluation

C1

NATIONAL COMMUNITY BASED REHABILITATION EVALUATION

Questionnaire for Project Manager/Co-ordinator

rovince:..... Study No. ☐☐

istrict:.....

rofession:

ehabilitation Technician ☐ Age ☐☐

ıysiotherapist ☐ Sex M ☐ F ☐

cupational Therapist ☐ Year of qualification ☐☐☐☐

eech Therapist ☐ Duration of training ☐☐

thopaedic ☐ No. of years in services ☐☐

How long have you been involved in Community Based Rehabilitation?

.....

Is there a national policy on Community Based Rehabilitation?

Yes ☐ No ☐

If Yes what is the Policy:.....

.....

hat is your understanding of the Community Based Rehabilitation concept?

.....

.....

hat are the objectives of CBR in your District?

.....

.....

o you think the objectives are being achieved?

es ☐ No ☐

f no, what are the constraints?.....

.....

at is your role in Community Based Rehabilitation?.....

.....

you have any reference material on Community Based rehabilitation?

☐ No ☐

yes, what material?.....

Did you receive any training in Community Based Rehabilitation?

Yes ☐ No ☐

If yes where?.....

Did the training prepare you to work in a community Based Rehabilitation Programme?

Yes ☐ No ☐

Comment:.....

.....

i) What difficulties, (if any) have you faced whilst implementing Community Based Rehabilitation in your area?.....

.....

What successes (if any) have you met whilst implementing Community Based Rehabilitation in your area?.....

.....

a) What support do you get from the community in running the programme?

.....

.....

b) What support do you give to the local supervisors.....

.....

.) Are there any other organizations running Community Based Rehabilitation in your district?

Yes ☐ No ☐

) If yes, list them.....

.....

How do you co-ordinate your activities?.....

.....

.....

what meetings do you discuss Rehabilitation issues?.....

.....

.....

ere do you get the resources to run the programme?

.....

...nat resources have been provided by the community in the running of the programme?.....

.....

15. What are your future concerns regarding resources for the running of the programme?.....

.....

16. i) Do you keep any records on the programme?

Yes ☐ No ☐

ii) What type of records?.....

iii) Which records do you find useful?.....

.....

17. What problems are you facing in record-keeping?

.....

.....

18. Who supports you in your CBR work?.....

.....

19. Do you have any suggestions about improving the programme?

.....

.....

NATIONAL COMMUNITY BASED REHABILITATION EVALUATION D1

(Interview Schedule for Policy Makers)

1. What do you know about Community Based Rehabilitation?

   - Generally ask on what progresses in districts
   - Probe appropriately
   - Mention disability

2. What is your involvement in the programme?

3. How has co-operation and co-ordination with other rehabilitation partners been?

   At what fora are rehabilitation issues discussed?

4. How is government supporting the rehabilitation programme for people with disabilities?

5. Other areas for discussion are:-

   i) Provision for training of staff in rehabilitation;

      - what type of training?
      - by whom?
      - importance of staff development

   ii) Allocation of resources;

      - manpower
      - material
      - money

   iii) Sustainability of the programme.

6. do you have any suggestions to improve the programme?

D2

NATIONAL COMMUNITY REHABILITATION EVALUATION

(Interview Schedule for Rural Health Centre Staff)

1. Do you know about Community Based Rehabilitation programme?

Yes ☐ No ☐

2. If yes, what do you understand about Community Based Rehabilitation?

3. How are you involved in the programme?

4. Do you keep records on the programme?

Yes ☐ No ☐

5. If yes, what type of records on disability?

6. any suggestions to improve the programme.

NATIONAL COMMUNITY BASED REHABILITATION

D3

EVALUATION

interview Checklist- Focus Group Discussion

1. Community involvement and participation in Community Based Rehabilitation.

   - understanding of the programme
   - how community is involved in the programme

2. Attitudes of community towards people with disability

   - enquire about causes of disability
   - opportunities for disabled people in:-

     * schooling
     * employment
     * vocational training
     * other social activities

3. Problems faced by people with disabilities in community.

   - what are the main problems being faced?
   - what is community doing to solve the problem?

4. Benefits of the programme.

   - benefits in relation to :-

     * disabled person
     * community development
     * IGPs - details

5. Substainability of the programme.

   a) contribution of the community to the programme to date

   b) what can be done to increase the community involvement in the programme.

   c) how community will continue running of programme in the absence of external resources.

6. Community concerns about the programme.

   - general concerns of programme as a whole
   - suggestions for improvement of running of the programme.

Schedule of Analysis

APPENDIX 6

OBJECTIVE 1 - A1 Part I (9, 10, 12a, 14 & 15)
Part II(3, 4a & 4b)

OBJECTIVE 2 - AI Part I (7 (c) ii, 12 (a))
Part II(2 a, b, c, d)
FGD Qu. 3 & 5
Appliance register
PART II 2, 6, 5a & b,

OBJECTIVE 3 - A1 (7 a, b; 8 & 9
- BI (2, 3, 6 & 7)
- D2 (1 & 2)
- FGD No. 1

OBJECTIVE 4 - COMMENT IN FINAL REPORT

OBJECTIVE 5 - Discussion with all group

OBJECTIVE 6 - AI (9, 10 & 15)
- BI (2, 16 & 17)
- CI (10a, 14 & 18)
- FGD D3 (1 & 5)
- FGD D2 (3)

OBJECTIVE 7 - BI (17 & 18)
- CI (11 i, ii & iii; 12 & 18)
- DI

OBJECTIVE 8 - Reports on records

OBJECTIVE 9 - CI (7 & 8)
- BI (4 a & b; 5, 6 & 7)
Training - DI (5 (i))
Resources - AI (15)
- BI (16)
- CI (13, 14 & 15)
- DI (5(ii) and 5 (iii))
- D3 (5 a, b & c;6)
Qu. I Second part

Utilization of the referral system - AI Part II (5)
- BI (17, 18 a, b & c)
- CI (18)
- D2 (3)
- D3 (2)

APPENDIX 7

EVALUATION IMPLEMENTATION SCHEDULE

DATE	ACTIVITY	DURATION
27-29 March 1996	Pre-testing (Mat North)	3 days
3 April 1996	Core-Group Meeting	1 day
19 April 1996	Training of Enumerators	1 day
22 April-3 May 1996	Data Collection	10 days
6-17 May 1996	Data Compilation and Analysis, Report Writing	10 days
24-28 June 1996	Report Writing	5 days

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Department for Central and Eastern Europe

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