COMMUNITY-BASED REHABILITATION AND
THE HEALTH CARE REFERRAL SERVICES

A guide for programme managers
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INTRODUCTION

There are several hundred million people in the world with permanent disabilities as the result of movement, hearing, seeing, or mental impairments. Their precise number is unknown, but the inadequacy of current services to meet their needs is clear. In developing countries, even the most basic services and equipment are lacking. In developed countries, people with disabilities may benefit from medical and educational services, yet lack the opportunity to work or otherwise join in community life.

Countries acting to assist disabled people are motivated by a belief in equality and by the desire to limit the severity of disability and the hardship it imposes on individuals and families, as well as to limit the loss that occurs when a sector of the population is economically unproductive. All people have the right to health. In order to ensure that right for all of its citizens, a nation provides opportunities for disabled people to develop and use their physical and mental abilities.

The World Health Organization is striving to realize Health for All. In 1978, the International Conference on Primary Health Care, held in Alma-Ata, declared that primary health care would address the main health problems in the community and thus promote Health for All through the provision of promotive, preventive, curative, and rehabilitative services. Following the declaration, WHO developed the strategy of community-based rehabilitation (CBR) as a means of integrating rehabilitation with health and development activities at the community level.

The CBR manual *Training in the Community for People with Disabilities* (WHO 1989) was drafted in 1979. It was extensively field tested and revised. The manual explains how disabled people, their families, and their community can undertake the rehabilitation and social integration of people with disabilities. Many countries have initiated CBR programmes, but only on a small scale. CBR programme managers indicate that there is a need for guidelines to assess the situation, recommend policies, and plan programmes.

This guide has been prepared in response to these needs. It is aimed at the programme managers who advise on policy formulation, and who also plan, implement and evaluate rehabilitation programmes. The guide focuses on the role of the health care system in CBR and the rehabilitation referral services. The information can be used to train programme managers in rehabilitation, or it can be used as a working guide by managers who wish to improve their planning, implementation, and evaluation procedures.
The health sector is one of several involved in rehabilitation. Other sectors, including education, social, and labour, may also provide support and technology at the community level. Clearly, all sectors must work together. The multisectoral approach, promoted throughout the Decade of Disabled Persons, 1983-1992, will continue as part of the United Nations World Programme of Action Concerning Disabled Persons.

This guide describes CBR activities as managed by the health care sector. In some countries, another sector has this responsibility, in which case the Ministry of Health manages only rehabilitation services that are part of the health sector, but also participates in intersectoral CBR activities. The information in this guide is intended for use by rehabilitation management personnel in both of these situations.

Chapter 1 provides definitions of terms and concepts relevant to disability issues, a description of a CBR programme and the referral services in the health sector, as well as a brief description of the management cycle.

Chapters 2 and 3 are composed of ten modules that provide a guide for programme planning. The four modules in Chapter 2 cover assessment of the current situation and setting priorities. The six modules in Chapter 3 each present a step in the process of developing a plan for a national CBR programme.

Chapter 4 addresses six aspects of programme implementation that frequently require special attention from programme managers. Chapter 5 provides a guide for programme evaluation.

Every country has established practices and procedures for the planning and management of its health care system. The principles presented in this guide are intended for application within any national system.

Although all CBR programmes and rehabilitation referral systems have characteristics in common, each is naturally unique to its own national setting. The description of CBR and the health care referral services presented in this guide may be viewed as a model to be adapted to individual country situations.
**LIST OF ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CBR</td>
<td>Community-based rehabilitation</td>
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<tr>
<td>CHW</td>
<td>Community health worker</td>
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<tr>
<td>CRW</td>
<td>Community rehabilitation worker</td>
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<tr>
<td>ICIDH</td>
<td>International Classification of Impairments, Disabilities and Handicaps</td>
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<td>MLRW</td>
<td>Mid-level rehabilitation worker</td>
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<tr>
<td>MOE</td>
<td>Ministry of Education</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOSA</td>
<td>Ministry of Social Affairs</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<tr>
<td>PHC</td>
<td>Primary health care</td>
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<td>P/O</td>
<td>Prosthetics and orthotics</td>
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CHAPTER 1.
AN OVERVIEW

WHAT IS DISABILITY?

The management of a rehabilitation programme for people with disabilities requires a clear definition of who is disabled. In many countries, the definition varies among the health, educational, vocational, and social services. This can lead to confusion and lack of coordination in the provision of rehabilitation services.

The World Health Organization has developed the *International Classification of Impairments, Disabilities, and Handicaps* (ICIDH) (WHO 1980). The ICIDH has been translated into thirteen languages and is being used by governments and NGOs. It is currently under review and will be revised. Definitions of the terms *impairment, disability*, and *handicap* are presented in the box below.

<table>
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<tr>
<th><strong>ICIDH definitions</strong></th>
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<tr>
<td><strong>Impairment</strong>, in the context of health experience, is any loss or abnormality of psychological, physiological or anatomical structure or function.</td>
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<td><strong>Disability</strong>, in the context of health experience, is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.</td>
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<tr>
<td><strong>Handicap</strong>, in the context of health experience, is a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, social and cultural factors) for that individual.</td>
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The concept of handicap also includes the role of the society in creating barriers and limiting opportunities for people with disabilities.

The definitions of these terms are useful in planning for rehabilitation within the health care services because they bring attention to the continuum needed between disability prevention and rehabilitation. Prevention of disabilities begins with the primary prevention of diseases, injuries, and conditions that can lead to impairments and disabilities. Secondary prevention, or treatment of diseases, injuries, and potentially disabling conditions, prevents the sequelae of impairments and disabilities.

Tertiary prevention includes interventions to limit or compensate for impairments or disabilities. An example related to impairment is the proper
positioning and movement of paralysed limbs to prevent deformities. This prevents the impairment (paralysis) from progressing to deformities, which would increase the disability. In another example, eye glasses can compensate for a visual impairment and eliminate a disability.

Disabilities are limitations that a person experiences as a result of an impairment. When it is not possible to change or to compensate fully for an impairment, rehabilitation consists of training a person with a disability to improve his or her function despite the impairment. The person learns to perform activities, but in a modified manner or with the aid of special equipment. For example, a person who cannot hear learns to use sign language, or a person who is unable to walk learns to move around in a wheelchair.

Handicaps are social disadvantages experienced by people with impairments and disabilities when they are prevented from living a normal life. Barriers to participation in school, work, and social activities may be physical, such as buildings that are inaccessible or signs that cannot be read, or they may be attitudinal, such as customs that prevent disabled people from participating in community life.

In many countries, these definitions and concepts have not been clarified. Welfare or insurance payments for "disability" are often based on impairments, such as absence or paralysis of a limb, or degree of blindness or deafness. At the same time, educational and vocational services may be based on disabilities. The census or surveys may collect information on a mixture of impairments and disabilities without appropriate data to link the two conditions.

The definitions of impairment, disability, and handicap are important for planning rehabilitation services and the social integration of people with disabilities. Identifying impairments is useful for planning medical interventions and the provision of technical aids. Identifying disabilities is useful for planning services that include training for daily activities, education, and skills training for income-generating activities. Identifying handicaps is important for planning measures to remove barriers to social integration. For coordinated planning and programmes, the definitions of these terms should be the same for all sectors.

WHAT IS REHABILITATION?

Rehabilitation is a process that assists people with disabilities to develop or strengthen their physical, mental, and social skills. Rehabilitation has many aspects. At one point in the life of a child with a movement-related disability, for example, the most crucial need will be to provide training and equipment for mobility. For a child who is deaf, the first priority will be training for communication. Both children will later need education and perhaps skills training for work. Both should be able to join in the activities
of their families and communities. To achieve such ends, the rehabilitation process requires different types of services, as well as community action.

Rehabilitation within the health care services has traditionally been thought to involve the provision of therapy—physical, occupational, and speech—as well as special equipment. Traditional rehabilitation services are provided in various settings, for example, special institutions, hospitals, and out-patient clinics. In some countries, these services are delivered in people’s homes. They are generally not provided in coordination with other services. Community-based rehabilitation (CBR) enlarges the concept of rehabilitation to include all of the services that assist disabled people to develop their abilities.

The three major strategies for rehabilitation—institution-based, outreach, and community-based—are described in the box on page 4.

As noted in the Introduction, this guide was prepared for managers of programmes that use primarily the CBR strategy for the rehabilitation and social integration of people with disabilities.

THE SCOPE OF A NATIONAL CBR PROGRAMME

Rehabilitation for people with disabilities cannot be accomplished by only one sector or one type of service. Health, education, vocational, and social services all contribute to the rehabilitation process, although usually one ministry is designated responsible for management of the rehabilitation programme at the community level. This multisectoral support for CBR is presented in Community-Based Rehabilitation for and with People with Disabilities, a Joint Position Paper by the International Labour Organization, the United Nations Educational, Scientific and Cultural Organization, and the World Health Organization.

In countries where the Ministry of Health (MOH) is in charge, the community health worker (CHW) provides the link with the community and takes responsibility for rehabilitation activities at the community level. When the Ministry of Social Affairs (MOSA) is in charge, there may not be a contact person in every community, so volunteers are identified to become community rehabilitation workers (CRWs). Alternatively, a community development worker, where such a cadre exists, is designated responsible for rehabilitation.

Some countries have a national coordination committee for rehabilitation, composed of representatives of the various sectors providing rehabilitation services, of nongovernmental organizations (NGOs) of disabled people, and of NGOs providing rehabilitation services. A representative of the ministry concerned with local government may also be included, since this ministry works to promote disability-related issues as part of community development activities.
Major strategies for rehabilitation

Institution-based rehabilitation services may be provided in a residential setting, or in a hospital where disabled people receive special treatment or short-term intensive therapy. The institution-based approach focuses on the person's disability and gives little attention to the person's family and community, or to other relevant social factors. The major shortcomings of institution-based care are its high cost and its location, usually in urban centres, making it inaccessible to those living in outlying areas. In addition, specialized institutions often lack qualified personnel. Competent institution-based care, however, is an important part of the rehabilitation referral system for the provision of special assessments, surgical interventions, other skilled treatment, and specialized equipment.

Outreach rehabilitation services are typically provided by health care personnel based in institutions. Such a programme provides for visits by rehabilitation personnel to the homes of people with disabilities. The focus is on the disabled person, and perhaps the person's family. Education and vocational training are generally not included. Community involvement in these services is usually limited, with the result that they evoke little social change. The cost per person treated is high. Outreach services can be a valid part of the referral system, however, when used in special situations, such as the delivery of services to extremely remote areas.

Community-based rehabilitation (CBR) is characterized by the active role of people with disabilities, their families, and the community in the rehabilitation process. In CBR, knowledge and skills for the basic training of disabled people are transferred to disabled adults themselves, to their families, and to community members. A community committee promotes the removal of physical and attitudinal barriers and ensures opportunities for people with disabilities to participate in school, work, leisure, social, and political activities within the community. A person is available in the community to work with disabled people and their families in rehabilitation activities. Disabled children attend the local school. Community members provide local job training for disabled adults. Community groups assist the families of disabled people by providing care for their disabled children or adults, transportation, or loans to initiate income-generating activities. Community resources are supported by referral services within the health, education, labour, and social service systems. Personnel skilled in rehabilitation technology train and support community workers, and provide skilled intervention, as necessary.

In addition to participating in the national coordination committee, each sector and organization has its specific plans for the delivery of services or for activities to promote rehabilitation. Mechanisms for the coordination of these services and activities may be stated in general terms at the national level, but will be more defined at the peripheral levels, where referrals actually take place and where all sectors are involved with the community.
National administrations vary in their degree of decentralization. It is easier to coordinate services as part of CBR when authority has been decentralized to the local level. If decision-making is carried out primarily at the national level, it is imperative that plans for coordination of services and NGO activities be conveyed to the district and community levels.

To provide the variety of services necessary for rehabilitation is not an easy task in any country. The health care sector will be called upon to provide specialized rehabilitation personnel. The education sector will find that many disabled children can be integrated into local schools, but that the teachers will require training in order to be able to assist them. The social services sector will find that some disabled people can receive job training along with the able-bodied. Others, however, will require special training and specially adapted work places. Very often, ministries simply do not have the resources to provide for these.

To distribute services to all parts of the country is another difficult task. Most rehabilitation services are based in large cities. These services are rarely adequate to meet the need in urban, much less rural, areas. Here NGOs can make a significant contribution to a national plan by coordinating their activities with the government to ensure that rehabilitation personnel and services are distributed throughout the country.

The development and distribution of services is best done in response to needs identified at the community level. CBR provides a framework to facilitate this process. Services at other levels relay information from the community and back again. But the beginning and end of the action is always in the community.

**Community level**

In CBR, people with disabilities are active in their own rehabilitation, rather than passive recipients of services. Disabled people assist each other in the rehabilitation process and join in advocating for people with disabilities. Through sensitization programmes and by seeing the lives of disabled people improved through rehabilitation, the community becomes educated about disability. Negative attitudes begin to change. Information about skills training or income-generating projects for people with disabilities is made available to the community, with the result that opportunities are given to disabled people to work or to join in social and political activities. National organizations of disabled people are decentralized to the community level and become active in local activities.

In communities where there are few rehabilitation referral services, families may take the initiative to work alone in rehabilitating their disabled children or adult members. In many instances, the efforts of the family alone are effective. A child is taught to move around, for example, or to feed herself. For some rehabilitation activities, however, such as training a child who is deaf to communicate, preventing deformities in a child with
a paralysed limb, or providing appliances or other aids, the family may need outside help.

In a CBR programme, a local committee takes responsibility for the comprehensive rehabilitation process. This committee may be the community development (village) committee, the community health committee, or a specially formed rehabilitation committee. Its job is to facilitate the rehabilitation of disabled community members.

If it is the community development (village) committee that takes responsibility for rehabilitation, then the representation of local political and administrative bodies; the health, education, and social sectors; and community organizations is assured. People with disabilities should also be represented on the committee. If another local committee is responsible for rehabilitation, the representation should be the same.

The community alone cannot meet all of the needs of people with disabilities. Certain referral services should therefore be available in a region before a community programme is initiated. The extent of these will vary from country to country. However, the following preconditions will make it easier to begin CBR in any country:

- community leaders and organizations who agree to support and participate in the programme
- community rehabilitation workers who will be available
- personnel who will train and support the community workers
- rehabilitation personnel who will be available within the referral services
- referral services that will provide basic appliances and equipment

The way in which community activities are initiated will vary from country to country. It is generally neither a top-down nor a bottom-up process. It is unrealistic, however, to wait for each community to develop the idea of community involvement in rehabilitation. It is also unrealistic to expect community members to take part in the rehabilitation process if they have not participated in the initiation of the rehabilitation activities. Hence, a CBR programme begins with a stimulus external to the community, but develops within the community.

Also varying from country to country will be the ministry initiating the programme at community level, the committee responsible for rehabilitation within the community, and the cadre responsible for rehabilitation within the community.

The ministry in charge of CBR is usually the MOH or the MOSA, but that ministry may work through the local government in initiating and coordinating activities at community, district, and provincial levels. The initial contact with the community may be made jointly by the ministry in charge of CBR and the ministry responsible for local government. This is followed by the
development of community awareness and motivation, and then action. The initial actions are the formation of a committee and the selection of a rehabilitation worker. Sometimes communities do not participate fully until they see the community rehabilitation worker provide information that actually benefits people with disabilities, and that at least some referral services are available to support community efforts. NGOs can play an important role in stimulating community involvement. A Red Cross or Red Crescent Society or an organization of people with disabilities, for example, can work with community leaders to initiate CBR activities.

The ministries that have a cadre of workers in the community must decide whether these workers can add rehabilitation to their responsibilities. This decision is usually made at the national or provincial levels. It is not practical to make this decision within each community, which could result in different cadres of workers and systems of supervision within each district. If the ministries decide that the workers already in the community cannot take on additional responsibilities, then special volunteers for CBR will be required. In this situation, the selection of a community worker may be left entirely to the community.

If the MOH is in charge of CBR and it is decided that community health workers will also have the responsibility to act as community rehabilitation workers, the medical rehabilitation services will have a direct link to the community for the referral of clients and for the training and supervision of CBR workers. If another ministry is in charge and the CRW will be from that ministry or from an NGO, the procedure for supervision at the community level must be clarified. While it is necessary to have one supervisor for the CRW, it is also necessary to recognize the variety of activities that this person may carry out, and the need to have information from all services involved in rehabilitation (e.g., health, education, and vocational) reach the community through the CRW.

**District (first-referral) level**

The word *district* does not have the same meaning in all countries. In larger nations, it may encompass a population of one million people, while in a smaller country, a district may have a population of 100,000. In this guide, the term *district* refers to the area covered by the first-referral level hospital, and also to the most peripheral unit of local government and administration that has comprehensive powers and responsibilities.

There should be a district committee responsible for CBR to ensure that district-level services respond to community needs, and also to coordinate services. The district committee should be similar to the community committee in composition, but with an additional representative of the community committees. If the community development committee is responsible for CBR at the community level, then the district development committee should have this responsibility at the district level.
The district is a key point in the delivery of rehabilitation services. A district hospital or health centre will be accessible to most people in the area and can provide first-referral level services to disabled people. District-level rehabilitation staff can travel throughout the area to provide technical supervision, and district-level staff for health, education, and social services can coordinate their work in support of community activities.

The MOH may have mid-level rehabilitation workers (MLRWs) at the district hospital. The MLRW should be trained to work not only with people with locomotor disabilities, but also with people who have disabilities resulting from sensory or mental impairments. In addition to technical training for CBR, the MLRW is trained in management and supervision, including record keeping, reporting, and referral coordination. The MLRW also provides technical supervision of rehabilitation workers at the community level.

Other sectors involved in rehabilitation may have offices or centres at district level. An office for social welfare, for example, may be responsible for providing financial or material assistance to people with disabilities. In countries where the Ministry of Social Affairs (or Social Welfare) is responsible for rehabilitation, the district office may have a representative specifically for rehabilitation. At the district level, the Ministry of Education may also have resource teachers or a centre for special education. These teachers may be responsible for advising teachers in local schools how to integrate disabled children into regular classes.

**Provincial (second-referral) level**

For the purposes of this guide, only one level of health services between central and district levels is described. The term *provincial* is used to refer to the second-referral hospital and to the area covered by the health services under the administration of this hospital. Countries may use different terms, such as *regional* or *state*, to refer to this level. Countries may also have more than one level of service and administration between the first-referral and national levels.

At the provincial level, there should be a provincial committee responsible for CBR. The committee should be similar to the district and community committees in composition. If development committees have responsibility for CBR at other levels, then the provincial development committee should also have this responsibility.

The provincial health, educational, and vocational services are each distributed as evenly as possible. Staff based in provincial centres provide training and technical supervision for rehabilitation workers at the district level.

Within the medical services, routine procedures for rehabilitation are carried out by physicians, therapists, and prosthetists/orthotists. At the
provincial level, direct services are provided to clients referred from the district level. An important role for some of the rehabilitation staff is the training and supervision of rehabilitation workers at the district and community levels.

A few special schools and vocational training centres for the disabled may also be located in provincial capitals. These are likely to be managed by NGOs, but located according to a national plan for distribution of the services. Disabled people who wish to benefit from the education or training offered and who do not live in the larger cities must reside at the school or centre.

**Central (third-referral) level**

In this guide the term *central* is used to refer to the third-level referral services, such as speciality hospitals in major urban areas, which serve as national referral centres.

As noted above, a national coordinating committee for CBR should be established at the central level. The composition of the national committee should be similar to that of committees at other levels. In countries with centralized administrations, the national committee will be composed of the representatives who make policy and programme decisions related to their sectors. In countries with decentralized administrations, the national committee will act as an advisory group to the committees at provincial and district levels, and also promote national policies in support of rehabilitation.

In both types of administrations, the national committee should provide a forum for information exchange and identification of priorities at various levels. It also works to coordinate multisectoral activities, to identify gaps and redundancy in services, and to maintain communication between consumers and service providers to ensure that the services are actually responding to needs.

The MOH may have a medical rehabilitation centre or service located in a large central hospital. There may also be a university or private hospital that offers rehabilitation services. Within these services there will be physicians with specialties related to rehabilitation, such as orthopaedics, neurology, and psychiatry; physical, occupational, and speech therapists; and prosthetists/orthotists.

Within a national CBR programme, the MOH has a management team responsible for the distribution of rehabilitation services at all levels. In addition, staff at the central level provide specialized services to disabled people referred from other levels. The services within the central facilities should be coordinated. If services for people with a particular type of disability exist in several centres, it is preferable to review the location of these services in order to avoid redundancy. For example, services for
people with amputations might be expanded at one centre and services for children with cerebral palsy at another.

The Ministry of Education may provide special schools for children with specific disabilities, or such schools may be provided by NGOs and located according to a national plan. They are most often located in urban areas. Many are residential because of the difficulty for children with disabilities to travel each day between home and school. Within these schools there may be several special educators, trained to teach children with specific types of disabilities. The other teachers may have had training on the job from the special educators. There may be no service in the regular school system for children with disabilities.

As part of a national plan for CBR, the Ministry of Education promotes the integration of disabled children into local schools and provides specialists as resources for the regular school system. This allows more disabled children to attend school and to live at home, rather than in an institution. The specialists train teachers to teach disabled children who remain in regular schools. These specialists may also be available to assess children with impairments and recommend specific follow-up to teachers in local schools. Or such schools may be provided by an NGO and located according to a national plan.

Vocational training for people with disabilities may be provided by the Ministry of Labour or the Ministry of Social Affairs. It may be offered as part of training programmes available to able-bodied individuals. Sometimes NGOs provide this service for disabled people who require special training or an adapted workplace. Vocational training centres, however, are often located in urban areas and are not readily available to people from rural areas.

As part of a CBR programme, the Ministry responsible for vocational training coordinates the expansion of government and NGO vocational training programmes to increase their availability to disabled people throughout the country. This includes the orientation of staff in vocational training centres to the needs of people with disabilities. It also includes working with community organizations and artisans involved in job training or income-generation projects to help them understand what disabled people are able to do and how they can be included in community vocational training programmes.

The Ministry of Social Affairs (or Social Welfare) may be responsible for social support programmes for disabled people, such as disability payments or funding for special equipment. These services will be available through social welfare offices at national, provincial, and district levels. The Ministry of Social Affairs (or Social Welfare) also participates in intersectoral efforts to identify people with disabilities and ensure that they receive appropriate social support and services. Through their contacts with
community leaders and organizations, social workers can also promote positive changes in attitude towards disabled people.

Each Ministry involved in rehabilitation provides specialized services. Within these specialized services there may be little attempt to coordinate all aspects of the rehabilitation needed by one individual. Often it is only the most obvious need that receives attention. For example, a disabled child may be provided by one service with a brace for walking, but the child's family may not be informed of what opportunities will later be available from another service for training for income generation. This lack of coordination may be particularly marked within the central services, which are based in large urban areas and geographically separated from one another. At district level, there may be more communication, hence more intersectoral coordination.

Within a national plan, the CBR concept is applied at all levels. This requires the coordination of services and the active participation of the community in urban as well as rural areas. The central services coordinate services at all levels, including their own. To do this, the technical sectors for rehabilitation must work in collaboration with the local or municipal government structure.

**CBR managed by the Ministry of Health**

If the Ministry of Health is in charge of a CBR programme, the personnel within the health care system has responsibility for rehabilitation activities at all levels. At the district and community levels, the mid-level rehabilitation workers manage the programme and supervise the community rehabilitation workers. The MLRW therefore requires training in rehabilitation involving a variety of disabilities, as well as in community development and management. At the community level, community health workers assume responsibility for rehabilitation. If the CHWs have too many other responsibilities, a cadre from another ministry or volunteers must be identified to act as CRWs.

Before starting community-level rehabilitation activities, consideration should be given to the level of development of health services in the area. Experience has shown that CBR works best in communities that have access to health services. For most community members, disease and illness take priority over disability. When general health services are not available, people may not be interested in developing services only for people with disabilities.

**CBR managed by the Ministry of Social Affairs**

In some countries it will be the Ministry of Social Affairs (or Social Welfare), rather than the Ministry of Health, that is in charge of CBR. If the MOSA is in charge of CBR, it is responsible for coordination of services at all
levels. The MOSA will have social welfare officers, and perhaps rehabilitation officers, at district level. If a CBR programme is managed by the MOSA, these officers will be responsible for coordination of rehabilitation activities at the district and community levels and for supervision of the CRWs. The CRWs may be a cadre from another ministry or they may be volunteers.

When the MOSA is in charge of CBR, the role of the MOH is to provide rehabilitation referral services at all levels and to participate in the training of the CRWs. MLRWs provided by the MOH at the district level, for example, would work primarily with people referred to the district hospital.

SERVICES PROVIDED BY THE HEALTH SECTOR

Services for disability prevention, early detection, and intervention

Health services routinely implement some measures for the prevention of disabilities, such as immunization and maternal and child health care services. Within a CBR programme, however, the collaboration among primary health care (PHC) and rehabilitation personnel results in a continuum of services related to disability prevention. These include primary prevention; secondary prevention, or the treatment of diseases and injuries to prevent impairments; and tertiary prevention (which includes rehabilitation) to limit the effect of impairments, disabilities, and handicaps. *Disability Prevention and Rehabilitation in Primary Health Care: A Guide for District Health and Rehabilitation Managers* (WHO/RHB/94.2) was prepared for CBR managers who wish to strengthen health services within the district for disability prevention and the delivery of services for people with disabilities.

Primary health care personnel contribute significantly to disability prevention. In their various roles, physicians, nurses, health assistants, midwives, and other PHC workers provide preventive, promotive, curative, and rehabilitative care, which covers all levels of prevention. Nurses and midwives are particularly well placed to detect impairments or disabilities in babies or small children and to promote early intervention. All PHC personnel can be trained to detect conditions that cause impairments or disabilities and to recommend follow-up.

Rehabilitation and PHC personnel can collaborate to inform the community on the prevention of impairments, disabilities, and handicaps, through meetings with community groups, the general public, and the local media, for example.

Strengthening the referral system among PHC, hospital, and rehabilitation services can also contribute to the prevention of disabilities. Most people with acquired disabilities enter the hospital for intensive medical care
following an injury or the onset of a condition that has caused the disability, such as an amputation following an accident or paralysis caused by a stroke or polio. This provides the opportunity for immediate referral to rehabilitation services. Unfortunately, such referrals are often made irregularly or too late to provide the most effective intervention. It is the responsibility of rehabilitation personnel to work with other health care staff to establish a regular routine for referral to rehabilitation services and follow-up.

**General health services for people with disabilities**

Too often children and adults with disabilities do not receive the routine health services that are available to able-bodied people. Disabled children may not be immunized, for example, or may not receive routine care for common childhood illnesses. Adults with disabilities may also be deprived of health services. This situation exists for a number of reasons: health services may be inaccessible to disabled people, disabled people may not expect to receive services, or health professionals may not know how to judge the health status of a disabled person.

All doctors, nurses, and other health workers should be trained to work with people with disabilities. They will require a basic understanding of impairments and disabilities in order to provide basic health services, and also to advise disabled people and their families about the prevention of deformities and their potential to lead a normal life. All health care workers should be aware of the resources available to people with disabilities through appropriate referral.

**Coordination of general health services and rehabilitation services**

In a CBR programme, the coordination of medical, educational, vocational, and social rehabilitation services at the district level is crucial. The district level is the first level of support for community activities. To provide this support, district officers for health, education, and social services must agree on mechanisms for referral and exchange of information.

District-level personnel, however, require the approval of the central and provincial levels for their activities. Coordination of various district-level services is thus facilitated by communication and cooperation at the central and provincial levels. In countries where there is a national committee for rehabilitation, coordination is encouraged at all levels. When there is no committee, or the committee does not function well, rehabilitation services may be coordinated in some provinces or districts, but not in others.

In many countries, the Ministry of Social Affairs chairs the national committee for rehabilitation. It is extremely important that the MOH be
active on this committee. Personnel within the medical rehabilitation services often have the first contact with disabled people seeking services and therefore the first opportunity to make referrals. If the medical rehabilitation personnel do not work in coordination with other services, some disabled people will not complete the rehabilitation process.

The responsibility of the MOH for planning, coordinating, and implementing its rehabilitation services should not be viewed in isolation. Rather, it should be seen as part of the overall national rehabilitation programme. In order to have optimum impact on the lives of disabled people, the health system’s rehabilitation services must be combined with the other services that are part of rehabilitation. The efforts spent in coordination with other services are also efforts directed at the efficiency and effectiveness of the rehabilitation services in the health care sector.

**Services that provide rehabilitation equipment**

Depending upon the country, responsibility for specific rehabilitation services and personnel may fall under a variety of ministries. Prosthetic and orthotic workshops, for example, may be managed by the ministry in charge of social services, while technical aids and special equipment are provided by NGOs or the private sector. The MOH may be responsible for the provision of artificial limbs and braces, but ministries rarely take responsibility for the production of technical aids and special equipment. The MOH, however, should be aware of what services exist in this area and should promote their development. The provision of equipment can be included in the MOH national plan for rehabilitation services, even though the ministry is not responsible for the actual implementation of that part of the plan.

In developing countries, a major problem for people with movement-related disabilities is the lack of appropriate wheel chairs. Models imported from industrialized nations are often inappropriate, and their repair difficult or impossible locally. Different types of special equipment may be needed in different parts of the country. A small trolley, which allows the person to sit close to the ground, may work well in or around the home, while another aid would be better for moving about in a village or city. Each country must decide what equipment is most appropriate to meet the needs of its people and what can be produced locally.

People with movement-related disabilities also need aids for walking. These include canes, crutches, and walking frames. Some hospitals maintain a supply of these aids and give, rent, or sell them to clients. In some CBR programmes, the family of a disabled person or a local craftsman is asked to make them. The production of these aids is not as simple as it appears, and the results of such efforts are mixed. Aids should be tested, and if breakage is common, the materials or design should be changed.
People with disabilities also need adaptive devices. These devices are usually simple and can be made by local craftsmen or the family. They include utensils, tools, or other household items specially adapted for the disabled person’s use. Furniture may also be adapted. Beds or chairs may be raised or lowered, for example. Special seats may be made for small children who require support while sitting. CBR staff should provide disabled people with examples of adapted equipment and the directions for making them. Some rehabilitation centres may have a small budget to provide materials to disabled people who cannot afford them.

People with seeing impairments may need eye glasses. For example, children with visual impairments may be disabled unnecessarily, simply because they have no glasses. An appropriate pair of glasses could eliminate the disability and allow the child to live normally. Older people with visual impairments will have the same need. Eye glasses can be produced at relatively low cost.

A blind person may use a cane to move around. Although a stick could do the job, a cane is easier to hold and more attractive. Canes for the blind can be produced together with canes for the mobility impaired.

As with people with visual impairments, people with difficulty hearing may be unnecessarily disabled because they do not have hearing aids. Hearing aids cannot be produced as inexpensively as eye glasses, but they can be made available at low cost. If hearing aids are to be provided as part of a CBR programme, the programme should ensure that hearing aid batteries are also available and that the hearing aids can be repaired as necessary.

If special equipment for the disabled is produced at only one or two centres within a country, then a reliable distribution system will be needed. Services for repair and replacement must also be established. The MOH can facilitate the production, distribution, and maintenance of equipment.

THE REHABILITATION PERSONNEL

Community rehabilitation workers

In primary health care, the community health worker facilitates community action to improve the health of all members of the community. In community-based rehabilitation, the community rehabilitation worker facilitates community action to improve the physical, psychological, and social status of people with disabilities. The CRW is a resource for disabled people and their families, and for other community members who wish to contribute to the rehabilitation process. Since the roles of the CHW and of the CRW are closely related, it can be helpful to have the same person fill both.
When the CRW is a volunteer, the community may select the individual. The community also decides on the tasks to be performed by the CRW, the amount of time the volunteer should devote to rehabilitation, and the remuneration that the community will provide. If the volunteer is provided by an NGO that is active in the CBR programme, the NGO and the community together may select the volunteer.

The responsibilities of the CRW include

- identifying people with disabilities;
- undertaking basic assessment of the disabled person's capabilities;
- providing information to disabled people and their families on appropriate training;
- referring disabled people to district level, as necessary;
- maintaining records of training and progress of disabled people;
- providing information to the community on the causes and prevention of specific disabilities;
- working with community leaders and organizations to assist people with disabilities or their families, as necessary, and to facilitate the integration of disabled people in family and community life;
- assisting people with disabilities to establish or strengthen their own organizations, which can participate in the CBR programme;
- participating in the community committee for CBR.

These activities are described in *Training in the Community for People with Disabilities* (WHO 1989). In this manual, the CRW is referred to as the *Local Supervisor*.

**Mid-level rehabilitation workers**

The tasks of the mid-level rehabilitation worker are defined in *The Education of Mid-Level Rehabilitation Workers; Recommendations from Country Experiences* (WHO/RHB/92.1). These recommendations were developed on the basis of country experiences illustrating a wide variety of CBR infrastructures. For example, some countries have MLRWs who work in both the hospital and the community, while others have MLRWs who work only in the community. The recommendations are considered preliminary, pending further country experience.

The recommended responsibilities of the MLRW include

- identifying disabilities and the specific rehabilitation needs of individuals;
- providing mid-level therapeutic interventions;
- referring individuals to higher levels or other sectors, as necessary;
- assisting community rehabilitation committees to plan and implement CBR programmes;
• supporting and monitoring rehabilitation activities of CHWs;
• supervising record-keeping and reporting by CHWs;
• training CRWs and providing information to the community in support of CBR activities.

These tasks require skill in technical aspects of rehabilitation, as well as skill in community work, management, and training. The MLRW is generally under the supervision of the district medical officer, with periodic technical supervision from therapists at the provincial level. The MLRW must have space and equipment in order to provide adequate services at the district hospital.

Because of their responsibilities at district level and their position between community and provincial or central levels, this group of workers is referred to as mid-level. Titles for this cadre differ from country to country.

Countries have found different ways to provide for MLRWs. Some MOHs have developed a specific cadre of personnel with one to two years of rehabilitation training. Another approach is to re-train personnel who are being made redundant, for example workers in a leprosy programme located where the incidence of the disease is greatly reduced and fewer workers are needed. Some countries add rehabilitation to the responsibilities of a cadre of personnel already in place, such as social workers. In this case, the MLRW works exclusively within the community, providing supervision to CRWs and interventions for disabled people referred by the CRW. As noted earlier, if the MLRW is not based within the health services, the MOH collaborates with the appropriate ministry to provide training of MLRWs and referral services.

In order to coordinate services for people with different types of disabilities, the MLRW is required to work with referral services in the health, education, vocational, and social sectors. The MLRW maintains contact with all services and resources related to rehabilitation.

**Prosthetists and orthotists**

Most countries have prosthetists/orthotists in at least one central facility. Their task is to fabricate and fit artificial limbs and braces. In many developing countries, the number of prosthetic/orthotic personnel is minimal, as is the number of disabled people who have access to these services. This service is considered costly because it involves not only the training and posting of prosthetists/orthotists, but also the establishment of workshops and a regular supply of materials. Despite the cost of establishing and maintaining orthopaedic workshops, this service is vital for disabled people who need specialized appliances in order to move around. Braces, for example, can allow a disabled child to attend school or a disabled adult to work.
In many countries, it is customary to train personnel in both prosthetics and orthotics. Most countries, however, cannot field sufficient staff to meet the needs. One approach to this situation is to train personnel selectively, depending upon specific needs. Personnel could be trained in either lower limb orthotics or lower limb prosthetics, for example. The former would be appropriate where there are many children with disabilities caused by polio, and the latter where a natural disaster or war has left many people with amputations. Such selective training is described in the WHO document Guidelines for Training Personnel In Developing Countries for Prosthetic and Orthotic Services (WHO/RHB/90.1).

Staffing for prosthetic/orthotic services also includes technicians. These may be craftsmen skilled in wood, metal, or leather working; or they may be workers trained on the job to prepare specific components of the appliances. This second group of workers can undertake much of the manual labour, while the prosthetists/orthotists focus on the fitting and alignment of the appliances.

In countries where it is not possible to have prosthetic/orthotic workshops in each district, prosthetic/orthotic staff must travel to outlying areas to provide services, or disabled people who need appliances must travel to the workshops. In either case, a CBR programme should provide follow-up for individuals who receive appliances. This consists of periodic checks to ensure that the person is using the appliance and that the appliance fits comfortably and is in good repair. The MLRW may be trained to make minor repairs of appliances. When major repairs or alterations are needed, the individual should be referred to the prosthetist/orthotist.

**Physical, occupational, and speech therapists**

Most developing countries have at least a few physical therapists in central hospitals. In larger countries, there may be many physical therapists at the central level, some at the provincial level, and a few at the district level. In smaller countries, the therapists may be only at the central level in the government service, or perhaps also at the provincial level in hospitals managed by NGOs.

Physical therapists in large central hospitals are often fully occupied with caring for people with acute, short-term conditions, rather than providing rehabilitation services to people with permanent disabilities. In such a situation, the therapists may not be prepared to provide skilled services for the permanently disabled, or to act as trainers and supervisors of mid-level and community workers.

Therapists who provide exclusively acute care may forget their basic training in rehabilitation procedures for disabilities caused by chronic conditions such as cerebral palsy or hemiplegia. Therapists who join a
CBR programme may require refresher courses to enable them to provide referral services. They may also need experience at the community level before they can provide technical advice to people in rural areas. Therapists who will be involved in the planning and implementation of medical rehabilitation services may also require training in management. Others who will become trainers at the district and community levels may need training to prepare themselves as teachers.

In all countries the number of occupational therapists is less than the number of physical therapists. In general, occupational therapists focus on training disabled people in functional activities, such as eating, dressing, and carrying out household tasks. Occupational therapists usually work with the permanently disabled, whereas physical therapists work with both permanently disabled people and those with acute needs. Occupational therapists are also trained to work with people with mental disorders. Hence, they are prepared to work in mental health programmes, as well as in programmes for people with locomotor impairments.

Like physical therapists, occupational therapists should be included in the national CBR management team and in the group that trains and supervises mid-level workers. Their training in mental health should be utilized to ensure that people with mental disorders are included in the CBR programme.

Like physical therapists, occupational therapists working at central level may require experience at the community level before they can provide technical advice to people in rural areas.

Speech therapists are needed within the health care system to provide services for individuals with neurological impairments that affect either their speech or language. Very few developing countries have speech therapists in the government health service. Most countries give priority to physical and occupational therapists because of the greater need in these areas. Experience shows, however, that as CBR services develop, the demand for speech therapy also grows, and these therapists are added to the staff at central and provincial levels.

A few countries may have speech therapists in the school system. These therapists generally work with children with speech impairments, such as stuttering, and are not trained to work with individuals with language impairments, such as aphasia. However, if speech therapists are available, arrangements can be made to use their services within a CBR programme. For example, they can inform teachers in the regular schools about speech impairments commonly found in children and basic techniques to help a child correct a speech impairment. Speech therapists can also provide referral services at the central and provincial levels for children with severe impairments who have been referred.
Teaching language to children who are deaf is another special skill. Individuals trained to provide this service are called special educators. They work in special schools for the deaf, but may also be available to the CBR programme to train MLRWs to work with the families of deaf children.

Physicians who provide rehabilitation services

The general physician may have the most important role in the care of people with disabilities, yet he or she is usually poorly prepared to assume this responsibility. The doctor is often the disabled person’s first contact with health services. The disabled person, the person’s family, as well as nurses and other rehabilitation personnel all look to the doctor for advice. Indeed, the disabled person and the family may expect the doctor to provide a cure for the disability. The health and rehabilitation workers may want an opinion on the disabled person’s general condition or ability to perform an exercise or undertake a training programme. Unfortunately, the general physician has probably had no exposure to people with disabilities during his or her medical training. The doctor most likely does not know how to judge the potential of a disabled person and may be unable to predict the outcome of rehabilitation.

A major contribution to the development of a national CBR programme would be to include information on disabilities in the basic training of physicians and nurses and to provide in-service education on disabilities to those already working in the health care system. This would be appropriate at both the community and the first-referral levels.

Specialist physicians can provide referral services for rehabilitation. Specialty fields relative to rehabilitation include rehabilitation medicine, orthopaedic surgery, neurology and neurosurgery, paediatrics, psychiatry, plastic surgery, and ophthalmology, for example. In some countries, specialists in these areas are found only at the central level. Long-term plans for the national CBR programme, however, should provide for specialty services at the provincial as well as central levels.

The distribution of personnel at different levels of the referral system is discussed as part of detailed planning in Module Eight.

THE MANAGEMENT OF A CBR PROGRAMME

As noted in the Introduction, this guide is intended for CBR programme managers in the Ministry of Health who must advise on disability policies, as well as plan, implement, and evaluate their rehabilitation programmes. The focus is on planning, although all aspects of programme management are presented.

The management cycle

Management can be defined in several ways. To manage a business or a service, for example, may mean “to operate it.” In a large-scale
enterprise involving a large number of people, management can be defined as the art of “getting things done through people.” The emphasis on “getting things done” implies that people are organized and motivated to do the right things. Sometimes, to figure out what to do next, plans are made. Most of the time people carry out what is planned: they allocate resources, implement, and supervise. Occasionally, they measure the effect of what has been done: they assess performance and evaluate results.

A manager is the person responsible for carrying out these functions in an ongoing way. These inter-linked functions form “the management cycle.” This cycle consists of activities that actually overlap, leading naturally from one to another. There are three main components of management:

- planning
- implementation
- evaluation

Management begins with planning, which leads to implementation. Yet planning continues to occur during implementation. Evaluation also occurs during implementation and leads to further planning. Although the management cycle is dynamic, each component can be described and applied to any situation in which activities are carried out to achieve specific goals.

The management structure

The management structure of a CBR programme will depend on the existing structure of the ministry in which it is located. However, there may be flexibility in that structure, so that the CBR programme will be able to modify it. Some of the questions to be answered early in the planning process are

- Will the CBR programme management be centralized or decentralized?
- Will the programme be considered a specialized or vertical programme, or will it be integrated with other associated services and programmes in the health sector?
- Will the Ministry of Health work alone within the government, or will it coordinate its rehabilitation activities with other ministries?
- Will the CBR programme be implemented by the government alone, by nongovernmental organizations, or by a combination of the two?

In each of the above questions, the second alternative would be the ideal management structure to facilitate the implementation of a CBR programme. However, the planning and implementation of a national CBR programme must be done within the management structure that already exists within the country.
A major consideration is whether programme management will be centralized, decentralized, or a combination of the two. The following aspects of centralized and decentralized programmes may be useful to consider:

- A centralized programme may be appropriate for a small or sparsely populated country. Centralized management may be appropriate to a national programme that can be implemented consistently throughout the country and can function as a cohesive entity.

- A decentralized programme may be more appropriate for a large and densely populated country. Decentralized management may be more appropriate for programmes that cannot be implemented uniformly in all parts of the country, due to differences in geographical, social, or cultural conditions.

The following aspects of the planning process may be useful to consider:

- In a completely centralized programme, the planning for all areas of the country and for all levels is done at the national level.

- In a completely decentralized programme, policies and broad guidelines for planning are established at the national level. Detailed planning is then done at the provincial and district levels.

In many programmes there is a combination of the centralized and decentralized approach to planning, as well as to the other aspects of programme management. Each country must decide which responsibilities will rest at central level and which will be given to provincial and district levels.

The planning for a CBR programme is done more appropriately in a decentralized manner because the provincial and district levels necessarily coordinate their activities with other sectors at their levels. However, all of the factors noted above must be considered in this decision.

**The programme manager**

Management responsibilities at the various levels of the CBR programme will depend on the type of management structure selected. However, in both centralized and decentralized structures there must be some responsibility for management at all levels. Within the MOH there should be a national programme manager for rehabilitation. Depending on the degree of decentralization, however, the responsibilities of the national manager will vary. In a centralized structure, the national manager may be directly responsible for programme planning, implementation, and evaluation, as well as for coordination with other sectors involved in rehabilitation. For this degree of responsibility, a management team is required. In a decentralized structure, the national manager may be responsible for coordination among various sectors and for the coordination
of programme planning, monitoring, and evaluation. In a large country, a management team would also be required for these responsibilities.

Programme managers are also needed at provincial and district levels. In a large country, with a decentralized programme, it may also be necessary to designate a management team at these levels, or at least to designate one person with full-time responsibility for programme management. In a smaller country, with a more centralized system, responsibility for management may be given to rehabilitation personnel, who also retain some responsibility for providing services.

The planning process

Planning for a CBR programme will be carried out in a manner consistent with the planning procedures used within the MOH. A special planning committee may be formed to carry out the planning process. In some countries, a planning committee may be intersectoral, while in other countries, planning may be done within one ministry. If planning for CBR is done within the MOH, representatives of various programmes should be included in the process, particularly those involved in primary health care and the delivery of services at district level.

Since CBR requires support from various sectors, it is desirable to provide for an exchange of ideas and information with other sectors during the planning process. If this is not accomplished through an intersectoral committee, it can be done by the rehabilitation manager, who will be on the planning committee and who can maintain contact with the other sectors during the planning process.

The initiation of a CBR programme will take place within an established rehabilitation programme, which has decided to use the CBR strategy to expand services and to promote a complete rehabilitation process. At the time that a decision is made to prepare a national plan, the strategy may have already been implemented in one or more small areas of the country. The experience gained can be used in the planning. Rehabilitation staff currently in place will be responsible for implementing the new strategy, so they must be involved in the planning process to the greatest extent possible. The national programme manager, as well as managers from other levels and representatives of the various types of rehabilitation personnel, will be key members of the planning committee.

Chapters 2 and 3 present ten steps in the planning process. Each rehabilitation programme, and the ministry in which it is located, must decide how it will carry out the planning process for a national CBR programme.
CHAPTER 2.
THE CURRENT SITUATION

The first step in planning, and in policy formulation, is an analysis of the situation. The present situation is reviewed to determine what needs exist, which needs are currently being met, and what further action is required. A situation analysis regarding the needs of people with disabilities should include an analysis of existing policies related to disability issues, the number and location of disabled people and the constraints they face, and the rehabilitation services currently available to them. Based on this analysis, priorities for policies and for action can then be set.

When planners are identifying needs related to these three factors, they should keep in mind different kinds of needs. There are felt needs, which can be determined only by asking disabled people and their families what they feel is needed. There are expressed needs, as represented by the demand for services. This type of need must be considered cautiously because people may not seek services if they are unaware that the services exist, or if the services are inaccessible financially or geographically. There are also needs identified by professionals and administrators.

This chapter contains four modules. The first three describe components of the situation analysis, while the last suggests a method for setting priorities based on the analysis.

MODULE ONE: ANALYZING POLICIES CONCERNING PEOPLE WITH DISABILITIES

Contents

- Types of policies
- Specific legislation for people with disabilities

Types of policies

In general, a policy is a statement of goals and purposes. A policy may also specify overall principles to be followed in order to reach certain goals. Public policies are formulated by government, while any organization may formulate its own internal policies.
A national rehabilitation policy is an expression of goals for improving the situation of people with disabilities, the priorities behind these goals, and the main directions for attaining them. Some national policies concern all people and are therefore relevant to disabled people. Such policies may refer, for example, to human rights, the family, or children.

One aspect of the situation analysis is to determine how and to what degree current national policies influence the lives of disabled people. Many policies will be expressed in existing laws and legislation, and the review of legislative content is thus part of the situation analysis.

Policies are sometimes explicit, that is, they are clearly stated and adopted by legislative bodies and issued by various agencies. Explicit policies can be found in the country's constitution, national development plans, national budget documents, and official statements, as well as in legislation concerning the health, education, work, and social protection of disabled people.

Often policies are implicit, that is, they are not clearly specified. Implicit policies may be deduced from current ministerial decrees, administrative rules and procedures, statements by political parties, influential groups, or the press, for example.

When there are no explicit or implicit policies, the manner in which disabled people are perceived and treated within the society may be determined from current social customs and traditions—religious, ethnic, or other.

Various information sources will be useful in the policy review. The principle ones may be national organizations of people with disabilities, the Ministry of the Interior, and other ministries involved in providing services to people with disabilities. Information on existing or planned welfare, educational, and vocational programmes for the disabled may be found in the social section of a national development planning agency, as well as at the various ministries concerned.

The fundamental purpose of policy analysis is to determine whether and to what extent the government feels responsible for the rehabilitation of people with disabilities. The United Nations Decade of Disabled Persons (1983-1992) made it clear that governments are responsible for implementing measures recommended by the World Programme of Action Concerning Disabled Persons (United Nations 1983). These measures include the prevention of disability, the provision of rehabilitation services, and the equalization of opportunities for people with disabilities.

National policies naturally affect particular plans and programmes, their content and structure. It will be useful for planners to know to what extent decentralized authority patterns are encouraged by national policies and,
similarly, how far community or private self-help initiatives are supported politically.

Beyond the review of existing policy statements and national plans, knowledge of the national mechanism for policy making will help the planners to identify potential support for the actual implementation of measures to benefit disabled people. This may also explain why, in some cases, policies are not implemented, existing legislation is not enacted, and programmes not funded. Programme planners will need to uncover such "latent" or silent policies.

If issues related to disability are ignored and there is a clear absence of national policies on the subject, it becomes the responsibility of programme planners to show that disability is indeed a national priority. Promotion and education of the public and policy makers then become major programmatic thrusts.

In this endeavour, programme planners may find two powerful allies. The first is society's traditional approaches and positive attitudes toward the disabled. The second is the community's own spontaneous initiatives, however modest, to assist people with disabilities. Such examples should be examined and perhaps made the subject of further research. Positive outcomes of such initiatives can then be publicized and replicated through new policies in support of community initiatives.

Support for the development of national policies can also be found in international declarations and agreements, such as the Declaration on the Human Rights of Disabled Persons (UN 1975), the World Programme of Action Concerning Disabled Persons (UN 1983), UN Resolution (A/RES/47/88), Towards full integration of persons with disabilities into society: a continuing world programme of action, and the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (UN 1993).

CBR planners must be aware that any plan or programme may legitimately recommend the adoption of new policies or the enforcement of existing policies, as part of a proposed plan for the future. This is a good way to fill existing policy gaps. Therefore, it may be true that policies provide input to programmes, but they can also be their output, as when new policies are proposed among measures recommended for a new or expanded programme.

Specific legislation for people with disabilities

Laws relating to social welfare often ensure equal rights for various disadvantaged groups, including people with disabilities, by proclaiming their social equality. Some legislation may specifically mention disabled persons and attempt to define their legal or work status.
Specific legislation may protect disabled persons against negative discrimination, by imposing penalties for unequal treatment. An example of this is the "quota system," regarding employment. The first quota laws were passed in Europe in the 1940s. Quota laws require employers with more than a certain number of employees to hire a certain percentage of disabled people. Another type of law requires employers who neglect or choose not to hire disabled people to pay special taxes. Funds collected may be used to promote job opportunities for disabled people. In some countries, the employer who does not meet the quota is threatened with fines or prison terms. In developed countries, experience has shown that quota laws are relatively ineffective.

Any legislation may be ineffective if there is no authority to whom complaints can be addressed. For the disabled person, it is not easy to argue for one's rights when legal advice is unavailable or inaccessible. Legislation to benefit disabled people should be accompanied by the authority to enforce it.

The review of current legislation on disabled persons and information on how these laws are acted upon provide valuable insight to the planners and may also incite them to propose new legislation or amend existing legislation.
Contents

- Types of information
- Collecting information

Types of information

In addition to policies, information useful for planning a rehabilitation programme includes incidence and prevalence of different types of disabilities, their causes, their demographic distribution, and the experiences of people with disabilities.

Quantitative data, that is, information providing exact numbers and percentages, are important in planning. When available and reliable, this type of data enhances the accuracy and credibility of a plan. When such data are unavailable, however, planners can learn how to work without it.

Qualitative data, that is, descriptive information, are also important. Descriptions of the impact of disability can be obtained from people with knowledge and experience in particular aspects of disability or rehabilitation. The planners should seek opinions and views from a wide variety of people, organizations, and agencies, including people with disabilities; rehabilitation personnel from government and private services; organizations of people with disabilities; NGOs involved in rehabilitation; and all levels of administration. Those expressing their opinions should be regarded as knowledgeable about the issues or recognized as representing various points of view.

Collecting information

Data review should be undertaken in an orderly way. It is preferable to start with the data on the prevalence of various disabilities and then proceed to the information on existing services, personnel, and other resources.

Information on prevalence may be available from a disability survey conducted country-wide or within a particular region. During the International Year of Disabled Persons, 1981, some countries conducted such surveys. Although the data would now be out-of-date, the results may still be useful. An increasing number of countries now include
questions about disability in national censuses or surveys, so information may be available from these sources.

Although statistical information will help to determine the current situation and to plan for additional services, the initial planning and establishment of a national rehabilitation programme should not be delayed due to insufficient preliminary data.

There is often a temptation to do a survey specifically to identify disabled people before planning services. This may not be the best way to proceed. To identify people with disabilities and then have no services to offer them may raise expectations and lead to disappointment. If services are very limited, it may be better to expand the services and then gather data. In any case, the rehabilitation programme should include simple and continuous reporting on people with disabilities, and questions related to disability should be introduced into the national census and routine surveys. In this way, the necessary statistics can be developed in due time without delaying the services.

If survey or census data are not available, there are other possible sources of information, such as the number of people with disabilities who are receiving services through government or NGO programmes.

The box below contains a list of possible sources of information about the numbers and types of disabilities that exist within the society.

International statistics, drawn from a variety of countries, may also allow sufficient extrapolations to start planning for rehabilitation. International

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<tr>
<th>Possible sources of information on numbers and types of disabilities</th>
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<tr>
<td>• National census data on people with disabilities</td>
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<td>• National surveys, such as demographic and health, socio-economic, and labour</td>
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<td>• Surveys of people with disabilities</td>
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<td>• Registries of people with disabilities</td>
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<td>• Lists of persons receiving social security (which may include people on pensions and people receiving material assistance, such as prostheses or orthoses)</td>
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<tr>
<td>• Lists of children in special education programmes (which may be found within government and private schools)</td>
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<td>• Lists of members of organizations of disabled people</td>
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statistics on disability are available from the United Nations Statistical Office, which has prepared a *Disability Statistics Compendium* (1990) with data from 55 countries. The data consist of disability statistics based on national household surveys, population censuses, and registries. The information from each country is coded according to the *International Classification of Impairments, Disabilities and Handicaps*. In addition to demographic information, the data include socio-economic characteristics, causes of disabilities, and information on special aids used by people with disabilities.

The percentages of the population with disabilities reported by the 55 countries in the *Disability Statistics Compendium* varied from 0.2% to 20.9% of the surveyed population. The data reveal a difference in prevalence of people with disabilities when the questions posed focus on disabilities rather than impairments. Questions about disability result in a higher prevalence of disability than questions about impairments. For example, asking if there is someone in the household who has difficulty walking will produce a higher number of people with disabilities than asking whether someone in the household has paralysed legs.

Part of the responsibility of the planners should be to review whatever data are available within the country and to make recommendations about future data collection. In particular, the database to be established should include demographic information on the prevalence and, if possible, the incidence of all types of disabilities. Comparisons of the prevalence of different types of disabilities in different age groups, in males and females, and in urban and rural areas would be very useful in long-term planning of services.

The plan for a rehabilitation programme may not contain specific plans for the prevention of disabilities. Nonetheless, information about causes of disabilities can be used for disability prevention programmes, as well as to anticipate country-wide prevalence of disabilities and future needs for referral services. Table 1 on page 32 presents common causes of various types of disabilities. The causes will vary from one country to another, so the most common causes of disabilities must be determined within each country.

The planners should also try to identify ongoing changes in the causes of disabilities. For example, polio may be declining as a cause of movement-related disabilities, but services providing braces may be needed for many years. Children whose legs have been paralysed by polio will grow and need bigger braces for at least fifteen years, and they will need brace repairs and replacements throughout their lifetime.

Sometimes a change in the cause of disabilities will allow resources for rehabilitation to be redirected. For example, if the incidence of trachoma as a leading cause of blindness is decreasing, there will be fewer cases
Table 1

<table>
<thead>
<tr>
<th>Disability</th>
<th>Preventable causes</th>
<th>Non-preventable causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving difficulty</td>
<td>Poliomyelitis&lt;br&gt;Cerebral palsy&lt;br&gt;Accidents&lt;br&gt;Tuberculosis&lt;br&gt;Stroke</td>
<td>Arthritis&lt;br&gt;Osteo-arthritis&lt;br&gt;Diabetes&lt;br&gt;Muscular dystrophy&lt;br&gt;Genetic diseases</td>
</tr>
<tr>
<td>Seeing difficulty</td>
<td>Trachoma and other eye infections&lt;br&gt;Xerophthalmia&lt;br&gt;Onchocerciasis&lt;br&gt;Accidents&lt;br&gt;Glaucma</td>
<td>Cataract&lt;br&gt;Diabetes&lt;br&gt;Degenerative eye diseases&lt;br&gt;Genetic diseases</td>
</tr>
<tr>
<td>Hearing and/or speech difficulty</td>
<td>Cerebral palsy&lt;br&gt;Ear infections&lt;br&gt;Infected diseases during pregnancy (e.g., rubella)&lt;br&gt;Goitre&lt;br&gt;Meningitis&lt;br&gt;Use of ototoxic drugs</td>
<td>Neurogenic deafness&lt;br&gt;Genetic diseases</td>
</tr>
<tr>
<td>Learning difficulty</td>
<td>Cerebral palsy&lt;br&gt;Goitre</td>
<td>Idopathic mental retardation&lt;br&gt;Genetic diseases</td>
</tr>
<tr>
<td>Behavioural difficulty</td>
<td>Drug abuse&lt;br&gt;Alcoholism</td>
<td>Cognitive, affective, or behavioural impairments</td>
</tr>
</tbody>
</table>

of blindness. Resources used to treat trachoma may then become available for other activities related to eye impairments. Perhaps such funds could be used to establish eye glass factories, for example.

Some information about causes of disabilities will be available from the health services. A social service, such as social security, may also have information on the causes of disabilities for those people who receive the services or benefits.

Descriptive information about the everyday life conditions of the people with various disabilities is an essential component of the situation analysis. Life conditions of people with disabilities should be analyzed throughout the life cycle from infancy to old age. Questions to be asked include

- At what age was the impairment or disability identified?
- Who identified the impairment or disability?
- What services have been offered to the disabled person or the disabled person’s family?
• If the disabled person needs assistance for daily activities, who provides the assistance?
• Does the disabled child of school age attend school?
• Does the disabled child receive any special assistance at school?
• Does the disabled child play with other children at school and/or at home?
• Does the disabled young adult join in normal daily activities within the family and community?
• If the disabled child or young adult does not take part in normal activities, what are the reasons for this?
• Does the disabled person have access to appropriate appliances or equipment, such as hearing aids, prostheses, braces, and wheelchairs?
• Does the elderly disabled person receive services?

An assessment of the quality of life of people with disabilities should include what they think is most needed to help them to achieve social equality. The planners may think that they know these needs. However, it is necessary to ask disabled people and their families for their opinions, which may be very different from those of the planners. Information about life situations and needs should be collected from a sample of disabled people representing different areas of the country and different socio-economic groups.
MODULE THREE: REVIEWING THE REHABILITATION REFERRAL SERVICES

Contents

- Identifying rehabilitation services
- Analyzing the distribution, coverage and accessibility, and quality of services

Identifying rehabilitation services

A review of referral services focuses on rehabilitation services provided by the health care system. However, people with disabilities need general health services as well, so a review should also cover the utilization of general health services by disabled people. The educational, vocational, and social services provided to disabled people will also be of interest to the planners in this review, in order to identify fully what opportunities exist for disabled people. The review should cover the services provided by government and by NGOs. The information gathered should later be made available to rehabilitation personnel to help them make appropriate referrals.

A complete list and description of all rehabilitation referral services (as described in Chapter 1) is particularly important to the planners. The services provided by the government, NGOs, and the private sector should all be covered, including the location of rehabilitation facilities and services, the types of disabilities for which services are provided, exact services provided, and how many disabled people are served. Operating costs of these services should also be identified, if possible.

Also important is information on numbers of rehabilitation staff, their qualifications, and their distribution throughout the country. The nature of their work environment, the condition of equipment, and the availability of supplies should also be considered. A rehabilitation plan that includes the posting of prosthetists or orthotists, for example, must take into account the location of orthopaedic workshops in which they can work.

Within the general health care services, disabled people may receive preventive, curative, and rehabilitative services. Community health workers may be spending some of their time with people with disabilities. Medical services in the areas of orthopaedics, surgery, physical therapy, paediatrics, psychiatry, neurology, cardiology, rheumatology, geriatrics, and ophthalmology may devote some time to disabled people. It should be established to what extent disabled people use these services and what percentage they form of all users of the services. Such figures will
be difficult to obtain. Nevertheless, rough estimates can be made on the basis of interviews with staff in medical centres or questionnaires sent to staff members.

Similar information will also be available from educational institutions, job placement agencies, and social services. Inquiries can be made to see if other ministries or organizations have such information.

In the review of services, it is useful to examine quantitative data, presented by geographical area, in tables that provide numbers of facilities and numbers of in- and out-patients, beds, and personnel. The recurrent costs for services should be identified whenever possible. The capital costs for any recent expansion or establishment of services should also be noted. Resources supplied by external donors should be noted. Quantitative data must be supplemented with descriptive information assessing the quality of existing services.

Information about some services can be obtained from their performance reports. For other services, particularly special rehabilitation centres, information can be gathered through questionnaires. Requests for information can be followed by a request for an interview with the director of the services, in order to assure a good response rate.

The information gathered should later be distributed to all of the rehabilitation services, so that they become more familiar with each other and better able to make appropriate referrals. Informing the services that they will receive the information collected may motivate them to respond.

It should not be the job of the planners to collect and collate information already available. Rather this could be prepared by the bureau of statistics or the MOH. The planners can then check and add to this information. The box on page 36 contains a checklist of possible sources of information on general and special services.

Analyzing the distribution, coverage and accessibility, and quality of services

After all available information has been gathered, the planners must determine as accurately as possible what proportion of the need for services is being met. Distribution of services will be relatively easy to determine. It will be more difficult to determine the coverage and quality of services throughout the country.

The distribution of services will be clear from the location of the services. The planners can determine whether services for all types of disabilities are distributed throughout the country. Distribution should be considered along with accessibility. Different geographical areas must be examined because equally distributed services may not be equally accessible. For example, a provincial centre in a large urban area may be accessible to
Possible sources of information about rehabilitation services

- Rehabilitation centres: types of disabilities for which services are provided, types of services provided, records and reports on number of people served, etc.
- Health personnel department: distribution of rehabilitation personnel by category, facility, and geographical location
- Government and other sources: budget figures on rehabilitation
- Medical and health auxiliary schools: curricula on rehabilitation, course titles per total training hours for each category of professional staff
- Nongovernmental, non-profit community, religious, or other private services operated by or for disabled people: purpose, capacity, number and categories of personnel, etc.
- Bilateral or international project documents on community health development in general or specifically on rehabilitation
- Publications on medical and social research, special research project documents, monographs

many people with disabilities, but a provincial centre in a smaller town, surrounded by a vast rural area poorly served by public transportation may be accessible to very few disabled people.

In addition to assessing the physical accessibility of services, the planners should also assess the financial accessibility of services. Fee-based services may not be accessible to many disabled people. Potential sources of financial assistance, such as social security or private foundations, should be identified.

Coverage of rehabilitation services is difficult to determine and is thus usually only an estimate, based on the estimated number of disabled people in the country and the estimated number receiving services. The implementation of the national plan will include the establishment of a database on the number of disabled people and the number who receive services. Therefore, as time goes on, more exact figures will become available. Coverage will also naturally improve as the programme is implemented.

The quality of services is also difficult to determine. A practical approach to this would be to hold discussions with people receiving various types of rehabilitation services and with a variety of rehabilitation personnel.
In conclusion, the planners wishing to assess the current services and resources available for disabled people in various sectors, should

- inventory and describe all services specifically available for disabled people;
- estimate how frequently and in what way public and private-sector general services are used by disabled people;
- analyze, to the extent possible, the coverage and quality of medical rehabilitation services provided to disabled people.

The review of information on policies related to disability, disabled persons, and the services available to them will help the next step: the identification of priorities for action.
Contents

- Reasons for setting priorities
- Formulating priority problems

Reasons for setting priorities

Is setting priorities necessary? The obvious response is that needs may be infinite, but resources are not. If resources for rehabilitation are limited, it must be decided how they will be used. For example, should resources be allocated to serve the greatest number, the people who need them most, or perhaps the people who could benefit from them the most?

Too often rehabilitation services are established in response to a specific need perceived by a small group of people, often with a special interest, without consideration of the needs of the greatest number. Sooner or later, such services disperse their limited resources, having made little impact on the lives of people with disabilities. Identifying all types of needs and determining which are priorities will have a greater impact on the situation of disabled people.

A label of “priority” gives a particular issue prominence in terms of time, effort, and resources. This should not mean, however, that all attention is focused on one issue, to the neglect of others.

The mention of priorities naturally raises the question as to who determines them. Divergent views may exist within any group of planners that is called upon to set priorities. For this reason, the planners must find a mechanism to decide on priorities as objectively as possible.

Formulating priority problems

The planners may first formulate “problems” on the basis of the information gathered as part of the situation analysis. They can then decide which aspects of the present situation will be addressed by the rehabilitation programme. The more information the planners have, the more specific the problems are likely to be.

The way a problem is formulated often determines the way in which it will be tackled. Emphasizing the medical aspect of a problem will suggest a medical response to the situation, while a social definition will suggest a social solution. For example, a child born with a severe hearing impairment will have difficulty learning to communicate. The problem can be defined in a number of ways, such as difficulty hearing, difficulty
developing language, difficulty interacting with the family, or difficulty attending school. The first and second difficulties would likely be those identified by the health system, and the third and fourth would be those identified by the child's family. In this situation, the health system would be best suited to address the first and second problems, and if there were intervention early in the child's life to provide a hearing aid and to teach the child to communicate, the other problems would diminish.

Problems frequently identified in relation to disability include limited ability to function in self-care or difficulties related to mobility, communication, or social behaviour. Other problems may be limited opportunities to attend school, to work, or to be socially integrated. Delayed detection of impairments and disabilities is also a problem, since it delays appropriate intervention to limit the impact of impairments and possibly prevent the development of disabilities.

Most disability-related problems involve a variety of factors that must be considered in setting priorities. For this reason, planners may want to judge each problem according to a number of factors. Examples of factors which planners may wish to consider are presented in Table 2 on page 40. These factors reflect different types of disabilities, different age groups, and differing resources. The planners should list the factors that they will take into consideration when they review the problems and decide which ones will have priority. Once the factors are ranked according to importance, the problems can be analyzed according to these factors.

Table 2 also presents an example of rating assigned to the factors. Each factor that the planners wish to consider should be rated in comparison with the other factors. The factors are rated with reference to how much priority should be given to a problem. For example, the creation of a new cadre of personnel for rehabilitation is an important consideration. In many situations, it is not possible to expand services without expanding personnel. However, the planners may decide to give a negative rating to the need to establish a new cadre of personnel because they believe that existing personnel can be retrained.

The rating of factors can be done by assigning numbers or plus (+) and minus (-) signs in the following way:

+++] = High priority
[++] = Moderate priority
[+] = Low priority
[-] = No priority
<table>
<thead>
<tr>
<th>Examples of factors used to select priorities</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Concerns a type of disability of high prevalence</td>
<td>+++</td>
</tr>
<tr>
<td>B Concerns all types of disability: seeing, hearing, moving, learning, and behavioural</td>
<td>+++</td>
</tr>
<tr>
<td>C Can be addressed at the community level</td>
<td>++</td>
</tr>
<tr>
<td>D Requires a new cadre of personnel</td>
<td>-</td>
</tr>
<tr>
<td>E Requires new facilities</td>
<td>-</td>
</tr>
<tr>
<td>F Concerns disabled children</td>
<td>+++</td>
</tr>
<tr>
<td>G Concerns disabled people of working age</td>
<td>++</td>
</tr>
<tr>
<td>H Concerns elderly disabled people</td>
<td>+</td>
</tr>
</tbody>
</table>

The ratings in Table 2 indicate that high priority would be given to problems involving disabilities of high prevalence (A), all types of disabilities (B), or children with disabilities (F). Factors such as the need for new personnel (D) or facilities (E) would decrease a problem’s priority.

These sample factors certainly do not reflect all factors that planners may want to consider. Many factors may be identified, but only a few actually used in setting the priorities. Eight factors are presented here, but this may be more than the planners wish to use. It is possible to select only five or six factors.

Table 3 on page 41 presents an example of how priority problems are identified by applying the rating of the factors to the problems identified by the planners. The problems in this example, which are stated in a very general way, indicate a situation in a country where disabilities are not detected early; where there are inadequate services available for assisting disabled people to develop skills in self-care, mobility, communication, and behaviour; and where there is a high prevalence of mental retardation.

In Table 3, the ratings given to factors A through H from Table 2 are noted under the problems to which the factors apply. The explanation below describes how the factors apply to the problems.

Factor A (Concerns a type of disability with a high prevalence) was rated ++++. Hence, the rating +++ is noted under the three problems of delayed detection, self-care, and behaviour. This reflects a situation in which
mental retardation (which has a high prevalence in the sample country) is detected late and causes many disabled people to be limited in self-care and normal behaviour.

Factor B *(Concerns all types of disabilities)* was also rated +++. Hence, +++ is noted under the problems of delayed detection and self-care. This indicates a situation in which all types of disabilities are detected late in children. People with all types of disabilities need some training in self-care.

Factor C *(Can be addressed at the community level)* was given a rating of ++. This rating is noted under all of the problems because each of these can be addressed at this level through community-based rehabilitation. When planners find that one factor applies to all problems, they should pay special attention to that factor, even if it did not have the highest priority rating.

Factor D *(Requires a new cadre of personnel)* was rated -. This rating is noted under two problems: communication and behaviour. In this example, the country does not have speech therapists or psychologists.

Factor E *(Requires new facilities)* was rated -. This rating is noted under the problem of mobility because new facilities would be needed to extend prosthetic and orthotic services.

<table>
<thead>
<tr>
<th>Table 3</th>
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</thead>
<tbody>
<tr>
<td><strong>Factors</strong></td>
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<tr>
<td></td>
</tr>
<tr>
<td>A</td>
</tr>
<tr>
<td>B</td>
</tr>
<tr>
<td>C</td>
</tr>
<tr>
<td>D</td>
</tr>
<tr>
<td>E</td>
</tr>
<tr>
<td>F</td>
</tr>
<tr>
<td>G</td>
</tr>
<tr>
<td>H</td>
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<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>
Factor F (Concerns children with disabilities) was rated ++++. The rating is noted under all of the problems because all are of concern in the care of children with disabilities. Like Factor C, Factor F deserves special attention by the planners because it applies to all of the problems.

Factor G (Concerns disabled people of working age) was rated ++. This rating is noted under all of the problems except delayed detection. Detection of disabilities in adults is usually not delayed because its onset is frequently obvious, often as the result of injury or disease.

Factor H (Concerns elderly people with disabilities) was rated +. This rating is noted under self-care, movement, and communication—areas of disability that often affect elderly people.

The total number of points assigned to each problem is shown at the bottom of the table. In this example, the highest priority (14) has been given to the problem of self-care. Priority actions, therefore, would be to expand services that assist disabled people in mastering self-care.

The next highest priority (11) is assigned to the problem of delayed detection. This means that priority would also be given to actions to increase early detection of impairments and disabilities in infants and young children.

The lowest priorities (7 and 8) are given to the problems of mobility and communication. This does not mean that no programme activities should be carried out to assist disabled people to improve their skills in these areas. However, it may mean that these activities are developed more slowly or in fewer areas of the country.

The problems formulated in this example are generalizations. In a country where some rehabilitation services are established and there is an existing database on disabilities, the problems identified would be more specific. However, even when more specific problems are identified, they should focus on disability issues. The planners will think of other types of problems, for example, administrative or financial, but these should be considered only in the context of formulating objectives, targets, and activities to address problems directly related to disability.
CHAPTER 3.
DEVELOPING THE PLAN

Chapter 2 has described how to analyze a national situation and how to set priorities for action. When that process is completed, the planners will have sufficient information to develop a programme plan. The information that has been analyzed will also provide background and support for recommendations to policy makers. Based on the situation described, programme managers can formulate disability policies to be recommended to the sectors directly involved in rehabilitation programmes, and also to the policy makers concerned with the rights of all citizens.

As noted in Chapter 1, the rehabilitation programme may be developed within a management system that is either centralized or decentralized. The planning process at the national level will depend on the existing structure and how closely the rehabilitation programme will follow it. If the management of the rehabilitation programme will be centralized, the national level will follow the steps outlined in the six modules of this chapter. If the management will be decentralized, the national planners may prepare only broad objectives and guidelines for planning, leaving the detailed planning to the provincial and district levels.

Chapter 3 begins with a module on setting objectives and targets. It also includes five other components of the planning process: selecting strategies, listing activities, identifying resources, estimating costs, and reviewing the plan.

MODULE FIVE: SETTING OBJECTIVES AND TARGETS

Contents

- Definitions
- Objectives
- Targets

Definitions

An objective is a definition of purpose. Objectives define the desired outcome, or what a programme seeks to accomplish. They indicate
- the problem to be addressed
- the specific change that should occur
- the time period in which it should occur
- the specific population that should benefit

Objectives identify the outcome, but the means for reaching the outcome must also be defined. This is done by setting targets, or specific steps to achieve the objectives. Targets may be operational, or they may refer to infrastructure.

Operational targets indicate what technical rehabilitation interventions will be carried out, the specific population and area to be covered, and the time frame involved.

Infrastructure targets indicate what the rehabilitation service will do with regard to manpower, facilities, organization, and management in order to support the technical interventions. These targets should also specify time frames.

**Objectives**

The desired outcome of health care programmes is naturally an improvement in the health status of a population. The planners of a health programme set objectives to this end, i.e., objectives stating what health problems will change, in what way they will change, in what specific population the changes will occur, and over what time period.

Similarly, the planners for rehabilitation set disability-related objectives, indicating what outcomes or changes will occur, within which group of disabled people, and during what time period. The following are examples of disability-related objectives, based on the priorities identified in the example in Module Four:

At the end of \( X \) years, there will be an increase of \( X \) % in the number of disabled individuals in \( X \) districts who improve their function in self-care.

At the end of \( X \) years, \( X \) number of children, aged 0-3 years, with impairments or disabilities, in \( X \) districts, will be participating in a programme for prevention of deformity and/or promotion of normal development.

At national level, objectives are usually stated in broad terms. Hence, the objectives usually refer to percentages rather than numbers. However, if there are little or no baseline data on which to base percentages, numbers may be used as rough indicators of the coverage that the programme expects to achieve.

Sometimes health improvement objectives are stated with reference to a degree of reduction in health problems. For example, a health objective
may specify a "reduction in malnutrition rates in children under five." This can also be done for disability-related objectives. However, the baseline data on disabilities may not be sufficient for the planners to set this type of objective. The rehabilitation programme may not be able to refer to a reduction in the rate of a particular disability because the prevalence of specific disabilities may not be known.

It is important to realize that objectives set at the beginning of any planning process are tentative. Objectives must later be confirmed by resource and cost estimates. If they are found to be overly ambitious, they may be modified.

**Targets**

One way in which the planners begin to judge whether the objectives are realistic is by setting targets. Targets will specify, for example, how many people with particular types of disabilities will be identified, how many rehabilitation services will be set up in district hospitals, or how many rehabilitation personnel will be trained. At this point, the planners may realize, even before assessing the resources needed, that the targets cannot be met and that the objectives are unrealistic.

Operational targets state the types of services to be delivered and the population groups intended to receive them. The following are examples of operational targets based on the objectives stated above:

At the end of \( X \) years (or months), there will be an increase of \( X \)\(^\text{\%} \) (or number) of people with all types of disabilities who will be receiving training in self-care activities in \( X \) districts.

At the end of \( X \) years (or months), there will be an increase of \( X \)\(^\text{\%} \) (or number) of children, aged 0-3 years, with impairments or disabilities who will be identified in \( X \) districts.

Infrastructure targets state what services will be strengthened, what new services will be established, or what information system will be established, in what area of the country, and in what time frame. The following are examples of targets related to infrastructure:

At the end of \( X \) months, there will be an increase of \( X \) number of nurses trained for early detection of impairments and disabilities in infants and young children in \( X \) districts.

At the end of \( X \) years, there will be an increase of \( X \) number of professionals in rehabilitation units in all provincial hospitals.

At the end of \( X \) years, a training programme will be established for a new cadre of personnel: mid-level rehabilitation workers.
At the end of \( X \) months, a database on prevalence of disabilities will be established.

If all planning for the rehabilitation programme is done at the national level, the objectives and targets should be specific, so that expectations for implementation are clear at all levels. In the decentralized system, if the managers of the rehabilitation services at the provincial level will also be responsible for planning for their areas, the national objectives and targets may remain more general, leaving the provincial-level planners to elaborate specific objectives and targets.

Specific objectives and targets are prepared in the same way as the broad objectives and targets, but with reference to shorter time frames, more limited areas or populations, and more precise figures.
MODULE SIX: SELECTING STRATEGIES

Contents

- Types of strategies
- Selecting strategies

Types of strategies

Like objectives and targets, strategies may be defined broadly or specifically. Broad strategies commonly used in health care are prevention, promotion, treatment, and rehabilitation. Each one of these strategies may include a broad range of actions. Planners may focus on just a few or on many of the actions implied within any one of these strategies.

Health problems are usually addressed with strategies for prevention and treatment. Problems related to disability are addressed with a rehabilitation strategy. However, strategies for prevention and treatment can also be part of a rehabilitation plan.

The broad strategy of rehabilitation can be broken down into three major, specific strategies, or approaches: institution-based, outreach, and community-based. (See Chapter 1 for a description of these three strategies.)

The institution-based strategy can be used to address one aspect of rehabilitation. Within the health services, it may be used to address specific functional limitations experienced by people with disabilities. Institution-based services may provide correction of deformities, guidance for specific exercises, or provision of special equipment, for example. The strategy can be used within a centralized or decentralized management structure. Since it focuses on only one aspect of disability, it does not require intersectoral collaboration.

The outreach strategy can also be used to address one aspect of rehabilitation. Within the health care system, it can provide services that focus on the limitations that disabled people face in performing daily activities. It can also be used to provide information and support to family members of people with disabilities. This strategy can be used within a centralized or decentralized structure and does not require intersectoral collaboration.

The community-based strategy is appropriate for addressing all aspects of rehabilitation (medical, educational, and vocational), as well as the social integration of people with disabilities. Within the health system, it can be used to provide services that address the functional limitations
experienced by disabled people in the home and the community. This strategy gives responsibility and support for the rehabilitation process to all levels, and thus requires a decentralized management structure and intersectoral collaboration. Because this strategy provides for a comprehensive approach to rehabilitation, it is the one recommended in this guide.

Selecting strategies

The nature of the problems identified as priorities and the objectives established to address them will dictate the choice of the most appropriate strategy or combination of strategies. In practical terms, it is difficult to select only one strategy. Usually a primary strategy is selected, and other strategies are recommended to complement or support that major strategy.

Planners may want to select the primary strategy in the way they identified priorities, i.e., by identifying factors on the basis of which they will select the major strategy. This process is intended to result in a strategy that is

- appropriate for achieving the programme objectives and implementing programme activities
- appropriate for achieving increased coverage
- compatible with present policies and structures
- applicable by available services and personnel
- affordable
- sustainable

The planners may find that some of the objectives they have set could be achieved by using a combination of institution-based and outreach strategies. However, these strategies may not be the best choices with regard to other factors of concern to the planners.

The coverage by rehabilitation institutions and outreach programmes can be estimated on the basis of the number of institutions or services and the number of staff in each. In many countries, there has not been a significant increase in rehabilitation staff during the past decade, so it may be assumed that there has not been a significant increase in coverage. It is difficult to determine the exact increase in coverage achieved through community-based rehabilitation because historically countries have not reported coverage-related data. It appears, however, that CBR has contributed to an increase in services for people with disabilities because it has been initiated by various sectors and by NGOs. Thus more staff are involved in delivering services and in mobilizing rehabilitation activities at community level.

Many countries are decentralizing the management structure in all sectors. Within the health care system, the primary health care strategy may be the
major strategy for improving the health status of a population. CBR is compatible with that strategy for health.

Many countries have also recognized the need for an intersectoral approach to health promotion. Hence, health personnel have become accustomed to working with other sectors. CBR provides an intersectoral approach for the comprehensive rehabilitation of people with disabilities.

The high cost of institution-based and outreach services is another major reason for selecting CBR as a strategy. The sustainability of the first two strategies is questionable. In many countries, external donors support small residential institutions, or small centers that provide outreach services for disabled people. These are usually not sustained when the donor support is withdrawn.

The cost and sustainability of CBR programmes have not been adequately assessed. The cost of initiating the CBR strategy is greater than some countries can support. In such cases, external funds may be used for training and perhaps for the provision of materials and equipment, such as vehicles needed for programme supervision. Rehabilitation programmes supported entirely by external funds are not likely to be sustainable. When assessed on the basis of the cost per person served, the CBR strategy is not as costly as the institution-based approach. However, the increase in the number of people served will ultimately result in an overall increase in the cost of services.

The experience of programmes using the CBR strategy has shown that a combination of strategies is necessary. Community activities must have the support of rehabilitation personnel, who provide training, supervision, and specialized services. Institution-based and outreach services do not provide comprehensive rehabilitation, but they do provide the necessary support that the comprehensive approach requires.
Contents

- Preparing an activity list
- Managerial tools

Preparing an activity list

After specific objectives and targets have been formulated at the national or provincial level, a list of programmatic activities is generated. Essentially, the list is generated in response to the questions: where? how? and by whom? The activity list, in turn, generates the list of resource requirements, such as manpower, facilities, equipment, and supplies. The amount of detail of the activity list, however, should be limited to that which helps to identify resources and justify their use.

The activity lists to be prepared by the planners will contain three types of activities:

- rehabilitation service activities, i.e., interventions directed towards people with disabilities, their families, and their communities
- supportive activities, i.e., training, provision of information, and administrative and logistical support that make possible the rehabilitation activities
- development activities, i.e., actions aimed at enhancing the potential of the above types of activities. These are one-time activities, for example, the construction of a facility, the setting up of a prosthetic/orthotic workshop, the drafting of a training curriculum or a training manual, and the passing of new legislation related to disability.

The listing of activities is done with reference to each objective and target. The example below illustrates one objective with an incomplete list of targets and some of the activities relevant to the targets.

Objective: At the end of five years, 50% of the people with hemiplegia who make use of in- or out-patient services in X district will have achieved independence in self-care and mobility within their homes.

Target 1: At the end of the first year, all hospitals and out-patient services in the district will be able to identify people with hemiplegia and refer them for rehabilitation services (infrastructure).

Activities:

- Develop guidelines for health care staff to identify people with hemiplegia (development).
• Develop a system for record keeping, indicating the individuals identified, their degree of independence at the time of identification, and their progress in achieving independence in self-care and mobility in their homes (development).

**Target 2:** At the end of the second year, 10% of the people identified with hemiplegia will have achieved independence (operational).

**Activities:**

• Monitor the use of the guidelines for identification and the records of progress (supportive).
• Provide rehabilitation services in the hospitals and follow-up support in the out-patient services and in the homes (rehabilitation service).
• Monitor and support the work of the CHW (or CRW) who provides follow-up (supportive).

Another way to prepare an activity list is first to note all of the rehabilitation activities that must be carried out in order to meet all of the objectives and targets. Table 4 on page 52 presents an example of a list of rehabilitation activities for the identification, training, and referral of disabled people. The table also indicates the level of services involved and the personnel responsible for providing the services.

A description of rehabilitation activities may make it easier to define supportive activities. For every rehabilitation activity, the question should be asked, What is the appropriate support needed? Examples of support are

• supervision of personnel;
• personnel recruitment and training;
• record keeping and reporting;
• provision of facilities and equipment;
• transportation for home visits, referrals, and supervision;
• manufacture, delivery, and maintenance of appliances and technical aids;
• financial management.

For costing purposes, rehabilitation activities, supportive activities, and development activities must be drawn up in detail.

Table 5 on page 53 presents an example of a list of supportive activities relative to the rehabilitation activities listed in Table 4.

If either the rehabilitation or the supportive activities require new facilities, training programmes, or equipment, it may be necessary to prepare a list
<table>
<thead>
<tr>
<th>Level</th>
<th>Activities</th>
<th>Responsible persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home and community</td>
<td>a) Identify children and adults with difficulty hearing, speaking, seeing, moving, or learning; or with fits or strange behaviour  &lt;br&gt;b) Assess disabilities  &lt;br&gt;c) Select training methods  &lt;br&gt;d) Identify and instruct family trainers  &lt;br&gt;e) Carry out training activities  &lt;br&gt;f) Check for accurate use of training packages by families  &lt;br&gt;g) Supervise and advise family trainers</td>
<td>Family members of disabled people  &lt;br&gt;Disabled people  &lt;br&gt;Community rehabilitation workers (CRWs)  &lt;br&gt;Primary health care workers</td>
</tr>
<tr>
<td>First-referral (district) level</td>
<td>a) Provide training for disabled people who have been referred</td>
<td>Mid-level rehabilitation workers (MLRWS)  &lt;br&gt;Primary health care workers</td>
</tr>
<tr>
<td>Second-referral (provincial) level and Third-referral (national) level</td>
<td>a) Provide specialized assessments and training not carried out at lower levels  &lt;br&gt;b) Design special training programmes for people who do not respond to standardized training  &lt;br&gt;c) Provide equipment and appliances not available at other levels</td>
<td>Physical, occupational, and speech therapists  &lt;br&gt;Specialized physicians  &lt;br&gt;Prosthetists/orthotists</td>
</tr>
</tbody>
</table>

of development activities. Sometimes particular development activities (e.g., the establishment of a new training centre) assume such importance that they require the preparation of a development project, with a project management team for the duration of the project.
Table 5
Supportive activities for rehabilitation activities in Table 4

<table>
<thead>
<tr>
<th>Level</th>
<th>Activities</th>
<th>Responsible persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community level</td>
<td>a) Make decision to set up a CBR programme</td>
<td>Community rehabilitation committee</td>
</tr>
<tr>
<td></td>
<td>b) Plan the programme:</td>
<td>Local organizations</td>
</tr>
<tr>
<td></td>
<td>• Select CRW</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Determine remuneration of CRW and other economic inputs, e.g., subvention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for appliances, special consultants, schooling, apprenticeships, revolving</td>
<td></td>
</tr>
<tr>
<td></td>
<td>fund for self-employment initiatives</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Confer with MLRW and refer disabled people to higher-level services, as</td>
<td>CRW</td>
</tr>
<tr>
<td></td>
<td>necessary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d) Monitor and evaluate programme</td>
<td></td>
</tr>
<tr>
<td>District level</td>
<td>a) Plan district-level services</td>
<td>District committee</td>
</tr>
<tr>
<td></td>
<td>b) Manage district-level services</td>
<td>District manager</td>
</tr>
<tr>
<td></td>
<td>c) Train and supervise CRWs</td>
<td>MLRW</td>
</tr>
<tr>
<td></td>
<td>d) Liaise between community and referral services</td>
<td></td>
</tr>
<tr>
<td>Provincial and National</td>
<td>a) Plan national- and provincial-level services</td>
<td>National and provincial committees</td>
</tr>
<tr>
<td>levels</td>
<td>b) Manage national- and provincial-level services</td>
<td>National programme manager</td>
</tr>
<tr>
<td></td>
<td>c) Train and supervise MLRWs and other rehabilitation personnel in the health</td>
<td>Rehabilitation staff at each level</td>
</tr>
<tr>
<td></td>
<td>services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d) Monitor and evaluate programme</td>
<td></td>
</tr>
</tbody>
</table>

Managerial tools
Managerial tools will help in the implementation of the programme and can be prepared during detailed planning. Managerial tools include an organizational chart, job descriptions for the main categories of programme staff, outlines of curricula for staff training, lists of standard rehabilitation equipment and supplies, recommended designs for facilities, an activity
schedule, and a detailed budget. In addition, such tools as standard procedures (e.g., procedures for patient referral or for staff supervision) will be necessary for the programme manager. If these tools are not generated during the planning process, they have to be prepared later, during implementation.

One example of a managerial tool, a job description for a mid-level rehabilitation worker, is presented in the box below. Based on the list of rehabilitation and support activities, it is possible to define tasks for various types of personnel. The description of tasks forms a job description, which becomes the basis for training and hiring for a specific category of personnel.

<table>
<thead>
<tr>
<th>Sample job description for a mid-level rehabilitation worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>A mid-level rehabilitation worker</td>
</tr>
<tr>
<td>• works on full-time basis under the supervision of the district medical officer and reports to him or her;</td>
</tr>
<tr>
<td>• provides medical rehabilitation in a district hospital;</td>
</tr>
<tr>
<td>• trains, supervises, and supports community rehabilitation workers, as well as PHC staff;</td>
</tr>
<tr>
<td>• ensures linkages between the district and higher referral levels;</td>
</tr>
<tr>
<td>• ensures linkages between health and other services: social, educational, welfare, and vocational services for disabled persons;</td>
</tr>
<tr>
<td>• is responsible for the materials, supplies, and rehabilitation appliances and for their procurement, storage, and distribution;</td>
</tr>
<tr>
<td>• is responsible for record keeping and reporting on disabled people.</td>
</tr>
</tbody>
</table>

It is the planners' decision as to how far they should go in preparing managerial tools. Certainly some of these items can be left to those responsible for programme implementation.
MODULE EIGHT: IDENTIFYING RESOURCES

Contents

- Justifying the need for resources
- Personnel
- Facilities and equipment
- Other resources for rehabilitation

Justifying the need for resources

Detailed planning links activities with the resources needed to carry them out. Resources for rehabilitation include personnel, facilities, equipment, supplies for appliances and technical aids, supplies for administrative support, transportation, and perhaps staff housing. Every resource requested for the programme should be justified in the detailed activity list. In order to justify requests for new resources, the planners must also indicate how existing resources—particularly personnel, facilities, and equipment—will be used and why additional resources will be necessary. Lack of proper justification may make it difficult to obtain the needed resources.

The planners must also take into consideration the sharing of resources with other programmes within the health care services. Technical aspects of the rehabilitation programme will require special knowledge, skills, and equipment. Rehabilitation support activities, however, can be integrated into the health services. Resources such as office space, managerial supplies, and transportation are often shared among programmes.

Personnel

A question often debated is whether existing personnel can take up additional duties as needed to undertake new activities. This may be possible up to a point. If it is determined that staff can absorb new tasks in addition to their current workload, it must be decided how they will cope with the new duties. The following measures can be taken to prepare existing staff to carry out new or additional tasks:

- briefing sessions for personnel
- in-service training
- retraining of personnel for new roles
- re-drafting of job descriptions and work procedures

In a CBR programme, existing resources, particularly specialized personnel, are utilized more intensively than in other types of rehabilitation
programmes. CBR activities create awareness of what can be done for people with disabilities, so that disabled people are motivated to seek services, often for the first time. Although it is difficult to estimate what the demand will be before programme activities are initiated, the likely increase in the use of services must be taken into consideration by the planners.

Planners can project the numbers of each category of personnel that will be needed for national coverage by the programme. The objectives and targets will probably not call for national coverage immediately, so only a percentage of the resources for full coverage will be needed at the beginning of the programme.

When planning for large programmes involving several categories of personnel, the variables that must be monitored (for each category) are

- number of personnel needed to meet the programme objectives
- number of existing posts
- number of vacancies
- rate of post creation
- rate of training
- rate of attrition
- rate of retirement

The number of personnel needed can be estimated based on the situation in countries with existing CBR programmes. Approximately 1.5% of the population is actively involved in a rehabilitation programme at any one time. The time commitment of a community rehabilitation worker should average one half hour per week for each disabled person. This includes time spent with the person and the family each month, as well as time spent collaborating with rehabilitation personnel or community members in arranging other activities.

The number of mid-level rehabilitation workers required will depend on their tasks. If they provide services at a district hospital and in the community, planners must estimate the number of treatments to be given in the hospital and the number of times a MLRW will visit a community each year. The latter may vary from twice a month to once every three months.

The number of specialized personnel needed will be determined by the number of disabled people to be served within the referral system and the amount of time they will spend supervising district-level personnel.

Table 6 on page 57 presents an example of the distribution of health service rehabilitation personnel within a community-based rehabilitation programme. This is an example of a country with a population of four million. The number of personnel suggested here is an example, not a
standard, for the number of personnel needed to provide basic rehabilitation services throughout a country. Table 6 does not indicate the distribution of nurses, midwives, and other health personnel, who can play a very important role in the identification of people with disabilities. Health care staff can also supervise mothers in early intervention activities for children with delayed development, and refer people with disabilities to appropriate rehabilitation services.

Each country may have a slightly different pattern of service delivery. In one country, the Ministry of Health may employ the rehabilitation staff at all levels of service, and there may be a community health worker who takes responsibility for rehabilitation. In another country, the community

<table>
<thead>
<tr>
<th>Location and number of rehabilitation services</th>
<th>Type and number of personnel in each service</th>
<th>Total number of personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community level</td>
<td>CRW (1)</td>
<td>2000 CRWs</td>
</tr>
<tr>
<td>2000 communities (each with 2000 population)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District level</td>
<td>MLRWs (4)</td>
<td>160 MLRWs</td>
</tr>
<tr>
<td>40 district (first-referral level) hospitals (each covering 100,000 population)</td>
<td>Lower-limb prosthetist or orthotist covering 8 districts (1)</td>
<td>8 prosthetists/orthotists</td>
</tr>
<tr>
<td></td>
<td>P/O technicians (2)</td>
<td>16 technicians</td>
</tr>
<tr>
<td>Provincial level</td>
<td>Physical or occupations therapists (3)</td>
<td>24 therapists</td>
</tr>
<tr>
<td>8 hospitals (each covering 500,000 population)</td>
<td>MLRWs (2)</td>
<td>16 MLRWs</td>
</tr>
<tr>
<td></td>
<td>Prosthetist or orthotist (1)</td>
<td>8 prosthetists/orthotists</td>
</tr>
<tr>
<td></td>
<td></td>
<td>32 technicians</td>
</tr>
<tr>
<td>Central level</td>
<td>General physicians and specialists, in areas such as paediatrics; orthopaedics; ophthalmology; ear, nose, and throat; and neurology</td>
<td>Number to be determined by needs in the country</td>
</tr>
<tr>
<td>2-3 hospitals</td>
<td>Physical therapists</td>
<td>Number to depend on the specialist services available</td>
</tr>
<tr>
<td></td>
<td>Occupational therapists</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Speech therapists</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prosthetists/orthotists</td>
<td></td>
</tr>
</tbody>
</table>

|
workers may be within another Ministry, and both the MOH and NGOs may provide referral services according to a national rehabilitation plan. The information presented in Table 6 assumes that all personnel are under the supervision of the MOH.

In this example, there are 2000 people in each community. On the basis of an estimated 1.5% of the population being involved in rehabilitation, it may be assumed that there are 30 disabled people in each community who will be participating in a rehabilitation programme. Assuming two hours of work by the CRW each month (or one half hour per week) per disabled person, this means that the CRW spends 60 hours per month (or 15 hours per week) on rehabilitation activities.

At the district level there are four MLRWs to provide services in the hospital and supervise the CRWs in the communities. In this example, each district has approximately 50 communities. Three MLRWs travel to supervise the community programme, and one MLRW stays at the hospital. Each MLRW who works outside the hospital covers 16 or 17 communities; each community is visited once a month. If communities are spread over a large area and public transportation is unavailable, the schedule for supervision would be modified based on the available transportation.

Eight lower limb prosthetists or orthotists are placed in eight of the district hospitals. This is done to meet the needs in areas farthest away from provincial hospitals or in locations where there is a special need, for example, where people have been injured as the result of a natural disaster or paralyzed following a polio outbreak. Each lower limb prosthetist or orthotist is assisted by two technicians.

At the provincial level, covering a population of 500,000, there are three physical and/or occupational therapists. Two therapists provide in- and out-patient services at the provincial hospital, and one therapist travels to the districts to supervise the MLRWs. In this example, each province has five districts under its supervision. In a province with a large geographical area, the provincial-level therapist could visit each district once a month.

One prosthetist/orthotist is placed at every provincial hospital. The prosthetist/orthotist has the skills to fit and align the appliances. This person is assisted by four technicians who are trained on the job to perform the skilled manual labour required to make artificial limbs or braces.

At central level the number of personnel should be sufficient to provide a team for the medical referral services. In addition, therapists and prosthetists/orthotists provide services for people in the catchment area of the central facilities. These services may be considered as provincial-level services. The total number of staff at central level also depends on the number and types of specialist physicians in the country. Special services, such as orthopaedics, neurology, or cardiology, for example, may require additional therapists.
A rehabilitation programme must have some personnel with special skills. The cost of training and employing skilled personnel may be viewed as a constraint to the development of rehabilitation services. Some countries have begun training MLRWs, who receive less training than therapists but can nonetheless carry out many important rehabilitation activities. To develop an adequate number of skilled personnel, a long-term plan should be prepared and closely followed. External funding can be sought for the training of personnel, but the cost of maintaining permanent posts should be covered by the government or by a local organization that will be able to sustain the service.

Facilities and equipment

All countries have some facilities for rehabilitation. They may be run by the government or by NGOs; they may be well-developed or very modest. In a new or expanded plan for rehabilitation, these existing facilities will be needed and should be utilized intensively. In particular, they will be used for

- referral services
- training courses for personnel
- data collection and research

Existing facilities often require new equipment in order to provide more appropriate services. This must be taken into consideration by the planners.

A major concern within a rehabilitation programme is the cost of establishing and maintaining a prosthetic/orthotic service. To set up a P/O workshop with basic equipment is costly and may require external funding. The recurrent costs, however, should be managed within the national budget of the government or a national organization.

Another concern is the cost of providing electrical equipment for physical therapy services. Planners must distinguish between rehabilitation services for disabled people that do not require electrical equipment and physical therapy treatments for acute care, such as soft tissue injuries and fractures. Electrical stimulation and heat modalities are frequently used for such treatments, although they are not essential.

Other resources for rehabilitation

Other resources needed for a rehabilitation programme are supplies, transportation, and possibly staff housing. As noted above, some of these resources will be shared with other programmes within the health care system. The planners must indicate what resources are currently used by rehabilitation, what is available through other programmes, and what new
resources are needed. The sharing of resources with other programmes should be confirmed before it is written into a plan.

Specific supplies for rehabilitation include the devices that disabled people need to perform daily activities, such as artificial limbs, braces, wheelchairs, assistive devices for walking, eye glasses, and hearing aids. The rehabilitation plan need not provide for the manufacture, distribution, and maintenance of these, but planners should be aware of the need for them and should identify available sources. The plan may include measures to promote the provision of rehabilitation devices through other ministries, organizations, or the private sector.

Managerial supplies may be included in a larger budget for health services or for a hospital. The rehabilitation programme will require special forms for record keeping. Forms for referrals and reports may be standard within the health services. Adequate office supplies should be included in the appropriate budget.

Supplies for education are also needed. In addition to preparing, printing, and distributing educational materials for the training of personnel, educational materials are also needed for disabled people, their families, and the community. Materials already available, such as the WHO manual Training in the Community for People with Disabilities, may need to be translated. General educational materials for the community, such as leaflets or posters, may also be needed.

Transportation for personnel who travel to the community or to other levels of service may be one of the resources most difficult to establish for the programme. In densely populated areas, it may be possible to travel by bus or bicycle. In more sparsely populated areas, motorbikes or cars may be necessary. In such cases, the rehabilitation programme will undoubtedly have to share transportation and schedule visits in cooperation with other health service personnel. The initial cost for bicycles, motorbikes, or vehicles may be covered by external funds, but the cost of their maintenance should be included in the programme budget.

Staff housing may be necessary in order to post rehabilitation personnel at district or provincial hospitals. The construction of housing is another cost that may be covered by external funding, but the maintenance of housing must be provided for within the programme budget. Planning for the construction of housing must be timed with the placement of personnel and must allow time to identify funds for construction.

The identification of resources needed for each activity can be one of the most time-consuming steps in the planning process. However, once a resource list is completed and has been costed, it provides a valuable reference, not only for the implementation of the programme, but also for future planning.
MODULE NINE: ESTIMATING COSTS

Contents

- Purposes for estimating costs
- Estimating the cost of resources
- Preparing a programme budget

Purposes for estimating costs

Costing a programme is an essential element of the planning process. Planners begin to think specifically about costs when they draw up programme activity lists and note the resources that will be required. Some activities may be clearly beyond the financial means of the government and will therefore be modified before the detailed cost analysis is done. Thus, when the planners complete the activity and resource lists, they should feel that what is proposed is realistic, and they can then proceed to a detailed costing. The planners will be assisted in this task by government offices, particularly supply and finance officers familiar with salary scales and the cost of equipment, supplies, construction, and transportation.

Estimating the cost of resources has two main purposes: it shows whether the required resources can be provided within existing financial constraints and it establishes a basis for the programme budget.

A detailed cost estimate must be done to verify what costs can be covered by available funds and what additional funds must be obtained. At the beginning of their work, the planners will have a general idea of what funding is available within the country and what additional funding must be sought from donors outside the country. Planners should also have an indication of interest from external donors before making detailed plans for activities that will require their support. If funds prove to be insufficient, some programme activities will have to be eliminated.

Analyzing the cost of resources for a programme is standard procedure in many countries. Although the rehabilitation plan may cover a number of years, costing is done annually. Often the resource costs are presented as the budget for the programme. However, there is a difference between a resource budget and a programme budget.

A resource budget allows for future planning by resources, i.e., by increasing the budget only on the basis of resources used. A programme budget itemizes resource costs by activity and provides cost estimates for
the entire time period covered by the plan. A programme budget keeps the planners and managers focused on the activities to be accomplished, rather than on resources.

A programme budget is an ongoing reference for programme managers and later serves as a basis for programme evaluation. When programme managers find that the cost for one activity has exceeded the estimate, for example, they will know that another activity will have to be curtailed in order to remain within the budget. Or if a particular resource has not been used, they can analyze why. The fact that a resource has not been used does not necessarily mean that it was not needed. Its disuse may have been due to problems with programme implementation. Later, during the programme evaluation, the activities and the costs will be compared for efficiency.

**Estimating the cost of resources**

Estimating the cost of resources is done by determining the annual costs for all resource items. The costs are divided into recurrent and capital costs. Recurrent costs are those that apply to resources used each year. Capital costs apply to resources that are added to the programme exceptionally.

Recurrent costs are usually applied to rehabilitation and supportive activities. These are the costs that should be covered by the government or national organizations that are capable of sustaining them over a long period of time.

Capital costs are usually applied to development activities, e.g., the construction of a building or the preparation of a new training programme. These are the costs that are frequently covered by external donors.

The costing of resources is done according to the list of required resources prepared by the planners. These resources were discussed in Module Eight. Table 7 on page 63 presents a list of resources for which recurrent and capital costs may be estimated.

**Preparing a programme budget**

A programme budget presents the cost of activities rather than resources. Costs are presented for each year of the plan, taking into consideration inflation and depreciation of facilities and equipment. To determine the cost of an activity, it is necessary to identify the required resources and then cost them. The costs can then be presented for each activity, or for a group of activities. For example, a programme budget might present the annual cost of implementing different types of activities, such as training, service delivery, and programme management; or rehabilitation activities at different levels of services or in different areas of the country.
### Table 7

**Resources for which recurrent and capital costs may be estimated**

<table>
<thead>
<tr>
<th>Resources</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recurrent Costs</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Personnel | • Includes costing by category of personnel and number of posts for each category  
• Does not include training of personnel as separate item (cost of training covered under personnel [trainers], supplies, and perhaps facilities and equipment) |
| Supplies | • Includes rehabilitation supplies, e.g., appliances, technical aids, and special equipment and/or the materials to make them  
• Includes managerial supplies, e.g., forms for record keeping and reporting, and standard office supplies |
| Equipment | • Includes operation and maintenance of electrical and mechanical equipment used in the provision of therapy and the production of appliances |
| Facilities | • Includes operation and maintenance of facilities for rehabilitation services and housing for staff |
| Vehicles | • Includes operation and maintenance of vehicles, motor bikes, bicycles, etc., used for service delivery and programme supervision |
| **Capital Costs** |  |
| Equipment | • Includes new equipment for therapy services or prosthetic/orthotic workshops |
| Facilities | • Includes new facilities for rehabilitation services and training, and housing for staff |
| Vehicles | • Includes new vehicles, motor bikes, bicycles, etc. |

Costing can be done in different degrees of detail. Table 8 on page 64 provides an outline for a programme budget that simply distributes the resources and their costs among different levels of services. This may be considered a compromise between merely listing the resources and presenting a full list of activities in the programme budget. This degree of cost breakdown can be helpful in comparing total costs for each level, as well as for monitoring and evaluating the use of resources at the different levels.
<table>
<thead>
<tr>
<th>Resources distributed for activities at different levels</th>
<th>Annual cost for resources (includes recurrent and capital costs)</th>
<th>Annual cost for activities at each level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-level activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>######</td>
<td>######</td>
</tr>
<tr>
<td>Supplies</td>
<td>######</td>
<td></td>
</tr>
<tr>
<td>District-level services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>######</td>
<td></td>
</tr>
<tr>
<td>Supplies</td>
<td>######</td>
<td></td>
</tr>
<tr>
<td>Equipment</td>
<td>######</td>
<td></td>
</tr>
<tr>
<td>Facilities</td>
<td>######</td>
<td></td>
</tr>
<tr>
<td>Vehicles</td>
<td>######</td>
<td></td>
</tr>
<tr>
<td>Provincial-level services: (repeat list of district level services)</td>
<td>######</td>
<td></td>
</tr>
<tr>
<td>National-level services: (repeat list of district-level services)</td>
<td>######</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 9 on page 65 provides an outline for a budget that presents costs for individual activities at each service level. Such a budget can be a useful tool in monitoring and evaluating a programme because it provides information not only for monitoring the use of resources at each level, but also for monitoring the implementation of programme activities.
### Table 9

<table>
<thead>
<tr>
<th>Activities at each level</th>
<th>Annual cost for each activity</th>
<th>Annual cost for activities at each level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community-level activities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working with disabled people and their families</td>
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<tr>
<td>Working with the community</td>
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<tr>
<td><strong>District-level activities:</strong></td>
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<tr>
<td>Providing services at the district hospital</td>
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<tr>
<td>Training the CRW</td>
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<tr>
<td>Supervising the CRW</td>
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<tr>
<td>Training PHC staff</td>
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<tr>
<td>Maintaining referral network, record keeping/reporting</td>
<td>###</td>
<td></td>
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<tr>
<td><strong>Provincial-level activities</strong></td>
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<td></td>
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<td>(list appropriate activities)</td>
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<td><strong>National-level activities:</strong></td>
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<td>(list appropriate activities)</td>
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<tr>
<td><strong>TOTAL</strong></td>
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Estimating the cost of the resources needed for the programme will provide a realistic budget figure for the programme. The planners will know if the funds needed will be available. If the costing reveals that the necessary resources can be provided, it is likely that the plan can be implemented without modification.
Contents

- Reviewing previous steps
- Reviewing the risks
- Revising the plan
- Confirming the management structure

Reviewing previous steps

It is useful at this point to make a final review of the plan to ensure that the detailed objectives and targets will lead to the broad objectives and targets; to check the detailed activities to ensure that they will meet the detailed targets and objectives; and to make certain that all resources needed have been identified and costed.

This type of review can be done most effectively by a person who has not been involved in the planning process. Someone who has not worked with the programme plan may be better able to note discrepancies between broad and detailed objectives and targets, between the detailed targets and the activities, or between the activities and the resources needed for the activities. Perhaps this type of review could be carried out by someone in the ministry for planning. However, it may not be possible to have this done by someone other than the planners. If the preparation of the plan was divided among a group of people, it may be possible for each person to review a part of the plan that is not well-known to him or her.

The final review of the work done in each step of the planning process will usually reassure the planners that the programme is ready for implementation. At this point, they may note other factors that could be considered risks to programme implementation.

Reviewing the risks

Lack of funds is not the only constraint that could affect programme implementation. Potential constraints will have been considered during the planning process and noted as possible limitations to be overcome. The following are examples of situations that could put a rehabilitation plan at risk:

- lack of political will;
- inadequate intersectoral collaboration and cooperation at any level;
• lack of cooperation among the medical rehabilitation professionals to promote the expansion of services and rehabilitation activities to district and community levels;
• lack of enthusiasm within communities for participation in rehabilitation activities;
• reversal of the financial commitment from cooperating organizations or agencies, e.g., NGOs providing rehabilitation services or international agencies;
• unexpected economic constraints due to changes in the national economy.

Although such risks need not mean that a programme cannot be implemented, these potential difficulties should be recognized and measures for dealing with them proposed. Programme staff may devote more time than planned on facilitating cooperation among different sectors or different groups of personnel, for example. Or perhaps extra time may be allocated for raising awareness within communities.

Revising the plan

The most common reason for revising a programme plan is lack of funds. If the cost of the resources exceeds available or anticipated funding, the activities must be revised. Most plans do not require major revisions for this reason because the planners are aware of financial constraints throughout the planning process. However, it can happen that the cost of a particular activity has been significantly underestimated. This may make it necessary to adjust the plan, but not necessarily to eliminate the activity entirely, which may be an essential component of the programme.

Sometimes the more expensive activities within a plan are identified as items to be eliminated in order to reduce the budget. This may not be practical in the long-term. The most expensive activity may be essential to a number of objectives and targets. For example, the establishment of a school for training a new cadre of personnel may be essential to the long-term development of rehabilitation services. The planners may have already considered alternatives, such as retraining existing staff, and found that a new training programme would have to be established. If a costly activity is to be maintained in the plan, it may be necessary to eliminate a variety of less costly activities.

Sometimes a plan is revised by decreasing the geographical area of expansion originally proposed for the programme. Any area to be eliminated from the plan must be chosen carefully. A priority identified by the planners may have been to place the rehabilitation services in the most populated areas of the country first, in order to achieve high coverage. In that case, activities for programme implementation in less densely populated areas would be cut back. Or the plan may have placed priority
on the delivery of services to the most remote areas of the country. In such a situation, activities to strengthen services in urban areas may be scaled down.

Any revision should be made with reference to the objectives and targets of the programme. Activities to be cut back should be those which relate to the objectives and targets with the least priority. This requires a review of the entire plan.

**Confirming the management structure**

The management structure for the CBR programme will have been considered at various stages of the planning process. At this point, the responsibilities for further planning and implementation of the programme should be clarified. The degree of centralization and decentralization will determine the managerial responsibilities at the various levels.
CHAPTER 4
IMPLEMENTING THE PROGRAMME

The ten modules in Chapters 2 and 3 presented a guide for planning. The planning process prepares the programme manager for programme implementation, and also provides a great deal of information that can be used to support policy recommendations. This chapter presents six aspects of programme implementation: scheduling programme activities, training, developing rehabilitation activities at community level, establishing a system for record keeping and reporting, supervising, and monitoring.

After a new plan for rehabilitation has been prepared, there will be an expectation of change in services for people with disabilities. Naturally, it will be expected that the plan has been prepared in order to expand or strengthen services. This implies that there will be services for more people and services of a better quality. However, such changes may not come about quickly. The programme will take time to implement.

Change in a rehabilitation programme occurs gradually for a number of reasons. First it requires retraining of existing staff and possibly training of new staff. Time is needed to organize training courses, to implement them, and thereafter to change the patterns of work based on the training. Full-time training courses alone may take one to three years.

Posts must be provided for the people who are trained. The government will probably not be able to establish many new posts each year, so expansion of personnel will be slow. Some newly trained staff may be employed by NGOs working in rehabilitation and contributing to the objectives and targets set by the national plan.

While the activities related to staff development may take a long time to implement fully, other activities, such as scheduling and establishing procedures for record keeping and reporting, can be accomplished in a short time. Developing activities at the community level also takes some time, so this should be initiated as soon as staff are available to support the community. A first step in implementation is the scheduling of programme activities at different levels and in varying degrees of detail.

SCHEDULING PROGRAMME ACTIVITIES

The rehabilitation plan defines what activities will be carried out with reference to objectives and targets within the specified time frame of the plan. The detailed scheduling of these activities, however, is usually left to the programme managers.
Depending on the degree of decentralization of the programme, the amount of scheduling done at each level of services will vary. At the national level, the programme manager may schedule only the activities that will take place at the national level or will affect services at all levels, such as the establishment of new training programmes and the posting of personnel. The staff responsible for management at the provincial and district levels may schedule activities specific to their areas, such as short training courses, supervision of personnel, and development of community-level activities.

Table 10 on page 71 presents a schedule of activities that could be prepared by a national manager. The number of each activity in the table corresponds to the activities listed below. The schedule shows that development and support activities will be carried out for three years before services based on those activities can begin. Meanwhile, the manager in this example is transferring some staff from national centres to expand services at the provincial level.

<table>
<thead>
<tr>
<th>Numbers</th>
<th>Activities</th>
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<tbody>
<tr>
<td>1</td>
<td>Restoration of training facility for MLRW training course</td>
</tr>
<tr>
<td>2</td>
<td>Preparation of two-year MLRW training curriculum</td>
</tr>
<tr>
<td>3</td>
<td>Selection of faculty</td>
</tr>
<tr>
<td>4</td>
<td>Selection of 20 MLRW students</td>
</tr>
<tr>
<td>5</td>
<td>Implementation of MLRW training course</td>
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<tr>
<td>6</td>
<td>Training of 3 students in neighbouring countries in physical, occupational, and speech therapy (repeated in the first, third, and fifth years)</td>
</tr>
<tr>
<td>7</td>
<td>Strengthening of 1 provincial hospital for rehabilitation (each year)</td>
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<tr>
<td>8</td>
<td>Transfer of 1 therapist from a national centre to a provincial hospital (each year)</td>
</tr>
<tr>
<td>9</td>
<td>Equipping of 5 district hospitals for rehabilitation (each year, beginning the third year)</td>
</tr>
<tr>
<td>10</td>
<td>Posting of 10 MLRWs at district hospitals and 5 at provincial hospitals (each year, beginning the fourth year)</td>
</tr>
</tbody>
</table>

A schedule made out at the provincial or district level would also show the activities to be carried out at this level during the designated time frame. Additional, more detailed schedules, covering shorter time frames, would be used to guide the actual implementation of activities. The provincial level manager would list those activities carried out at provincial level, including the services at that level and activities that affect all of the districts in the province, such as training and supervision. Likewise,
<table>
<thead>
<tr>
<th>Activities (see list page 70)</th>
<th>First year</th>
<th>Second year</th>
<th>Third year</th>
<th>Fourth year</th>
<th>Fifth year</th>
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schedules at the district level would detail the sequence of events to take place at the district and community levels.

Table 11 on page 73 presents an example of a schedule for one district for one year of activities. In this example, the district hospital has space, equipment, and supplies for rehabilitation, and two MLRWs on staff.

Detailed schedules are helpful for implementing specific activities. For example, a schedule of the specific tasks to be carried out in the preparation and implementation of a short training course will help the planners and the teachers. Such a schedule would include all of the necessary steps, such as arranging the facilities for the course, selecting the faculty, preparing the curriculum and training materials, selecting the trainees, arranging for equipment and supplies, and arranging for travel and per diem.

Preparing a schedule clarifies the time frames for the implementation of activities and also highlights when funds must become available. If the source of funds for a particular activity has not been identified, fundraising will be one of the activities listed in the schedule.

Scheduling is a process that is carried out at the various levels, for various time periods, and in varying degrees of detail. Programme managers may use schedules covering months or years. Supervisors of specific services and personnel may prepare schedules for shorter periods, covering weeks or months. Schedules can be distributed to staff so that everyone has a clear understanding of what is to be accomplished within a particular time frame.

TRAINING PERSONNEL

The training of staff may be a major activity within the rehabilitation plan. All developing countries have a shortage of rehabilitation personnel, so long-term rehabilitation plans include the establishment of posts and the training of additional staff. A new plan for rehabilitation, particularly one which uses the CBR strategy, also requires additional training of current personnel.

The basic training of new rehabilitation personnel may take one to four years. The training of therapists may take four years. Upgrading the skills of therapists already working in the rehabilitation services, however, may take only several weeks or months. The following are examples of types of training that may be needed:

Basic training of additional rehabilitation personnel:

- mid-level rehabilitation workers;
- prosthetists/orthotists;
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<tr>
<th>Activities</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
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<tbody>
<tr>
<td>Two MLRWs provide service at the district hospital</td>
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<td>One MLRW makes contact with leaders in five communities and with</td>
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<td>representatives of other sectors</td>
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<tr>
<td>Community rehabilitation committees established and CRW selected</td>
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<tr>
<td>CRWs trained by the MLRW</td>
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<tr>
<td>CRWs begin to identify disabled people and advise on training</td>
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<tr>
<td>One MLRW provides supervision in the five communities</td>
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• physical, occupational, and speech therapists;
• doctors specialized in rehabilitation.

Short training for rehabilitation and health personnel:
• re-orientation of rehabilitation personnel (e.g., therapists and therapy assistants) for work in the community rather than the hospital;
• upgrading skills of rehabilitation personnel to work with people with permanent disabilities rather than acute conditions;
• training of community rehabilitation workers.

The types of personnel involved in the programme should include not only rehabilitation specialists, but also other categories of health workers who can contribute to rehabilitation. The following are examples of the types of training that may be useful to support the rehabilitation programme:

• training of nurses and midwives for early detection of disabilities, early intervention, and appropriate referrals;
• training of physicians for first-referral level services in the care of disabled people, including diagnosis, prevention, reduction, or limitation of impairments and disabilities; and appropriate referrals.

In addition to formal training courses, it is necessary to hold short seminars or briefing sessions to inform staff in all relevant ministries and organizations, as well as the community, about a new or expanded programme for rehabilitation. In particular, it is necessary to explain what CBR is and how people with disabilities will benefit from it. Orientation sessions may be held separately or jointly with the following groups:

• representatives of all sectors concerned with rehabilitation at national, provincial, and district levels;
• community and district leaders;
• community groups, such as organizations of women, youth, and disabled people.

Plans for training community workers, health, and rehabilitation personnel are based on the tasks outlined in their job descriptions. Training plans should also be based on the numbers and distribution of workers and personnel that will be needed to implement the planned activities. Plans for major training programmes should be outlined in the detailed plans for the programme. However, the precise content of the training courses, the number of personnel to be trained in each course, and the dates for the training will be decided by the programme managers and staff.

Training should be scheduled at the time when personnel are expected to assume new responsibilities or to change the manner in which they are
working. If training is provided at the appropriate time, staff will be more willing to accept changes in their tasks. They will recognize that they are getting the support they need to make changes in their work. If training is done too early, before services are changed or initiated, the staff may forget the training content. If training takes place a long time after personnel have been given different responsibilities, they may be frustrated and less eager to change, or they may have developed inappropriate ways of doing new activities.

Training of community workers must also be done at the time when the community is ready to implement the programme. This means that the community leaders are willing to support the community worker in rehabilitation activities, and community members are prepared to participate in rehabilitation activities. Training of community workers must be done in groups, since it would be impossible to have a special training programme for each community. Some communities in a district may be prepared earlier than others to start the programme. Depending on the size of the district, several training programmes may be needed. This allows the trainers to form several groups of communities and to begin training for those that are ready.

It bears repeating that the establishment of basic training courses for one or more cadre of personnel takes time. At least one year should be allowed to prepare a course of one to two years. For a longer training course, two years of planning may be required. The implementation of some rehabilitation activities will be delayed until the first group of students completes the training programme. Some countries have used expatriate staff to initiate or expand rehabilitation services while national personnel are in training. Since new graduates of a training programme are not yet prepared to accept responsibility for delivery of services, training and supervision of other personnel, and programme management, the expatriate staff may be retained for a couple of years after the first graduates are posted, to allow them time to gain experience.

DEVELOPING REHABILITATION ACTIVITIES AT COMMUNITY LEVEL

Community-based rehabilitation cannot happen without community involvement. Developing awareness at community level and motivating community members to become active in rehabilitation activities are thus crucial to a national CBR plan. This aspect of the rehabilitation programme should take place within the context of community development and should be integrated with other self-help efforts within the community. Because rehabilitation is dependent on many sectors, a commitment to cooperation and coordination of activities should be made at all levels. To ensure such cooperation, the ministry in charge of local government should have the role of coordinating rehabilitation activities, with technical
advice from the MOH and other appropriate ministries. The MOH must stimulate interest and then commitment from the ministry for local government and other relevant sectors, and must support them in their efforts to organize and implement rehabilitation activities.

Initial contact with the community is made through its leaders—political, traditional, and religious. After these initial contacts, disabled community members and their families should be invited to join discussions about the CBR programme so that their priorities are considered in planning community activities. If there are national organizations of or for disabled people, their local representatives should be sought for participation in discussions. Local organizations, such as women’s groups or the Red Cross or Red Crescent Society, are also important for the development of rehabilitation activities and should be included in discussions and planning.

The time needed to develop community involvement in rehabilitation activities may vary greatly among communities, even within one district. In general, communities that are already active in various efforts to improve their community will act more quickly to take up rehabilitation than communities that have been slow to take responsibility for their own health and well-being. Some communities may have other priorities, such as rebuilding after a war or natural disaster. Another factor influencing the interest of the community is their prior awareness of disabilities. If a prominent member of the community has become disabled, for example, people may be more aware of the limitations caused by disability, and also of the abilities of disabled people.

Another factor influencing community involvement is the way in which CBR is presented. Community leaders will understand that services are being brought to the community for their disabled members. They may be grateful for this and praise the workers who will provide services, but they may not recognize what contribution the community itself can make to the programme. Leaders and community members need to understand that it is they who provide opportunities for people with disabilities to participate in community activities. For example, the local school should accept children with disabilities. Community members can assist the families of the children to arrange transportation to and from school. Local organizations can assist mothers of disabled children by arranging periodic child care, so that mothers are free to do activities outside the home. Parents of able-bodied children can help their children understand the problems disabled children may face when they try to do the same things as able-bodied children. The able-bodied children should be shown how they can help the disabled children. Business people in the community should help disabled adults to develop income-generating skills. The community can form a small revolving fund to assist all members of the community, including those with disabilities, to buy tools or materials for income-generating projects.
Sometimes community leaders are eager to do something to assist people with disabilities, but do not know how. They need information and perhaps advice. Personnel in the health sector can provide appropriate information about causes of disability; about the limitations imposed by different types of disabilities; about the abilities of disabled people; about what disabled people and their families can do to decrease disabilities; and about technical aids available to disabled people. Representatives from other sectors should also provide information to the community, particularly regarding education and possible income-generating activities.

Development of a CBR programme involves not only the initiation of community involvement, but also the identification of a CRW. If there is already a cadre of personnel or volunteers at the community level that is responsible for community development activities, this group may be the most appropriate to assume the role of CRW. If there is already a CHW in place and the MOH is in charge of the community health development activities, it is likely that the CHW will assume responsibility for rehabilitation activities. If there is no community worker who can do this, the community must select someone for the task. In turn, the community worker identified will be responsible to the community. The MOH may have primary responsibility for providing technical input and support to the worker and the community, but other ministries will also contribute to the programme by providing information and guidance.

**ESTABLISHING A SYSTEM FOR RECORD KEEPING AND REPORTING**

The planners may comment on the need for a system of record keeping and reporting, but leave the task of preparing a specific system to the programme managers. Within the health services there is no doubt an established system for record keeping, and any system devised for the rehabilitation services will have to fit into the general system. Nonetheless, the rehabilitation programme will need to identify what information it should record and report, so as to provide a basis for programme monitoring, evaluation, and further planning.

Examples of information that can be gathered through a rehabilitation programme and how the information can be used are described below. Reference is made to the guidelines for record keeping and reporting that are presented in the WHO manual *Training in the Community for People with Disabilities*.

**Recording information about numbers and types of disabilities**

Any rehabilitation programme records information on people with disabilities. If the programme is not community-based, it will record
information only on those individuals who come for services. In a community-based rehabilitation programme, however, all disabled people in the community are identified, even if they do not require rehabilitation assistance. CBR programme records include the following information:

- names of individuals with disabilities
- type of disability
- sex
- age group
- place of residence (rural or urban)

Form 1, in the “Guide for Local Supervisors” (page 36) in the WHO manual Training in the Community for People with Disabilities, presents an example of how information can be recorded.

There are questions in the CBR manual that can be used to identify people with different types of disabilities. The questions are intended to identify the following types of difficulties a person may have: difficulty seeing, difficulty hearing and speaking, difficulty moving, no feeling in the hands and feet, strange behaviour, fits, and difficulty learning.

The box on page 79 contains a list of questions from the CBR manual's “Guide for Local Supervisors” (pages 23 to 34). These questions are meant for use in house-to-house surveys to identify people with disabilities. They are listed according to the type of disability they are intended to identify.

To determine how the information about numbers and types of disabilities will be used, the programme manager for rehabilitation must confer with the staff responsible for data collection in the MOH and in the Central Office for Statistics. If there is a national database on disabilities, the information from a CBR programme could be contributed to that data. It must be decided how much information will be reported to the national level and where the data will be maintained.

The following are examples of the information that could be reported to national level:

- number of people with disabilities;
- number of people with each type of disability;
- number of people with each type of disability according to sex, age group, and place of residence (rural or urban).

This information will be useful at all levels and in all sectors in planning for the types and numbers of rehabilitation personnel needed, the types of special education needed, and the types of equipment or technical aids needed; and in determining the location of needs.
Questions for use in identifying people with disabilities

People who have difficulty seeing
Is there a person in the family
• who cannot see as well as the others?
• who cannot see well when it is dark?
• who cannot see objects that are far away, such as trees or birds?
• who cannot see objects that are very close, such as seeds held in his or her hands?
• whose eyes look very different from other people’s?

People who have difficulty hearing or speaking
Is there a baby in the family who does not make sounds?
Is there a person in the family who
• has difficulty hearing what others say?
• cannot understand what others say?
• cannot speak?
• cannot speak clearly enough to be understood?

People who have difficulty moving
Is there a person in the family
• who has difficulty moving part of the body, such as the arms, legs, back, or neck?
• whose arms, legs, back or neck are weak?
• who has a great deal of pain in the arms, legs, back, or neck?

People who have no feeling in the hands or feet
Has any person in the family lost feeling in either the hands or feet or both?
Does any person in the family injure or burn his or her hands or feet often?

People who show strange behaviour
Has anyone in the family changed so much that now he or she behaves like a different person?
Does the person not talk to anyone any more?
Does the person talk much more than before?
Does the person become excited or angry for no reason, or frighten other people?
Does the person hear voices that other people do not hear or see things that other people do not see?
Has the person stopped keeping clean?
Has he or she stopped dressing properly?
Does the person speak or move around in a strange way?

People who have fits
Does any person in the family have fits?

People who have difficulty learning
Is there a child in the family who cannot learn to do things that other children of the same age do?
Is there a child who, when compared to other children, has been slow in learning to sit up, stand, walk, speak, eat, or dress?
Is there a child in the family who has not learned to do these things at all?
Does any person appear to be backward, dull or slow when compared to others of the same age?
Is there an adult who does not do the things that other adults do?
Recording information about the condition of people with disabilities

All rehabilitation programmes should maintain records on the individuals who receive services. Such records should contain a description of the person's condition and activities at the time that services are initiated. This baseline information is needed in order to assess the individual's progress as the result of the services. A summary of the information can later be used for monitoring and evaluating general programme effectiveness.

A disabled person should be assessed before any training begins. The "Guide for Local Supervisors" in the WHO CBR manual contains 23 questions for use in assessing a person with a disability (Form 2, pages 38 to 40). These questions are presented here in the box on page 81. The questions determine how much difficulty a person has with 23 activities. The responses indicate what type of training the person needs. For periodic re-assessments during training, the questions should be used again and any changes in the person's condition noted.

The programme manager should discuss with other staff how the records on disabled people will be used. Perhaps a summary of this information will be maintained at district level and used for programme monitoring and evaluation. Some countries may want reports on progress made by people with disabilities to be summarized and sent to provincial or national level, as part of reporting on achievement of programme objectives. It must be decided what information will be reported and to what levels. Such information may include

- the number of people in training as part of the programme;
- the number of people in training according to type of disability, sex, age group, and place of residence (urban or rural);
- the number of individuals whose situations improve as the result of the training;
- the number and type of equipment and appliances needed by people with disabilities;
- the type and number of equipment provided;
- the number and type of referrals made to other services.

This information would contribute to other information gathered when identifying people with disabilities. The information on people who are in the rehabilitation programme gives more precise information about needs. Information about people benefitting from the programme would also reveal when there is lack of progress, which should be investigated. There may be a particular group of people in the community or with a particular type of disability who do not appear to benefit from the rehabilitation programme.
The 23 questions and the list of information to be reported are examples of what can be recorded at community level and reported to the district. The professional staff in rehabilitation services will have more detailed forms for assessment of individuals referred for services. These assessments will contain information that will also be useful to future programme evaluation and planning. For example, assessments of impairments and descriptions of types of medical or surgical interventions needed by people with disabilities can be used in planning future services.

<table>
<thead>
<tr>
<th>Questions for use in assessing a person with a disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeds himself or herself?</td>
</tr>
<tr>
<td>2. Keeps himself or herself clean?</td>
</tr>
<tr>
<td>3. Uses the latrine?</td>
</tr>
<tr>
<td>4. Dresses and undresses?</td>
</tr>
<tr>
<td>5. Understands simple instructions?</td>
</tr>
<tr>
<td>6. Expresses needs?</td>
</tr>
<tr>
<td>7. Understands movements and signs for communication?</td>
</tr>
<tr>
<td>8. Uses movements and signs for communication which others understand?</td>
</tr>
<tr>
<td>9. Lip reads?</td>
</tr>
<tr>
<td>10. Speaks?</td>
</tr>
<tr>
<td>11. Sits?</td>
</tr>
<tr>
<td>12. Stands?</td>
</tr>
<tr>
<td>13. Moves inside the home?</td>
</tr>
<tr>
<td>14. Moves around the village?</td>
</tr>
<tr>
<td>15. Walks at least 10 steps?</td>
</tr>
<tr>
<td>16. Has aches or pains in the back or the joints?</td>
</tr>
<tr>
<td>17. Breast-feeds and grows like other babies?</td>
</tr>
<tr>
<td>18. Plays like other children of the same age?</td>
</tr>
<tr>
<td>19. Goes to school?</td>
</tr>
<tr>
<td>20. Joins in family activities?</td>
</tr>
<tr>
<td>21. Joins in community activities?</td>
</tr>
<tr>
<td>22. Does household activities?</td>
</tr>
<tr>
<td>23. Has a job or has an income?</td>
</tr>
</tbody>
</table>

**Recording information about causes of disabilities**

Rehabilitation programmes are concerned with the prevention of deformities, the limitation of the impact of impairments, and the limitation or reduction of the impact of disabilities. These actions are usually referred to as tertiary prevention. CBR programmes should also be concerned with primary prevention, or the prevention of disease, injury, or congenital conditions that cause disabilities. Community activities should include promotion of measures to prevent diseases and injuries, as well as impairments and disabilities.
The rehabilitation programme manager may confer with other staff in the MOH to determine what contribution the CBR programme can make to primary prevention. There may not be a national system for reporting causes of disabilities, but rather a system for reporting causes of impairments, such as blindness or deafness. The referral system of the CBR programme could gather this type of information. The national health system may want to know causes by categories of impairments or by specific diseases, injuries, and congenital conditions.

After decisions are made about what information will be recorded and what data will be reported to other levels, a system for recording and reporting must be established. Forms should be prepared for use by all services. A system for reporting, entering data into a database, and making data accessible must also be clarified.

**SUPERVISING**

The purpose of supervision is to ensure that staff members and community workers associated with the programme are able to carry out the necessary activities in an effective and efficient manner. Hence, supervision is the process that identifies and solves problems faced by staff and workers as they implement the activities aimed at achieving programme targets and objectives.

The process of supervising staff is an integral part of rehabilitation programme activities. The programme may follow routine procedures for supervision within the MOH. These procedures may determine the methods for supervision, the information to be gathered through supervision, and the frequency of supervisory visits. In reference to these standard procedures, the rehabilitation programme will identify what information it will gather and how supervisors will meet with staff and observe programme activities.

Methods for supervision include monitoring of reports, staff meetings, and on-site visits. The system of record keeping and reporting described above will provide supervisors at district or provincial level with information on the number of people participating in the programme and their progress. Reports may also contain information about the activities carried out by the community workers, for example, the number of home visits, community meetings, visits to the school, or visits to the employers of people with disabilities. Based on such information, a supervisor can evaluate a worker and the worker's impact on people with disabilities.

Rehabilitation staff at district and provincial levels can also report on the number of people who receive services as in- or out-patients at the hospital, the progress they make, the referrals to other services, and the staff time spent visiting the community or supervising other staff. Such information is necessary for monitoring the referral services.
Although reports are useful for monitoring and supervision, meeting with the community workers and staff members is also necessary in order to identify constraints they face and to determine what can be done about these. Some problems can be dealt with in staff meetings. The advantage of staff meetings is that workers from several communities or staff from several district services can get together and compare their experiences. This can help to show what problems may be common, and it also provides the opportunity to solve problems by working together.

In addition to staff meetings, it is desirable for supervisors to visit community workers in the community, or to meet with rehabilitation staff in the hospitals or centres where they work. On-site visits allow the supervisor to verify reports, to observe the quality of care provided, to correct practices that are not carried out correctly, to confirm what is being done well, and generally to encourage workers or staff.

Visiting communities for programme supervision is desirable, but may be difficult to do routinely. In many countries, lack of transportation limits the number of visits each programme can make to community or peripheral health services. In countries where communities are not close together and public transportation irregular, it may be impossible to visit a community more than a few times each year. Although programmes may plan jointly so that several supervisors travel together, or one supervisor may review a variety of activities at community or peripheral level, it is still unrealistic to plan for monthly or bimonthly on-site visits. When transportation is inadequate for full programme supervision, a combination of on-site visits, staff meetings, and review of reports must be used.

Staff supervision involves specific responsibilities. When a supervisor finds that a planned activity is not being carried out, it is his or her responsibility to confer with the community workers or staff involved to determine the constraints and to seek a solution to the problem. When there is a question about procedures or responsibilities, it is the responsibility of the supervisor to clarify what is expected. If someone is not performing well, that person should be given the chance to improve. This may require nothing more than a clear explanation of what is to be done, or it may require additional training or closer supervision for a period of time. If a supervisor finds that a number of workers or staff members are performing a particular activity inappropriately, it may mean that they were never properly trained. It may be necessary to organize a special training session to address a common problem.

As noted earlier in this chapter, technical supervision of the work done at community level is carried out with the agreement of the community. The MOH provides technical supervision for promotive, preventive, and curative care provided by the CHW. In the same way, supervision can be provided for rehabilitation activities. However, since the community worker is not an employee of the MOH, the MOH may provide support rather than
supervision. It may be a MLRW who visits the community, observes the training activities carried out by disabled people and their families, and advises the community worker on possible changes in individual programmes. The MLRW can also support the community worker in meetings with local leaders, school teachers, or community employers.

Scheduling of a rehabilitation programme should include a schedule for supervision. Whatever methods are used—review of reports, staff meetings, or on-site visits—the supervisory activity should be scheduled. The schedule should be distributed to the staff so that they know when to submit their reports or to prepare for a meeting or supervisory visit.

**MONITORING**

Monitoring is a continuous process of reviewing programme activities to ensure that programme targets and objectives are being met. Staff reviews also provide an opportunity to review programme activities. As part of monitoring, the supervisor notes whether activities are taking place according to plan. When activities are not taking place as planned, the supervisor must determine why and explore how constraints or problems can be handled. The supervisor may have to confer with the programme manager to decide whether the plan must be modified, or whether another strategy may put the activities back on track. Programme monitoring and supervision can be carried out simultaneously.

Tools for monitoring include the list of programme targets; the detailed activity plan, with resources specified; activity schedules; and records and reports. With this information, programme managers can be continuously aware of whether programme activities are on track.

More formal monitoring can also be done in order to keep the national level manager informed about the general implementation of the programme. Regular reporting will keep provincial and national level managers informed about the implementation of activities, but the reports may not indicate what is being done to deal with unexpected changes. Programme managers at district level should annually summarize programme activities for the district, indicating whether there have been deviations from the plan and what has caused these. These summaries can be sent to provincial level, where they are reviewed along with a similar analysis of the activities carried out at provincial level. Provincial-level managers can then forward these reports to the national programme manager. If significant deviations from the plan have occurred in one part of the country, for example, the national level manager will want to be aware of this before it is time for a national evaluation. In consultation among managers at the various levels, it can be decided if activities should be modified to more effectively reach programme targets, or whether the plan itself must be adjusted. This type of review should not wait for the periodic evaluation of the national programme.
CHAPTER 5.
EVALUATING THE PROGRAMME

Evaluation of the national rehabilitation programme is carried out to determine whether the broad programme objectives have been met and to provide a basis for further planning.

A full evaluation should be carried out at the end of the time period covered by the national plan. However, an evaluation may be scheduled before the end of that period if the monitoring process indicates that most activities are not taking place as planned and that the objectives may therefore not be met, or if the plan covers an extended period. If the plan covers a ten-year period or longer, a mid-term evaluation should also be done. The timing of the evaluations should be written into the plan, and the budget should include funding for the evaluation process. The evaluation budget should cover the preparation of background materials and the final report, as well as travel and per diem for the evaluation team members. If an external donor has supported the programme, the donor may also contribute to the cost of the evaluation, but this should be planned at the time that funds are provided.

Continuous monitoring of the programme at the provincial and district levels indicates ongoing accomplishments and allows the adjustment of short-term planning to ensure that targets are met and, eventually, objectives achieved. A full programme evaluation is necessary in order to determine whether the broad objectives of the national programme have been met and how the situation on which they were based has changed. The findings can then serve as a basis for further planning, thus completing the management cycle of planning-implementation-evaluation-planning.

THE EVALUATION PROCESS

Programme evaluation, like other programme activities, should be carefully planned. Guidelines for the evaluation process may already be established within the responsible ministry, and the programme planners may have provided some suggestions for evaluation. However, it is the responsibility of the national programme manager to plan the evaluation process in detail. Essentially, the programme manager must decide what is to be evaluated, who will do it, and how it will be done. Planning should begin about one year before the evaluation to ensure that appropriate background material is prepared, procedures clarified, and the evaluation team available as necessary.

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What is evaluated?

In order to determine whether the broad objectives have been met, five questions can be posed about the programme. Three of the questions focus particularly on the three major aspects of the CBR programme:

- people with disabilities
- community participation
- referral services

The five questions, which form five components of the evaluation, are presented in Table 12 below.

<table>
<thead>
<tr>
<th>Components</th>
<th>Questions</th>
</tr>
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<tbody>
<tr>
<td>Effectiveness</td>
<td>To what degree have the programme targets and objectives been achieved?</td>
</tr>
<tr>
<td>Progress</td>
<td>Have the programme activities been carried out according to schedule?</td>
</tr>
<tr>
<td>Impact</td>
<td>What has been the overall effect of the programme on people with disabilities, their communities, and the society?</td>
</tr>
<tr>
<td>Efficiency</td>
<td>What is the relationship between the effect of the programme and the resources invested in it? Have the results justified the investment in resources?</td>
</tr>
<tr>
<td>Relevance</td>
<td>Did the programme objectives prove relevant to the needs originally identified?</td>
</tr>
</tbody>
</table>

To determine the **effectiveness** of the programme, the evaluators analyze how and to what degree the outcome objectives and targets have been met. If an objective or target has not been met, they also analyze the reasons for this. Since the objectives identified improvements in the situation for people with disabilities, this component of the evaluation focuses particularly on them and the services provided.

To determine the **progress** of the programme, the evaluators compare programme activities that were planned with those that were actually carried out. They identify activities that were not carried out fully, or perhaps not initiated, and analyze the reasons for this. This component of the evaluation examines particularly the management of the programme.
To measure the impact of the programme, not only on people with disabilities, but on communities and the society as a whole, the evaluators must analyze to what degree handicaps have been reduced. This involves determining the changes that have taken place as the result of the programme. For example, has there been an increase in school attendance by disabled children? Has there been an increase in employment opportunities for disabled adults? Has there been an increase in participation by people with disabilities in family or community life. Social changes to look for include new policies and regulations that benefit disabled people. This component of the evaluation is concerned with both the community and people with disabilities.

To measure the efficiency of the programme, the evaluators compare the effectiveness and impact of the programme with the resources used in its implementation: human, financial, administrative, technological, and material. Each country must decide what is an acceptable ratio of input, or resources used, to output, or programme achievements. It may be useful here to compare this ratio with that of other programmes. Other factors should not be forgotten, such as the long-term input/output for the programme and the overall priorities of the country. If either a cost analysis or a cost-effectiveness analysis is to be part of this process, the evaluation team should include economists, who may be available from within a government ministry.

To determine the relevance of the programme, the evaluation team examines the basis for the original programme objectives, i.e., the situation analysis, the problems identified, and the programme priorities and their relation to the programme objectives. They also compare the situation at the time the plan was prepared to the current situation.

Table 13 on page 88 provides a summary of the components of evaluation, what they aim to analyze, and what sources of information can be used in the process.

**Who does the evaluation?**

The programme manager selects the evaluation team. However, those who planned the programme may have made recommendations regarding the composition of the team. There will also be interested groups who will expect to be represented. The programme manager may have difficulty keeping the team to a reasonable number that allows proper representation but remains small enough to work together effectively.

A programme manager may try to weigh the pros and cons of having an external or an internal evaluation, i.e., involving a team from outside the programme or involving a team from within the programme. A combination of the two is usually best. An outside evaluator may be more objective in assessing the programme results, but an internal evaluator will be better
Table 13

<table>
<thead>
<tr>
<th>Component</th>
<th>What to analyze</th>
<th>Source of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness</td>
<td>Degree to which targets and objectives have been met</td>
<td>Reports of activities and documented results of activities</td>
</tr>
<tr>
<td></td>
<td>-compared to-</td>
<td>Field observations and interviews</td>
</tr>
<tr>
<td></td>
<td>Planned objectives and targets</td>
<td>-compared to-</td>
</tr>
<tr>
<td></td>
<td>Special focus: disabled people</td>
<td>Original programme objectives and targets</td>
</tr>
<tr>
<td>Progress</td>
<td>Schedule of programme activities implemented or in progress</td>
<td>Reports on programme activities</td>
</tr>
<tr>
<td></td>
<td>-compared to-</td>
<td>Field observations and interviews</td>
</tr>
<tr>
<td></td>
<td>Planned schedule</td>
<td>-compared to-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Original broad and detailed programme plans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Original schedules of activities at all levels</td>
</tr>
<tr>
<td>Impact</td>
<td>Overall effect on health and social development of disabled people</td>
<td>Review of situation analysis through policy and programme review</td>
</tr>
<tr>
<td></td>
<td>Special focus: disabled people and the community</td>
<td>Field observations and interviews</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Impact of programme</td>
<td>Reports on the results of activities</td>
</tr>
<tr>
<td></td>
<td>-compared to-</td>
<td>Field observations and interviews</td>
</tr>
<tr>
<td></td>
<td>Resources used</td>
<td>-compared to-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Audits and documentation showing resources invested</td>
</tr>
<tr>
<td>Relevance</td>
<td>Situation analysis, problems, and programme priorities</td>
<td>Documents containing background information prepared by the national planning committee</td>
</tr>
<tr>
<td></td>
<td>-compared to-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Broad objectives</td>
<td></td>
</tr>
</tbody>
</table>

evaluator will be better able to identify constraints and explain why a target or objective has not been met. Both perspectives are valuable.

If the programme is funded by an external donor, the donor will expect representation on the team. The donor may be providing ex-patriate staff
for the programme, but the donor’s representative on the evaluation team will most likely be a person from outside the programme. The person may be selected by the donor, but should also have the approval of the programme manager.

The groups that should be represented on the evaluation team include organizations of people with disabilities, CBR committees from all levels, rehabilitation personnel from within the MOH, and rehabilitation personnel from other ministries and NGOs working in rehabilitation. In addition, the programme manager may want to include representatives from the programme planners; from within the health sector, but outside the rehabilitation programme, such as a representative from the primary health care programme; and from the ministry in charge of planning or finance. The number of team members will depend on the size of the programme. If a national programme is implemented throughout the country, each province may have an evaluation team made up of representatives from these groups. If the programme has been implemented only in selected areas, there may be only one team, including representatives from various levels.

The programme manager is not a member of the evaluation team, but remains available to the team during the evaluation to ensure that the members have access to all necessary information. The manager also ensures that the evaluation proceeds as scheduled and that the team produces a report within the specified time frame.

**How is the evaluation done?**

The time needed to conduct the evaluation can vary from three to five weeks, depending on the size of the programme. Although some background documents may be sent to the team members prior to the evaluation, the first few days of the evaluation will be used to review documents, to assign responsibilities to individual team members, and to make visits to the offices of the ministries and organizations involved in rehabilitation, as well as the offices of policy makers and programme planners. Again, depending on the size of the programme, one to two weeks will be needed for field visits at community, district, and provincial levels. Following the field visits, the team may wish to review additional documents or carry out additional interviews at the national level. At least one week must be allowed for the team to prepare a report. The team may designate two or three members to prepare the text of the report, which is then reviewed by all of the team members before submission of the final report. Before joining the evaluation team, members must agree to respect the time frame. This can help to avoid undue delay.

As noted in Table 13, the background information from the original plan will be needed as a basis for the evaluation. This includes the description of the situation analysis, the problems and priorities identified, the broad
objectives set by the programme planners, and the programme budget. The evaluation team will also need monitoring reports from each province, with reference to detailed plans, targets, and activities. The team may also ask for specific monitoring reports from district level. The financial monitoring of the programme may have already been done at national or provincial level, depending on the degree of decentralization. A full report of the programme expenditures should be prepared prior to the evaluation, so that it is available for review when the evaluation team begins its work.

The programme manager should also prepare summaries of information from each province. These data should include

- the number of disabled people identified;
- the number of people who have received services;
- the types of services provided;
- the number of people with disabilities who have benefitted from the services;
- the types of benefits disabled people have experienced, e.g., improved function in daily activities, school attendance for disabled children, and skills development for income generation.

The team will also wish to see some results of the programme implementation and to carry out interviews to confirm reports and observations. It will be necessary to interview people with disabilities who have been assisted within the communities or through the referral system, families of people with disabilities, community rehabilitation workers, community leaders, members of the community not directly involved in the CBR programme, members of CBR committees at each level, rehabilitation personnel within the health sector, and personnel within other sectors or NGOs involved in rehabilitation.

Prior to the evaluation, the programme manager can draft questionnaires to be used in interviews, to ensure that the same information is gathered in different parts of the country. If possible, members of the evaluation team should work with the programme manager to do this, or the team may review and revise the questionnaires early on in the evaluation. The questions posed in interviews should seek to

- confirm the monitoring reports;
- explain, if necessary, why activities were not completed or targets not met;
- define changes in the quality of life of people with disabilities as the result of the programme;
- identify changes in societal attitudes regarding disability.

Based on the data collected at national level, monitoring reports, field observations, and interviews, the evaluation team will have both quantitative and qualitative data to analyze. The quantitative data should show
improvements in comparison with data available when the planning process first took place, since the programme should have stimulated the development of national databases on disability.

After the evaluation committee submits its final report, the programme manager should ensure that everyone involved in the rehabilitation programme is informed of the findings. The programme manager may ask that information be presented in meetings so that it can be discussed. The national manager may meet with representatives from the provincial level, who then meet with district-level representatives, who, in turn, share the information with the community committees. The programme manager may also prepare a summary statement for distribution at all levels. It is important to inform all of those who have contributed to the programme of the results of their work, to help them feel a part of the process and to see the fruits of their labour.

**COMPLETING THE MANAGEMENT CYCLE**

The planning process to prepare new objectives for the ongoing programme should be the same as that carried out for the first national plan, but it will take less time because the necessary information should now be readily available.

The evaluation process will have produced information to help identify new priorities and develop new programme objectives and targets. The new plan will consider both the successes and the failures of the initial programme, with the goal of correcting the failures. Activities that were not completed and objectives or targets that were not met should be examined to determine whether they are still appropriate and, if so, how constraints can be overcome.

Programme planners will be concerned with the sustainability of a programme, i.e., whether the government can continue to support the existing programme and any planned expansions. Recurrent costs of services under the management of the government, which would include the ongoing programme, should be covered by the government budget. National rehabilitation plans usually provide for programme expansion because the rehabilitation programmes in most countries are limited. The programme evaluation will indicate whether the expansion foreseen in the original plan can be sustained or whether expansion must be limited in the next plan.

As noted in Chapter 1, the three components of the management cycle lead naturally from one to another. The evaluation of the CBR programme is part of the cycle which leads to further planning, modifications in programme implementation, and eventually, to another evaluation.
PLEASE COMPLETE THIS QUESTIONNAIRE AND RETURN IT WITHIN ONE MONTH OF RECEIPT OF DOCUMENT TO: THE WORLD HEALTH ORGANIZATION, REHABILITATION UNIT, 20 AVENUE APPIA, 1211 GENEVA 27, SWITZERLAND

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   2-5
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3. Please comment on the usefulness of the publication?

   very useful
   fairly useful
   not useful

4. How could the document be improved?

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5. Any other comments?

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Date: Thank you for your help