

**THE NATURE AND EXTENT OF PARTICIPATION
IN CBR IN MIDLANDS PROVINCE
IN ZIMBABWE**

by

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LIST OF ABBREVIATIONS

ADL	Activities of Daily Living
CBR	Community-Based Rehabilitation
CRC	Community Rehabilitation Committee
DDC	District Development Committee
DMO	District Medical Officer
DNO	District Nursing Officer
DPO	Disabled Persons Organisations
EHT	Environmental Health Technician
EPI	Extended Programme of Immunisation
FGD	Focus Group Discussion
IGP	Income Generating Project
IMR	Infant Mortality Rate
MOE	Ministry of Education
MOH	Ministry of Health
NGO	Non-Governmental Organisation
PEP	Participatory Extension Process
PRA	Participatory Rural Appraisal
PWD	Person with disability
VCW	Village Community Worker
VHC	Village Health Committee

CHAPTER 1

INTRODUCTION

1.1 COMMUNITY-BASED REHABILITATION (CBR)

Reports of the World Health Organisation (WHO) indicate that 10% of the world's population has some form of disability (WHO 1981). In Zimbabwe, community-based rehabilitation programmes that were implemented found that 2.5 - 4.5% of the population require active rehabilitation intervention in any community (Zimbabwe Ministry of Health 1990).

Community-based rehabilitation (CBR) is a systemised approach that offers an opportunity for local resources, which can be used in rehabilitation, to be made available to the community (Helander *et al.* 1989). The concept of CBR evolved more concretely over the last half century as a result of many factors. One of the contributing factors put forward by Miles (1998) is the growing voice of organisations for disabled people (DPOs) demanding more appropriate and effective service. The International Society for Rehabilitation of the Disabled also outlined the need to realign the training of professionals in order to meet the demands of people with disability (PWDs). This was backed by a call to change the technology orientation of rehabilitation services and for a shift in the service delivery from the more established institution-based delivery to community-based service delivery.

Miles (1998) has outlined the main and current uses of CBR across the world, as listed below:

- a. Therapy or special measures provided by families to disabled members in their homes, with some efforts in the neighbourhood to change public attitudes and improve access to local services such as schools and public buildings;
- b. Therapeutic, educational, vocational or social self-help projects run by disabled people and partners (with or without some technical help);

- c. Development of an ideology whereby an entire nation's resource for medical and legally defined rehabilitation and social inclusion are centrally planned and allocated equitably across the whole population. This promotes the activities mentioned in the foregoing points a and b.
- d. Promoting activities of rehabilitation institutions or disability resource centres, to periodically take knowledge and skills to rural deprived communities (This is sometimes referred to as outreach activities).
- e. Establishing an externally funded programme in which a network of paid and trained CBR field workers without a specific rehabilitation centre base but with clear management structures, ongoing in-service training and negotiated referral contacts undertake mobilisation, training and public education.
- f. Some residential institutions caring for children with disabilities now refer to their programmes as CBR on the grounds that if children are not living with their parents, they must somehow still be based in the community.
- g. Finally, Miles (1998) states that CBR has been used as a buzz word by which well meaning people, not actively involved in community development, soften the contrast between their own access to professional services and the access of most of mankind, and by which aid agencies and institutions can appear to have adopted the latest trends.

Miles' analysis clearly illustrates that the models of CBR are not concrete; rather, the underlying concepts are inherently shifting the service delivery model to promote the needs of the PWD, albeit to differing extents. In Zimbabwe, CBR has been regarded as an important mode of service delivery in meeting the current needs of people with disabilities. As a national programme, CBR is operating within the health delivery system and is complemented by other efforts in the education and social sectors and other independent bodies, including organisations of and for the disabled.

1.2 BACKGROUND ON ZIMBABWE

The country of Zimbabwe is situated in Southern Africa, between longitude 25E and 34E, and latitude 15S and 23S. It is bordered by Zambia, Mozambique, South Africa and Botswana. It has a population of 11,500,000 people (1992 census). The country is subdivided into nine provinces and has two main vernacular languages, namely Shona and Ndebele.

1.2.1 Historical background - The health situation at independence

In 1980, Zimbabwe gained independence from British colonial rule. As outlined in the White Paper for Equity in Health (1981), the most marked characteristic of the health care sector in Zimbabwe at that stage was the inverted use of resources. The document reviewed the health care sector in Zimbabwe, its major problems, and inequalities in material, manpower and financial resources as shown in Table 1.1.

Table 1.1 Basic data on government hospitals, 1981 (White Paper for Equity in Health 1981).

Hospital Category	Number	Beds	Doctors	Nursing cadres	%Gov Hosp. Expenditure
Central	4	3 000	223	1 568	60
General	11	2 038	39	789	21
District	28	2 400	16	422	10
Rural	46	2 029	0	235	3

Rural populations with the greatest health needs received the least amount of health care resources (as illustrated by the distribution of the health care personnel), and health expenditure was geared towards support for curative services consuming 60% of total government expenditure. This situation developed as a result of the needs of the settler economy.

In the area of health care, the first task was to correct the gross inequalities in the health care service provision. National health policies were outlined in the White Paper entitled "Planning for Equity in Health" (1981), a sector review and policy document. The document furthermore outlined major causes of morbidity and mortality. The described major causes of morbidity and mortality at independence are shown in Table

1.2. Many of these conditions, if not treated early and effectively, will cause residual disabilities and functional limitations.

Table 1.2 Major causes of morbidity and mortality

Children	Adults
Measles	Problems associated with pregnancy and child birth
Whooping cough	Malaria
Diarrhoea	Dysentery, typhoid, etc.
Acute respiratory infections	Schistomiasis
Tetanus	Pneumonia
Malaria	Tuberculosis
Malnutrition	Anaemia
Tuberculosis	Hypovitaminosis
Premature birth	Scabies
	Trachoma

The document further explained the new health policy of the Zimbabwe Government, with the emphasis on primary health care. It also outlined the new structure and the health care workers required for the implementation of the new approach to health. At that stage, a significant effort was made to address community participation in health care by ensuring structures were established at primary, secondary as well as tertiary levels to ensure institutionalisation of community participation.

The sectoral review of 1981 concluded that "*a broad attack on social inequalities, which lie at the root of the peoples' ill health*", was an essential component of the Government's primary health care programme. Basic health services were unequal; hence, already marginalized groups in society were marginalized even further, especially in the rural areas. The inequalities that existed are indicated in Table 1.3. Consequently, the priority of the Government at that stage became one of directing the health sector

away from curative bias, to one where curative, preventive and promotive services were integrated.

Table 1.3 *Infant mortality rates vs. per capita expenditure and income*

Population Groups	IMR (Infant mortality rates)	Health care expenditure per person in Z\$	Annual Income in Z\$
Whites	14	144	8500
Blacks in Harare	40	31	1150
Rural Blacks	146	4	220

Source: MOH 1987. Planning for Equity in Health.

Little mention was made in the document about rehabilitation or CBR. Under the investment programme, a national rehabilitation centre and the development of physiotherapy departments were suggested as priorities. Furthermore, under the mental health programme, the rehabilitation and care of patients were mentioned, with emphasis on treating patients with mental illness as close to home as possible. However, the essence of the primary health care approach in the document embodied many of the underlying principles of CBR, for example community involvement and democratisation of the health service.

The Zimbabwe Health for All Action Plan followed the White Paper in 1986. This Plan translated the policies outlined in the Planning for Equity in Health document into an action plan. More specifically, it gave direction to the planning and implementation of health sector programmes. Infrastructure requirements, objectives, targets and plans of action for each programme were outlined in more detail. The relocation of resources from central and general hospitals to district hospitals, clinics and community outreach services became a major goal. The new comprehensive health package combined curative, promotive, preventive and rehabilitative services. The public health system was restructured to enable each level of service to support the implementation of the Health for All Action Plan adequately. At Central Government level, the Ministry of Health (MOH) expanded its offices to support the provinces with leadership, direction, coherence and consistency in performance in the delivering of health care services. Provincial Medical Directorates were established and were responsible for the management of preventative, curative and rehabilitative services in each province.

1.2.2 Development of the rehabilitation services

At independence (1980) little or no services existed in the district and rural areas of Zimbabwe. The few rehabilitation professionals in the country were concentrated in the few urban institutional based services at both government institutions such as hospitals, and at welfare organisations such as Jairos Jiri. The rural population had no access to rehabilitation services. Thus, rehabilitation services were unequal in a similar way to the rest of the health care services. A new approach was required to increase access to these services.

The Rehabilitation Department of the Ministry of Health (MOH), which functioned under the Mother and Child Health Unit, outlined its programme and adopted the CBR concept. CBR compliments and reinforces the philosophy of Primary Health Care (PHC). It emphasizes the need for prevention, provides an affordable, locally available service to those who are disabled and mobilises community resources to assist the disabled in living as normal a life as possible in his/her community. The broad goals of the programme were:

- To promote a comprehensive programme for CBR of the disabled;
- To prevent impairment, disability and handicap (Zimbabwe Ministry of Health 1983). Training and education targets and action plans were outlined. Part of the plan was to develop institution-based rehabilitation facilities as a prerequisite to putting a CBR delivery system into place.

As mentioned previously, rehabilitation services were amongst the last to be developed in the Zimbabwean health system. The Rehabilitation Department (MOH) embarked on developing both institution-based rehabilitation services and CBR services. The latter had to complement the primary health care concept, emphasizing the involvement of the community in rehabilitation.

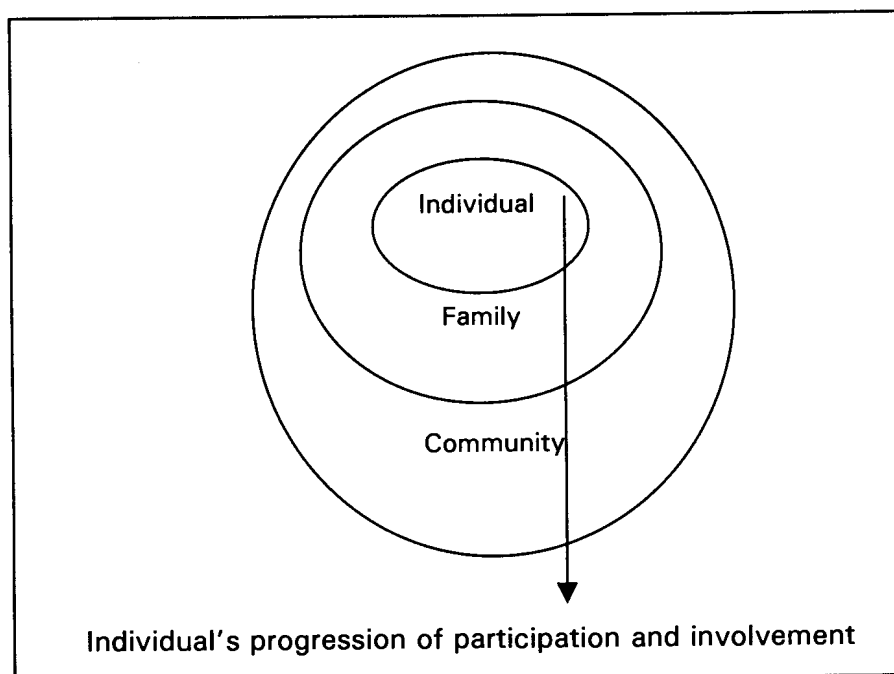
Some of the key concepts considered while developing the rehabilitation services, included those suggested by Bauer (1989). The development of a comprehensive rehabilitation service, which include the components of using and adapting the clients' environment, coordinating all branches of rehabilitation and employing an active participatory process, has been the primary aim of the Rehabilitation Department (MOH). For rehabilitation to be effective, there must be an active **participatory** process of helping people to return to leading a full normal life. In order for this process to be

fulfilled, the PWD should be actively participating in his or her own rehabilitation process. The blind person should not only answer questions, but also raise them, and not only provide data, but evaluate it and work through solutions. The client should have the final say about the entire rehabilitation process. Participation is the core of CBR because it allows a programme to be owned by its participants. It also promotes sustainability and empowerment of the PWD and the community. This process should start from first contact with the client at any stage or interface of the rehabilitation process. It should therefore be pervasive throughout the process of rehabilitation and increase in its sphere of influence. Participation should take place at both programme and individual level.

If a client is treated individually and does not actively participate in his/her rehabilitation process, including setting of the treatment aims, no amount of effort from anyone else will yield success. Similarly, at programme level, if the key community members do not take an active part in all aspects of the programme, it cannot be successful.

The progress of participation is illustrated in Figure 1.1.

Figure 1.1: *Individual's progress in participation and involvement in CBR*



The development of rehabilitation in health care services progressed along two lines:

- The MOH embarked on training rehabilitation technicians to bridge the shortage gap of rehabilitation personnel such as therapists and orthopaedic technicians. Along with the qualification of this group of health care workers, new rehabilitation departments were opened in the districts. The services therefore developed from nine (9) departments in 1981 (only in the major cities) to sixty four (64) in 1999 (in almost all districts in the country). In 1986, the University of Zimbabwe also introduced the training of physiotherapists and occupational therapists. The institution-based services were developed first; i.e. rehabilitation departments offering physical and occupational therapy. Basic orthopaedic services were offered by referring clients to the two major government orthopaedic centres, situated in Bulawayo and Harare.
- Outreach services were developed by using existing infrastructure and established programmes such as the extended programme of immunisation (EPI). The Rehabilitation Department utilised its transport and logistical arrangements to access the community. Through this, some of the components of CBR, such as awareness raising, social mobilisation, education for the client and family and collection of base line data, were put into place simultaneously. Complementary developments through other sector ministries, i.e. education, local government and agriculture also took place at community level. Some of these developments included the establishment of development structures (development committees) and the training and inception of village community workers (VCWs). DPOs also called for accessibility and equal opportunities (Zimbabwe Ministry of Health 1983 - 1990). This indicated the start of participation in CBR by community members.

In 1984, the International Red Cross in Zimbabwe set up the first CBR programmes in two districts (Red Cross Zimbabwe 1985). Their efforts constituted an initial experience base for the community-based programme in Zimbabwe. Other agencies such as the International Labour Organisation (ILO) also introduced key CBR concepts in their programmes, and the MOH initiated its first CBR programme in 1987 in Manicaland (MOH 1990). Since then, CBR programmes have systematically expanded to other districts and at present 58 districts have CBR programmes (84% geographical coverage to date).

The statistics from the first seven CBR programmes are shown in Table 1.4.

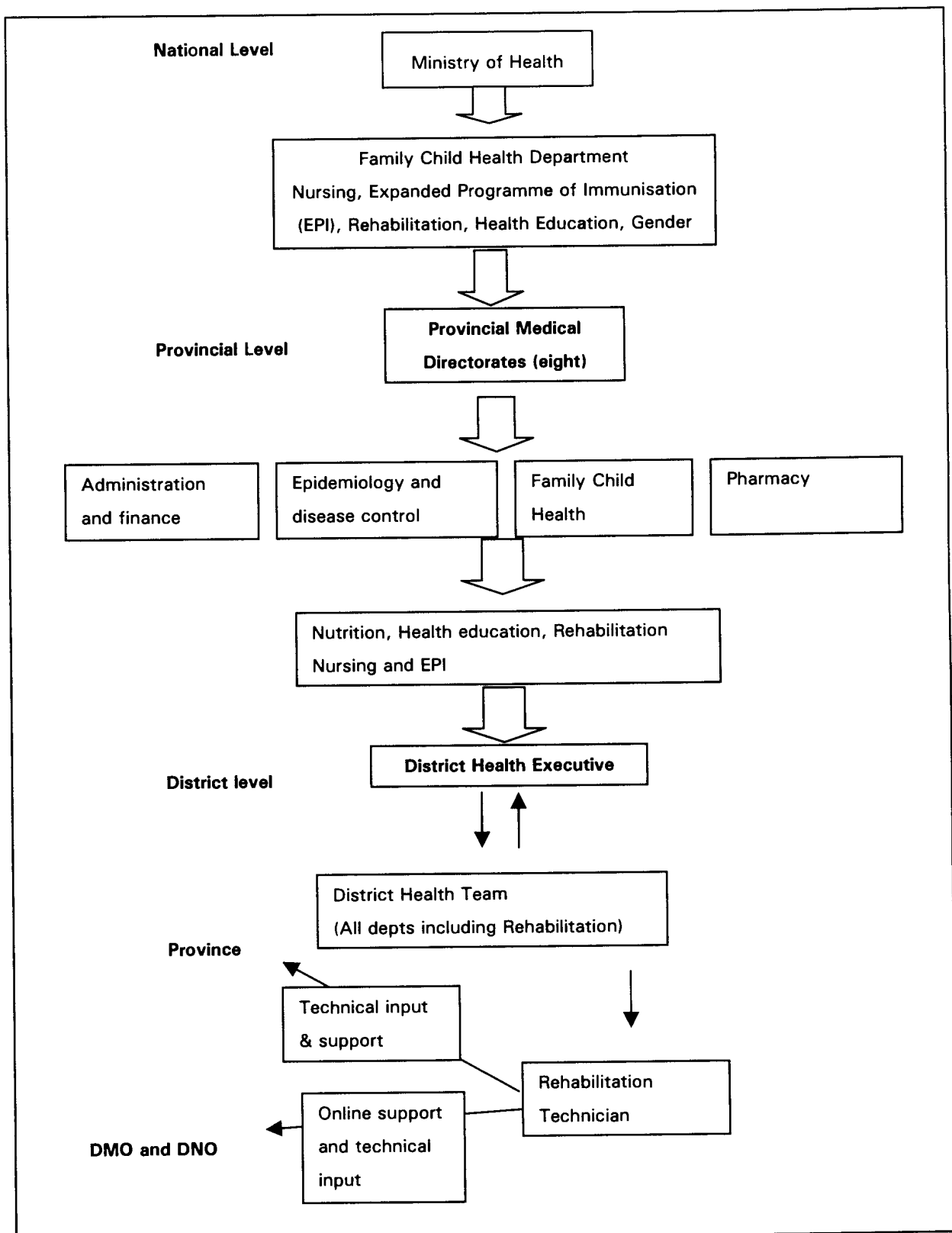
Table 1.4 Statistics of the first seven CBR programmes, per province, 1989-1991

District	No. of people attending training	No. of people attending screening	No. of people identified as in need of rehabilitation
Nyamidzi	689	171	141
Ntoli	1 219	598	100
Zvishavane	721	376	45
Seke	960	377	254
Binga	1 372	749	152
Dotito	500	279	177
Ngezi	691	659	325

1.2.3 Integration of the rehabilitation department within the health care system

Figure 1.2 illustrates the integration of rehabilitation into the current health system.

Figure 1.2 The Rehabilitation Department within the Health System



Key: DMO = District Medical Officer; DNO = District Nursing Officer)

1.2.4 The Rehabilitation Department within the health system organisational structure

The Rehabilitation Department (MOH) is represented by rehabilitation personnel at all levels of the health system:

Central Level: At central level, an office exists as part of the central top management team of the MOH. Its main agenda is to contribute to health and rehabilitation policy. Although a rehabilitation policy has not been formulated formally, CBR was articulated as a policy of the Rehabilitation Office in collaboration with the central level top management. Currently, this office is staffed by one officer.

Provincial Level: At provincial level, as shown in the Figure 1.2, rehabilitation is represented in the provincial office, and rehabilitation departments were established at all provincial hospitals. The provincial office is also responsible for interpreting policy and facilitating its implementation at provincial, district and community level. To enable the provincial offices to carry out its function, more staff had to be appointed. The number of staff at provincial level is indicated in Table 1.5.

Table 1.5 Rehabilitation staff at provincial level, 2000

Province	Staff available in each province to date		
	P.T.	O.T.	R.T.
Mashonaland East	1	1	21
Rehabilitation Technician Training School	0	2	N/a
Mashonaland Central	2	1	19
Mashonaland West	4	2	22
Manicaland	4	0	21
Midlands	4	1	24
Masvingo	2	1	22
Matebeleland South	2		24
Matebeleland North	1	1	16

(RT = Rehabilitation technicians; PT = Physiotherapists; OT = Occupational therapists).

Although CBR programmes are offered at provincial level and CBR itself cannot be disassociated from this level because of the referral system being so inter-linked, this study will concentrate on the CBR programmes at the district level of operation.

District Level: Most districts have at least one district hospital with a rehabilitation department. At this level, the department is responsible for the actual implementation of CBR and other rehabilitation activities such as providing services to the hospitals. The number of rehabilitation staff at district level is indicated in Table 1.6.

Table 1.6 Rehabilitation staff at district level (1999)

Province	No. of districts	Average No. of RTs / district	Therapists/district
Mashonaland East	8	2	0
Rehabilitation Technician Training School	0	2	N/A
Mashonaland Central	8	2	0
Mashonaland West	8	2	2 districts with therapists
Manicaland	8	2	0
Midlands	8	2	1 district with therapists
Masvingo	8	2	0
Matebeleland South	8	2	0
Matebeleland North	7	2	2 districts with therapists

(RT = Rehabilitation Technicians)

1.2.5 Management systems within the Rehabilitation Department

The main management functions for the Rehabilitation Department are: planning (which includes setting priorities with regard to rehabilitation and CBR in collaboration with the PWD, his family and the community members), organising, staff development, leading, controlling and monitoring. Planning the core and backbone of the CBR activity remains in the community, with some major activities taking place to support the efforts of the initial implementation phases of the community-based programmes. The main activities constituting CBR implementation are:

- Social mobilisation and awareness raising;
- Training and education activities for the community;
- Survey activities to ascertain the status of disability and needs in the community;
- Implementation of intervention strategies based on identified needs.

Following this systematic implementation, certain activities were carried out on the basis of needs identified through the management system. These included:

- Need based training of community-based workers; i.e. VCWs, family members of the PWD, community members and community leaders;
- Client, local facilitator, therapist and technician training sessions;
- Income generating facilitation exercises, either directly or through community-based health and rehabilitation workers such as environmental health technicians and extension workers from other ministries or departments;
- Home visits and outreach consultations to take care of individual needs as well as reassessment of chronic and new referrals;
- Regular attendance of inter-sectoral and development meetings by clients, VCWs, and periodically, technical rehabilitation staff, to allow facilitation of developmental issues for PWDs;
- Referral of clients in need of services not available in the community.

To coordinate and manage this multifaceted service, various management components have been implemented and developed within the Rehabilitation Department in Midlands Province. The management system aimed at providing input at all levels of the referral system in order to facilitate delivery of service. It was assumed that the needs of the community were articulated by the community at informal and formal meetings, through local rural health centres, direct meetings with the Rehabilitation Department and needs identified at individual therapy or other intervention sessions.

It was deemed necessary to implement standardised systems to ensure that services rendered met the needs of the community. The management functions with a direct bearing on outcome at client and community level include:

- A standardised planning system to capture the needs of the community, in particular the expansion and consolidation of CBR services, which include activities to meet needs within an area where CBR has been implemented. These activities are based on feedback from the community. All plans are expected to have clear objectives (specific, measurable, achievable, result based and time framed), and each case should have a clear expected outcome;

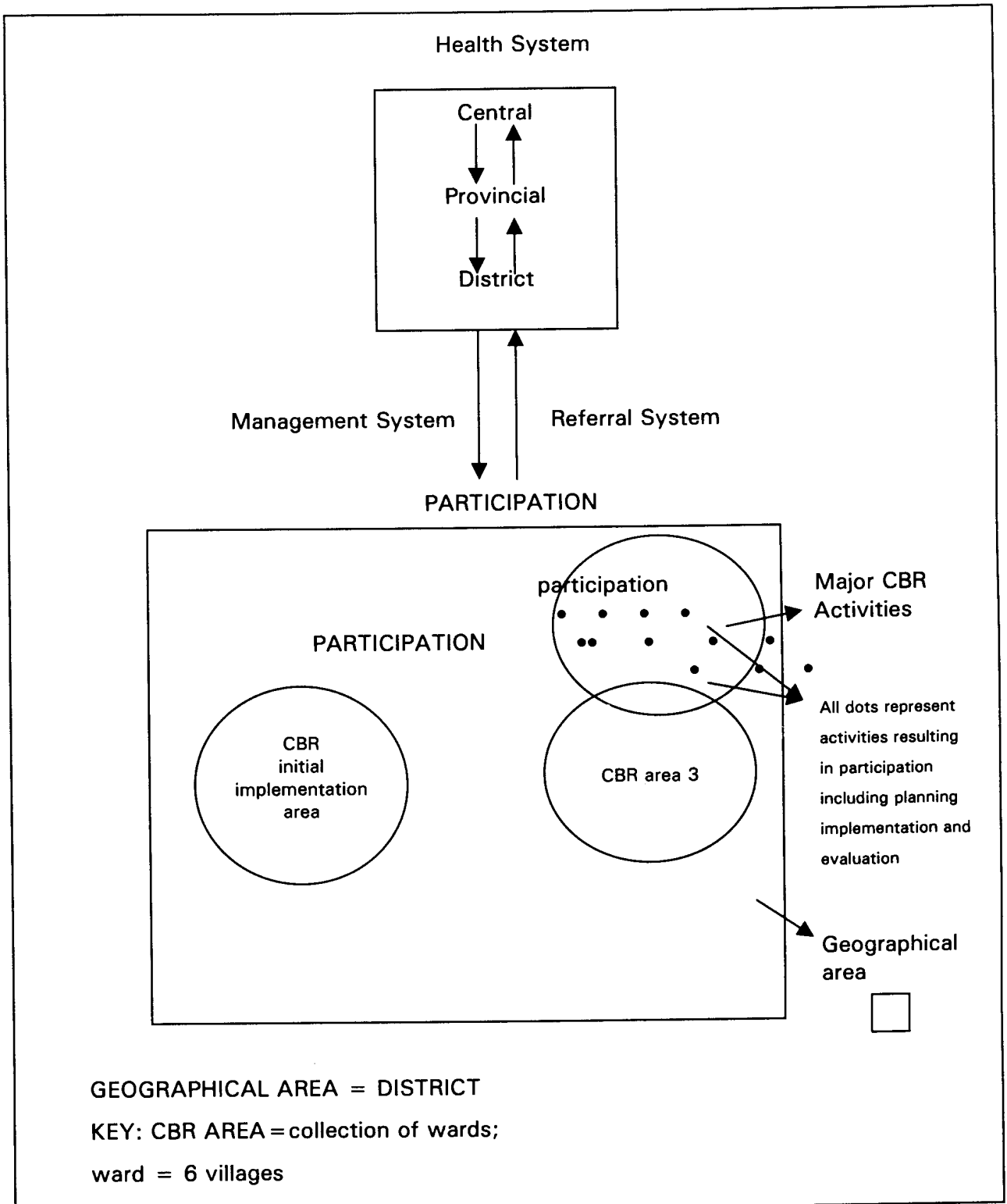
- A quality assurance programme to ensure that the clinical work at all levels meets a minimum standard of operation. (The staff members within the Rehabilitation Departments at district and provincial level collectively agreed upon this standard);
- Implementation of specific activities to meet expressed needs by the PWD and the community;
- The establishment of standardised communication systems at community level and at district level. These systems include the line of communication as well as the other more formalised methods of communication such as attending meetings, report writing, records for clients at community level and community consultations.

To promote community participation, an effort was made to put health management systems in place that would be sensitive to the client's needs, as well as to actively promote community participation. It is important to determine how successful community participation has been and how it is manifesting in the management and service delivery of CBR at community and district level.

1.2.6 Community participation in CBR

In order to understand the discussion on the importance of community participation in CBR, a schematic representation is provided in Figure 1.3. The diagram shows the referral system from community level through to the national level. The larger box represents a district and the circle represents the CBR areas within the district (A CBR area is usually a collection of two or more wards. A ward consists of six villages). Various activities take place within each CBR area. These activities constitute the CBR programme. It includes awareness campaigns, social mobilisation, individual in-service training and treatment of PWDs, training of their families and support systems, community consultations between all role-players and many more. These activities are determined by the needs of the PWDs in the specific area. In the diagram, all the mentioned activities are represented by the bold black dots (●●). The achievement of these activities will depend on the linkages between different community members and leadership within the community as well as the multisectoral referral system within the community from the district through to the provincial level.

Figure 1.3 *Diagrammatic representation of CBR activity at community level emphasizing the role of participation at different levels*



To reach an effective outcome of a rehabilitation programme, the community should contribute in a collaborative manner towards the CBR programme. The experience of the researcher is that this level of collaboration and therefore participation from the community has thus far not been attained. The community leaders and the PWDs show reluctance to suggest actions and to express their needs. Community leaders at times render rehabilitation and disability issues very low priority. According to the literature, the reluctance of most communities to participate in rehabilitation programmes is a complex issue (Rifkin 1993). Community leaders' cultural and historical perspective on disability have an important influence on the process of participation, with most community leaders' perspective being an exclusion of the PWD in all decision-making processes within a community, including CBR.

Participation is a gradual process and its success will depend on a fine balance between creating awareness, social mobilisation and economic activities for PWDs in the community. As stated by the World Council of Churches (1981 volume 1): *"Neither awareness with no tangible objective, nor short term gains with no substantial base for longer term participation are satisfactory recipes."* In the progress of any programme, the degree of emphasis on the process of participation as opposed to immediate quantitative outcomes is important for attaining a high degree of participation. It is unclear to what degree this was attained in the CBR programme.

Oakley *et al.* (1991) assert that maintenance and regular support and contact between people as well as supporting structures are fundamental to the process of participation. It must be both regular and reliable. The process of participation will take hold if there is regular contact between the parties involved; otherwise it becomes limited to periodic responses and contributions. This contact and communication may not have been clearly defined and understood by all role-players in the past, and may have affected participation.

There has been some measure of standardisation of the implementation methodologies for CBR and it has been assumed that these methodologies are encouraging participation, which is considered the backbone of the rehabilitation programme. Currently, Zimbabwe has no rehabilitation policy, but plans to develop one in the next few years are underway. The findings of an investigation into the participation of the community in the management and decision-making processes may contribute meaningfully to the content of the policy. Furthermore, the findings may provide the

groundwork for other sectors of health to improve their own community-based strategies aimed at facilitating and encouraging community participation.

The MOH's current drive is to decentralise most of its functions to district level and has recognised in its plan the need to increase and enhance community participation in the delivery of health services.

1.2.7 Indicators for community participation

Indicators outlined by Rifkin (1993) that can be used to investigate and determine participation on community and individual client levels are the following:

- Needs assessment: identify how these needs are decided on at individual and programme (community) level and how it links with plans at district level;
- Leadership: the level of involvement and degree of rigidity or flexibility that the organisation has in meeting CBR goals;
- Organisation at community level - level of involvement and degree of rigidity or flexibility that the community has in meeting CBR goals;
- Resource mobilisation: identify the extent of manpower, material and other resource mobilisation in order to reach CBR goals;
- Communication links: identify the extent of utilisation.

There are no scales to measure the above-mentioned aspects. The other factor is that it needs to be measured by means of qualitative measuring techniques. Furthermore, the degree of control that the community perceives itself as having is an important tool for measuring the level of community participation that the community has. Table 1.7 shows a measure of community participation as outlined by the Community Participation Group of the United Kingdom for All Network (1991).

Table 1.7 Levels and forms of community participation

DEGREE	COMMUNITY PARTICIPATION	EXAMPLE
HIGH	Has control	Organisation asks community to identify the problem and makes all key decisions on goals and means. Willing to help community at each step to accomplish goals.
	Has delegated power	Organisation identifies and presents a problem to the community, defines the 'I' and asks the community to make a series of decisions that can be embodied in a plan that the organisation will accept.
	Plans jointly	Organisation presents tentative plan subject to change to those affected. Expect to change plan at least slightly and perhaps more subsequently.
	Advises	Organisation presents a plan and invites questions. Prepared to modify plan only if absolutely necessary.
	Is consulted	Organisation tries to promote plan. Seeks to develop support to facilitate acceptance or give sufficient sanction to plan so that administrative compliance can be expected.
	Receives information	Organisation makes a plan and announces it. Community is convened for informational purposes. Compliance is expected.
LOW	None	Community is told nothing.

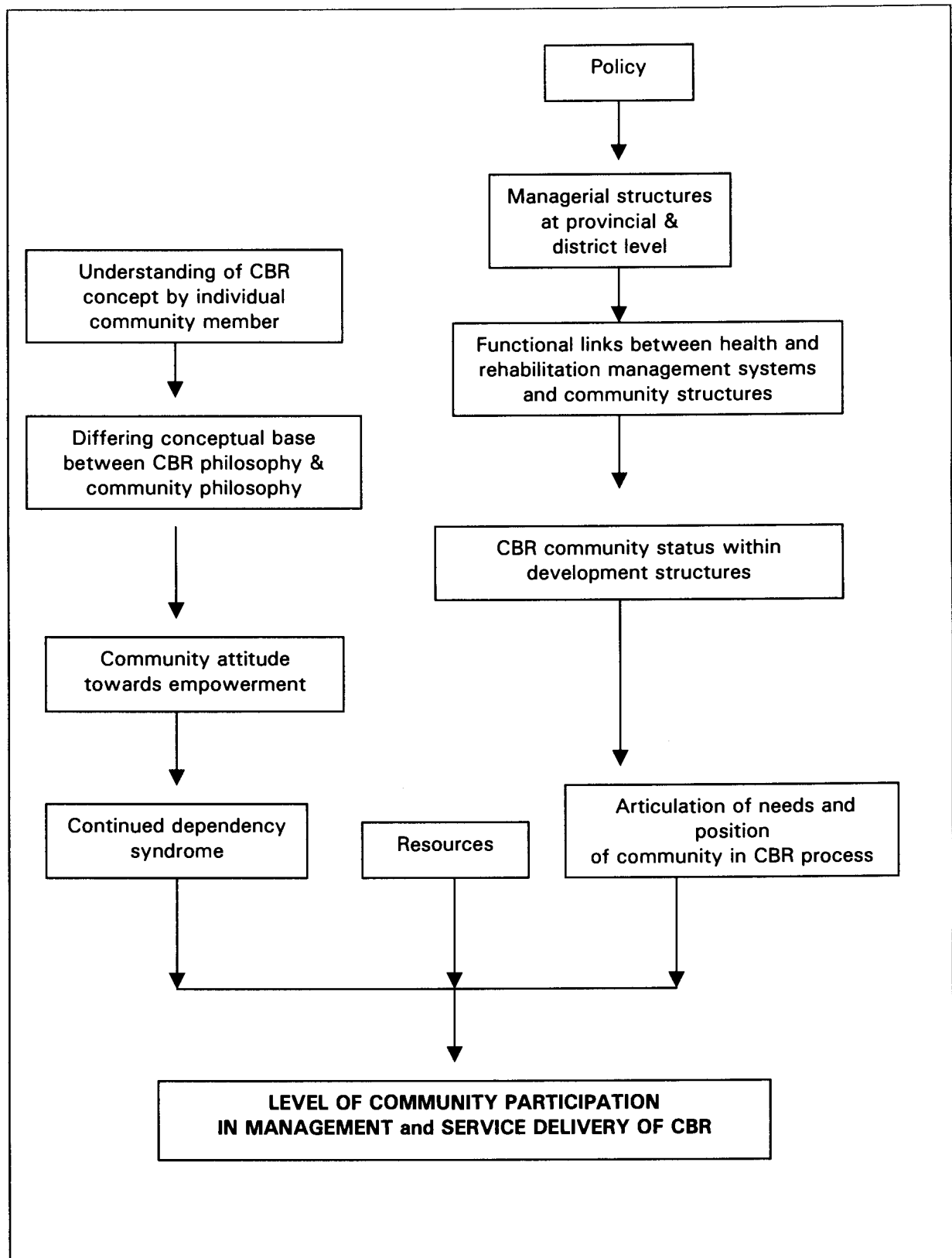
Although Table 1.7 offers a scale for measuring the degree of perceived community control in participation in the community, it is very broad and vague. The parameters and scales need to be refined and developed further.

As mentioned before, the community's feedback through the available forums is considered a very important component of CBR and a crucial facet for community participation in the management of the CBR programme. In Midlands Province, the community leaders managing the CBR programme have made concerted efforts to enhance community participation in CBR. Determining the extent of community participation in Midlands Province is thus of utmost importance in the evaluation of CBR service, as well as for the formulation of the National Policy on CBR.

The questions that lie at the root of the success of CBR is: to what extent do community members, including community leaders, participate in the management and implementation of the CBR programme, and to what extent are they sustaining this participation?

The conceptual framework as set out in Figure 1.4 is a representation of some of the factors that may affect the level of participation in the management of CBR by key role-players such as the PWDs, the community leaders, VCWs and the health and rehabilitation workers themselves.

Figure1.4 Conceptual Framework of community participation in community-based rehabilitation (CBR)



1.3 JUSTIFICATION

For any community programme, the management and administration systems that are put in place and utilised, need to enhance the functional outcome of the client by meeting the needs of the clients and the community. Utilising and enhancing the community structures and modalities that are available in the community at all levels may result in meeting these needs. Through the use of community structures and modalities, the communities have the ability to fully participate in decision-making, planning and activities related to CBR. The extent to which this is happening is unknown, and it is the opinion of the researcher that it is less than expected standards. It is therefore vital to determine how far the community is participating and what factors are hindering and facilitating this process.

1.4 PURPOSE OF THE STUDY

The purpose of this study is to establish whether the management systems and structures used by the Rehabilitation Department at community, district, provincial and national levels in Midlands Province, have the full collaborative participation of the community, with particular emphasis on the person with disability (PWD).

As shown in Figure 1.2, the management system starts at the national through to the community level. It is beyond the scope of this study to go extensively into depth regarding the management systems at national level; however, the researcher will explore to what extent the national policies have influenced rehabilitation and community-based service in Midlands Province.

The study will investigate community participation in planning, implementation and evaluation of the CBR programme. The management inputs, processes and outcomes as shown in the conceptual framework in Figure 1.4, and the way in which the community has participated in these processes, particularly planning (as planning basically underpin and underlies all other management functions) will be investigated.

1.4.1 Aims and objectives of the study

The aim of this study is to determine to what extent the community in Midlands Province has participated in the management of CBR.

Specific aims and objectives are to:

1. Determine the level of participation of the community in the management of CBR, specifically the extent to which participation in Midlands Province can be measured by using the Rifkins model of community participation.
2. Determine the level of understanding of participation in the CBR delivery system by all key role-players, with the emphasis on CBR service delivery at community level.
3. Determine the attitude of community leaders, PWDs and key health and rehabilitation workers towards participation in CBR.
4. Determine the areas of participation in CBR by all key role-players at community level.
5. Determine the dynamics of participation by key role-players from the community at the community and district levels of management in the service delivery of CBR. This includes the formal and informal links between the management inputs and processes in the health and rehabilitation system that are currently in place to establish contact with the community at district and community level;
6. Determine the factors that are promoting or hindering community participation, and the extent to which availability of resources influence participation.
7. Determine how the existing rehabilitation management system collaborates, links and functions with the community and district level structures.
8. Determine the level of communication between the key community role-players and the role-players in the rehabilitation and health delivery system.

9. Describe the present situation and make recommendations regarding future developments that will enhance the effective and efficient management and delivery of CBR service with the full participation of the community.

1.5 RESEARCH METHODOLOGY

1.5.1 Study type

The researcher considered a cross-sectional, qualitative analytical study of the relevant activities of, and communication between the stakeholders in the CBR programme on all levels of management, as most appropriate to achieve the aims and objectives of the study. The research techniques used in the study included questionnaires, structured interviews, focus group discussions and analysis of documents. The researcher decided to conduct the research by making use of different techniques to collect the various aspects of information.

Respondents included a sample of clients, health and rehabilitation workers, community leaders and Village Community Workers (VCWs) from three districts in Midlands Province. Documents on national, provincial and local government levels, as well as on community level, were analysed.

1.5.2 Demarcation of the study

The study is confined to Midlands Province, although relevant data was sought from documents on national level influencing CBR in Midlands Province. The researcher chose this particular province because it is known to have had systematic management input on all levels of the health system, as documented in the provincial and district guidelines (MOH 1998, District and Provincial Guidelines for Midlands Province).

1.5.3 The primary research methodology

The research methodology is summarised in Table 1.8:

Table 1.8 **Summary of the primary research**

Respondents	Method	Technique	Respondent segmentation	No.
Clients	Qualitative descriptive approach.	Personal interviews.	Mental Illness Orthopaedic Neurological Hearing Visual Other	122
VCWs	Qualitative descriptive approach.	Personal interviews and focus group discussions; analysis of records.	Nominated VCWs. Working directly in the wards where CBR has been implemented.	25
Community Leaders	Qualitative descriptive approach.	Personal interviews and focus group discussion; analysis of official records.	Elected community leaders such as councillors, village heads and designated chiefs. Nominated committee members.	18
Health and rehabilitation workers	Qualitative descriptive approach.	Questionnaires	Nurses, rehabilitation technicians and environmental health technicians working in the district. One doctor completed the questionnaire.	15

1.5.4 Triangulation

In order to enhance the trustworthiness of the research, the same data was gathered from different perspectives, making use of different sources from which data were gathered; i.e. the clients, the VCWs and the community leaders (Annexures 2, 3 and 5). The basic information required from the clients, VCWs and the community leaders were in essence the same; however, the questions were adapted to obtain each group's specific point of view in terms of their specific role in the process of CBR as well as their participation in the process.

The fact that a structured interview as well as focus group discussions were held with the VCWs and the community leaders not only enriched the data, but also ensured saturation of data – all of which enhanced the trustworthiness of the results.

1.5.5 Ethical considerations

The researcher sought consent from the relevant authorities of Midlands Province in writing and seeking consultation with the Provincial Medical Director. Permission was granted in writing (Annexure 6). Consent from the various participants in the study is discussed in Chapter 3.

1.5.6 Data analysis

Data analysis was done in two ways:

- Analysis of quantitative descriptive data using frequency tables; and
- Analysis of the qualitative data from the structured interviews and focus group discussions using open and axial coding of data.

1.5.7 The course of this study

The factors that gave origin to this study, as well as the problem that the core aspect for the success of CBR, i.e. participation of the PWD in the management systems and structures used by the Rehabilitation Department at community, district, provincial and national levels, is not optimised fully, are described in Chapter 1. Furthermore, the aims

and objectives of this study and the principles of the research methodology that were implemented to achieve it, are indicated.

In Chapter 2, a wide range of literature on community participation is reviewed. Although comprehensive literature on participation in general could be found, little were found on participation within a CBR programme. Measurement tools for participation were found in the generic form; however, no literature could be found to indicate the role of participation in CBR. This lack of relevant literature necessitates this study even more.

Chapter 3 describes the research methodology of the study extensively. The results, based on the implementation of the research methodology, are also described in table or graphic format.

In Chapter 4, the results are discussed based on the objectives of the study.

The conclusions reached in this study, the limitations of the study and recommendations for further study are discussed in Chapter 5.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The literature review was conducted using an electronic database search in the library and through reviewing grey literature (this is literature that is not published but available in report form, for example student dissertations, and is the property of the institution). An electronic search was conducted using the key words: community participation, community development, community-based rehabilitation, rehabilitation and management in the community. Journals relating to community work were sought and reviewed individually. Some were electronically available but most were not. Unpublished research dissertations were also reviewed within departments of rehabilitation at the universities of Zimbabwe and Pretoria. Reports and relevant documents were reviewed within the Ministry of Health at national, provincial and district levels.

A wide range of literature on community participation was reviewed. This literature revealed that community participation as a concept is almost always associated with any community development issue. Most literature relates community participation in agricultural and economic enhancement activity programmes. Articles by Rifkin (1996) & Tumwine (1993) provide some analysis on the basic tenets of Primary Health Care. Rifkin (1996) considers community participation in primary health care programmes to be fundamental, enabling the community to take responsibility for their own health care programmes.

Community participation is often referred to in relation to development programmes and the rural poor. Disability, however, is often sidelined in debates and discussions on the participation of the rural poor in community programmes. Coleridge (1993, p. 7) has found that any programme that has been implemented to tackle the problems of PWDs, have been inadequate in achieving the goal of PWDs taking responsibility for their own rehabilitation programmes:

"Whether institution based or community based or whatever....disabled people are human beings with all the economic, emotional, physical, intellectual, spiritual, social and political needs that other people have. The main implication of this is

that unless they are involved in the planning and implementation of services, these services will always be inadequate in extent and in philosophy, whatever form they take" (Coleridge 1993, p. 7).

The relationship between participation and disability-oriented programmes has been discussed intrinsically and extrinsically by Coleridge (1993); i.e. how does participation function among the recipients themselves and within the wider community? This is important because the following question is often asked: *What has disability got to do with development?* It has been the experience of the author when first having discussions with policy makers and community leaders on including disability issues on their agenda, that even people who are more "progressive", "gender aware" and in all other respects "developmentally minded", perceive disabled people as belonging to the social welfare category, which is a new term for charity (Coleridge 1993).

Most rehabilitation programmes based on a medical model have been viewed as inadequate in that they treat the client as a passive recipient (Miles 1993). In order to link community participation and rehabilitation programmes, the definitions in the literature on these concepts are described.

2.2 DEFINITIONS USED IN REHABILITATION

2.2.1 Definition of rehabilitation

Rehabilitation is usually defined as a third phase in health care, after firstly prevention and secondly curative care. The definition of rehabilitation has evolved over the past three decades, with the current W.H.O. (1989) operational definition being:

"Rehabilitation includes all measures aimed at reducing the impact of disabling and handicapping conditions and enabling disabled or handicapped people to achieve social integration" (Helander et al. 1989, p. 17).

2.2.2 Important CBR concepts

Bauer (1989) lists six concepts that should be considered when developing a rehabilitation philosophy or attitudinal approach:

- Coordination of all primary branches of rehabilitation, namely physical, mental, psychological, educational and vocational;
- Restoration of function, its use and maintenance; i.e. there is little use in gaining movement without function (Warren 1977);
- Multiple service objectives; i.e. primary prevention, restoration of function, prevention of secondary disabilities and the maintenance of function;
- A 'whole person' approach. Rehabilitation is concerned with the whole person/individual;
- Bauer goes on to say that the nature of the environment in which a person must function is of critical importance in rehabilitation. The majority of rehabilitation programmes involve three components:
 - Regaining pre-morbid function within the usual environment;
 - Adapting function to enable the person to cope effectively in the usual environment;
 - Modifying the environment to facilitate function despite restricted abilities (Kallio 1982).

The government of Zimbabwe endeavoured to develop a service enveloping all these components. As outlined in Section 1.1 and indicated in the various plans and documents (Paper for Equity in Health 1981, 1986, 1991, 1995 and 2000), the services that were developed include both institution-based and community-based services. It was understood that the institution-based services were (and still are) a prerequisite to the development of such a service.

In 1982, the Zimbabwean Ministry of Labour and Social Services, in collaboration with the Ministry of Health and UNICEF, presented the results of a survey on disability in Zimbabwe. A total of 276,300 disabled people in the 23 districts were surveyed (Report on the National Disability Survey of Zimbabwe 1981). The aim of the survey was to determine the extent of the causes and related aspects of disability in Zimbabwe. In order to identify/classify a person as disabled, the survey team had to work from a uniform definition of disability; i.e. who should the survey attempt to identify? The study concentrated on more serious forms of physical and mental disabilities in order to focus attention on where it is needed most. For example, it was viewed as useful, but by no means essential, to know how many people suffer from flat feet or astigmatism.

The WHO International Classification of Impairments, Disabilities and Handicaps (WHO 2001) was taken as a point of departure for the survey that was done in 1981. In brief, the survey team defined impairment as the dysfunction of bodily parts or organs; disability as when an individual describes deviations from normal performance whether performance is in the physical, emotional, mental or social realm; and handicap as when society imposes barriers to participation in activity and fails to accommodate the injured or disabled worker.

The survey team was of the opinion that to attempt a survey identifying all forms of impairment, disability or handicap was beyond the technical and financial resources of the country. Therefore, for the purposes of the survey, the following definition of disability was adopted:

"A physical or mental condition which makes it difficult or impossible for the person concerned to adequately fulfil his or her own normal role in society."

(Report on the National Disability Survey of Zimbabwe 1981, p. 4).

The survey was followed by a conference with a series of workshops involving persons working in the disability field, with the aim of reviewing and redirecting their efforts. Many recommendations were made, amongst them the development of rehabilitation services, training of personnel and the establishment of appropriate services to meet the needs enunciated by the survey. Of the 276,300 PWDs, the highest single type of disability encountered was that of eyesight, followed by disabilities of the lower limb, then upper limb disabilities and finally mental retardation and behavioural problems. The estimated prevalence of disability was 3.4%.

2.2.3 Community-based rehabilitation

Community-based rehabilitation (CBR) can be defined as a systemised approach that offers the opportunity for local resources for rehabilitation to be made available in and for the community. In CBR, there is a large-scale transfer of knowledge about disability and skills for rehabilitation to PWDs, their families and members of the community. In this process, there is also community involvement in planning, decision-making and evaluation of the programme (Helander *et al.* 1989).

2.2.4 Models of CBR

A diverse number of CBR models has emerged in various countries (Murphy & Gopalan 1992). The emergence of a model is dependent on the needs of the community and the economic and social background of the community. Some of the models defined are:

- The Medical Rehabilitation Model, which emphasises community health, prevention of disability and early medical intervention. This model is referred to as the disability-related primary care approach.
- The Education Model, with the emphases on the education of disabled children and adults through various educational plans, both formal and informal.
- The Economic Model, which emphasises the provision of vocational training to PWDs. In some areas, this falls under the umbrella of the welfare rehabilitation approach, which concentrates on vocational and social rehabilitation.
- The Community Development Model, which emphasises community awareness and creative innovation in all aspects of development, including the rehabilitation of the disabled.
- The Comprehensive Model, which emphasises all aspects of development pertaining to the prevention of disability and early intervention rehabilitation, for the PWD as well as the community. Various countries such as China, Zimbabwe and India are using this approach.

For CBR to be effectively implemented, there are important concepts that must be understood by all concerned. Murthy & Gopalan (1992) outline these as follows:

- The services to PWDs should reach them in their own communities;
- The local community should, from the beginning, be involved in service delivery to PWDs. The community should recognise the needs of the PWDs and appreciate their potential for becoming contributing members, if the required opportunities are extended to them. This underpins the importance of

participation very much. PWDs are often denied the opportunity to participate in social and economic activities of the majority in their societies;

- PWDs should be regarded as both recipients and contributors to concerned community welfare;
- Mainstreaming of all activities should occur so that the responsibility for PWDs becomes a part of the community's responsibility for its members, regardless of disability;
- PWDs should play a leadership role where disability is concerned. They should be active and work actively to their maximum potential for themselves and other PWDs in the community and their families. The principle of solidarity should prevail.
- Local resources should be utilised to a maximum. Specialised services and other agencies should play a supplementary role in the service delivery mechanism.

2.3 ADVANTAGES AND DISADVANTAGES OF CBR

It is important to look at some of the advantages and disadvantages of CBR that emanate from some of these presumed concepts.

2.3.1 Advantages

If services are to be provided within the PWDs' own communities, the service may reach a larger number of people. This availability of services at local level, and its accessibility to the PWD in his community, contributes to the programme being cost-effective in the long run.

In line with the PHC concept, the emphasis on prevention of disability and early intervention will not only reduce the incidence of disability, but also the frequency and intensity of disabling and handicapping factors. Early intervention also encourages an early integration process, which assists in reaching the ultimate objective of the rehabilitation process (Helander 1991).

The process of CBR emphasizes integration and provides an opportunity for PWDs to have full participation and equalisation of opportunity within their societies (WHO 1989). During this process, PWDs are exposed to day-to-day risks, which equip them with

confidence and teach them skills to overcome problems and achieve their rehabilitation through self-help programmes.

A CBR programme provides an opportunity to the community to develop awareness about:

- The development needs of PWDs;
- The skills they need to acquire in order to cope with their physical, psychological and environmental problems;
- Knowledge about integration itself. This continued realisation by the community and family is paramount to the success of CBR because disability is not a static situation. Vanneste (1997) asserts that disabled children become disabled adults with great vulnerabilities and needs. CBR can evolve and adapt to such fluid situations, while the rehabilitation centres will often only be able to "take a photo"; i.e. deal with one set of problems at one point in the life of a PWD.

Some authors, e.g. Miles (1998), assert that it is difficult to tell whether genuine community participation has been initiated. Tumwine (1986) is of the opinion that true participation in any programme will not take place unless communities are given the opportunity to make decisions for themselves and gain ongoing control of health programmes in any area. Murthy & Gopalan (1991) in turn, state that when the community learns to take care of its PWDs, it enhances its own potential for being a better community.

2.3.2 Disadvantages

Some arguments against CBR have also been made, e.g. the risk of providing substandard service due to the decreased use of professionally trained workers. This can also result from some advances in and benefits of technology being lost in the course of translating the technology into simple technical terms to be implemented by families and grassroots level workers. Furthermore, the existing infrastructures in the various implementing agencies, e.g. health and social welfare, may not be ready to integrate CBR. There is a fear of dilution of quality of services resulting in poor results. The stated objectives need to be closely monitored and, even more so, the systems put in place to fulfil these objectives (Murphy & Gopalan 1992).

The need for closely monitoring and evaluating CBR has been greatly supported. Pruthvish & Thomas (1992) state that until recently, most development organisations tended to focus on client management, with programme management being regarded as less important. They express that of late, programme management is being given equal importance. This is due to factors like decreasing funds for welfare work, increasing need for accountability, reduction of costs, improved effectiveness of interventions and improved sustainability. With this in mind, the different management systems in place in CBR programmes and in particular in Midlands Province were fully analysed to see to what extent the community is participating.

Koontz & Weinrich (1991) define management as the process of designing and maintaining an environment in which individuals, working together in groups, accomplish selected aims effectively and efficiently.

2.4 IMPORTANT MANAGEMENT THEORIES

The definition of management is explained by Koonz & Weinrich (1988) as people carrying out the managerial functions of planning, organising, staffing, leading and controlling. The following are the traditional functions of management:

- Management applies to all kinds of organisations;
- It applies to managers at all organisational levels;
- The aim of all managers is the same, namely to create a surplus;
- Management is concerned with productivity. It implies effectiveness and efficiency.

Bateman & Snell (1996) go further to make a value judgement. They assert that good managers do all these things effectively and efficiently. All managers carry out the managerial functions mentioned above. However, the time spent on each function will differ at each level of management.

McLaren *et al.* (1986) emphasize that effective management is essential to ensure that rehabilitation services are well coordinated and integrated. It implies that staff should have vision, abilities, skills and the necessary resources to facilitate collaborative planning and implementation of programmes. It implies the building of a sense of teamwork and shared goals between rehabilitation personnel working at different levels, the community

and others who are working for the enhancement of PWDs, e.g. the promotion of their rights in the community.

Management of the above-mentioned services needs the establishment of mechanisms to monitor and evaluate the impact of rehabilitation services, and, unless supportive, coordinating management structures are in place, there is a danger that rehabilitation services will be fragmented, uncoordinated and piecemeal.

Much of the literature reviewed (Bauer 1989; Coleridge 1993; Helander 1991; WHO 1987 & 1989; Murthy & Gopalan 1992) alluded to the need for an effective management system, but few reports (Bauer 1989; Helander 1991; Ferrinho *et al.* 1991) actually looks at the management systems themselves. Furthermore, none of the literature relate management to the essential community participation. What the community says should strongly influence the direction of the management systems, structure and activities. Werner & Bower (1988) are of the opinion that rural people should actively participate in development in order for them to contribute a countervailing force to those elite groups who inevitably dominate development sources.

2.4.1 Management of the CBR programme in Zimbabwe

In Zimbabwe, the CBR programme has been evaluated through in-house monitoring and evaluation as well as external evaluation. Two of the studies, namely the National Evaluation of CBR by the Ministry of Health (MOH) (1991) and The Client's View by Myezwa (1995), investigated the extent of coverage of the programmes in terms of the number of PWDs who have been part of the CBR programme and have received and perceived benefit from it. In general, there has been a positive impact on communities within Zimbabwe. The communities as well as the PWDs expressed a felt benefit with regard to knowledge gained from community attitudes towards disability and skills gained in dealing with disability. Specific groups such as the mentally ill and older children and adults with mental retardation were pointed out as requiring more attention and specific focus. Community workers felt a need for a review of training methods and content (Myezwa 1995). The two evaluations focussed strongly on the impact of the programme on the client, and resulted in a lot of qualitative data.

An independent team was commissioned by the MOH and the Swedish International Development Agency (SIDA) to look into the progress of the rehabilitation programme,

employed a different focus. This evaluation touched on a lot of management issues such as the administrative structure, staffing, training and service delivery and funding, and focused on some quantitative results, e.g. the number of PWDs who have been assisted by the MOH (the services were reaching 15% of PWDs by 1991). Other quantitative data included budget breakdown and financial management of the programme (Njini *et al.* 1991). Much of the data and recommendations have been used to improve the service delivery within the department, and a need-based management system has been put in place. It furthermore investigated the extent to which community participation has been achieved, and it was concluded that a lot had been done to increase awareness and knowledge among the lay people in the community, i.e. political, educational and development leaders. At the time, it was expected of the rehabilitation technician to carry out all the necessary awareness or CBR activities. The evaluation team found that in the CBR programme areas visited, community participation had not taken place. However, they acknowledged that at the time of the evaluation, the programme was still in an early stage for both the rehabilitation therapist and the community. Thus, further efforts were recommended to improve and increase community participation in the management and running of CBR programmes. It was also found that the very people who were targeted, did not identify what they themselves were doing to contribute to the CBR programme, and more specifically, to the lives of PWDs.

2.5 MANAGEMENT AND PARTICIPATION

Bauer (1989) specifically alludes to the need for service providers to learn from management theory, with the management process providing a very suitable structure upon which to build a rehabilitation programme and enhance the needs of a client. The management of any programme is closely related to how well the target population participates. Ferrinho *et al.* (1991) emphasize that developing a participatory management style is as important as ensuring democratic control, since it enables maximum worker participation and involvement in setting objectives and in developing strategies to achieve objectives. This statement can be extrapolated to the community, as the same is true for its members. In Midlands Province, a management system evolved and was subsequently developed to enhance CBR efforts at community level and, more importantly, to capture the needs of the community and support community participation. The extent and nature to which the community has participated is unknown; therefore it remains the main objective of this study.

2.6 COMMUNITY PARTICIPATION

2.6.1 Definition of concepts

Community participation defies any single attempt at definition or interpretation. Oakley & Marsden (1984) review a whole range of interpretations of community participation:

- Community participation is considered a voluntary contribution by the people in one or other of the public programmes supposed to contribute to national development. However, the people are not expected to take part in shaping the programme or criticising its contents (Economic Commission for Latin America 1973);
- With regard to rural development, participation includes people's involvement in decision-making processes, the implementation of programmes, their sharing in the benefits of development programmes and their development and efforts to evaluate such programmes (Cohen & Uphoff 1977);
- Participation is concerned with organised efforts to increase control over resources and regulative institutions in given social situations on the part of groups and movements of those hitherto excluded from such control (Pearse & Steifel 1979);
- Community participation is an active process by which beneficiary or client groups influence the direction and execution of a development project with a view of enhancing their well-being in terms of income, personal growth, self reliance or other values they cherish (Paul 1987).

A review of the literature reveals interchangeable use of the terms "community involvement" and "community participation" (Walt n.d; Gilbert 1993; Myezwa 1997; Simmons-Mortom, Greene & Gottlieb 1995; Oakley 1991; Ferrinho 1992). While community participation was the term used in the original Alma-Ata declaration (1978, community involvement is now the preferred term, as *"to participate may be simply a passive response"* (Walt quoting the WHO 1989, pp. 199-204). Nevertheless, Simmons-Mortom, Greene & Gottlieb (1995) describe community participation as highlighting principles of inclusion and "starting where the people are" in terms of their perceived needs, rather than with the needs and goals of the change agency. Genuine involvement in the social change process is important because participants become empowered by

their ownership of the programme. Some authors view community involvement as a means of empowering communities (Gilbert 1993; Myezwa 1997).

Simmons-Mortom *et al.* (1995, p. 10) describe empowerment as *"a process by which communities are enabled to act effectively in transforming their lives and their environments"*, and includes attributes such as *"negotiation, control, willingness, competence and autonomy"* (Coyne 1996). It therefore encompasses an ability to influence the conditions of life that resulted from increased awareness, social support, and problem-solving skills.

In exploring the meaning of involvement, Poulton (1999) proposes that it exists on a series of levels ranging from providing information to true empowerment. This is supported by and Gilbert (1993), who describe three levels of community involvement:

- Compliance level, which emanates from the medical approach and includes examples such as immunization and family planning;
- Contribution level, which essentially implies the contribution of manpower, materials and possibly money. There is much debate regarding the validity of this type of participation; and
- Collaboration level, which takes on a community development approach. This is the preferred approach where collaboration takes place and the community participates at every stage of the programme, e.g. planning, implementation and evaluation. It implies a role in decision-making in health systems. The different levels of community authority also depend on where the authority is located within health systems and how far the health worker is willing to widen the inclusion of different social groups in decisions that have often been under their control.

The researcher sought literature on strategies that have been used to encourage participation. Most literature looked at disadvantaged groups who have been encouraged to participate in community development programmes. The most studied group is women. Studies have examined the isolation of women and efforts to include them in more development activities (Boserup 1970). The dominant approach treats women as a separate category and seeks to improve their economic status by skills training or small income generating activities. On the other hand, another approach seeks to get to the

heart of women's isolation and regards women's participation as more structural as opposed to a more limited economic sense (Boserup 1970). These two approaches are not mutually exclusive but suggest two different strategies for enhancing women's participation. An analysis of the approach to dealing with disability brings out the same parallel; i.e. where PWDs are approached by looking at the core of their problems, e.g. the total development of the PWD as a socially conscious member of the community. On the other hand, the approach looks at the special needs of the PWD within the context of their environment (Coleridge 1993).

Several authors (McEwen *et al.* 1983; Myezwa 1991; Oakley & Bjaras 1991) have warned against some of the common pitfalls of community participation:

- Participation must not be a euphemism for cost cutting;
- A second criticism is that 'self-help' addresses itself to the symptoms of the problem rather than the causes. Instead of providing what is not provided by government, it could be said that groups should pressure the government into allotting them a fair share of the resources. In reply to this it is argued that:
 - Grouping people together can raise consciousness about the shortcomings of the government and can result in people becoming politically active;
 - It raises the tricky question of where the obligations of welfare and government should stop. Should the government provide all the health care? Or is there an inherent value in groups being health providers outside of the establishment?

As with the presence of pitfalls and disadvantages in community participation, there are important obstacles to participation that have to be taken into consideration. Various unpublished articles that were reviewed, illustrate obstacles that impact on community participation both positively and negatively. These obstacles include:

- The political environment, where the prevailing ideology does not encourage openness and freedom of speech and discourages comments by citizens preferring to maintain direction and decision-making concerning the affairs of state. In a

centralised political system, less emphasis is placed on strengthening local management and empowerment mechanisms.

- The legal system will also contribute to seriously frustrating efforts of participation if it only maintains a status quo, and on the other hand if rural people are unaware of their legal rights (Chambers 1987). In the researcher's experience, this was evident in the already marginalized groups such as PWDs. Studies undertaken by the International Labour Organisation (ILO) have highlighted how this right of association has been legally withheld from categories of rural workers, frustrating their efforts to build organizations to represent their interests.
- Administrative obstacles, where centralised administration systems tend to retain control over planning, decision-making, information and knowledge that rural people require to enable them to participate in development activities. Administrators often have negative attitudes to community participation, resulting in administrative procedures becoming a real obstacle to participation.

2.6.2 Community participation and health care

Most health programmes have acknowledged the need for community participation. The essence of participation in any country will depend largely on the political and, to some extent, the economic climate as illustrated by the South African and Zimbabwean experience. In Zimbabwe, the first National Health Plan (1980) made provision for the community to participate actively by making representation of the community in the structures through the establishment of structures such as health committees. Eighteen years later, the government's assessment is that through this process, the communities have played a significant role in implementing primary health care. However, the involvement has been viewed as largely peripheral. The dependency syndrome that is characteristic of communities is a symptom of the community's involvement not being total and evident of marginalisation (MOH 2000). The new National Health Strategy for Zimbabwe (MOH 2000) has therefore sought to strengthen the community's participation in improving health and quality of life. Some of the relevant key objectives are:

- Make information on health status available to all Zimbabweans;
- Create an enabling environment for all individuals to take responsibility for their own health as well as that of others;

- Establish methods to seek a broad based national consensus on priorities to be addressed;
- Make individuals and families aware of their rights and responsibilities;
- Reintroduce the village community worker (VCW).

The proposal of South Africa's African National Congress (1992) describes community involvement for health development as a process to establish partnership between government and local communities in the joint planning, implementation, evaluation and use of health services in order to increase local self-reliance and control over health care. Community involvement means people have the right and duty to participate in solving their own problems, have greater responsibilities in assessing health needs, mobilising local resources and suggesting new solutions, as well as creating and maintaining local organisations.

2.6.3 Community participation and CBR

In the CBR programme, all the above concepts and characteristics of community participation are applied. CBR as a programme is often presented in the community development model. Community participation is a vital part of community development, and it has also been said that one leads to the other. In the CBR programme, the key target group is the PWD, his/her family and the community, with special reference to the key community leaders who represent them in various community structures, e.g. the councillor, the VCW and the leadership in PWD organisations. Within the community structures, self-help groups such as the CBR Committee emerge. They are assisted by the systematic development structures (MOH 1983-1990, Rehabilitation Unit Annual Reports).

McEwen *et al.* (1983) emphasise that if participation is introduced in order to achieve a goal, it stands a better chance of being a dynamic force in the system. If participation is introduced as a token gesture, in response to pressure for democratisation, it is unlikely to make an effective contribution to planning and policymaking.

Participation of the consumer can be at individual level or in a group. Participation by the group or the individual can also be at individual needs level and at programme level. These groups may include pressure groups or self-help groups. In the functioning of these groups, the new perspective demands that self-help should not have to fit into the

existing framework built around the ideas of professionals, but that the professionals should fit in with the ideas from the people. The growth of participation should not be seen as a new sort of health care with a commitment of burgeoning of professionalism and expertise, but as a move back to first principles; an effort to move back the blinkers that professionalism has imposed upon individuals; a dismantling of the structure whereby others have come to have more power over individuals than they have over themselves (Coleridge 1993; Helander 1991)

In CBR, there has been a concerted effort towards empowering the client, the family and community in dealing with the problems of disability. The efforts have been in shifting the power base to community level and trying to make the system and structures support these efforts. The experience of this process is taken from a paper by Myezwa and Mkumbuzi (in Press), showing how participation in CBR has so far been perceived. Most of the information regarding CBR has been documented from the researcher's experience.

2.7 THE CBR PROCESS

The process of CBR emphasizes integration and provides an opportunity for PWDs to have full participation and equalization of opportunity within their societies (WHO 1989). During this process, PWDs are exposed to day-to-day risks and the solutions equip them with confidence and teach them skills to overcome problems and achieve their rehabilitation through self-help.

In Zimbabwe, CBR was implemented through four major steps (MOH 1990):

- 1. Social mobilisation and awareness raising.** The process of social mobilisation took off by informing the community about the process of CBR through existing community channels and structures. This often involved health and rehabilitation workers meeting with chiefs, councillors or other political leaders and attending various community development meetings. Where required, special arrangements were made, e.g. the sensitisation of PWDs, their family and other community support systems such as schools and community workers commenced at individual treatment contact and in the home. Through this process, needs could be identified and training programmes planned.

2. Education and training. The



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VCWs, community health workers, family members, PWDs, community members and community leaders was carried out. The areas in which education most often took place included education on the types and causes of disability, training on the processes and intervention in rehabilitation. A key component in the training methodology was to inspire positive attitudes toward PWDs.

3. **Survey and needs analysis.** After training the key role-players, a rapid assessment of the status of disability and the situation of PWDs was conducted. Community workers selected by the community carried out this survey. They used screening tools, developed and refined jointly with the professional staff.

4. **Implementation.** Examples of activities to meet the identified needs include:

- Client, local facilitator, therapist and technician training sessions;
- Income generating facilitation exercises, either directly through community-based health and rehabilitation workers such as environmental health technicians, or through extension workers from other ministries or departments;
- Home visits and outreach consultations to take care of individual needs, and reassessment of chronic and new referrals;
- Regular attendance of inter-sectoral and development meetings by clients, VCWs and, periodically, technical rehabilitation staff, to allow facilitation of developmental issues for PWDs;
- Referral of clients in need of services not available in the community.

2.7.1 Participation in CBR

The process of rehabilitation includes prevention, the identification of PWDs, their referral, treatment, resettlement, integration into the community and vocational training, as well as the provision of aid and appliances to PWDs. Planning, implementation and

evaluation of the PWD must be synchronized at individual and community level for a successful rehabilitation outcome.

One of three types of participation could be engaged in during the different stages of CBR, namely compliance, contribution and collaboration (Poulton 1999). While collaboration was the desired type of participation, it became evident that communities found the contribution type a more tangible and hence more meaningful type of participation. Often, this was in the form of labour contribution, and on occasion it was in the form of contribution of material resources to the PWD or CBR programmes.

2.7.2 Participation in identification and referral

In the past, one of the problems for rehabilitation and dealing with disability was the lack of knowledge about CBR on the part of the community, and more specifically the community health workers. The PHC concept, with the emphasis on prevention of disability, early identification and intervention will not only reduce the incidence of disability, but will also reduce the prevalence and intensity of disabling and handicapping factors. Early intervention also encourages an early integration process, which helps to reach the ultimate goal of the rehabilitation process (Bauer 1989). After an intensive education and awareness programme, these same community members continue to play a vital role in the identification and referral of PWDs. Myezwa (1993) found that 41% (n = 100) of the clients at the Rehabilitation Department in Mash Central were referred by the community health worker.

2.7.3 Participation in CBR programme planning

A CBR programme provides the community with an opportunity to develop an awareness about the:

- Development needs of PWDs;
- The skills PWDs need to acquire in order to cope with their physical, psychological and environmental problems;
- Knowledge about methods, process and advantage of integration of the PWD into the community. This continuous realization by the community and family is paramount to

the success of CBR, because disability is not a static situation. Disabled children become disabled adults with great vulnerabilities and needs. CBR can evolve and adapt to such fluid situations, while the rehabilitation centres will often only be able to "take a photo"; i.e. deal with one set of problems at one point in the life of a PWD (Vanneste 1997). However, in the Zimbabwean experience of implementing more than twenty CBR programmes, the community, once aware, participated in planning through defining the geographical parameters, and at times participated in the programme design. The community would, through discussion, identify implementers, participants and priority areas. The community leaders would participate in raising awareness and community mobilization.

2.7.4 Participation in programme implementation

In CBR, the PWD and the family are expected to take the lead role in determining the key objectives of the rehabilitation process (Murthy & Gopalan 1992). For example, in identifying the problems faced by the PWD, the professional's role would be one of guiding the process and teaching the family and client simple and appropriate technologies for coping with disability. Concrete examples expressed in the report of the National Evaluation of the Ministry of Health (1998) included:

- Material and financial support;
- Assistance in running income generating projects;
- Identification and referring of PWDs;
- Moral support;
- Motivation of the community through local leaders;
- Setting up of community centres for self-help activities.

Thereafter, the family and client will determine where and when to get subsequent assistance. The focus is on minimizing the dependency of the PWD and the family on the professional, allowing active participation of the PWD and the family, and through these activities facilitate ongoing and sustainable rehabilitation.

2.7.5 Participation in programme evaluation

The direction of CBR is determined by the ongoing evaluation carried out by the family, client and community. In CBR, it is hoped that participation will be enhanced if the clients and community see that the progress and direction of the programme is determined primarily by their input. In the process of CBR, focus group discussions are held regularly with community workers, family members and with clients themselves to gain insight and input into what they perceive as key problems areas (MOH 1983-1990, Rehabilitation Unit Annual Reports)

Some of the obstacles to participation that were noted by implementers of CBR, according to Myezwa *et al.* (In press) are:

- Poor knowledge of CBR and participation in community-based programmes such as CBR;
- Cultural orientation with regard to disability;
- Expectations of the community;
- Poverty within the communities;
- Social environment;
- Health worker attitudes;
- Health organization orientation and community development orientation.

2.8 EVALUATION OF COMMUNITY PARTICIPATION

In order to ensure effective and ongoing community participation in health, it is necessary to assess the level and value of such participation (Bjaras *et al.* 1991) and to assess the degree of change that occurs. Oakley *et al.* (1991) is of the opinion that the development of methods of evaluation in community participation is in its infancy. The evaluation of participation in community development projects is not necessarily the same as "participatory evaluation". The evaluation of participation refers to the evaluation of specific objectives or outcomes in a community development project and participatory techniques may form part of the evaluation.

2.8.1 Contribution of quantitative and qualitative techniques

The two methods, although distinct, complement each other in the process of evaluation of community participation.

2.8.1.1 *Quantitative techniques*

Quantitative techniques are necessary for the evaluation of participation. The more physical and tangible outcomes of participation are available more effectively and will be sought in this study. The Statistical Analysis System (SAS) package will be used in this study to produce frequency tables, cross tabulations and the chi squared test to analyse the data and draw interpretations and conclusions from the data.

The groups that were compared are independent, therefore the biomedical data processing was used to perform the Kruskal Wallis test. This compared the means of the level of involvement found for each group.

The literature was also examined for methods by which participation has been measured and evaluated. One of the quantitative frameworks for measuring community participation is proposed by the Community Participation Group of the United Kingdom for All Network (1991) in Table 2.1.

Table 2.1 *Levels and forms of community participation* (Community Participation Group of the United Kingdom for All Network 1991).

DEGREE	COMMUNITY PARTICIPATION	EXAMPLE
HIGH	Has control	Organisation asks community to identify the problem, and makes all key decisions on goals and means. Willing to help community at each step to accomplish goals.
	Has delegated power	Organisation identifies and presents a problem to the community, defines the 'I' and asks the community to make a series of decisions, which can be embodied in a plan that the community will accept.
	Plans jointly	Organisation presents tentative plan, subject to change, to those affected. Expect to change plan at least slightly and perhaps more subsequently.
	Advises	Organisation presents a plan and invites questions. Prepared to modify plan only if absolutely necessary.
	Is consulted	Organisation tries to promote plan. Seeks to develop support to facilitate acceptance or give sufficient sanction to plan so that administrative compliance can be expected.
	Receives information	Organisation makes a plan and announces it. Community is convened for informational purposes. Compliance is expected.
LOW	None	Community is told nothing

A second framework described by Bjaras, Haglund, Rifkin (1991, p. 200), has described the conceptual framework for community participation by defining it as follows: *"A community is a group of people living in the same geographical area sharing defined basic values and organisations and or a group of people sharing the same basic interest"*. Based on the above definition, an analytical framework focusing on the need to assess the process of change is presented by Rifkin (1993). Five factors outlined as influencing this participation process are:

- Needs assessment;
- Leadership;
- Organisation;
- Resource mobilisation;
- Management.

Both the above frameworks encompass both qualitative and quantitative techniques in trying to evaluate and measure community participation.

2.8.1.2 *Qualitative techniques*

Qualitative evaluation is concerned with describing the characteristics and properties of a process like participation over a period of time, and then with interpreting the data and information available in order to make statements concerning the nature and extent of the participation that has taken place.

The following important characteristics of evaluation by way of qualitative methods will be taken into account (Oakley *et al.* 1991):

- **Naturalistic**

The evaluator must not attempt to manipulate the programme or its participants for the purpose of the evaluation. Naturalistic inquiry studies processes as they occur, and not on the basis of pre-planned experiment.

- **Heuristic**

Similarly, qualitative evaluation is heuristic in nature in that the evaluation approach is subject to continuous redefinition as our knowledge of the project and its outcomes increases.

- **Holistic**

Qualitative evaluation is considered holistic as the evaluation will consider the programme as a whole, which needs to be both understood and analysed from many different perspectives.

- **Inductive Analysis**

The evaluator must seek to understand the outcome of the programme without imposing predetermined expectations.

The literature emphasises the need for evaluation of participation to include relevant and continuous monitoring. In this study, this component will be evaluated by analysing the continuous monitoring systems established through the management systems.

2.9 INDICATORS IN COMMUNITY PARTICIPATION

Searching the literature using the keywords indicators, evaluation and community participation for possible indicators and models of evaluation of development projects, and more specifically CBR, did not yield extensive examples that could be used in this evaluation. All authors reviewed (Rifkin 1993; Oakley 1991; Chambers 1983; Poulton 1999) suggest the use of both qualitative and quantitative indicators, based on thematic key issues as outlined below.

Indicators provide valuable means by which outcomes of a project can be understood. The following is a list of indicators drawn up by Oakley (1989) from a number of authors:

- Hamilton (1978) suggests identifying critical traits of participation. He does not go into detail about what they are, but provides a broad definition from which indicators can be derived. These need not necessarily be cut and dry but will be determined by the nature of the programme; hence the critical traits will depend on the nature of the programme.
- Lassen (1980) refers to the indicators as the vital signs of participation; He also does not go into detail about what they are, but provides a broad definition.
- Charlick (1984) propose a simpler who, what, where being the basis of participation;
- Rifkin *et al.* (1988) propose a broad continuum of participation and regard the two ends of the continuum as two extreme indicators.

2.9.1 Quantitative indicators under broad themes

Oakley (1989) outlines a number of quantitative indicators derived from different authors (Haque *et al.* 1977; Huizer 1983; United Nations 1984; Stephens 1988).

Economic	Who is participating? Who benefits?
Organisational	Percentage of participants with knowledge of programme. Frequency of attendance of organisational meetings - agenda of the meetings. Changing size of membership. Linkages with management systems. Participation in programme. Number of CBR project groups formed. Attendance rates of project group meetings. Number of members actively involved in groups. Development Momentum. Number of CBR project members aware of and in contact with development agencies. Number of CBR project members receiving some training from the programme.

2.9.2 Qualitative indicators

Oakley & Marsden (1991) recognises the difficulty in quantifying indicators of participation and suggest the need to structure observation and recording a series of predetermined aspects of the programme:

- Income generating and other projects and group activities;
- Economic and other productive activities;
- Physical or construction work;
- Project group internal structuring;
- Changes in the project group behaviour;

- Nature of group meetings;
- Level of explanation and discussion during meetings and in general;
- People's involvement in project group discussions;
- Incidence of consensus and disagreement;
- Emerging patterns of leadership;
- Group action and articulation of the PWDs needs and desires;
- Nature of initial relationship between group members;
- Building up of the programme target group;
- Nature of changes in relationship between programme and target group, i.e. the way in which the target group would perceive the programme and its managers and their intentions;
- Programme maturation, i.e. how far the programme is achieving its objectives of the target group participating within its operational definition.

CBR programmes have been monitored in some of these qualitative aspects. The only tool in the literature and through which the CBR management system has been monitored is the Operations Monitoring and Results (OMAR) tool, designed by Jonsson (1992). Indicators for participation of PWDs and other community members in the areas of management, communication, accessibility and service delivery are outlined in the OMAR tools. The OMAR tools consist of questionnaires to be completed at community level. The information gathered in this way, may come from different data sources. For example, the local supervisors activities are monitored using a tool that seeks to find out all about their activity in relation to CBR. Another specially designed form for the clients seeks to determine the client's progress and his/her participation in the rehabilitation programme.

2.10 CONCLUSION

Chapter two provided a detailed interpretation of the literature reviewed as it relates to participation in the management of CBR. The literature was reviewed in a guided manner under specific topics outlining the concept definition and how each concept relates and contributes to participation in CBR. Participation is defined generically in the literature (Section 2.1) and it is found that the concept is implied in the very nature of CBR (Section 2.2.2). The model and principles of CBR and rehabilitation discussed/ chosen will determine if participation of the PWDs is recognised and achieved (Sections 2.2.3

and 2.2.4). The importance of the management system is recognised in the literature (Section 2.4) as a process that can provide a suitable situation upon which to build a CBR programme that will enhance the needs of a client.

Although there was comprehensive literature on participation in general, little was found on participation within a CBR programme. Measurement tools for participation were found in the generic form and little has been adapted or tested in a CBR setting. It is hoped that this study will contribute to the literature on community participation in CBR and its nature and extent, as well as provide a baseline for measuring participation using the selected indicators that can be obtained from data available in the community.

CHAPTER 3

RESEARCH METHODOLOGY AND RESULTS

3.1 INTRODUCTION

The main aim of this study, as mentioned in Chapter 1, is to determine the extent to which the community, and in particular people with disability (PWD) and their caregivers, have contributed / participated towards the management of Community-Based Rehabilitation (CBR). During this process of determining the extent of community participation in three (3) specific districts, factors that can serve as quantitative as well as qualitative indicators of community participation will be identified.

In this chapter, the research methodology that was applied to gather the data, as well as the results, by which this study attempts to answer the research questions, are presented. The results emanate from:

- Information obtained from four questionnaires used to guide structured interviews with clients (PWDs), village community workers (VCWs) and community leaders, as well as the self-administered questionnaire completed by the health and rehabilitation workers;
- An analysis of official records relevant to CBR.

3.2 GENERAL RESEARCH METHODOLOGY

The gathering of data for this study was based on the opinion of people, as well as an analysis of the participants' actions that would indicate their participation in the managerial structures, leadership roles and organisation in existence at the time of the study at the different levels of the health service delivery system.

The key role-players in CBR are the clients, the VCWs and the community leaders. Questionnaires were compiled, and these served as guidelines according to which structured interviews with participants in all three groups were conducted. The questionnaires (guidelines) are attached as Annexures 2, 3 and 5. The analysis of the role of the health and rehabilitation workers in CBR and their opinion about the extent to

which the clients (PWD and their care-givers) participate in the management of CBR, was also done by means of a questionnaire and is attached as Annexure 4.

The analysis of the managerial structures and the activities performed, was done through analysing archives in the health sector, which consisted of written records or reports of meetings, policies and monitoring mechanisms of the programme plans on national, provincial and district level. The guideline according to which the archives were analysed is attached as Annexure 1.

Focus group discussions were held with community leaders as well as VCWs to gain insight into their perceptions, attitudes, behaviour and experiences about the concept of community participation in CBR. During the focus group discussions, it could be established **how** information about CBR activities in a community was passed on between the key role-players (clients, VCWs and the community leaders). It was furthermore possible to establish where the resistance to the realization of community participation lies and whether there are any incentives for the community to participate in CBR or not.

Therefore, the basic research methodology used to conduct this study is a qualitative, analytical research methodology.

3.2.1 Compilation and testing of the questionnaires

Annexures 2-5 outline the questionnaires consisting of quantitative and qualitative questions used in this research. All the questionnaires were designed around the objectives of the study, broadly matched and tailored to suit each respondent's input. The questionnaires were formulated in English and translated into the vernacular Shona. They were cross-checked and re-translated into English, then back into Shona by a qualified Shona teacher with a degree in the language.

3.2.1.1 *Pilot study*

The questionnaires were pre-tested in a district in the east of the country, which had implemented CBR one and a half years previously and was not selected to be part of rest of the study. During the pre-test, the questionnaire were completed by the following people:

Community Leaders	2
Clients	10
VCWs	4
Health and rehabilitation workers	4

Questions that were found to be ambiguous and unclear were changed after discussion with two of the trained research assistants and the respondents.

The following were the main problems that were dealt with after the pilot study:

1. The need for clear standardisation of the translation of certain of the questions into the vernacular, especially terms such as rehabilitation, community control and responsibility. No single word could be found in the vernacular to express these terms. Therefore, an experienced Shona teacher translated the terms and each research assistant was asked to translate using his/her own interpretation of the terms. With the teacher's translation as a standard and within the context of the study, the terms were described and an operational definition of terms agreed to.
2. Rephrasing of some of the questions for grammatical clarity.

Following the pilot phase, the questionnaires were prepared for data collection. Research assistants were appointed to assist the researcher in the data gathering process.

The research assistants comprised of six final year students as rehabilitation technicians. They were chosen because of their understanding of the rehabilitation jargon and terminology.

The training was conducted over a one-day period. The programme consisted of:

- An explanation of the purpose of the research study;
- Background information on community participation and CBR;
- Overview of questionnaires;

- Discussion of each questionnaire and role-play of some of the more difficult questions;
- Training of research assistants to complete the questionnaires for clients, VCWs and community leaders;
- Emphasis of the ethical considerations - All respondents were to receive an explanation of the purpose of the study and their individual consent sought for responding to the questions.

The question concerning community level of involvement (e.g. client's level of involvement in question 2, Annexure 3) had to be clearly explained during the training of research assistants because the interpretation among them varied. All research assistants read the questions and any misunderstandings were clarified during discussion. Role-play between the research assistants was used to let them gain experience in the actual completion of questionnaires. Some areas of misinterpretation were also clarified. Thereafter, training of the focus group discussion facilitator was conducted.

3.2.2 Sample selection

The study was limited to the health sector as the implementing ministry of CBR. The researcher took cognisance of the involvement of other sectors such as education and social welfare, but due to financial and manpower limitations the study was limited to the community level and its direct links with the established structures in the MOH.

A combination of purposive sampling and stratified random sampling was used (Leedy 1985). Random sampling was used to determine the districts and specific wards in which the study had to be conducted. This was done by first putting together all the district names and using a lottery method. The three districts that were selected in this way and in which the study was conducted were Gweru, Mberengwa and KweKwe. The same procedure was carried out to select the wards. For key informants such as community leaders, trainers, VCWs and health and rehabilitation workers, purposive sampling was used. The research assistants had to interview all key community leaders such as chiefs and councillors. Additional leaders such as village headmen and committee members, especially of the community rehabilitation committees, were interviewed or participated in the focus group discussions.

Difficulty was experienced in accessing all VCWs, especially in Mberengwa and KweKwe, where they had gone to attend various funerals in the community. Therefore, a disparity occurred in the number of VCWs interviewed in Gweru, as compared to the other two districts.

Clients were sampled using a snowball effect where the VCW in the area directed the researcher and her team from house to house. In some cases, clients were not at home and the research team then moved on to the next household. The team double-checked with the health centre once a list of clients interviewed was completed to ensure there was no convenience bias and that the entire ward was covered. Distances were not a problem as transport had been appropriately arranged.

The local clinic staff and the district rehabilitation staff requested all the community leaders, VCWs and those clients who had no ambulation problems to gather at the clinic in the interest of saving time, as well as to save costs. The VCWs and community leaders who were not present were followed up at their homes.

At **Gweru**, twelve (12) VCWs were waiting at the clinic. Community leaders such as the village headmen and the chief were also present. The councillors were interviewed at their offices. Seventeen (17) clients were interviewed at the clinic while the remaining thirty-five (35) were followed up and interviewed at home with the help of the VCW.

At **Mberengwa**, only two (2) VCWs were available at the clinic. All the community leaders were at the clinic attending another meeting. They were interviewed and a focus group discussion was conducted while they were there. Only two clients were present at the clinic and the remaining thirty-six (36) were followed up and interviewed at their homes by going from household to household. This was due to logistical problems, as the rehabilitation therapist from the district had not received the letter in time to be able to organize all the targeted groups. Two (2) more VCWs were collected from their homes and the focus group discussion was conducted at the clinic.

At **KweKwe**, all the community home-based care workers, community leaders and eighty percent (80%; n=25) of the clients interviewed were at the hospital. The remaining clients and VCWs were followed up at their homes. Fifty percent (50%; n=6) of the VCWs that could have been interviewed were neither at home nor at the clinic, as they were away attending a funeral.

The total number of people who completed the relevant questionnaires was:

Health and Rehabilitation Workers – Questionnaire 2	15
Clients – Questionnaire 3	122
Community Leaders - Questionnaire 4	18
Village community workers – Questionnaire 5	25

3.2.3 Data collection process

In order to enhance the trustworthiness of the research, the same data was gathered from different perspectives; i.e. the client, the VCW and the community leaders (Annexures 2, 3 and 5). The basic information required from the clients, VCWs and the community leaders was in essence the same; however, questions were adapted in order to obtain each group's specific point of view in terms of their specific role in the process of CBR as well as their participation in the process. Due to the fact that the same type of information was gathered from different groups, multiple sources of data were used, therefore further enhancing the trustworthiness of the data gathered.

The questionnaires were compiled to serve as guidelines for the structured interviews with clients, VCWs and community leaders, and were based on the objectives of the study. The health and rehabilitation workers were asked to complete a self-administered questionnaire. At the end of each day, all questionnaires completed were checked and corrected, as on the first day it was evident that questions involving the level of participation and responsibility for the PWD required much explanation. The translation into the vernacular for the question on responsibility for the PWD and the question on asking what the participant's level of involvement was, were not consistent. The translation had to be standardized on the first day and checked throughout the data collection process for consistency.

To validate the data gained from the respondents (clients, VCWs, community leaders and health and rehabilitation workers), an analysis of the existing records was carried out. The guidelines for the analysis of the archives were also based on the objectives of the study. Additional relevant information gained from the analysis of formal administrative records from the Ministry of Health (MOH) and the Ministry of Local Government, were included. This was reviewed based on Annexure 1.

To ensure that saturation of the data was reached, focus group discussions were conducted with VCWs and community leaders. The guidelines for the focus group discussions were derived from the interview schedules for the specific group. Only those questions requiring answers in the individual capacity were excluded from the focus group discussion schedule. The focus group discussions were conducted after the interviews were completed. They enriched the data because they allowed a detailed discussion around each question, with examples and explanations being explored in detail.

Emphasis in the focus group discussions was on obtaining information on the level of participation, communication among the role-players and factors promoting or hindering participation. To ensure a free and enhancing environment, the researcher undertook to explain the purpose and process of the research to the focus group participants and introduced the focus group facilitator. Each group had several questions about the research and in all cases these led to the discussion. All groups wanted to know when they would receive the results, and as a consequence of this, the researcher undertook to produce a preliminary report for the province and to hold feedback discussions. This has been done in two of the districts.

The focus group discussions were recorded on tape and one of the research assistants as well as the researcher took notes during the discussions after seeking permission from the group. The data were compiled from the research assistant's notes, and then compared with the researcher's notes and the recorded proceedings.

The data collection took place over a one-week period. Two days were spent in each district.

3.2.4 Ethical procedures

Prior to entering the sampled districts, permission had been sought through the Provincial Medical Director (PMD), who had in turn informed the districts. The provincial rehabilitation team then informed the community through the district rehabilitation technician and the local clinic staff.

All interviewees received an explanation regarding the purpose of the study and anonymity was guaranteed. Furthermore, in compliance with the University of Pretoria regulations, an informed consent form was presented to each client after explanation. However, most clients opted to give verbal consent. Most clients felt uncomfortable with signing the consent form and said they were comfortable with the purpose of the study and did not feel it was controversial. An example of the written consent form is attached as Annexure 6.

The research protocol has been submitted to the Medical Research Council of Zimbabwe and permission to carry out the research was granted after the Council reviewed the protocol.

All respondents' answers were kept anonymous, except the information they offered during the focus group discussions.

The researcher's responsibility towards the community to give feedback on the outcome of the results of the study, has been honoured.

3.2.5 Analysis of data

Quantitative data were analysed through frequency tables using the SAS statistical package. Where relevant, the correlations between the results were calculated. These are indicated in the relevant discussions of the results. Due to the fact that a vast amount of data were gathered, the researcher decided to present the results relevant to the objectives formulated in Chapter 1 of this study. In this way, data could be presented in an organised and focused way.

Qualitative data were open coded, conceptualised and categorised. Axial coding of data determining the causal conditions, context, interaction between data and consequences of events, all of which is discussed in Chapters 3, 4 and 5, followed. Coded data are presented in table or graphic format or in descriptive paragraphs. In relevant cases, thick descriptions (direct quotes from participants) are used to enrich the data.

The relevant records were identified in the archives on central, provincial and local government levels. The documents were studied with the thought in mind to answer any aspect of the aims and objectives mentioned in section 1.4.1, Chapter 1. The

analysis of the documents was done according to the guideline in Annexure 1. During this process, the researcher bracketed her conclusions from the documents by discussing the outcome and the implications of the information in the documents on participation in CBR with the relevant health and rehabilitation workers.

As mentioned before, during the compilation of the questionnaire, every question in each of the Annexures contributed to meeting an aspect of each of the objectives. This step made it possible to organise the results gathered during the study using objectives as a guideline for presentation of the data. The objectives (Chapter 1, section 1.4.1) became the framework within which data were organised, without manipulating or interfering with the trustworthiness of the data.

3.3 PRESENTATION OF THE RESULTS

3.3.1 Introduction

In the following paragraphs, tables and graphs, the results of the information gathered through the questionnaires and focus group discussions are presented. As the client is the central focus of CBR, and all efforts by the stakeholders should culminate in an optimal service rendered to the client, the clients' viewpoints are presented first. This is followed by the presentation of information from the VCWs, community leaders and health and rehabilitation workers. The data gathered from the archives and documents are presented at relevant intervals to explain the outcome of the rest of the data gathered from the respondents.

3.3.2 Profile of clients

Figure 3.1 shows the condition status of the clients that were interviewed, and Table 3.1 provides further information on the condition status of the respondents who participated in the questionnaire for clients.

Figure 3.1 *Condition status of clients interviewed*

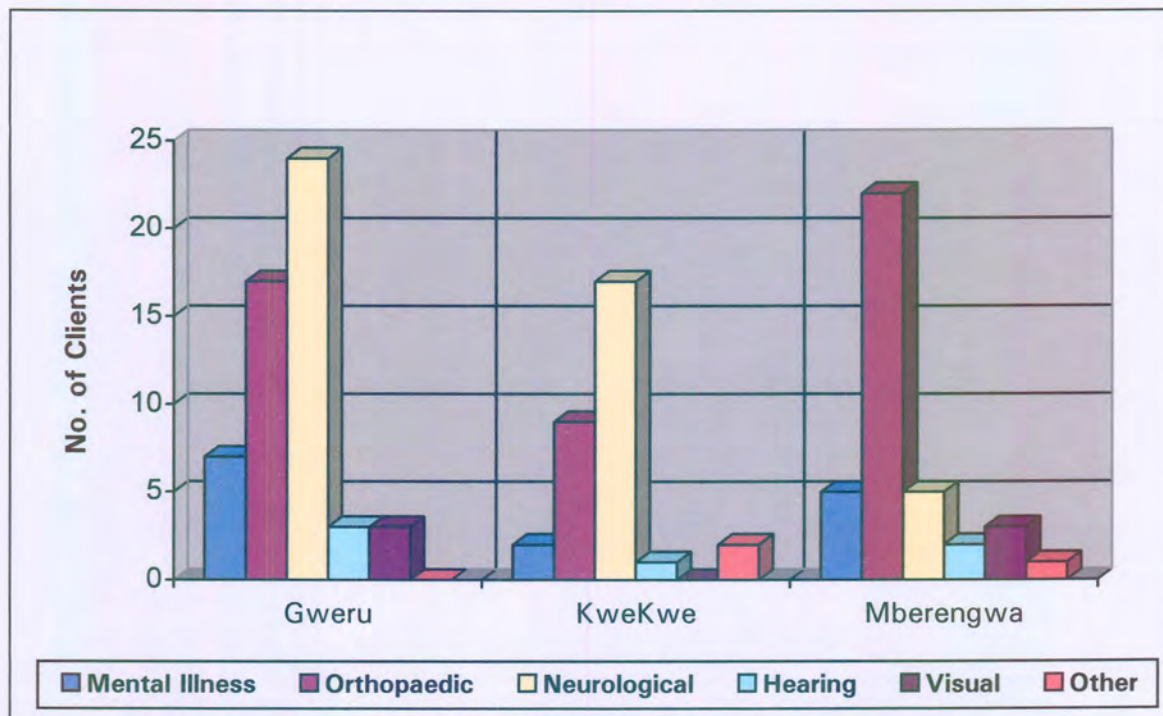


Table 3.1 *Condition status of clients interviewed*

	GWERU	KWEKWE	MBERENGWA	TOTAL
Mental Illness	6 (12%)	2 (2%)	5 (13%)	14 (11%)
Orthopaedic	16 (31%)	9 (29%)	22 (57%)	47 (39%)
Neurological	24 (46%)	17 (55%)	5 (13%)	46 (38%)
Hearing	3 (6%)	1 (3%)	2 (5%)	6 (5%)
Visual	3 (6%)	0	3 (8%)	6 (5%)
Other	(0)	2 (6%)	1 (3%)	3 (2%)
TOTAL	52	31	38	121

n = 121, missing 1 (Client condition could not be established).

In Gweru, forty six percent (46%; n = 24) clients suffered from neurological conditions, and thirty one percent (31%; n = 16) from orthopaedic conditions. In KweKwe, fifty five percent (55%; n = 17) suffered from neurological conditions and twenty nine percent (29%; n = 9) from orthopaedic conditions. In Mberengwa, the highest number of clients suffered from orthopaedic conditions, namely fifty seven percent (57%; n = 22), followed in number by thirteen percent (13%; n = 5) with mental problems and thirteen percent (13%; n = 5) with neurological problems. The distribution was similar to the monthly statistics available in the district departments (Provincial Rehabilitation Monthly Return Forms – Annexure 7). This consistent pattern implies that the client profile in this study is representative in terms of the existing official statistics.

Of the clients who responded, thirty eight percent (38%; n=55) were male and sixty two percent (62%; n=66) female. A breakdown of client gender per district is shown in Figure 3.2. Table 3.2 shows the gender status of all clients interviewed, per district.

Figure 3.2 *Distribution of clients by gender*

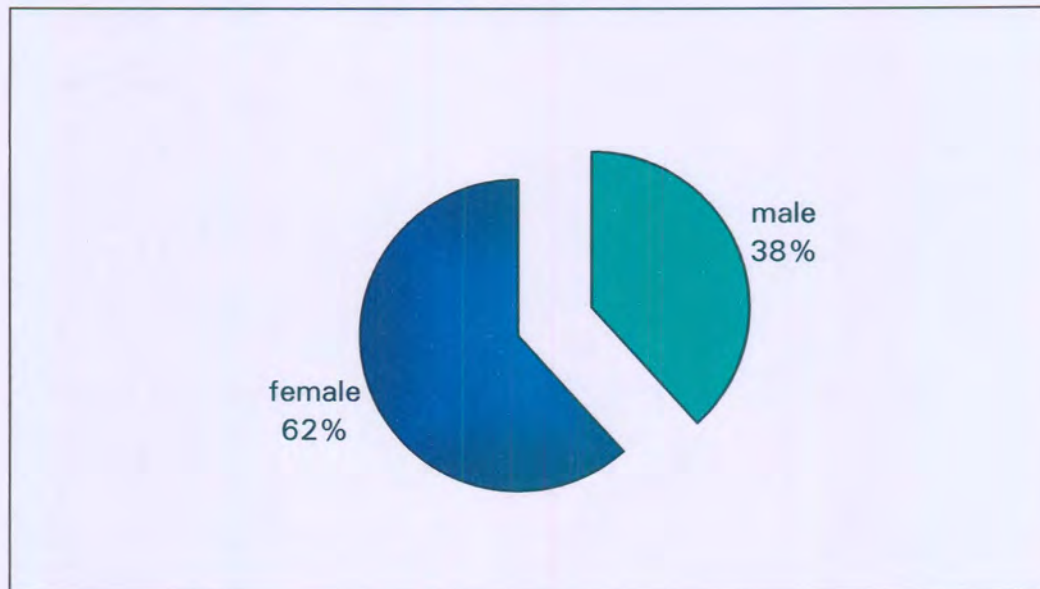


Table 3.2 *Gender status of clients interviewed per district*

	GWERU	KWEKWE	MBERENGWA	TOTAL
Male	20	14	21	55
Female	32	17	17	66
Total	52	31	38	121

n = 121, 1 missing (client's gender not indicated).

3.3.2.1 *Clients interviewed / persons interviewed on behalf of clients*

Not all the information was obtained from the clients themselves, as some of them were minors and/or unable to answer for themselves. In other cases, clients were unable to answer questions due to the nature of their condition, for instance mental retardation or communication problems. In such cases, parents or other caregivers present at home answered the questions on their behalf.

Of the people interviewed in Gweru, forty five percent (45%; n=23) were clients, and fifty five percent (55%; n=28) were parents of the PWD. In KweKwe, thirty eight

percent (38%; n = 12) were clients and sixty two percent (62%; n = 19) were parents or caregivers. In Mberengwa, sixty percent (60%; n=23) were clients and thirty four percent (34%; n=13) parents. Only five percent (5%; n=2) of all those who were interviewed on behalf of clients in Mberengwa were neighbours or other relatives who knew a lot about the client.

3.3.2.2 *Age range of clients interviewed*

Table 3.3 shows the age range of clients who participated in the study. Twenty eight percent (28%; n = 33) were over 40 years old, and twenty percent (20%; n = 25) were below the age of 10. Twelve percent (12%; n=10) were below the age of 5. In the other age ranges, the numbers ranged from 8 - 13 per age group. Statistically insignificant differences existed in the numbers of these age groups. Only two (2) clients were unable to provide their age because they were uncertain of their date of birth. In terms of participating actively in all aspects of the programme, more than fifty percent (50%; n=61) of the clients interviewed were over the age of being a minor, which is 18 years. For those clients who were under this age, the responsible parents were interviewed and their level of participation on behalf of their minors assessed. The age range of clients who participated in the interviews is shown in Table 3.3:

Table 3.3 *Age range of total number of clients who participated in the study*

AGE RANGES	TOTAL NUMBER OF CLIENTS WHO WERE PART OF THE STUDY
0 – 5	10 (8%)
6 – 10	15 (12.5%)
11 – 15	13 (11%)
15 – 19	12 (10%)
20 – 25	7 (6%)
26 – 30	14 (12%)
31 – 35	8 (7%)
35 – 39	8 (7%)
40 +	33 (28%)
Age unknown	2
TOTAL	122

n = 122 Two (2) clients did/could not specify age

Seven percent (7%; n=8) of the clients who participated in the study were children below the age of 5, while thirty three point five percent (33.5%; n=40) were between 6 – 19 years of age. The age ranges displayed in Table 3.3 are similar to those used by the MOH for their statistics and programming. Programmes for the clients under five

years of age are considered very important for public health and prevention programmes. For rehabilitation to be successful and in tune with the MOH, the study has disaggregated the data using the same ranges. However, if the age ranges are collapsed into three age ranges, namely 0 - 19, 20 - 39 and over 40 years, the picture is as follows:

0-19	-	41% (n=50)
20-39	-	31% (n=37)
Over 40	-	28% (n=34)

Although there appear to be few children below the age of five with disabilities in terms of prevention, this is the point of entry to disability that affects figures in later age groups. The figures for the under five year-olds cannot be adequately explained from the results in this study, and may be an area for future study.

Forty one percent (41%; n=50) of the clients were at school-going age, while the majority (59%; n=72) were in the economically active group. These differences in age distribution are important for planning and programming rehabilitation, and have an effect on the participation and the areas of social mobilisation, which is an important method of enhancing community participation.

Another key stakeholder in CBR and participation in CBR is the VCW. The profile of the VCWs who participated in the study is discussed in the following Section.

3.3.3 Profile of village community workers (VCWs) (Annexure 5)

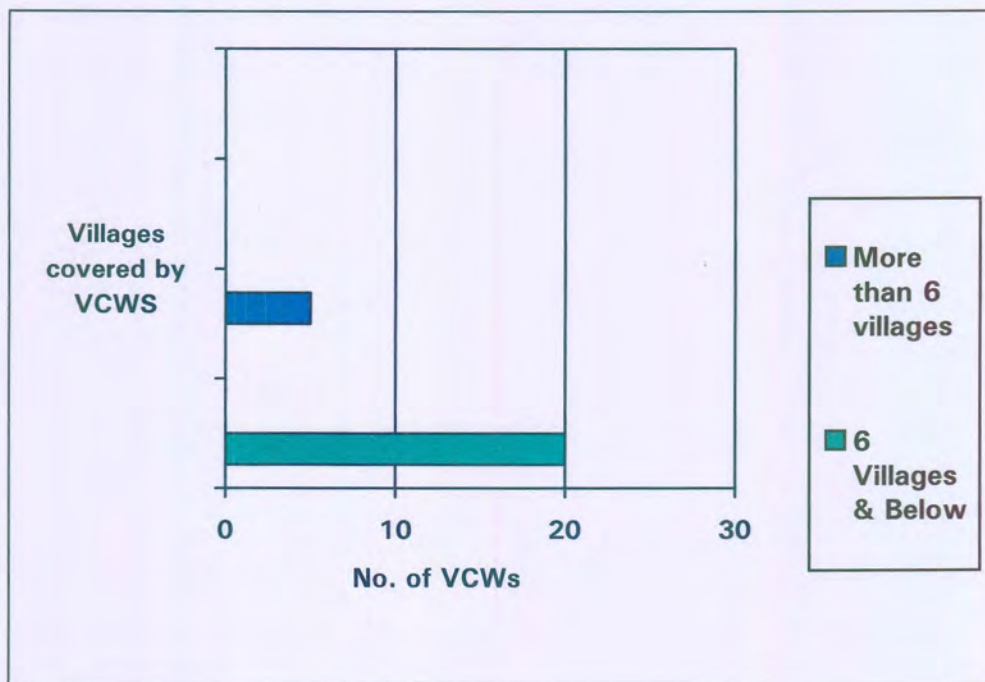
Twelve (12) VCWs worked in Gweru, while six (6) worked in KweKwe and seven (7) in Mberengwa respectively. In KweKwe and Mberengwa, five (5) and (6) VCWs respectively were away visiting sick relatives in town or attending a funeral. They could therefore not be interviewed. A convenient sample of sixty nine percent (69%; n=25) of all VCWs in the three districts was interviewed.

Sixteen percent (16%; n=4) of the VCWs interviewed were male, while eighty four percent (84%; n=21) were female.

The numbers of villages served by the VCWs are indicated in Figure 3.3. Eighty percent (80%; n=20) VCWs covered six (6) villages or less. Twenty percent (20%; n=5) of the

VCWs covered more than 6 villages. Of the latter five (5; 20%) VCWs, two (2) covered between seven (7) and twelve (12) villages; another two (2) between thirteen (13) and seventeen (17) and only one (1) covered eighteen (18) villages or more. Sixty percent (60%; $n=11$) of the VCWs served a population of 2000 and less, while forty percent (40%; $n=10$) served a population of more than 2000.

Figure 3.3 *Number of villages covered by interviewed VCWs*



Forty eight percent (48%; $n=12$) of the interviewed VCWs reported that they had less than twelve (12) PWDs in their area, while fifty two percent (52%; $n=13$) reported between thirteen (13) and thirty-four (34) PWDs in their area. One (1) VCW reported 120 PWDs in his/her area. This was the VCW covering a large area.

The profile of the community leaders who participated in the study is discussed in Section 3.3.4.

3.3.4 Profile of community leaders (Annexure 4)

All the community leaders (100%; $n=18$) from the three districts were interviewed. Of the eighteen (18; 100%), five (5; 28%) were interviewed individually in Gweru District, eight (8; 44%) in KweKwe and five (5; 28%) in Mberengwa. Two (2; 11%) of the

interviewees were community members who had important posts in a committee, while sixteen (16; 89%) were community leaders such as councillors, a Village Development Committee chairperson, headmen and chiefs. They were representative of the hierarchical structure of the leadership. Fourteen (14; 78%) respondents were male while two (2; 11%) were female. Two (2; 11%) did not have the gender indicated.

Focus group discussions were conducted with the community leaders in each district. The community leaders who attended the focus group discussions consisted of the councillors and chief (where available), the village headmen, chairpersons of important committees, and other informal leaders.

3.3.5 Profile of health and rehabilitation workers interviewed (Annexure 2)

Of the health and rehabilitation workers that were interviewed, six (6) were from Gweru District, three (3) were from KweKwe and six (6) were from Mberengwa.

The full population of health and rehabilitation workers in the three districts participated in the study by completing questionnaires. The staffing levels at most clinics were two (2) qualified nurses and an environmental health technician (EHT). The rehabilitation technician in charge of the district was also asked to complete a questionnaire.

The staff overall in charge of a district, i.e. the District Nursing Officer (DNO), the District Medical Officer (DMO) and the District Environmental Health Officer (DEHO) (all members of the District Health Executive (DHE)), as well as the provincial therapist, completed a questionnaire.

In one district, the District Medical Officer was not available and although a questionnaire with a self addressed envelope was left for him, it was not returned. In KweKwe, there was no District Medical Officer at the time, but the matron who was in charge of the hospital and district completed the questionnaire (Annexure 4).

In addition to completing the questionnaire, the researcher held informal discussions with all the health and rehabilitation workers that were available during the process of observing the records at each institution. The discussions centred on clarity of the information collected, through analysis of relevant records of meetings, policies, plans for CBR and other archives (Annexure 1).

Table 3.4 Profile of health and rehabilitation workers interviewed

HEALTH AND REHABILITATION WORKERS INTERVIEWED	TOTAL
Nurses	7
Rehab Technicians	3
Environmental Health Technicians	2
Physiotherapists/Occupational Therapists)	2
Doctor	1

n = 15

The health and rehabilitation workers consisted of the different professions as outlined in Table 3.4; i.e. nurses, Environmental Health Technicians (EHT), doctors, rehabilitation technicians and therapists. However, in the presentation of results, a distinction will be made between staff of the Rehabilitation Department (rehabilitation technicians and therapists) and the other health workers. This is done to distinguish, in context, the different functions and roles of the Rehabilitation Department as a key facilitator in CBR, whereas the other health workers, while being facilitators, are in a supportive role.

Five (5) health and rehabilitation workers were male while ten (10) were female. Their ages ranged between 26 - 52.

The following section (section 3.4) describes the results on the areas and level of participation of all these stakeholders in order to gain a full understanding of their role in CBR.

3.4 AREAS AND LEVEL OF PARTICIPATION IN THE MANAGEMENT OF CBR, OF THE CLIENTS (PWDs), HEALTH AND REHABILITATION WORKERS, VCWs AND COMMUNITY LEADERS

3.4.1 Introduction

This section outlines the results of interviews conducted with the clients (PWDs), health and rehabilitation workers, VCWs and community leaders. Their understanding of participation in CBR is outlined, while their actual participation, illustrated by the activities they were actually engaged in, are described. The level of participation by these role-players as indicated by them is according to the London Community Participation Group of the United Kingdom for All Network (1991), which is described in Table 2.1, Chapter 2.

To determine the level of involvement of each of the clients, the VCWs and community leaders were asked to what extent they saw themselves involved in the planning of the CBR programme. The health and rehabilitation workers were asked to what extent **the community** is involved in the planning and management of the CBR programme.

Within this context of CBR, each stakeholder's understanding and actual area of activity and level of involvement in CBR are outlined in the following sections.

3.4.2 Areas and level of clients' participation in the management of CBR

Under this section, the results of the clients' understanding of community participation, their perception of the person responsible for the PWD, their reasons for their opinions, the type of activities that indicate their participation, their perception of the outcome of participation and their level of participation according to the London Community Participation Group of the United Kingdom for All Network (1991) are presented.

Table 3.5 shows the different concepts expressed by clients when asked about their understanding of community participation.

Table 3.5 Clients' understanding of community participation

CATEGORY OF UNDERSTANDING	UNDERSTANDING OF COMMUNITY PARTICIPATION	TOTAL	%
1) <i>Involvement of PWD in decision-making</i>	- PWD working together with others and playing an active role to mobilise other PWDs. Try to provide a low cost high quality service by attending meetings to learn more and coming up with problem lists, solutions & future plans.	13	34%
2) <i>Integration of PWDs into community</i>	- Participation focuses on caregivers and community members as active participants to integrate PWDs into community activities and continue activities after it is launched; - Being included in making decisions about matters within the community; - Working together with rehabilitation team and VCWs but we are hindered by poor economic status, therefore we cannot be consistent; - PWDs carrying out CBR activities and not health workers alone.	19 10	
3) <i>Attended meetings but unsure how to participate</i>	- Participated by attending meeting but forgotten details and doesn't know how to participate; - Knows nothing about participation in CBR; - Did not understand anything about participation; only knows her exercise programme; - Not sure, has heard of the programme but does not know how to participate.	35	29%
4) <i>Active participation of PWDs in community activities</i>	- Active involvement of PWDs in solving their problems after identifying them. Come up with solutions to promote development within the community; - Active participation of PWDs in activities, with the community.	22	18%
5) <i>Education</i>	- Participation brings knowledge on how to look after PWDs and help them to look after themselves; - Impart knowledge to others for better integration into the community and to mobilize community resources; - Teaching PWDs skills to work in IGPs and to help themselves.	13	11%
6) <i>Active participation in development</i>	- Participating to generate income for PWDs; - Helping PWDs to help themselves – e.g. through exercise therapy and IGPs; - Improve integration of PWDs by attending meetings; - Encourage child to participate in all activities; - Client learnt how to help herself and others and participates in training others; - Active participation in development issues within the community.	7 5	10%
7) <i>Material contribution</i>	- Material contribution for PWD; - Working together with other community members to generate funds for PWDs and helping them materially; - PWDs are provided with funds and resources and knowledge to start IGPs.	7	6%
8) <i>General assistance for PWD</i>	- General assistance in all areas. - Understanding how PWDs can be helped to improve their living standards.	3	2%

n = 122 (Clients gave more than one answer).

One third of the clients (34%; n=41) regarded participation in CBR as being involved in some way in decision-making regarding the services rendered to PWDs, as well as integration of PWDs into community activities. Almost one third (29%; n=35) of the participants did not know what participation means or implies. Four (4) clients said although they attended the meetings, they had no idea what to do to participate or what it meant. Twenty percent (20%; n=24) indicated that it means active participation of PWDs in community activities. The rest of the categories indicated in Table 3.5 provide a description of some examples that would indicate participation; i.e. education about participation, active development of IGPs and participating in other community activities, material contribution towards PWDs, and general assistance of PWDs. Collaboration between the client and different people in the community and CBR facilitators is implied but not strongly stated in some statements, e.g. active involvement of PWDs in solving their problems after identifying them; come up with solutions to promote development within the community; and active participation of PWDs within the community activities. Twenty-nine percent (29%; n=35) of clients could not explain and did not understand community participation.

In order to determine the attitude of the clients towards participation in CBR, their attitude towards the person responsible for participation was sought:

It has been established that attitude towards disability has a bearing on participation (Coleridge 1993). It was therefore important in this study to establish what the clients' perceptions were with regard to whom they perceived as the responsible person / body for PWDs.

In the question, clients could indicate more than one possible answer. The results in Table 3.6 must therefore be read across and not vertically.

Table 3.6 *Clients' perception of whom and to what extent the following body(s) or people should take responsibility for PWDs*

PARTICIPATION	Responsibility		
	TOTALLY	PARTIALLY	NOT AT ALL
Community	21 (30%)	36 (51%)	14 (20%)
Government	48 (55%)	34 (39%)	6 (7%)
Individual	12 (20%)	36 (60%)	12 (20%)
Family	48 (58%)	32 (39%)	2 (2%)

Respondents could give more than one answer (n = 122).

According to the results, at least fifty five percent (55%; n=48) of the total number of clients (n=122) who answered this question felt that either the government or the family (58%; n=48) should be totally responsible for the care of the PWD. The major conclusion that can be drawn from this table is that a similar number of respondents were of the opinion that the responsibility for PWD should be shared between at least three of the four parties: the community (51%; n=36), the government (39%; n=34), the family (39%; n=32), as well as the individual (60%; n=36). Although some respondents felt that the community, the government, the individual and the family should not be involved in the care of the PWD at all, they were in the minority.

The reasons given by the respondents for, who should be responsible for the PWD, are described in Table 3.7.

Table 3.7 Clients' reasons for their choice of responsible person or body for PWDs

CLIENTS' REASONS FOR GOVERNMENT, FAMILY OR COMMUNITY TAKING RESPONSIBILITY OF PWD	TOTAL
The family is close, always provides basic needs, stay with the PWD, understand the PWD better, and knows the PWD's problems. They can therefore support the PWD better in terms of access to school, other places, ADL and communication. However, the families are often poor and need assistance in care, which mean additional expenses.	59
The family should set an example for involvement or participation by the community, who can then help the government to identify problems that the PWD experience. By example and experience, families can sensitise the community to be totally involved in CBR and supporting PWDs through identifying their problems and helping to solve them.	15
The individual also need to help himself. The PWDs must play their part in caring for themselves.	3
They have all played a part in the clients' rehabilitation programme, for example in my IGP, "the family and community buys produce and is supportive in this way. Swedish International Development Agency SIDA through the Rehabilitation Department funded the projects" (Direct quote from raw data).	2
- The government must help because the family does not have access to funding. Government gets all the money from donors and everyone depends on government to disburse these funds.	61
- Government and community leaders have the responsibility in playing a stewardship role by providing schooling facilities/capital for projects/general needs of PWDs. This is because the government has the most knowledge about resources and funds (gets money from donors) - more than the community. Communities cannot manage alone. All community leaders are part of the government, hence they should help, since we pay taxes to them.	
- They must help PWDs in the same way they help people without disability. They are the backbone and are responsible for everyone's welfare and must give free treatment as well. We depend on the government, so they must assist the PWD, and the government is always there even if the family dies. We look up to the government.	
- Local and community leadership is available and they visit me and check on my problems. The community should help the PWDs. They live with us, it is their responsibility.	
Have seen few people helped by the government.	2

n=122

What is clear from the reasons given by clients on who should bear the responsibility for PWDs is that the clients see a role for both the family and the government to an almost equal extent. This indicates that they have a positive attitude towards their own responsibility for caring for themselves or caring for a disabled family member / child, but they also have substantial expectations for outside help.

To fully understand the client's role in caring for the PWD, it is important to look at the areas or types of activities the client and his/her family participates in caring for himself/ the PWD.

3.4.2.2 *Areas / type of activities that indicate clients' participation in terms of caring for the PWD*

The areas / type of activities in which clients and their families participate in around the context of CBR, are outlined in the following section. The specific type of activity represents the family support for the PWD and gives an indication of the time spent on these activities in support of PWDs.

With regard to CBR, sixty percent (60%; n=72) of the clients said their families always participated in their rehabilitation programme; twenty four percent (24%; n=29) said they seldom participated; and sixteen percent (16%; n=19) said they never participated in the client's rehabilitation programme.

The type of activities that characterise families' active participation in supporting the rehabilitation of the PWD, are shown in Table 3.8:

Table 3.8 *Type of activities that characterise families' active participation*

AREAS OF PARTICIPATION	% OF FAMILIES ACTIVE IN THIS AREA
Activities of daily living (ADL)	45 (39%)
Access to school and work	40 (33%)
Ambulation	33 (27%)
Leisure activities	22 (18%)
Access to community amenities e.g. transport to public hall	34 (28%)

n = 122

From Table 3.8 it is clear that the type of activities in which the families participate with regard to the rehabilitation or care of the PWD, can be classified into activities concerning the PWD's ADL and accessibility in the community, educational and economic activities.

During the interview, clients provided details about some of the activities performed by the families as described in Table 3.8. These specific types of activities are described in Table 3.9.

Table 3.9 *Specific activities carried out by the PWD and family*

ACTIVITIES CARRIED OUT BY PWD AND FAMILY	TOTAL
Specific exercises and activities We work all the time because we stay with child or client to teach skills e.g. Teaching ADL issues to do with self care: - Bathing; - Dressing and toileting; - Psychological repeating exercises; - Sign language/communication; - Putting splints, play. Spends time (15 minutes) doing specific exercises taught for husband and does other chores. 1-2 hours teaching child or self new skills. - Help with ADL and house work, going to church; - Give sadza only (sadza is the staple maize meal diet.) Does self care all the time, no specific time set for disability. Grandmother (brothers wife) dedicates most of her time to her granddaughter/does activities such as bathing, dressing.	64 (53%)
Activities of daily living and more functional related activities Carries out his chores and activities of daily living around the home, e.g. sweeping, collecting water, and gardening. Disability does not require special attention. Assisted with activities around the home, e.g. cooking, gardening. Other activities carried out by PWD. Walking, sewing, IGPs, gardening, ploughing, household chores, thatching, building – client feels family lacks education.	40 (33%)
Income generation PWDs reported spending time on finding out how to help themselves through income generation and finding a job, educating community on disability and other household chores.	11 (9%)
Preventative activities Taking medication, and first aid during epileptic fits. - Preventive - protecting fireplace; - Avoiding what triggers his fits.	5 (4%)
None Clients old enough - takes care of themselves.	2 (1%)

n = 122

The results in Tables 3.8 and 3.9 show that the families and the clients already play a very significant role in the rehabilitation of the clients, e.g. in ADL.

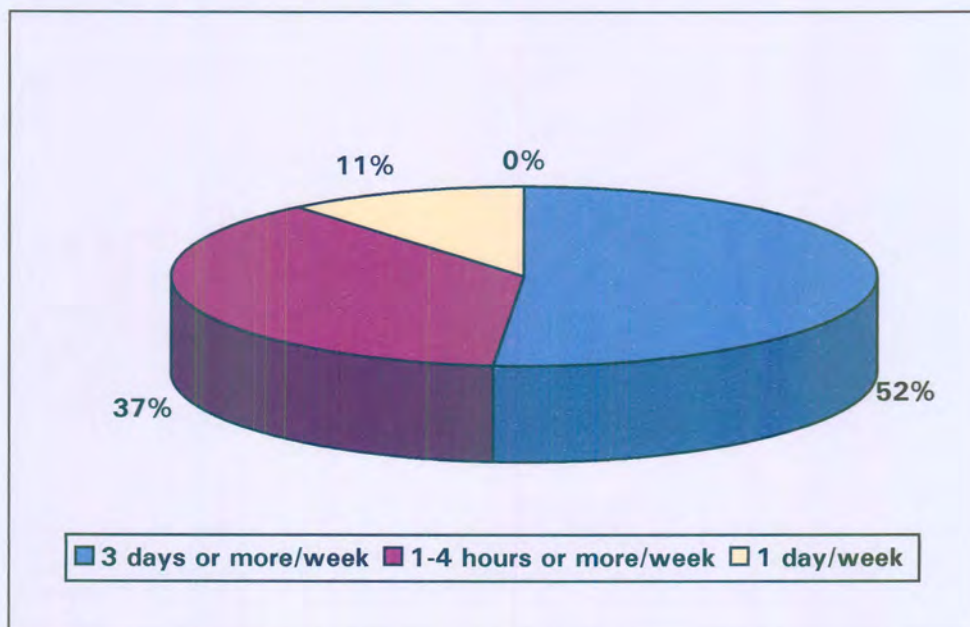
Over half of the clients (53%; n = 64) reported spending time on specific exercises and ADL. One third (33%; n = 40) of the clients' caregivers spent time solely on activities to improve functional ability, such as enabling them to carry out household chores and activities concerning their own personal care, e.g. washing and dressing. Only nine percent (9%; n = 11) reported spending time on IGP and four percent (4%; n = 5) on preventive activities that were mentioned by families of clients who suffer from epilepsy. Specific exercises and activities leading to self-care and functional

improvement were practiced mainly at family level. A few of the examples of activities involving IGP and prevention given at family level include / enable the client to participate on community level. These include activities such as educating the community on disability and where PWDs reported spending time on finding out how to help themselves through income generation.

In Figure 3.4, the time that clients and their family spent on issues to do with disability is indicated. Forty nine percent (49%; $n=59$) of clients interviewed, spent three days or more on issues relating to disability issues or the PWD, while thirty five percent (35%; $n=40$) spent 1 - 4 hours per week assisting the PWD.

In terms of the time spent on specific issues regarding the PWD and their disability, Figure 3.4 indicates the time that the family had spent either with the client (PWD) or with issues related to disability.

Figure 3.4 *Time spent on issues related to disability*



The families of PWDs reported spending much of their time on activities such as specific exercise and activities related to the PWD (refer to Table 3.8). The client profile showed that twenty percent (20%; $n=24$) of the clients are less than 10 years of age. Children of this age group need more care from their parents / caregivers than older children / persons.

From the results, it was determined that fifty percent (50%; n=61) of the families spend almost fifty percent (50%) of their week (3 days per week) carrying out supportive activities for their family members who suffer from disability. This is a significant undertaking of commitment and participation on a personal level. The type of activities carried out by family members are those activities needed by the PWD for basic functioning, his/her ADL, and then to a lesser extent activities pertaining to income generation and facilitation of community activities as indicated in Table 3.9. However, given the fact that thirty eight percent (38%; n=46) of the clients were in the 20 - 39 age group, which is the economically active age group, more activity in relation to IGP was expected.

3.4.2.3 *Areas of activity where clients reported that CBR had helped them*

The families reported spending time on issues relating to the PWD. One of the objectives of this study was to determine to what extent the PWD benefited through the time that family members spend with him/her. By identifying the outcome of CBR activities in the major categories of functional limitations taken from the WHO International Classification of Functioning Disability and Health (2001), this objective could be achieved.

To quantify the outcome of CBR, clients and their families were asked (Annexure 3) to what extent their participation in the CBR programme and activities helped them in the areas that they could not perform previously and could perform now after the intervention, e.g.:

- Communication (understanding, expressing and communicating with others in the family and community);
- Problems regarding the mobility of the PWD (mobility of joints and mobility around the home);
- Participation in the community in issues such as schooling, household activities and community activities.

(1) Improvement in communication

In the area of communication, one third (31%; n=39) of clients could now understand, express and communicate with others where they could not do so before. Less than

eleven percent (11%; n=13) of clients could still not express thoughts, needs and feelings, understand simple instructions and communicate with others.

(2) Improvement in mobility and functional problems

In the area of movement and mobility around the home and community, clients reported the following:

Improvements in body function and joint mobility (Moving all limbs)	25 % (n = 30)
Still unable to move at all	4 % (n = 5)
Improvement in mobility around the home and community	51 % (n = 62)
Still unable to move around the home or village.	13 % (n = 16)

Seventy six percent (76%; n=93) of clients indicated that they experienced either improvement in body function and joint mobility and/or improvement in mobility around the home and community.

(3) Clients' improvement in participation in community activities

Clients indicated that their participation in community activities improved due to their participation in CBR with regard to the following:

Go to school and learn	22 % (n = 27)
Participation in family activities	47 % (n = 57)
Participation in household activities	49 % (n = 60)
Participation in community activities	39 % (n = 48)
Participation in IGPs	41 % (n = 50)

All the activities indicated above relate to an improvement in the clients' functional level. In Section 3.4.2.3 (2), it was indicated that seventy six percent (76%; n=93) of clients reported improvement in body function and joint mobility and/or improvement in mobility around the home and community. The figures in this section (3) indicate the impact that these improvements of body mobility and functional level had on the client's functioning in the community. These figures must be interpreted against the client profile (50%; n=61) of clients were under the age of 20, Table 3.3). Therefore, the

type of activities in which PWDs are engaged in, in their families and in the community, will differ according to their age. Clients' participation will also be dependent on the severity and the morbidity of the disability, as well as the degree of improvement reported in Section (2). The correlation between these factors falls beyond the scope of this study.

This section describes the results (Annexure 3) of clients who did not improve in participation in various community activities such as attending school, participating in IGP and other community initiatives. Thirty five percent (35%; n=42) of clients of school-going age still did not attend school, while over twenty five percent (25%; n=31) reported the inability to participate in community and IGP activities. Previous results reflected the amount of time clients spent on these activities, in the reported areas of benefit. In Figure 3.4, it is indicated that much time was spent on exercise and activity to improve functional ability, and it is in this area that the greatest improvement among clients took place. Only nine percent (9%; n= 11) (Figure 3.4) of clients reported spending time on IGP (refer to Table 3.9). In contrast to this result, in another question (Annexure 3, question 3) clients were asked to indicate what they have benefited from CBR. Forty-one percent (41%; n=29) of the clients who responded reported improvement in IGP. This question was either not understood well or the interviewers did not express the question well, because the answer does not correspond with the results in Table 3.9.

Another dimension of determining clients' integration into community activities, which would indicate their participation in planning and implementing projects, is by identifying their participation in organisations and community projects that were established specifically for the PWD. Table 3.10 shows the results of the community initiatives for PWDs that clients were involved in:

(4) Involvement in community initiatives for PWDs

Community initiatives for PWDs entail participating in any formal or informal organisation that would involve PWDs in some or other way.

Table 3.10 *Clients' involvement in community initiatives for PWDs*

COMMUNITY INITIATIVES	CLIENTS INVOLVED
Disabled peoples organisation (DPO)	10 (12%)
Non-governmental organisation (NGO)	2 (2%)
Income generating project	44 (36%)
Other	55 (45%)

n = 122

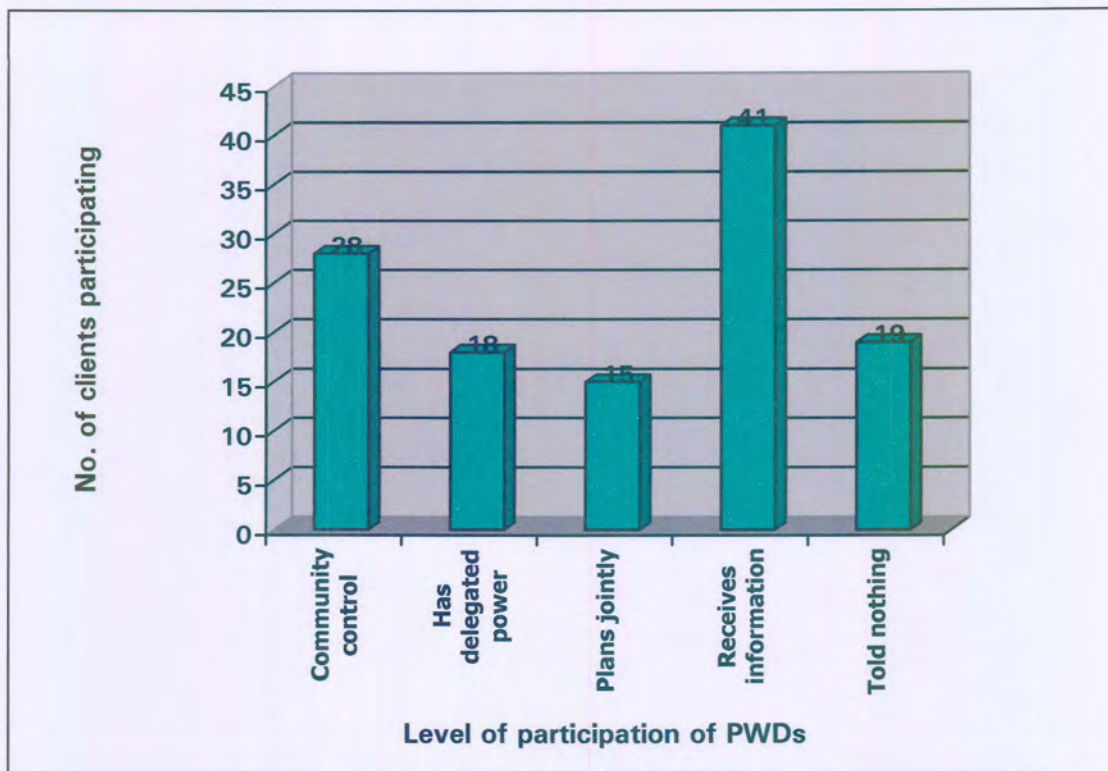
The clients who responded indicated that they experienced a functional improvement in their home and the community environment, with regard to participation in decision-making on issues pertaining to PWDs. However, according to Table 3.10, it seems that this was not the case. The results in Table 3.10 show little activity of PWDs in DPOs or NGOs. Very few PWDs (less than 10%; n=12 and 2%; n=2 respectively) were aware of or belonged to community initiatives like DPOs and NGOs. They either did not exist in the district or area of the village that was included in the study, or they were unknown to the PWDs and their families.

However, many respondents indicated that they were involved in 'other' community initiatives. When asked for an explanation of these 'other' community initiatives during the interview, they said that they participated in groups such as church clubs and church-related organisations. Participation in community initiatives is a good indication of the clients' involvement in the community in general.

3.4.2.4 *Clients' level of involvement in community participation*

Clients were asked regarding their level of involvement in the planning for CBR. This was done according to a scale proposed by the Community Participation Group of the United Kingdom for All Network (1991). The scale ranges from having community control to no involvement in community participation at all. Based on the scale in Chapter 1, Table 1.7, and Chapter 2, Table 2.1, the clients' perception of their participation in the planning process for CBR is shown in Figure 3.5.

Figure 3.5 Participation of clients (PWD) in CBR planning process



Twenty-three percent (23%; $n=28$) of the clients viewed themselves as having community control. Fourteen percent (14%; $n=18$) perceived that they were planning jointly with the community leaders. Twelve percent (12%; $n=15$) were planning jointly with the programme facilitators and the community, while thirty three percent (33%; $n=41$) were only receiving information on what was planned. Fifteen percent (15%; $n=19$) felt they had been told nothing.

With only twenty three percent (23%; $n=28$) of the key target group (in this case the client) reporting community control and forty eight percent (48%; $n=60$) only receiving information or told nothing, the clients' involvement and participation at planning level could be regarded as below average.

The next major key role-player in CBR is the VCW. The results of the questionnaire completed by the VCWs, as well as the data gathered during the focus group discussions with them, are discussed in the following section.

According to the CBR guidelines (MOH 1990), the VCW is a key link between clients and the community. It is important to establish what the VCWs' level and areas of participation were, as they are the main link with the community, the clients and other health sector ministries.

3.4.3 Area and level of VCW participation in the management of CBR

The VCWs are central to rendering a CBR service in Zimbabwe as shown in the CBR guidelines (MOH 1990). They are part of most of the development committees that are operational in the community, including the Community Rehabilitation Committee. The Community Rehabilitation Committee was established to promote the advancement of disability and CBR issues. It consists of important community members and works closely and often under the umbrella of other community development committees within the community.

VCWs render a CBR service in a given geographical area as shown in Figure 3.3. This would often include anything from 200 - 500 households. Their major activities are:

- Educating the community and family on disability and attitude change;
- Teaching caregivers;
- Facilitating IGP projects, and
- Facilitating contact between the PWDs and community leaders by way of formal and informal discussions during various committee meetings, e.g. the community development committees. This is illustrated in the MOH CBR Guidelines (1991) and the evaluation report by Njini *et al.* (1990).

As in the case of the presentation of the data gathered from the clients, the first aspect of the gathered data to be presented is the VCWs' understanding of community participation. The areas of participation and the level of involvement of the VCW in community participation are also presented.

Concerning the VCWs' understanding of community participation, the data resulted from the various focus group discussions held in five different timeslots in order to accommodate all the VCWs participating in the study.

3.4.3.1 VCWs' understanding of community participation

The following views emerged on community participation during the open coding of the raw transcribed data:

- In all focus group discussions with VCWs, they outlined community participation as cooperation and working together for the successful implementation of CBR programmes, with the involvement of all key stakeholders in all the planning, implementation and decision-making processes. One participant summarised the role of the VCW in CBR as follows:

"Encouraging our target group (PWDs) to help themselves and achieve their own objectives." (Direct quote from the participants of the focus group discussion).

- Helping each other and contributing to meet the needs of PWDs.
- Cooperating with 'outside' role-players, e.g. NGOs and Ministries.

From the core aspects identified from the discussions with the VCWs, it can be concluded that they regarded themselves as playing a central role in community participation. However, although they emphasised collaboration and cooperation with clients as well as the official decision-makers in the health care hierarchy, they did not emphasise the aspect of their contribution in the definition of community participation. The VCWs understood the concept of community participation to a large extent, but for a more balanced view some aspects may need to be clarified more.

3.4.3.2 Activities indicating VCWs' participation in CBR

The type of activities that the VCWs were engaged in at the time of this study was identified from Annexure 5, questions 2 - 8. These included home visits, record keeping and the miscellaneous activities described in the open question, which were carried out by VCWs in response to both the CBR program and client needs.

(1) Home visits carried out by VCW

- 1 home visit to a client per month - 44% (n = 11)
- 2 home visits a month - 24% (n = 6)
- 3 home visits a month - 28% (n = 7)

No reasons were rendered for the differences in the number of visits paid to a client per month. Forty eight percent (48%; n = 12) of the VCWs had spent at least 30 minutes per visit and fifty two percent (52%; n = 13) had spent an hour or more per visit with the client.

(2) Record keeping

The rehabilitation worker designs the format of record keeping used by the VCW regarding a client's progress in the CBR program. The reason for this is that the VCW has to report the client's progress to the rehabilitation worker, who is the supervisor of the VCW. Through monitoring the VCW documentation of a client's progress, the rehabilitation worker can determine the extent to which the VCWs coordinate their activities at community level with those of the rehabilitation worker. These records also give an indication of the communication between the VCW and the rehabilitation worker.

Based on the answers in Annexure 5, eighty four percent (84%; n = 21) VCWs reported keeping client records in books or registers. Nineteen percent (19%; n = 4) reported keeping a list of the clients they visit and render a service to.

VCWs were asked how often they meet with the health and rehabilitation workers. The feedback was as follows:

- Sixty percent (60%; n = 15) reported one (1) meeting with health and rehabilitation workers per month;
- Twenty percent (20%; n = 5) reported two (2) or more meetings with health and rehabilitation workers per month;

- Twenty percent (20%; n = 5) reported less than one (1) meeting with health and rehabilitation workers per month.

From the results, it is indicated that VCWs met with health and rehabilitation workers on a regular basis. The majority met once a month. It is at these meetings that the records were utilised.

(3) Activities of VCWs related to CBR

VCWs were asked what type of activities relating to CBR they carried out. The activities are described in Table 3.11.

Table 3.11 Activities carried out by VCWs in relation to CBR

ACTIVITIES CARRIED OUT BY VCWS	NO. (%)
Activities to:	
• Promote effective integration and functional relationships in the community;	6 (24%)
• Promote income generation;	18 (72%)
• Improve the circumstances of the individual or community;	4 (16%)
• Increase the knowledge and practice in the rehabilitation of PWDs and other community members for the benefit of PWDs.	10 (40%)

n = 25

Seventy two percent (72%; n = 18) of VCWs were recorded as spending their time on activities to promote income generation for PWDs. Forty percent (40%; n = 10) engaged in activities to increase their knowledge and practice with regard to the rehabilitation of PWDs.

Relating this to the activity of the clients and their families: fewer clients and their families reported spending time on activities for income generation (9%; n = 10; Table 3.9). There was some contradiction in the results reported by clients because forty one percent (41%; n = 50) reported improvement in their participation in the IGP activities of the clients reported. The latter results therefore indicate that the VCWs were spending time promoting activities for income generation for PWDs, although this may not be correlating with what's happening at the individual client level. The other possibility is that VCWs spend more time on clients who have the potential of getting involved in IGPs than on other clients.

The activities that the VCWs were engaged in indicate that the VCWs contributed meaningfully to CBR. The activities covered a comprehensive range of activities, which to a large extent meet the different aspects of rehabilitation. From these activities VCWs derived most of their plans in consultation with health and rehabilitation workers and community leaders. In the focus group discussions, few VCWs reported actively involving PWDs in planning.

All VCWs (24) except one (1) reported having a Community Development Committee with whom they collaborate. This result indicates that there are such Committees in the studied areas. The question would now be - how active and effective are they? VCWs indicated the following interaction with the Community Development Committee to whom they have to report:

- Fifty two percent (52%; n = 13) attended Community Development Committee meetings;
- Twenty four percent (24%; n = 6) attended other informal meetings;
- Sixteen percent (16%; n = 4) attended / reported back to the Community Development Committee during specific CBR meetings.

Sixty eight percent (68%; n = 17) VCWs are actively communicating with the Community Development Committees on matters to do with disability and CBR. This should enhance the integration of CBR and disability into community development.

(4) Evaluation of the process of CBR and client's progress

Evaluation of the nature, quality and quantity of programme activities is an important aspect of CBR, in order to monitor the progress and outcome of the programme as well as the progress of the clients. VCWs were asked what activities they carry out to evaluate their programme activities.

The evaluation activities carried out by the VCWs are described in Table 3.12.

Table 3.12 Evaluation activities carried out by VCWs

EVALUATION ACTIVITIES CARRIED OUT BY VCWs	TOTAL
- We check with caregivers if the client is making progress and keep records thereof. Review / reassess the client's progress and interview clients on their difficulties and reassessment of clients. We check how many PWDs have received assistance after referral to any service.	20 (80%)
- We check how profitable IGPs are and hold meetings at the IGP site so that PWDs and other members can learn from each other.	5 (20%)
- Evaluate if the client is accepting his/her disability and is taking responsibility for his/her rehabilitation.	2 (8%)
- Carry out discussions with caregivers and PWDs during follow-up visits and write reports for clinic. We refer to our records to view progress.	9 (36%)
- We have not carried out any evaluation yet as everything is still in progress.	1 (4%)

n = 25

The results show that the VCWs were active in the process of monitoring the clients' progress and assisting in the way forward. The evaluation by VCWs is centred on the client's individual progress and assessed needs. The outcome of the evaluation seems to form the basis for ongoing communication between VCWs and health and rehabilitation workers, including those at clinic level. Twenty percent (20%; n = 5) of VCWs said they monitored the profits of IGPs, which include those IGPs where PWDs and able-bodied people are involved.

From the data presented in Table 3.12, it is clear that the evaluation activities and the documentation there-of as carried out by the VCWs do not necessarily reflect community participation by the clients and other role-players in the CBR programme. This is because the VCW records concentrate on the clinical aspects of the client's needs.

Another important facet of the VCW's role in CBR is to facilitate the referral system for clients, in order to utilise the health and other services at different levels of operation. In order for the client to travel from the community to e.g. the orthopaedic centre at the provincial hospital, he/she should first contact the VCW and would then be referred to the local clinic to ensure it is not something that can be dealt with at the clinic level. Subsequent referral would take place once this is established.

(5) The referral system

There are a variety of reasons why a referral system should be implemented. For example, a referral system is instituted so that the client could seek assistance in his

areas of need as close to his home as possible. The system allows for clients' problems to be dealt with within the community or district. It also allows the local clinic and support system to be aware of the needs and possible changes in the needs and/or status of its community members.

The referral system is therefore the way in which a client proceeds from community level to any service that is available at district, provincial or national level. In either case, the VCW is the PWD's first contact with the health system and often any other sector from which they might need help. It is therefore important that the PWD be aware of the referral system that exists in the health and other sectors in order to take full responsibility for his/her own rehabilitation and as such participate in matters relating to his/her disability on community or even provincial level. Clients see the VCW as the first contact in the referral system; i.e. the VCWs capacity as the local supervisor of the CBR programme at community level.

Clients were asked if they knew about the referral system and if they used it. Fifty eight percent (58%; n=70) of the clients indicated that they were aware of the referral system and used it, while thirty percent (30%; n=36) indicated that they were not aware of it. Twelve percent (12%; n=16) did not indicate whether they knew about the referral system within CBR.

Thirty four percent (34%; n=40) of clients saw and had contact with the VCW once in two months or less, while thirty one percent (31%; n=37) saw them once a month and nineteen percent (19%; n=23) once a week. Forty four percent (44%; n=11) of VCWs carried out one visit a month and the rest, i.e. fifty six percent (56%; n=14), two to three visits per month. During these home visits, they carried out activities to do with function, mobility and IGP. Eighty percent (80%; n=20) reported that they also assessed the client's progress. This result illustrates that at community level, the contacts between the VCWs and clients are operational and are forming the first contact in the referral system.

The number of monthly visits is a good indication of the contact between VCWs and clients and the VCW's level of participation in CBR. However, it is also important to see the level of participation by analysing the amount of time the VCW spent with the client. The time spent during contacts with the local supervisor are shown in Table 3.13.

Table 3.13 The time clients spend with the VCW

TIME SPENT/WEEK WITH VCW	% CLIENTS
1 – 4 hours	74%
1 – 3 days	7%
Other	19%. (This varied from one visit per month to less than one thirty (30) minute visit a month.

n = 122

The researcher wanted to determine if clients were aware of the referral system and if this knowledge alone was sufficient for the effective utilisation thereof. A chi square test was used to test for dependency between awareness of the referral system, its use and the contact that the clients had with the VCW. The test was not significant at a ten percent (10%) level, with $P=0.3250$ indicating that factors other than knowledge of the referral system played a role in the referral system.

On community ward level, referral was also evident as VCWs reported the following referrals: Forty percent (40%; n=10) VCWs referred clients weekly to the health workers through the clinic. Forty percent (40%; n=10) VCWs referred clients monthly to the Department of Social Welfare within the community.

The VCWs were active in all the above-mentioned activities, which indicate that they not only contributed towards the process of CBR, but also towards the client's participation in CBR. In conclusion it can be said that the VCWs were fairly active in the referral system. Their level of involvement in CBR was evidently high.

VCWs were asked to what extent they were involved in the planning process of CBR. In answer to this question:

- Fifty six percent (56%; n=14) of the VCWs reported they participated in the community control over participation and development. This implies the highest level on the scale of the Community Participation Group of the United Kingdom for All Network (1991).
- Sixteen percent (16%; n=4) felt power had been delegated to them to perform CBR. This implies the second highest level of community participation on the Community Participation Group of the United Kingdom for All Network (1991) scale.

- Twenty percent (20%; n=5) felt they had planned jointly with the health workers and other stakeholders in performing CBR. On the scale provided by the Community Participation Group of the United Kingdom for All Network (1991), it implies the third highest level. This implies that a plan was presented to them, which was adjusted in accordance to their input.
- No VCWs felt they had been excluded from planning for CBR; i.e. told nothing or even only received information on planning for CBR.
- Two (2) of the VCWs did not answer the question.

According to the scale of the Community Participation Group of the United Kingdom for All Network (1991), it would appear that the level of participation of the VCWs was moderately high. The VCW is a central figure in the implementation of CBR activities and an important link in communication between the community and the rest of the health system and other sectors in the community. It is appropriate that the VCWs level of involvement in the planning of CBR was found to be moderately high, as this would influence the effectiveness and the operations of the programme directly. The VCWs high level of activity is also supported by the reference to the VCW's role by the other key stakeholders, e.g. clients, community leaders and health and rehabilitation workers.

3.4.4 Areas and level of community leader participation in management of CBR

People like headmen, chiefs and councillors are regarded as community leaders who serve in significant committees in the community. Community leaders are responsible for the status of development within the community. CBR is therefore only one of the aspects they need to coordinate within the community.

As in the case with the clients and the VCWs, community leaders' understanding of CBR, their attitude towards it and their level of planning of relevant CBR activities for their communities will have a major impact on participation of the community in CBR.

3.4.4.1 Community leaders' understanding of participation in CBR

Table 3.14 shows a breakdown of what the community leaders understand by community participation in CBR.

Table 3.14 Community leaders' understanding of community participation in CBR

UNDERSTANDING OF PARTICIPATION IN CBR BY COMMUNITY LEADERS	TOTAL
General and specific assistance for PWDs: To help with IGP for the disabled people within the community and to help PWDs to help themselves. – Looking into their problems and finding solutions; – Empowering PWDs; – Teaching them good ways of living; – Bringing rehabilitation to people, e.g. aids and appliances.	11 (61%)
Contribution to the education and to the change process required to change attitude to disability and PWDs: To teach people about accepting PWDs and other chronically ill people.	2 (11%)
As teachers, we organise and create awareness in people to give help to people in need.	1 (5%)
Involvement in activities to provide CBR services in the community: CBR requires community involvement in helping PWDs, reduce negative attitudes and working with them to help themselves, e.g. PWDs are like anyone else. Stops community from hiding PWDs.	7 (39%)

n = 18

(Respondents gave more than one explanation).

The community leaders that were interviewed tended to understand community participation as contribution and collaboration in participation. Less emphasis was placed on the aspect of compliance in participation. In this aspect, the client and other community members would be required to understand the issue at hand and comply with an agreed-upon course of action.

In the focus group discussions, community leaders said they understood participation as: *"a process of understanding the way they as a community live, helping others and themselves within the community to achieve a common objective through training and support to do their own thing"* (Direct quote from raw data).

They emphasized that participation entails cooperation between community members and helping them to develop as a community. Community leaders further emphasized the need for community education on the concept of participation, before it can be achieved. They furthermore emphasized that leadership needs to be in a position to teach the concept so that the community can ultimately cooperate and work together with them to carry out projects.

3.4.4.2 Community leaders' attitude to disability issues

Community leaders' attitude towards disability would affect the manner in which they participate in CBR, or as leaders, affect and influence participation within the community. Identification of the community leaders' perception of the responsible party for PWDs can provide an indication of their attitude towards disability.

Table 3.15 should be read across only, because the community leaders were asked to give their opinion about each group's responsibility for the PWD:

Table 3.15 Community leaders' perception of the responsible party for PWDs

RESPONSIBLE	TOTALLY	PARTIALLY	NOT AT ALL	TOTAL
Community	7 (53%)	6 (46%)		13
Government	4 (33%)	8 (67%)		12
Individual	1 (11%)	7 (78%)	1 (11%)	8
Family	7 (58%)	4 (33%)	1 (8%)	11

n = 18 (Community leaders could give more than one answer).

Fifty three percent (53%; n = 7) of the community leaders felt the community and the family should hold total responsibility for the PWD, while only thirty three percent (33%; n = 4) felt the government should have total responsibility. Sixty seven percent (67%; n = 8) community leaders felt the government have partial responsibility and forty six percent (46%; n = 6) and thirty three percent (33%; n = 4) felt the community and family respectively should be partially responsible. From the results it is clear that the community leaders ascribe more responsibility to the community and the family and less to the government that they represent. However, the community leaders did not leave total responsibility on the individual.

It is important to explore those community leaders who felt that the community was totally responsible for caring for the PWD, as this position can result in abdication on the part of leaders. When the opinion of only those community leaders who incorporated CBR into their community development plans were considered, the following tendency was noticed (community leaders could indicate more than one answer):

- Seven (7) of the eleven (11) respondents who incorporated CBR into community development plans felt that the community was totally responsible for the plight of the PWD.
- Eight (8) of the eleven (11) respondents who had incorporated CBR into the community development plans felt the government was partially responsible for the plight of the PWD.
- Six (6) out of eight (8) felt the family was partially responsible.

Analysing only the opinions of those community leaders who had already showed a positive attitude towards CBR, the major tendency corresponded with some of the major tendencies in the opinion of the whole group of community leaders; i.e. that the community is totally responsible, and the government and family are partially responsible for caring for the PWD.

3.4.4.3 Areas in which community leaders participate in CBR

The community leaders were asked to indicate who from the community were (from their own experience) involved in the CBR programme. Eighty nine percent (89%; n=16) of the community leaders reported the following key role-players as being involved: local leadership, PWDs and their families, local health staff and the VCW. They asserted *"PWDs are now more active and try to help themselves. They are less passive than they were previously"* (Direct quote from raw data). Two (2) community leaders reported the involvement of PWDs in organisations for the disabled. Activities that indicate the participation of community leaders in CBR are shown in Table 3.16. In the focus group discussion, community leaders explained that in the actual planning process, the direct input of PWDs was not actively sought.

Table 3.16 Activities indicating community leaders' participation in CBR

CONCEPT – COMMUNITY LEADERS' INVOLVEMENT IN CBR	YES, INVOLVED
Facilitating contribution of materials	7 (38%)
Facilitating contribution of manpower	10 (55%)
Facilitating contribution of money	7 (38%)
Participation in building	5 (28%)
Participation in education projects	2 (11%)
Negotiation on behalf of PWDs	7 (38%)

n = 18 Community leaders could give more than one answer.

According to Table 3.16, facilitation of the contribution of manpower, materials and money and negotiation on behalf of PWDs seemed to be the most common ways for community leaders to contribute to the CBR programme implementation.

Other “organisational” contributions by community leaders were also made, such as intervening on behalf of PWDs and carrying out administrative duties. Only one (1) community leader said he never contributed to CBR programmes. Table 3.17 indicates the specific ways in which community leaders contributed towards CBR.

Table 3.17 Specific contributions by community leaders

CONCEPT – SPECIFIC AREAS OF CONTRIBUTION	TOTAL
• Raised money / manpower and material to: ◦ Build up poultry centre for PWDs; ◦ Provide material for projects; ◦ Provide land for projects; ◦ Provide seeds for IGP; ◦ Establish community associations and societies and draught power; ◦ Establish DURA – “Zunde ra Mambo” (communal granary); ◦ Mould bricks; ◦ Mobilise collection of sand for building where PWDs are involved.	2 (11%) 9 (50%)
• Intervened when PWDs were being stigmatised, e.g. at the well.	1 (5%)
• I have committed myself as secretary of the Community Rehabilitation Committee. Duties include: Give moral support; visit PWDs to assist them; am an <i>ex officio</i> member of all committees, including those for PWDs, and help when called upon.	3 (17%)
• Have given it thought but have no resources and when I approach the nurses, they only write names down.	2 (11%)
• Rehabilitation Department have not come back although we have continued negotiating with people.	2 (11%)
• Community leaders not involved.	4 (22%)

n = 18 (Community leaders could give more than one answer).

The contribution of community leaders can be divided into three main categories:

- Contribution of material goods;
- Management intervention; and
- Facilitating processes that help PWDs.

Three percent (3%; n=4) of the community leaders reported that they were not involved.

Although the community leaders reported contributing to the programme as shown in Table 3.17, much of the help they reported were on an individual basis to individual

cases. Where manpower was required for assistance/projects, the community leaders reported that they used Community Development Committees to mobilise participation. In the Silobela area, KweKwe district, the community leaders gave a more integrated account of their assistance at Community Development Committee meetings where they outlined their activities as follows:

- Discussion of disability issues and their right to land;
- Problem analysis during meetings;
- Fund raising;
- Project promotion;
- Education of other community members;
- Contribution of materials;
- Encouragement of PWDs to work for themselves and not expect handouts.

The community leaders regarded the Community Rehabilitation Committee as an important body of support for the PWDs in the community, in collaboration with the Community Development Committee. The people who are members of the Community Rehabilitation Committee are indicated in Table 3.18.

Table 3.18 Community Rehabilitation Committee membership

MEMBERS	NO.
Village community workers	13
Ordinary members of the community, including PWDs	12
Community Leaders	12
Others e.g. businessmen, leaders in other sectors such as the church and clubs	11

Those who reported that they have a Community Development Committee in their area said they viewed its functions as follows:

Table 3.19 Functions of the Community Development Committees

FUNCTION OF THE COMMUNITY DEVELOPMENT COMMITTEE	TOTAL
Social and economic issues and all developmental issues, e.g. - Advice on projects; - Fair distribution of resources; - Address problems as they arise. Assist with integration of PWDs into community.	7
Assist in the development of community health programmes: - Ensure good health facilities to everyone.	12
To assess problems within the community and see if they are working well, e.g. - Supply of water to the community, including PWDs; - In their plans, but no action yet; - No resources but good initiatives.	6
Seek donations on behalf of PWDs and addressing their care / assistance.	3
Identify and refer patients to hospital.	1

n = 18

The functions of the Community Development Committees and the Community Rehabilitation Committees were in line with the Rural District Councils Act (Zimbabwe Ministry of Local Government and Rural Resettlement 1999). PWDs and disability issues are not explicitly mentioned in the RDC Act, but the community leaders included this function as part of their brief. Concerning the time frame of this study, their functions in assisting PWDs were comprehensive in that they covered the social, economic and physical needs of the PWDs. Although caring for or assisting in the psychological needs of PWDs were not explicitly mentioned by the community leaders, it may be implied in the category mentioning the assessing of problems within the community and meeting the challenges (Table 3.19).

3.4.4.4 Community leaders' level of involvement in CBR

Along with all the activities the interviewed community leaders said they were undertaking, the researcher also wanted to determine the involvement of the community leaders in the planning of CBR.

Fifty seven percent (57%; n = 8) of the community leaders who incorporated CBR into their Community Development Committee plans reported that they themselves were part of the problem identification and planning process of CBR. They rated themselves

as having community control (Highest level on the Community Participation Group of the United Kingdom for All Network 1991) in the community participation process. Two (2) out of fourteen (14) said the MOH presented the CBR programme and they had some power delegated to them to decide how it should be implemented (second highest level on the Community Participation Group of the United Kingdom for All Network 1991), while three (3) felt the MOH asked their opinion on the presented plans (third highest level on the Community Participation Group of the United Kingdom for All Network 1991). None of the community leaders reported having been told nothing about planning and implementation of the CBR programme. The opinion of the community leaders was that their participation and involvement could be rated as fairly high.

In the focus group discussions, some community leaders were unaware of the existence of the Community Development Committee. In the one district, community leaders expressed their frustration as follows: *"In general we are happy with our level of involvement, but are unhappy because we can do what we can with our hands but we need concrete resources like cash for most activities. What we get from the provincial and central level of Government is inadequate and the mechanisms are slow"* (Direct quote from raw data).

During the focus group discussions, some of the community leaders from the same district felt they had a very low level of involvement in planning for CBR. Some of the leaders reported that since the CBR programme started, they had done nothing to participate, although they admitted receiving information through the VCWs and Community Rehabilitation Committee. These leaders asserted, *"There is really no organisation which looks after the disabled"* (Direct quote from raw data). This statement implies that the leaders believed the responsibility for participation or for caring for the PWD, might lie with 'someone else' outside the community.

These same leaders reported participation and involvement as individuals, but not in their capacity as leaders. In another district, the leaders reported that they worked and collaborated well with the Health Department through meetings. However, their lack of awareness of the Community Development Committees and Community Rehabilitation Committees working with PWDs showed the inadequacy of their collaboration with key structures that facilitate CBR and participation in CBR. In one district, community leaders felt they were participating well and collaborating through meetings held at community level.

3.4.5 Areas and level of health and rehabilitation workers' participation in the management of CBR

This section outlines the results of the health and rehabilitation workers' understanding and areas of community participation. The results of members of the community that were consulted by the health and rehabilitation workers are presented in Table 3.22. The health and rehabilitation workers' perception of the community's level of control in the CBR process is presented in Table 3.23.

3.4.5.1 *Health and rehabilitation workers' understanding of community participation*

In Annexure 4, health and rehabilitation workers were asked what they understand by the term or concept community participation. Table 3.20 shows the results:

Table 3.20 *Health and rehabilitation workers' understanding of community participation*

HEALTH AND REHABILITATION WORKERS' UNDERSTANDING OF COMMUNITY PARTICIPATION	TOTAL
Contribution of material, manpower and money: Community participation is the contributory role of the community as a whole or through selected representatives in programmes or projects undertaken. The contribution may be material or in the form of labour or money.	6
Involvement in activities to provide services in the community: Involvement of the community in all services and health activities, e.g. rehabilitation available to them.	4
Collaborative role in planning, implementation and evaluation of CBR: Active participation of the community in the planning, organising and implementation of all health activities in the community; i.e. community will decide what will happen to them; identifying their problems and empowering them to make a decision.	13

n = 15 (Respondents could give more than one answer)

The health and rehabilitation workers' most popular explanation for the concept 'active community participation' was that it entails participating in the planning, organising and implementation of all the agreed-upon activities by the community. These health and rehabilitation workers said the community would decide on what will happen to them, i.e. identify their problems, and this will empower the community to make decisions. This opinion reflects a collaborative process and should be the ideal of CBR.

Twenty six percent (26%) of the weighting of the answers by the health and rehabilitation workers were given to 'the community's contribution to the CBR process', while seventeen percent (17%) of the weighting of the answers explained community participation as a more collaborative process. Contribution towards CBR alone is inadequate in terms of participation to be effective. It tends to promote a passive role by the recipient (which is the client). One could say the health and rehabilitation workers' understanding was balanced in terms of their explanation of participation within the three aspects of compliance, contribution and collaboration. In conclusion, it can be said that the majority of the health and rehabilitation workers had a good understanding of their role in community participation in CBR.

3.4.5.2 *Community stakeholders consulted by health and rehabilitation workers*

Health and rehabilitation workers who participated in the study were asked whom they consulted when planning for CBR. They reported having consulted all the key stakeholders (community leaders, VCWs, clients, other health and ministry departments) in planning and implementing CBR.

Table 3.21 shows the stakeholders that were consulted by the health and rehabilitation workers. All the health and rehabilitation workers (n=15) had worked with the community leaders, while all but one (n=14) involved the VCWs in the CBR process. Sixty percent (60%; n=9) of the health and rehabilitation workers, of which twenty percent (20%; n=3) were rehabilitation personnel, involved the PWDs and their families. Sixty percent (60%; n=9) of the health and rehabilitation workers consulted PWDs, and ninety four percent (94%; n=14) consulted community leaders. This was supported by the results shown in Table 3.23, where two major key stakeholders, e.g. community leaders and VCWs, reported that they felt they were involved in the planning and the client reported a lesser degree of involvement.

Table 3.21 Persons consulted by health and rehabilitation workers when planning for CBR

PERSONS CONSULTED WHEN PLANNING FOR CBR	TOTAL (no of health workers that consulted given target group)
Community leaders	14 (93%)
Village community workers	15 (100%)
PWDs and family	9 (60%)
Other health departments	8 (53%)

n = 15

Health and rehabilitation workers reported that the Rehabilitation Department plays a leading role in the process of planning for CBR, while other health and rehabilitation workers such as nurses, doctors and environmental health technicians (EHTs) support the community members involved in CBR.

These results coincide with the information gathered from the CBR reports and procedures. From these reports, it is clear that all the health and rehabilitation workers were educated on the process of CBR. That explains why they understood the full CBR process and identified their role in the management, implementation, logistical support, educational awareness and social mobilisation aspects of the CBR process. The health and rehabilitation workers' understanding of CBR should be at a high level so that it does not compromise their position in facilitating community participation.

Health and rehabilitation workers emphasized the need for the community to be involved in any programme, and not only CBR or any facet of the CBR process. They asserted: *"This results in the community and the PWD feeling important"* (Direct quote from one participant). They reported that they identified the problems pertaining to disability together with all stakeholders, and planned, implemented and continuously evaluated the CBR program in a joint effort with the clients. This joint effort (community participation) was achieved mainly through discussions at meetings and not by implementing any particular participatory tools.

3.4.5.3 Health and rehabilitation workers' view of the level of participation and community involvement

The health and rehabilitation workers were asked to rate the level of the community's participation in the management of CBR. This question was in contrast with the clients,

VCWs and community leaders, who were asked to rate their **own** level of participation in the management of CBR. The reason for this is that health and rehabilitation workers are involved in the planning, implementation and facilitation of all stages of the CBR program. It is thus expected that their own participation in CBR is high. Their specific role in CBR is to facilitate the clients', VCWs' and community leaders' participation.

The result of the health and rehabilitation workers' rating of the community's participation in the management of the CBR program is described in Table 3.22.

Table 3.22 Health and rehabilitation workers' rating of level of community participation

RATING OF LEVEL OF COMMUNITY INVOLVEMENT OF HEALTH AND REHABILITATION WORKERS	Rating
Community have control	5 (33%)
Some power delegated	7 (47%)
Plans jointly	3 (20%)

n-15

A third (33%; n=5) of the health and rehabilitation workers were of the opinion that the community has control over the CBR process. This implies a high level of participation by the community. Forty seven percent (47%; n=7) of the health and rehabilitation workers were of the opinion that the community has some control in CBR management through the delegation of power. This implies a moderate rating of two (2) on the scale of the Community Participation Group of the United Kingdom for All Network (1991).

In explaining their level of participation, the health and rehabilitation workers referred to the MOH's outline of the problem of disability in the communities, its guidelines on how to develop a CBR programme and their request to the community to make decisions on how to carry out CBR. Twenty percent (20%; n=3) of the health and rehabilitation workers felt they had planned jointly after compiling a tentative plan, which can be graded as moderate participation.

Table 3.23 shows the mean score of participation as perceived by each group at a 10% significance level:

Table 3.23 Mean level of community participation of all stakeholders

GROUPS	MEAN SCORE
Village community worker	1.8
Health and rehabilitation workers	2.0
Community Leaders	2.1
Clients (PWDs)	3.0

$p = 0.01$

A non-parametric test, the Kruskal Wallis test, was used to compare the mean score of the different groups on the question of involvement in planning, control and participation in CBR. A significant difference was found between the clients' opinion of their involvement and that of the VCWs and of the community leaders, at 10% significance. A difference in opinion was also found between the clients' opinion of their involvement and the health and rehabilitation workers opinion of the clients' involvement. At 5% significance, a difference in the level of involvement was found between the clients and of the community leaders.

The conclusion that can be reached here is that the clients, who have attained a mean score of three (3), have less involvement and control in the management of the CBR programme in comparison to the community leaders, VCWs and health and rehabilitation workers.

From all the results presented, it was ascertained that the communities in the three sample districts were participating to some extent in the management of CBR. Community leaders as representatives of the community were asked about their perception of community support, as this implies a manifestation of community participation. This will be discussed further under the next heading.

3.4.6 Practical areas that indicate participation and support by community to disability issues and clients in general

Table 3.24 outlines the community support systems that are in place for the PWDs and disability issues as perceived by the community leaders.

Table 3.24 Support systems within the community for PWDs as perceived by community leaders

OPINION OF COMMUNITY LEADERS ON SUPPORT SYSTEMS IN THE COMMUNITY	TOTAL
Most NGOs and Community Development Committees remain in the background or are not active. There is a need for continually reminding us to recognise the need and take responsibility.	6
NGO Plan International (an international NGO whose mandate is relief and development), is active in facilitating basic needs such as food and education. The Epilepsy Foundation is not active in awareness and education on epilepsy.	3
NCDPZ and ZPHCA (Zimbabwe Parents of Handicapped Children Association) are trying to help. Through the Community Rehabilitation Committee, people have collected money although outcomes have not materialised.	8
No support structures available so far.	4
PWDs now more active and try to help themselves and are not passive anymore.	1

n = 18 (Respondents could give more than one answer)

Only sixteen percent (16%; n=3) community leaders were aware of the presence of Plan International whose contribution to PWDs had been more on the aspect of social welfare in relief through the provision of food and education. Forty four percent (44%; n=8) community leaders were aware of the existence of the Zimbabwe Parents of Handicapped Children Association and the efforts of the Community Rehabilitation Committee. Sixty six percent (66%; n=12) community leaders were not aware of any support systems and felt the NGOs within the community remained passive in the background.

As outlined in Section 3.4.2.3, Table 3.10, very few PWDs and their caregivers were aware and belonged to community initiatives such as the DPOs and NGOs. They either did not exist, or they were unfamiliar to the PWDs and their families in these areas.

In answer to question 10, Annexure 4, sixty seven percent (67%; n=11) of the community leaders reported the emergence of the Community Rehabilitation Committee as the main support system that emerged in the community. Only two percent (2%; n=3) reported the inclusion of rehabilitation in the community development agenda in contrast to seventy eight percent (78%; n=14) (Section 3.4.3.2) who had reported including CBR in their development agenda. Twenty eight percent (28%; n=5) viewed NGOs as a support system for PWDs and not as a means to facilitate client participation.

The presence of community support systems was regarded as a good indicator of participation by the community in CBR management. The presence or absence as well as the subsequent use of community support structures are indicators of a successful and effective level of participation by the community. The community support systems are still poorly developed. The community leaders viewed the Community Rehabilitation Committee as a main support structure for community rehabilitation issues. The community leaders did not regard the inclusion of CBR in the community development agenda as a support system, although in another question they included CBR in their community development agenda. DPOs and even less so, NGO's, are not regarded by community leaders as a source of support by PWDs.

3.5 THE INFLUENCE OF THE DYNAMICS AND LINKS BETWEEN KEY ROLE-PLAYERS ON COMMUNITY PARTICIPATION IN THE MANAGEMENT OF CBR

A broad term such as 'links' is used deliberately at this stage of the study to limit bias from the researcher's perspective to suggest the nature of possible links to participants. In this case, links are referring to the structures in place and used by role-players to achieve participation. In addition, the flow of communication within the structures at all levels of management and the formal and informal dynamics presented within this structure are all considered part of the links. The dynamics refer to the actual relationships between the different role-players and the way in which they relate to each other. The dynamic interaction between stakeholders relates to the flow of information in order to explore the nature of the contact between:

- the clients and all the stakeholders;
- the VCWs and health and rehabilitation workers;
- the clients and community leaders;
- the health and rehabilitation workers and the community, including clients.

Oakley (1991, p. 10) state that *"the practice of participation does not occur in a vacuum"*. He asserts that there are many contextual issues that will influence participation. Among the obstacles to participation that he outlines are the structural obstacles, which involve the political system in all its facets. The political system influences the local mechanisms for administration and decision-making and in turn

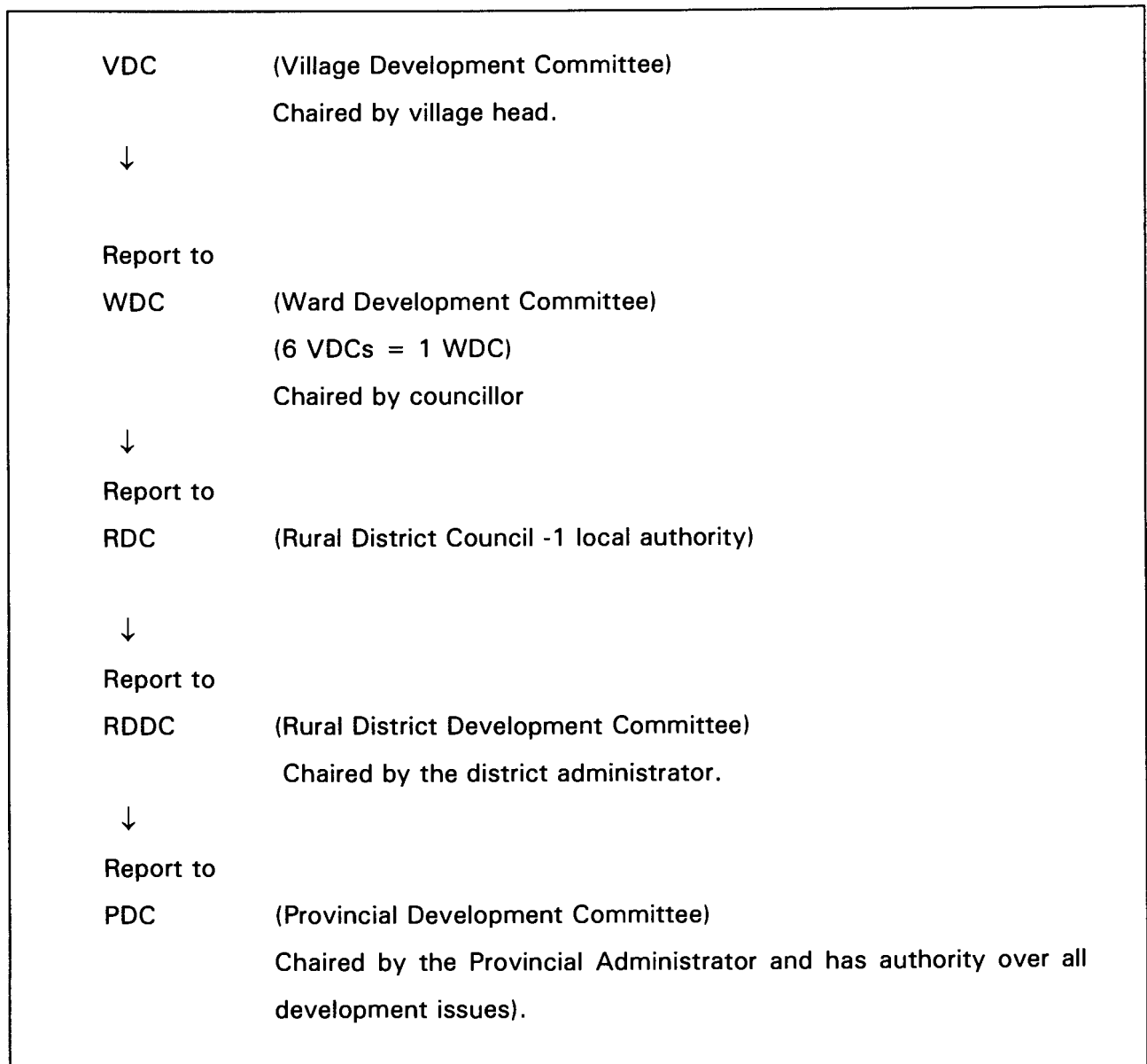
these mechanisms influence the dynamics and links of the people functioning within the areas served by these systems.

With this in mind, the researcher therefore investigated and analysed the underlying mechanisms, dynamics and links that would influence participation. The dynamics, community structures and communication channels in the selected communities were established by investigating and analysing the administrative structures (defined by the Government) that would be utilised by communities in their own development issues. Since community developmental issues fall under the local government, the policy documents that clearly outline the communication and administrative structures in this Ministry was analysed to gain insight into the underlying systems that can influence participation. The most important document for this purpose (pointed out by the Provincial Administrator's Office) was the Prime Minister's Directive of 1999. In this document, the official community structures and communication channels for use within the community are outlined.

3.5.1 Official link in community and rural development

A study of the Prime Minister's Directive of 1999 revealed clear official community structures and communication channels as shown in Figure 3.6, which would enhance community participation, development management and communication. Community links to enhance community projects in their development and management as well as participation are outlined in Figure 3.6.

Figure 3.6 *Official community structures and communication channels between the different community development levels*



The Prime Minister's Directive of 1999 is supported further by the Rural District Council (RDC) Act of 1999 and the Provincial Council and Administration Act of 1985. The RDC Act outlines the services that must be provided and facilitated by the RDC. This act outlines all services relating to community development such as social services, roads planning, agriculture and conservation, human resources, administration and finance. The Health, Education and Social Welfare Departments are placed under the Social Services Sector under the authority of the Provincial Administrator. The Traditional Leaders Act of 1999 recognises the role of the Village Development Committees and the Ward Development Committees in the provision, planning and management of

community development issues. One of the duties of the village that is described in section 12 of this Act is: *"To preside over the Village Development Committee, to coordinate its work and to submit the resolutions and plans of that committee to the village assembly for consideration and where appropriate implementation"* (Zimbabwe Ministry of Local Government and Rural Resettlement 1999, p. 22).

Services for disadvantaged groups, where PWDs are included in a category of their own, fall under Social Welfare. Curative, preventive and environmental services are placed specifically under the auspices of the Health Department. There was no evidence in the documents studied of an integrated community development approach to poverty issues and such issues as dealing with PWDs.

Information from the Rural District Council plans were integrated into the provincial plan to investigate the extent of integration of rehabilitation in the Council plans. As an example, the Rural District Council Plan of Mberengwa was studied. In all areas the Council outlined its main capital projects. Most of the projects were related to structural development such as dams, boreholes, toilets and equipment. Even the rehabilitation centre alluded to by the community in Mberengwa was listed. CBR was listed under the Social Development Committee and the main remark was that *"its the major source of funding [for CBR] being donor sourced, i.e. SIDA being the main donor "* (Ministry of Health 1990-99 Annual Plans, p. 6). There was no reference regarding resource input from the community. The non-tangible managerial issues regarding CBR and participation in CBR were not mentioned.

The adoption of CBR plans and other related activities into the district's annual plan are positive signs that the official structures and dynamics of development within the district are incorporating the concerns of PWDs officially into the plans. However, from the documents studied (Prime Minister's Directive of 1999, Rural District Development Plan of 1999, Mberengwa District Plan), there is no clear sign of integration of disability issues into mainstream community development. From the questionnaire (Annexure 4), the community leaders said they had incorporated CBR and disability issues into their Community Development Committees but had contributed mainly material and provided labour towards the projects. The integration of disability issues into official documents was not evident, however, at local level, the community leaders incorporated CBR as shown in Section 3.4.4.2.

After studying the documents (the relevant documents are referred to in the following relevant paragraphs), a discussion was carried out with officers in charge of monitoring the development plans from the capacity building unit in the Provincial Administrator's Office. The officers were asked what planned activities and communication channels from their experience, were evident between disability issues and community development plans. As a unit monitoring development at community level, the officers said they hardly got reports on issues to do with disability or health and that this information went directly to its beneficiaries, i.e. the Community Development Committees, Community Rehabilitation Committees and Ministries of Health or Social Welfare.

Some of the reasons given for this lack of feedback on disability issues were:

- 1) The Rural District Council cannot "touch" or "see" the tangible benefits of disability interventions.
- 2) In the planning phase, the key players are not channelling the projects through the Rural District Council, therefore funding was not forthcoming, because the projects would not have been included in initial budgets. The officers explained that all projects planned at village and ward level must be channelled through the Rural District Council in order to get recognition at all levels of operation. Once missed at the primary level the information on these projects will not filter through the entire system.
- 3) Poor communication structures and channels (who reports to who, when and how reporting should take place) between the different sectors and technical ministries such as the Ministry of Health (MOH), Ministry of Social Welfare, Ministry of Agriculture and the Rural District Council Committees. The officers reported that there was no real forum for these Ministries to meet and discuss the comprehensive and overall plan for the district.

In conclusion, it would appear that the administrative structures supporting coordination, communication and management in the areas under study are clear. The integration of disability issues into these structures and implementation of this into action has remained fragmented. There is evidence of some integration of disability issues in the MOH at community level, which was not the case before. However, there

is no evidence of communication and integration of disability issues in the mainstream of development planning, management and administration under the Rural District Council. This is a situation that is present in spite of the high level of CBR activity at community, village and ward level.

3.6 RETROSPECTIVE STUDY OF EXISTING RECORDS WITHIN MINISTRY OF HEALTH

3.6.1 Introduction

At provincial level, the records available at the time of the study were the MOH Policy and Strategy documents of 1980, 1995 and 2000. The operational departmental annual plans were drawn up from the national strategic plans as well as from input from the community. All these documents outlined the strategic plan for CBR, which basically direct the CBR programme at operational level. The researcher's aim was to establish if these plans were available and if they were formulated in response to the needs generated from the community.

Statistics at provincial level include the consolidated statistics from the Health Information System, compiled from information collected at clinic level. The researcher wanted to establish the extent to which data on clients from the community was captured at the provincial level and how it was used for planning. These statistics are not sufficiently sensitive to disability and injury related data because of the way the data collection was designed.

In light of this, the researcher limited the analysis of the records to determining the extent to which the policies and plans facilitated CBR and participation of key players in the CBR programme.

3.6.2 Records at provincial and district level

The researcher limited the study of records to those within the Rehabilitation Department at provincial level because:

- The policies available in the Rehabilitation Department would reflect and would be representative of the national and provincial policies;

- The plans would be derived from the policies, records and information from the community;
- All the records available in the Provincial Health Information System will have been submitted to them by the Rehabilitation Department. The available documents that were thus analysed for the purpose of this study were:

- **Policy documents:**

The rehabilitation and health departments at provincial and district levels had copies of the PHC policy and MOH Strategy Plans of 1980, 1985 and 2000, which outline the CBR approach as a national policy.

- **Planning documents:**

The Province had guidelines and standard procedures for the implementation of CBR for the districts and copies were distributed at district level in all three districts.

All provincial and district rehabilitation plans dating back to 1994 include CBR. The three districts that participated in the study sample had current annual plans for rehabilitation, including CBR, available.

- **Records:** Quarterly statistic forms from the CBR areas, which provide information on the number of referrals of clients to various specialised services (e.g. services for visually handicapped and hearing impaired people, Agritex, income generating projects, social welfare and orthopaedic services) were available. The statistics are incorporated into the mainstream rehabilitation statistics from the referring district hospital together with the report of other rehabilitation services such as rendering services at outreach points, in and out patients, or special clinics (for instance orthopaedic clinics and clinics for cerebral palsied children or burnt patients), and submitted as monthly rehabilitation statistics. At the time of studying the records, the provincial therapist was in the process of building a database of clients in the CBR areas and their health status in terms of progress and management. It was difficult, however, to ascertain the current figures of the clients being actively followed up in

the CBR program by the health and rehabilitation workers or VCWs, from these records. The number of clients on the current register would give an indication of the numbers of clients under active follow-up and treatment, even including the static services such as rehabilitation departments at district level. The level of collaboration between health and rehabilitation workers and VCWs within the various districts could not be extrapolated from the statistics. It was possible to obtain the baseline CBR statistics from the implementation reports in each of the sampled districts.

Table 3.25 shows the type of CBR statistics that could be identified from the current rehabilitation records.

Table 3.25 CBR statistics from VCW client records

DISTRICT	TOTAL NO. OF CLIENTS IDENTIFIED AFTER SCREENING DURING CBR IMPLEMENTATION	CURRENT CLIENTS ON REGISTER
Gweru	160	Difficult to ascertain
KweKwe	207	
Mberengwa	300	

In conclusion, within the MOH and the Rehabilitation Department, rehabilitation and disability issues have been integrated into the policy and strategic documents. At CBR programme level, the data gathered by VCWs and health and rehabilitation workers (including rehabilitation workers) provides the key players (clients, VCWs and community leaders) as well as the health and rehabilitation workers with insight into the number of clients participating in the program and their geographical distribution. The development of a client database for CBR that will provide further insight into specific issues regarding participation and management of the clients, is in process. The existing records reveal that some statistics are going through the health information system and there is some inclusion of rehabilitation issues into mainstream health activities. This situation is a step in the right direction for ensuring that rehabilitation is mainstreamed at all levels of the health system, thus becoming more visible to policy and management decision makers as well as to the community, and attracting the correct support in all areas. However, the current position is that all budget support for CBR programmes is predominantly donor funded.

3.6.3 Records at community level

At community level, the records available include the following:

1. Chronic disease registers kept at clinic level. These records were not fully updated in KweKwe and Mberengwa districts at the time of the study.
2. Rehabilitation registers in rehabilitation departments. These records were available in all three districts in the sample selection. The rehabilitation registers contained the clients' socio-demographic data, diagnosis and rehabilitation assessment and treatment information.
3. Unstructured records kept by the VCWs in exercise books. From each district, at least three record books from VCWs who had recorded information on clients and who had the books with them during the data gathering for this study, were reviewed. These contain the client's name and his/her problem, the intervention being undertaken and the number of review visits per client per month.
4. Structured forms at community and district level. The forms contain client numbers and diagnostic categories for the collation of district rehabilitation information. Other structured forms from the OMAR (Operations Monitoring and Records Analysis) system were available but not in use by the VCWs.

VCWs who were interviewed said they keep records in exercise books, in which they record client details and problems. In all three (3) districts studied, the use of exercise books in which client details were kept, was evident. The VCWs were aware of structured forms based on the OMAR system. The prototype of the forms were available and in Gweru and KweKwe, VCWs were in the early stages of being trained in record keeping on these forms, while in Mberengwa, VCWs did not expand on this.

One (1) clinic in each of the districts serving as CBR areas was randomly selected and visited by the researcher. The aim was to determine which records were available and used for facilitating contact between the community and the health and rehabilitation workers. All three (3) clinics had chronic disease registers in which the health and rehabilitation workers recorded, amongst others, information regarding PWDs. It was evident that this was not an updated list/record and seemed to be mainly a list of clients

on some chronic medication. On seeking clarification from the clinic staff for this observation, it was explained that those clients who were not on medication and requiring rehabilitation were not listed or recorded. This situation questions the validity and reliability of the chronic diseases register as such. The Provincial Rehabilitation Department would need to revisit the adoption of this register as a means of capturing disability data at clinic level.

The results of studying the records and contacts (Annexure 5, questions 5, 6, 7, 8, 10) between VCWs and health and rehabilitation workers imply a high level of information exchange through meetings, outreach, home visits and clinic visits. It was however evident that written records are being used inadequately for improving participation by the key stakeholders, because it does not capture activities that reflect their participation. The exchange of information between VCWs, health and rehabilitation workers is indicated in the following sections.

3.7 FORMAL AND INFORMAL COMMUNICATION BETWEEN THE KEY STAKEHOLDERS (CLIENTS, VCWs, COMMUNITY LEADERS AND HEALTH AND REHABILITATION WORKERS)

3.7.1 Introduction

One of the aims of this study is to explore the dynamic interaction between stakeholders, i.e. the flow of information, in order to explore the nature of the contact between:

- The clients and all stakeholders;
- VCWs and rehabilitation staff;
- Clients and community leaders;
- Health and rehabilitation workers and the community, including clients.

In this regard it is also important to identify the specific collaboration between the VCWs and rehabilitation staff with regard to:

- Planning for CBR;
- Identification and facilitation of community contacts;
- Enhancing functional ability of clients;

- Resource mobilisation for use in activities for CBR, e.g. training workshops, IGPs.

The formal communication structures outlined in the Prime Minister's Directive of 1999 are provided in Section 3.5.1. It is known that communication can be formal and informal. It was the aim of the researcher to identify which channels were being used, the exact nature of the contacts and how they were being used.

In seeking a clear picture of contacts within the community, the uses of key communication channels were explored to show the function of the official and unofficial channels and linkages. These are:

1. The use of the referral system by the clients to achieve rehabilitation objectives;
2. The function of the VCW as key operational person linking the VDC and the community members;
3. The contact/communication between clients and community leaders with regard to their needs at community level, and the resultant participation of the clients in community activities;
4. Health worker official and unofficial contacts with the community and activities that result from this communication and collaboration.

3.7.2 Contact and communication between VCWs and clients

The hierarchical referral system runs from village to clinic, clinic to district, district to provincial level and from there, if necessary, to the central level of health and other forms of care and support. Examples of other forms of care include social services, vocational services, specialised medical care (audiometry and orthotics), income generating and agricultural support. Fifty eight percent (58%; n=70) of the clients were aware of the referral system and used it, while thirty percent (30%; n=37) were not aware of the referral system and did not use it (Annexure 3).

The first contact in the referral system is the local supervisor (i.e. the VCW). Thirty four percent (34%; n=40) of the clients saw and had contact with the VCW once in two

months or less, thirty one percent (31%; n=38) had contact once a month and nineteen percent (19%; n=23) once a week (Annexure 3). In the focus group discussion, VCWs reported *"People come to us with problems or even new disabilities that they do not know what to do with"* (Direct quote from raw data). This implies that the VCW is not only an available contact but readily utilised by the community and PWDs in solving their problems. The VCW should be supported in all sectors involved in community development, in order to be more effective in this role and meeting the needs of the PWD.

The clients had spent a significant amount of time with the local supervisor (VCW) as shown in Table 3.13. Seventy four percent (74%; n=83) clients had spent between one and four hours per week with the VCW, and seven percent (7%; n=8) had spent one to three days per week with the VCW. The remaining nineteen percent (19%; n=21) had spent a varied amount of time, between thirty minutes per month to an hour per month, with the VCW.

3.7.3 VCW utilisation level of referral system

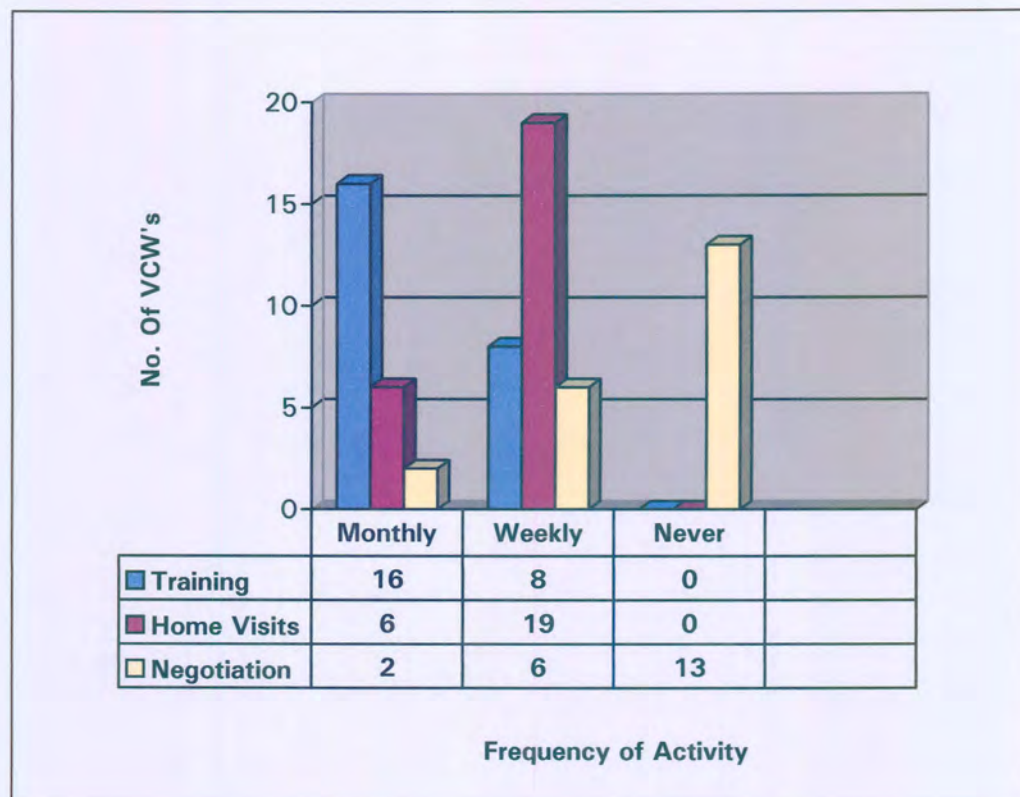
Sixty percent (60%; n=15) of the VCW's reported having one contact per month with rehabilitation personnel. Twenty percent (20%; n=5) reported two (2) or more contacts per month and the remaining twenty percent (20%; n=5) reported less than one contact per month. The study did not distinguish between the type of clients visited in each of the categories into which the client's condition was classified (refer to Table 3.1) or the geographical areas in which these visits took place.

Sixty percent (60%; n=15) of the VCW's referred six (6) and fewer clients per month to other sectors within the referral system, while forty percent (40%; n=10) referred ten (10) and more clients.

Figure 3.7 shows the type of activities VCWs engaged in during their contact with PWDs and the CBR program at community level:

Figure 3.7

VCW's rehabilitation and CBR activities



Sixty percent (60%; $n=15$) were involved in training activities during which they underwent training on a monthly basis, while twenty four percent (24%; $n=6$) did so on a weekly basis. This indicates that VCWs undergo a lot of training in their participation in CBR. All VCWs also frequently undertook home visits. More VCWs undertook home visits on a weekly basis than on a monthly basis. Home visits are very important and a well-used operation mode for contact and delivery of service though manpower incentives. This is illustrated by the fact that forty eight percent (48%; $n=12$) of the VCWs had spent 30 minutes per visit and fifty two percent (52%; $n=13$) had spent an hour or more per visit. Fewer VCWs had spent time negotiating with community leaders. Thirty two percent (32%; $n=8$) VCWs reported negotiating with community leaders or other relevant people on issues of need for clients.

The frequency of visits to clients is high and the length of time spent is adequate for a home visit. However, one would need to explore in a different study exactly what is being done during such a home visit.

3.7.4 PWD contacts with the community

Table 3.10 shows that ten percent (10%; $n=10$) of the PWDs were involved at community level in Disabled Peoples Organisations (DPOs), thirty six percent (36%; $n=44$) in IGPs and the majority, i.e. forty five percent (45%; $n=55$), in other community related activities and groups such as church based organisations. These are the organisational groups representing community initiatives that support the participation of the community and PWDs in community activities.

Client contact with any community-based organisation is considered a developmental milestone in participation at local level (Helander 1994). However, very few people with disability were aware and belonged to community initiatives such as the DPOs and Non-Governmental Organisations (NGOs). They either did not exist or they were unknown to the PWDs and their families. However, there is evidence from the results that some significant initiatives in supporting PWDs in IGPs exist. Forty five percent (45%; $n=55$) of clients indicated support and participation from community clubs and church related support systems. This is an important source of support and should be explored to determine whether it is consistent with CBR principles; i.e. is the approach PWD oriented, or, does it promote empowerment of PWDs? In conclusion it can be said that the impact of DPOs and NGOs is not felt at community level.

3.7.5 Interaction between clients and community leaders

Sixty seven percent (67%; $n=81$) of the clients interviewed have approached the Community Development Committee with specific needs. The response they received from the Committee is outlined in Table 3.26.

Table 3.26 Community Development Committee response to PWD needs

(This Table should only be read across)

AREA OF NEED	RESPONSE		
	<i>They helped</i>	<i>They did not help</i>	<i>They tried to help</i>
Mobility needs	12	4	7
Medical needs	23	6	8
Financial needs	9	8	6
Access to education	9	4	5
Accessing community amenities	14	4	7
Accessing social welfare	10	12	15
Total	77	38	48

n = 81

Clients could indicate that they approached the Community Development Committee with more than one of their needs. The numbers in the table represent needs.

On approaching the Community Development Committee, generally more clients were assisted than not. As shown in Table 3.26, nineteen percent (19%; n = 23) clients who approached the Community Development Committee were successful in accessing help for medical needs; seventeen percent (17%; n = 14) were successful in access to the community amenities; fifteen percent (15%; n = 12) clients' mobility needs were met; twelve percent (12%; n = 10) received access to social welfare, and eleven percent (11%; n = 9) received financial assistance and access to education.

There were more clients (15%; n = 12) unsuccessful in accessing social welfare and financial assistance than those who were successful (12%; n = 10). More clients were successful in access to education, mobility needs and access to community amenities than were unsuccessful. The areas in which clients had the least success in meeting their needs were social welfare and financial needs. In terms of participation, the community leaders were playing a significant role in solving the needs of PWDs. Of the eighty-one (81) who approached the Community Development Committee, forty seven percent (47%; n = 38) did not have their needs met.

On an organisational level, seventy eight percent (78%; n = 14) of the eighteen (18) community leaders said they have incorporated CBR into their community development programmes and said they have done this through one or more of the following actions:

- Developing a register and recording all PWDs in order to be able to respond to their needs, e.g. ploughing needs for their land, in which case the Community Development Committee would provide the draught power. Two community

leaders mentioned incorporating the PWDs into other community-based programmes such as the Community Home Based Programme.

- Help in the management of income generating and other development projects:
An example of the community centre in Mberengwa, where the community leaders were instrumental in mobilising the resources, was given. Other projects include the poultry project in KweKwe, where the community leader mobilised the raw materials and supervised the labour.
- The four leaders who did not include CBR in their community development projects said it was due to:
 - Lack of health education among community leaders;
 - People from the health sector who introduced CBR never came back for follow-up;
 - *"No one has brought problems to me"* (direct quote from raw data) – I have not discussed it with other community leaders. We have not fully realised the needs of PWDs.

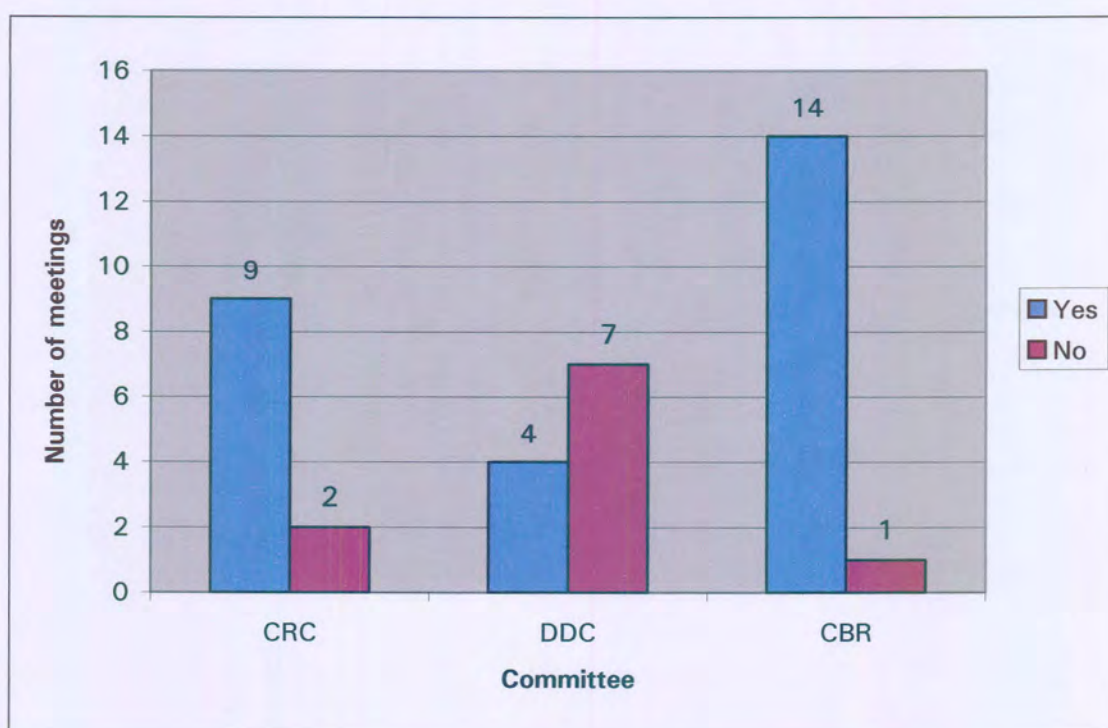
From Table 3.16, where the type of activities the community leaders were engaged in is discussed, it is also clear that community leaders have been involved in activities such as material contribution and organisational issues. They complained that the Rehabilitation Department and the nurses at clinic level did not follow up and follow through on some of their promised activities. They further suggested that there should be better feedback from the health and rehabilitation workers. Even if they could not attend meetings physically, they should send a letter or report on how far the agreed plans have developed.

CBR at this level is visible, accepted and integrated by community leaders. To enhance this visibility and integration further, it is important for the health and rehabilitation workers to follow through and manage their flow and frequency of communication better in order to sustain and enhance community leader participation.

3.7.6 Health worker contacts with the community

Ninety four percent (94%; $n=14$) of the health and rehabilitation workers interviewed reported holding meetings specifically to enhance CBR. Sixty percent ($n=9$) held meetings with the Community Rehabilitation Committee while only twenty seven percent (27%; $n=4$) held meetings with the District Development Committee with the aim to integrate, communicate and enhance the participation of other sector ministries into CBR. The results are shown in Figure 3.8.

Figure 3.8 *Meetings held by health workers at community level*



Health and rehabilitation workers held more CBR and Community Rehabilitation Committee meetings than District Development Committee meetings. It is important for better integration of disability issues into community development that they attend District Development Committee meetings, because it is the umbrella body for community development. CBR and Community Rehabilitation Committee meetings, although important, may enhance the development of the CBR programme in isolation from the rest of the community and important policy makers, and as such reduce participation of the leaders and other ministries.

3.7.7 Information generated from the community by health and rehabilitation workers for planning of CBR

From the meetings that took place at community level, the health and rehabilitation workers reported obtaining the following categories of information, and indicated whether they made use of it (Table 3.27):

Table 3.27 Information gathered from the community and used by health and rehabilitation workers

TYPE OF INFORMATION GENERATED	GOT IT AND USED IT	GOT IT AND DID NOT USE IT	DID NOT GET IT
Educational and information needs	7	1	4
Income generation needs	4	3	7
Clinical needs	4	1	5
Vocational needs	1	3	6

n = 15

More health and rehabilitation workers received information on the community's need for education and information than for clinical services, income generating projects and vocational services. On the whole, more health and rehabilitation workers did not receive any information in the different areas of needs in comparison to those who gathered the information and used it.

Table 3.28 and Table 3.29 show the results of health and rehabilitation workers' response to what information and needs were generated from the community and how it affected their plans. Furthermore, they had to indicate how they used the information. In a related question (question 7), health and rehabilitation workers indicated how they used the plans for implementing and managing CBR.

Table 3.28 Ways in which health and rehabilitation workers implemented the information obtained from the community

USE OF INFORMATION TO MANAGE REHABILITATION	TOTAL
We do not manage the programme; Rehabilitation Department does it.	1
We planned meetings and workshops, and:	7
- Made strategies;	
- Made plans based on this information;	
- Gave advice based on problems identified.	
The CBR programme has been designed, based on core problems identified by community.	1
Ward Health Committee has been more active in the community as a result of regular visits and education workshops in response to community needs.	2
The information was disseminated to the community and they were taught skills on identification, referral and care of PWDs through workshops, meetings.	1
Mobilised funds from donors and other NGOs to make CBR sustainable.	2
We made the community responsible for most of the projects through the CRC.	2

n = 15

Table 3.29 shows how health and rehabilitation workers reported having used the plans they have made for implementing CBR.

Table 3.29 Implementing plans for managing CBR by health and rehabilitation workers

USE OF PLANS	TOTAL
In collaboration with rehabilitation and CBR team, we give outreach services.	2
Meetings were held with the ward health team and information on how CBR was to be carried out asked from the community.	1
We held meetings with CBR coordinators, then held workshops with the community, in the process making community and clients concerned, agree on issues to be dealt with, such as: providing information, delegation of duties and social mobilisation.	5
Liaison with other NGO and planning and launching CBR.	1

n = 15

Health and rehabilitation workers were communicating with the community through the different structures available, i.e. CBR, Community Development Committee and Community Rehabilitation Committee meetings. Health and rehabilitation workers need to strengthen communication with the Community Development Committee. Most of the health and rehabilitation workers' plans and activities for CBR were based on the information they have obtained from the community in the first place. Table 3.28 and 3.29 show the way that health and rehabilitation workers used information gained from the meetings to plan further meetings and training workshops in which action plans for CBR were formulated with the community.

3.7.8 Health worker collaboration with VCWs

As explained before in this Chapter, the VCW plays a key and pivotal role in the planning, implementation and evaluation of CBR. The researcher sought to explore the depth and extent of collaboration between the health and rehabilitation workers and the VCWs in key activities such as:

- Role of VCW in health and rehabilitation workers' activities of obtaining community contacts and communication;
- Role of VCW in health and rehabilitation workers' activities of facilitating the function of the client;
- Role of VCW in health and rehabilitation workers' activities of mobilising resources from the community;
- Role of VCW in health and rehabilitation workers' activities of monitoring and evaluation of the CBR programme.

The outline of the VCW / health worker collaboration is shown in Tables 3.30, 3.31, 3.32 and 3.33 based on data gathered from Annexure 5.

Table 3.30 Collaboration between VCWs and health and rehabilitation workers in the community, from the VCW's perspective

COLLABORATION IN COMMUNITY CONTACT	TOTAL
Encouraging each other and seeing how best to increase the ability of PWDs and the community to help themselves in areas of need, e.g. projects, education and therapy, and provide feedback to patients.	5
During meetings, health and rehabilitation workers encourage us to give clients the authority to choose projects.	
Giving feedback about problems and patients in the area on what rehabilitation has taught us and looking at new problems within an existing project.	9
Discuss income-generating projects.	2
Home visits/outreach patients and community visits - Liase and share ideas during these visits, review previous lessons taught on disability and get information on how to care for PWDs.	12
We discuss new referrals, e.g. strokes. As VCWs we remind PWDs about their review dates.	4
We rarely work together.	1
We carry on with the programme when we are at home.	1

n = 25 (VCWs answered this question)

The most frequently used method of collaboration between the health and rehabilitation workers and the VCWs were home visits, outreaches and reporting at clinics. VCWs supported this in the focus group discussions, where they reported that when they obtain information from their collaboration with health and rehabilitation workers, they report the outcome thereof to the village heads and other community leaders. The

village heads then call a meeting to inform the community. VCWs talk to the community with the community leader's blessing. Subsequently, they provide feedback and information to the health and rehabilitation workers on the outcome of the meetings with the community. It is through these meetings that they are able to resolve individual client problems related to functionality in the community and at individual level, i.e. IGP, ADL and problems regarding community integration. This explanation of the collaborative process through the focus group discussions put the rest of the methods of collaboration mentioned in Table 3.30 into context and highlights the dynamic interaction between the key stakeholders.

Another important forum for the VCWs to meet with the health and rehabilitation workers was at the Extended Programme of Immunisation (EPI) points (sites where the EPI takes place). During the immunisation sessions (where most mothers and children gather from a given area) VCWs and the clients consult and are assisted by the rehabilitation staff. VCWs reported that they meet on a regular basis with sisters and nurses at clinics, giving them regular reports on clients being seen in the community.

Table 3.31 Collaboration between VCWs, health and rehabilitation workers on activities of function, and economic empowerment of clients

COLLABORATION IN ACTIVITIES SPECIFICALLY FOR FUNCTIONAL AND ECONOMIC EMPOWERMENT	TOTAL
We liaise with the community on what health and rehabilitation workers would have communicated, e.g. education, dates and times to improve lives of FWDs. Rehabilitation staff help by liaising with donors on behalf of clients. We are part of the process of who should be funded and for which projects. Thereafter, when they start, we monitor and liaise with rehabilitation staff on progress and problems of the clients.	14
It is easier to carry out home visits and approach clients after training by health and rehabilitation workers. They would have given us health education and other ideas and boosted our moral and helped in identifying suitable projects.	5
We subsequently have talks with community leaders.	1
We have received no help from rehabilitation staff on IGP because nothing is happening. Rehabilitation staff applied for funds and they have not materialised but we have received help in obtaining appliances, crutches, mobility aids etc.	5
Rehabilitation is supposed to follow up on training but they have not done so yet.	1
Monitoring and evaluation of process, functional improvement and economic empowerment. The clients are going through with the involvement of the client and health and rehabilitation workers.	1

n = 25

Activities to optimise functional ability and economic empowerment in the community centre around IGP. IGP facilitation within the community involves activities of sourcing for funding, identifying suitable projects and awarding the available funds to these projects. Fourteen (14; 56%) VCWs indicated that this process constitute a

collaborative effort among the VCWs, the community leaders, clients and health and rehabilitation workers. Although this result is very encouraging, it is important to note that forty four percent (44%; n=11) of the VCWs had only spent time on one of the aspects of promoting functional ability and economic empowerment of the client.

Another important activity where the health and rehabilitation workers collaborated with the VCWs was in mobilising resources. Table 3.32 indicates the collaboration between the VCWs, health and rehabilitation workers in response to needs expressed by the community.

Table 3.32 Collaboration between VCWs, health and rehabilitation workers when mobilizing resources

COLLABORATION FOR RESOURCE MOBILISATION	TOTAL
We liaise with the health committee, EHTs and ward coordinators to gain and pass on information.	1
We do not collaborate at the moment because they did not give us any help with any funds.	3
Rehabilitation staff is not active in acting on issues of resource mobilisation but are active in giving educational sessions.	1
We ask for help and further advice with referral and where to seek funds for IGP. Rehabilitation staff assists us with writing request letters to different organisations.	2
During meetings we get instructions and help from rehabilitation staff at community and outreach points. They help in assessing needs and finding suitable assistance. They have given lectures. Other stakeholders in these meetings contribute in solving problems.	7
VCW consult with village heads before they forward problems and discuss them with rehabilitation staff.	2

n = 25 (EHT: Environmental Health Technicians)

In Table 3.32, different ways in which the VCWs collaborate with health and rehabilitation workers are described. The VCW identify the problems that are related to the mobilisation of resources with the aim to fund IGP. They discuss the problems with the health and rehabilitation workers and seek guidance on where to get funding and other suitable assistance.

VCWs felt they benefited more by health and rehabilitation workers educating them on where to obtain funds, but said the health and rehabilitation workers were not actually mobilising funds themselves. As this is not a core function for health and rehabilitation workers as facilitators of CBR, it implies a misunderstanding on the part of VCWs.

Community participation in monitoring and evaluation of the CBR programme is as important as community participation in some of the core activities of management of

CBR, such as planning. The VCWs' perception of their collaboration with health and rehabilitation workers in the monitoring and evaluation of CBR is outlined in Table 3.33.

Table 3.33 Collaboration between VCWs, health and rehabilitation workers in monitoring and evaluation of activities in the CBR programme

COOPERATION IN EVALUATION AND MONITORING OF CBR	TOTAL
Visit clinics, meet rehabilitation workers and give reports. The rehabilitation staff and VCWs revise the intervention for clients together.	14
Rehabilitation staff teach VCWs how to assess progress and evaluate, and give ideas on care of PWDs by means of: - Home visits; - Workshops and meetings; - Meeting at clinic.	
VCWs made the above mentioned comment and added the following comment: <i>"But rehabilitation staff have not participated practically"</i> (Direct quote from raw data).	12
Very little collaboration and inadequate communication from health and rehabilitation workers. We have no feedback on reports. Health and rehabilitation workers do not have adequate communication with clients.	2
Rehabilitation workers coordinates through the different community committees and also run or attend existing meetings	1

n = 25

VCWs gave more than one answer.

Ninety two percent (92%; n = 23) of the VCWs reported collaborating on evaluation activities at meetings, workshops, clinic visits and home visits. At these venues, the VCWs were taught how to evaluate, monitor and assess clients' progress. They however reported the lack of practical involvement of the rehabilitation staff in their community work setting. Only two VCWs did not feel they received any help from rehabilitation staff in the monitoring and evaluation of the CBR programme.

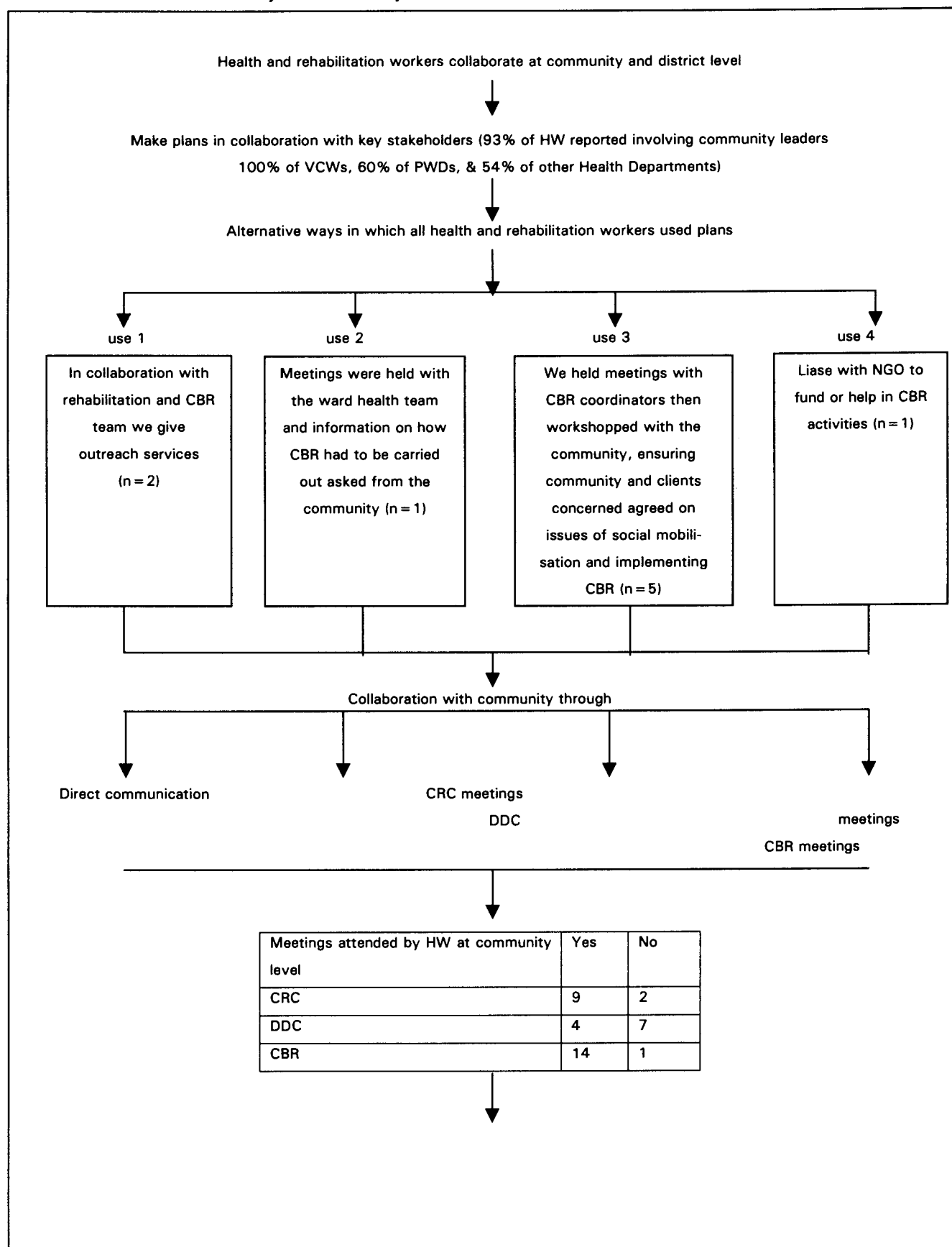
3.7.9 Collaboration between the existing rehabilitation management system and community and district level structures

In addition to analysing the existing structural and communication channels among key stakeholders, the researcher wanted to establish the extent to which collaboration between the Rehabilitation Department and the District Health System structures was taking place. This was felt to be important because the role of the Rehabilitation Department and the style of programme management in the CBR programme are crucial to programme survival. The style of management will influence the level of participation by the community. The current structures within the community development and government systems are by their very nature centralised and autocratic and do not

necessarily encourage participation by the community. By studying the communication structures in more detail, the researcher hoped to reveal the extent to which the rehabilitation department had *"its finger on the pulse"* and the way in which they communicated and acknowledged contributions from the community.

From the communication channels revealed by the health and rehabilitation workers in Annexure 2, a flow diagram (Figure 3.9) was drawn up to illustrate the type of communication and the flow of information as part of the management system in the Rehabilitation Department.

Figure 3.9 The communication channels and process of communication between the health system and key stakeholders of CBR.

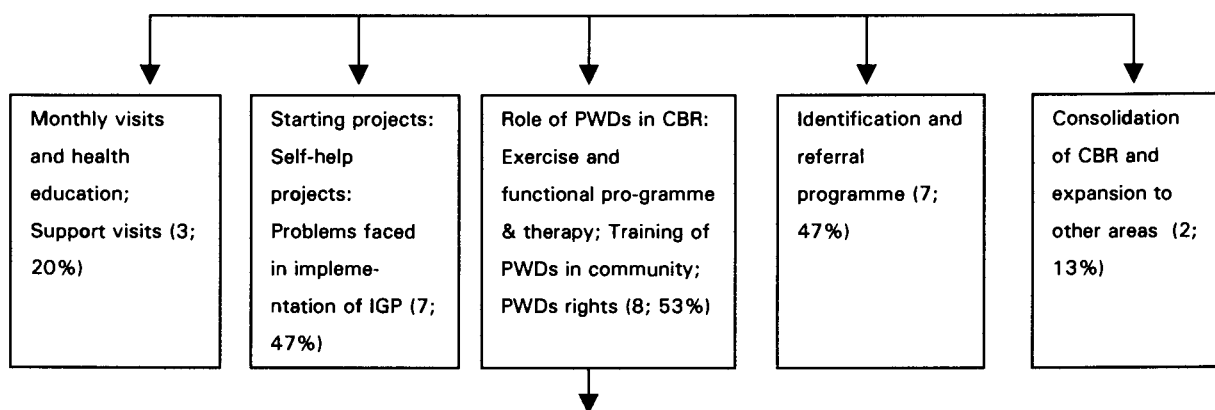


Frequency of Health and Rehabilitation Worker contacts with Community (n = 15)

CBR contacts	Once /month	Once /week	Daily	Never	Doesn't exist
District health committee			1	3	6
Village community worker	5				2
District Development Committee	6	1			
Other	4			1	3

↓

Examples of issues discussed at meetings



↓

Health and rehabilitation workers' contact with community leaders, VCW and clients and their caregivers result in different activities, for example:

Time spent by client and family on disability issues

Time Spent on issues relating to Disability by PWD and family/week	n = 107
3 days or more	49% (55)
1-4 hours more	35% (40)
1 day	11% (12)

It was clear that communication channels existed between the District Health System, Rehabilitation Department and the community. The flow diagram shows the frequency and type of meetings held by health and rehabilitation workers. In addition, the type of information emanating from the meetings is shown within the flow chart. Finally, the action resulting from the communication is included in this diagram. It is illustrated by

the time spent by the family and client and the way the health and rehabilitation workers use the information in their plans.

The consistency and content of these contacts need to be analysed in more detail. The frequency in contact between the health and rehabilitation workers and the District Development Committee is an area that is under-utilised and has potential for enhancing participation in the CBR programme.

3.7.10 Current formal and informal contacts between the Rehabilitation Department and community regarding management inputs and processes

3.7.10.1 *Health and rehabilitation workers' contacts with the community*

The communication channels indicated in the flow diagram in Figure 3.9 were explored further by identifying the extent to which all the management systems are in place, and to what extent they are being utilised by the District Health System, health and rehabilitation workers and the VCWs.

In Annexure 2, health and rehabilitation workers were asked what communication channels exist between the health system at district level and the community. Table 3.34 shows the channels outlined by the health and rehabilitation workers.

Table 3.34 *Communication channels between the District Health System and the community*

REPORTED COMMUNICATION CHANNELS BETWEEN THE DISTRICT HEALTH SYSTEM AND THE COMMUNITY	TOTAL
District communicates verbally and in written format with the staff; the staff with the community using committees, and the local clinic using the VCW.	11
Communicates with village heads through EHTs.	2
Communicates with CRC, and home based caregivers to follow up clients	2

n = 15

Health and rehabilitation workers reported the most frequently used communication route used by the District Health System as being verbal or written communication from the District to the rural clinic using the existing committees and VCW. This supports the identified communication channels and processes found to be in operation, as explained

by health and rehabilitation workers and the VCWs during focus group discussions. Communication with the community through the village heads or Community Rehabilitation Committee was used by only two of the health and rehabilitation workers (the village heads are important leaders in the community and are recognised by the whole community development system). Contact with the community through the Community Rehabilitation Committee was low, considering that the community chooses the representatives who serve in the Community Rehabilitation Committee.

In Annexure 2, health and rehabilitation workers were asked to indicate whether the management system facilitates participation. Table 3.35 outlines the responses from the health and rehabilitation workers in this regard.

Table 3.35 *Management tool that facilitate participation for health and rehabilitation workers*

MANAGEMENT TOOLS IN PLACE	YES, IN PLACE
Individual treatment with focus on client	13 (87%)
Regular meetings	13 (87%)
Reporting system	12 (80%)
Meetings with family	10 (67%)

n = 15

Table 3.35 shows the formal management tools reported by health and rehabilitation workers that are in place to facilitate participation. Through these tools, health and rehabilitation workers have regular contact with the client and VCW and should get feedback on issues of concern to key stakeholders. Through these management tools, the continued participation of the community can be enhanced in that health and rehabilitation workers can respond to their needs and can facilitate activities as requested by the community.

The health and rehabilitation workers, VCWs and community leaders reported contact through regular pre-scheduled meetings and through presentation of reports. Through the meetings and reports, information needs were generated, as shown in Table 3.27.

3.7.10.2 Consequences of communication structures between the health and rehabilitation workers, VCWs and the community

From the contacts through management links, the researcher explored the consequences of contacts between the health and rehabilitation workers, VCWs and community by asking what the outcome of the contact between health and rehabilitation workers and VCWs with key community members was. One of the outcomes of the contact between the health and rehabilitation workers and the VCWs is the increase in referral of clients through the health system (clients can also be referred to services in other sectors but in this case the referral took place through the health system).

Table 3.36 shows referrals to health and rehabilitation workers from the community and VCWs.

Table 3.36 Number of referrals to health and rehabilitation workers from the community and VCWs

FREQUENCY OF REFERRALS	NUMBER OF REFERRALS
2-5/week	4
10/week	0
1/week	4
Less than 1/week	6

n = 14 (One health worker did not answer the question)

The number of referrals from the VCWs varied from less than once a week to five (5) per week. Health and rehabilitation workers said referrals increased after they conducted a training workshop for the community VCWs.

In response to a question on the type of activities they carried out in response to community needs, (Annexure 2) health and rehabilitation workers reported the following (Table 3.37). This process was therefore iterative.

Table 3.37 Activities carried out by health and rehabilitation workers during the foregoing year in response to expressed community needs

ACTIVITIES CARRIED OUT BY HEALTH AND REHABILITATION WORKERS IN RESPONSE TO EXPRESSED COMMUNITY NEEDS DURING THE AFOREGOING YEAR	TOTAL
Obtained Funding.	5
Helped clients and mobilised funds to start a gardening project together with those who are not disabled:	
- Find funds for IGP;	
- Deal with social needs of PWD.	
Treatment of clients, training VCWs, refers clients to specialists and provides outreach services.	5
Health education with specific reference to disability and attitudinal change for the community.	6
Proposed "hands-on training" for VCWs on use of WHO manual.	
No activity due to no funds.	1

n = 15 (Health and rehabilitation workers could give more than one answer).

It is evident from the results that active communication and resulting activities between the Rehabilitation Department and the community, and more specifically the VCW (through the clinic contacts), took place through scheduled meetings, home visits, training sessions and meeting at outreach points. Communication between the health and rehabilitation workers and VCWs resulted in activities within the CBR programme.

3.7.10.3 VCW contacts with the community

The VCW is an important role-player not only in CBR, but also in all health programmes. All except one VCW reported having a Community Development Committee that facilitated their contact with the community leaders. They reported interacting with this Community Development Committee through:

- Community Development Committee meetings (n = 13);
- Other informal meetings (n = 6);
- Specific CBR meetings (n = 4).

Of the twenty four (24) VCWs who answered this question, seventy nine percent (79%; n = 19) reported having a Community Rehabilitation Committee to which they could liaise with, and in some cases they reported to the Community Development Community. The composition of the members of this Community Development Community are outlined in Table 3.38:

Table 3.38 Composition of members of the Community Development Committee as reported by VCW

Composition of members	TOTAL
Village Community Workers (VCWs)	13 (54%)
Ordinary members of the community	12 (50%)
Community leaders	11 (46%)

n = 24

Less than half (46%) of the Community Development Committees had community leaders as members and over half (50%; 12 and 54%; 13) respectively had ordinary members of the community and VCWs as members. The composition of the Community Development Committee was therefore balanced, with fair representation from different sectors of the community.

VCWs reported having set some objectives for themselves with regard to PWDs and their needs in the community. These objectives included:

- Setting up IGPs (n = 17);
- Teaching PWDs to fend for themselves (n = 10);
- Continuing with the education and awareness process for the community on disability issues, including change in attitudes and empowerment (n = 5);
- Improving mobility problems and integration of PWDs into schools (n = 2).

VCWs outlined the objectives they have set as a result of contact between themselves, the health and rehabilitation workers and the PWDs.

VCW communication with the community and community leaders is evident through their many contacts with the different committee members such as community leaders and other ordinary members of the community, as shown in Table 3.38. The needs of PWDs require action, and the VCWs outlined the kind of objectives they have set for themselves in response to the needs of the PWDs. Some of the needs include income generation, aids and appliances and access to community amenities.

Another aspect of formal and informal contact that was explored was that of the collaboration of community leaders with the MOH, the Rehabilitation Department and

other sectors such as the Ministry of Education (MOE), Local Government and Ministry of Agriculture (MOA). The results are shown in Table 3.39

Table 3.39 Community Leaders' collaboration with MOH, Rehabilitation Department, MOE, Local Government and MOA

COLLABORATION WITH DIFFERENT MINISTRIES AND DEPARTMENTS	TOTAL
Ministry of Health (MOH)	
- The MOH initiates projects at community level; the community leaders work as go-between and often the community is keen to cooperate.	12
- Through the clinic we collaborate with MOH and through health education we facilitate upgrading of living standards, e.g. building Blair toilets and water sources.	
- We use local clinic as first point of referral - this involves identifying clients and referring, negotiate where problems exist and volunteer labour and money for the development of the clinic. Leaders negotiate for fee for those PWDs who cannot afford services.	6
- Communicate well through VCWs/Social Services Committee/World Health Committee.	1
Rehabilitation Department	
- Community leaders are often a go-between for the community and Rehabilitation Department. They provide information on use of referral channels and other information about PWDs within the community.	6
- Rehabilitation Department visits on monthly basis, refers PWDs to specialist services and acts as a resource and advisor (through the workshops). We integrate and collaborate with Rehabilitation Department through these monthly visits and the Community Rehabilitation Committee. If there are problems we moderate and help.	11
- However, the Rehabilitation Department is too far, and results in poor communication, so we feel integration with community leaders is poor.	
Ministry of Education (MOE)	14
- We meet with headmasters and cooperate well; i.e. provision of places for school enrolment of children with disabilities, especially those with mobility problems.	
- We provide manpower and money for new buildings through Parents Teachers Associations.	3
- Besides education, teachers release children for work in community projects.	
- Liaise with headmaster but have NOT YET worked with them in relation to disability. We collaborate but we never discuss disability.	1
	1
Other sectors that community leaders collaborate with	
Community leaders did not express any collaboration regarding PWDs in the following sectors; however, they said they worked together with them on other issues:	6
o Local Government;	
o Home affairs;	
o Church leader support through projects;	
Community leaders do not see how other ministries are helping the cause of PWDs.	

n=18

All community leaders reported collaborating with the MOH in areas of public health, such as referring PWDs to the clinic and intervening when they have problems. Sixty six percent (66%; n=12) reported direct contact with the Rehabilitation Department.

Through the school headmasters, all community leaders liaise with the MOE and they discussed issues to do with enrolment for PWDs. Five (5) community leaders said they never discussed issues to do with disability with the MOE.

Through the focus group discussions, in one district the community leaders reported that although they have a Community Development Committee, they have not included disability issues on the agenda. The community leaders also reported that there have been changes in the system as a result of a Presidential Directive that is hindering the smooth running of the community affairs. They stated: *"Now it has changed, it no longer works well, the new village development committees (VIDCOS) works according to the village. One village, one committee.... we are still getting used to this system"* (Direct quote from raw data).

The community leaders underscored the need for health and rehabilitation workers to undertake regular follow-up of activities within the community. They recommended communication between the health and rehabilitation workers and themselves every three months. Leaders felt that all communication to them should be conducted through the local counsellor and he should communicate with the other leaders. They even said that if it was not possible to meet, communication to them should be in writing; i.e. letters of explanation or submission of reports on the progress of the programme.

What became evident in the focus group discussions is that although the community leaders could see the link between the MOH and disability issues, they could not see the link or association of disability with the other ministries. This was expressed clearly in the focus group discussions. This opinion shows a lack of insight into the role of other ministries in disability issues.

3.8 THE LEVEL OF COMMUNICATION BETWEEN THE VCWs, COMMUNITY LEADERS AND THE HEALTH AND REHABILITATION WORKERS

3.8.1 Introduction

From the management contacts and structures outlined in Figure 3.9, the researcher wanted to determine how much communication was taking place between the key stakeholders using the same committees and communication channels.

The first contact in the referral system for the client is the local supervisor (i.e. the VCW). Table 3.40 shows the different services as well as the frequency with which clients were referred to these services.

Table 3.40 Referral of clients to services by VCWs

SERVICES REFERRED TO	NEVER	WEEKLY	MONTHLY
Social	3		10
Health		10 (40%)	12 (48%)
Vocational		7	2
Legal	1		3
Community	2	3	4

n = 25

Thirty four percent (34%; n=40) of the clients saw and had contact with the VCW once in two months or less. Thirty one percent (31%; n=37) saw and had contact with the VCW once a month, and nineteen percent (19%; n=23) saw and had contact with the VCW once a week.

Table 3.40 shows the referral patterns of VCWs. However, the community referrals needed to be analysed to identify which facilities within the community the VCWs were utilising. The referral patterns in Table 3.40 show whom the VCW was referring clients to. Forty percent (40%; n=10) and forty eight percent (48%; n=12) of the VCWs referred clients to the health delivery system weekly and monthly respectively. Another forty percent (40%; n=10) referred clients to the social welfare system. This implies that the VCWs have a higher level of contact and communication with the health and social welfare services. Less communication and contact were recorded between the VCW and the vocational, legal and community services.

The clients had contact with the health and rehabilitation workers as shown through the referrals to the Rehabilitation Department, outreach visits and CBR meetings. The statistics of clients seen were studied in the three district departments of the areas under study. From Annexure 5, sixty percent (60%; n=73) of clients reported having contact with rehabilitation personnel once per month. Twenty percent (20%; n=24) reported two (2) or more contacts per month and the remaining twenty percent (20%; n=24) reported less than one contact per month.

Clients were asked what information they gained through the contacts and communication they had with role-players such as health and rehabilitation workers,

social welfare workers, education authorities and community leaders in the CBR programme. The information was coded and categorised as shown in Table 3.41.

Table 3.41 Specific information gained by the client through the CBR programme

INFORMATION GAINED FROM CBR	TOTAL
Information on identification and referral for different disabilities:	24
Some added that they gained information on treatment - did not know about causes and how to treat conditions and correct disability, e.g. club feet. We also learnt about how to live positively.	
Integration Issues:	24
- Information on IGP and that the PWD can progress even if condition can't be reversed;	9
- Integration and working productively in community and at home; improve quality of life;	
- Teaching others about disability;	8
- How to solve schooling problems.	
	3
	5
Treatment Issues:	27
<i>"With rehabilitation, a person can improve thoughts through continuous exercise and activity and activities around the home"</i> (Direct quote from raw data).	20
Different methods of communication for a child with learning problems were learnt.	7
Nothing yet - clients feel they need more information.	13
Attitudinal issues - A PWD is a full human being like everyone else and one must not laugh at them.	23
PWD persevere with the programme in order to get good results and start early on their rehabilitation.	
<i>"Personally I gained confidence in what I was doing."</i>	
PWDs should be given a chance to do things their way in order to help themselves and be progressive and self-reliant.	
Other: Learnt how to handle myself as a PWD to avoid isolation and not get spoilt.	8
PWD can get assistance if stakeholders cooperate and work together.	

n = 122

(3 clients did not answer this question).

From the above array of information, one can see that clients gained information in different areas of their rehabilitation needs and the information can be categorised within the framework of the stages of rehabilitation. Information ranges from prevention, early identification and referral, treatment and activity issues, integration into the community and family and issues relating to attitude. Some of the information was on tangible issues and some non-tangible issues that affect the outcome of their rehabilitation programme by affecting their attitude. The range of information they gained from the programme included specific knowledge about treatment, which affects their attitude, and information on how to integrate better with the community. As one client said: *"I have learnt how to handle myself as a PWD to avoid isolation and not get spoilt"* (Direct quote from raw data).

3.8.2 Records kept by Village Community Worker (VCW)

In section 3.4.2.2, the type of records on clients kept by VCWs was discussed. To explore the use of these records and what kind of communication they gained through these records, the VCWs were asked in Annexure 5 why they kept the records. Their explanation of the purpose of the records is given in Table 3.42.

Table 3.42 The main purpose of records kept by VCWs

PURPOSE OF RECORDS KEPT BY VILLAGE COMMUNITY WORKER	TOTAL
For referral and following up clients.	3
To keep statistics.	1
Problem and 'needs identification' record.	14
Assist in report writing and communication to Rural Health Centre (RHC) and Rehabilitation Department.	6
Information records for diagnosis, the state of progress (on how to help themselves) and continuity. They also help us to know and remember number of PWDs in area.	16
Generally the records help to monitor the condition of the patient.	

n = 25

The reasons as given in Table 3.42 provide insight into the functions in which the VCW collaborate with the Rehabilitation Department, such as information records for diagnosis and progress of the client. The records are a point of reference for referral to the different services. In addition, Table 3.43 outlines the collaboration between the health and rehabilitation workers and the VCWs in record keeping.

Table 3.43 Collaboration between the VCW and health and rehabilitation workers in record keeping

COLLABORATION WITH HEALTH AND REHABILITATION WORKERS IN RECORD KEEPING	TOTAL
We have good cooperation with health personnel; they assist us in collecting the information when there is need. We conduct combined home visits at the client's place and address client's concerns.	6
We refer to clinics and Rehabilitation Department. During follow-up, rehabilitation workers use information left by VCWs at the clinic.	7
Once a month or more we report back at meetings and for planning purposes, Rehabilitation Department follows up on how records are kept up to date.	9
When records are reviewed, the VCW get advice about how to handle client problems; i.e. education on general hygiene and the physical capacity of the client on how to cope with the income generating projects.	2
They provide reference books and resource material to help with problem identification. However, we need the books in Ndebele.	1
Taught record keeping – no other follow-up in this regard yet.	1

n = 25 (VCWs could give more than one answer).

Table 3.43 shows that thirty-six percent (36%; n = 9) of the VCWs used their records to report back and plan with the health and rehabilitation workers, and twenty-eight percent (28%; n = 7) reported leaving these records at clinic level to be used by the health and rehabilitation workers. Other specific purposes for the records were for referral of clients and to keep a record of the home visits. The VCWs had a clear understanding of why they keep records. This study did not look into the quality of these records but sought to establish the existence of the records and the intended purpose thereof. The records were kept for tracking the number of people in the area, their problems and the programme they were undergoing. The VCWs also said they kept the records as a source of information for feedback to the health and rehabilitation workers.

3.8.3 Level of contact between community leaders, Rehabilitation Department and MOH

As shown in Table 3.39, sixty six percent (66%; n = 12) of the community leaders communicated through the clinic and reported using the clinic for referral. Sixty six percent (66%; n = 12) communicated with the Rehabilitation Department when they conducted their clinic visits. In terms of the type of issues communicated, the community leaders explained how they are catalysts, as well as how they give guidance to all programmes initiated by the MOH through clinics within the community. From Annexure 4, eleven percent (11%; n = 2) expressed that they felt the distance and the lack of visibility of the Rehabilitation Department at community level weakened the communication with it after implementation of CBR.

Communication between role-players is an important factor in improving the level of community participation in the CBR programme. From the above results, it appears that although much effort has gone into communication, there are inconsistencies in the perception, the existence of structures that support communication (i.e. active committees), and actual communication taking place with key stakeholders.

To illustrate the level of communication further, the health and rehabilitation workers were asked what and through whom they had contact with the community and how often. Table 3.44 shows the frequency of communication and whom they communicated with.

Table 3.44 Health and rehabilitation worker contacts with the community

CBR CONTACTS	ONCE / MONTH	ONCE / WEEK	DAILY	NEVER	DOES NOT EXIST
District Health Committee			1	3	6
Village Community Worker	5				2
District Development Committee	6	1			
Other	4			1	3

n = 15

A lot of contact exists between the different role-players in CBR, with some definite structures used as communication channels. For example, as shown in Table 3.44, thirty three percent (33%; n=5) and forty percent (40%; n=6) health and rehabilitation workers used the different established structures such as the District Development Committees and the VCWs once a month respectively. There are still areas where the contact and communication are scant and under-utilised by the health and rehabilitation workers, for example a third of the health and rehabilitation workers said that the District Health Committee does not exist, while almost twenty percent (20%) said that the VCWs and the District Development Committee do not exist.

3.9 FACTORS AFFECTING COMMUNITY PARTICIPATION

In order to understand fully what may be hindering or promoting community participation, the researcher studied three major factors separately:

- The extent to which disability issues had been mainstreamed into community development activities as shown in Section 3.6.2;
- Availability of, and access to resources;
- Community leaders' attitudes: Attitudes of leadership have been shown in the literature to inhibit or promote community participation (Chambers 1987).

The above three factors that the literature (Chambers 1987) had outlined were studied separately in order to understand the finer details of the extent to which they might have hindered participation. However, the researcher also acknowledged that other less obvious factors might potentially be present.

To further understand inhibiting factors, which may not be apparent, the researcher asked the clients, VCWs and health and rehabilitation workers what difficulties or obstacles they were facing with regard to community participation.

3.9.1 Factors affecting community participation as seen by the clients

3.9.1.1 *Obstacles facing the client in solving their problems and gaining full participation*

Involving clients in the planning process as well as other stages of management in CBR is considered a very important factor in promoting clients to participate. As shown in Figure 3.5, the involvement of clients in the planning, implementation and evaluation of CBR was not adequate, with twenty six percent (26%; n=32) of clients reporting only being presented with a plan while twenty three percent (23%; n=28) were involved in the whole process. Eleven percent (11%; n=10) were told nothing about the process of CBR. This in itself is an obstacle to their participation. In Table 3.45, reasons on the obstacles they faced when trying to solve their own problems within the community, are described.

Table 3.45 *Obstacles clients identified in solving their own problems in the community*

PROBLEMS	YES	NO
Inadequate or no cooperation from community in general.	39 (57%)	29 (43%)
Poor resources. Give money, for example to buy bus tickets, materials for IGP and aids and appliances.	49 (61%)	31 (39%)
Inadequate or no cooperation from health personnel/system.	21 (37%)	36 (63%)
Inadequate or no cooperation from community leaders.	13 (28%)	34 (72%)

n = 122 This table must be read across.

Poor resources were cited by sixty one percent (61%; n=49) of clients as a hindrance to solving their problems in the community, and fifty seven percent (57%; n=39) felt that they had inadequate or no cooperation from the community in general. Thirty seven percent (37%; n=21) felt they did not receive adequate assistance from the health personnel.

When asked to explain the problems with resources, 64% (n=36) of clients explained that they had received some resources from the community after the introduction of

CBR (these contributions seemed to consist of material goods such as soap and blankets). Clients explained that the community itself is impoverished and therefore cannot give adequate assistance. Clients lack money for hospital fees and transportation to referral centres, financial resources for school fees, and facilitation of IGPs. Depending on their personal experience, of the sixty four percent (64%; n=78) of clients who said resources were a major problem, ten percent (10%; n=11) said they only received assistance from health and rehabilitation workers, while nine percent (9%; n=10) received assistance from their family and other community members.

Fifty seven percent (57%; n=67) of the clients reported inadequate cooperation from the community and said they felt the community did not care about disability issues. They gave the following reasons:

- Community leaders and members do not cooperate because they do not benefit directly from dealing with disability issues (2 clients);
- Community leaders exclude us from meetings and feel our contributions are useless they don't take us seriously (5 clients);
- The community at large does not care for PWDs and do not cooperate, especially in IGP or centres for PWDs (7 clients);
- Community lacks knowledge on importance of participation and the rights of PWDs (8 clients);
- Breakdown in the family as a cause of lack of cooperation (3 clients).

Five (5) clients who did not perceive obstacles said they felt they had gained some basic skills and found themselves more acceptable within the community than others. Others (3) said the community was helping in providing land and that the health personnel were supportive.

From the results, it is clear that clients are not fully involved in the planning process of CBR, at least not in an active way. Lack of resources presents an obstacle to their full participation. Some clients also reported a lack of cooperation from health and rehabilitation workers, the community in general and community leaders (Table 3.45). Some clients still reported feeling excluded from the management of CBR and these are areas that need to be examined further in future studies.

3.9.2 Factors affecting community participation as seen by VCWs and community leaders

Table 3.46 outlines the factors expressed in the focus group discussions with VCWs and community leaders. The two groups expressed the factors they regarded as hindering or even stopping community participation in CBR. Some of the categories of opinions of the VCWs and the health and rehabilitation workers coincided and are therefore presented in one table.

Table 3.46 Factors hindering participation as seen by VCWs and Community Leaders

FACTOR	VCWs	COMMUNITY LEADERS
Transport	Lack of transport for referrals.	Referrals are hampered, as buses are expensive.
Resources - Money - Raw Materials - School Fees	A shortage of such items hinders essential purchase of materials and access to services.	There is a shortage of resources; It is made worse by the general poverty. The PWDs feel it more.
Poverty, no food	Basic needs hinder further progress even when people have the will to participate.	PWDs sometimes cannot get food, giving PWDs "double" problems.
No draught power	Most PWD have few resources and cannot afford draught power because they do not have the resources.	
Participant Fatigue		Community gets tired. We need help on how to stop this. In addition, health staff should not give empty promises.
Feedback		Not enough communication after launching of CBR in community.
Parents' attitudes		Some parents and community members want nothing to do with PWDs.

Many of the factors outlined in Table 3.46 are not peculiar to the PWD, but affects the community as a whole. However, the way in which these problems impact on the participation of the PWDs is peculiar to them. The problems are exacerbated by the already impoverished situation that the PWDs find themselves in. They therefore feel the burden of the lack of resources more and are unable to carry out activities, which

culminate in their participation. For example, the lack of transport perceived by the VCW and community leaders is the result of a lack of resources to utilise the buses to attend referral appointments. Similarly, the lack of draught power is a result of the lack of money to buy ploughs or cattle. More specifically, both groups underscored the issue of general poverty on the lives of PWDs. Examples given include the lack of school fees, which prevents a PWD who might want to participate in the education system, or the lack of raw materials for a PWD who may want to participate in income generating activities.

In Annexure 5, VCWs were asked what problems they experienced with regard to getting PWDs to fully utilise the referral system. These details are given in Table 3.47. The community leaders added the factors of participant fatigue, inadequate feedback and inappropriate attitudes of parents.

Table 3.47 Problems with referral system as perceived by VCWs

PROBLEMS HINDERING THE SMOOTH FUNCTION OF THE REFERRAL SYSTEM	TOTAL
Resource related: - No money for transport for both VCWs and clients; - Medical charges exorbitant; - Difficult to start IGPs without resources; - Aids and appliances, especially wheelchairs, difficult and expensive to obtain.	22
Organisational related: - Manpower to escort the client where he/she cannot help him/herself; - Patients send back from hospitals due to insufficient documentation; - Time taken for client to get a response is too long especially if using letters of referral / seeking funding; - PWDs not following timetables/procedures in the referral system therefore send back without services being rendered.	7
Attitudinal - No help received with regard to disability, therefore, they do not refer; - PWD prioritise activities that give them food and do not see value of being referred.	6
No problems	3

n = 25

The smooth flow of the referral system and the outcome of the clients' rehabilitation programme will have a strong impact on the client and his/her family's desire to continue participating.

The VCWs perceived some important obstacles to the process of referral. Obstacles related to resource shortages were felt by eighty eight percent (88%; n=22) of the

VCWs. Because of the lack of financial resources, the medical charges are perceived as exorbitant. Even the simplest of IGPs becomes difficult to get off the ground and aids and appliances difficult to pay for.

Difficulties in the flow of referral due to clients forgetting or losing referral letters, insufficient documents, misunderstanding time and being sent back by health and rehabilitation workers for various reasons, de-motivate clients to participate in CBR. VCWs also said that families don't give enough priority to disability. This reduces the chances of utilising the referral system effectively.

3.9.3 Factors affecting community participation as seen by community leaders

3.9.3.1 *Mainstreaming of activities related to disability into community development activities by the community leaders*

Mainstreaming involves ensuring issues to do with disability become cross cutting in community activities and included in every relevant sector of the community. If the budget, education policy or development policy is being discussed in the Community Development Committee, the concerned representatives should consider in what way disability issues are affected and should be addressed. With regard to the community leaders, it is expected from them that in the community development plan, they should ensure that disability is cross cutting and not an afterthought or fringe issue. Therefore, the community leaders' opinion on the extent to which they had incorporated CBR in mainstream development activities was sought and is reflected in Table 3.48.

Table 3.48 Incorporation of CBR in community programmes by community leaders

AREAS OF INCORPERATION	TOTAL
Yes, we have incorporated disability issues. Examples of some of the areas where disability issues have been incorporated or mainstreamed: - Names of PWD with needs were documented and a register developed indicating their needs. Community leaders encourage them and respond to their needs, e.g. ploughing (the researcher did not see any of the registers physically). - CBR is one of the first community development programmes, so we are participating in it. We have no structure from previous experience. - We have included CBR in all home based care for chronically ill people and people with HIV. - Developing structures for PWDs: - o We look out for projects related to PWDs and assist in management, e.g. brick making – we formed a committee and are building a centre for PWDs in Mberengwa. - o Community understand the need to help PWDs. Leaders called a meeting and informed people on how CBR helps and can be incorporated in Mberengwa. Had other projects so we incorporated CBR into those project meetings. - o Community leaders help in leading all programmes focused on CBR	14 (78%)
No, we have not incorporated disability issues Reasons for this: - Lack of health education among community leaders. - People from health sector introduced CBR but never came back. - No one has brought problems to me – have not discussed it with community leaders. We have not fully realised the need for incorporating disability issues into mainstream development.	4 (22%)

n = 18

Mainstreaming of CBR and disability issues is important for the successful implementation of any programme. Seventy-eight percent (78%; n=14) of community leaders incorporated CBR into their community development plans. This was done through various ways, from acknowledging the presence of disability and taking action, to including PWDs in community initiatives. However, the community leaders contradicted themselves in that although they incorporated disability issues into their plans, they did not see the relation between disability issues and other sectors.

Twenty two percent (22%; n=4) community leaders had not incorporated CBR into their plans and their reasons are shown in Table 3.48. Their reasons are related to lack of knowledge and communication with regard to CBR.

3.9.3.2 Attitude of community leadership towards disability

The attitude of the community leaders in relation to the plight of the PWDs was determined by asking them who they thought should bear the responsibility and participate in responding to the plight of the PWD. Community leaders' perception of the

key responsible persons for the plight of PWDs has been shown in Table 3.15. An equal number of community leaders had an almost opposite opinion and thought that the family (58%; n=7) and the community (58%; n=7) should be totally responsible for the PWD. Forty six percent (46%; n=6) community leaders felt that the community should be partially responsible for the PWD. Thirty three percent (33%; n=4) community leaders felt that the government should be totally responsible, and thirty three percent (33%; n=4) felt the family should be partially responsible for the PWD.

From these results, it is clear that the community leaders do not have a clear consensus about who should be responsible for the PWD. The reasons for their answers (given in Table 3.15) are shown in Table 3.49.

Table 3.49 Community Leaders: – Reasons for choice of key responsible person for the plight of PWDs

COMMUNITY LEADERS' REASONS FOR GOVERNMENT, FAMILY OR COMMUNITY TAKING RESPONSIBILITY OF PWD	TOTAL
Community should take full responsibility and come up with plans; they are closest and live with PWD. Government should take the leading role with the more severe disabilities and should be the provider of funds as lack of resources is often a drawback for CBR.	9
If family shows responsibility, everyone else will know and they will set an example. The family knows everything about client and is with them 24 hrs a day. If people do not have a PWD in their homes, they are usually unconcerned.	7
If the government provides resources, everyone else will follow. This community leader referred six (6) children and they all got help.	4

n = 18

(Some leaders gave more than one answer).

As shown in Table 3.49, thirty nine percent (39%; n=7) of the community leaders regarded the community and family to be totally responsible for PWDs and twenty two percent (22%; n=4) ascribed total responsibility to the government. Forty four percent (44%; n=8) community leaders felt the government was partially but not totally responsible for the plight of the disabled. In their reasons they said the government has to take a leading and provisory role. None of the community leaders said the community or government had no responsibility whatsoever. This indicates a recognition on their side that both the government and the community have a social responsibility to the plight of the PWD. They noted that the community and family live closest to the PWD and should set an example for the rest of the community to respond.

Thirty nine percent (39%; n = 7) community leaders regarded the individual PWD to be partially responsible for him or herself. Another Thirty nine percent (39%; n = 7) felt that the PWD is the total responsibility of the family. The results imply that the community leaders again recognised the importance of the individual and the family in CBR. Two (2) leaders ascribed no responsibility to the family and individual and it is important to explore the reasons for such opinions, as they may cultivate a charity mentality as opposed to empowerment of the PWD.

3.9.3.3 *Level of incorporation of CBR into mainstream activities*

In the focus group discussions, the VCWs reported, *"before CBR was implemented, the community leaders and people were as hard as a rock, we could not penetrate. However, there is a marked change, people are beginning to understand"* (Direct quote from raw data). Getting through to the people is no longer a problem. Even community leaders react quicker and come up with help. The community leaders are responding and mainstreaming CBR issues into development, but as the results show, not all community leaders have a full understanding of the balance of responsibility required to optimise participation in CBR. In the focus group discussions, the community leaders who have not incorporated CBR into the community development plans, provided reasons such as not realising the need and lack of adequate knowledge on how to mainstream and incorporate disability issues into community development.

3.9.4 Difficulties faced by health and rehabilitation workers in encouraging community participation

It is important to determine what factors the health and rehabilitation workers (as instrumental facilitators of CBR) regard as affecting community participation. Table 3.50 outlines the difficulties expressed by the health and rehabilitation workers.

Table 3.50 Difficulties faced by health and rehabilitation workers with regard to community participation in rehabilitation

TYPE OF DIFFICULTY	TOTAL
The communities are afraid and at times not confident to carry out activities.	4
Transport problems to visit projects.	4
Coordination of messages is at times difficult because of the distances between the people and health facilities.	4
The PWDs complain of a lack of commitment from caregivers while on the other hand they want to isolate themselves.	1
If there is good communication from district through to the community there would be few problems.	1
False promises on the part of both parents and staff to PWD. Clients at times miss review dates and have false expectations (want handouts and when not delivered, withdraw.	6
Community leaders at times make decisions for community without consulting them.	3
None	1

n = 15

The health and rehabilitation workers expressed both logistical and organisational difficulties (such as transport and problems with communication due to the distances and the lack of a reliable communication system) as factors hindering participation. The communities' lack of confidence was cited as a problem and would perhaps explain why the health and rehabilitation workers perceived the community leaders as making all the decisions for the community. In discussing the referral system (Section 3.7.3 and 3.4.2.1), the clients and their families explained the difficulties they experience with using the referral system; hence the difficulty with keeping appointments for PWDs. Conversely, the health and rehabilitation workers expressed that they perceive false promises and missing appointments on the part of clients as a hindrance to community participation.

3.10 THE EXTENT TO WHICH AVAILABILITY OF RESOURCES INFLUENCE PARTICIPATION

The researcher wanted to determine the extent to which the clients, VCWs and community leaders regarded resources as a hindrance to participation in CBR.

3.10.1 How resources influence community participation

Table 3.45 outlines the results of the major obstacles for PWDs in solving problems in the community. Sixty one percent (61%; n=49) of clients who responded to this question found the lack of resources to be a major hindrance. All VCWs (100%) in citing

their difficulties with the referral system said the lack of money for transport for both VCWs and PWDs in obtaining help and following the referral chain, had a negative influence on participation. Other difficulties in participation were also related to resources, such as the inability to purchase aids and appliances. PWDs, when referred for specialised services, prioritise activities that would provide them with food and resources if they have to make a choice between attending a referral date and activities to improve their basic needs.

In the focus group discussions for community leaders and VCWs, resources were mentioned as a hindrance. Participants felt that the lack of basic needs for daily survival distracted many clients and families from participation. As one community leader stated: *"We want to help but we ourselves are impoverished"* (Direct quote from raw data).

3.10.2 Resource mobilisation by the community

In the light of the lack of resources having an impact on every aspect of the rehabilitation process as illustrated above, Table 3.51 outlines the efforts of the community to mobilise resources, in this way trying to lessen the burden of poverty and dependence on external assistance.

Table 3.51 Ways of mobilising resources to promote activities at community level

ACTIVITIES BEING CARRIED OUT TO MOBILISE RESOURCES BY VCWs	TOTAL
Attending village/ward church, farm club and project meetings and seeing where others get resources.	3 (12%)
Collaborating with other Government departments and NGOs already in operation to try and find where resources can be sought.	
Seek assistance of community leaders and councillors for:	11 (44%)
- Approaching donors, assistance in finding donors;	
- Follow-ups of boreholes for gardening;	
- Mobilise some community resources, e.g. human resources from community;	
- Seek assistance from donors and organisations such as SIDA and Agritex (an agricultural extension service).	
There are no resources:	4 (16%)
- Have not done anything;	
- Tried IGP but with little result;	
- Never asked the community.	
Raise funds through:	3 (12%)
- IGP – use water reeds to make hats and sell them;	
- Join savings club;	
- Seek contributions from community;	1 (4%)
- VCWs assist disabled in joining already existing projects e.g. the poultry project.	

n = 25

Availability of various types of resources is a major problem for community participation in CBR. From the results it is clear that resources underlie every activity in both the client care activities and in the organisational issues such as transport. The community's efforts to raise resources (material and financial) are centred on the community's income generating projects and turning to the leadership for assistance. The leadership itself expressed that they are already an impoverished community, hence it is difficult to mobilise the resources.

3.11 RECOMMENDATIONS REGARDING FUTURE DEVELOPMENTS THAT WILL ENHANCE THE EFFECTIVE AND EFFICIENT MANAGEMENT AND DELIVERY OF CBR SERVICE WITH THE FULL PARTICIPATION OF THE COMMUNITY

Clients, community leaders and VCWs were asked what recommendations they have regarding the management of and their participation in CBR. Tables 3.52 - 3.55 outline the recommendations provided by the three groups of stakeholders.

3.11.1 Clients' recommendations

In Annexure 3 clients were asked what recommendations they could make to enhance effective and efficient management and delivery of CBR service as well as participation from the community. Table 3.52 outlines the results:

Table 3.52 Clients' recommendations with regard to their participation in the management of CBR

AREA OF RECOMMENDATION	RECOMMENDATIONS FROM CLIENTS	TOTAL	%
Clients' needs:			48%
1) <i>Capacity building in CBR programme</i>	- PWDs expressed the need for an improvement of their management capacity to resuscitate their programmes. PWDs feel they need the capacity to boost morale and to improve participation in the community. They suggested someone should help them initiate this process. PWDs take it from there. They felt the Rehabilitation Department must help since they know where to access funds.	15	
2) <i>Continuing Education for clients in community</i>	The Health Education programme should continue with the aim to: - Continue having contact with health and rehabilitation workers and other ministries –They felt that education programmes come and go too quickly. - Education of the community on CBR and more education on participation awareness. The education should encourage sharing of ideas and change attitudes, especially of community leaders.	42	
3) <i>Management training</i>	Need training on management, budgeting and writing proposals and how to get new initiatives in IGPs.		
Organisational issues:			34%
1) <i>Decentralisation of CBR and continuous motivation of community</i>	- Decentralise CBR more and revamp it, boost it every 2 years to maintain sensitisation and motivation of the community.	9	
2) <i>Programme committees</i>	- Form committees for specific programs - set up IGP fund; Release funds for projects.	4	
3) <i>Involvement of all stakeholders in management</i>	- Involve all stakeholders in process of identification, planning, implementation and evaluation.	7	
4) <i>Fulfilment of promises by the implementers of CBR and Government.</i>	- The government should fulfil its promises to PWD, and: - They should support rehabilitation, train more professionals, have rehabilitation at clinic level; - Give PWDs some priority and work to obtain tangible results; - Set up a fund for IGP and work with the communities; - It is important for the programme organisers to promise things that they can fulfil. When they cannot fulfil promises it brings the programme down and it appears as if PWD are not taken seriously; - "Even if they can't fulfil, they must still give feedback".	4	
5) <i>Team work and cooperation</i>	- People need to work together (community and PWDs) as a team to get more participation, e.g. even raise funds. Don't mix politics with programme especially government, DPOs and health and rehabilitation workers.	12	
6) <i>Decentralise</i>	- CBR roots should be in the community and not the city, e.g. in Gweru, caregivers should be more involved in planning and implementation of CBR. Only they can help themselves.	6	
Resource Needs	- Need more financial and other resources. In this regard, the community should take more initiative to mobilise funds and PWDs should find money for IGPs. - Support for IGP projects from both community and other supporters, e.g. government (also need new IGPs). - We need resources such as manpower, material and money to get tangible results that will help encourage people to participate in CBR.	35	29%
Rehabilitation care / client care			27%
1) <i>Identification of clients</i>	- Identification and referral should continue through surveys and screening sessions to identify all clients; - Programmes should not end so quickly and should be continuous; - Teach mothers on how to look after child with disability, and how to do exercises.	2 22	
2) <i>Vocational training</i>	- Vocational training for adults.	9	
Communication		6	11%
1) <i>Regular communication</i>	- For community participation to improve, meetings and communication should take place and be followed up regularly.		
2) <i>Feedback and regular update</i>	- Facilitators must have better communication and contact to avoid collapse of programmes and maintain everyone's awareness. Regular follow-up and support from facilitators especially the health team. - Update community regularly on the status of the CBR programme.		

Provision of basic needs 1) <i>Land</i> 2) <i>Reduce distances from rehabilitation</i> <i>Improved social welfare assistance</i>	- Meet basic needs e.g. community leaders should assist with resources like land, and facilitate the reduction of distances that people walk to meet rehabilitation personnel. - We need to be included in land provision - Rehabilitation must come to the community - Improve social welfare; - Get more social welfare for food and basic needs.	7	6%
Schooling	- Client wants to go to a better school that is accessible so he can help others. He feels government must provide schooling.	3	3%
Improve facilities for PWDs 1) <i>Build community centre</i> 2) <i>Sporting facilities</i>	- Clients have a centre halfway completed and they must finish this in order to have somewhere to operate from. Need more facilities to encourage community participation, e.g. soccer and games facilities.	4	3%
No suggestions	- Know nothing; - Everyone in community has own mission.	6	5%

n = 122

There were many recommendations, and when categorised, key focus areas could be identified. Recommendations include capacity building needs and organisational issues. Forty eight percent (48%; n = 58) of the clients regarded capacity building for enhancing participation, how to educate the community on CBR, IGPs, budgeting and writing proposals as the major issues that need to be addressed. Of concern among the clients were the issue of *"broken promises"* (Direct quote from raw data) and the lack of a perceived follow-through of activities by the health worker, community leaders and government structures. The client interpreted this lack of feedback and follow-through as *"we are not being taken seriously"* (Direct quote from raw data).

In conjunction to this, regular communication and frequent feedback was recommended. Approximately ten percent (10%; n = 11) recommended regular communication to avoid the *"collapse of the programme"* (phrase used by clients). In some of the recommendations regarding the organisational issues, the clients said CBR should not be *"mixed with politics"*. The study did not explore this statement further but the implications thereof for participation may need to be explored.

Under the category of rehabilitation and patient care, clients recommended that in order to continue the identification process, the continual survey and screening of clients within the community should take place regularly and must not be a once-off event. In line with capacity building but specifically under client rehabilitation care, it was requested that the mothers with disabled children be trained in their areas of need. Each of the clients' recommendations, no matter how small the number of clients who put it forward, should be taken seriously and investigated, because it is the fulfilment of the client's needs that will drive the CBR programme.

Not surprising, resource mobilisation needs and improved access to resources were among the recommendations from clients. Clients recommended that the government and the community assist them with resource mobilisation. Related to resources was the request for improved community facilities such as sporting facilities and a community centre.

As found from the study and mentioned previously, the VCW is a key role-player in the CBR programme and in driving the participation process. Recommendations from the VCWs are shown in Table 3.53.

In Annexure 5, the VCWs were asked to outline what recommendations they had as far as the CBR programme was concerned. The recommendations were also discussed at length in the focus group discussions. It is important to note that the same recommendations as those in the questionnaires were put forward in the focus group discussions.

Table 3.53 VCWs' recommendations for participation in and management of CBR

AREA OF RECOMMENDATION	RECOMMENDATIONS MADE BY VCWs	TOTAL
Resources from government	Government should give/assist in cash and provide land especially for IGP. IGP assistance currently available through MOH should be boosted and supported by other sectors.	9 (36%)
Organisational and management issues	- Projects should be started, e.g. IGP and be planned long-term. Health workers and other role-players must not take too long before making contact with the community and key stakeholders.	6 (24%)
1) <i>Project sustenance</i> 2) <i>Meetings: Specific meetings for VCWs.</i>	- Must meet at three or six monthly intervals for consultations and education. Although the VCWs and health and rehabilitation workers meet at EPI points, they want other specific meetings to deal with issues that are specific to disability.	6 (24%)
VCW status:		
1) <i>Incentives motivation</i>	- Provision of transport and uniforms for VCWs that visit clients, e.g. bicycles and transport for PWDs to improve referral; - More recognition for VCWs in order to be motivated (for disability issues) to do the work.	7 (28%)
	- Uniforms and badges would improve recognition in the community. - More training and refresher courses for VCWs.	6 (24%)
Participation:		
1) <i>Stakeholder involvement</i>	- All stakeholders should help us achieve our objectives; especially chiefs should give a better hand in CBR issues. In one district an example was made of the Mberengwa Centre for PWDs.	5 (20%)
1) <i>Community involvement</i>	- There is need to encourage the community to get involved in identifying PWDs and to accept CBR as their programme through more community awareness campaigns and more training.	4 (16%)
Other	- Build clinic nearer; - Social welfare for PWD for basic needs; food and clothing should be provided.	6 (24%)

n=25 (VCWs gave more than one recommendation).

The VCWs had recommendations in three major categories, namely resources, organisational and management issues, including improvement of VCW status in the community and the need to improve community participation. The VCWs expressed the

lack of resources as a hindrance to CBR and have recommended the need to boost CBR resources. Because the VCW is a key person in the CBR programme, it is important for the managers of the programme, to always reflect on the motivation of VCWs. They have brought this up and recommended that incentives for them be considered. In the focus group discussions, this point was discussed at length and the VCWs explained that they were not primarily looking for monetary gain, but there are advantages in improving their status and recognition in the community.

3.11.3 Recommendations of community leaders on their own level of participation

Community leader involvement was regarded as an important contribution to community participation. In the light of this, community leaders were asked if they were happy with their own level of involvement (Annexure 4) and if they had specific recommendations that would improve this area. Table 3.54 outlines the areas recommended by community leaders for improvement of their own participation.

Table 3.54 Community leaders' recommendations on areas needing improvement of their own involvement in CBR

CATEGORY	RECOMMENDATIONS AND AREAS NEEDING IMPROVEMENT	TOTAL
Consistent funding	For example, funds donated for the community rehabilitation centre came in small amounts and not at once, which made the progress difficult.	2 (11%)
Management lost Momentum	Community Rehabilitation Committee seems to have lost momentum – 'we need to restore this'.	2 (11%)
Involvement of community in CBR	Involvement of all community members should increase. There's no involvement at all except discussions, which have not yielded anything.	6 (33%)
Notification of events	Health and rehabilitation workers notification of events to community leaders was said to be very low – community leaders wanted to be notified monthly.	2 (11%)
No communication with coordinating office	Better communication can be achieved by liaising and sharing information with the District Council Office.	4 (22%)
Poor understanding	Community leaders have not fully grasped the concept of involving PWDs. Education sessions among the community leaders recommended more capacity building.	2 (11%)

n = 18 (Community leaders gave more than one recommendation)

Twenty two percent (22%; n=4) of the community leaders that said they were happy with their own level of involvement and felt an improvement in the consistency of funding would enhance their participation. Those community leaders that were unhappy with their level of involvement felt an improvement in the communication between

themselves and the health and rehabilitation workers would affect their involvement positively. This was echoed by fourteen (14) out of the eighteen (18) leaders in the general recommendations described in Table 3.55 below.

Table 3.55 General recommendations by community leaders for managing and participating in CBR

AREA OF RECOMMENDATION	RECOMMENDATION BY COMMUNITY LEADERS	TOTAL
Regular visits and communication	- The health and rehabilitation workers should visit more regularly, have regular meetings with community leaders and should be seen to be involved and more visible. This can be done through: - o Attending Ward Health Team (WHT) meetings; - o Health and rehabilitation workers writing and sending reports to community leaders; - o Getting VCWs to give information on what is happening at community level; - o CRC should communicate more with leaders and leaders must apply what they have learned in the community; - o Rehabilitation Department and government to "move closer to the people" - i.e. decentralise. Problems should be attended to quickly when brought forward to health and rehabilitation workers.	14 (78%)
Capacity building through fund-raising	- MOH should help us understand how we can source funds, involve community fully. In addition, Rehabilitation Department should work closely with community leaders in order to understand them.	4 (22%)
Poverty alleviation	- We need more assistance for poverty alleviation, especially from NGOs (in the form of money, material input and resources.) Resources will quicken most processes.	6 (33%)
Support IGPs	- Support IGPs fully to decrease poverty among PWDs – training on how to manage IGPs is required. It should be encouraged that if anyone is doing a project, they should involve PWDs.	3 (17%)
Disability issues should be incorporated at the Rural District Council	- Rural District Council should systematically provide assistance to PWDs.	6 (33%)
Resources for community workers	- Bicycles should be provided to community workers and community leaders to help with work - meetings often far away.	2 (11%)

n = 18 (Community leaders gave more than one recommendation)

In Table 3.55, seventy eight percent (78%; n=14) of the community leaders recommended improved communication with the health and rehabilitation workers and made concrete suggestions as to how this can be done. They also cited the reduction in poverty as tantamount to quickening most processes in CBR; hence improving participation. Community leaders' participation and vantage point of being able to use the political and administrative systems puts them in a powerful position, enabling them to influence the programme. Their recommendations in all the other areas outlined in

Table 3.55 should be taken seriously and implemented to improve the participation of community leaders.

3.12 CONCLUSION

Chapter 3 provides a detailed presentation of the research methodology in practice and the results obtained from the data collected. The results are presented around both the respondents and the objectives with the first section covering the area and level of involvement of the key stakeholders in CBR. The client is the central focus of the whole programme; hence the results concerning the client, their level of participation and all the key issues that would affect their participation have been presented in that order. The clients' understanding of participation, their attitude, specific areas in which they participated and level of involvement and participation in planning for CBR has been presented first. The community leaders, VCWs and health and rehabilitation workers' results have also been presented in this order.

The mean score of the level of involvement in planning for CBR of all four key stakeholders concluded this section. Other aspects in which the results indicated the level of community participation, were the presence of support systems such as community-based organisations, NGOs and community initiatives. The results further indicated the dynamics and links between key role-players, the official linkages and structures (both formal and informal communication) and the different aspects that the key role-players communicated about. The factors that affected participation, such as resources and community cooperation, were included into the discussion on the linkages and structures. Finally, the recommendations from the clients, community leaders and VCWs were presented.

In the chapter 4, the above results are discussed, highlighting the key findings and their significance.

CHAPTER 4

DISCUSSION OF RESULTS

4.1 INTRODUCTION

In this chapter, the results of the data gathered through the questionnaires as well as the focus group discussions and analysis of relevant archives of official reports on CBR on National, Provincial and District level, are interpreted and discussed, with reference to the relevant literature where applicable.

The discussion takes place in the same sequence in which the results were presented in Chapter 3, i.e. understanding participation (Objective 2), participants' attitude towards participation (Objective 3), areas in which the participants participate in CBR (Objective 4), and the level of participation in CBR (Objective 1) of the respondents in the study. The discussion is also aimed at answering the objectives of this study (Section 1.4.1, Chapter 1). Due to the integration of the results in order to discuss the outcome of the study in terms of the objectives described in Section 1.4.1, Chapter 1, mention will be made to the relevance of the discussion to the respective objectives of this study.

4.2 AREAS AND LEVEL OF PARTICIPATION IN THE MANAGEMENT OF CBR, BY THE CLIENTS (PWDs), VILLAGE COMMUNITY WORKERS (VCWs), COMMUNITY LEADERS, AND HEALTH AND REHABILITATION WORKERS

The rationale behind studying the level of understanding and subsequent action of the key role-players in CBR is that the very concept of ownership and empowerment requires that a person have a full understanding of the issue at hand (Chambers 1987). In practice, this means community members must understand what participation is and why they should participate and become active subjects in the process, instead of only becoming objects of the process. Therefore, the aim of the study was to find out how much of the concept of participation they understood and what action they took subsequently; hence getting them to reflect on their level of participation. The results of the clients are discussed first, followed by that of the VCWs, community leaders and the health and rehabilitation workers.

4.2.1 Clients' understanding of CBR, the areas and level of participation

Each of the aspects of the clients' understanding of CBR, their areas of participation, their attitude to participation and the level at which they were participating are discussed in the following sub-sections. Each subsection is formulated in order to answer objectives 2, 3 and 4 in that order. Finally, objective 1 is answered with reference to each of the target groups.

4.2.1.1 Clients understanding of participation in CBR

Poulton (1999) and Simmons-Mortom *et al.* (1995) describe the essence of participation in three categories, i.e. compliance, contribution and collaboration. Poulton (1999) defines compliance as when people agree with planned activities and are relatively passive in their own contribution materially and conceptually. Contribution refers to their active contribution materially, or through their ideas or labour. Collaboration involves a combination of both conceptual and physical contribution. It also implies a deeper exchange of ideas and collaborative implementation, with every role-player contributing to all stages of the programme.

In Table 3.5, Chapter 3, clients stated that as PWDs, they should attend meetings, thereby implying that their understanding of participation can be categorised as compliance. According to the clients, they receive information and are taught how to look after themselves, perform exercise therapy and how to participate in income generation. They receive general assistance and information. Based on this perception, it can be said that clients are empowered to participate in CBR. Therefore, their participation can be interpreted as taking place on the level of compliance according to the definition given by Poulton (1999). With regard to contribution, they felt they should contribute to development issues in the community and be included in decision-making aspects.

Clients implied collaboration in their statements when they said that PWDs should be involved in solving their own problems, working together with the rehabilitation team and *"PWDs doing it and not health workers"* (Direct quote from raw data). Despite this, they explained that they did not really collaborate due to economic constraints. Seventy one percent (71%) of the clients did not regard contribution in the form of concepts and ideas as collaboration, while twenty nine percent (29%) had no understanding of

contribution at all (Section 3.4.2, Chapter 3). It is therefore clear from the discussion that the clients' understanding of participation in CBR is not optimal, as there is a tendency to compliance and contribution rather than collaboration.

Oakley (1989) quoting Chambers (1987) highlights the importance of when an outsider (in this case a therapist on provincial level or any similar expert) wants to intervene in the community, he/she should intervene from the perspective that a local community should be empowered and not be advised or shown how to solve their problems from the expert's perspective. This is the concept that Chambers in Oakley refer to when he says: *"shifting and reversing the practice"* (Oakley 1989, p. 4). From the results in Section 3.4.2, Chapter 3, where it is indicated that twenty nine percent (29%; n=35) of clients had no understanding of participation, twenty nine percent (29%; n=35) had a limited understanding of the concept of participation, and thirty four percent (34% n=13) had an understanding of participation, the conclusion can be made that:

- Although the participation of clients in CBR is poor, it seems to be in a developing stage (29% of clients could describe some aspect of contribution to CBR);
- The level of clients' understanding of participation in CBR (almost a third of clients with a limited understanding of participation and almost a third with no understanding of participation) has a negative impact on the client's level of involvement in CBR;
- The empowerment of clients therefore needs to be emphasised more to achieve a greater understanding of clients' understanding of their own potential in development.

4.2.1.2 *Clients' attitude to participation in disability issues*

It has been established that attitude towards disability has a bearing on participation. Coleridge (1993) and Triandis (1996) argue that attitudes are multidimensional entities composed of a cognitive component (belief), an affective component (feelings) and a conative (behavioural) component. This implies that what the client believes and feels, as well as previous behaviour, will influence his attitude. With this in mind, a client's attitude towards his own participation in CBR depends on, or relates to his/her perception of who should hold the responsibility for the rehabilitation or care of the PWD.

From the results in Tables 3.6 and 3.7, Chapter 3, the attitude of the client with regard to CBR would be implied by his/her perception of who holds responsibility for the PWD. Clients felt that the government, community and family hold partial responsibility for the care of PWDs. No clients denied that they have responsibility for caring for themselves or participating in their rehabilitation. However, they did not indicate that responsibility of the PWD in caring for themselves, as a priority. Reasons for this may be that the majority of clients may not be able to take responsibility for themselves because of the nature of their disability and the age range of PWDs as shown in Table 3.3, Chapter 3. The fact that forty percent (40%) of PWDs in this study were below the age of nineteen and would probably have been in the care of their parent/s or caregiver anyway, could have influenced the answer given during the interview.

However, the Midlands Province Annual CBR Report of 1997 reported that clients have a definite charity oriented attitude among PWDs, quoting that *"Clients asked why couldn't you just provide us with social welfare in the form of food and clothing?"* This quote supports the results discussed in the former paragraph.

The conclusion made is that clients still do not have inner self-reliance, but instead rely on external players to take responsibility for them. This would therefore affect participation negatively in that clients and their caregivers may not be proactive and take the initiative to do things for themselves either in a contributory, collaborative or cooperative manner.

Clients' attitude towards participation in CBR will also be reflected by the types of activities of daily living (ADL) that they perform. According to the results from Table 3.8, Chapter 3, clients carried out various ADL, access to community amenities, ambulation and leisure activities. The ADL in which clients participated, as shown in Table 3.8, Chapter 3, reflects that although at least half of the clients spend time on their exercises and other ADL, participation is taking place at a family and individual level, i.e. ADL, access to community amenities and leisure activities. Again, the age range of the respondents in this study could have influenced the specific activities carried out by the PWD and their families.

According to Coleridge (1993) on empowerment, the client should feel that responsibility for participation lies first and foremost with the individual, before the family, community and government. The results imply the reverse.

Coleridge (1993, p. 4) asks the pertinent question: “*What creates change? Is it achieved by feeling pity towards people ... or by the poor and oppressed recognising their own strength to solve their problems?*” He promotes the latter, implying that in this context, people who are disadvantaged should be empowered to recognise their own problems and their own potential in order to solve their problems.

In Table 3.7, Chapter 3, the opinion of the clients with regard to the person responsible for the PWD is shown. It offers an indication of the attitude to participation in disability issues. What is clear from the reasons given is that the clients see a role for both the family and the government to an almost equal extent. Based on the literature of Coleridge (1993), the Midlands Province Annual CBR Report of 1987 and the results from this study, one can therefore conclude that the attitude among clients is not negative; however, it is still not one of inner reliance, as fifty five percent (55%) of clients still regard the government as totally responsible for the PWD. It is also important to realize that Coleridge’s principle (1993) regarding the self-responsibility of the PWD for recognising and managing their own problems will not only depend on the age of the client but also on the type and extent of the disability.

When applying Coleridge’s principle (1993) to a specific community, it should be emphasised that in the case of a disabled child of a severely disabled person, it can be expected from the family to recognise *their own strength to solve their problems*.

4.2.1.3 *Practical areas of involvement and participation by PWDs and family in CBR*

The clients’ areas of participation are discussed under two sections. The first is activities carried out by the PWD and the family on a personal level. The second section looks at activities involving PWDs within the community. The latter is an expression of participation in CBR.

On the personal level of clients’ participation in CBR, the trustworthiness of the results from the study are optimised by correlating the data from:

- The type of activities (ADL, ambulation, mobility, access to school and community amenities and leisure activities; Table 3.8, Chapter 3);

- Specific activities carried out by the PWD and his/her family (Table 3.9, Chapter 3);
- Time spent on the activities (Figure 3.4, Chapter 3);
- The way in which these activities helped the PWD (Section 3.4.2.3, Chapter 3).

(1) *Activities carried out by the PWD and his/her family*

Despite the above position of reliance on external players to take major responsibility for CBR, the results in Tables 3.8 and 3.9, Chapter 3, indicate that the clients and their families already play a very significant role in the rehabilitation of the clients, e.g. in ADL.

Helander (1991) asserts that most people who are dependent on others and have the potential to improve their functional performance, will need rehabilitation. Helander (1991) is also of the opinion that some disabilities only become apparent as a result of environmental factors such as restriction of human rights, resulting in denied entry into school or participation in family activities. To avoid such restriction, there is a need for integration of intervention and responsibility, and the PWD taking responsibility for himself. This intervention and responsibility for the PWD should be shared between himself, his family and the local and provincial government.

In this study, families reported spending much of their time on activities related to the disability of the client, such as specific exercise and activities. Only nine percent (9%) had spent time on community related factors.

The results in Table 3.9 and Figure 3.4, Chapter 3, imply that families spent fifty percent (50%) of their week carrying out supportive activities for their family members who have disability. The type of activities carried out by the family concern those issues regarding the basic survival of the client around the home, and to a lesser extent in the community and income generating projects. Thomas & Abrahams (1994) support the importance of the family as a source of support and manpower in rehabilitating the PWD. The results from this study show that the family is active in the clients' rehabilitation and participates actively in the clients' needs around the home. From all the time spent with the client, the clients and their families reported perceived benefits such as improvement in mobility, self-esteem and other functional activities.

The results reflect the amount of time clients spent on these activities, and which are in line with the reported areas of benefit. There was consistent improvement in all areas of activities for clients who could not perform these activities before the CBR programme was introduced and could do so at the time of the interview. The degree of improvement reported by the client and the family indicates an increase in the level of participation by the family since the introduction of CBR. The families and clients attributed their participation at the level they were involved in to an improved knowledge base and attitudinal change that they obtained through the meetings as outlined in Table 3.40 and figure 3.5, Chapter 3. Furthermore, Myezwa (1995) and Helander (1991) have both proved that home programmes definitely result in benefits for the client.

2) *PWDs' involvement in community initiatives*

In Section 4.2.1.3 (1), Chapter 4, it was indicated that, at the immediate family and household level, the client showed improvement on a personal functional level. However, in the broader community it was not the case. The community leaders also echoed this view of less involvement of clients in community initiatives in Table 3.24, Chapter 3.

In the description and definition of rehabilitation, Helander (1991) outlines several concepts that the term rehabilitation encompasses. He outlines the concepts that focus on:

- The individual with disability "*Rehabilitation includes all measures aimed at reducing the impact of disabling and handicapping conditions and enabling disabled or handicapped people to achieve social integration*" (Helander *et al.* 1989, p. 17);
- The presence of physical barriers in the environment; i.e. terrain, home environment and community surroundings;
- Concept related to equalisation of opportunity;
- Concept of focussing on human rights.

In Section 4.2.1.3 (1), Chapter 4, the concept encompassing the individual and the presence of physical barriers, particularly around the home, has been dealt with and illustrated as they have been applied by clients in the CBR programme. However, the

second two concepts, i.e. equalisation of opportunity and the concept of human rights, have not been fully applied.

The concept of equalisation of opportunities means the process through which general systems of society, such as the physical environment, housing, transportation, social and health services, educational and work opportunities and cultural and social life, including sports and recreational facilities, are made accessible to all people. This concept drew attention to the widespread discrimination against PWDs in all societies, and resulted in the UN World Programme of Action (1982) drawing attention to this point.

Some examples from the results that reflect the application of the concept of the equalisation of opportunities are given in Table 3.8, Chapter 3. It shows that thirty three percent (33%; n=40) of the clients have tried to gain access into school and twenty eight (28%; n=34) into public amenities. A small number, eleven percent (11%; n=13) of the clients said they tried to access activities of income generation and employment (Table 3.9, Chapter 3). However, in the final analysis, it was found that it is the client's opportunity to participate in planning the CBR programme that is not at an optimal level (Figure 3.5). This fact touches on both the equalisation of opportunity and the human rights concepts of CBR.

Finally, the concept focussing on human rights sought similar goals as that of equalisation of opportunities, but also sought the full participation and equitable opportunities for PWDs. This concept has drawn attention to human rights issues and will influence the future direction of CBR programmes. In this study, clients were actively participating in CBR at household level. The results in Table 3.8, Chapter 3, show that clients were less active in community activities. The activities the clients were involved in revolved around the individual with disability, the terrain and the environment within the home. Some clients concentrated on activities within the community. As described above, only eleven percent (11%; n=13) of the clients reported being involved in IGP, thereby reflecting their reduced capacity for economic empowerment. In addition to this, it can be interpreted through statements made by clients, e.g.: *"community leaders exclude us from meetings and do not take us seriously"* (Direct quote from raw data) (Section 3.9.1.1, Chapter 3).

From the results it can be concluded that clients themselves did not feel involved and did not feel that they and their opinions are valued in the community, which indicates an infringement of their human rights. Intervention through the CBR programme will need to be re-examined from a human rights conceptual perspective. CBR underscores the need to recognise this concept and the entire process of planning for CBR. Efforts to protect and promote the human rights of PWDs should be the cornerstone of CBR.

4.2.1.4 *Clients' level of involvement in CBR planning*

As shown in Section 3.4.2.4, Chapter 3, twenty three percent (23%; n=28) of the PWDs viewed themselves as having community control. Fourteen percent (14%; n=18) perceived that they were planning jointly with the community leaders. Twelve percent (12%; n=15) planning jointly while thirty three percent (33%; n=41) only received information on what was planned. Fifteen percent (15%; n=19) felt they hadn't been told anything. The clients' mean score was calculated on the Community Participation Group of the United Kingdom for All Network (1991) scale. Forty eight percent (48%; n=60) of the clients did not participate in CBR planning, which is a significant number. It can therefore be concluded that the client's involvement can be interpreted as low and needing improvement. This is in agreement with the results that show that the clients felt left out of the planning process. In addition, it also agrees with the fact that lower numbers of health and rehabilitation workers (60%; n=9) and community leaders included PWDs directly in the planning process. (Figure 3.5, Sections 3.4.1, 3.4.4.3 and Table 3.21)

4.2.2 VCWs understanding of participation, areas and level of participation

This section discusses the VCWs' level of understanding, areas and level of participation in the same trend of thought that explains that understanding the concept of participation will influence the areas and level of participation by the VCW.

4.2.2.1 *VCWs' understanding of community participation*

The VCWs are central to the CBR process. They are part of most of the development committees that are operational in the community, i.e. the Community Rehabilitation Committee, Community Development Committee, District Health Committee and in some areas the Village Development Committee. Community leaders (n=15) reported

that the specially formed Community Rehabilitation Committee was the main support system for the PWD.

The following direct quote recorded at the Gweru VCW focus group discussion illustrates the role of the VCW in CBR: "*As people who are close to the community, we are the chief actors and we are there throughout the process*". VCWs regard themselves as playing a central role in community participation in CBR. They emphasised the contribution and collaboration aspects in the focus group discussions. VCWs gave less emphasis to contribution when compared with the community leaders and clients. However, they displayed a balanced understanding of community participation (Section 3.4.3.1, Chapter 3).

4.2.2.2 *Areas in which VCWs participate in CBR*

Helander *et al.* (1989) state that organisational problems in most developing countries include the lack of infrastructure. In their description, infrastructure goes beyond the physical building and includes the organisational structure (human resources). However, the VCWs in the areas of study were evidently important players in the organisational support for CBR. The results in Table 3.11, Chapter 3, show that the VCWs were active in many areas. The activities of VCWs in these areas will be discussed separately.

The level of participation by the VCWs can be regarded as very high in the activities outlined in Section 3.4.3.2, Chapter 3. Furthermore, the reference to the VCWs' key role was supported by the other key stakeholders, namely the clients, the community leaders and the health and rehabilitation workers (Tables 3.13, 3.18 and 3.19; Section 3.4.3.2 and Section 3.7.8, Chapter 3). The level and degree of participation of the VCWs in CBR were also measured by looking at the different activities and the amount of time spent with clients in their own environment. Therefore, it was important to study the activities being carried out by the VCWs and understand how they filter through to the client. These activities are discussed in Sections 4.2.2.2 (1) - 4.2.2.2 (2), Chapter 4.

(1) *Activities carried out by VCWs*

Seventy two percent (72%; $n = 18$) of the VCWs that were interviewed had spent their time on activities for income generation and forty percent (40%) on activities to

increase knowledge and practice on the part of the client and the parents/caregivers. Relating this to the activity of the clients and their families, fewer clients (11%; n = 13) and their families reported spending time on activities for income generation. There was some contradiction in the results, because thirty six percent (36%; n = 44) of the clients reported being involved in community initiatives for income generation, while forty one percent (41%; n = 50) reported improvement in their participation in IGP activities. The latter results would therefore support that the VCWs were spending time promoting activities for income generation for PWDs, although this may not be recognised at the individual client level. The community leaders and VCWs also said that income generation was one of the means they used to alleviate poverty for the PWDs. In conclusion, the results show some disharmony in the perceived efforts of VCWs and the felt needs of clients. VCWs and CBR facilitators would need to evaluate the effective outcome of their efforts in IGP.

(2) *Evaluation activities carried out by VCWs*

Earlier research done by Finkenflugel (1991) and Njini *et al.* (1991) showed that the VCWs in their capacity as local supervisors were key role-players in keeping the CBR programme alive. In his article, Finkenflugel (1991) suggests strengthening the local community and local people to supervise, train, support and monitor the progress of PWDs. In Midlands Province, the VCWs were active in many activities, with forty four percent (44%; n = 11) carrying out one (1) visit a month and the rest two to three (2-3) visits per month to clients. During these home visits, they carried out activities to do with function, mobility and IGP. Eighty percent (80%; n = 20) reported also monitoring the client's progress in all these aspects as well as the client's general progress in the agreed rehabilitation programme. This was viewed as an important aspect of ongoing monitoring and evaluation. It can therefore be concluded that VCWs are active in the continuous evaluation of the client's status, by reviewing their present status and areas of need.

Thirty six percent (36%; n = 9) of the VCWs said discussion with caregivers and compilation of subsequent reports for health and rehabilitation workers was a major activity of evaluation for them. None of the evaluation activities were structured. All these activities could indirectly influence the future direction of the CBR programme; however, in addition, none of the VCWs mentioned involvement in evaluation of the overall programme. Due to the lack of structure, they could not visualise their specific

contribution to a holistic evaluation of the programme. This situation is not desirable and should be addressed by the programme facilitators. The need for the VCWs to see the whole picture is important because they hold such an influential position in the programme and facilitates many of the key functions in CBR, such as the referral system and collaboration with other key stakeholders.

4.2.2.3 *The referral system*

An important activity for the VCWs is their role in and facilitation of the referral system. The referral system for the client involves the use of health and other services at the different levels of operation. In order for the client to get from the community to, for example, the orthopaedic centre at the provincial hospital, he/she would first contact the VCW and would be referred to the clinic to ensure it is not something that can be dealt with at clinic level. Subsequent referral would take place once this is established.

The clients' level of awareness of the referral system was not a significant factor in influencing whether they used the referral system. The major factor was the lack of resources and related difficulties concerning transport, communication and logistics (Section 3.4.3.1 (5) and Table 3.47, Chapter 3). The VCW was instrumental in raising awareness on referral and assisting PWDs logistically, but had difficulties in solving the problems related to resources with regard to PWDs meeting services at the point and time of referral.

4.2.2.4 *VCWs' level of involvement*

In the MOH CBR Evaluation of 1991, it was found that the VCWs role was not clearly defined. However, in comparing the results from the report, the VCWs role in this study is certainly more defined in terms of their management and facilitation of CBR.

In Section 3.6.3, Chapter 3, the type of records that VCWs kept, is outlined. Section 3.7.2, Chapter 3, show the number of contacts the VCWs had with clients, Section 3.7.3, Chapter 3, indicates the VCW's utilisation of the referral system, and Section 3.7.8, Chapter 3, outlines the different roles of the VCW in collaboration with the health and rehabilitation workers. From these results, it is clear that the VCW is a central figure in the implementation of CBR activities and an important link in communication to the community. In Table 3.23, Chapter 3, the VCWs rated their level of participation as two

(2) (Table 3.23 in Chapter 3) on the Community Participation Group of the United Kingdom for All Network (1991) scale, which means they regarded their participation as high. This high level of involvement is a positive reflection of the effectiveness and the operation of the CBR programme.

4.2.3 Community leaders' understanding, areas and level of participation in CBR

4.2.3.1 Community leaders' understanding of participation in CBR

In the decade 1981-1991, the general impression regarding disability was that *"the perception of many governments and people in general is that rehabilitation, education and job placement for disabled people is costly and non-productive"* (Coleridge 1993, p. 5). In this regard, the researcher studied the level of participation, attitudes, understanding and areas of participation of community leaders as representatives of the government in the community as a whole.

In Zimbabwe, the administrative and political structures remain largely centralised as shown in the Prime Ministers Directive of 1999. Many of the community level committees depend on the guidance and interpretation of community leadership. In Table 3.14, Chapter 3, the results show that the community leaders tended to understand community participation as contribution (providing materially) and collaboration (engaging in discussion and decision making) in participation. There was less emphasis on compliance in participation, although it was implied.

In the focus group discussions, community leaders said they understood participation: *"as a process of understanding the way they as a community live, helping others and themselves within the community to achieve a common objective through training and support to do their own thing"* (Direct quote from raw data). They emphasized cooperation between community members to help themselves develop as a community. Community leaders emphasized the need for community education before participation can be achieved. The community leaders explained that leadership need to be in a position to teach the concept so that ultimately the community could cooperate and work together with them to carry out projects (Section 3.4.4.1, Chapter 3).

The understanding of community participation by community leaders in CBR is graded as fair because there are some gaps in their knowledge, especially in relation to CBR.

This can influence their guidance of the process of participation significantly. Community leaders said although they had a fair understanding of participation, the question of *how to facilitate participation* was not understood adequately.

4.2.3.2 Community leaders' attitude to disability issues

The community leaders' knowledge will shape their attitude towards PWDs, and their attitude can be interpreted according to their perception of who is responsible for the PWD.

(1) Perception of community leaders of responsible party for PWDs

As indicated in Table 3.15, Chapter 3, an equal number of community leaders felt the responsibility for the PWD lies with both the family and the community. Thirty three percent (33%; n=6) felt the responsibility lies with the government. Those who answered the question on the PWD's individual responsibility to himself, felt it lies only partially with the PWD.

Community leaders showed balance in their apportionment of responsibility for PWDs. It is important to explore those community leaders who felt that the community is totally responsible, as this position can result in abdication on the part of the community leadership.

In general, the perceptions of the community leaders imply a positive attitude towards CBR. Community leaders' attitudes can be viewed as not impacting negatively on participation in CBR in the districts under study. However, there are aspects of inactivity among the community leaders on issues to do with disability, which they need to be made aware of in order to address it effectively. In some areas community leaders showed a poor understanding of the concept of participation and inadequate collaboration and utilisation of the official structures in enhancing CBR. Twenty two percent (22%; n=4) of community leaders did not understand community participation and CBR. Some community leaders acted in their individual capacity and not in their official status as community leaders. This could be as a result of the absence of health and rehabilitation in the integrated community development plans (District Development Plans).

4.2.3.3 *Areas in which community leaders participate in CBR*

In this study, the community leaders were included in their capacity as representatives of the government. Oakley (1989) in his discussion of the role of government in participation states that it is more important to study the nature of participation; i.e. is it understanding control and mobilising local resources for the local development, or redressing of imbalances in previous strategies in favour of people previously excluded from community programmes.

(1) Activities indicating community leaders' participation in CBR

In Table 3.16, Chapter 3, the contribution of materials, manpower and money and negotiation on behalf of PWDs seemed to be the most common way for community leaders to contribute to the implementation of the CBR programme. Only one community leader said he never contributed. It can therefore be concluded that community leaders in the areas studied participate actively in activities for PWDs. Their participation is however more evident in easier activities such as contribution of labour and manpower, and less visible and tangible in activities encouraging collaboration and cooperation.

The community leaders regarded the Community Rehabilitation Committee as an important support body for the PWDs in the community, in collaboration with the Community Development Committee (Section 3.4.4.3, Chapter 3). However, it is not clear how the community leaders supported the Community Rehabilitation Committee as leaders. Although eighty percent (80% n=12) (Table 3.18) indicated that community leaders were members of the Community Rehabilitation Committee, the respondents were not the only leadership that would be present as members of the mentioned Committee.

It can be concluded from the results that the community leaders are contributing to the CBR programme and participating in their capacity as leaders but more so in their capacity as individuals (Section 3.4.4.3, Chapter 3). Their role as leaders in office is therefore not being fully realised and utilised to enhance the full potential of community participation in CBR. This view is supported by their own admission in Section 3.4.4.1, Chapter 3, to the fact that they need education on how to facilitate community participation in CBR.

4.2.3.4 *Level of participation of community leaders in CBR*

O'Toole (1991) states that a community response to disability can be judged by the way they look after the needs of those with disability in the community. In Table 3.26, 3.39 and Section 3.7.5, Chapter 3, the community leaders reported that they work well with the health department and collaborate well through meetings, but their lack of awareness of the committees working with PWDs show an inadequacy in their collaboration with regard to CBR and participation in CBR. In one district, community leaders felt they were participating well and collaborating through meetings.

Although the impression was not one of community leaders' completely abandoning the PWD and disability issues, there are areas as outlined under each area of participation of PWDs in CBR, where the community leaders need to improve their participation, especially their role in mobilising community resources and facilitating the functioning of the various committees. Another important duty of the community leaders is the facilitation of community support systems for PWDs and redressing the imbalances for PWDs in various community initiatives and functions. In this regard, this study also explored the support systems that had been developed in the community.

(1) Support systems within the community for PWDs as regarded by community leaders

The community leaders regarded the emergence of community support systems as a good indicator of participation. The presence or absence and the subsequent use of community support are indicators of the successful and effective participation of the community through the established structures (Oakley 1989). This manifestation of community support systems is still poorly developed.

Community leaders were asked what community support systems exist. They regarded the Community Rehabilitation Committee as a main support structure; i.e. a specific committee for community rehabilitation issues (Section 3.4.4.3, Chapter 3). However, its effectiveness within an apparently verticalised structure may be questioned. It is the balance of understanding such a concept involving mainstreaming that needs to be realised. This lack of understanding is illustrated by the community leaders who did not regard the inclusion of CBR in the Community Development Committee as a support

system, although in another question they had included CBR in their community development agenda (Table 3.39 and Table 3.19, Chapter 3). Disabled Peoples Organisations (DPOs) and even less so, Non-Governmental Organisations (NGOs) were not regarded by the community leaders as a source of support for PWDs.

From the results in this study it can be concluded that support systems for the PWDs are not fully developed and operational. The very nature of a support system is still poorly understood by the community leaders themselves. Without the necessary support, PWDs and their caregivers may be discouraged and this would in turn affect participation.

4.2.4 Health and rehabilitation workers' understanding, areas and level of participation in CBR

4.2.4.1 Health and rehabilitation workers' understanding of community participation

Poulton's (1999) definition of participation, where he describes participation as falling into three categories, namely compliance, contribution and collaboration, was also used to classify health and rehabilitation workers' understanding of community participation. The health and rehabilitation workers that were interviewed for this study showed a balanced understanding of community participation, describing it in all three areas. Their resultant action to encourage participation was studied by looking at whom they involved in the planning for CBR. They viewed their own involvement as a prerequisite for the implementation of CBR.

4.2.4.2 Community stakeholders consulted by health and rehabilitation workers

In the Zimbabwe Strategic Health Plan 2000 – 2005 (Zimbabwe MOH 2000), the MOH refers to the definition of community involvement outlined by the 1987 WHO Report on the Inter-regional Meeting on Strengthening District Health Systems based on Primary Health Care. This definition brings to attention some aspects that are studied under this section:

Community involvement for health development is understood to refer to a process to establish partnership between government and local communities in the joint planning, implementation, evaluation and use of health services in order to increase local self-reliance and control over health care. Community involvement means that people, who have the right and duty to participate in solving their own health problems, have greater responsibilities in assessing health needs, mobilising resources and suggesting new solutions, as well as creating and maintaining local organisations. (Zimbabwe MOH 2000, quoting WHO 1987, Community Involvement in the Health Development, p. 65).

In light of this, the health and rehabilitation workers were asked whom they consulted in the process of implementing CBR. In answer, they emphasized the need for the community to be involved in any programme, stating: *"this results in the community and the PWD feeling important"* (quote from raw data). They reported in Section 3.4.5.2, Chapter 3, that they identified the problems pertaining to disability together with all stakeholders and planned, implemented and continuously evaluated the program as a joint effort. This was done mainly through discussions at meetings and not by implementing any particular participatory tools. All but one health and rehabilitation worker involved VCWs, and all worked with the community leaders (Table 3.21, Chapter 3). Sixty percent of health and rehabilitation workers (60%; n=9) involved the PWD in the planning process. However, taking into consideration that the PWD is the key role-player and therefore fundamental to CBR, this is not an optimal situation. This non-involvement was expressed by the PWDs themselves and their families, as only twenty three percent (23%; n=28) of the PWDs regarded themselves as having control and full involvement in CBR planning (Figure 3.5, Chapter 3).

There was a statistically significant difference at a ten percent (10%) level between the involvement of the community leaders and VCWs in CBR. The VCWs were more involved in the planning process and their involvement was higher compared to that of the clients. It can be concluded that even the health and rehabilitation workers did not adequately promote the involvement of PWDs into the planning process. They depended largely on community organisational structures, which did not capture the involvement of PWDs in CBR.

4.2.5 A comparison of the level of participation and community involvement among clients, VCWs and community leaders

Coleridge (1993, p. 5) asserts: *"Existing models of project design, no matter how community oriented, tend to treat disabled people as recipients rather than participants in the decision making process"*. The Kruskal Wallis test was used to compare the mean score of the different groups on the question of involvement in planning, control and participation. A significant difference was found between the clients' opinion on their involvement and that of the VCWs and the community leaders. At 10% significance, a difference in opinion was also found between the clients' opinion of their involvement and the health and rehabilitation workers' opinion of the clients' involvement. At 5% significance, a difference in the level of involvement was found between the clients and the community leaders (Table 3.23, Chapter 3).

The conclusion reached here is that the clients have less involvement and control in the management of the CBR programme in comparison to the community leaders, VCWs and health and rehabilitation workers. From this it is evident that the paradigm shift from a situation where PWDs were completely left out to one where they are core decision makers, has not completely taken place. Although it was found that PWDs are not totally passive, they have not yet reached a state of real participation.

4.3 THE INFLUENCE OF THE DYNAMICS AND LINKS BETWEEN KEY PLAYERS IN COMMUNITY PARTICIPATION ON THE MANAGEMENT OF CBR

4.3.1 Official linkages in community and rural development

In answer to objective 5 (Section 1.4.1, Chapter 1), which sought to establish the dynamics of participation by the key role-players, official community structures and communication channels between the different community development levels were studied.

After studying the different structures, it would appear that the administrative structures supporting coordination, communication and management are clear, with the various committees in place as shown in Figure 3.6, Chapter 3. The integration of disability issues into these structures and translation of this into action has remained fragmented. There is evidence of some integration of disability issues in the MOH and at

community level, which was not the case before. However, there is no evidence of communication and integration of disability issues in the mainstream of development planning, management and administration under the Rural District Council. This is a situation that is present in spite of the high level of activity in CBR at community, village and ward level. The structures, i.e. the development committees at all levels to monitor development at community level, have not captured CBR and issues of disability as a development issue. It is beyond the scope of this study to answer why this is the case.

One of the major functions outlined in Subsection 12 of the Prime Ministers Directive of 1999 is that of coordination and submission of resolutions and plans. The structures do not encourage outwardly the integration of social and health services and education into development issues, or even integration of disability issues, and seem to treat them as separate entities. This is evident where CBR was not evidently integral but added on to a fully comprehensive plan, that CBR and other social issues are aligned within the development plans studied. The lack of integration of disability issues into development, impacts negatively on effective participation of the communities, especially the leadership, because they tend to follow what is written in official documents. Although the results show that seventy two percent (72%; n = 11) of the community leaders had incorporated disability into development plans, (Table 3.48, Chapter 3) there were those who had not and those clients who complained that they still perceived a lack of support from the leadership (Table 3.45, Chapter 3). In addition to this, the logistical problems could be attributed to the lack of resources from the official mainstream structures.

4.3.2 Retrospective study of existing records within MOH

4.3.2.1 *Records at provincial and district level*

The WHO state clearly in their Community-Based Rehabilitation and Health Care Referral Services Guide for Programme Managers (1994) that there is a relationship between the existing policies, the level of CBR activity and the participation of key role-players, including the community. From the study of the existing records within the MOH and the Rehabilitation Department, rehabilitation and disability issues have been integrated into the policy and strategic papers. In the local government policies, disability issues are only mentioned under social welfare issues.

At programme level, the data gathered by VCWs and health and rehabilitation workers, including that on rehabilitation, may allow for the key role-players to gain insight into the number of clients being seen and their geographical distribution per district. The development of a database currently in progress for CBR clients will give further insight into specific issues for the participation and management of clients. The records reveal that some statistics are going through the health information system, resulting in some inclusion of rehabilitation into mainstream health activities. However, all budget support for CBR is predominantly donor supported (MOH 1996, Midlands Plans). In this regard, development studies have shown that programmes that are donor driven are in the short term successful and even efficient, but in the long term they are ineffective and unsustainable (United Nations Development Plan 2000). The bulk of the funding for the CBR programme for activities that require funding is coming from donor funds; however, the larger needs for salaries and manpower are provided for by the community and the government.

The three areas of policy, information and funding (more specifically the provision of resources), which have been studied in the records, show anomalies that impact negatively on participation. Community participation in CBR has made progress from a situation in 1980 where nothing or very little was going on to the levels of participation shown in the study. In 1987, the WHO held an inter-regional meeting on strengthening District Health Systems and identified critical issues concerning community involvement in health. The issues include:

- *"Inherent contradictions between the orientation and structure of most government health systems and the conditions necessary for community participation"* (WHO 1987, p. 6). Some of the contradictions have become evident in this study, with the central government showing inadequate integration of governmental sectors and contradicting the needs at community level.
- *"Methodologies for re-educating and reorienting health staff towards community involvement have not been very effective"* (WHO 1987, p. 6). The health and rehabilitation workers interviewed could define participation, and their action in terms of the community they were involved in, was positive. Again the loopholes were evident, particularly in the area of communication and involvement of the PWD.

- *District Medical Officers and their teams often do not appreciate the value of community participation and are not sufficiently motivated or skilled to facilitate and support community involvement* (WHO 1987, p. 6).

The district health teams who completed the questionnaires showed sufficient understanding. However, they did not get involved any further than sanctioning activities and not actively stopping them. To quote one district medical officer: *"I know they go to the community to involve them but I leave it to them"*.

The records kept at provincial level captured the activities taking place at district level; however, details of what was actually taking place at community level was only captured as far as the statistics of numbers of clients, meetings (mainly at district and not at community level) and training were concerned.

4.3.2.2 *Records at community level*

The results of studying the records to determine the contact between the VCWs and the health and rehabilitation workers (Annexure 5) revealed a high level of information exchange through meetings, outreaches, home visits and clinic visits. Records kept at community level include those by:

- The VCW (keeping notes on patients in exercise books);
- The clinic (keeping a chronic patient register).

No records of minutes of meetings were seen at community level. Furthermore, no evidence of participation was seen in the records, although the other results about the type and frequency of activity carried out by the VCWs and outlined in Section 3.4.3.1 (1), Chapter 3, showed differently.

From the observed records it can be concluded that written records are being used inadequately for improving participation and their use could be improved for enhancing the flow of information and participation. Participation of all key stakeholders is not captured in these records at all. The client information contained in the records is in itself evidence of some participation, however, the documentation is not instrumental in enhancing participation. The quality of the documented information was not investigated in this study.

4.4 COLLABORATION BETWEEN THE EXISTING REHABILITATION MANAGEMENT SYSTEM AND COMMUNITY AND DISTRICT LEVEL STRUCTURES

This section discusses the results from this study in order to indicate how the existing rehabilitation management system collaborates, link and functions with the community and district level structures (Objective 6, Section 1.4.1, Chapter 1). The collaboration between the rehabilitation management system and the community and district level structures, is discussed under this section. This collaboration relies on communication between the rehabilitation department and the whole district health system, collaboration with VCWs in record keeping and how information gained from the community is used by health and rehabilitation workers in their planning process. Contact and communication within the community by VCWs and community leaders are also outlined.

4.4.1 Communication channels between district health system and the community

The communication channels are present in all three districts under study, as shown in Figure 3.9, Section 3.7.9, Chapter 3. The researcher took a closer look at each of these stages in the flow diagram. It was recognised that communication channels are complex and not always straightforward. Communication channels can be influenced by many factors. It is for this reason that contacts between the different role-players were investigated to study exactly what was taking place.

The health and rehabilitation workers reported making plans for CBR together with the community members through direct communication. Written communication was used in communication to and from the district while communication to the community was mainly verbal. The health and rehabilitation workers either set up meetings or relayed the information via the VCW or environmental technician to the community. While this is effective in passing on messages, it may not have lasting effects in influencing participation, because concepts may be lost in the process of relaying the message. This would explain why the community leaders emphasised that in order to improve communication between them and the health and rehabilitation workers, it should be in written format as well.

Thirteen percent (13%; n = 2) health and rehabilitation workers used the environmental health technicians exclusively because of their direct contacts with the village heads. Furthermore, it is surprising that only thirteen percent (13%; n=2) health and rehabilitation workers used the Community Rehabilitation Committee directly to discuss community issues to do with the CBR programme and PWDs. It can be concluded that health and rehabilitation workers were using whatever part of the structure was most active and convenient in their district without necessarily utilising the full extent of the communication structures available. The use of individual treatment sessions and any regular meetings, were used as a forum for communication.

The results also show good contact existed between the various role-players in CBR, with some definite structures in the communication channels being utilised, e.g. the District Development Committees and the VCWs. There are still areas where the contact and communication are scant and under-utilised, e.g. the District Health Committee and the health and rehabilitation workers' direct communication with the community leaders. The health and rehabilitation workers could explore the situation and use it better. Although the informal or verbal communication in general is good, the formal or written communication is scanty and some structures, such as the communication between the District Health Committee and community leaders, as well as health and rehabilitation workers and community leaders, are under-utilised or not existing. The written records studied do not in any way capture the fervent activity in communication that is taking place.

4.4.2 Collaboration between the VCWs and health and rehabilitation workers through record keeping

Concerning record keeping, the main records kept were on the demographic and basic clinical information of clients. Thirty six percent (36%; n=9) of the VCWs used their records to report back and plan with the health and rehabilitation workers and twenty eight percent (28%; n=7) reported leaving these records at clinic level for use by the health and rehabilitation workers (Section 3.8.2, Chapter 3). The VCWs had a clear understanding of why they were keeping records. This study did not look into the quality of these records but sought to establish the existence of the records and the intended purpose of its use. The records were kept for tracking the number of people in their area, their problems and the programmes they were undergoing. The VCWs also said they keep the records as a source of information in order to give feedback to the

health and rehabilitation workers. The latter reported using this information to plan community activities.

4.4.3 Health and rehabilitation workers' use of information in planning for implementing CBR

Previous studies in Zimbabwe (Broer & Rottier 1992) have shown that if there is no contact and feedback between health and rehabilitation workers and the local supervisor (VCW), the local supervisor's (VCW's) enthusiasm and activity will be reduced. The health and rehabilitation workers in this study utilised the information gained from the community by the VCWs to organise programme activities in CBR and therefore responding to community needs based on information from the VCWs. The activities included assistance with sourcing for funding, training, health education, referral and actual intervention treatment. Only one health and rehabilitation worker reported no activity (Section 3.7.6, Chapter 3). Utilisation of information from the community for CBR planning should be emphasised more to ensure sustained activity on the part of VCWs and subsequently the community.

4.4.4 VCW contact and collaboration with the community

The VCWs reported contacts with the community as a result of their collaboration with the health and rehabilitation workers (Section 3.7.2 and 3.7.3, Chapter 3). This was done through Community Rehabilitation Committee meetings, other informal meetings, and CBR meetings. The results show that health and rehabilitation workers do not have direct contacts with the Community Development Committee, but that the VCW links the two. In this regard he/she plays an extremely important role in facilitating contact between the health workers and the community, because the health and rehabilitation workers have poor direct links (Figure 3.8, Chapter 3) with the Community Development Committee, and much of the contact is indirect. To ensure the correct information is filtering through, the health and rehabilitation workers should explore a monitoring mechanism, or improve direct contacts with the Community Development Committee (Section 3.7.6, Figure 3.8, Chapter 3).

The VCW reported utilising the information gained from contacts to formulate the programme plan and objectives. The programme objectives outlined by the VCW tally well with the areas where clients have reported that CBR helped them, as well as the

activity areas that the client and his/her family were active in (Figure 3.9, Section 3.7.8, Table 3.30, Table 3.37, Chapter 3).

Furthermore, clients and their families said they have gained information from the programme through the VCWs. The kind of information they cited included specific treatment knowledge, issues that affect their attitude, and information on how to integrate better with the community. As one client state: *"I have learnt how to handle myself as a PWD to avoid isolation and not get spoilt"* (Direct quote from raw data). A parent of a PWD went on to explain that much information is required to achieve this. The parent explained that she needs information to cope. *"Having a child with disability can be a burden because you have to look after her all the time"* (Direct quote from raw data).

Information exchange with clients is the crux of CBR (Helander *et al.* 1989). The entire WHO Manual on Training in the Community for PWDs by Helander *et al.* (1989) is based on the notion of empowering clients through information exchange and training.

The contacts and consequent activities outlined above show that participation levels at the operational level (involving the VCW and client) are high. It is perhaps higher than it appears on the written evidence, which captures the clinical interventions more than the management input. In addition, the preference for verbal communication makes it difficult to gauge and capture the level of activity and subsequent participation.

4.4.5 Community leaders' collaboration with MOH / Rehabilitation Department / MOE

To enhance participation in CBR, all role-players need a better understanding of causal issues to any problem experienced by the community (especially at provincial and central levels and in all relevant sectors and intersectoral management) (WHO 1987). Looking at disability, there is no question about the need to work with other sectors as well. The community leaders were asked how they collaborated with the different sectors. Although they collaborated with all sectors on development issues, they were not clear on their role in disability and CBR, except within the MOH and to a lesser extent the MOE. From the results in Table 3.43, Chapter 3, it seems the community leaders could not see the link or association of disability with other ministries. This lack of insight would certainly impact negatively on participation in CBR.

In the focus group discussions in one district, the community leaders reported that although they have a Community Development Committee, they have not included disability issues on the Committee's agenda (Section 3.4.4.2 and Section 3.5.1). The community leaders also reported that the changes in the community structures as a result of the Prime Minister's Directive of 1999 are hindering the smooth running of the community structures: *"Now it has changed, it no longer works well. The new Village Development Committees works according to the village. One village, one committee."* This comment would imply that there are communication and practical problems emanating from the policy change in the Prime Ministers' Directive (1999) (Section 3.5.1).

The community leaders underscored the need for regular follow-up in the community by health and rehabilitation workers. They recommended a follow-up every three (3) months. Community leaders felt that all communication to them should be done through the counsellor, and he should communicate with the other leaders. They even said that if it was not possible to meet, communication to them should be in writing, i.e. letters of explanation or submission of reports on the progress agreed to in the Committee agendas (Section 3.7.10.3, Chapter 3).

A closer look at the various contacts and links between the different role-players and structures has shown that a lot of communication in various forms was taking place. Some of the areas of communication could result in increased community participation in CBR, but due to inadequate attention to the detail and process, this is not the case. Examples of areas where attention to detail is needed, are:

- Meetings: The health and rehabilitation workers hold more meetings with the Community Rehabilitation Committee and specific CBR meetings, and less Community Development Committee meetings. This is a missed opportunity for influencing the community leaders directly (Figure 3.8, Chapter 3).
- Client support systems – clients' contacts with churches and church related organisations are poorly exploited (Table 3.7.4, Chapter 3).
- Client and community leader contacts and request for assistance - this yield less success in attempts to obtain financial and social welfare assistance.

Community leaders have the mandate to follow this through and solve this problem at a higher level (Table 3.26, Chapter 3).

- In Section 3.7.10.3, Chapter 3, VCWs set objectives that cover all needs that have surfaced for PWDs in the community. However, the detailed process of education and awareness need to be explored. The results show that some attitudinal gaps exist among community leaders and some clients with regard to community participation (Table 3.5 and Section 3.7.10.3, Chapter 3).

The conclusion is therefore that the community structures that are supposed to facilitate communication for development, are not working effectively. However, the detailed aspects (of which the examples are given above) of inadequacy are relatively easy to correct. Many of the answers with regard to some of the issues raised above have already come from the community and should be corrected to allow for better effectiveness and efficiency in participation.

4.4.6 Formal and informal communication between clients, VCWs, community leaders and health and rehabilitation workers

Based on objective 7 (Section 1.4.1, Chapter 1), this study investigated the formal and informal links between the different management inputs and processes in the health and rehabilitation systems that are in place to link the latter systems with the community at community and district level. The type and nature of the contact and communication between the following role-players were studied:

- VCWs and clients, including the referral system;
- Clients and the community;
- Clients and community leaders;
- Health and rehabilitation workers in the community.

The level of communication was determined from these contacts in answer to objective 7.

4.4.6.1 *Communication and contact between VCWs and clients*

The VCW is an important role-player in the process of CBR for facilitating community participation to improve the lives of PWDs.

The first contact the clients have with the referral system (which includes all sectors and all levels of care) is the VCW, also referred to as the local supervisor. Thirty four percent (34%; n=40) clients saw and had contact with the VCW once in two months or less, while thirty one percent (31%; n=38) had contact with the VCW once a month and nineteen percent (19%; n=23) once a week (Section 3.7.2, Chapter 3).

The clients had spent a significant amount of time with the local supervisor as shown in Table 3.13, Chapter 3, where it is indicated that seventy four percent (74%; n=90) had spent 1-4 hours with the VCW. Home visits are very important and a well-used operation mode for contact and delivery of service though manpower incentives. Thirty two percent (32%; n=8) of the VCWs reported negotiating with community leaders or other structures on issues concerning clients' needs.

From the results it can be concluded that the frequency of visits by VCWs to clients is adequate for the nature of the conditions of the clients and circumstances of both the VCW and client, and the length of time spent is adequate for a home visit. One would need to explore in a different study exactly what activities are carried out in such a home visit. In the areas studied, the VCW has a high level of participation and frequent contact with the client. The level of referral by VCWs illustrates this further.

(1) *Level of referral by VCWs*

The level of referral by the VCW as the local supervisor is an important indicator for the level of activity at community level (Broer & Rottier 1992). Figure 3.7, Chapter 3, show that the VCW was very active at community level with activities such as attending training, home visits and negotiating on behalf of and with clients. All these activities contribute to the VCW being more active in identifying the needs of clients and subsequently referring them when necessary. Emanating from the home visits, the VCWs referred clients to other services such as social, vocational and special medical services or agricultural support, where necessary. The number of referrals was

adequate, with sixty percent (60%) VCWs referring between one (1) and six (6) clients per month (Section 3.7.3, Chapter 3).

4.4.6.2 *Client contact and communication with the community organisations*

Client contact with any community-based organisation is considered a developmental milestone in increased participation at local level (Helander 1994). However, in the areas studied, very few people with disability were aware and belonged to such community initiatives as DPOs and NGOs (Table 3.10, Chapter 3). Such organisations either did not exist or they were unknown to the PWDs and their families. Oakley (1989) found in his examination of community involvement in health that support of NGOs can provide additional resources for health and can equally play an important role in developing community involvement in health.

There is evidence from the results that some significant initiatives in supporting PWDs in IGPs exist. Forty five percent (45%; n=55) of clients perceived support and participation for CBR from community clubs and church related support systems. This is an important source of support and should be explored to find out the type of support they provide in line with CBR principles, i.e. charity vs. empowerment of PWDs. Thus, the conclusion is that the impact of DPOs and NGOs in promoting involvement and participation is not felt at community level by the clients. The programme facilitators, in particular the community leaders, need to assess the missed potential in this area.

4.4.6.3 *Contact and communication between clients and community leaders*

Murthy and Gopalan (1991) underscore the principle of the client fulfilling an active role in his/her own rehabilitation process. The clients were asked whom they approached and how successful they were in obtaining assistance. This also assesses a second underlying principle of CBR outlined by Murthy and Gopalan (1991), where they state that the community and its leaders should be involved and recognise the needs of the disabled, appreciate their potential of becoming contributing members and extend opportunities to them. Table 3.26 under Section 3.7.5, Chapter 3, outlines the Community Development Committees' response to clients who approached them for help. Clients who approached the committee were more successful in accessing help for their medical needs (48%; n=23). Thirty two percent (32%; n=12) were successful in accessing help for mobility needs, and thirty seven percent (37%; n=12) in accessing

community amenities. They were less successful in accessing social welfare, education and financial assistance.

In terms of participation, the community leaders played a significant role in solving the needs of PWDs. Of the sixty six percent (66%; n=80) clients who approached the Community Development Committee, thirty one percent (31%; n=38) could not be helped. Two issues became evident in this regard. The first is the need for better intersectoral co-ordination so that the underlying problems can be understood and tackled, e.g. problems related to education, finance and social welfare needs. This would result in enhanced community participation. The second issue is the need to strengthen the capacity of different community-based committees, e.g. the Community Development Committees and Community Rehabilitation Committees as vehicles of community participation.

As shown in Table 3.16, Chapter 3, community leaders were involved in activities involving material contribution and organisational issues at community level. However, they complained that the Rehabilitation Department and the nurses at clinic level did not follow up and follow through on some of their activities. They suggested better feedback from the health and rehabilitation workers. Even if they could not visit the community leaders physically, they should send letters or reports on how far the agreed plan has advanced.

CBR at community level is visible, accepted and integrated by the majority of the community leaders. To enhance this further, it is important for the health and rehabilitation workers to follow through with the communication and to be better managed in order to sustain and enhance community leader participation.

4.4.6.4 *Health and rehabilitation worker contact and communication with the community*

One of the important mechanisms outlined by Oakley (1989) in his study for the WHO was the development of local, community-based structures (e.g. health committees and traditional health groups) that would serve as vehicles through which people could participate. Although everyone could indicate which committees existed, they could not say clearly which ones were active. In the communities under study, three major committees were in existence and active at the time of the study, as they were referred

to often. These were the Community Development Committee, the District Development Committee and the Community Rehabilitation Committee (as a subcommittee of the Community Development Committee). The District Health Committee was only active in one district. Specific CBR meetings were held during preparation and implementation of the CBR programme.

Health and rehabilitation workers held more CBR and Community Rehabilitation Committee meetings than District Development Committee meetings. The conclusion that can be made here is that for better integration of disability issues into community development, more District Development Committee meetings should be held, as this is the umbrella body of the district under study. CBR and Community Rehabilitation Committee meetings, although important, may make the programme vertical and reduce participation of the leaders and other ministries. Enhancing vertical communication through the health system may reduce the level to which the community leaders and other sector ministries (Social, Education and Rural Development) are informed about CBR matters, which may reduce their participation. The District Development Committee, if utilised appropriately, would further enhance the effectiveness of CBR because it represents all Ministries. For CBR to be effective, it must have the participation of all Ministries, sectors and intersectoral collaboration (Helander 1991), which were found lacking in the areas studied. The information generated from the meetings with the committees and stakeholders in the community by health and rehabilitation workers is important for CBR programme management and direction, as well as for the enhancement of community participation.

(1) Information for planning in CBR generated by health and rehabilitation workers from the community contacts, and communication

According to the guidelines for CBR, it is important for programme facilitators/managers to gather information from the community itself in order to plan according to the appropriate community needs. This is in line with any development-oriented programme (Oakley 1991; Coleridge 1993).

From the results, it was found that the health and rehabilitation workers were communicating with the community through the different community structures available, i.e. CBR meetings, Community Development Committee meetings and Community Rehabilitation Committee meetings (Figure 3.8, Chapter 3). However, the

health and rehabilitation workers need to strengthen communication with the Community Development Committee and the District Development Committee. Most of the health and rehabilitation workers' plans and activities for CBR were based on the information they have obtained from the community in the first place. Information on all aspects of rehabilitation was generated, i.e. prevention through information and educational, clinical and income generating needs (Table 3.27, Chapter 3). The question that remains is: Are vocational needs low or is the capacity to act on them inadequate and lacking? In Tables 3.28 and 3.29, Chapter 3, health and rehabilitation workers outlined the way in which they used information for planning and management; i.e. they planned meetings and workshops, formulated strategies, made plans based on the information and gave advice based on the problems identified. The conclusion is that health and rehabilitation workers are utilising information from the community in order to prepare their plans for CBR. Acting on information needs generated from the community will not only strengthen the CBR programme, but also community participation itself (Murthy & Gopalan 1991). Communication to the community through the VCW was most frequently used.

4.4.6.5 *Health and rehabilitation workers' collaboration with VCWs*

The results (Section 3.7.8 and Tables 3.31-3.33, Chapter 3) demonstrated that health and rehabilitation workers communication with the VCWs was more collaborative than just contributive or one of compliance. A high level of communication and collaboration on issues to with disability resulting from communication between the health and rehabilitation workers and the VCWs was found in this study.

Home visits, outreaches and reporting at clinics were the most frequently used forums for meeting (Table 3.30, Chapter 3). This was supported by views expressed in the focus group discussions, where VCWs reported that when they obtain information from the health and rehabilitation workers, they report to and inform the village heads and other community leaders, which in turn inform the community. Sometimes the VCWs talk to the community with the community leader's blessing. Thereafter, they provide feedback to the health and rehabilitation workers on the outcome of the meeting.

Another important forum for VCWs meeting with the health and rehabilitation workers was the Extended Programme on Immunisation (EPI) points, where, during the immunisation sessions, VCWs and the clients could consult and be assisted by health

and rehabilitation workers. VCWs reported that they met on a regular basis with nursing staff at clinics giving them regular reports on clients being seen in the community. The high level contact and communication can facilitate better participation of the VCWs and should be developed and supported further.

(1) *Collaboration between VCWs and health and rehabilitation workers on activities of function, economic empowerment and mobilising resources for clients*

Tables 3.31, 3.32 and 3.33, Chapter 3, clearly outline the detailed collaboration between VCWs and health and rehabilitation workers in the three areas of:

- Functional and economic empowerment of clients;
- Mobilising resources for clients;
- Monitoring and evaluation of CBR.

VCWs were clear in indicating the assistance they received from the health and rehabilitation workers to improve their own level of function through educational sessions. In all three districts, they described a process whereby they identified problems from the client and consulted the health and rehabilitation workers for advice in solving the problem. Four (4) VCWs said they did not receive any help, indicating that there are gaps in the collaboration between VCWs and health and rehabilitation workers. These same gaps are evident in the area of mobilising resources, where three VCWs said they did not receive any help.

What is clear and can be concluded from the results is that the VCWs have a high level of contact with the health and rehabilitation workers (all VCWs reported contact). The responses they gave, indicate that the contacts were fruitful, and that contact must result in tangible action and results. The need for continued contact between the health and rehabilitation workers and the VCWs cannot be overemphasised. Although more than ninety percent (90%) of the VCWs in all three districts explained the collaboration they had with the health and rehabilitation workers, those that did not have collaboration, though few, may negatively impact the community and client participation, especially as the VCW is such a central figure in the CBR programme.

4.5 FACTORS AFFECTING COMMUNITY PARTICIPATION

The literature studied outline three major factors that promote or hinder community participation. These factors include the extent to which disability and CBR have been mainstreamed into community development (Coleridge 1993), the availability and accessibility of resources (Oakley 1991) and community leadership attitude (Helander 1991 and 1994). These three (3) factors have been addressed in Sections 3.9.3.3, 3.10 and 3.9.3.2, Chapter 3, respectively.

4.5.1 Mainstreaming CBR and disability into community development

The extent to which disability and CBR have been mainstreamed into community development issues can be interpreted as high, with seventy eight percent (78%; n=14; Table 3.48, Section 3.9.3.1, Chapter 3) of community leaders including disability and CBR in their community development plans and agendas. This inclusion is in no way official and is dependent on the exposure of the individual community leader and active lobbying by the VCW. The attitude of the community leadership is intertwined with their willingness to recognise the importance of disability and subsequently mainstreaming.

4.5.2 Community leadership attitudes

In the focus group discussions the VCWs reported: *"before CBR was implemented, the community leader and people were as hard as a rock, we could not penetrate. However, there is a marked change, people are beginning to understand"* (Direct quote from raw data) (Section 3.9.3.3, Chapter 3) Getting through to the people is no longer difficult. Even community leaders react quicker and come up with help. The community leaders are responding and mainstreaming CBR issues into development, but, as the results show (Table 3.45, Chapter 3), not all community leaders have a full understanding of the balance of responsibility required to make participation in CBR successful.

The community leaders however contradicted themselves in that although they incorporated disability issues in their plans, they did not see the relation between disability issues and other sectors. In addition to this, community leaders show gaps in their knowledge on how to facilitate community participation beyond providing materially and realising the full potential of collaboration with PWDs. Collaboration

should result in empowerment and a balance of opportunity for PWDs, as well as a balance of opportunity within the community.

Four (4) community leaders had not incorporated CBR into their plans. Their reasons are shown in Table 3.48, Chapter 3, and are related to a lack of knowledge and communication. They said they had not done so because: "*no organisation facilitates this*". This statement illustrates a lack of understanding of the concept of community empowerment, as they are implying the intervention of an outside agency.

The organisation structure does not fully support the attainment of community participation in health related programmes in that they themselves are very fragmented and the mechanism of co-ordination is not clear. The Rural District Councils (RDC) Act (1999) outlines the services to be provided and co-ordinated by the council, but does not make integration clear (Figure 3.6, Chapter 3).

Mainstreaming and integration is evident at operational level but not at the higher levels of planning, especially in the Provincial Development Plans. This in turn does not facilitate the attainment of resources and the necessary support for it. To ensure sustained participation, formalised inclusion of disability in development structures at all levels would be advisable. This will also help to cement the process of integrating PWDs into all activities, especially within the community.

4.5.3 The influence of resources on participation

Resources were perceived by all respondents as a major hindering factor in community participation. Sixty-one percent (61%; n=74) of clients (Section 3.10, Chapter 3) expressed this, as well as all (100%; n=25) VCWs and community leaders (100%; n=15). In the focus group discussions, the VCWs and community leaders explained at length how the lack of resources hindered them. They were of the opinion that resources underlie the outcome of most activities. They explained how they couldn't access transport for attending referrals, materials for use in IGP and equipment in treatment intervention. Furthermore, the community leaders, clients and VCWs all expressed the fact that the community they are seeking assistance from, is in itself poor; hence it is difficult to obtain adequate resources.

The VCWs and community leaders were asked what measures they took to counter the inhibiting state of poverty. In the focus group discussions with the VCWs, they reported: *"Resource Mobilisation is done mainly within the community through seeking outside assistance and internally through IGP, clubs and community donations. Outside assistance is not always forthcoming and if so it is slow. We therefore depend on the generosity of an already strained community"* (Direct quote from raw data). It can therefore be concluded that despite all efforts for poverty alleviation at community level, resources still remain a very key factor in hindering optimal levels of community participation.

4.5.4 Other factors affecting community participation as viewed by clients

In addition to the three factors explained above, the clients explained other factors that they felt were hindering community participation in CBR. Fifty seven percent (57%; n=70) of the clients reported a perceived lack of co-operation by the community leaders. The clients felt it is extremely important for the community leaders to participate in CBR. However, their perceptions differ from the opinion of other community members concerned. This difference in opinion indicates a lack of communication and understanding about the position/activities of the different role-players. The following results explain and illustrate this. The community leaders have reported that they would incorporate disability issues into development issues and including the PWDs in their planning for CBR. However, more than half of the PWDs did not feel included. In the results shown in Table 3.52, Chapter 3, they said they perceived this lack of co-operation because community leaders left them out of community meetings. Therefore, they felt their opinion was not valued. This contradictory situation implies that the process of incorporating disability issues into CBR planning has been done largely at an organisational level. Much still remains to be done to ensure that operationally, these two positions dovetail and that the PWD feel actively and effectively involved in CBR planning.

4.5.5 Factors affecting community participation as viewed by VCWs and community leaders

Many of the factors outlined in Table 3.45, Chapter 3, are not peculiar to the PWD but also to the community as a whole. However, the way in which they impact on the PWDs' participation in CBR, is peculiar to them. The problems PWDs experience are

exacerbated by the already impoverished situation of PWDs (Tables 3.45 and 3.46, Chapter 3). PWDs therefore feel the burden of the lack of resources and are unable to carry out activities that culminate in their participation in CBR. For example, the lack of transport perceived by the VCWs and community leaders is the result of a lack of resources to utilise buses. Similarly, the lack of draft power handicaps their ability to undertake IGPs involving farming activities. More pointedly, both groups underscored the issue of general poverty. They gave examples of the lack of school fees, which stops a PWD who may want to participate in the education system; or the lack of raw materials for one who may want to participate in income generating activities. The importance of feedback to participants has already been dealt with under communication channels, but it certainly seems to be a strong factor that came up at several points in the study.

4.5.6 Problems with referral system as perceived by VCWs

The smooth flow of the referral system and the outcome of the clients' rehabilitation programme will have a strong impact on the client and his family's desire to continue participating. If the referral system does not function, felt and real needs of the client are not met.

The VCWs perceived some important obstacles to the process of referral. Obstacles related to resource shortages were felt by 88% of the VCWs (Section 3.9.3, Table 3.47, Chapter 3). Because of the lack of financial resources, the medical charges were perceived as exorbitant, and even the simplest of IGPs becomes difficult to start and aids and appliances difficult to pay for.

Hitches in the flow of referral due to clients forgetting or losing referral letters, or having insufficient documents and times of appointments, result in them being sent back by the health and rehabilitation workers. This creates problems in the client's motivation to participate in CBR. An analysis of the processes that lead to these problems would be useful in obtaining some solutions to the problems causing these difficulties.

4.5.7 Difficulties faced by health and rehabilitation workers in encouraging community participation

The health and rehabilitation workers expressed both logistical and organisational difficulties (such as transport and problems with communication due to the distances and the lack of a reliable communication system) as factors hindering participation (Section 3.9.4, Chapter 3). The community's lack of confidence was offered as a problem and would perhaps explain why the health and rehabilitation workers perceived the community leaders as making all the decisions for the community.

In discussing the referral system (Sections 3.36, 3.39 and 3.9.4, Chapter 3) the clients and their families explained the difficulties they experienced with using the referral system. Conversely, the health and rehabilitation workers expressed that they perceive false promises and missing appointments on the part of clients as a hindrance to community participation (Section 3.9.4, Chapter 3). These factors can only be considered as they are expressed, and can be used in the monitoring of the CBR programme to understand and correct any miscommunication and consequent actions on the part of the role-players.

In conclusion, the factors outlined by all respondents are important in community participation in CBR. The community leaders' attitude affects their ability to mainstream and is closely related to the clients' perception and how they are being integrated into the community activities. Lack of resources underlies a lot of problems perceived by the clients, VCWs and community leaders. They ultimately affect the referral system negatively. The experience of the health and rehabilitation workers, clients and VCWs differs with regard to the obstacles, indicate a need to study the problems and minimise their negative impact on participation.

4.6 THE LEVEL OF PARTICIPATION

Objective 1 sought to establish the level of community participation achieved in the CBR programme. The level of participation has been established by using the scale of Community Participation Group of the United Kingdom for All Network (1991).

The clients as the central focus of the programme were asked to assess their own level of participation by using a scale that rated their level of participation in planning for

CBR. In a similar manner, other key role-players within the community were asked to rate their own level of participation. The means scored (Table 3.23, Chapter 3) by the different role-players are as follows:

Clients	3
Community leaders	2.1
VCWs	2
Health workers	2

As shown in Figure 3.5 and Table 3.23 a significant difference was found between the clients' opinion of their involvement and that of the VCWs and the community leaders, at 10% significance. A difference in opinion was also found between the clients' opinion of their involvement and the health and rehabilitation workers opinion of the clients' involvement. The clients' level of involvement was therefore low and indicative of failure in empowering the client fully in gaining control of the CBR programme. Some of the reasons for this failure are apparent in the structural, organisational leadership and management shortcomings of the programme. The study sought the status of the key role-players' (VCWs, community leaders and health and rehabilitation workers) knowledge, attitudes and practice with regard to participation in CBR. Furthermore, it focussed on the dynamics, links, structures and communication processes that promote or hinder participation. The results have been used to answer the guiding questions in the five key factors that are important in the process of participation, according to Rifkin (1993).

4.6.1 Level of participation according to the Rifkins Model

A second assessment of the level of participation is based on an analytical framework by Rifkin (1993), focussing on the need to assess the process of change.

Bjaras, Haglund & Rifkin (1991), have described the conceptual framework for community participation by defining it as follows: *"A community is a group of people living in the same geographical area sharing defined basic values and organisations and/or a group of people sharing the same basic interest"*. They define community participation as a social process whereby specific groups, with shared needs, living in a defined geographical area, actively pursue identification of their needs, take decisions

and establish mechanisms to meet their needs. Three characteristics appear common in the concept of participation:

- Participation must be active;
- Participation implies that people have a right to and the responsibility to make choices and therefore have power over their lives;
- In order for participation to take place, mechanisms must be in place to allow choices to be implemented.

Based on the above definition, an analytical framework focusing on the need to assess the process of change is presented by Rifkin (1993). Five factors influencing this participation process are:

- Needs assessment;
- Leadership;
- Organisation;
- Resource mobilisation;
- Management.

In view of this, the researcher investigated the possibility of using this method as a tool to present participation in the CBR programme in Midlands Province graphically. Such graphic presentation can then form the baseline for the future measuring of the level of participation in the CBR programme.

4.6.1.1 *The process used to allocate a score*

Key questions in all the questionnaires to all the key role-players sought to understand the level to which these factors were functioning, basically answering the underlying questions stated in the following sections. Each factor is discussed after presentation of the questions, the results of the study are summarised and a score is allocated on a continuum of 1 to 5, where 5 is an optimum state of participation and 1 the least optimum. The study looked at the process of participation, with the aim to determine if the concept of participation has actually evolved into action; the extent to which the PWDs' needs were assessed; the response to this by the leadership; organisation; resources mobilisation; and management within the community and the support system.

Each question was answered by the results from the questionnaires, focus group discussions and the study of records. An arbitrary mark was allocated after studying the extent to which each question was satisfied by the results. In this way, the score was directly determined by the results and indirectly by the key role-players.

4.6.1.2 *Needs assessment*

Key questions asked in the questionnaires were:

- How were needs identified?
- Who was involved?

In the study, the clients' (and therefore the community's) needs assessment was done by the VCW (Tables 3.41 and 3.42, Chapter 3). All role-players were used to identify the PWD and community needs, however **ongoing** identification of needs was carried out by the health and rehabilitation workers, who reported this as a weak area. They hope to address using the Operations Management and Results System (OMAR). This is a series of rapid assessment questionnaires that is being used as a tool for continuous monitoring of different aspects of the CBR programme.

The mean score for the assessment of needs in the programme is three point five (3.5).

4.6.1.3 *Leadership*

Key aspects regarding leadership that were covered in all questionnaires were the following:

- Who are the leadership?
- To what extent were they involved?
- What was their attitude towards participation?
- How does the leadership mobilize support?
- How did the target group profit from the leadership?

The key groups of leadership, i.e. chiefs, headmen and councillors were aware of the CBR programme and said they were involved. They regarded their role as being

providers of support and guidance (as reflected in the question on attitude), with their key responsibility lying with the client and his/her family (Table 3.15, Chapter 3). Their contributions were mainly in the form of materials and manpower, and their collaborative role with the PWDs was very poor (as indicated in Table 3.16, Chapter 3). This was reflected further by the poor support of disability issues by the formal community structures (Figure 3.6 and Section 3.5, Chapter 3) and the lack of discussion of disability issues at Community Development Committee meetings. However, Table 3.16, Chapter 3, shows the community leaders do indeed mobilise manpower, which is supportive to the PWDs. In this way, as well as through direct intervention, the PWD derives some benefits from their intervention (Section 3.7.5, Table 3.26, Chapter 3). The leadership role, though not comprehensive in all areas, is regarded as relatively high.

The arbitrary score for leadership is four (4).

4.6.1.4 Organisation

Who is involved in the organisation?

What are the linkages of the organisation?

How is it funded?

What is the relationship of the health professionals and the organisation?

Where do disability issues fit into the organisation?

Who owns the programme?

At community level, the VCWs are very active and are carrying out programme activities regularly (Section 3.4.3.2 and Table 3.11, Chapter 3). However, the supporting organisational issues in the official structures are not as effective. It was therefore found that the community leaders in many instances acted in their individual capacities and not in the official capacity. There is no budgetary support from the local councils and the rural development plans acknowledge disability but refers to the funding as predominantly donor (Section 3.5.1, Chapter 3 and 4.6.1, Chapter 4). Health professionals are still central to the direction of the CBR programme. Input from the community and disability issues are no longer unknown or ignored in the community but are integrated, albeit to a limited extent. In terms of ownership of the programme, the question is still who drives it? To a very large extent, the strategic planning and key resource mobilisation still lies with the health and rehabilitation workers (MOH Annual

Plans 1996-2000). However, the community is now more involved (Table 3.23, Chapter 3). The family and the VCWs are in fact driving the programme at the operational level and although the activity is not outwardly visible, it is certainly very active. Another aspect that came out of the results and that affects organisation negatively, is the perceived lack of visibility of the health worker to the community leaders. They complained that once the programme was initiated, the health and rehabilitation workers did not maintain consistent communication with them (Table 3.48; Chapter 3).

An arbitrary score of three (3) is given for participation in the organisation.

4.6.1.5 *Resource mobilisation*

What resources are brought into play?

How are they mobilized?

Who is contributing to the resources?

The resources mobilized from the community are within the limits of their own limitations of poverty (Section 3.9.1.1, 3.9.2.1 and 3.9.3.1, Chapter 3). The level of activity of the VCWs, who are not really salaried but get a generic allowance not specific to disability issues, is very high. The family input is a major resource that keeps the activity level of the PWD relatively high. In terms of money and material, this area is limited. The government funded the CBR activities through the MOH, providing manpower, transport and at times material and money. Community support took place through provision of manpower. However, the intersectoral resource has not been tapped and the community has not in this area tapped its own potential to mobilise other resources.

Currently resources in the form of manpower and materials are sourced from the community (Table 3.9, Table 3.17, Section 3.4.3, Chapter 3). The monetary resources are sourced mostly through the MOH and donors.

A score of two (2) is allocated for participation of the community in resource mobilisation and allocation.

4.6.1.6 *Management (How does the organisation achieve its goal?)*

What are the roles of all stakeholders in managing the programme?

On who does the ultimate responsibility fall?

Who has the ultimate responsibility for the programme?

Who decides on activities?

The leadership and VCWs were involved in CBR management through planning, implementation, monitoring and evaluation. The PWD was less involved in this process (Figure 3.5, Chapter 3). The health and rehabilitations workers, although still key managers, did not make the plans in isolation (Tables 3.35, 3.27, 3.28 and 3.29; Figure 3.9, Chapter 3). Much still needs to be done to make the process more comprehensive and involve the client and community leaders more appropriately.

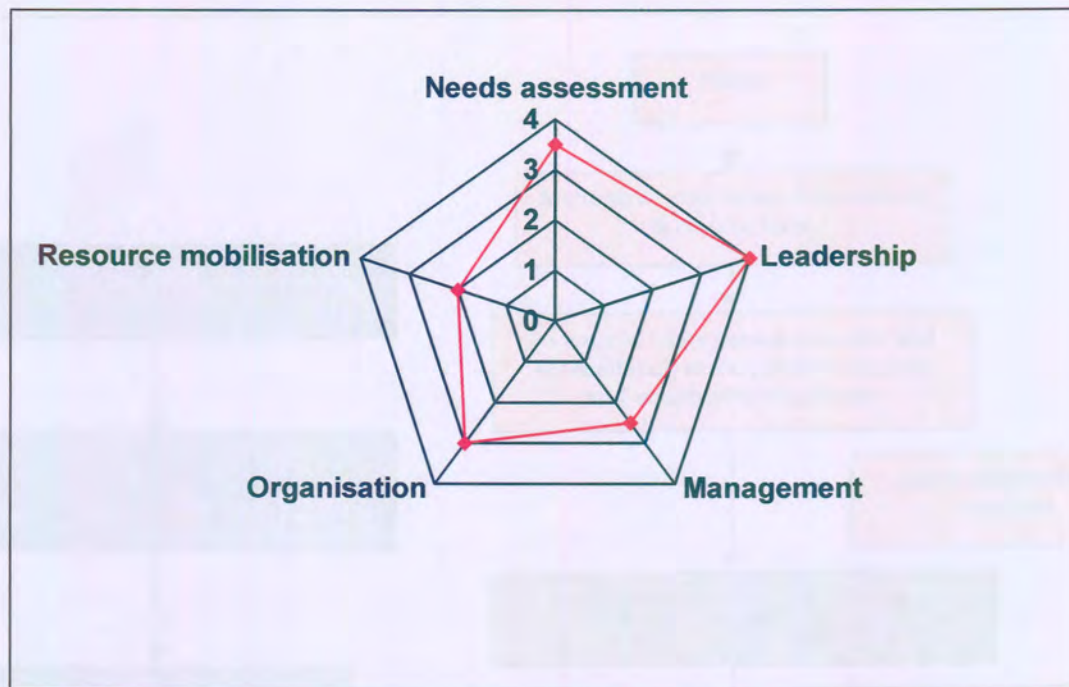
It would appear the ultimate responsibility for planning still lies with the health and rehabilitation workers, with the plans dependent on the input from the community as shown in Table 3.27, Chapter 3 and the use of the information collected in Table 3.28 and in Figure 3.9, Chapter 3. At community level activities are self-perpetuated by the needs of the clients and their caregivers (Section 3.7.5, Table 3.26, Chapter 3). From an organisational point of view, the community leaders reported incorporating CBR into their community development plans (Section 3.7.5). However, the kind of activities carried out as a result of this incorporation are mainly dealing with operational problems and not necessarily formulating strategic or longer-term operational plans

The arbitrary score for participation in the management of CBR is two point five (2.5).

4.6.1.7 *Results*

The five (5) key areas were analysed using the principle of the Rifkins model on a five-point scale. The qualitative and quantitative results and discussions with the health and rehabilitation workers and VCWs during a preliminary feedback of the research results were used to determine the value.

Figure 4.1 *Diagrammatic presentation of the level of participation in the Midlands Province*



4.7 RECOMMENDATIONS REGARDING FUTURE DEVELOPMENTS THAT WILL ENHANCE THE EFFECTIVE AND EFFICIENT MANAGEMENT AND DELIVERY OF CBR SERVICE WITH THE FULL PARTICIPATION OF THE COMMUNITY

In answer to objective 9, clients, community leaders and VCWs were asked what recommendations they have regarding the management of and their participation in CBR. Tables 3.51 - 3.56, Chapter 3, outline the recommendations offered by the three groups of stakeholders.

4.7.1 Clients' recommendations

In Annexure 3, clients were asked what recommendations they would make to enhance effective and efficient management and delivery of CBR service as well as participation from the community.

There were many recommendations and when coded and categorised, they focused on some key areas. Recommendations included capacity building needs and organisational issues. Forty eight percent (48%; n=59) of the clients regarded the following as major

areas that need to be addressed: capacity building through enhancing participation itself, educating the community on CBR, IGP, budgeting and writing proposals. Of concern among the clients were the issue of “broken promises” and the lack of a perceived follow-through of activities by the health and rehabilitation workers, community leaders and government structures. This lack of feedback and follow-through was interpreted by the clients as *“them not being taken seriously”* (Direct quote from raw data). Eleven percent (11%; n=13) of the clients recommended regular communication to avoid the *“collapse of the programme”* (Direct quote from raw data). In some of the recommendations regarding organisational issues, the clients said CBR should not be *“mixed with politics”* (Direct quote from raw data). The study did not explore this statement further but the implications may need to be studied to understand the implications.

Under the category of rehabilitation and patient care, clients recommended that in order to continue the process of identification, a continual survey and screening of clients within the community should take place and not be a *“once-off event”* (Direct quote from raw data). In line with capacity building, but specifically under client rehabilitation care, it was requested that mothers with disabled children be trained in their areas of need. This may imply a perceived need. Each of the clients’ recommendations, no matter how small the number of clients who put it forward, should be taken seriously and investigated as it is the fulfilment of the clients’ needs that will drive the CBR programme.

As found from the study and mentioned previously, the VCW is an instrumental figure in the CBR programme and in driving the participation process. Recommendations from the VCWs are shown in Table 3.53, Chapter 3.

4.7.2 VCWs recommendations for improvement of management of and participation in CBR

In Annexure 5, the VCWs were asked to outline what recommendations they had as far as CBR was concerned. The recommendations were also discussed at length in the focus group discussions. It is important to note that the same recommendations as those that were written in the questionnaires were repeated in the focus group discussions.

The VCWs had recommendations in three major categories namely resources, organisational issues and management issues, including improvement of the VCW's status in the community and the need to improve community participation. In answer to Annexure 5 and in the focus group discussions, VCWs expressed the lack of resources as a hindrance and voiced the need to find CBR resources. As a key person in the CBR programme, it is important that the managers of the programme always reflect on the VCW's level of motivation. They have brought this up and recommended that incentives for them be considered. In the focus group discussions, this point was discussed at length. The VCWs explained that they were not looking for monetary gain primarily, but that there are gains in improving their status and recognition in the community.

4.7.3 Community leaders' recommendations

The involvement of community leaders in CBR is regarded as an important facet in community participation. In the light of this, community leaders were asked if they were happy with their own level of involvement (Annexure 4) and if they had specific recommendations to improve this area. Table 3.55, Chapter 3, outlines the areas recommended by community leaders for improvement of their own participation.

Twenty two percent (22%; n=4) of the community leaders that answered that they were happy with their own level of involvement felt an improvement in the consistency of funding would enhance their participation. Those community leaders who were unhappy with their level of involvement felt that an improvement in the communication between themselves and the health and rehabilitation workers would affect their involvement positively. This was echoed by seventy eight percent (78%; n=14) of the fifteen (18) leaders in the general recommendations given in Table 3.55, Chapter 3. Concrete suggestions on how to improve communication, such as the use of written communication where physical contact was not possible, were recommended and should be taken seriously.

The community leaders cited a reduction in poverty as tantamount to quickening most processes pertaining to CBR; hence improving participation. Community leaders' participation and vantage point of being able to use the political and administrative systems put them in a powerful position, enabling them to influence the CBR programme. Their recommendation in all the other areas, such as capacity building, integration of disability into the council and provision of resources for the community

workers should be taken seriously and implemented to improve the participation of community leaders.

4.8 CONCLUSION

This chapter aimed to discuss the data gathered through the questionnaires, focus group discussions and the study of official records. The discussion brought together the different results and correlated issues where possible. Each target group's results had been discussed under objectives 2, 3 and 4. Subsequently, objectives 5, 6, 7, 8 and 9 were discussed.

Objective 1 sought to establish the level of participation. This objective was achieved through establishing what each of the key role-players' (clients, community leaders, VCWs and health and rehabilitation workers) level of participation was. Each target group has obtained a certain level of participation, which was shown in Table 3.23, Chapter 3, where the client attained the lowest level and the VCW's and the health and rehabilitation workers the highest. The systems of management and organisation within the community that support participation were also assessed using the study results by applying the Rifkins model (1993). Using this model, the processes of change influencing participation were assessed arbitrarily on a scale of 1-4 (where one is low in attainment and 4 is the highest). Based of the results of the study, each area was assessed and an arbitrary score given. The summary of the scores are as follows:

Needs assessment	3.5
(Assessment of disability and CBR needs in the community)	
Leadership	3.5
(Ability of the leadership to guide and facilitate the process of participation).	
Organisation	3
(Capacity of the organisation to support the process of participation in CBR)	
Resource Mobilisation	2
(Availability and accessibility to the necessary resources)	

Management

2.5

(Management systems that support the process of participation)

Objective 2 established the level of understanding of participation by all key role-players. This was assessed by using the categorisation by Poulton (1999), who describes the essence of participation in three categories, i.e. compliance, contribution and collaboration. The results showed that clients erred towards compliance and contribution (Table 3.5). VCWs emphasized compliance and collaboration with contribution being mentioned very poorly (Section 3.4.3.1). Community leaders had a balanced view of the three aspects, although they expressed inadequacy on how to promote participation (Table 3.14). Health workers had a balanced view in the three categories (Table 3.20). The key role-players in the communities studied can be viewed as having a fair understanding of community participation. However, there are many areas that need more clarity, for example the difference between contribution, compliance and collaboration, as well as on how to promote participation itself.

With objective 3, the researcher wanted to determine the attitude of the clients and community leaders through the question on where responsibility lay for disability issues. (The researcher did not pose this question to the health and rehabilitation workers and VCWs, as they were considered as core players whose job responsibility included CBR). The clients and the community leaders apportioned some responsibility to the client, his family and to the government. However, half (53%; $n = 7$) of community leaders felt the community had total responsibility. This may be detrimental to their participating in CBR. In a similar way, fifty five percent (55%; $n = 48$) of clients still felt the government was totally responsible for PWD's. A small number of clients (20%; $n = 12$) felt they and their families held no responsibility. This attitude would have a negative impact on participation.

The areas in which all role-players participated in were established in answer to objective 4. Each role-players' area of activity in participating in CBR was established. Clients played a significant role in their own rehabilitation and were very active in and around the home (Tables 3.8 and 3.9, Chapter 3). However, they were less active in the planning and management of programme activities (Table 3.23, Chapter 3). VCWs carried out a variety of activities that can be considered as sustaining the momentum of the programme. The type of activities they carried out, includes promoting IGP's (72%; $n = 18$; Section 3.4.3.2(3), evaluation activities (Table 3.12, Chapter 3) that involved

home visits (Section 3.4.3.2 (1), Chapter 3), record keeping (Section 3.4.3.2 (2), Chapter 3), and follow-up and referral (Section 3.4.3.2 (5), Chapter 3). They facilitated communication between clients and health and rehabilitation workers, as well as clients and community leaders. Community leaders were active in contribution of material goods, management intervention and facilitating processes that help PWDs (Table 3.17, Chapter 3). Community leaders felt ill equipped in promoting community participation.

Health and rehabilitation worker activities involved training, management (Figure 3.8, Chapter 3) and facilitation and guidance of the programme (Table 3.27, 3.28 and 3.29, Table 3.43, Chapter 3).

Guided by objectives 6 and 7, this study explored how the existing rehabilitation management system collaborates, links and functions and how much communication takes place within it. The results revealed that a complex network of communication channels were utilised. Health and rehabilitation workers used both formal and informal communication. The health and rehabilitation workers had contacts with community leaders, VCWs, clients and other community members, both verbally and in writing (Table 3.34 and 3.35, Chapter 3). They also used meetings and liaised with other professionals in the community, such as the environmental technician and sector ministries (Table 3.39, Chapter 3). There are still areas where the contact and communication are scant and under-utilised, e.g. the District Health Committee and the health and rehabilitation workers' direct communication with the community leaders. The VCW had many contacts within the community (Section 3.7.10.3, Table 3.40, Chapter 3). Much of the information was communicated to the health and rehabilitation workers (Table 3.43, Chapter 3).

Another important loophole was that in the planning phase, the key players such as the VCWs, the community leaders and the health and rehabilitation workers were not channelling the projects through the Rural District Council. Funding was therefore not forthcoming, because the projects would not have been included in the initial budget (Section 3.5.1, Chapter 3).

In answer to objective 8, each target group, i.e. clients, VCWs, community leaders, VCWs and health and rehabilitation workers, were asked what factors they saw as hindering community participation. In addition, three factors that are considered in the

literature as having the potential to hinder participation were studied. These were community leadership attitudes (Helander 1991 and 1994), mainstreaming CBR and disability into community development (Coleridge 1993), and resources and resource availability (Oakley 1991). The study found that integration was evident at operational level but not in the official structures (Figure 3.6, Chapter 3). Resources were hindering community participation (Table 3.46 and 3.47 and Section 3.10, Chapter 3). Another factor was community leadership attitudes (Section 3.4.4.2 and Table 3.15, Chapter 3), which were not negative but also did not fully correlate with their knowledge base to facilitate effective participation.

Factors put forward by the clients, VCWs, community leaders and health and rehabilitation workers provide insight into what the specific groups perceived as being hindering factors and should be thus dealt with in this context, for example the clients felt the community leaders did not take them seriously (Section 3.9.1.1 and Table 3.45, Chapter 3), while the VCWs wanted more support in resource mobilisation (Table 3.47, Chapter 3).

There are many recommendations that do not require any resource mobilisation but rather a change in the management of the programme. Some recommendations require emphasis of concepts such as involvement and empowerment of the PWD in CBR planning and general community meetings. The process of shifting the balance of equity in resources, decision-making and community participation of PWDs in CBR, need to be explored and implemented.

CHAPTER 5

RECOMMENDATIONS AND THE WAY FORWARD

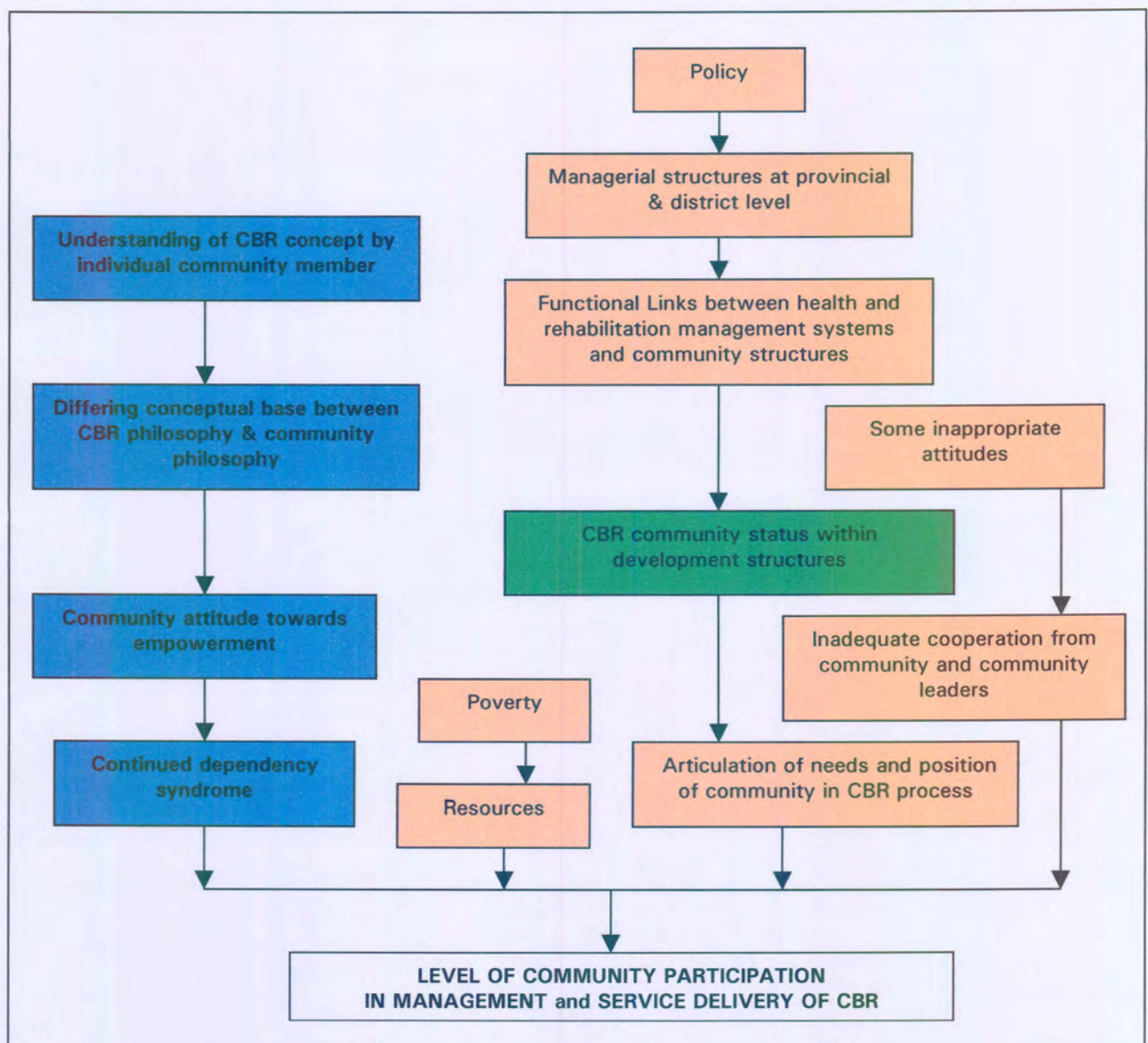
5.1 INTRODUCTION

The purpose of this study was to establish to what extent the community, and in particular the PWD, participate in the CBR management systems and structures implemented by the Rehabilitation Department at community, district, provincial and national levels in Midlands Province. In section 1.2.7 in Chapter 1, a conceptual framework, based on the insight of the researcher and that guided the research process of this study, is presented. The factors that are shown in the conceptual framework in Figure 1.4 were explored in depth to establish the nature and extent to which they were promoting or hindering participation of the community.

This chapter concludes the study by presenting the conceptual framework (Figure 5.1) as it is influenced by the results. The factors that influence participation remained essentially the same, with a few additions. It is important to note that the additional factors reflect the factors as perceived by the clients and stakeholders and the factors supported by the results. However, what has been highlighted in the study is the nature (dynamics of the links) and extent to which they have either been developed or mitigated, or that the issue has not been addressed at all. The study, as shown in Chapter 4, Section 4.6, provides a baseline using the Rifkins wheel to indicate the level of participation in management processes attained by the programme in Midlands Province.

Finally, recommendations emanating from the results and literature are outlined in this chapter. The recommendations are drawn from the results and discussion, and are discussed around the objectives stated in Chapter 1, Section 1.4.1. The way in which the results from this study influenced the conceptual framework is presented in Figure 5.1.

Figure 5.1 Conceptual Framework of Community Participation in Community-Based Rehabilitation (CBR)



Key		Factors where positive changes were found in the study
		Factors where the are significant efforts but had limitations, difficulties and many areas of need
		Factors that were missing

The status of each of the above factors has been described in Chapter 3 (Results) and Chapter 4 (Discussion). The implication of the results found for the CBR programme is discussed under the recommendations and it is from this point of departure that the recommendations to the CBR programme are discussed.

5.2 RECOMMENDATIONS

The recommendations described in this section, are based on the recommendations made by all the participants in the study, as well as the results of the study.

5.2.1 Improving the level of participation among PWDs

Objective 1: To determine the level of participation of the community in the management of CBR, specifically the extent to which participation in Midlands Province can be measured by using the Rifkins model of community participation.

The main aim of the study was to determine the level of participation of the community in the management of CBR. The level of involvement in the process of community participation in CBR of the community leaders and the VCWs was fairly high, with the VCW scoring higher on the Community Participation Group of the United Kingdom for All Network scale and in the array of activities they were involved in. The health and rehabilitation workers, being the drivers of the programme, had a high level of participation. The family and the clients (PWDs) were not at the same level of participation as the others. Despite the community mobilisation and awareness processes that had been carried out, the clients were not fully participating in CBR. In this regard, the clients pinpointed a few areas where *“They felt they were still not taken seriously enough in the development cycle even in matters that involve them primarily”* (Direct quote from raw data).

This study recommends that the health and rehabilitation workers reassess the entry points (i.e. from what angle the programme is approached - medically, economically or socially) for PWDs into the CBR programme. Although the study did not look in depth into the processes used to encourage community participation, the records studied had guidelines that outlined the steps to follow when implementing CBR. None of the records placed any emphasis on strategies to encourage participation. In women’s

programmes, the present strategies have been two-pronged. One approach treats disabled women as a separate category and seeks to improve their status by enhancing their economic status through skills training and small income generating projects. The other approach seeks to get to the heart of the disabled women's isolation and regards women's participation in a structural sense, as opposed to looking at their economic inadequacies only. Both approaches are embraced in the principles of CBR; however, the participatory processes of comprehensive community participation, which encourage more inclusiveness of PWDs, are not clearly outlined in the official documents.

Using the Rifkins model on a scale of 1 to 4 on a continuum, Figure 4.2, Chapter 4, provides a baseline from which all the major role-players in CBR in the three districts can assess their participation. The Rifkins wheel provides a tool to take a critical look at the five areas of needs, i.e. assessment, leadership, management, organization and resource mobilisation and make them an integral part of the programme design, monitoring and evaluation.

5.2.2 Enhanced participation of different community players

The formal and the informal links in the community showed enhanced activity emanating from health and rehabilitation worker intervention; i.e. the client and his family spent more time on issues relating to activities of daily living (ADL). There was less activity on issues such as schooling (Section 3.4.2.3 (3), Chapter 3), social welfare (Table 3.26, Chapter 3), and mobilisation of resources (Table 3.32, Chapter 3) that required cross-sectoral participation. The results also showed a lower level of activity involving DPOs and NGOs (Table 3.10, Chapter 3), collaboration with Ministries of Social Welfare, Local Government and Education (Table 3.39; Chapter 3).

It is recommended that an inventory of what services/opportunities for participation is available and the potential areas of better collaboration be examined together with the PWD, using a participatory approach to CBR. Furthermore, it is recommended that the programme facilitators (health and rehabilitation workers and community leaders) promote a community-based support system through community participation, advocacy and lobbying by the PWDs themselves. This will require mobilising of organisations for PWDs in order to carry out training for the PWDs to enhance their own advocacy skills.

The clients, their families and community leaders, should lobby for better recognition of disability issues together with the political administration structures, e.g. the integration of health and social welfare issues into development structures and the forming of committees to carry out policies and decisions.

5.2.3 Improving the understanding of community participation in CBR

Objective 2: To determine the level of understanding of participation in the CBR delivery system by all key role-players, with the emphasis on CBR service delivery at community level.

Understanding the conceptual base of CBR requires that the community member, in this case the key stakeholder, understands participation. What the community as a whole understand about participation will influence their attitude and subsequently their participation as such.

The researcher looked at the understanding of participation by the key stakeholders under three major areas of its definition, i.e. compliance (referred to as actual involvement by doing something within the programme), contribution and collaboration. The VCWs (Section 3.4.3.1, Chapter 3) and health and rehabilitation workers (Section 3.4.5.1, Chapter 3) seemed to have a balanced understanding of these three areas. The community leaders (Section 3.4.4.1 and Table 3.14, Chapter 3) and the PWDs (Table 3.5, Chapter 3) viewed compliance as actual involvement and any form of contribution (material, money or manpower) in the programme, as participation. Collaboration would encompass much more than physical contribution of money and/or manpower. The planning and mainstreaming of PWDs/CBR were poorly understood as part of participation. It is therefore recommended that in the process of CBR, the health and rehabilitation workers must clarify and facilitate through a process of helping the community to gain a deeper understanding of community participation.

The CBR programme facilitators (health and rehabilitation workers) should note the gaps in the key role-players' knowledge of community participation (e.g. those community leaders who apportioned total responsibility for the PWD to the community (Table 3.15, Chapter 3), or where community leaders understand participation as contribution (Table 3.14, Chapter 3), or the twenty two percent (22%) of the community leadership who

still remain to integrate disability and CBR into community development plans (Section 3.4.4.2, Chapter 3). The areas where there are poor attitudes towards CBR or PWDs, or inappropriate action by community leaders, or no action at all, reveal difficulties in translating the concept of participation into action, especially by community leaders and clients. Appropriate training and education sessions by the health and rehabilitation workers for all key role-players, and follow-through of participatory activities, are recommended.

5.2.4 Improving the attitude towards PWDs participation in community programmes

Objective 3: To determine the attitude of community leaders, PWDs and key health and rehabilitation workers towards participation in CBR.

The client's understanding and his conceptual base of participation are factors that will influence his attitude towards participating in CBR. The factors that influence attitude as outlined by Triandis (1996), are explained in Section 4.2.3, Chapter 4. According to the VCWs and the health and rehabilitation workers, the community and community leaders' attitude to clients, i.e. PWDs and their families, has improved significantly (Section 3.9.3.3, Chapter 3). The VCW reported the community leaders as *"initially being as hard as rock"* (Direct quote from raw data), but now they are much more approachable. Despite this, the results show some residual negative attitudes that may affect participation. (Sections 3.9.3.3, 3.9.3.2 and Table 3.15, Chapter 3).

Out of one hundred and twenty two (122) clients, only twelve (12; 10%) ascribed total responsibility for the PWD to the individual him/herself. It is therefore recommended that the health and rehabilitation workers continue to perform or enhance activities aiming at changing the client's attitude in this regard. The results have shown that there has been a shift in attitude with the clients moving from a position of total dependence to a greater degree of self-reliance as outlined in (Table 3.6, Chapter 3).

It is also very important for the leadership to recognise the effect of their attitudes towards PWDs and CBR on the community's and client's participation. Another parallel can be drawn from the gender operation cycle (GTZ 2000) used by rural development programmes, where the process of recognising where gender biases come from is a deliberate and a facilitated exercise. Health and rehabilitation workers working in the disability area may learn from experience in this process and incorporate that as part of

their activities to facilitate participation. Health and rehabilitation workers, together with the community players, should map out a strategy to promote inner reliance, using participation strategies that would enhance community development. Ultimately, the goal is to promote the direct involvement of PWDs in all aspects of planning for CBR.

5.2.5 Enhancement of support of community-based activities

Objective 4: To determine the areas of participation in CBR by all key role-players at community level.

The support of VCWs in their activities of rendering a service to clients through home visits, reporting and support of community activities, and mobilising resources and IGP projects, should be improved.

Activities carried out by the VCWs should be studied further to ensure that they are resulting in maximum benefit for the client (there were discrepancies in some of the perceived benefits by the clients in response to activities that the VCWs spent a lot of time on, e.g. IGP and community support (Section 3.4.3, 3.4.3.2 and Tables 3.11 and 12, Chapter 3). It is important to ascertain whether activities for the promotion of IGPs are capturing the felt needs of the client.

5.2.6 Strengthening the linkages in the management system

Objective 5: To determine the dynamics of participation by key role-players from the community at the community and district levels of management in the service delivery of CBR. This includes the formal and informal links between the management inputs and processes in the health and rehabilitation system that are currently in place to establish contact with the community at district and community level

Objective 6: To determine the factors that are promoting or hindering community participation, and the extent to which availability of resources influence participation. (Only the recommendations for the first half of objective 6 is discussed in the following paragraphs).

Objective 7: To determine how the existing rehabilitation management system collaborates, links and functions with the community and district level structures.

This recommendation is made in terms of objectives 5, the first half of objective 6 and objective 7, based on the results given in Chapter 3 and the discussion in Chapter 4 regarding the formal and informal contact and communication between the community and the health and rehabilitation workers. This recommendation has several aspects that will contribute to strengthening contact and communication in the management system and are presented in Sections 5.2.6.1 to 5.2.6.2 below. It also includes the links (contact) and communication between key role-players as well as *mainstreaming* disability into the community development system.

5.2.6.1 *Links (contact) and communication between key role-players*

The facilitators of CBR, i.e. the health and rehabilitation workers and the community leaders, should go through an evaluative process of identifying where participation is taking place and to what level it is taking place. This will highlight the poor linkages in the system. The study showed strong links between the VCWs and clients and VCWs and community leaders. Weaker links were evident between the clients and health and rehabilitation workers. The contact and interaction between the community (including the CBR programme) and other sectors such as social welfare, education and local government were also poor. Poor communication was also evident between the community leaders and the health and rehabilitation workers.

5.2.6.2 *Mainstreaming disability into the development system*

There is a lot of activity at community level that is not supported by the official structures; i.e. there is no official integration or inclusion of disability issues in the official structures outlined in the Rural District Council Act and the Presidential Directive of 1999. This, as will be shown later in Section 5.2.9, affects the provision of resources. Although it is difficult to get disability mainstreamed into these legal acts, it is important for the health and rehabilitation workers to conscientise the PWDs, VCWs and community leaders on the effect of this non-inclusion throughout the management process. It is for this reason that the "CBR community status within development structures" factor in the conceptual framework is coded as absent despite the fact that

seventy eight percent (78%) of the interviewed community leaders (Table 3.48, Chapter 3) reported including disability issues into their community development plan at operational level. This in itself is a good sign, and it is recommended that it be fully encouraged with the aim of all community leaders aiming to fully include disability issues in their community development plans, as this will minimise the major problem of resources.

The examples of mainstreaming provided by community leaders (Table 3.48, Chapter 3) show that they lack insight into the practical implications of mainstreaming. Because of this, they estimated mainstreaming high. Community leaders' insight into what mainstreaming of CBR entails, must also be investigated and improved if it is found to be lacking. It is also clear that there is a need for the promotion of better mainstreaming of CBR and disability issues into the official policy, which will affect resource allocation and the recognition of disability issues by important decision-makers within the management structures. This process is part and parcel of the process of promoting community participation, seeing that participation begins with all parties concerned. The community leader needs to be the manager or facilitator of the programme. However, they have expressed their lack of knowledge in this area. Nonetheless, the health worker may facilitate the training and could perhaps incorporate the services of an expert to achieve the goals set for the programme.

5.2.6.3 *Improvement of the evaluation system of CBR and participation in CBR*

The evaluation system for CBR (which is currently in its infancy) should be reviewed with the aim to establish it fully and correct any problems that become evident during the evaluation. The OMAR system should continue to be explored and modified to suit the demands of the CBR programme. VCWs should become more systematically involved in the evaluation system, not only to collect data, but also to understand its uses and application for the redirection of the CBR programme and the enhancement of participation. In conjunction with this, official records should be reviewed to optimise the findings of the evaluation system and to enhance participation. It could also reveal the need to change the way in which documentation was performed in order to obtain a comprehensive data capturing system. The quality and standards of written records should be explored, as the results (Table 3.25 and Section 3.6.2, Chapter 3) show that only a part of the activities are actually documented.

5.2.6.4 *Utilise community-based committees*

In each area it is necessary for health and rehabilitation workers to assess whether the various committees are functional, and that their activities complement each other. Lobbying for those committees that were found useful for the attainment of objectives for CBR, such as inter-sectoral collaboration, should be encouraged.

It is recommended that an assessment of the different areas of dysfunction within the system of committees in each community be undertaken. The aim with such an assessment should be promotion of better contact and communication between all role-players, and as such facilitating community participation.

5.2.7 Improvement of the level of communication among key players

Objective 8: To determine the level of communication between the key community role-players and the role-players in the rehabilitation and health delivery system.

As mentioned before, the stakeholders that were found to have poor contact and communication were the health and rehabilitation workers and the community leaders, and the health and rehabilitation workers and the clients after implementation of the rehabilitation programme. Community leaders recommended that health and rehabilitation workers improve all channels of communication and not wait for meetings or workshops only to communicate with them. They suggested that health and rehabilitation workers communicate through the local council and councillors either by sending letters or even copies of reports of what has transpired after community activities has been carried out. Their collaboration with one of the main development committees, the District Development Committee, was found to be urging. It is therefore important for the health and rehabilitation workers to improve their collaboration with the District Development Committee, as it is an important committee for communication and enhancing collaboration in the whole district.

5.2.8 To increase the resource base for CBR

Objective 6: To determine the factors that are promoting or hindering community participation, and the extent to which availability of resources influence

participation (Only the recommendations for the second half of objective 6 is discussed in the following paragraph).

All respondents (Section 4.5.2) perceived resources as a major hindering factor to community participation. The community expressed its need for funding from external sources, which has been slow and not forthcoming. The client and community leaders felt that resources underlie all activities, and that it need to be addressed. In their recommendations, all the stakeholders refer to the need for resources to be mobilised. Using the participatory cycle (GTZ 2000) may highlight areas where the community has not made use of available resources themselves. (The participatory cycle is a method where all people involved in a programme go through a process of analysing the causes, effects and underlying assumptions. The process may be undertaken to shed light, create understanding and reveal new avenues for programme development where possible). Furthermore, investigation into the participatory cycle may highlight organisational structural areas that might help to strengthen the resource base. Health and rehabilitation workers and key stakeholders should look at incorporating CBR and its principles into other development programmes that embrace participation.

5.3 RECOMMENDATIONS BY STAKEHOLDERS

Objective 9: To describe the present situation and make recommendations regarding future developments that will enhance the effective and efficient management and delivery of CBR service with the full participation of the community.

Recommendations from the different respondents who are key stakeholders are outlined below. These recommendations emanated from the study results, for example the need for resources and capacity building. It is important to present the recommendations by the key stakeholders separately to ensure that the specific context-based recommendations are understood from the different groups' point of view.

5.3.1 Clients' recommendations

The interviewed clients made the following recommendations:

- Need for more resources, e.g. seed money for small projects, financial, sporting facilities (32%; n = 39), material and manpower.
- Continuing education in areas for capacity building in disability, including management of their own programmes (42%; n = 51) and other technical issues like teaching mothers how to handle their disabled children.
- PWDs felt teamwork with the community should be emphasized and politics should not interfere with the programmes (15%; n = 18). Clients emphasised the need for programme managers, in particular the health and rehabilitation workers, to fulfil their promises and give tangible results.
- The CBR programme needs to be decentralised and revamped in some areas (13%; n = 15).

5.3.2 Community leaders' recommendations

The community leaders recommended:

- Regular and more consistent communication between the community leaders and the health and rehabilitation workers is necessary. Specific mechanisms of communication, such as written reports to the leaders and attendance of ward health team meetings, should be used. They feel this will enhance mutual understanding.
- Capacity building and training - i.e. how to integrate disability issues into development issues. This can be done by inviting an outside expert to facilitate the community integration process.
- Mechanisms to reduce poverty, through increased support to such mechanisms. The community leaders, VCWs and health workers should seek the expertise and

collaboration of the Ministry of Rural Development, which specialises in poverty alleviation and reduction programmes.

- Systematic integration of disability issues into Rural District Council - this should be enhanced by better communication from the VCWs and health and rehabilitation workers' side.
- Community must increase the community's capacity to raise and save funds in order to mobilise resources.

5.3.3 VCWs' recommendations for participation and managing CBR

The VCWs recommended:

- Consistent funding should be made available for the programme activities.
- There should be management revamping as the CBR programme has lost momentum;
- VCWs should be trained continually and supported with regard to CBR programme goals, in order to keep up its momentum

5.3.4 The health and rehabilitation workers

The health and rehabilitation workers were not asked to give recommendations. The rationale behind this is that they were the initial facilitators of CBR. Therefore, they should not make recommendations but, based on the principles of participation and CBR, they should have been working towards the clients and community obtaining more control over CBR. It was also assumed that the recommendations from the study would give a fair representation of recommendations from a management point of view.

5.4 LIMITATIONS OF THE STUDY

1) *Availability of key respondents:*

In KweKwe and Mberengwa, VCWs did not come to the pre-arranged meeting points and had to be followed up at home. In Mberengwa, the letter that was sent to the district medical officer and the rehabilitation department did not arrive on time. This created logistical problems such as transport and time constraints on the day, because all the clients had to be followed up in their homes. In KweKwe, there was a funeral in the area and the VCWs were away attending the funeral. As a result, only half the number of VCWs ($n=7$) that could have been interviewed, were actually interviewed. Furthermore, some community leaders were away on business in the city and did not participate in the study. In Gweru, the three councillors representing the area had to be followed up in the city where they were attending to council business.

2) *Logistical problems*

Some of the logistical problems that had to be overcome included the distance between the districts and the shortage of transport and fuel at the time of the study. The data collection days were extended by one day so that over 30% of each target group was interviewed in order not to affect the reliability and validity of the outcome of the study.

3) *The age and nature of disability*

Twenty percent (20%) of the clients were below the age of ten (10) and could not speak for themselves. Some clients were limited by the nature of their disability. This influenced the true picture where the researcher had to depend on the opinion of the caregiver - even with questions that concerned the clients' own perspective. It is unlikely that this affected the outcome of factual and event related questions such as exercises and home visits. The caregivers would know with accuracy the detail about events concerning their children. However, where attitudinal and issues to do with knowledge on participation are concerned, it is better to obtain the client's opinion. Besides, allowing the client to express and direct his own future is the start of real participation.

among the community, with or without the facilitation of external players such as health and rehabilitation workers, which will keep the programme going.

Data were gathered from the clients, VCWs and community leaders from the point of view of their own participation and from the literature, in order to provide a guideline on how to ensure participation takes place. The results (Clients participation - figure 3.5, Section 3.4.3, Chapter 3; VCW participation, Section 3.4.3.2, Chapter 3; and community leader participation, Section 3.4.4.4, Chapter 3) have shown that participation by the key stakeholders is indeed taking place, although with limitations. Some of the limitations are the inconsistent activity of the community-based committees that should support community development (Table 3.24, Chapter 3). Of importance is the lack of incorporation of disability issues at a higher level of policy making and decision making; yet there is much activity at community level (as indicated by the incorporation of CBR in the Community Development Committee). There is inadequate involvement of the PWD (an adequate level is very important for a successful CBR programme, Coleridge 1993). Different perceptions exist regarding the way support for PWDs is provided by community leaders and health and rehabilitation workers. All these limitations are impacting negatively on participation in CBR.

If the detailed results and recommendations are considered and implemented, it will optimise participation by the key stakeholders.

From the results it is clear that the Midlands CBR programme has been of benefit to people with disability. Section 3.4.2.3 (Chapter 3) shows how the client himself has benefited in improving in physical, communicative and social function. The less tangible benefits are also expressed, where for example the client says: *"I have learnt how to handle myself as a PWD to avoid isolation and not get spoilt"* (Direct quote from raw data; Table 3.41, Chapter 3). VCWs have become capacitated and instrumental to advancing the plight of PWDs in the community. The CBR programme has moved disability from a time when the community ignored the PWDs and the community leaders were not cooperative, to a situation where the community is making attempts to not only take care of the PWDs but also empower them to take care of themselves. Within the structures of the Ministry of Health, rehabilitation and disability issues have also become more visible, although this is not the case in the community development sector. With the results from this study, which include a positive change in leadership attitudes, the integration of disability issues should be pushed forward. The optimal

situation would be where disability issues are a part of development issues and are driven from within the community.

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Annexure 1

RETROSPECTIVE STUDY OF EXISTING RECORDS/ OBSERVATION CHECK LIST

District Hospital ☐
Clinic ☐

MANAGEMENT of CBR at District Level

1. Are there policies to facilitate community participation in programmes?

If yes:

a) Indicate the type and description
Local Policy?

Available Yes ☐ No ☐

Policy document	
Guidelines	
Other	

b. What type of plans are involved?

- ☐ Strategic
☐ Operational

c.) Do they reflect community needs? Yes ☐ No ☐

3. What systems are in place for monitoring at district and community level?:

	District		Community	
	yes	no	yes	No
Structured Records				
Unstructured Record				
Achievement of results documented				

Explain:

.....
.....

4. Review of minutes of meetings at district and community level:

Determine the disability issues that were on the agenda:

.....

.....

What results were achieved from issues raised at meetings?

.....

.....

5. Do VCW keep records of their activities? Yes ! No !

Indicate in what manner:

Type of record	
In Exercise books	
On Structured forms	
Other	

What type of information is captured in these records?

.....

.....

6. How is liaison with other organizations and service providers recorded?

As Reports	
In Minutes	
On Referral forms	
Other (specify)	

7. Where are clinical records of people with disabilities kept?

Chronic diseases register	
Rehabilitation register	
Client cards and records	
Other (specify)	

What are the Linkages evident in the records?

.....

.....

.....

Annexure 2

Questionnaire No _____

QUESTIONNAIRE FOR REHABILITATION AND OTHER HEALTH PERSONNEL

District Level

In what district are you working at present?

District 1	
District 2	
District 3	

Position :

Nurse	
EHT	
Doctor	
Rehab Tech	

Gender Male: ☐ Female: ☐

What is your age? Years

1. What do you understand by the term community participation?

.....

.....

.....

.....

What management systems does your team have in place that supports community participation?

	YES	NO	Don't Know
i) Individual treatments with focus on client participation			
ii) Regular meetings with Community representatives			
iii) Reporting System			
iv) Meetings with family			
v) Other			
iv) Don't know			



- 2b. What difficulties do you experience with community participation in relation to rehabilitation programmes?

.....

.....

.....

3. Who did you consult when for planning Community based rehabilitation (CBR) with in the community and in what way?

	Please tick	Explain how	
With community leaders			
With V.C.W.s			
With P.W.Ds and families			
Other health depts. (Specify)			

4. When Planning for Community based rehabilitation, what would you say about community control ? Indicate

Degree of community control and participation in planning	Please tick
Community has Control Identified the problem and made decision on CBR implementation and means	
Has delegated power Ministry of Health (MoH) identified the problem outlined the CBR programme and asked the community to make decision on how CBR was to be carried out	
Plans Jointly MoH presented a tentative plan subject to change from those affected and changed plan accordingly	
Advises MoH presented a plan and invited questions. Prepared to modify plan only if absolutely necessary	
Receives information MoH made a plan announced it. Community convened for informational purposes. Compliance expected	
None Community told nothing	

4b. Explain your choice

.....

.....

5. How have you used your plans for implementing CBR?

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.....

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6. What information / needs have been generated from the community that have affected your plans?

	Got it and used it	Got it and did not	Did not get
Educational and information needs			
Income generation needs			
Clinical needs			
Vocational needs			

6b. Explain where used

.....

.....

.....

7. How have you used this information for managing the programme?

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8. How many CBR/Community Contacts do you have a month in the community?

	ONCE MONTH	ONCE WEEK	DAILY	NEVER	DOES NOT EXISIT
District Health Committee					
Village Community Worker					
District Development Committee					
Other Specify					

Explain your answer

.....

.....

9. Number of new referrals received from the community based area:

- 2-5/week ☐
- 10/week ☐
- 1/week ☐
- Other ☐

10. What communication channels exist between the district health system and the community?

.....

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11. In the last year what meetings have you attended at community level?

CRC meetings Yes ☐ No ☐

DDC meetings Yes ☐ No ☐

CBR meetings Yes ☐ No ☐

Other (specify):

.....

.....

12. Give two examples of the issues discussed concerning CBR

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13. What activities have you carried out in the last year in response to the expressed needs by the community?

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Annexure 3

Questionnaire No.

CLIENT LEVEL (interview schedule)

District	
Ward	
Village	

Indicate the Clients' area of Disability:

Mental	
Orthopaedic	
Neurological	
Hearing	
Visual	

Gender

Male ☐

Female: ☐

Person Interviewed:

Client	
Parent/caregiver	
Teacher	
Other	

1. What do you know about participation in Community Based Rehabilitation ?

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If the respondent does not understand the question rephrase as follows: What do you understand by contributing or being involved in CBR?

2. When CBR was planned, what would you say about your involvement in this process?

Degree of community control and participation in planning	
Community has Control As a person with disability you were involved with identifying key problems faced by PWDs and included them in the CBR programme.	
Has delegated power Ministry of Health (MoH) identified the problem outlined the CBR programme and you as a PWD to make decision on how CBR was to be carried out	
Plans Jointly MoH presented a tentative plan then asked you where you felt the changes were necessary, then changed the plan accordingly	
Receives information MoH made a plan announced and informed you. You joined the process and agreed with the activities	
None As a PWD I was told nothing	

Explain your answer:

.....

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.....

.....

3. In what ways have this program helped you?

	Could do it	Could not do it before and can do it now	Could not do it now can do it with assistance	Still cannot do it
Eating/and or drinking				
Washing/keeping clean				
Latrine use				
Dressing/undressing				
Understanding simple instructions				
Expressing thoughts, needs, feelings				
Communicating with others				
Getting up from lying				
Moving hands and arms				
Moving legs				
Mobility around the house				
Mobility around village				
Play activities				
Schooling individual adults				
Participation in family activities				
Participation in household activities				
Participation in community activities				
Income Generating Projectss (adults only)				
Other				

3b. What specific information about disability have you gained?

.....

.....

4. Have you ever approached community leaders / Community Rehabilitation Committee or community Development Committee with specific needs?

Yes ! No !



4a. If yes how did they respond:

	No	Yes and they helped	Yes and they did not help	Yes and they tried
Mobility needs				
Medical needs				
Money				
Access to education				
Accessing community amenities				
Accessing Social Welfare				

4b. If Helped, explain the type of help received:

.....

.....

.....

5. What obstacles have you experienced in solving your problems within the community?

	yes	no	Give examples
Inadequate or no cooperation from community in general			
Poor resources give egs			
Inadequate or no cooperation from health personnel / system			
Inadequate or no cooperation from community leaders			
No Problems at all			
Other			

Explain your answer:

.....

.....

6. Is your family participating in your rehabilitation programme?

Always ☐ Seldom ☐ Never ☐

7. In what way are your family participating?

Activities of daily living/ self care	
Access to school and work	
Ambulation	
Liesure activities	
Access to community amenities e.g. transport public halls and houses	
Other give e.g.	

Explain your answer

.....
.....
.....

8. To what extent is the plight of the PWD responsibility of :

Participation	Totally	Partially	Not at all
Community			
Government			
Individual			
Family			

Explain your answer:

.....
.....

9. How much time do you and your family spend on issues directly relating to your disability / week

1-2 hours ☐
2-4 hrs ☐
1day ☐
3 days or more ☐

Explain

Give examples of some of the activities that you carry out:

.....

.....

.....

.....

10. Are you aware of the referral system within the health service and rehabilitation?

Yes, used it ☐ Yes, not used ☐ No ☐

11. Give an example of a time when you have used the referral system.

.....

.....

12. How much contact do you have with the local supervisor of the CBR programme?

Once a week ☐

Twice a week ☐

Once a fortnight ☐

Every month ☐

Other ☐

Explain

.....

13. How much time do you spend with the local supervisor / week?

1-2 hours ☐

2-4 hours ☐

1-2 days ☐

2-3 days ☐

Other ☐

14. Do you belong to any community initiative such as:

- Disabled Peoples Organisations ☐
Non-governmental Organisations ☐
Income Generating Project ☐
Other ☐

What activities do you carry out?

.....

.....

.....

.....

15. What recommendations would you give to improve community Participation in your programme?

.....

.....

.....

.....

Annexure 4

Questionnaire no:

COMMUNITY DEVELOPMENT COMMITTEE and COMMUNITY LEADERS INTERVIEW SCHEDULE

District	
Ward	
Village	

What is your position in the community?

Community Worker ☐ Community Member ☐ Community Leader ☐

Gender: Male ☐ Female ☐

1. What do you understand by CBR?

.....

.....

.....

2. What do you understand by community participation?

.....

.....

.....

.....

3. Have you incorporated the CBR programme into your community development programme?

Yes ☐ No ☐

4. If so, how?

.....

.....

5. If no, why?

.....

.....

6. Who has been involved in the CBR programme?

Local leadership (specify)	
Disabled peoples families	
Disabled peoples organisations	
People with disability	
Local health staff	
Village community worker	
Other (specify)	

7. How have you been involved in the past year?

Contribution of materials	Yes ☐	No ☐
Manpower time	Yes ☐	No ☐
Money	Yes ☐	No ☐
Participation in building	Yes ☐	No ☐
Participation in education projects	Yes ☐	No ☐
Negotiation on behalf of PWDs	Yes ☐	No ☐
Other	Yes ☐	No ☐

Explain and list the activities and numbers where applicable:

.....

.....

.....

.....

8. Are you happy with your level of involvement?

Yes ☐

No ☐

If not, how would you like it to be improved?

.....

.....

.....

9. To what extent is the plight of the PWD responsibility of :

	Totally	Partially	Not at all
Community			
Government			
Individual			
Family			

Explain your answer

.....

.....

10. What support systems have emerged within your community for PWD?

Community Rehabilitation Committee	
Rehabilitation on Community Development Committee agenda	
Non Governmental Organisations	
People with Disabilities	
Other	

Explain your answer:

.....

.....

.....

11. Tell us how you intergrate and collaborate with:

a) Ministry of Health

.....

.....

.....

b) The Rehabilitation Department

.....

.....

.....

c) Ministry of Education

.....

.....

.....

d) Other Ministries, specify

.....

12. When CBR was planned, what would you say about your involvement in this process:

Degree of community control and participation in planning	
Community has Control As the local leadership, I was part of the process of identifying the problem and making decision on CBR implementation and means	
Has delegated power Ministry of Health (MoH) identified the problem outlined the CBR programme and asked the community leadership to make decision on how CBR was to be carried out	
Plans Jointly MoH presented a tentative plan and as a leadership we were asked for our opinion on the plan and it was changed accordingly	
Receives information As community leadership we only supported the programme after the plan was made.	
None Community leaders were told nothing	

Explain your answer:

.....

.....

13. In managing and participating in CBR, what recommendations do you have?

.....

.....

.....

.....

Annexure 5

Questionnaire no.:

QUESTIONNAIRE INTERVIEW SCHEDULE

VILLAGE COMMUNITY WORKER

Area covered:.....

District	
Ward	
Village	

Gender: Male ☐ Female ☐

No. of Villages covered:

6 and below !
7 – 12 !
13 – 18 !
18 and above !

Population of catchment area:

No. of PWD's in the Area:

1. How many clients do you refer per:

Week Month

2. How often do you carry out the following rehabilitation and community based rehabilitation functions?

	Monthly	Weekly	Never
Training			
Home Visits			
Negotiation with community leaders or other community structures			
Other Specify			

3. Average number of visit to each PWD in your catchment area per month

One ☐

Two ☐

Three ☐

Other ☐

Specify.....

4. Average length of visit

30 min ☐

1 hour ☐

2 hours ☐

Other ☐

Specify

5. What records do you keep?

Cards ☐

Client Records ☐

Client Lists ☐

Other ☐

Specify

6a. What is the main purpose of these records?

.....

.....

6b. Explain your collaboration with the health or rehabilitation staff in this activity.

.....

.....

7a. Average number of contacts with rehabilitation personnel / month

One ☐

Two ☐

Three ☐

Other ☐

Specify.....

7b. Explain your collaboration with the health or rehabilitation staff in this activity.

.....

.....

8a. What other activities related to CBR do you carry out?

Activities to promote effective integration and functional relationships within the community	
Activities to promote income generation	
Activities to improve the circumstances of an individual or community	
Activities to increase the knowledge and practice of PWD's and other community members	

8b. Explain your collaboration with the health or rehabilitation staff in these activities:

.....

.....

.....

9. What objectives have you set for yourselves in terms of the PWDs and their rehabilitation within the community?

.....

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.....

.....

.....

10a. How do you mobilise resources to promote these activities?

.....

.....

10b. Explain your collaboration with the health or rehabilitation staff in this activity.

.....

11. What services do you refer to and how often?

	Never	Once weekly	Once monthly
Social	☐	☐	☐
Health	☐	☐	☐
Vocational	☐	☐	☐
Legal	☐	☐	☐
Community	☐	☐	☐

12. Out of 10, how many clients were successful in the objective for referral to the district or province?

.....

.....

.....

13. What problems do you have with the referral system?

.....

.....

.....

14. Do you have a Community Rehabilitation Committee?

Yes ☐ No ☐

15. How do you interact with Community Rehabilitation Committee?

At CDC Meetings ☐

Other informal meetings ☐

In specific CBR programmes ☐ Give eg's

.....

.....

16a. Do you have a community based rehabilitation committee?

Yes ☐ No ☐

16b. Who are the members? ...

Community village workers	
Ordinary members of the community	
Community leaders	
Others: Specify	

17. What are the community development committee's main functions?

.....

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.....

.....

18a. What evaluation activities do you carry out?

.....

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18b. Explain your collaboration with the health or rehabilitation staff in this activity.

.....

19. How do you do this?

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.....

.....

.....

20. When Planning for CBR would you say:

Degree of community control and participation in planning	
Community has Control As the village community worker, I was part of the process of identifying the problem and making decision on CBR implementation and means	
Has delegated power Ministry of Health (MoH) identified the problem outlined the CBR programme and asked the village community workers to make decision on how CBR was to be carried out	
Plans Jointly MoH presented a tentative plan and as village community workers we were asked for our opinion on the plan and it was changed accordingly	
Receives information As village community workers we only supported the programme after the plan was made.	
None Village community workers were told nothing	

21. In managing and participating in CBR, what recommendations do you have?

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ANNEXURE 6

CONSENT FORM

GTZ
C/O Blair Research Institute
Josiah Tongogara Avenue
Harare
Zimbabwe

To whom it may concern

Dear Sir Madam

Mrs H Myezwa is conducting research into the area of CBR. The aim is to find out how much participation there has been by the community in the programme. This will help in mapping the way forward for the programme and in enhancing participation of the community. The Provincial Medical Director as well as the District Council has given permission.

Your input, as a member of this community, to this exercise is greatly valued and therefore your permission and consent is sought.

I.....agree to partake in the research exercise and will answer any questions to the best of my knowledge and ability.

Signature.....
Date.....
Place.....

Mrs Hellen Myezwa
Researcher