

THE OPEN UNIVERSITY OF TANZANIA
AND
THE SOUTHERN NEW HAMPSHIRE UNIVERSITY

**MASTERS OF SCIENCE IN COMMUNITY ECONOMIC DEVELOPMENT
(2007)**

**THE ARUSHA COMMUNITY BASED REHABILITATION SUPPORT UNIT:
THE CONTRIBUTION OF THE COMMUNITY IN IMPROVING THE LIVING
CONDITION OF PEOPLE WITH DISABILITIES IN ARUSHA REGION**

**SUBMITTED IN PARTIAL FULFILMENT FOR THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SCIENCE IN COMMUNITY ECONOMIC
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SUPERVISOR'S CERTIFICATION

I, Shungu Hamidu Abdallah being the supervisor of Ngatunga B. Angelus on his project,
The Contribution Of The Community In Improving The Living
Condition of People with Disabilities in Arusha Region, have read the project report and
found it to be acceptable for review.

Signature 


Date 10th August 2007

CANDIDATE DECLARATION

I, Ngatunga B. Angelus, am declaring that this project report submitted in partial fulfillment for the requirements for Master of Science in Community Economic Development in the Southern New Hampshire University at the Open University of Tanzania, 2007, is my own original work, and that it has not been submitted for the similar degree in any other university.

Signature _____

Date _____


25/06/07

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ABSTRACT

This research reports the activities of Arusha Community Based Rehabilitation Support Unit, a local Community Based organization which aim at improving the living condition of people with different kinds of disabilities in Arusha region.

The study findings reveal that so far the organization is has played a significant role in raising awareness about the needs and rights of people with disabilities in the community. As a result to this, community leaders, parents of children with disabilities and people with disabilities have been stimulated to work tirelessly to address the needs of people with disabilities in their communities. People with disabilities have received different services such as rehabilitation and referrals to different social services which in turn have improved their living condition.

The results also show that the local NGOs , CBO and government authorities have played a significant role in supporting this initiative in addressing needs such as healthcare and education, just to name few, which could not be offered by this project to people with different kinds of disabilities.

Despite the good progress made by this project and other organizations working with the communities to address their community needs, there is an urgent need for more support from Government and other stakeholders in order to mobilize resources which could address different needs of people with disabilities and community at large in the operational area. This is because Arusha CBR Support Unit perceives disability as a dimension of diversity which needs to be addressed from different angles; socially, economically, culturally and physiologically just to name few aspects.

EXECUTIVE SUMMARY

It has been estimated that globally, there are 335 million people living with different kinds of disabilities, 70% of whom live in developing countries¹. In Tanzania the population of people with disabilities is estimated to be 3.5 million (10%) people out of 35 million people constituting the population of the country.

The result of Community Needs Assessment conducted during field work attachment with Kilimanjaro CBR from in 2005 in Arusha region, showed that people with disabilities are excluded from services and activities which are considered to be normal for other people. This exclusion is mostly felt in the fields of health care services, education and training, and employment. Literature reviewed also showed that this problem is experienced in different countries of the world, and especially, in developing countries.

In order to address the problems facing people with disabilities in Arusha region, community members were mobilized by their leaders to find out how to address the needs of their disabled members in their respective communities. This led to establishing the Arusha CBR Support Unit which aimed at improving the quality of life of people with disabilities in Arusha region by promoting community based strategy which seemed to be very appropriate for them. This is in line with the United Nations Convention on Human Rights and the Government of Tanzania commitment towards

¹ Dr. Asha Yousafzi et al, Double Burden; A situation Analysis of HIV/AIDS and Young People with disabilities in Rwanda and Uganda (Norwich: Norfolk, 2004, p. 9.

improving the living condition of people with disabilities through its recent National Policy on Disability.

After the implementation of this project, it has become evident that partnership is the key to progress. Communities, parents and disabled people are potential resources to be drawn upon through a process of community consultation. Arusha CBR Support Unit workers will be in a key position to liaise between the key players, but they need to be encouraged to share this responsibility with teachers, people with disabilities, community and religious leaders and all other initiatives aiming at improving the living condition of people with disabilities. The rehabilitation process also needs to shift from rehabilitating people with disabilities to rehabilitation of the society and from rehabilitation on basis of charity to rehabilitation on basis of right.

LIST OF ABBREVIATIONS

CED: Community Economic Development

CAN: Community Needs Assessment

CBR: Community Based Rehabilitation

CCBRT: Comprehensive Community Based Rehabilitation

PWDs: People with disabilities

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CHAPTER ONE

COMMUNITY NEEDS ASSESSMENT

1.0. INTRODUCTION

This chapter focuses on the Community Needs Assessment survey, which was conducted in Arusha region, one of the operational areas of Kilimanjaro CBR. This part explores the Community profile of Kilimanjaro CBR programme and the Community Needs Assessment Survey. The latter section will include the research methodology, data analysis and presentation. The results of this research will lead to problem identification in the next chapter.

1.1. COMMUNITY PROFILE

1.1.1. PROJECT ORGANISATIONAL CONTEXT

Kilimanjaro Community Based Rehabilitation (Kilimanjaro CBR) is a program, which offers rehabilitation and preventive services for people with disabilities (PWDs) in their local communities in four regions namely: Kilimanjaro, Arusha(Arumeru and Karatu districts), Tanga (Lushoto district) and Manyara (Babati and Mbulu districts).

Kilimanjaro CBR began in 1996 and is a programme under CCBRT (Comprehensive Community Based Rehabilitation) a Tanzanian Non Governmental Organization (NGO) Registration Number: SO 8261 with its headquarters in Dar-Es-Salaam.

1.1.1.1. KILIMANJARO CBR MISSION

To build an inclusive society, which accepts, respects and takes responsibility to give equal rights to people with disabilities so that they may live quality integrated lives within their communities.

1.1.1.2. OBJECTIVES

- i. To provide the community with improved eye health services and to decrease the prevalence of blindness.
- ii. To assist people with disabilities to develop their abilities to their maximum and to live fulfilling lives as respected and integrated members of their community.
- iii. To train community members, students and professionals in ways of respecting, supporting and improving the lives of PWDs so that they are integrated into their communities.
- iv. To improve the quality of life of disabled people in Kilimanjaro and surrounding regions, through special disability weeks of intensive training for parents, children and adults with disabilities.

1.1.2. COMMUNITY CONTEXT

Kilimanjaro, Tanga, Arusha and Manyara are among the 26 regions of Tanzania situated in the Northern part of the country with the total population of about 2,534,605 people (Census 2002). According to the World Health Organization's formula of 1 in 10 being persons with disabilities, the total population of people with disabilities in Kilimanjaro's operational area is, therefore, estimated to 253,460 people.

The primary industry of the region is agriculture, with large fruits, sisal plantations coffee vegetable and flower producers sending high-quality produce to Europe. Small-scale agriculture was badly hit by the coffee crisis of recent years and is now largely subsistence farming. There are several factories including a sisal processing, brewery, tyre, fiberboard plant, and a large pharmaceuticals maker.

One of the principal industries, especially, in Arusha and Kilimanjaro is tourism, with the cities playing host to numerous safari companies, hotels and lodges.

Prior to establishment of Kilimanjaro CBR, a survey was done in order to assess the needs of the communities mentioned above. The survey revealed that:¹

- a) There were many barriers such as long distances, which prevented people with disabilities from accessing different services such as medical care, education facilities, rehabilitation services and others.
- b) There was an acute need to improve the living condition of people with disabilities through rehabilitation and addressing the negative attitudes and beliefs about disability, which contributed greatly to exclusion of people with disabilities from taking part in different community activities.

In response to the needs of people in the areas mentioned above, Kilimanjaro CBR was launched to provide comprehensive rehabilitation services to people with different kinds of disabilities and of all ages in the operational area.

1.2. COMMUNITY NEEDS ASSESSMENT

As a SNHU researcher student in collaboration with Kilimanjaro CBR staff, we did a needs assessment survey in Arusha region, which is one of the operational regions of Kilimanjaro Community Based Rehabilitation. I was privileged to meet some representatives from all the regions who were undergoing rehabilitation services and some of the community based workers at the headquarters of Kilimanjaro CBR in Moshi town in Kilimanjaro.

1.3. COMMUNITY NEEDS ASSESSMENT RESEARCH METHODOLOGY

This section outlines clearly research methods used to collect and analyze data for the Community Needs Assessment.

¹ Comprehensive Community Based Rehabilitation in Tanzania Report, 2005.

1.3.1. MAJOR FEATURES OF THE SURVEY IN RELATION TO COMMUNITY NEEDS ASSESSMENT

1.3.1.1. OBJECTIVES OF THIS SURVEY

1.3.1.1. THE GENERAL OBJECTIVE OF THIS STUDY

The overall aim of the study is to examine the needs of people with different kinds of disabilities in Arusha region.

1.3.1.2. SPECIFIC OBJECTIVES OF THIS STUDY

- a) To review the involvement of persons with disabilities, their families and community in Kilimanjaro CBR program.
- b) To assess the needs of people with disabilities in Arusha region.
- c) To examine the role-played by Kilimanjaro CBR in facilitating accessibility to different services by people with disabilities living in Arusha region.
- d) To assess the change in living conditions of persons with disabilities after the implementation of Kilimanjaro CBR in Arusha region.
- e) To explore the disability specific challenges of people with disabilities.
- f) To determine the gender specific challenges of people with disabilities.
- g) To make recommendations on how Kilimanjaro CBR and other stakeholders can foster inclusion of people with disabilities in different services and activities in Arusha region.

1.3.2. RESEARCH QUESTIONS

- a) What are the needs of people with disabilities in Arusha region?
- b) What factors hinder the accessibility of people with disabilities to different services and community activities?
- c) How has Kilimanjaro CBR changed the lives of people with disabilities in the Arusha region?
- d) Has Kilimanjaro CBR improved the access of people with disabilities in Arusha region to health services, rehabilitation, education and assistive devices and equipment?
- e) What specific challenges face people with disabilities Arusha region?
- f) What specific gender challenges encountered by people with disabilities?
- g) What can be done to improve different services offered by Kilimanjaro CBR and other institutions to people with disabilities in Arusha region?

1.3.3. THE CHOICE OF EFFECTIVE METHODS OF COLLECTING EVIDENCES

In order to find an effective method for evidence or data collection, measuring the quality of life and assessing the relevance of Kilimanjaro CBR initiative, a number of desk studies were carried out. The following are the major studies made:

- a) A study of information gained through previous surveys^{2 3 4} on Community Based Rehabilitation made in different parts of the world concerning the impact of CBR as perceived by persons with disabilities themselves.

² Krefting L, Krefting D, Evaluation report NDA/NHR/SHIA CBR program in Nepal, 'December 1998.

³ O'Toole B, Participatory evaluation, Ghana Community-based rehabilitation program, Government of Ghana/NAD/SHIA/UNDP, April 1996.

⁴ Miles J, Pierre L, Offering hope, an evaluation of the Guyana CBR program. AIFO, July 1994.

- b) Study of data obtained by WHO in collaboration with the UN Special Rapporteur on Disability in 1999 by means of questionnaire sent to all governments of members states of the WHO and to 600 NGOs working in the disability field in the member states of WHO. The information focuses on issues related to four of the 22 Standard Rules on the Equalization of Opportunities for Persons with Disabilities: Rule 2 on Medical care, Rule 3 on Rehabilitation, and Rule 4 on Support services.⁵
- c) Study of “quality of life” research and literature to establish possible categories for systematization of evidence. Some of the major points discussed in some of the researches on the needs and quality of life included the extent to which needs and quality of life are subjective and related to culture and personal perceptions, and the extent to which objective, general indicators can be used to measure the same across cultures and individual situations.⁶

1.3.4. THE CHOICE OF PARTICIPATORY RESEARCH METHODOLOGY

In order to determine how persons with disabilities, their family and the community at large perceive their needs, it was necessary to find a method that involved active participation in the study by individuals. The participatory method (qualitative participatory research approach) was chosen as the main best option in this study. Reasons for this choice are as follows:

- a) Participatory research expands the knowledge and awareness of both.⁷ It is a learning process for all involved, and not just a process whereby some people accumulate information about others. Local people and professional researchers are equal in the research process; they are both researchers and learners.⁸

⁵ WHO, Community Based Rehabilitation as we experience it: Voice of persons with disabilities: Part 1, 2002.

⁶ World Health Organization quality of life assessment (WHOQOL): development and general psychometric properties, 1998.

⁷ Brown LD, Organizing participatory research: interfaces for joint inquiry and organizational change. *Journal of Occupational Behavior*, 1983.

⁸ Couto R, Participatory research. *Methodology and Critique, Clinical Sociological Review*, 1987.

- b) In participatory research, all who participate are both co-researchers and co-subjects. Cooperative inquiry is therefore also a form of education, personal development and social action.⁹
- c) The goal of this research is social change derived from the information gathered. Knowledge gained in the process can be translated immediately into action for social change. Local people through participation control the process of problem definition, information gathering and decision about the action to be taken based on the information given.¹⁰

1.3.5. STUDY DESIGN

A survey's design is the way in which its environment is controlled or organized in order to collect data on a particular topic¹¹. During the survey, the researcher used the following designs:

1.3.5.1. CROSS SECTIONAL SURVEY DESIGN

With this design, data are collected at a single point in time.¹² This method was selected because most of respondents of this survey were scattered in different communities in the study area, which made it difficult for the researching team to return again to those communities to collect other information within a short period of research. In other words, this design to a great extent was easy to use because it saved time and it was financially viable.

1.3.5.2. LONGITUDINAL SURVEYS

With longitudinal survey designs, data are collected over a period of time. The longitudinal survey design, which was selected, is Cohort design. By using this design a group is studied over time

⁹ Reason P, Human inquiry in action. Thousand Oaks, CA: Sage Publications, 1988.

¹⁰ WHO, Op.Cit, 2002, p. 18.

¹¹ Arlene Fink et al, How to Conduct Surveys: A Step by Step Guide, The International Professional Publishers, Newbury Park London, 1985, p.53.

¹² Ibid. p.

though the people in a group may vary.¹³ This method was, particularly, useful when the researcher wanted to ascertain the attitudes of:

- People with disabilities towards themselves and other people with other disabilities.
- Society towards people with disabilities.
- People with disabilities towards the society.
- Their needs.

During the whole period of study in the different communities, the researcher could gather information on the points mentioned above.

1.3.5.3. QUALITATIVE AND QUANTITATIVE METHODOLOGIES

Both qualitative and quantitative methodologies were used to enrich the study, and to allow the collection of detailed information from the respondents in their social context.

Quantitative methods are, “methods such as surveys and experiments that record variation in social life in terms of categories that vary in amount. Data treated as quantitative are either numbers or attributes that can be ordered in terms of magnitude”¹⁴. This method was selected because the researcher wanted to establish the magnitude of the problem facing people with disabilities in terms of numbers.

On the other hand qualitative methods include participants’ observation, intensive interviewing and focus groups discussions that are designated to capture social life as participants experience it rather than in categories predetermined by the researcher¹⁵. A qualitative research design was selected

¹³ Cf. Ibid. p.

¹⁴ Russell K. Schutt, *Investigating the Social World: The Process and Practice of Research*, University of Massachusetts, London, Pine Forge Press, (Class handout).

¹⁵ Cf. Ibid.

because it is a systematic process of discovering social interactions and understanding how they interrelate and influence their environment.

1.3.6. SAMPLE

1.3.6.1. THE SAMPLING PROCEDURE

Two basic sampling methods namely probability and non-probability were used:

1.3.6.1.1. PROBABILITY SAMPLING METHOD

This is a method whereby each person in the population has an equal chance of being selected.¹⁶ This method was purposefully chosen because its resulting sample is said to be representative. Two probability-sampling methods were selected. The first method, which was selected, is simple sampling. “In simple random sampling, you choose a sub-set of respondents at random from a population”¹⁷. This method was purposefully selected because:

- a. It is simple and easy to conduct.
- b. The researcher did not have the knowledge of the characteristics of all the individuals in a population in most of communities.

1.3.6.1.2. NON-PROBABILITY SAMPLING METHOD

A non-probability sampling method, which was used, is accidental. Accidental samples were used, especially, while doing home visits with Kilimanjaro CBR staff in different communities. Interviews or observations were made when people were available. This method best suited while doing home visits because most of the people visited were doing different activities such as farming and others. In

¹⁶ Arlene Fink et al, How to Conduct Surveys: A Step by Step Guide, The International Professional Publishers, Newbury Park London, 1985, p.53.

¹⁷ Ibid. p.56

addition to that home visits were not always done after communicating to the families to be visited. This is done purposely because Kilimanjaro CBR wants to assess how families take care of their disabled members. Prior –communicating to the families to be visited could distort the reality because some family members would prepare a good atmosphere to impress Kilimanjaro CBR staff.

1.3.7. STUDY AREA

The catchment area of Kilimanjaro CBR is four regions, namely, Kilimanjaro, Tanga, Arusha and Manyara. The CED student selected Arusha region to be the study area because of his familiarity with the region, constraint of time and resources.

This research was conducted in 3 districts of Arusha Region namely Arumeru, Arusha Municipal and Karatu with a total population of about 1 million people.

1.3.8. RESEARCH UNIVERSE/POPULATION SAMPLING

Random sampling was used to select 100 parents of children with disabilities children who have received Kilimanjaro CBR services to be interviewed. Out of this number 64 parents, constituting 64% of the expected parents sampled responded to the survey. We also used purposive sampling to select 45 NGOs partner, legislators, social welfare departments and network of organizations working with and/or for people with disabilities in the study area for survey in the three districts of the study. Out of whom 31 took part in the study. Other respondents who were selected include 10 staff of Kilimanjaro CBR, 5 teachers of special units classes supported by Kilimanjaro CBR and 4 therapists working in different hospitals and rehabilitation centers in the operational area. 100 people with disabilities and some with preventable disabilities were chosen as well. Out of this number, 70 people turned up. A total of 264 respondents were targeted in the three districts of study but 184 respondents took part.

From previous evaluations done elsewhere in the world in various Community Based Rehabilitation programs, it can be concluded that the number of persons benefiting from CBR programs remain low. The number of communities reached is limited, even in government-supported program such as those in Ghana and Zanzibar just to cite few. Even in the communities reached by CBR programs, many persons with disabilities are not found or targeted. The reason for this limited contact is not fully understood, but persons with severe and multiple disabilities are often seen as too difficult.¹⁸

Thus the sample population of 264 people is not representative of people with disabilities and other community members served by Kilimanjaro CBR in Arusha region. According to Kilimanjaro CBR annual report of 2005 the total number of people with disabilities served by Kilimanjaro CBR in all regions where it operates were 2939¹⁹. This does not include other community members assisted by this project. Though the response rate of targeted population is 67%, this does not mean that sampled population is representative of people with disabilities and other community members in Arusha region.

1.3.9. RESEARCH INSTRUMENTS/ DATA COLLECTION TECHNIQUES

The following research instruments were used to gather data for this study:

1.3.9.1. PRE-FIELD CONSULTATION

Pre-field consultations were held with various stakeholders including NGOs, relevant departments in the central and local governments (social welfare department, educational officers, ward leaders etc), disabled people organizations, networks of organizations working with and/or for people with disabilities in the Northern Tanzania and individuals concerned with the welfare of people with

¹⁸ WHO et al, Community Based Rehabilitation as we have experienced it... voices of persons with disabilities, 2002, p. 19.

¹⁹ Kilimanjaro CBR annual report-2005.

disabilities. Pre-field consultation was conducted by the researcher in the first month of research in order to facilitate his insertion in the different communities of study. This was done because the researcher found it was necessary to get familiar with the communities concerned in order to facilitate future work of collecting data.

1.3.9.2. PRIMARY DATA

Primary data was collected using a number of methods, observations, interviews, as well as conventional questionnaires. These are discussed here below.

1.3.9.2.1. OBSERVATION

Observation was one of the ways used by the researcher all the time of research process in the study area, in order to collect data. This method was much focused on the schools and institutions for disabled people, where respondents live, work places, and in the different communities where Kilimanjaro CBR beneficiaries live, just to name few. In this case, conversations, non-verbal communication, general behaviour of respondents and the environment in general were observed. In other words, through this participatory method, the researcher was able to come in touch with the reality of disabled people in these communities. This method was chosen purposefully to compliment other methods, and especially, interviews. In addition to that in some circumstances people would shy off from interviews, and therefore, observation seemed the best data collection tool.

Through observation, the researcher aimed at gathering more information on the conditions, facilities and services available for people with disabilities such as schools, medical centers, observing different activities done by disabled on the streets and examining the role different organizations, associations for disabled and local community play in the lives of the disabled people.

1.3.9.2.2. INTERVIEWS

Interviews were used to gather data from various sources. The major areas where this method was used include different schools and centers for disabled, during unstructured encounters with disabled people during home visits, community meetings and other activities. Some of the organizations and associations visited were Disabled Departments of social welfare in Arusha and Kilimanjaro regions and network group of organizations working with and/or for the welfare of people with disabilities in the Northern Tanzania.

Those involved in the interviews and discussions were co-coordinators/ directors of school/ training and rehabilitation centers/ different organizations, caretakers and Kilimanjaro CBR employees, relatives and friends of the disabled people and the handicapped persons themselves. Some of the interviews were structured; that is to say, some guiding questions were prepared by the researcher in order to facilitate the discussions. Other interviews, however, were unstructured. The researcher could meet with some people and especially, the disabled persons and discuss with them on different issues affecting their day-to-day life in the area of catchments of Kilimanjaro CBR.

These interviews enabled the researcher to gather different information from primary and/or key informants on the general situation of disabled people in the operational area. In addition to that the researcher wanted to establish if at all there are any visible signs of co-operation between the churches, NGOs, International Organizations and Tanzanian government in working with and/or for disabled people in the study area.

This method was chosen because it takes less time and high response rate. Moreover, interviews are popular because they are flexible and participatory as they can form an interactive conversation²⁰. The interviewing guide was prepared for guidance purposes.

1.3.9.2.3. FOCUS GROUPS DISCUSSIONS

Two focus groups were held one in Arumeru district and the other in Arusha municipal in order to gather qualitative data. These groups discussed the factors that hinder people with disabilities to have equal access to different social services and community activities. In addition to that the group discussed on how to address inaccessibility as well as the role played by Kilimanjaro CBR in improving the living condition of people with disabilities.

The first focus group discussion was held in Arumeru district involved 66 people with disabilities. In Arusha municipal's focus group discussion, a total of 40 people were selected to participate in the discussion including: 10 people with disabilities, 5 community social workers and 10 being parents/close relatives of people with disabilities, 10 community members without children or close relatives with disabilities and 5 ward leaders.

A focus group guide was prepared in order to enable the researcher to gather specific information from the participants.

1.3.9.2.4. QUESTIONNAIRES

Questionnaire is defined to be a form that people fill out, used to obtain demographic information and views and interests of those interviewed²¹. Another definition of questionnaires is a method for the elicitation and recording and collecting information²². In other words, researchers use questionnaires

²⁰ Cf. Cemal Yitmaz et al, "Survey Methods: Questionnaires and Interviews" Department of Computer science. (University of Maryland: College Park, Md 20742, USA, 2001).

²¹ (Brehob, 2001)

²² Cf. Kilakowski., J "Questionnaires in Usability Engineering" at www.ucc.ie/hfrg/resources/qfal.html 16/5/2006.

to provoke people to say what is in their minds. Data collected from a group of respondents is recorded in a permanent medium for analysis and future reference. Questionnaires were designed in order to obtain specific information about the condition of people with disabilities in the operational area.

There were three kinds of questionnaires used to collect data from different respondents. Some of the questionnaires were administered by the researcher and others by Kilimanjaro CBR field staff.

The first set of questionnaire containing seven questions was addressed to community leaders (village, wards, and religious leaders). This set of questionnaire aimed at assessing their understanding on different issues concerning disabilities and their understanding about Kilimanjaro Community Based Rehabilitation and other similar initiatives in their localities. Further more the questionnaire aimed at gathering information on the following points:

- a) Problems facing people with disabilities
- b) Other organizations working with and/or for people with disabilities in the different localities.
- c) The impact of Kilimanjaro CBR on the condition of people with disabilities, their families and their communities.
- d) Services needed from Kilimanjaro CBR in order to improve the living condition of people with disabilities in the respective communities.

The second set of questionnaires was distributed to people with disabilities themselves. This aimed at exploring their experiences on daily life, services they receive from Kilimanjaro CBR and other initiatives and challenges facing them in the communities.

The third set of questionnaire was addressed to parents (families/relatives) of people with disabilities.

The major aim was find out the following:

- a) Their first contact with Kilimanjaro CBR.
- b) Problems facing their children/relatives with disabilities.
- c) Problems facing them as parents of people with disabilities.
- d) The impact of services offered by Kilimanjaro CBR.
- e) Problems facing them in accessing different services.
- f) Suggestions on how Kilimanjaro CBR could improve its services.

1.3.10. SECONDARY DATA

1.3.10.1. LITERATURE AND RECORDS REVIEW

Literature review was done in order to gather some information about people with disabilities. The literature sources consulted for this study included documents from Kilimanjaro CBR, United Nations documents on Community Based Rehabilitation, national and international policies' documents on disability, documents from bureau of statistics, reports from different partners and other books tackling disability issues in different communities. Other sources were the internet and Microsoft encyclopedias.

Secondary data was used to guide, inform and enrich the final analysis and discussion of the data collected during the study. Nevertheless, the researcher is aware that he had not exhausted the information about disabled people in Arusha region.

The researcher used all these research instruments in order to collect data from different sources. This is because the researcher believes that in order to get reliable data it is important to crosscheck information by using different instruments.

The survey attitude was positive because 67% of targeted respondents expected participated in this study.

1.3.11. RELIABILITY:

- a) Information provided was measured by comparing information's of respondents among the different groups and the physical observation method used to ascertain the reliability of the respondents.
- b) After analyzing data the information obtained have been critically viewed to test its validity and truthfulness of the data obtained from the respondents
- c) The data gathered have been compared with the documented findings obtained at the initial stage of the project, and findings of other similar project carried within the country and elsewhere in the world.
- d) The survey objectives were clearly defined to all stakeholders and the feedback questions showed that they understood clearly the objectives.
- e) Questions for both questionnaires and interviews were designed to reflect the need of the survey and were tested before and modified where it seemed necessary.

1.3.12. VALIDITY

- a) Information gathered during need assessment have been used as baseline source of information. In order to validate the data gathered, some other documents/literatures were reviewed on the same topic.
- b) There has been adequate description and methods to establish reliability (Homogeneity).

1.3.13. ADMINISTRATION

- a) Some of the Kiliamanjaro CBR staffs involved in this research were trained on how to conduct an impact study and how to conduct focus group discussions and other methods of data collection in 2005 by Kilimanjaro CBR. This was prior to the impact study done by the organisation in the same year.
- b) The staff selected includes therapists, community social workers, cataract surgical rate workers who are involved in rehabilitation of people with disabilities in the four regions. They all have experience in working in the community and have been involved in different researches such as the impact study conducted by Kilimanjaro CBR in 2005. The selection was based on the available staff working in the different communities.
- c) Pre-testing of the questions was done at the centre with people who were undergoing rehabilitation and in different villages in Arumeru district during the first month of survey. This led to modification of some of the questions, which were not clear.
- d) The survey was coordinated by CED student who has local and international experience in disability issues.
- e) The whole survey took three months (October, November 2005 and December 2005).

1.3.14. DATA ANALYSIS AND PRESENTATION PROCEDURES

Data analysis means, "...tallying and averaging responses, looking at their relationships, and comparing them..."²³ qualitative and quantitative data analysis was employed. Qualitative analysis

²³ Arlene Fink et al, Op. Cit.p.73

²³ T. D. Jick, Multiplying qualitative and quantitative methods: Triangulation in action, in Administrative Science Quarterly, Vol. 24,1979. P.59-68.

²³ WHO et al, Guideline for Conducting Monitoring and Self-Assessment of Community Based Rehabilitation Programmes: Using Evaluation Information to Improve Programmes, Geneva, 1996. P.10

involves presenting text or narrative data. Quantitative data analysis involves the use of scales of measurement and descriptive statistics. In this study numerical counts or frequencies, percentage, graphs were used. Qualitative analysis is, especially, very useful for Kilimanjaro Community Based Rehabilitation for several reasons:

- a) Kilimanjaro CBR deals with people with different kinds of disabilities, their families and community at large. All these come from different families' and community backgrounds. Qualitative information can show the diversity of the programme and does not try to compare people in standard way, which often is done in quantitative approach.
- b) Qualitative analysis shows the difference between what Kilimanjaro CBR is supposed to be doing, for example as described in project objectives or mission statement, and the actual situation in the community.
- c) Qualitative information can be more powerful than quantitative information. For example, a well-written case study accompanied by photos etc, may stay in people mind a lot longer than many pages of charts and numbers.

This does not mean that among qualitative and quantitative analysis one is better than the other. What is important to note here is that both have its strength and weaknesses depending on various situations.

To validate the conclusions in this study, comparisons have been made with findings on the similar initiatives reported in earlier evaluations. This has further strengthened the conclusions in this study as early findings were very similar.

Presentation of data was done using 3 computer software programmes: SPSS, Microsoft word and Microsoft Excel.

1.4. DATA ANALYSIS, FINDINGS AND RECOMMENDATIONS

Data analysis means, "...tallying and averaging responses, looking at their relationships, and comparing them..."²⁴. Both qualitative and quantitative data analysis methods were employed. Qualitative analysis involves presenting text or narrative data. Quantitative data analysis involves the use of scales of measurement and descriptive statistics.

This section is going to analyze the collected data in both qualitative and quantitative form, which will be followed by an interpretative discussion. The analysis will be based on the results of different kinds of respondents of questionnaires, interviews and the researcher's observation during the time of the study. Secondary data will also be analyzed. This analysis will look also at the objectives of the study and find out if they are attained. In addition to that this chapter will attempt to find out if the basic assumptions we had at the beginning of this work are confirmed or not. Finally the analysis will try to answer the basic questions the researcher had in the beginning of this research.

1.4.1. CHARACTERISTICS OF RESPONDENTS

The respondents of this survey were: parents of children with disabilities, people with different kinds of disabilities (permanent and preventable), community leaders and representatives of different organizations in the study area, Kilimanjaro CBR staff, teachers of special education schools supported by Kilimanjaro CBR and therapist working in different organizations.

²⁴ Arlene Fink et al, Op. Cit.p.73

²⁴ T. D. Jick, Multiplying qualitative and quantitative methods: Triangulation in action, in Administrative Science Quarterly, Vol. 24, 1979. P.59-68.

1.4.1.1. PARENTS OF DISABLED CHILDREN

We managed to interview 64 (64% of the target) parents of children different kinds of disabilities. We failed to reach the targeted number because of the following reasons:

- a) Time limitation
- b) Cost involved in reaching those who are situated far in the interior where there is the problem of transport
- c) It was difficult to reach some of the parents due to their absences whenever we visited their homes because they were either employed or doing other economic activities elsewhere.

Table 1: Gender of respondents

		Frequenc y	Percent	Valid Percent	Cumulative Percent
Valid	Male	16	25.0	25.0	25.0
	Femal e	48	75.0	75.0	100.0
	Total	64	100.0	100.0	

Out of the 64 interviewed parents, 48 were females and 16 males. The number of female interviewees is bigger than that of male because females are more responsible in attending the children than males. This was alleged by some respondents and staff of Kilimanjaro CBR. Researcher's observation also concurred with this view. When parents were interviewed on who normally takes care of their children most of the time, out of 45 out of 64 parents asserted that most of the children were being taken care of by parents. Others were living with their grand parents and relatives either because their mothers abandoned them or they were working far from the home places. One of the respondents, a grandmother of one of the children revealed that her daughter just left the child at home and disappeared. Also it was easier to interview females than males because they were easily available compared to males.

Table 2: Marital status of respondents

		Frequenc y	Percent	Valid Percent	Cumulative Percent
Valid	Married	42	65.6	65.6	65.6
	Single	8	12.5	12.5	78.1
	Divorced	9	14.1	14.1	92.2
	Widowed	5	7.8	7.8	100.0
	Total	64	100.0	100.0	

On marital status, 42 respondents were married, 8 were single and 5 were divorced.

Table 3: Education of respondents

		Frequenc y	Percent	Valid Percent	Cumulative Percent
Valid	Primary education	36	56.3	56.3	56.3
	Secondary education	17	26.6	26.6	82.8
	College	5	7.8	7.8	90.6
	No education	6	9.4	9.4	100.0
	Total	64	100.0	100.0	

Out of the 64 respondents 11 were found to be non-educated, 39 primary school leavers (the majority group in this case), 12 secondary school leavers and 4 possessed tertiary education.

Table 4: Age of respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18-24	6	9.4	9.4	9.4
	25-34	19	29.7	29.7	39.1
	35-44	22	34.4	34.4	73.4
	45-54	11	17.2	17.2	90.6
	55-above	6	9.4	9.4	100.0
	Total	64	100.0	100.0	

In terms of age out of 64 respondents, 6 parents found to have less than 25 years, 19 parents were between 25 to 34 years, 22 were between 35 and 44, 11 parents were 45 to 54 years old, and 6 parents were 55 and above.

1.4.1.2. PEOPLE WITH DIFFERENT DISABILITIES AND PREVENTABLE DISABILITIES

Out of 70 people with different kinds of disabilities and preventable disabilities who responded to this survey, 38 were females and 32 males ranging from 15-20 and 4 above 40 years old.

1.4.1.3 LEADERS AND REPRESENTATIVES OF OTHER ORGANIZATIONS

Out of 45 questionnaires distributed to different leaders, a total number of 31 leaders responded by filling the questionnaires distributed. 25 were male and 6 females. These leaders were found to be with education level as follows; 10 primary education, 11 secondary education and 10 tertiary education (Table 5). This shows that fewer females holds leadership position compared to males.

1.4.1.4 KILIMANJARO CBR STAFF

10 Kilimanjaro CBR staff were interviewed, 3 were males and 7 females.

1.4.2. CHALLENGES FACING PEOPLE WITH DISABILITIES IN THE OPERATIONAL AREA

1.4.2.1. ACCESSIBILITY TO DIFFERENT SERVICES AND COMMUNITY ACTIVITIES

The study revealed a variety of factors related to family, community, school /vocational training and rehabilitation centers environment and healthcare services that hinder people with disabilities from accessing different services and involvement in community activities (Factors which foster exclusion of people with disabilities). These include:

1.4.2.1. NON SUPPORTIVE ATTITUDES

The respondents from the five districts of study had both positive and negative attitudes towards people with disabilities. The negative perceptions included: viewing people with disabilities as burden, apathetic and bad omens. About 45% of people with disabilities revealed that within their families/communities they were not considered 'normal' or the same as none disabled kin.

Findings indicates that the family perception of a disabled member greatly affects whether the disabled person in question would be enrolled in school, has access to different facilities and entrusted with family and community responsibilities. Some community members were supportive to people with disabilities but others would harass and bully them, especially, children with disabilities.

Table 5: Perceptions on disability

Response	Frequency	Percentage
Given attention	5	12.5
Not cared for	3	7.5
People with disabilities are normal	5	12.5
Sympathy	11	27.5
Needy	8	20
People with disabilities are burden	8	20
Total number of respondents	40	100

Table 1 above clearly illustrates that the perceptions of disability are still negative among community and family members despite the massive awareness raising work done by Kilimanjaro CBR staff. Only 12.5% of sampled population view people with disabilities as normal.

1.4.2.2. DISTANCE TO SCHOOL, HEALTH CARE AND REHABILITATION SERVICES AND OTHER FACILITIES

Transport is one of the key challenges preventing people with disabilities from accessing different services such as rehabilitation services. Responses from both parents/relatives and people with disabilities indicate that they want to access services, but are unable due to lack of transportation. 68% of the total sampled population agreed that education, healthcare and rehabilitation facilities were located far from their reach. 24% of respondents believed that transportation to these services is

a barrier to accessing them, especially, in rural areas. Uneven terrain and slippery roads magnifies this problem even to those who can use tricycles and other special appliances.

1.4.2.3. LOW HOUSEHOLD INCOME

The relationship between levels of poverty, low per capital incomes and how people with disabilities and their families access different services is still a serious problem. Over 70% of the respondents agreed that poverty within communities is still high. Families with low household income have difficulties affording scholastic materials and other special appliances such as calipers and special chairs just to name few for their disabled members.

It is in rural areas where poverty levels are quite high and the costs of rehabilitation, including the cost of purchasing special appliances and medical care are quite high.

Other factors that contribute to exclusion of people with disabilities, which were mentioned, include: non-conducive physical infrastructures and lack of enough trained special teachers who could be placed in different villages' schools.

As regards to skills training and small business training, most of the interviewees about 79% (parents and people with disabilities) reported to have acquired their skills by means of relatives or other private initiatives. Although Kilimanjaro CBR has facilitated in one way or the other some apprenticeships as reported by few individuals, lack of skills training opportunities was seen as a challenge for Kilimanjaro CBR to consider in the future.

About 78% of parents interviewed wished Kilimanjaro CBR could empower them financially in order to be able to take care of their children. Some were of opinion that Kilimanjaro CBR was supposed to find them donors because they could not afford to take care of their children. Others wished Kilimanjaro CBR could provide them with loans to undertake different economic activities.

Concerning employment, about 95% of adults with disabilities interviewed revealed that they did not have regular employment, 2% were self employed and 3% were employed in public and private sector. This shows that most people with disabilities do not have equal access to employment as compared with people without disabilities. Those interviewed that this was due to employers' negative attitudes towards people with disabilities.

1.4.3. DISABILITY AND ACCESS

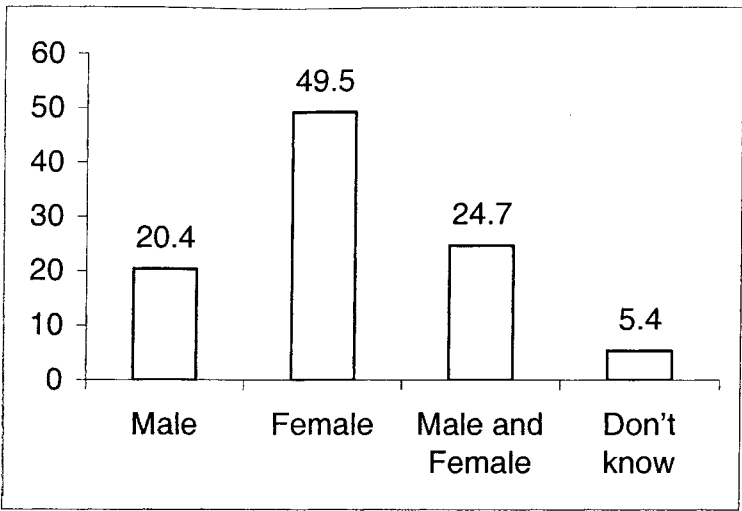
While some challenges generally affect all categories of disabilities, there are some, which are specific according to each disability. For example, people with speech difficult expressed big concern of not being understood by others. This contributes greatly to their exclusion from different services and other activities.

1.4.4. GENDER AND ACCESSIBILITY

From this survey, it was also apparent that male and female with disabilities faced different challenges in accessing different services such as education. This is mainly due to the fact that still there gender imbalances affecting the access to services by different genders. In other words, the degree of exclusion of people with disabilities in accessing different services such as education depends on gender as well.

Findings from the survey indicated that both boys and girls with disabilities faced many challenges but the girl child faced more challenges than the boy. The graph below shows the responses that were generated from the study as to which gender face more accessibility challenges.

Figure 1: Accessibility challenges according to gender



The above graph clearly indicates that female children and adults with disabilities face more accessibility challenges accounting for 49.5% of the responses as compared to male counterpart who account for 20.4%. The reasons for this difference can be illustrated below:

Culturally, boys are seen to undertake more responsibility in the future as house heads. They need to be more empowered with education etc. than girls/female who are often viewed as useless or used as helpers in the homes. More male with disability were actually enrolled in schools and other training centers that were visited during the study period as compared to female with disabilities. In some instances, school records indicated that a number of girls with disabilities were enrolled but were not retained as many of them would drop out faster as compared to boys. One key informant observed: “Priority of education should be given to boys because girls have a dependency syndrome, have low self-esteem and society has very low opinion of girls”²⁵.

In one of the focus group discussions held in Arumeru district, the participants agreed that girls’ children adults with disabilities faced a number of accessibility challenges. The challenges

²⁵ Parent of a disabled child-Hai district

highlighted include: overprotection from parents/care takers, especially mothers, overworked at home more than the boys, rape and sexual harassment, inferiority complex, problems during their menstrual periods, torture and isolation at school and employment.

Table 6: Gender challenges

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Overprotection	6	15.0	15.0	15.0
	Overworked	4	10.0	10.0	25.0
	Sexual harassment/abuse	6	15.0	15.0	40.0
	Torture	4	10.0	10.0	50.0
	Inferiority complex	4	10.0	10.0	60.0
	Negative attitudes	6	15.0	15.0	75.0
	Biological problems	4	10.0	10.0	85.0
	Isolation	6	15.0	15.0	100.0
	Total	40	100.0	100.0	

This is a result of responses from the focus group discussion conducted in Arumeru district comprising 66 people with different kinds of disabilities from different communities in Arusha region.

The table above indicates that both male and female people with different kinds of disabilities face different challenges whilst accessing different services and societal activities. While the main challenges for male are societal negative attitude inferiority complex both averaging 13.9%, for female with disabilities the main challenge is sexual abuse 20%, especially for children. This is followed by overprotection 16.7%.

Although both male and female with disabilities may face similar challenges, in some instances these challenges are gender specific. For instance, female face a higher risk of child abuse in comparison to male children.

The focus group discussion comprising people with disabilities also expressed concern that more girls with disabilities dropped out of schools/training centers as compared to boys. The reasons attributed to this trend are: female girls with disabilities are expected to undertake household responsibilities, looking for their siblings, parental negative attitudes towards girls and sometimes because girls got unwanted pregnancies.

Although both male and female with disabilities face challenges in accessing employment, female with disabilities face more challenges than male. Some of the reasons given include negative attitudes employers have to people with disabilities, and especially, women. In addition to that most women have low level of education as compared to men due to some of the reasons mentioned before.

1.4.5. SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

This part highlights the findings of this study, makes the conclusions and also draws recommendations that can be adopted in order to increase accessibility or inclusion of people with disabilities in different social services and other societal activities such as employment in Arusha region where Kilimanjaro Community Based Rehabilitation operates.

1.4.5.1. SUMMARY OF FINDINGS

The accessibility challenges identified during the study are environmental, economic, social and institutional. These can further be elaborated as follows:

The findings indicate that there are a number of challenges that hinder people with disabilities from accessing different social services and taking part in society activities. Among these were those associated with physical structures, services located far from the reach of people with disabilities due to transport and poverty problems, lack of assertive aids and appliances, low household income and negative attitudes towards people with disabilities.

Although both male and female with disabilities faced a number of challenges, their challenges were quite different due to gender biasness that exists in most of the communities in the study area.

Socially, the negative societal attitudes have limited people with disabilities from accessing different services and societal activities through stigmatization and isolation.

Politically, the policies, few laws and programmes that can be used to enforce the inclusion of people with disabilities exist but are not well implemented. There is still lack of knowledge among civil society, especially, the communities in the study area about the existing policies on inclusion of people with disabilities.

Basing on the findings of this study, people with different kinds of disabilities in the study area are to the great extent excluded from different services and community activities. This is due to different factors that have widely been explored. These findings are important to all stakeholders.

1.4.5.2. RECOMMENDATIONS

Based on the findings of the Community Needs Assessment conducted in Arusha region, the following recommendations are made:

1.4.5.2.1. ACCESSIBILITY TO DIFFERENT SERVICES

The study has indicated that accessibility to different services is a key factor to improving the living condition of people with different kinds of disabilities. In order to facilitate the accessibility, Kilimanjaro CBR and any other initiative can focus on the following:

1.4.5.2.2. AWARENESS RAISING

This programme needs to put more efforts in raising awareness about the situation of people with disabilities and possibilities available for them. This could be done in the following ways:

- a) To engage more actively people with disabilities and parents with disabled children as advocates because the most successful advocacy tools are living examples of success and personal stories about discrimination and how to overcome it.
- b) Use media regularly in order to raise awareness and advocate for the rights of people with disabilities.
- c) Use drama as tool to make prejudice visible.
- d) Work closely with clan leaders who have great influence on family issues of their respective clans.

1.4.5.2.3. MEDICAL CARE

Access to medical care for people with disabilities and their families is reported to be limited despite the efforts made by this programme. Kilimanjaro CBR needs to give more priority to influence health authorities in the operational area to take their responsibility as stipulated by the Standard Rules on medical care. Kilimanjaro CBR needs to have more specialist workers in order to support health authorities:

- a) To improve competence and capacity of primary health care in order to make early interventions, correct diagnoses, treatments and referrals.
- b) To provide subsidies for medical care.

1.4.5.2.4. REHABILITATION AND SUPPORT SERVICES

The study has indicated that among the services mostly appreciated by parents of children with disabilities and people with disabilities is rehabilitation process undertaken by a Kilimanjaro CBR rehabilitation specialist's team in collaboration with parents and other stakeholders. The programme needs to mobilize more resources and open branches in all regions where it operates so that more people with disabilities can be reached easily by CBR workers without having to travel long distances before offering services.

1.4.5.2.5. INCOME MAINTENANCE AND SOCIAL SECURITY

This is one of the challenges Kilimanjaro CBR needs to consider for the parents and people with disabilities to be involved fully in the implementation of its activities. The study has shown that poverty is one of the major factors which contribute greatly to poor living condition of people with disabilities in the operational area. Kilimanjaro CBR needs to facilitate access to loan schemes

outside this programme for parents and people with disabilities who prove ready to undertake different income generation activities according to standards set by loan granters.

1.4.5.2.6. ESTABLISHMENT OF CBR SUPPORT UNIT

Most of the people interviewed recommended strongly the establishment of CBR support unit in Arusha region which could facilitate easy accessibility of people with disabilities to different services available in the region and elsewhere.

CONCLUSION

This chapter has explored on the Community Needs Assessment survey, which was conducted in Arusha region, one of the operational areas of Kilimanjaro CBR. Community profile of Kilimanjaro CBR programme and the Community Needs Assessment Survey have been clearly elaborated. The section has also included the research methodology and data analysis and presentation. The results of this survey give the basis for the next chapter.

CHAPTER TWO

PROBLEM IDENTIFICATION

2.0. INTRODUCTION

This chapter focuses on problem identification. The major components of this chapter include; problem statement, resources, stake holders analysis, Kilimanjaro CBR and CED project's goals and objectives.

2.1. PROBLEM STATEMENT

From the needs assessment survey conducted during my fieldwork attachment with Kilimanjaro CBR we found that, in most communities in Arusha region people with disabilities finds themselves excluded from the services and activities which are considered normal for other people.

Firstly, in the study area mentioned the lack of inclusion in ordinary health care service results in a higher death rate for disabled infants and children. In most cases people with disabilities frequently have difficulty obtaining preventive and curative services because nurses and physicians in general practice do not know how to asses the health status of people who can not see, hear, move or behave in unexpected manner. It is estimated that in urban areas of developing countries only 15% of the disabled persons who need rehabilitation receive them, while in rural areas only 2% of the need is met (World Health Organization 1996).

Very few people with disabilities in Arusha region have the opportunity to receive rehabilitation services from specialists who are knowledgeable about disabilities and know how to assess an individual with disability. Usually, these services are located far from where people with disabilities come from and in most cases are very expensive. For instance, they need technical aids/appliances to

enhance their functional ability. Such aids include white cane, hearing aids, wheelchairs/tricycles, special tables and chairs just to point few. Despite their importance to them, they are not readily available. When they are available they are very expensive to the extent that only few can afford them.

Secondly, disabled children and youth rarely receive a formal education and also it is difficult for adolescents and adults to gain access to vocational training. Most of them are denied opportunity to acquire education and only few of them have access to it. There are so many obstacles, which hinder people with disabilities to acquire education. Some of them include: lack of teaching aids and lack of specialized teachers to name few things. Not only that but also some parents still perceive children with disabilities as a burden and opt not to send them to school. Also, most of the schools facilities at all levels in Arusha region are inaccessible for most of the disabled children. It is estimated that children with disabilities enrolled in different schools is less than one percent. This figure is lower in secondary schools, higher learning institutions and skills training centers available in the region.

Last but not least, persons with disabilities are rarely entrusted with family or community responsibilities. For instance, most persons with disabilities find themselves in difficult situation in accessing work. This is because in the different communities in the study area as it is elsewhere, the capacity to work has been associated with complete functional ability of the body. Disability is associated with lack of ability and most people with disabilities see themselves in the same light. Most of them are unemployed because of poor education background or lack of education. Some who have basic education but lack professional skills. Those with required education and skills are left out because of prejudice the employers have towards them.

People who are mostly affected are those with different impairments such as; Physical impairments, Hearing impairments, Learning impairments (mental disability), Visual impairments and multiple impairments. In some cases the families of people with disabilities are affected by the exclusion. This

means that they are discriminated and isolated from living normal life in their different communities. In other words their basic rights to live in dignity and participate in different community activities just to name few are violated. According to the housing and population census of 2002, the total population of the area mentioned above was estimated to be more than one million people. According to the World Health Organization's formula of 1 in 10 being persons with disabilities, the total population of people with disabilities in the study area is, therefore, estimated to more than 100,000 people.

In many cultures in Arusha region the impact of exclusion is even more pronounced in the case of disabled girls and women, for whom the fact of being a woman constitutes a further social disadvantage.

The major factor which fosters the exclusion of people with disabilities in different communities is the presumption that a disabled person lacks the capacity to be independent and can survive only if he or she is looked after by the family, or lives on welfare, or begs. In other words, disability is associated with prejudice and negative attitude. People with disabilities are viewed as worthy of pity, dependent and as such not an integral part of the community they live. Subject to different beliefs and conceptions of the people in the study area, it brings to mind the image of a person with a physical impairment and also suggest the image of a person who has limited abilities to participate in work or in social activities. Most people interviewed associate disabilities with bad omen/evils²⁶.

Skills training offered in vocational training centers for people with disabilities is also inadequate and does not provide the competence required to enable people with disabilities to work independently and compete in a free labor market. Besides, the training environment is not adequately accessible. This contributes greatly to exclusion of people with disabilities in employment and other sectors.

²⁶ WHO et al, Multisectoral Collaboration for Equalization of Opportunities for People with Disabilities, 1996.

In addition to that lack of proper information and awareness about disabilities contributes a great deal towards exclusion of people with disabilities in different activities and services.

Consequently, most people with disabilities and their families live in abject poverty. They live in this situation because they cannot access work due to their disabilities and competition in the labor market. In addition to that they have not been sufficiently sensitized to access and benefit from public funds allocated to special groups like the youth and women. These funds could help them initiate different income generating activities to enable them earn their living. Hence, their participation in income generating activities is minimal. The families of people with disabilities spend most of their time and resources taking care of their disabled members. The services and care for disabled member is very expensive and this leads them to low income/poverty.

In order to ensure that people with different kinds of disabilities live in good condition, a comprehensive approach need to be put in place which will enhance building of an inclusive society which accept, respect and take responsibility to give equal rights to people with disabilities in the region. By improving the accessibility of people with disabilities in education, health care, and employment to name few, their living condition will improve. This will eventually improve the condition of their families and community at large because they will play part in the development process of their communities.

In response to all the problems facing people with disabilities and those with preventable disabilities, different stakeholders and the CED student found the need to improve the living condition of people with disabilities by promoting CBR strategy which seem to have played a significant role in this effect in the communities where it is implemented intensively.

In some of the community meetings held, especially, in most communities of Arusha region, participants identified the need of having CBR support unit in Arusha region which could facilitate

the provision of rehabilitation services to more people with disabilities by Kilimanjaro CBR and other similar organizations.

2.2. RESOURCES AND STAKEHOLDERS ANALYSIS

2.2.1. HUMAN RESOURCES

Kilimanjaro CBR has employed 50 people to perform different activities. Some of these staffs have undergone professional training in higher learning institutions while the helping staff have been trained in by Kilimanjaro CBR.

The professional staffs include; Programme Manager (speech therapist), Accountant, Administrator, Liaison officer, Centre supervisor, 2 Occupational therapists, Physiotherapist and Eye referral coordinator. Others include the driver, receptionist and security head.

Other employees who have been trained by the other professional staff include; 15 community social rehabilitation workers, 4 gardeners, 2 cooks, 4 cleaners and 8 watchmen.

In addition to the permanently employed staff other people with different experiences contribute greatly towards enabling this project to achieve its goals. These include; volunteers, parents of people with disabilities, students who do field work in the project, local community leaders, government officials (e.g. social welfare staff) and religious leaders just to mention some of them.

The board of governors which is very committed to ensure that this project offer optimum services to its beneficiaries is chaired by the prominent politician and a member of a parliament representing Karatu constituency, Wilbroad Slaa.

2.2.2. PHYSICAL RESOURCES

This project owns a new modern centre which includes offices adequately furnished, dormitories and other services which are necessary for rehabilitation of people with different kinds of disabilities. The project also has vehicles and motorcycles which are very instrumental in visiting different communities in order to deliver services to people with disabilities and their communities.

2.2.3. STAKEHOLDER ANALYSIS

In Arusha region where Kilimanjaro CBR works, there are different organizations working in the similar area. The following are the major known services:

- a. Mental Health Association of Tanzania (MEHATA): Their aim is to assess people with mental illness and treats them.
- b. Sibusiso Foundation: Aims at ensuring that children with mental disability live in dignity and facilitate their integration into their communities in Arusha region.
- c. Tanzania Association for the Mentally Handicapped: Raise awareness on the condition of people with mental disabilities and advocate for their rights.
- d. Olkokola Vocation training centre and USA River Rehabilitation Centre: they provide vocation training in different fields like carpentry, masonry and tailoring to young people with physical disabilities in Arusha region.
- e. Monduli Rehabilitation Centre: It provide rehabilitation services to people with physical disabilities.
- f. Special schools: Iliboru, Meru, Moivaro, Patandi, Tuvaila and Uhuru.

- g. Umoja: A network of organizations working with/and or for people in Arusha and Manyara regions.
- h. Patandi College of special education.

2.2.3.1. SIMILARITIES BETWEEN THESE ORGANIZATIONS AND KCBR

- a. All are working for the welfare of people with disabilities.
- b. They are all heavily dependent on external donors for running.
- c. The organization like Sibusiso Foundation and Monduli Rehabilitation Centre use comprehensive approach of serving children with mental disabilities by providing different services such as therapy, nutrition, counseling and home based care services. Kilimanjaro CBR does the same.

2.2.3.2. DIFFERENCES

- a. Most of the organizations work with one kind of disability while Kilimanjaro CBR addresses the issues of people with different kinds of disabilities.
- b. Most of the organizations work in a small geographical area while Kilimanjaro CBR works in a very diverse area.

2.2.3.3. OTHER STAKEHOLDERS

(See appendix 1. Stakeholders impact analysis).

- a. People with different kinds of disabilities (Physical impairments, Hearing impairments, Learning impairments, Epilepsy, Visual impairments, multiple impairments, mental health problems).

- b. Kilimanjaro CBR Staff
- c. Volunteers/students
- d. Communities of PWDs
- e. Hospitals
- f. Other NGOs, institutions and special schools
- g. Hospitals
- h. Religious institutions

2.3. CED PROJECT VISION, GOAL AND OBJECTIVES

2.3.1. VISION

To promote Community Based Rehabilitation and disability rights in Tanzania and to train people in rehabilitation and disability issues in a way that empowers them and the community.

2.3.2. GOAL

To improve the quality of life of people with disabilities in Arusha region by promoting Community Based Rehabilitation strategy.

2.3.3. OBJECTIVES

- i. To involve the community and the family in addressing the rights and needs of people with disabilities.
- ii. To facilitate the establishment of Arusha Community Based Rehabilitation support unit.
- iii. To raise public awareness on disability prevention and rehabilitation.

- iv. Screening people with different kinds of disabilities.
- v. To facilitate people with disabilities have access to different services in accordance with their needs.
- vi. To assist people with disabilities in improving their community life through leadership and counselling.
- vii. To encourage people with disabilities to form their own organisations and strengthen the existing ones.
- viii. To train community members, students and professionals in CBR approach to rehabilitation and professional intervention in the lives of PWDs.

By the end of second year, February 2007, we expect to achieve the following:

- a. To have completed the establishment of Arusha CBR support unit.
- b. To have visited and facilitated the accessibility of different specialised services to more than 1,000 people with different kinds of disabilities.
- c. Screening of more people with disabilities in the operational area and start rehabilitation processes.
- d. Most of the communities with disabled people would be rehabilitated in order to increase awareness and actions that will eliminate barriers and promote the inclusion of disabled persons in their respective communities.

In order to achieve all that is mentioned above, proper planning of activities and allocation of resources needs to be done properly. In addition to that the project needs to collaborate with other organizations working with and/or for people with different kinds of disabilities in order to avoid

duplication of services offered by the others. The project can also rely on the information gathered by other organizations which can help them to reach their beneficiaries without spending a lot time and other resources trying to trace them.

In order to achieve all the objectives mentioned above, the CED project secured resources from the following sources:

Human resources: from community, volunteers, CED student, rehabilitation specialists from Kilimanjaro CBR and other rehabilitation centers in Arusha region.

Material and financial resources: transport and funding from Action for Children in Conflict Tanzania chapter, which is the Host organization. Local contributions from communities in Arusha contributed greatly in the implementation of this project.

2.4. MY ROLE IN THE PROJECT

My role in this project is facilitating the establishment of Arusha CBR Support Unit in Arusha region.

2.5. LEARNING CONTRACT

My professional goals that I hope to achieve through my participation in the community project will be:

- To learn more on the art and science of project planning and management by using CED approach in practice. CED approach considers Community, Economy and Development to be the pillars of any holistic approach to improvement of living condition of people.
- To develop my expertise on managing projects which address the issues of people with different kinds of disabilities in Arusha region.

- To share my experience and expertise in management of project addressing issues of people with disabilities.
- To promote CBR strategy in Arusha region.

CONCLUSION

The needs assessment outcome revealed that people with disabilities generally live in poor condition in the study area. To address these problems, community in collaboration with CED student and other rehabilitation specialists came up with a CED project with the goal of facilitating the improvement in the living condition of people with disabilities, their families and community at large. In addition to that CED goal and objectives could play a vital role in ensuring that rehabilitation and other services are easily accessed by people with disabilities, especially, in Arusha region where community members felt the need to have a CBR support unit.

CHAPTER THREE

LITERATURE REVIEW

3.0. INTRODUCTION

It has been estimated that globally, there are 335 million people living with different kinds of disabilities, 70% of whom live in developing countries²⁷. In Tanzania the population of people with disabilities is estimated to be 3.5 million people out of 35 million people constituting the population of the country.

The focus of this chapter is on reviewing literature concerning the situation of people with different kinds of disabilities in Tanzania and other countries of the world. The major parts, which will be covered, include; theoretical review, empirical review and policy review. Finally is a brief conclusion.

3.1. THEORETICAL REVIEW

3.1.1. MEANING OF DISABILITY

According to the New Dictionary of Catholic Spirituality, "...persons with disabilities or the disabled are those whose capacities of mind or body are diminished in any way during the pre- or post-natal period or at some later period in the course of psychological development so as to necessitate particular attention or special assistance in meeting basic human needs".²⁸

²⁷ Dr. Asha Yousafzi et al, Double Burden; A situation Analysis of HIV/AIDS and Young People with disabilities in Rwanda and Uganda (Norwich: Norfolk, 2004, p. 9.

²⁸ Michael Downey, "Disability, the Disabled", in The New Dictionary of Catholic Spirituality, Michael Downey, Editor (Collegeville, Minnesota: Liturgical Press, 1993), p.273.

According to our understanding, this definition points out clearly that disability can be seen as the physical or mental limitations, which can hinder a person from achieving his, or her basic and other needs in life such as food, shelter and self-esteem.

In 1981, the Zimbabwe National Disability Survey team defined disability as: “A physical or mental condition which makes it difficult or impossible for the person to adequately fulfill his or her normal role in society”²⁹. This definition shows clearly that in any society there are roles a person is supposed to perform normally. Those who can not because of their physical or mental condition are then considered to be disabled or handicapped. Since different societies assign varied roles to their members, a person who can be considered abled in one society can be disabled in the other. In other words, “Disability is relative to culture and circumstances. Defining who is disabled is not an easy matter. We all have different abilities”³⁰.

The world Health Organization has developed the International Classification of Impairments, Disabilities, and Handicaps (ICIDH). Impairment is described as a condition resulted from a disease, disorder, accident that can be anatomical, psychological or mental. Disability is the condition that is resulted by persistence of the impairment that hinders a person from doing things such as walking, talking, speaking, hearing and reasoning. Handicap, is seen as an obstacle resulting from impairment or disability that hinder a person to perform normal roles in the society.³¹ The Dictionary of Pastoral care and Counseling summarizes, “Thus impairment is the cause; a disability is what a person can not do; a handicap is the social barrier, attitude, or condition that restricts participation”³².

²⁹ Peter Coleridge., *Disability, Liberation and Development* (Ireland: Oxfam, 1993), p. 107.

³⁰ *Ibid.*, p. 9.

³¹ Cf. WHO, *Community-based rehabilitation and health care referral services: A guide for programme managers*, (World Health Organisation 1994), p. 1.

³² P. Way, “Handicap and Disability”, in *The Dictionary of Pastoral Care and Counseling*, Rodney J. Hunter, ed. (Nashville: Abingdon Press), p. 493.

From all the different understandings of the terms disability, impairment and handicap as described above, we therefore define disability as the physical or mental limitation a member of particular society has which hinder him or her to perform the normal roles each normal member of that community is expected to perform. All in all our main concern in this venture is the permanent physical, mental and sensory disabilities. The terms disability, impairment and handicap will be used interchangeably to mean the same in line with the definition we have just given. Some of the common known types of disabilities include blindness, mental retardation, physical handicap, deafness and dumbness.³³

3.1.2. DIFFERENT VIEWS ON THE CAUSES OF DISABILITIES

There are different reasons that are considered to be causing disabilities in different African societies. The common factors, which are commonly pointed out in different societies, including the four regions where KILIMANJARO CBR works, are as follows:

3.1.2.1. PUNISHMENT FOR PARENTAL MISCONDUCT OR NEGLIGENCE

Childhood disabilities are sometimes regarded by different societies, especially in Africa as a punishment from the external, non-human forces to the family concerned. This can be associated with the misconduct of the parents. For instance, it is believed in some societies such as the Akamba of Kenya, that if the ancestors are not given due respect, the parents can be punished.³⁴ Giving birth to the handicapped child is one of the punishments. As a result of such beliefs, most parents do not feel happy and develop a feeling of guilty when the baby born is declared to be handicapped. Therefore,

³³ In this study no difference has been made between hearing impairment and deafness, visual impairment and blindness. This is because, often hearing and visual aids are inaccessible to such groups.

³⁴ C.W. Hobbey, *Ethnology of the Akamba and other East African tribes* (London: Cambridge University Press, 1971) p. 61.

disabilities such as “ Blindness is considered as a symbol of punishment and parents look upon their blind child as a visitation of divine disapproval”.³⁵

3.1.2.2. SORCERY AND WITCHCRAFT

Some societies believe also that disability is caused by bewitchment of the expectant mothers. As John Mbiti puts it, “...that misfortunes were the work of some members especially the workers of magic, sorcery and witchcraft, against their fellow men”³⁶.

3.1.2.3. BLESSING FROM GOD

Some African societies such as Kabyle of Algeria, believe that children disability is the sign of God's blessings towards the family concerned. This is due to the fact that people with disabilities are considered by this community to be nearer to God than other members. This is clearly described by the remark of one Kabyle member to a father of the disabled child as follows: “How lucky you are to have a child like that”.³⁷

The fact that many children are born handicapped makes us not to dismiss the arguments discussed above. Therefore, there is a possibility that the cultural beliefs mentioned above contribute to the problem. Nevertheless, the major causes of disability in Africa include communicable diseases (poliomyelitis, leprosy, tuberculosis, trachoma, otitis media, measles, meningitis, parasitic diseases etc), poor quality of parental care, injuries (especially those as a result of road traffic, domestic and occupational accidents), malnutrition due to deficiency of vitamin A and iodine deficiency, chronic somatic and mental conditions including rheumatic diseases, diabetes, paralysis, alcohol and drugs abuse.³⁸

³⁵ John S. Mbiti, *African Religions and Philosophy*, (Nairobi: Sunlitho Ltd, 1995), p. 211.

³⁶ Ibid. p. 211.

³⁷ Gerarld p. 5

³⁸ WHO, *Community Based Rehabilitation*

3.1.3. MAGNITUDE OF THE PROBLEM IN THE WORLD, AFRICA, TANZANIA

It is estimated that globally there are 355 million people living with different kinds of disabilities³⁹. In any country of the world, people with disabilities are estimated to form 7-10% of the total population of that country and around 2% would need some kind of rehabilitation. Yet only 0.01% to 0.02% of the population in developing countries actually gets such services.

In Africa, disability is a major health problem with about 35 million people constituting around 7% of the total African population. About 75%-80% of people with disabilities is in rural areas where services for prevention and rehabilitation are either limited or unavailable.⁴⁰ The incidence of disabilities has always been on the increasing trend, and about 60% of disabilities could have been prevented.⁴¹

According to the Census conducted in Tanzania in 2002, the population of this country was estimated to be 35 million people⁴². Basing ourselves on the WHO estimation of 10% of any population in the world is composed with people with different kinds of disabilities, the number of people with disabilities in Tanzania is, therefore, estimated to be 3.5 million people.

3.1.4. MAJOR STRATEGIES SEE FOR REHABILITATION

3.1.4.1. INSTITUTIONAL BASED REHABILITATION SERVICES

These are services which may be provided in a residential setting, or in a hospital where disabled people receive special treatment or short term intensive therapy. The institutional based approach focuses on the person's disability and gives little attention to the person's family and community or

³⁹ Dr. Asha Yousafzi et al, Double Burden; A situation Analysis of HIV/AIDS and Young People with disabilities in Rwanda and Uganda (Norwich: Norfolk, 2004, p. 9.

⁴⁰ cf. WHO, Community Based Rehabilitation

⁴¹ WHO Expert Committee, Murphy, 1992.

⁴² Census, 2002.

to other relevant social factors. The major shortcomings of institution based care are its high cost and its location, usually in urban centers, making it inaccessible to those living in outlying areas. In addition, specialized institutions often lack qualified personnel.. competent institution based care, however, is an important part of the rehabilitation referral system for the provision of special assessments, surgical interventions, other skilled treatment and specialized equipment.

3.1.4.2. OUTREACH REHABILITATION SERVICES

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

3.1.4.3. COMMUNITY BASED REHABILITATION (CBR)

This is characterized by the active role of people with disabilities, their families, and the community in the rehabilitation process. In CBR knowledge and skills for the basic training of disabled people are transferred to disabled adults themselves, to their families, and to community members. A community committee promotes the removal of physical and attitudinal barriers and ensures opportunities for people with disabilities to participate in school, work, leisure, social and political activities within the community. A person is available in the community to work with disabled people and their families in rehabilitation activities. Disabled children attend the local schools. Community members provides local job training for disabled adults. Community groups assist the families of disabled people by providing care for their disabled children or adults, transportation, or loans to

initiate income generating activities. Community resources are supported by referral services within the health, education, labor, and social service system. Personnel skilled in rehabilitation technology train and support community workers and provide skilled intervention as necessary.

3.1.5. APPROACHES

There are two major approaches to disabilities which have been existing for years in different countries of the world. These will be discussed here in the next part.

3.1.5.1. TRADITIONAL APPROACH

For many decades disability was viewed as a medical issue, particularly disability which resulted from disease or injury. Medical rehabilitation focused on the disability such as the inability to walk or to dress oneself. It ended when the disabled reached his or her maximum potential to carry out daily activities within the home. For some disabled people vocational rehabilitation followed that process. Special education also addressed intellectual disabilities, as well as training in communication for children who could not hear. None of these processes of rehabilitation addressed the fact that disabled people were not included in the usual work places and social activities, and rarely had leadership roles within their communities and societies.

The traditional concept of rehabilitation has been founded on the belief that disability is a deviation from normal and that a person with disability must be helped to compensate for deviation and learn to function as near to normal as possible. These beliefs have to a great extent affected the traditional ideas about rehabilitation. The focus of rehabilitation was exclusively on rehabilitation of individuals with disabilities.⁴³

⁴³ Multisectoral p2-3

3.1.5.2. NEW APPROACH TO DISABILITY

Currently, the relationship between disability and “normality” is undergoing a revolution. Disabled peoples’ organizations and other NGOs are playing a big role in this revolution. The growing belief is that “...it is natural for differences to exist in human societies. A society truly concerned with human rights is believed to be one which defends the rights of its minorities to be different and does not compel those minorities to adjust to a “norm” established by majority”. Given these beliefs, the limitations faced by disabled individuals are no longer linked to their disability as such, but to society ability to treat all citizens equally. This new approach is based on the notion of right rather than charity; of acceptance of differences rather than compulsory adjustment to the norms; of inclusion, participation and citizenship rather than exclusion.⁴⁴

As opposed to the traditional focus of exclusive rehabilitation on individual disabled person, the emphasis now is placed on the need to rehabilitate society in order to increase awareness and actions that will eliminate barriers and promote inclusion of disabled people into society.⁴⁵ This new approach has shifted from the rehabilitation of disabled persons to fit in the “normal society” towards rehabilitation of society in order to give room for disabled people to thrive as human. This approach is also known as social model.

This shift is very evident in most parts of the world, and especially, in regions where Kilimanjaro CBR is working. Different organizations, DPOs working in this area all have put great importance in rehabilitation of the communities through awareness meetings and other means. What is not clear is if different actions are undertaken out of charity or right.

According to our experience, the big challenge facing the implementation of this new approach to disability is lack of coordination of different services available within and across the different sectors.

⁴⁴ Ibid. p. 2-3

⁴⁵ Cf. *ibid.* p. 3

The needs of disabled are varied and it is important to devise a comprehensive response which takes into account both the whole person and various aspects of his/her life in the family and society at large.

The social model for analyzing disability issues emphasizes the lack of inclusion of disabled people in the society, and points out that this not due to the disability, but to the environment and the society⁴⁶. For example, the social model would suggest that the reason people in wheel chairs cannot get into many buildings is not because they cannot climb stairs, but because there are no appropriate means of access, such as ramps or elevators. The social model brings attention to the social disadvantage of people with disabilities, and the fact that alleviating their disadvantages and ensuring them equality and human rights need a multisectoral approach. This new approach to disability issues puts emphasis on the need to rehabilitate the people with disabilities as well as the society by addressing different issues; social, economic and medical just to mention few.

CBR has been practiced in communities for thousands of years. Families and communities have always worked out their own ways of responding to the needs of their disabled members and they continue to do so where there are no services catering specifically for disabled people.

The CBR approach was firstly introduced by WHO in 1979. ILO and UNESCO joined WHO in promoting CBR, a multisectoral approach which aims to provide a national response to the entire spectrum of needs of people with disabilities, while assigning them an active role in the process leading to their social integration. Among other things, CBR includes disability prevention, rehabilitation, primary health care, the integration of disabled children into the ordinary school system,

⁴⁶ Cf. WHO et al, Op. Cit. p. 29.

vocational skills acquisition by disabled youth and the adults disabled and the possibility of pursuing gainful employment among other things.⁴⁷

In 1976 the World Health Organization (WHO) formalized CBR into a strategy for developing countries by recommending the provision of essential services and training for disabled people through CBR as part of the 'Health for all' campaign. The original principles and reasoning behind CBR were thus very similar to Prime Health Care (PHC) and the relationship between the two is an important factor in the implementation of CBR.⁴⁸

Definitions of CBR have developed and changed in response to field experience and there is an, arguably, healthy lack of consensus on this issue. The latest UN definition provides a useful summary of some of the main themes.

"CBR is a strategy within community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities.

CBR is implemented through the combined efforts of disabled people themselves, their families and communities and the appropriate health, education, vocational and social services."⁴⁹

The needs of disabled people, their families and other members of the community are varied. Hence, multisectoral action is necessary if all needs are to be taken into account. The services provided to meet the needs must be located as close as possible to disabled individuals and their families in order to ensure that they are appropriate. In other words, these services need to take into consideration

⁴⁷ Multisectoral OP cit. p.23

⁴⁸ Finken Flugel H, ed., *The handicapped Community: the relation between health care and community based rehabilitation*. Amsterdam: VU University press, 1994.

⁴⁹ UN Joint Statement 1994

social and economic context; make use of available local resources, make use and integrate ordinary services and above all seek to promote positive social attitudes towards people with disabilities.

3.1.6. UNITED NATIONS STANDARD RULES ON CBR PROGRAMMES

The UN standard Rules list a number of areas where states should take action in order to promote equal opportunities and full participation for persons with disabilities. These rules could be successfully used to plan and to monitor Kilimanjaro CBR programme input towards human rights for disabled persons, because they cover a comprehensive range of preconditions for change in quality of life concerning persons with disabilities. However, no common methodology has been developed to make quantitative or qualitative assessment of the level of adherence to these rules .

As the standard rules cover a comprehensive range of preconditions for improved quality of life for disabled people, they have been used as a reference guide when examining and organizing the reflections made by the interviewees on the usefulness of different CBR programme initiatives. The following are the clusters of Standard Rules:⁵⁰

- a) Awareness raising: This involves all measures aimed at eliminating stigma, increasing the knowledge of different disabilities and creating an inclusive social environment.
- b) Medical care: This involves early interventions and access to medical treatments.
- c) Rehabilitation and support services: this involves measures to enable persons with disabilities to reach their optimal physical, sensory, intellectual and social levels, and to provide tools, services and assistive devices that compensate for the loss or absence of a functional limitation.
- d) Education: This involves access to basic education and literacy skills.

⁵⁰ Cf. Ibid. p. 14-15

- e) Income maintenance and social security: This involves employment, vocational skills training and loan facilities.
- f) Government and community commitment: This involves the implementation taken by the authorities and the community to fulfill their obligations towards persons with disabilities such as adoption policies and plans, legislation, resource allocation, coordination and training, just to name a few things.
- g) Support to Disabled People Organizations (DPOs): This involves the empowerment of persons with disabilities to form their own self-help and advocacy groups.

3.2. EMPIRICAL REVIEW

3.2.1. SIMILAR STUDIES/ASSESSMENTS

Various assessments and evaluation have been conducted in different countries of the world. Some of these studies have been very significant in improving the performance of other similar initiatives and establishment of the new ones. Some of the most remarkable studies done include:

- a. Miles J, Pierre, Offering Hope, an evaluation of the Guyana CBR program. AIFO, July 1994.
- b. Florisse S, Report from a visit to Guyana, WHO, 1999.
- c. Evaluation report NDA/NHR/SHIA CBR Program, Nepal, December 1998.
- d. A Decade with CBR NDA, May 2001.
- e. World Health Organisation quality of life assessment (WHOQOL): development and general psychometric properties, 1998.
- f. Quality of life: its conceptualization, measurement and application. A consensus document by the International Association for the Scientific study of Intellectual Disabilities, August 2000.

- g. Uganda Society for Disabled children, Accessibility and Relevance of education for children with disabilities in Uganda, October 2003.
- h. Annual Reports, Comprehensive Community Based Rehabilitation, 2005, 2006.

All these studies have been sources of inspiration and assistance to many CBR programmes and to the CED student as well. It is through the participation and involvement of people with disabilities, their families and community at large, improved living condition for people with disabilities is possible.

Although there have been many previous assessments and evaluations of CBR carried out to a very high quality, this study is unique because it focuses on how CBR strategies are digested to suit the needs of communities in Northern Tanzania. Thus, it adds value to the other studies and evaluations and establishment of CBR programmes.

3.2.2. OTHER SIMILAR ORGANISATIONS

There are a number of organizations in Tanzania and worldwide which aim at improving the living condition of people with disabilities in different communities. We can learn a lot from their experiences. The following are some among many other organizations working in the same field worldwide:

Firstly, CCBRT (Comprehensive Community Based Rehabilitation Tanzania) is a private Non-Governmental Tanzanian Society (NGO), registered under the Tanzanian Societies Act, N° SO8261 on October 12, 1994. Its goal is to contributing towards poverty alleviation by responding to the lack of accessible and affordable services for disabled people in Tanzania, who are among the poorest of the poor. A survey highlighted an extreme shortage of preventative, curative and rehabilitation services for people living with disabilities, in addition to AIDS patients and orphaned children.

Secondly, Kwetu Mbagala, is a project in Dar Es Salaam, which provides rehabilitation and education intervention to disabled children. This is one of the examples of the project where by a foreign organization DANTAN from Denmark joined with a local organization namely Salvation Army to establish and run this project.⁵¹

Thirdly, HOMIDED is a self-help organization, which is run by people with physical disability. The aim of this organization is to empower people with physical disability to become self-sufficient through handcraft and training.⁵²

Fourthly, Sibusiso Foundation is a program, which aim at improving the living condition of children with mental disability in Arusha region, Tanzania. This project ensures the dignity of children with mental disabilities by helping them to discover and develop their potential and facilitate their integration in their respective communities.⁵³

Fifthly, Ghana National CBR programme was initiated in 1992 by the Ministry of Employment and Social Welfare for persons with disabilities of Ghana. The program has been supported by two NGOs; the Swedish Organisations of Disabled Persons International Aid Association and the Norwegian Association of the Disabled and by UN agencies WHO, ILO and UNESCO. The purpose of this program is to improve the living condition of people with disabilities in the country.

Sixthly, The Guyana CBR program was started in 1986. It is a Non Governmental national program with its headquarters in Georgetown. This organizations has four major strategies: recruitment and training of volunteers, community based resource units, income generation programme and Disabled people's Organisation programme. Its major aim is also to improve the living condition of people with disabilities.

⁵¹ Cf. www.dantan.dk/kwetu/kwetu-salv.htm

⁵² Cf. www.compassion.ca/communityprojects

⁵³ www.sibusiso.com

3.3. POLICY REVIEW

3.3.1. CBR POLICY

“... a policy is a statement of goals and purposes. A policy may also specify overall principles to be followed in order to reach certain goals. Public policies are formulated by government, while any organization may formulate its own internal policies”.⁵⁴

Policies can be explicit or implicit. Those which are explicit are clearly stated and adopted by legislative bodies. These policies can be found in the country's constitution, national development plans, national budget documents, official statements as well as in legislation concerning healthcare, education, work and social protection of people with disabilities.⁵⁵

On the other hand, implicit policies are those which are not clearly specified. These policies may be deduced from current ministerial decrees, administrative rules and procedures, statements by political parties, influential groups or press just to mention few.⁵⁶

When there are no implicit or explicit policies, the manner in which disabled people are perceived and treated within the society may be determined by the current social customs and traditions, religious, ethnic or other ways.⁵⁷

Policies show whether and to what extent the government feels responsible for the rehabilitation of people with disabilities. The United Nations Decades for people with disabilities (1983-1992) made it clear that governments are responsible for implementing measures recommended by the World Program of Action concerning Disabled Persons. These measures include the prevention of

⁵⁴ WHO, Community Based Rehabilitation and the health care referral Services: A guide for programme managers, 1994, p. 25.

⁵⁵ Cf. Ibid. p. 26

⁵⁶ Cf. Ibid. p. 26

⁵⁷ Cf. Ibid. P. 26

disabilities, the provision of rehabilitation services and equalization of opportunities for people with disabilities.⁵⁸

3.3.2. INTERNATIONAL RECOGNITION OF THE RIGHTS

In December 2001, the General Assembly of the United Nations adopted resolution 56/168, which established an Ad Hoc Committee to consider proposals for an international convention to protect and promote the rights and dignity of people with disabilities. Since that time this committee has held two meetings;

All of this happens in the context of a dramatic shift in thinking on disability on the global scale. The increasing international acknowledgement of disability rights as human rights began with the International Year of Disabled Persons (1981) and the adoption of The World Program of Action concerning Disabled Persons⁵⁹ by the United Nations General Assembly. The year 1993 saw the adoption of the UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities.⁶⁰

Another very important milestone was seen in the late 1990s, when the United Nations Commission on Human Rights (CHR) passed a resolution recognizing the United Nations responsibility for the protection of the rights of people with disabilities. Specifically, the Commission discussed the human rights of persons with disabilities at its 54th session, in 1998, and as a result adopted resolution 1998/31,⁶¹ which recognizes that inequality and discrimination related to disability are violations of human rights.

⁵⁸ United Nations 1983.

⁵⁹ UN General Assembly Resolution (GA Res) 37/523 (37th session, December 1982).

⁶⁰ UN GA Res 48/96, Annex (48th session, December 1993).

⁶¹ UN Commission on Human Rights (CHR) Resolution 1998/31, ESCOR Supp. (No. 3) at 117, U.N. Doc. E/CN.4/1998/31 (1998).

Resolution 1998/31 represents a breakthrough in the way that disability is understood within the UN system. Indeed it represents a general recognition by the United Nations of its responsibility for the human rights of people with disabilities. The resolution makes a series of statements and recommendations of great importance for future development in this area, including current efforts to elaborate a new Convention.

The Commission adopted a new resolution in 2000,⁶² reaffirming Resolution 1998/31 and calling for an examination of measures to strengthen the protection and monitoring of the human rights of persons with disabilities.

The discussion of disability at the United Nations is not a new topic. It has been on the agenda in one way or another for over 50 years. What is fairly new, and promising, is the shifting context of these discussions. This shift has evolved from a very rehabilitation based (medical model) approach to a much more Human Rights (social model) approach in the few years.

3.3.3. DISABILITY POLICIES IN AFRICA

Different African countries have different disabilities' policies. We will, however, give the examples of two African countries namely Uganda and South Africa.

In Uganda disability concern have reached a level where they are part and parcel of the general countries concerns which have to be addressed in National policies and programme. The Ugandan Constitution of 1995 has laid a strong foundation for the inclusion and addressing different issues concerning people with through a number of legal provisions like the Parliamentary Elections Statute 1996, the Children Statute 1996, the Local Government Act 1997, the Land Act 1998, the Uganda Communication Act 1997, the traffic and Road safety Act 1998, the UNISE Act 1998 and the

⁶² UN CHR Res. 2000/51, UN Doc. E/CN.4/Res/2000/51 (2000).

Movement Act, 1998. Each of these Legal provisions has mainstreamed disability concerns in matters they regulate and the solution have always been geared to improving accessibility of persons with disability to all environments of the Ugandan Society and provision of equal opportunities to persons with disabilities to increase their capacity to participate in the development of the Ugandan society.⁶³

South Africa seem to have some of the most comprehensive legislation and policy protecting and promoting the rights of disabled people in the world, and disabled people are involved at all levels of government. In 1994–2004, legislation, policies, interventions, and programmes were formulated with the aim of influencing the environment for addressing equity in order to ensure that more people with disabilities could access government and other services.⁶⁴

3.3.4. DISABILITY POLICIES IN TANZANIA

Since independence in 1961, the government of Tanzania through the department of Social Welfare has been providing different services to people with disabilities without comprehensive policy. The adoption of National Policy on Disability in 2004 is a result of many years of consultation with different stakeholders on disability⁶⁵. This new policy still needs legislation and authority for it to be reinforced. “Without authority to which complaints can be addressed this policy will be ineffective”⁶⁶. In other words, for the 2004 policy on disability to be effective, legislation and authority to reinforce it need to be put in place.

Despite the fact that the government had no clear policy on disabilities for many years, Tanzania has actively been involved in different initiatives local and international aiming at improving the living condition of people with disabilities. Internationally, Tanzania is a signatory to various United Nations declarations on the rights of people with disabilities including the 1975’s Declaration on the

⁶³ Cf. <http://www.dredf.org/international/florence.html>

⁶⁴ Cf. http://www.disabilitykar.net/research/small_sa.html

⁶⁵ The Government of Tanzania, National Policy on Disability (Dar Es Salaam, Government printers, 2004).

⁶⁶ WHO, Op. Cit, p. 28.

Rights of People with disabilities, Convention on the Rights of the Child (1989), and the Standard Rules on the Equalization of Opportunities for People with disabilities (1993).

At the continental level Tanzania is a signatory to the Plan of Action for the African Decade of persons with disabilities and a member of African Rehabilitation Institute.

Locally Tanzania has taken various measures to address the issues concerning people with disabilities. Some of the initiatives include the health initiative to combat diseases that cause disablement such as polio, enactment of disability legislation such as Act No.2 of 1982 on Disabled Person Employment and ratification of the United Nations Standard Rules on the Equalization of Opportunities for People with Disabilities just to name few.

CONCLUSION

This chapter has explored on the different aspects concerning disability issues. The literature has revealed that there are different views on the causes of disabilities in different communities. In order to raise awareness about the real causes and rehabilitation of people with disabilities, different rehabilitation strategies/approaches have been used in different countries. One of these initiatives is Kilimanjaro Community Based Rehabilitation where I am doing my fieldwork. There are many other similar initiatives in different countries of the world. On policies, the United Nation General Assembly has set standard rules on the equalization of opportunities for persons with disabilities. In order to implement this, different countries have formulated policies and legal frameworks in order to ensure that the concerns of people with disabilities are cared for. In countries such as Tanzania the policy of disability need a legal framework for it to be implemented.

CHAPTER FOUR

IMPLEMENTATION

4.0. INTRODUCTION

In order to improve the living condition of people with disabilities in Arusha region, different activities were implemented. This chapter focuses mainly on the intervention taken.

4.1. PRODUCTS AND OUTPUTS

VISION: To promote Community Based Rehabilitation and disability rights in Tanzania and to train people in rehabilitation and disability issues in a way that empowers them and the community.

GOAL: To improve the quality of life of people with disabilities in Arusha region by promoting Community Based Rehabilitation strategy.

At the end of the second year the CED project is going to achieve different outputs as clearly described in the table below:

Table 7. Indicators for objectives

Objectives	Indicators
1. To involve the community and the family in addressing the rights and needs of people with disabilities.	<ul style="list-style-type: none"> • Number of communities/villages involved. • Number of families of people disabled people involved. • Number of social services providers involved. • Number of community mobilization meetings.

	<ul style="list-style-type: none"> • Consultation with government and local authorities. • Number of meetings with community leaders, parents and community organized and conducted. • Number of home visits done.
2. To facilitate the establishment of Arusha Community Based Rehabilitation support unit.	<ul style="list-style-type: none"> • A copy of planning manual • A copy of Constitution • Certificate of registration • Number of communities involved. • Resources mobilized • Reports of Monitoring and evaluation activities conducted.
3. To raise public awareness on disability prevention and rehabilitation.	<ul style="list-style-type: none"> • Number of community awareness meetings organized. • Number of Home visits conducted. • Number of people attending awareness meeting. • Number of communities where awareness campaigns were conducted. • Number of people received preventive and rehabilitation services. • Types of rehabilitation services provided.
4. Screening people with different	<ul style="list-style-type: none"> • Number of people with different kinds of

kinds of disabilities	disabilities screened.
<p>5. To facilitate people with disabilities have access to different services in accordance with their needs.</p>	<ul style="list-style-type: none"> • Number of people with disabilities referred to different services. • Number of people with disabilities who need special appliances. • Number of people with disabilities who have received special devices and those who have not received. • Number of different social services visited.
<p>6. To assist people with disabilities in improving their community life through leadership and counselling.</p>	<ul style="list-style-type: none"> • Number of people with disabilities trained and counseled. • Number of training sessions undertaken. • Other kinds of supports given
<p>7. To encourage people with disabilities to form their own organisations and strengthen the existing ones.</p>	<ul style="list-style-type: none"> • Number of Disabled Peoples' Organisations (DPOs) formed. • b. Number of DPOs identified and strengthened.
<p>8. To train community members, students and professionals in CBR approach to rehabilitation and professional intervention in the lives of PWDs.</p>	<ul style="list-style-type: none"> • Number of students, professionals who have been trained/who have done fieldwork. • Number of training sessions conducted.

4.2. PROJECT PLANNING

4.2.1. IMPLEMENTATION PLAN

In order to achieve the CED goal and objectives, the following elements are necessary; list of activities to be undertaken, people responsible, time frame and resource requirement (**See Appendix 2: Project implementation plan**).

4.2.1.1. LISTING OF ACTIVITIES

After specific objectives and targets of Arusha CBR support unit were formulated, a list of programme activities to be undertaken was generated. Essentially, the list was generated in response to the questions: where? How? and by whom? The activities list in turn helped in generating the list of resources requirements, such as human resources, facilities, equipment and supplies. The activity list that was prepared by rehabilitation specialists, community leaders in different communities of Arusha region, parents, people with disabilities and CED student contains three types of activities which will be clearly elaborated in the next part; Rehabilitation activities, Supportive activities and Developmental activities

4.2.1.1.1. REHABILITATION ACTIVITIES

These include all interventions directed towards people with disabilities, their families, and their respective communities.

4.2.1.1.2. SUPPORTIVE ACTIVITIES

It involves all activities such as training, provision of information, and administrative and logistical support that make possible the rehabilitation activities to take place.

4.2.1.1.3. DEVELOPMENT ACTIVITIES

All actions aimed at enhancing the potential of the above types of activities. These are usually one-time activities for example, the construction office and therapy room.

The following is the list of project activities under the three categories explained above in order to accomplish goals and objectives:

Objective 1: To involve the community and family in addressing the rights and needs of people with disabilities.

- a. Meetings with community leaders, parents and community
- b. Home visits
- c. Rehabilitation seminars and workshops
- d. Consultation with government and local authorities

Objective 2: To facilitate the establishment of Arusha CBR support unit.

- a. Making decision to set up CBR activities/programme in communities in Arusha region
- b. Planning programme activities
- c. Establish system for record keeping
- d. Prepare a budget for the budget
- e. Send the Budget to donors
- f. Mobilization of local resources
- g. Select and training of Community Rehabilitation workers

- h. Purchasing capital items (computer, furniture, mobile phones)
- i. Overall management of the programme
- j. Monitoring of activities
- k. Evaluation of project

Objective 3. To raise public awareness on disability prevention and rehabilitation.

- a. Home visits
- b. Provide equipment and appliances (special chairs) through referrals
- c. Provision of Preventive and Rehabilitation services
- d. Rehabilitation outreach clinics in the communities

Objective 4. Screening people with different kinds of disabilities

- a. Screening people with disabilities.
- b. Recording the number of people with disabilities in need of different services
- c. Community clinics
- d. Home visits

Objective 5. To facilitate people with disabilities have access to different services in accordance with their needs.

- a. Visiting different social services
- b. Home visits
- c. Community meetings

- d. Making referrals

Objective 6. To assist people with disabilities in improving their community life through leadership and counseling.

- a. Social counseling and support parents groups
- b. Empowerment training: workshops and seminars

Objective 7. To train community members, students and professionals in CBR approach to rehabilitation and professional intervention in the lives of PWDs.

- a. Fieldwork guidance.
- b. Training sessions

4.3. INPUTS

Inputs are goods and services used in production, such as capital goods (buildings, equipment, labor, raw materials etc).⁶⁷ For our case, inputs refer to the goods and services used to render rehabilitation and other services in the communities concerned. Resources inputs can be broken in different ways; by input, by function/activity or by level. On our part, we have chosen the classification of inputs which distinguishes two important categories of resources; those which are used up in the course of the year and are usually purchased regularly (i.e. recurrent or operating costs) and those that last longer than one year (i.e. capital costs). This classification was selected because of its familiarity to most members of the committee which was to plan and implement the activities.

⁶⁷ WHO, Cost Analysis for Management of Rehabilitation Programmes, Rehabilitation Unit, Division of Health Promotion, Education and Communication, 1997, P. 27.

The following is, therefore, a list of inputs classified under recurrent/operating costs and capital costs need to achieve the objectives:

4.3.1. RECURRENT COSTS/INPUTS

- a) Personnel: supervisors (steering committee), community social workers, consultants, rehabilitation technicians, secretary. (Salaries/wages, statutory expenses etc).
- b) Vehicles operations and maintenance: petrol, lubricants, tyres, insurance etc.
- c) Training recurrent: short workshops, seminars and in service training for staff and community members.
- d) Social mobilization: meetings etc.
- e) Food and accommodation for rehabilitation and community social workers.
- f) Supplies: materials used in the course of the year.

4.3.2. CAPITAL COSTS/INPUTS

- a) Furniture and equipment
- b) Training non recurrent: staff
- c) Vehicles: motorcycles, bicycles.
- d) Buildings: Rented office and rehabilitation avenue, accommodation for rehabilitation workers, electricity, telephone, cleaning.
- e) Equipment: Projector, parallel bars for walking, special devices, computers, rehabilitation equipment.

4.4. STAFFING PATTERN

The establishment of Arusha CBR Support Unit was born as a result of the needs perceived by several communities in Arusha region. Community members in collaboration with CED volunteer

and other rehabilitation specialists took a fore front in order to ensure that the project could materialize. The management of this project is as follows:

4.4.1. STEERING COMMITTEE

A steering committee of 7 people was selected by community members during a meeting which made a decision to establish this project. This committee is composed of 2 parents of people with disabilities, 2 local leaders, 1 person with disability and two other members of the community. In addition to this group which has the mandate to ensure the establishment of this project for two years, the CED volunteer/facilitator and rehabilitation specialists (Therapists) are involved in the planning and management of this project. (See **appendix 2. job descriptions**; committee members, CED facilitator and therapists.

4.4.2. COMMUNITY BASED REHABILITATION WORKERS

Four community based rehabilitation workers were selected by steering committee to work in different wards of Arusha region. These are paid by the communities concerned while solicitation of funds from other donors is worked out by the committee. (See **appendix 3.their job description**).

4.4.3. CONSULTANTS

Depending on the needs, different consultants contributed from time to time in giving advice for better planning and implementation of the project. Most of the consultants needed by this project are rehabilitation specialists. These are sought by the steering committee in collaboration with the CED facilitator/volunteer and other rehabilitation specialists.

4.4.4. OFFICE SECRETARY/ATTENDANT

The office secretary/attendant is permanently stationed at the office to give support to the implementation of day-to-day activities. (See **Appendix 4.Job description**).

4.5. BUDGET

A budget is a financial plan providing donors, project implementers and managers with financial information on how much it will cost to carry out a particular project.⁶⁸ The budget was prepared by the steering committee in collaboration with community social workers, CED volunteer and rehabilitation specialist to ensure that resources were available to carry out the objectives of the project and also to ensure that scarce resources are utilized efficiently and effectively. (See **appendix 4 Arusha CBR Support Unit Budget**.)

4.6. PROJECT IMPLEMENTATION

4.6.1. PROJECT ACTUAL IMPLEMENTATION REPORT

It is important at this point to note that all the objectives of Arusha CBR Support unit are interlinked. They are all focused on improving the living condition of people with disabilities. This means that most of the activities which were identified to achieve a particular objective were also in one way or the other contributing to achievement of other objectives. The following is the annotated outline of activities carried out to achieve each objective:

Objective 1: To involve the community and family in addressing the rights and needs of people with disabilities.

In order to achieve this objective, the following activities were carried out:

⁶⁸ Cedpa p. 82

- a) . In the year 2006/2007 Arusha CBR Support Unit in collaboration with other organisations conducted 23 parents' groups meetings, 4 wards meetings and 24 community meetings. All these were occasions to share information about disability and the role of this project in ensuring that the living conditions of people with disabilities improve progressively.
- a. 4 Rehabilitation seminars and workshops were conducted.
- b. Consultation with government and local authorities in different localities.

Objective 2: To facilitate the establishment of Arusha CBR support unit.

- a. After a series of meetings and home visits elaborated above, the representative from different meeting took part in 2 days workshop about rehabilitation and disability issues which led to making decision to set a CBR support unit with the name of The Arusha CBR Support Unit.
- b. A one-programe plan was made.
- c. Preparation of the budget
- d. The Budgets for specific costs items were sent to 10 different donors.
- e. Mobilization of local resources. Due to lack of financial, material and human resources in the initial planning and implementation, most services were provided under the assistance of different programmes such as Action for Children in Conflict, Kilimanjaro CBR and other private contributions in terms of voluntary work, finances and facilities and advice.
- f. 4 out of 10 targeted Community Rehabilitation workers were selected and were give preliminary training by rehabilitation therapists.
- g. Purchase capital items (computer, furniture, mobile phones)
- h. Monitoring and Evaluation of project

Objective 3. To raise public awareness on disability prevention and rehabilitation and **Objective 4.**

Screening people with different kinds of disabilities.

- a. Home visits as stated above.
- b. 30 people with disabilities were referred to different rehabilitation services in Arusha and Kilimanjaro regions. Provision of Preventive and Rehabilitation services
- c. Rehabilitation outreach clinics in the communities conducted during community meetings, which led to screening and identification of 231 people with different kinds of disabilities and 150 people with preventable disabilities such as cataract.
- d. Screening people with disabilities.
- e. Recording the number of people with disabilities in need of different services

Objective 5. To facilitate people with disabilities have access to different services in accordance with their needs.

- a. CED volunteer, therapists and community social rehabilitation workers visited 20 out of 30 listed social services. Some referrals were made as explained above.

Objective 6. To assist people with disabilities in improving their community life through leadership and counseling.

- a. Social counseling and support parents groups were done continuously during home visits, community meetings and other activities.
- b. Empowerment training: workshops and seminars were conducted as explained above.

Objective 7. To train community members, students and professionals in CBR approach to rehabilitation and professional intervention in the lives of PWDs.

c. Fieldwork guidance for two students.

d. Training sessions

In its initial stage, The Arusha CBR support unit depended heavily on the support of individuals and specialists, CED volunteer and rehabilitation specialists from other organisations working for the course of people with disabilities in the Arusha and neighbouring regions. Much of the time was spent on raising awareness and establishing the unit. Very little major fundraising activities were conducted though some proposals were sent to different donors. Major resources which were used include: finances, human resources (most of them working on voluntary basis or representative of other organisations which identified their beneficiaries through this project), material resources (transport, teaching materials, office supplies) most of them were from the contribution of parents and other well-wishers and transport provided by other organisations which were working jointly with this initiative in order to serve its clients and identify new ones.

Main challenges and Responses planned by the steering committee were:

Table 8. Challenges facing Arusha CBR support unit and solutions

Challenge	Solutions
1. Inadequate funding	The steering committee is doing its best to develop numerous proposals for different donors to attempt and encourage them to support this initiative.
2. Lack of training for most of the community social rehabilitation workers	Despite the initial training conducted, community social worker need to be more trained in rehabilitation services. The

	<p>committee is making effort to ask other organisations with specialist rehabilitation workers to give training to community social workers and other community members from time to time.</p>
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All in all, this initiative has been able to achieve its goal of improving the living condition of people with disabilities in Arusha region. This is because it has created a forum where people with disabilities, their families and other can share their experiences and challenges which lead to finding new strategies of addressing them. In addition to that this initiative has created a link between people with disabilities, their families and other services providers in the region.

CONCLUSION

The Arusha CBR Support Centre is born out of the field experience done with Kilimanjaro CBR by a CED student. The needs and impact assessment conducted during the fieldwork attachment identified strongly on the need of having CBR support units in different localities where Kilimanjaro CBR works. This was meant to facilitate the provision of different rehabilitation services by different initiatives. The initiative is in its infantile stage where a lot of commitment and volunteering spirit need to be promoted in order to enhance this project grow to its maturity. The CED volunteer is still committed to work with this initiative to see it mature.

CHAPTER FIVE

MONITORING AND EVALUATION

5.0. INTRODUCTION

This part outlines a comprehensive approach set to monitor and evaluate The Arusha CBR Support Unit. The evaluation policy and framework are part of the organizational ongoing commitment to work with other stakeholders in order to ensure that the set objectives are realized.

5.1. MONITORING

“Monitoring is collecting simple and relevant information to keep people informed about what is happening in the programme”.⁶⁹ At the end of the quarter the format is used to compare the planned with the actual achievements and to evaluate them (Assessment).

In this study, monitoring of project activities was done to assess whether the project activities were conducted as planned and also to assess if the available resources were used efficiently during the project implementation.

Monitoring provides the management with information needed to analyze current situation, identify problems and find solutions, discover trends and patterns, keep project activities on schedule, measure progress towards achievement of project’s objectives. In addition to that, it helps to formulate/revise future goals and objectives and finally make decisions about human, financial, and material resources.

Monitoring was a continuous process and project staff (steering committee, community social workers, rehabilitation specialists and CED volunteer) did the first level of monitoring. The steering committee was responsible for monitoring the staff and tasks under them, and the CED volunteer was

⁶⁹ International Disability Consortium, Guidelines for conducting monitoring and Self assessment of Community Based Rehabilitation Programmes: Using Evaluation Information to Improve programmes, Geneva, 1996 p.12

given the task to facilitate all aspects of the project's monitoring. The donors (internal and external) did the second level of monitoring in order to see how resources were used to achieve the set goals.

Monitoring was done through, field visits, review of service delivery and management information system.⁷⁰ Information that was planned to be collected included; the use of time, people, money, and other material resources. Others included; staff supervision, budget/expenditure, service delivery and training needs to mention few. Monitoring of project activities was done on weekly and monthly basis whereby the team members would meet and discuss on the progress of the project.

5.1.1. TYPES OF MONITORING CONDUCTED WITH THIS PROJECT

Five types of monitoring were considered vital for this project. More information is given below:

- a. **Monitoring of input (action):** The monitoring of inputs dealt with deployment of resources, which were at the disposal of the project such as; finance, equipment, materials and human.
- b. **Monitoring of results (products/outputs):** This was concerned with project's output in terms of services for the target group. It is concerned with goods and services realized with the participation of target group, community, steering committee and community at large.
- c. **Monitoring of reaction (Level of project purposes and effect):** With respect to goods and services rendered by the project it was necessary to know the reaction of the beneficiaries of the project. This helped to establish whether the outputs were in line with the wishes and needs of the beneficiaries and community at large.
- d. **Monitoring of context:** The context in a project means factors surrounding the project. Major factors, which were identified to be important in the planning of different activities, were to

⁷⁰ CEDPA, pp 57-59).

mark days of markets, rain seasons and harvesting seasons. Others include beneficiaries' settings; economic situation and cultural background.

- e. **Monitoring of impact (level of the overall objective):** After the provision of different services by Arusha CBR Support Unit, a certain change was expected in the living condition of people with disabilities in the region.

5.1.2. MONITORING METHODOLOGY

5.1.2.1. PARTICIPATORY MONITORING APPROACH

“Participatory monitoring is systematic recording and periodic analysis of information that has been chosen and recorded by insiders with the help of outsiders”⁷¹. In other words participatory monitoring and evaluation is a tool for learning from experience. It helps everyone involved to learn and plan better next time, or improve upon existing ways of doing things. It is above all a system developed primarily for use by those who are also beneficiaries of the project.⁷² It is due to this reason and advice from specialists working in other rehabilitation services that this approach was selected by steering committee in collaboration with other community members. Another important reason which prompted to the selection of this tool is because it is a practical approach to creating awareness on social economic and political dynamics of development as the programme participants and staff encounter living realities on first hand experience basis through the process of monitoring their project. Monitoring helped to assess the following vis-à-vis the project:

- Relevance: Does the project address the needs?
- Efficiency: Are we using scarce resources wisely?

⁷¹ The Community's Tool Box: The Idea, Methods and Tools for Participatory assessment, Monitoring and Evaluation in Community Forestry, p. 65.

⁷² Francis W. Mulwa, Participatory Evaluation (In Social Development programmes), Ideas and Tools for Orientation of Programme Teams on Participatory Monitoring and Evaluation, Triton Publishers, Nairobi, 1993, p.194.

- Effectiveness: Are the desired results being achieved?
- Impact: To what extent does the project improve the living condition of people with disabilities in Arusha region?

5.1.2.2. MONITORING QUESTIONS AND MONITORING INDICATORS

The following are the monitoring questions and indicators that were used to monitor this project in relation to the five monitoring levels as explained above:

Table 9. Monitoring type, questions and indicators

Monitoring type	Monitoring indicators	Monitoring questions
Monitoring of action	<ul style="list-style-type: none"> • Resources used • Number of activities realized • Frequency of contact with beneficiaries 	<p>How much did we spend on rehabilitation, supportive and development activities?</p> <p>How many people took part in planning and implementation of the project?</p> <p>How was the material resources availed utilized?</p>
Monitoring of results	<ul style="list-style-type: none"> • Coverage of service network • Respect of time scheme • Quality of delivery 	<p>How many communities have been involved in addressing the needs and rights of people with disabilities?</p> <p>Has Arusha CBR Support Unit been established?</p> <p>How many people with different kinds of disabilities have been screened, trained and counseled in Arusha region?</p> <p>How many Disabled Peoples' organizations (DPos) have been formed as a result of Arusha CBR in the region?</p>

		How many existing DPos have been supported by this project?
Monitoring of reaction	<ul style="list-style-type: none"> • Beneficiaries contacts and satisfaction rate 	How many people with disabilities, parents and other community members have been actively involved in day to day advocating and raising awareness about the situation of people with disabilities in Arusha region?
Monitoring of context	<ul style="list-style-type: none"> • Beneficiaries environment • Economic setting • Institutional setting 	What is the number of beneficiaries who can afford rehabilitation services cost?
Monitoring of impact	<ul style="list-style-type: none"> • Perceived change in the living condition of people with disabilities 	What is the change in the living condition of people with disabilities in Arusha region in comparison with the time before this project was initiated?

5.1.2.3. MONITORING PLAN

Table 10. Monitoring Plan

Category of information	What to monitor	What records to keep	Who collects data	Who uses data	How to use information	What decision can be made
Work plan activities	Timing of activities Availability of personnel and resources	Monthly/quarterly work plans Community meetings reports Home visits reports Statistical records Referral registration form	Community social workers Steering committee Rehabilitation specialists CED volunteer	Community social workers Steering committee Rehabilitation specialists CED volunteer	Ensure staff and other resources are available	Reschedule activities and deployment of resources as needed
Cost and expenditure	Budgeted amounts and Receipts & Expenditure	Ledger of expenditure Receipts and payment vouchers Bank statements Reports to donor Financial records and reports	Steering committee treasurer	Steering committee. Community social workers Donor Auditor	Ensure funds are available Ensure compliance with accepted funding regulations	Authorize expenditure determine need for other funding Source.
Staff and supervision	Knowledge & skills of staff, educational level and job performance	Performance review Job description Feedback from training	Rehabilitation specialists CED volunteer Steering committee	Steering committee	Advice staff on career development	Training needs Placement

Category of information	What to monitor	What records to keep	Who collects data	Who uses data	How to use information	What decision can be made
		attended				
Results	No and types of services provided	Attendance register Fieldworker reports Referral registration form	Community leaders, leaders Rehabilitation specialists CED volunteer Steering committee	Community leaders, leaders Rehabilitation specialists CED volunteer Steering committee	Ensure objectives are realistic Assess quality and appropriateness of services provided	Revise objectives Retrain staff Revise project strategy and approach

5.1.2.4. TOOLS FOR DATA COLLECTION

During the monitoring, different methods were used to gather information. These methods included focus group discussion, observation, and review of participant's record books. Others were attendance register and quarterly reports.

5.1.2.4.1. FOCUS GROUP DISCUSSION

Focus group discussion was done using the checklist prepared by the researcher before the interview.

The discussion was conducted by the steering committee by involving community leaders, parents of children with disabilities, people with disabilities and other community members in order to establish the progress of the activities aimed at achieving the goal of improving the living condition of people with disabilities in Arusha region.

5.1.2.4.2. OBSERVATION

Observation was done in a participatory process by attending different community activities such as community meetings and community rehabilitation clinics just to name few. The aim of this was to establish as to how the community members actively participated in the activities. This was also to observe as to how the members participated in the decision-making process, bearing in mind that the decision to start this project came from the community. Observation method was used for the purpose

of getting direct information about behavior of individuals and groups that could not be expressed verbally or in writing.

5.1.2.4.3. REVIEW OF RECORDS

Record review was useful for determining the understanding of communities, parents of children with disabilities and people with disabilities themselves on the needs and rehabilitation actions that were to be undertaken in order to improve the living condition of people with disabilities in Arusha region. Different records such as community meeting reports and attendance records were reviewed. Quarterly reports assisted all stakeholders and donors to understand what decisions were to be made in order to achieve the desired goal.

5.1.2.5. ADMINISTRATION

Data collection and monitoring process was carried out by Community Social Rehabilitation Workers, Steering Committee, rehabilitation therapist, community members and CED volunteer through meetings and other occasions.

5.1.2.6. DATA ANALYSIS, INTERPRETATION AND REPORTING

Interpretation of data collected during monitoring was done by involving the steering committees, volunteers/specialists, community social workers and community members in meetings.

- On weekly basis the steering committee, community social workers and volunteers did the interpretation of data.
- On quarterly basis, the interpretation of data was done during the community meeting involving all the members of the communities concerned present.
- Information was presented orally, in writing and with visual aids. Formal reports were also used.

5.1.3. MANAGEMENT INFORMATION SYSTEMS

In order to ensure smooth monitoring of project activities, management information systems were developed by the steering committee, rehabilitation specialist, CED volunteer and other members of

the community who volunteered to take part in the exercise due to their expertise in project planning and management. The following are the systems developed:

5.1.3.1. SYSTEM FOR DAY-TO-DAY MANAGEMENT

This is mainly concerned with smooth (administrative) functioning of the project organization: staff, administration and other day to day operations. Monitoring tools used include:

- Log books; used to record the use of equipment.
- Stock registration; record amounts of materials in stock, used and purchased.
- Bookkeeping system.
- Activity registration; provided an insight on how manpower was used for different activities.

5.1.3.2. SYSTEM FOR OPERATIONAL MANAGEMENT

Operational management concerns the delegation of activities and the coordination of different activities. The focus of this system was to monitor the timing, quality and quantity of services provided for the year. Tools that were used to gather information include:

- Bar charts: the planning techniques that facilitate assessment of progress made in relation to original planning.
- Monthly and quarterly reporting: it served to inform about the progress of activities and the occurrences of problems or constraints.
- Technical reports: Ad hoc reports that were to be written after the completion of any activity. These were used to assess the qualitative aspects of the work done.
- Back to office reports: Reports made after field trips that permit the steering committee management to know what has been done during the field trip.

5.1.3.3. SYSTEM FOR SUPERVISION

The interest of management at supervisory level was to know whether the project purpose and results were being achieved. Tools that were used included:

- Quarterly and yearly reports: described and assessed the progress towards achievement of results.
- Technical reports: used to assess the quality aspect of activities.
- Accounts quarterly and yearly statements.
- Project plan: comprehensive description of activities.

5.1.4. MONITORING RESULTS

Monitoring of project activities was done on weekly and monthly basis using qualitative and quantitative methods. Data was manually analyzed and the results showed that about 91 % of all the planned activities were timely done. All these activities contributed greatly to provision of preventive and rehabilitation services to people with disabilities of all ages.

- 15 meetings out of 15 planned meetings with community leaders were conducted (100%).
- 30 parents groups meetings out of 30 were conducted (100%).
- 32 wards and community meetings out of 35 were carried out (91%).
- 17 meetings with parents and other community members out of 20 originally planned were undertaken (85%).
- 4 rehabilitation seminars and workshops were conducted (100%).
- Two days workshop on rehabilitation and disability issues was conducted (100%). This led to making decision to establish The Arusha CBR Support Unit as a way in order to improve the living condition of people with disabilities in Arusha region.
- A one-year implementation plan was made (100%). This plan took more time to finish than planned before. This was due to the fact that most of the time of the steering committee was focused on raising awareness about the living condition of people with disabilities which seemed necessary in order to come up with a comprehensive plan to address the needs.

- 4 out of 10 Community Social workers (rehabilitation workers) were selected and trained (40%). Financial constraint contributed to this situation.
- 30 people with different kinds of disabilities were referred to other different rehabilitation services in Arusha and other regions.
- 381 people with disabilities were screened and registered by the project. Out of whom 60% with permanent disabilities and 40% with preventable disabilities.
- 800 home visits out of 1,000 were conducted (80%).
- Monitoring and evaluation plans made (100%).
- Monitoring and evaluation undertaken (100%).
- Renting of an office and purchase of office equipment (100%).

5.2. EVALUATION

“Evaluation refers in a general way to mean all the activities that are done to see how a programme is progressing. Monitoring and self assessment are two aspects of the evaluation process”.⁷³

In this regard, therefore, evaluation is not something done just at the end of the programme or when funding is finished, it is done throughout the intervention. Formative evaluation is usually done during activities implementation with the aim of finding what need to be done in order to improve the project performance. On the other hand, summative evaluation is conducted at the end of activities implementation in order to assess the overall impact of the project. That is why it necessary to make an evaluation plan during the planning of the project before any activities ever start. This means that there is a direct link between evaluation and planning. “If you do not have a clear idea what you want to achieve through your activities, then you will not know if you succeeded. That is why one of the

⁷³ International disability consortium guideline for conducting monitoring and self-assessment. P.6

first steps in planning is to organize how you are going to gather relevant information about your activities”.⁷⁴

5.2.1. BENEFITS OF EVALUATION

The Arusha CBR Support Unit management committee is committed to carry out evaluation of the project because of the following benefits:

5.2.1.1. FINDING OUT THE VALUE OF THE PROGRAMME

One of the most common questions asked in evaluating Community Based Rehabilitation programmes is, “How are we making a difference for disabled people?” In order to improve the living condition of people with disabilities in Arusha region, the following questions will tell the value of this programme:

- a) How have we changed awareness about disability in the general community?
- b) How many people with disabilities have we assisted?
- c) Are local employers employing more persons with disabilities?
- d) How have we facilitated the accessibility of people with disabilities to different services?
- e) Are we using our community rehabilitation workers and other volunteers effectively?

5.2.1.2. MAKING DECISIONS TO IMPROVE THE PROGRAMME

One of the best ways to improve this programme is to review it. Even informal evaluations can help to identify weaknesses in the programme. When problems appear, decisions about trying a new approach can be made.

⁷⁴ Ibid.p.6

5.2.1.3. FUNDING

Management committee has realized that, not only is evaluation important to staff, participants and community members, it is also important for getting programme funding. The committee experience shows that donors are very hesitant to give money or time to a programme without reviewing and evaluating it. It is now quite usual that some type of evaluation of current programme or at least a feasibility study to prove the need must accompany funding proposals.

5.2.1.4. FINDING NEW KNOWLEDGE

Evaluation results are especially important in CBR where there is a lot of talk about the idea of CBR but until very recently very little information on how CBR programmes work is available. Evaluation studies reveal how a programme works, and helps participants understand which activities work best with which types of people. Another type of new information that might be gained from evaluation is how the idea of CBR spreads both from the local community to another community or within a government.

5.2.2. TYPES OF EVALUATIONS CONDUCTED

In this study evaluation was done to assess the achievement of immediate objectives, output and activities. A team comprising of a CED technical adviser, steering committee members, rehabilitation specialists and community members were involved in the mid term and end term evaluation of the project. The evaluation process was done through interviews, review of progress report, existing group records and community financial accounts. The technical advisor formulated an evaluation plan, which consisted of both formative and summative evaluation.

5.2.2.1. FORMATIVE EVALUATION

Formative evaluation is a valuable tool that informs project management on the status of the project and provides the basis for a future summative evaluation of the project.

Formative evaluation is used to assess the current, ongoing program activities, it provides an internal process that compares the planned program with the actual program, and measures the progress made toward meeting the program goals. This evaluation type helps identify problems threatening the program's viability, enabling the program management and planning group to make appropriate corrections.

This evaluation was conducted seven months after the beginning of the project in order to assess the ongoing project activities and provide information that could be used to improve the project performance.

5.2.2.1.1. METHODOLOGY FOR FORMATIVE EVALUATION

5.2.2.1.1.1. THE SAMPLING PROCEDURE

Two basic sampling methods namely probability and non-probability were used to gather data for formative evaluation as described below:

PROBABILITY SAMPLING METHOD

This is a method whereby each person in the population has an equal chance of being selected.⁷⁵ This method was purposefully chosen because its resulting sample is said to be representative. In addition to that this method proved to be very instrumental during the collection of Community Needs Assessment information. Two probability-sampling methods were selected. The first method, which was selected, is simple sampling. "In simple random sampling, you choose a sub-set of respondents at random from a population"⁷⁶. This method was purposefully selected because:

- c. It is simple and easy to conduct.

⁷⁵ Arlene Fink et al, How to Conduct Surveys: A Step by Step Guide, The International Professional Publishers, Newbury Park London, 1985, p.53.

⁷⁶ Ibid. p.56

- d. The researcher did not have the knowledge of the characteristics of all the individuals in a population in most of communities.

NON-PROBABILITY SAMPLING METHOD

A non-probability sampling method, which was used, is accidental. Accidental samples were used, especially, while doing home visits in different communities. Interviews or observations were made when people were available. This method best suited while doing home visits because most of the people visited were doing different activities such as farming and others. In addition to that home visits were not always done after communicating to the families to be visited. This method was also selected by the researcher because it was effective during the Needs Assessment Survey. In addition it was familiar to most of the people who were collecting data.

5.2.2.1.1.2. RESEARCH UNIVERSE/POPULATION SAMPLING

Random sampling was used to select 30 parents of children with disabilities and adults disabled person who have received project services to be interviewed. Out of this number 29 parents, constituting 96% of the expected parents sampled responded to the survey. We also used purposive sampling to select 10 NGOs leaders who were collaborating with this project and ward Executives. All of them took part in the entire exercise. The seven members of steering committee, one therapist were purposefully sampled. Those above mentioned took very active role in the whole process of evaluation. In addition to the group mentioned above, random sampling was used in the sense that all community members who attended community meetings were part of the evaluation exercise. Records show that the total community members who took part in the whole evaluation exercise during community meetings was 215 people.

5.2.2.1.1.3. EVALUATION QUESTIONS

Table 11. Formative evaluation analysis plan

Evaluation question	Indicators	Data sources	Who collect data	Sampling approach	Analysis
To what extent is the project implementation plan being followed as documented in the work plan?	<p>Number of activities conducted and accomplished.</p> <p>Number and types of resources available and used</p> <p>Number of beneficiaries and rehabilitation workers available</p>	<p>Beneficiaries and Community leaders surveys</p> <p>Document review</p> <p>Training session observations</p> <p>Attendance register</p> <p>Implementation plan.</p> <p>Letters and papers relating to project.</p>	<p>Community social workers</p> <p>Steering committee</p> <p>Rehabilitation specialists</p> <p>CED volunteer</p>	<p>Random and Purposive sampling</p>	Descriptive statistics

Evaluation question	Indicators	Data sources	Who collect data	Sampling approach	Analysis
		Progress reports. Project monitoring records. Meetings minutes. Community meetings and home visits records.			

Evaluation question	Indicators	Data sources	Who collect data	Sampling approach	Analysis
To what extent has the project improved the understanding of people about the rights and needs of people with disabilities in the study area?	<p>Number of Awareness raising activities</p> <p>Change in knowledge and practice about disability issues and rehabilitation</p> <p>Number of beneficiaries served</p> <p>Number of community members taking part in project</p>	<p>project staff and leaders surveys</p> <p>Document review</p> <p>observations</p> <p>Attendance register</p> <p>Community meeting interviews</p> <p>Home visits and community meetings reports</p>	<p>Community social workers</p> <p>Steering committee</p> <p>Rehabilitation specialists</p> <p>CED volunteer</p>	Random and purposive sampling	Descriptive statistics
To what extent did the activities of the project improve the	Number of beneficiaries served.	Beneficiaries, project staff and	Community social workers	Random and Purposive	Descriptive statistics

Evaluation question	Indicators	Data sources	Who collect data	Sampling approach	Analysis
living condition of people with disabilities in area?	<p>Number of beneficiaries referred to other specialized services</p> <p>Number of beneficiaries involved in different Community activities.</p> <p>Number of community leaders actively involved in promotion of the project</p>	<p>community leaders</p> <p>surveys</p> <p>Documents review: referral reports, attendance reports</p> <p>Field visit</p> <p>Observations</p>	<p>Steering committee</p> <p>Rehabilitation specialists</p> <p>CED volunteer</p>	sampling	field visit
To what extent did	Number of	Documents	social	Random	statistics

Evaluation question	Indicators	Data sources	Who collect data	Sampling approach	Analysis
the Local Organizations, Government authorities and other development partners contribute towards addressing to the needs and rights of people with disabilities?	organisations collaborating with this project. Vivid support from the government	review: referral reports, Field visit Observations Visitors book	workers Steering committee Rehabilitati on specialists CED volunteer	and purposive sampling	
To what extent did the Community participated in the project activities?	Number of community members actively involved in daily activities of the project. Number of people	project staff and leaders surveys Document review observations Attendance register	social workers Steering committee Rehabilitati on specialists	Random and purposive sampling	statistics field visit

Evaluation question	Indicators	Data sources	Who collect data	Sampling approach	Analysis
	attending different occasions organized by the project	Community meeting interviews Home visits and community meetings reports	CED volunteer		
Did the scarce resources available used effectively to achieve the project objectives?	Number and types of available resources Number of beneficiaries benefit from available resources	Financial statements Documents /ledger review Observations	Steering committer treasurer Secretary	Random and Purposive sampling	Descriptive statistics

5.2.2.1.1.4. TOOLS FOR DATA COLLECTION

During the formative evaluation, different methods were used to gather information. These methods included focus group discussion, observation, and review of project documents. Others were attendance register and monthly reports.

FOCUS GROUP DISCUSSION

Focus group discussion was done using the checklist prepared by the researcher before the interview.

The discussion was conducted by the steering committee by involving community leaders, parents of children with disabilities, people with disabilities and other community members in order to establish the progress of the activities aimed at achieving the goal of improving the living condition of people with disabilities in Arusha region.

OBSERVATION

Observation was done in a participatory process by attending different community activities such as community meetings and community rehabilitation clinics just to name few. The aim of this was to establish as to how the community members actively participated in the activities. This was also to observe as to how the members participated in the decision-making process, bearing in mind that the decision to start this project came from community decision. Observation method was used for the purpose of getting direct information about behavior of individual and groups that could not be expressed verbally or in writing.

REVIEW OF RECORDS

Record review was useful for determining the understanding of communities, parents of children with disabilities and people with disabilities themselves on the needs and rehabilitation actions that were to be undertaken in order to improve the living condition of people with disabilities in Arusha region. Different records such as community meeting reports and attendance records were reviewed. Quarterly reports assisted all stakeholders and donors to understand what decisions were to be made in order to improve project implementation.

5.2.2.1.1.5. ADMINISTRATION

Data collection and evaluation process were carried out by Community Social Rehabilitation Workers, Steering Committee, rehabilitation therapist and community members and CED volunteer through meetings and other occasions.

5.2.2.1.1.6. DATA ANALYSIS, INTERPRETATION AND REPORTING

Interpretation of data collected during formative evaluation was done by involving the steering committees, volunteers/specialists, community social workers and community members in meetings in two days meetings organized for this purpose.

5.2.2.1.1.7. TIMELINE FOR IMPLEMENTATION

Project activities were implemented from September 2005 to February 2007. Observation was done on monthly basis in order to identify changes over the living condition of people with disabilities and the quality and quantity of services provided by this project. A review of documentation was also done during the process.

5.2.2.1.1.8. FINDINGS

Findings of the formative evaluation were discussed during the meeting. A formal report was prepared for project staff and other stakeholders, who combined survey analysis using frequencies and percentages, qualitative data, observations, and information gathered from the document review done throughout the year.

- i. To what extent has the project improved the understanding of people about the rights and needs of people with disabilities in the study area?

Ninety percent of the respondents indicated that The Arusha CBR Support Unit has managed to raise awareness of the needs and rights of people with disabilities in Arusha region. The community in this regard has gained more understanding on what need to be done to improve the living condition of people with disabilities.

- ii. To what extent did the activities of the project improve the living condition of people with disabilities in area?

Ninety percent of the respondents noted that this project been able to carryout properly its activities aimed at addressing the needs people with disabilities in their localities. A remarkable change has been observed in those who have received different services.

- iii. Did the scarce resources available used effectively to achieve the project objectives?

Ninety two percent of the respondents were of the opinion that resources available were used efficiently by the steering committee in order to accomplish most of the objectives.

- iv. To what extent did the Community participate in the project activities?

Ninety five percent of the respondents were of the opinion that community participation was high in conception of the idea, planning and implementing the project activities.

- v. To what extent did the Local Organizations, Government authorities and other development partners contribute towards addressing to the needs and rights of people with disabilities?

Sixty five percent of the respondents were satisfied with what the government and other organizations were doing to address some of their needs through Arusha CBR Support Unit.

- vi. To what extent is the project implementation plan being followed as documented in the work plan?

Eighty five percent of the respondents indicated that the project was being implemented according to plan. The twenty percent were of the opinion that there were several changes during the implementation of activities which were observed. This could be the result of monitoring process, which forced the steering committee to change the sequence of some activities and review some of them according to monitoring results.

5.2.2.1.1.9. DISCUSSION OF THE FORMATIVE EVALUATION

The above results show that the project is being implemented well within track, the activities are timely done. There is a high level of community participation and that guarantees ownership and continuity of the project.

5.2.2.2. SUMMATIVE EVALUATION

Summative evaluation measures the impact of the completed project. The result of summative evaluation can be used to recruit new host sites, funding sources, and participants, and to publicize the project. The summative evaluation often turns up unanticipated outcomes, identifying aspects of the project that would be otherwise overlooked. The evaluation issues considered in this project were; Relevance, Project Design and Delivery, Program Success and Program Cost-effectiveness.

5.2.2.2.1. SUMMATIVE EVALUATION METHODOLOGY

5.2.2.2.1.1. EVALUATION OBJECTIVES

The evaluation of the project was undertaken with the following objectives:

- a. To assess the degree to which the programme targets and objectives have been achieved.
- b. To examine whether the activities of the project have been carried out according to schedule.
- c. To assess the impact of the project on people with disabilities, their families and the society.
- d. To ascertain whether the objectives of the project addressed the needs originally identified.

5.2.2.2.1.2. THE CHOICE OF PARTICIPATORY RESEARCH METHODOLOGY

In order to evaluate the role played by the Arusha CBR Support Unit in their living condition of people with disabilities, their families and community at large, participatory method (qualitative participatory research approach) was chosen as the main best option for this exercise. Reasons for this choice are as follows:

- a. Participatory research that expands the knowledge and awareness of both.⁷⁷ It is a learning process for all involved, and not just a process whereby some people accumulate information about others. Local people and professional researchers are equal in the research process; they are both researchers and learners.⁷⁸
- b. The goal of this research is social change derived from the information gathered. Knowledge gained in the process can be translated immediately into action for social change. Local people through participation control the process of problem definition, information gathering and decision about the action to be taken based on the information given.⁷⁹
- c. The idea to start this project was born from the community and planning and implementation was carried out by the community through selected representatives. Evaluation was also planned to be a participatory evaluation to be undertaken by the community.

5.2.2.2.1.3. THE SAMPLING PROCEDURE

Three basic sampling methods were used during formative evaluation were also used for summative evaluation. These were probability, non-probability method and purposive sampling.

PROBABILITY SAMPLING METHOD

This is a method whereby each person in the population has an equal chance of being selected.⁸⁰ This method was purposefully chosen because its resulting sample is said to be representative. In addition to that this method proved to be very instrumental during the collection of Community Needs Assessment information and formative evaluation. Two probability-sampling methods were selected.

⁷⁷ Brown LD, Organizing participatory research: interfaces for joint inquiry and organizational change. *Journal of Occupational Behavior*, 1983.

⁷⁸ Couto R, Participatory research. *Methodology and Critique, Clinical Sociological Review*, 1987.

⁷⁹ WHO, Op.Cit, 2002, p. 18.

⁸⁰ Arlene Fink et al, *How to Conduct Surveys: A Step by Step Guide*, The International Professional Publishers, Newbury Park London, 1985, p.53.

The first method, which was selected, is simple sampling. “In simple random sampling, you choose a sub-set of respondents at random from a population”⁸¹. This method was purposefully selected because it was familiar to all who were involved in the exercise.

NON-PROBABILITY SAMPLING METHOD

A non-probability sampling method, which was used, is accidental. Accidental samples were used, especially, while doing home visits in different communities. Interviews or observations were made when people were available. This method was also selected by the researcher because it was effective during the Needs Assessment Survey and formative evaluation. In addition it was familiar to most of the people who were collecting data.

PURPOSIVE SAMPLING

With purposive sampling, the assumption is that with good judgment one can handpick a sample. This method was used because the evaluation team wanted to select respondents who took part in formative evaluation to take part also in this evaluation.

5.2.2.2.4. RESEARCH UNIVERSE/POPULATION SAMPLING

Purposive sampling was used to select 30 parents of children with disabilities and adults disabled person who have received project services to be interviewed. Out of this number 25 parents, constituting 83% of the expected parents sampled responded to the survey. We also used purposive sampling to select 10 NGOs leaders who were collaborating with this project and ward Executives. These were respondents who took part in formative evaluation. This was done so because the evaluation team agreed that those involved in formative evaluation had gained enough experience which would be very useful in ensuring that evaluation results were genuine. Those above mentioned took very active role in the whole process of evaluation. In addition to the group mentioned above, random sampling was used in the sense that all community members who attended community

⁸¹ Ibid. p.56

meetings were part of the evaluation exercise. Records show that the total community members who took part in the whole evaluation exercise during community meetings was 269 people.

Table 12. Summative Evaluation Questions

Summative evaluation issues	Evaluation Questions
Rationale/relevance	<p>Is the Project implemented within its objectives?</p> <p>Is it the most appropriate response to the needs of the community?</p> <p>Should the Program's objectives and/or the expected results be expanded or restricted?</p>
Design, delivery and management	<p>Are activities logically related to required outputs?</p> <p>Do all activities and outputs contribute to meeting the Projects objectives?</p> <p>Are any current activities or outputs not needed?</p>
Success/impact	<p>To what extent is the project achieving its expected results?</p> <p>Are the community satisfied with the services and support offered by the project?</p>
Cost-effectiveness/ alternatives	<p>Is the current project design the most effective and efficient way to achieve outcomes?</p> <p>Are the resources that have been allocated being used in the most efficient and effective way to deliver appropriate results?</p> <p>How do the government and other organizations contribute in order to ensure that project objectives are met?</p>

5.2.2.2.1.5. DATA COLLECTION TOOLS/TECHNIQUES

Data collection was a continuous process throughout the project period. Baseline data was collected in the beginning of the project in order to have a reference point from which to judge a project's impact. Both qualitative and quantitative methods were used in gathering information. The following research instruments were used to gather data for evaluation:

COMMUNITY INTERVIEW MEETINGS

Community meeting within the context of evaluation purpose can be defined as a structural assembly for a group of people that provide a forum either for hearing of issues or presentation of evaluation results/findings, a discussion of evaluation recommendations and/or decision making or plans of action. It is also a forum of information gathering. There are two types of community interview meetings namely; community interviews (all members of the village are invited) and focus group interview (participation is limited to few selected individuals)⁸². The former was selected because of the following reasons:

- a. Can gather information fast from many people.
- b. Respondents can correct information provided.
- c. Non-verbal behavior can also be recorded.
- d. Cost effectiveness.

PARTICIPANTS OBSERVATION

Observation was one of the ways used by evaluation team in order to collect data. In this case, conversations, non-verbal communication, general behaviour of respondents and the environment in general were observed. This method was chosen purposefully to compliment other methods, and

⁸² Franci W. Mulwa, Op. Cit. p. 193.

especially, interviews. In addition to that in some circumstances people would shy off from interviews, and therefore, observation seemed the best data collection tool. Further more, this method require minimal preparation.

ANALYSIS OF RECORDS AND REPORTS

A detailed checklist on different kinds of written documents was carried out by the evaluation team.

The documents include:

- a. Original program implementation plan.
- b. Letters and papers relating to project.
- c. Regular progress reports.
- d. Project monitoring records.
- e. Project budget and financial reports.
- f. Meetings minutes.
- g. Community meetings and home visits records.

This tool was selected because it was believed by many people including the CED volunteer that analysis of records available, if carefully done would meet more than half of the evaluation objectives. In addition these documents were reviewed because they provide the original plan and actual implementation of the activities.

PHOTOGRAPHS AND PICTURES

These were used to provide vivid documentation of project outcome. These were selected because of their power to convey message and especially in rural areas.

5.2.2.2.1.6. ADMINISTRATION

Data collection and monitoring process was carried out by Community Social Rehabilitation Workers, Steering Committee, CED volunteer, rehabilitation therapist and community members through meetings and other occasions.

5.2.2.2.1.7. DATA ANALYSIS

The interpretation of data collected was done in participatory way involving the steering committee, community social workers, community members, rehabilitation specialist and other volunteers who were willing to take part. Two community meetings for this regard were organized. Data compilation and report writing were done by the steering committee in collaboration with the volunteers available.

The study used observational descriptive design so as to get as much information for the evaluation purposes. The summative evaluation focused on concrete measurable CED outcomes that derive directly from the project. These include, number of people with disabilities served, rehabilitation clinics done, number of home visits made and number of people referred by this programme to other social services, to mention few. It is important to note that the process of data collection was done throughout the implementation period. A summative evaluation plan was developed in order to guide the evaluation process.

Table 13. Summative Evaluation Analysis Plan

Evaluation issues	Indicators	Data sources	Who collect data	Sampling approach	Analysis
1. Rationale/relevance	The extent to which project activities address needs identified	Community meetings and community leaders surveys, key informants Document review and reports Community interview meetings Participants observations Pictures	Members of the steering committee Rehabilitation specialists Community social workers CED volunteer	Random and Purposive sampling	Descriptive statistics Training observation
Design, delivery and management	Number of community social workers	Project staff, beneficiaries and steering	Steering committee	Random and purposive	Descriptive statistics Observation

Evaluation issues	Indicators	Data sources	Who collect data	Sampling approach	Analysis
	trained in rehabilitation activities skills Number of training tools used and the extent to its relevancy	committee. Community leaders surveys Document review Training session observations	Rehabilitation on specialists CED volunteer	sampling	of service delivery and beneficiaries
Success/impact	Change in knowledge about rehabilitation Change of attitude towards people with disabilities Changes in practice of	Community meeting interview, key informants, clan leaders, community leaders, beneficiaries, parents	Steering committee Rehabilitation on specialists CED volunteer	Random and Purposive sampling	Descriptive statistics

Evaluation issues	Indicators	Data sources	Who collect data	Sampling approach	Analysis
	people with disabilities				

Evaluation process was undertaken as planned. The process involved a number of activities which included; Review of documents, face to face discussion with key informants like people with disabilities, local community leaders, some influential personalities in the communities such as clan leaders and parents of children with disabilities to evaluate changes which occurred during the stated period.

5.2.2.2.1.8. EVALUATION RESULTS

The evaluation data show that the strength of this project has mainly been in terms of social change process that it has managed to start and develop in the community. The evaluation survey gives evidence that this initiative has started change process in communities targeted and brought about improvement in the quality of life of persons with disabilities in the operational area. However, the number of communities and persons with disabilities that have been reached is still very small. According to the records, only 381 people with disabilities were reached in the during the project implementation span. In other words, only 0.4% of the population of people with disabilities was served by this program that year. Basing our conclusions solely on numbers may be misleading simply because service provision to people with disabilities are very costly and rehabilitation and attitudinal change process in most cases takes long. In order to have a wide overview of the results of evaluation conducted, it is important to focus on the following elements:

QUALITY OF LIFE ANALYSIS

Arusha CBR seems to have started the change processes in social norms and values, which are essential for the further development of quality of life of people with disabilities in the communities. This study shows that the project has improved positively on the following aspects of the living condition of people with disabilities: self-esteem, social inclusion, acceptance and self-reliance. 80% of respondents reported that there has been increasing interest in the situation of persons with disabilities brought by The Arusha CBR Support Unit in their different communities.

Firstly, the study shows that this project has increased self-esteem as reported by people with disabilities, parents and other community members who have received services from this programme. Through this initiative, people with disabilities have become visible and shown that they can contribute to family life and in the community at large. A Case Study of Neema clearly illustrates this.

Through community meetings interviews and observation we realized that, parents/family members become proud when their children improve their social behavior, develop new skills and communicate better. 76 percent of the interviewed parents/guardians, whose children received project services, revealed that their children have demonstrated improvement of their behaviors/conditions against 19.7 percent who saw no changes and 1.5 percent who saw deterioration of their children condition. We were then interested to know more as to why some children did not show any improvement or even others saw their children deteriorating. Five of the parents interviewed revealed that they expected their children to improve immediately since there were qualified staffs who visited them in order to provide rehabilitation services in the communities. But to their surprise their children have not been able to be independent, as they grow older. Two of these parents said that they could not follow up all the instructions given by project workers because this could imply that they spent most of their time at home while they have no means to live.

When we asked community social workers and rehabilitation specialists about this situation they responded that rehabilitation process may take long or short time depending on the type and severity of the problem. They further revealed that this has been a major challenge even for them because some parents when they bring their children for rehabilitation process they expect sudden change. They always advice parents to play their part and that rehabilitation process does not intend to cure disability but rather enable people with disabilities to live better with their disabilities. Other adults with disabilities who were very proud about themselves were those who could contribute to the well being of their family, maintained themselves independently, contribute to the development of the community and ability to perform well in schools.

Secondly, this project has played a big role in fostering social inclusion and acceptance of people with disabilities in the operational area. In fact this is one of the major primary goals of establishing this program. When looking for reasons which have fostered inclusion and social acceptance of people with disabilities in different communities, the major reasons highlighted by respondents were:

- b) Community leaders, members and families of people with disabilities have been informed about disabilities, their causes and the way to support children and adults with disabilities.
- c) The project offers different rehabilitation services in the communities which have made people with disabilities visible.

56% of respondents revealed that persistent discriminatory attitudes towards disabled children and other people with disabilities have been reduced by promotion of collaboration among all partners in areas where the project works. Typical statements given by people with disabilities and family members were:

“Previously, I feared myself and others, I felt very inferior but since I came into contact with this project I feel a changed person, I can now asses myself with others and say that I can perform certain activities and tasks better than able bodied”

Thirdly, this project has played a positive role in the living condition of people with disabilities in developing self-reliance. Many children and adults with disabilities have been given training in daily living skills. Most of rehabilitation activities done at the centre and in the communities are geared towards enabling people with disabilities to be self-reliant to the maximum of their potentials. Social counseling, referral services, advice of daily living skills and mobility devices are the major factors highlighted by people with disabilities, family members and leaders as to have contributed significantly to improvement of living condition of people with disabilities in the operational area.

ANALYSIS OF ACTIVITIES

Activities which were considered most useful by (respondents) persons with disabilities their families and community members were; social counseling, training in mobility and daily living skills, parents meetings, community awareness meetings, eye screening, and facilitating people with disabilities to access different services. Others included provision of assistive appliances, therapy and home visits. In analyzing the impact of the activities implemented by this project in the context of United Nations Standard Rules, the following can be observed:

Firstly, awareness rising was perceived as an important and successful part of the project that has impacted positively on the quality of life of people with disabilities in the operational area. The activities such as social counseling to families and individuals, community meetings and house to house surveys, just to name few have played a big role in this.

Secondly, access to medical care was reported to be limited by majority of respondents. About 70% of the parents and people with disabilities interviewed highlighted that early detection and treatments,

especially for children, are inadequate in most communities in the operational area. This is aggravated by lack of appropriate knowledge at primary health care level and the referral services such as KCMC are expensive for most of the disabled people and their families.

Thirdly, rehabilitation and support services such as social counseling, advice and training in daily living skills that were provided contributed greatly to improving the living condition of people with disabilities in Arusha region.. This according to 76% of the parents of children who have received services provided by this programme admitted that they have increased self-esteem and self-reliance to their disabled children and themselves as parents. A number of children have received physiotherapy and occupational therapy.

5.2.2.2.1.9. SWOT ANALYSIS

SWOT stands for strengths, weaknesses, opportunities and threats the organization faces. This analysis was done to map the organization position and determine the way forward. This was done by the evaluation team which compiled the information gathered by using different tools discussed above.

STRENGTHS

- a) It is it has started to be known and accepted by many people in the communities where it operates.
- b) Good networking/relationship with other organizations with related mission
- c) Committed members of steering committee and volunteers.
- d) High support from the community.

WEAKNESSES

- a) Too much foreign donor dependency, this hamper sustainability because of the unreliability of the funding
- b) Small number of personnel in relation to the vast area it is providing its services. This may lead to inefficiency in service delivery as many people will need to wait very long before they get services. This is due to lack of adequate resources.
- c) Lack of adequate staffing due to the limited resources.

OPPORTUNITIES

- a) Government new policy on disability of 2004 and political will, encouraging non governmental organization to take active role in such endeavors is a good indication that that this programme can operate in good environment.
- b) Good network with other stakeholders addressing similar or related problems
- c) Donors willingness to support this project
- d) Committed steering committee and social community workers.
- e) Many parents, disabled people and community local leaders who are ready to support the implementation of this programme.

THREATS

- a) Poverty of the target population, some people fail even to afford bus fares to and from the programme centre. This also bar them from accessing rehabilitation services when they are referred to other rehabilitation programmes which can address their needs.

- b) Ignorance of some parents, so it may be difficult for them to understand and pass training to disabled children.

5.2.2.2.1.10. SUMMARY OF FINDINGS

This section of the report presents the summary of findings:

1. Is the Project implemented within its objectives? Is it the most appropriate response to the needs of the community?

Following findings from observation, document review and structured discussion with k people, clan leaders, beneficiaries, parents of children with disabilities and other stakeholders, it was revealed that the project is working within set objectives and is the most appropriate response to the needs of people with different kinds of disabilities in Arusi region.

2. Should the Program's objectives and/or the expected results be either expanded or restricted?

According to the results from interviewed respondents the project can be extended to other Wards but more support from donors, government, community members and other organizations addressing different needs of people with disabilities are urgently needed to achieve this.

3. Are activities logically related to required outputs? Do all activities and outputs contribute to meeting the Projects objectives? Are any current activities or outputs not needed?

From observation and results of the document review it be concluded that all activities contributed in one way or the other to achievement of the project objectives.

4. Are the community satisfied with the services and support offered by the project?

Survey results from focus group discussion with key informants and review of documents revealed that the community is satisfied with the services provided by the project.

In a span of 18 months project life, the project has been successful in achieving its goal which is, to improve the quality of life of people with disabilities in Arusha region by promoting Community Based Rehabilitation strategy.

5.2.2.2.1.10. SUSTAINABILITY

Sustainability as is for other CBR programmes the following three factors are necessary:

- a) Articulation of the need.
- b) A response from within the community indicating readiness' to meet this need.
- c) The availability of support from outside the community.

One cannot expect community involvement without a perceived need, and support should be offered to the community only when it is willing to address that need. The Arusha CBR Support Unit believes in this philosophy that is why before embarking in service delivery in different communities, meetings are organized in order to identify needs with the local communities' leaders and members. Politically speaking, an isolated programme which is not related to some government policy or other programmes has limited chance to be sustained. The program has mobilize different communities so that they take the fore role in ensuring that people with disabilities get rehabilitation services in their respective communities by paying (contributing) for some services they receive.

- a) Training more community social workers from the different communities so that they may be able to undertake rehabilitation services in their respective communities.

- b) In most rehabilitation activities, this programme uses locally available resources. For instance, local people produce special appliances such as special chairs and table, just to name few, by using locally available resource.

This project is ensured of sustainability through the capacity building given to the community social workers, local leader and the community as a whole in the identification of the social problems faced by the community and coming up with the solutions using participatory approach. This therefore has created a good social environment which makes the project to be well accepted among the community members.

Technical sustainability is also guaranteed by the training in project planning and management and basic rehabilitation skills training given to community social workers and the steering committee.

According to study results, Arusha CBR Support Unit is well accepted in the community and it has been working hand in hand with the community members through steering committee selected by community members themselves. In other words there is a strong sense of ownership of the project, which is very important factor for sustainability.

Last but not least, this project is receiving support from both community members and other donors. Members of the community and other stakeholders are also ready to offer their material and financial and technical support in terms of labor and knowledge in order to ensure that that planned activities are implemented accordingly. During the implementation period Arusha CBR Support Unit received fund and other supports from Action for Children in Conflict, Kilimanjaro CBR, the steering committee members and rehabilitation specialist to name a few..

Politically speaking, the project is well supported by the political local leaders and the government as whole and other organisations. The adoption of National Policy on Disability in 2004 give evidence to the political will to support initiatives like this.⁸³.

⁸³ The Government of Tanzania, National Policy on Disability (Dar Es Salaam, Government printers, 2004).

CONCLUSION

This chapter has given a comprehensive elaboration on how monitoring and evaluation were conducted by Arusha CBR Support unit in order to ensure that the programme was achieving its objective. The results of the evaluation, which have been to a great extent qualitative in nature, indicate that the project is going in the right direction despite many challenges which have caused some difficulties during the implementation.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0. INTRODUCTION

This part highlights the results of this project, makes the conclusions and also draws recommendations that can be adopted in order to increase accessibility or inclusion of people with disabilities in different social services and other societal activities such as employment in the area where Kilimanjaro Community Based Rehabilitation operates.

6.1. SUMMARY RESULTS

The accessibility challenges identified during the study are environmental, economic, social and institutional. These can further be elaborated as follows:

The findings indicate that there are a number of challenges that hinder people with disabilities from accessing different social services and partaking in society activities. Among these were those associated with physical structures, services located far from the reach of people with disabilities due to transport and poverty problems, lack of assertive aids and appliances, low household income and negative attitudes towards people with disabilities.

Although both male and female with disabilities faced a number of challenges, their challenges were quite different due to gender biasness that exists in most of the communities in the study area.

Socially, the negative societal attitudes have limited people with disabilities from accessing different services and societal activities through stigmatization and isolation.

Politically, the policies, few laws and programmes that can be used to enforce the inclusion of people with disabilities exist but are not well implemented. There is still lack of knowledge among civil

society, especially, the communities in the study area about the existing policies on inclusion of people with disabilities.

Basing on the findings of this study, people with disabilities in Arusha region are to the great extent excluded from different social services and societal activities. This is due to different factors that have widely been explored. These findings are important to all stakeholders. In order to address the issues highlighted above, the CED project was conceptualized and implemented in the study area. The study shows that the impact of the CED project is evidenced in the following area:

- a) At the individual level there had been, overall, a change from passivity, dependence, sometimes abuse and neglect, to a situation where the disabled person is enabled to utilize his/her potential and to contribute to the family and community.
- b) At the family level the programme has meant improved family relations and a considerable improvement for many women, who tend to be the primary carers. For women especially it has led to a way out of isolation, and the release of human resources within the community especially for the care of disabled children.
- c) On the community level there are strong indications that significant changes have occurred: disability issues that were previously neglected have come to the forefront, kindergartens and schools have become more receptive to children with disabilities, disabled people are accepted as participants in community life, both socially and politically, and communities have indeed acquired a deeper understanding of what community building means.

What is important to keep in mind about these results is that once disabled people are fully included, the entire community is enriched.

In our own experience, and probably yours as well, when disabled children are included in regular schools, if this is done well, the atmosphere in the whole school changes. The inclusion of disabled

people opens up a different kind of understanding, not just about disability but about the mystery of human life.

6.2. CONCLUSION

Partnership is the key to progress. Communities, parents and disabled people are potential resources to be drawn upon through a process of community consultation. The Arusha CBR Support Unit workers will be in a key position to liaise between the key players, but they should be encouraged to share this responsibility with teachers, people with disabilities, community and religious leaders and all other initiatives aiming at improving the living condition of people with disabilities.

In order for this project and other similar initiatives to achieve its objectives, it is necessary to involve all the stakeholders mentioned above. The rehabilitation process needs to shift from rehabilitating people with disabilities to rehabilitation of the society and from rehabilitation on basis of charity to rehabilitation on basis of right.

After the completion the first year of project implementation all members were in favor of continuing with the current program with the steady expansion basing on the deliberations; to increase advocacy and education on the program especially to “uncooperative” leaders and larger community, seeking other viable sources and spread the base of funding, increase cooperation with other stake holders to effectively realize the objectives.

6.3. RECOMMENDATIONS

In order to improve this project and other similar initiatives the following recommendations may be of great help:

- a. The project should give more rehabilitation education to parents and guardians. We recommend the organization to work on it since this will lead to programme sustainability, as

more people will be able to provide simple rehabilitation services in the communities where they live.

- b. It is important to increase cooperation with stakeholders so as to improve its services.
- c. Efforts should put on improving economic positions of parents. We recommend the programme to liaise with organizations with such objectives so that they can address the same. This is due to the fact that most of the people with disabilities and their families still live in abject poverty despite the implementation of this project, which in a way hinder them from accessing some services. This problem was clearly highlighted during the community needs assessment and during evaluation, most of people who aired their views pointed out to this problem again.

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