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Making sense of rehabilitation projects: classification by objectives

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Summary Rehabilitation of disabled persons can take many different forms according to the socio-cultural and political context in which it is undertaken. Some approaches have emphasized the restoration of the physical function of the client, while others have looked beyond to psychological and social well-being. Some have built on the expertise of professionals while others have emphasized the caring capacity available in the family and the community and sought to reinforce it. Besides providing a wide range of possible services to disabled persons, rehabilitation seeks to change the attitudes that prevail in society as a whole and promote the integration of disabled people into society with equal rights and opportunities. This paper reviews a range of models and approaches which have been put forward in the international debate on rehabilitation. Furthermore, four dimensions are described which can be used to characterize and define classes of rehabilitation projects based on the objectives that are defined for them. Thus types of rehabilitation projects can be distinguished. Management, evaluation and technical support for rehabilitation projects need to take these essential characteristics into account.

Introduction

With the introduction of new multi-drug treatment in 1982, substantial progress has been made towards ridding the world of leprosy. However, there remain many millions of people who are clinically cured but still suffer the consequences of the disease. Greater priority is now given to their physical, psychological, economic and social needs as reflected in the variety of rehabilitation programmes in countries around the world. This change of emphasis is a feature of the work of the Leprosy Mission International (TLMI). The present paper arises

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from the need of TLMI to evaluate the success of such programmes and to ensure that lessons learned are shared and applied for the future benefit of all those involved.

The rehabilitation of people affected by leprosy is concerned first of all with people and secondly with the variety of forms of disablement related to leprosy. While there is a parallel with the development of Community-based Rehabilitation (CBR) that took place over the past 2 decades, people with disabilities due to leprosy are more strongly stigmatized than most people with disabilities. The present paper therefore discusses historical and current models of CBR and considers their applicability to the field of leprosy. This results in the identification of a number of basic dimensions or objectives of CBR which may be used to classify projects, identify priorities and focus evaluations.

Towards a working definition of CBR

In 1994, UN agencies including WHO and ILO issued a joint statement, based on the early work in the 1980s of WHO and ILO in field testing CBR. This UN document was a consensus document which emerged after years of debate between the two UN organizations about what had to be considered as CBR. CBR was defined as a strategy within community development for the rehabilitation, equalization of opportunities and social integration of people with disabilities [1]. It is achieved through the combined efforts of people with disabilities, their families, and communities and the appropriate health, education, vocational and social services. For present purposes we will adopt the UN statement of the three-fold aims of CBR[1] as our starting point:

- Improvement of physical, social and psychological function of the person with a disability.
- Solidarity with those who are denied their rights and working for the adaptation of society.
- Working for integration and equality of rights of those with disabilities within the mainstream of community life.

We would like to emphasize that integration and equality of rights should be made operational to such an extent that people have equal enjoyment of rights within the confines of the socio-economic, cultural and political context. We would like to bring out two principles that are implicit in the above definition:

- Rehabilitation should where possible be part of community development.
- Rehabilitation is achieved through multisectoral collaboration.

These basic elements of CBR are supported by and continue to evolve through an extensive body of research and professional publications, which report field experience, define elements of best practice and discuss models and issues. There is no single pattern of service delivery that can fit all areas,[2] so applications of the CBR philosophy are very diverse and reflect the variety of cultures and levels of development throughout the world.[3] The diversity of programmes has given rise to rhetoric and claims that have contributed to a considerable amount of confusion over what CBR is. Some people go as far as saying that 'CBR is what people say it is'.[4] Wolffers and Finkenflugel are, however, convinced that the different interpretations refer mainly to conflicts of interest and therefore conclude that CBR is not 'what people say', but rather is an *approach and an attitude* towards rehabilitation whereby people with disabilities and caregivers define their own needs and negotiate with rehabilitation workers and policymakers to improve their living circumstances and to play their full part in society.[4]

Defining disablement

The World Health Organisation, in its International Classification of Impairments, Activities and Participation,[5] describes the impact of a disease on an individual in terms of impairment, activity or participation. In the context of leprosy these may be understood as follows:

- Impairment. A primary impairment may take the form of nerve damage, eye damage, facial deformity or personality disorder. Ulcers, bone loss and contractions are secondary impairments.
- Activity. An activity is the nature and extent of functioning at the level of the person. Activities may be limited in nature, duration and quality (ICIDH2).
- Participation. Participation is the nature and extent of a person's involvement in life situations in relation to Impairment, Activities, Health Conditions and contextual factors. Participation may be restricted in nature, duration and quality (ICIDH2).

Thus impairment may lead to limited activity and/or limited participation. In many countries, the diagnosis of leprosy alone may restrict participation, even where there is no impairment. In the present document and in the context of leprosy, the term disablement or disability may refer to any level of impairment or any level of reduced activity or participation.

Issues in CBR development

A number of issues in CBR classification arising from the reviewed literature are discussed under the following headings.

PRIORITY

In developing countries the provision of services for those with disabilities is always of lower priority than education, water supply and employment. Services to those with disabilities living in rural areas and urban slums are largely the responsibility of the private or voluntary sector and generally receive little attention of governments.

KNOWLEDGE AND ATTITUDES TO DISABILITY IN THE COMMUNITY

The most realistic and frequently achieved form of participation in the rehabilitation process is the involvement of the close relatives of those with disabilities.[6] The WHO statement has been criticised for not placing enough emphasis on this point. Others have commented that it is not realistic to expect the entire community to become involved in rehabilitation activities.[7] This is why some CBR programmes try to get influential people with close experience of disability, either in themselves or in a close relative, involved in their programmes, since these key activists are the most likely persons to bring about substantial change in resource allocation and public attitudes. Closely linked to the issue of community participation is the claimed integration of people with disabilities into society.

FEASIBILITY

CBR has been proposed over the past 2 decades as the best and only way to meet the needs of people with disabilities in lesser-developed countries. It is seen as the best way to integrate

people with disabilities into mainstream social life. It is regarded as the most cost-effective rehabilitation approach given shortages of qualified rehabilitation personnel and other resources. While it has been criticised as a second rate service for the poor living on the fringes of society, there are many situations in which it must be recognized as the only practical way to meet needs in a different and hopefully more favourable way than the coping mechanisms.

MANAGEMENT

Sony Gill[8] identifies primary elements of CBR, three of which match those quoted above. He adds a fourth element, which recognizes the vital role at national, regional, district and community level of planning, managing, and monitoring CBR programmes. Recognizing the contribution of managers and the importance of monitoring systems embraces the project cycle approach and the need for projects to pay attention and respond to information coming from the field.

HUMAN RIGHTS

At the 1998 Harare Conference, Miles[9] referred to a number of issues that need to be considered when developing models of disability service delivery. With its western bias the Disability Movement tries to portray disability as a rights issue and uses slogans derived from the individualizing societies of educated, urban Northerners. Miles warns that the rhetoric of CBR tries to appeal to 'traditional community spirit', however weak or failing, to support and include people with disabilities. He points out that the now well-known slogan 'Nothing about us without us'[10] is misleading, since most modern life involves trusting strangers to play their part. Similarly, the contribution of specialists who are not themselves disabled should not be discarded off-hand. In many of the countries in which TLMI works rights issues are concerned with issues of access and equality of opportunity. These are the emphases that will in many situations provide an entry point for new programmes and activities.

GLOBALIZATION AND UNIFORMITY

Current trends towards the globalization of ideas, information and the media contrast with practical respect for differences of culture and concepts of disability related to them. Miles[9] has described the continuing struggle between the search for uniformity, for example in the form of mass-directed 'best packages' as recommended by WHO or UNESCO, and an approach which is strongly local, small scale, which allows choice, takes risks and allows mistakes.[11] The value of the local is recognized, though it must be workable and have credibility in the eyes of those in authority.

Many of the issues that we raise here refer to rehabilitation policy and planning, in which various stakeholders with different agendas and ideas defend their interests. It seems that quite often policy debates concentrate around issues such as power and control. The various CBR models signify a need for strengthening community components. This can only be achieved by organizing people with disabilities, and the communities in which they live, focusing on felt needs and fostering active involvement in negotiation and shared decision-making [5] as an essential characteristic of CBR development.

Models of CBR

There has been a tendency to address rehabilitation needs through the delivery of professional services, for example, combinations of medical, educational, economic (vocational), or community development activities.[12] The limitations and failures led people to develop alternative approaches, involving relatives of disabled people (Helander)[13] or disabled persons themselves (Werner)[14] as service providers. As opportunities have arisen and new programmes have been launched, alternative frameworks for understanding CBR have been formulated. The following headings provide a brief description of some of these.

HISTORICAL DEVELOPMENT

Miles[15] recognizes an historical evolution of five models for CBR, each with access to, or making use of, different levels and kinds of 'information' and each with its own unique strengths and weaknesses. *Traditional* rehabilitation is the established response to disability in the community, rooted in local religion, ideology and economy and often stigmatizing. Local healers, holy persons, people with disabilities and their relatives are the actors. By recognizing this traditional model, Miles emphasizes that nobody is starting from scratch. The planning of a new programme must acknowledge and build on the context of traditional knowledge, local skills and the coping mechanisms that have existed for thousand of years. Between 1950 and 1980, there was a large expansion of technological innovation. Capital-intensive treatment methods were concentrated in medical institutions, hence *Institution-based* rehabilitation. From 1970 onwards, a new emphasis developed on consumer self-advocacy, self-help, integration, normalization and de-mystification. Activities took place in the local community and in the homes of people with disabilities – *community-based* rehabilitation. In the 1980s and 1990s, the *resource centre* provided a middle way between the institution and the home, where people with disabilities and their families can meet and obtain services they cannot use at home. I*nformation-based* rehabilitation came up in the 1990s, which is described by Miles as an analytical tool for examining different strategies and building an understanding of what is going on and how more resources may be brought into play. As such, it is not in competition with other approaches.

PHILOSOPHY

The philosophies underlying current rehabilitation programmes vary. *Individual, service or medical* models usually aim to 'cure' the existing impairment and/or to 'care' for the disability. These models have the advantage of offering what families, communities and many people with disabilities actually want and ask for. By contrast, in *social* models the focus is on empowerment and enabling. The staff in such programmes have a facilitating function, building partnerships with people with disabilities. They impart skills and knowledge, which enable people with disabilities to become responsible for their own development. The existing power base is changed so that people with disabilities are able to exert influence over their own affairs. *Inter-sectoral* programmes can also be found with links to primary health care and community development and having characteristics of both the individual and the social model. Murthy and Gopalan[16] identify specific aims such as medical interventions, educational components such as the transfer of skills and knowledge, awareness raising and prevention, economic, vocational, advocacy, issues of legal restrictions, social aspects and technology.

STRUCTURE

Peat and Boyce,[16] Miles[9] and others refer to different contexts or structures in which CBR takes place:

- *Institution-based*: rehabilitation which takes place within specialized centres, designed and controlled by professionals in which resources, technology and interventions are delivered at a high price to usually few people.[17] Professional staff and 'clients' are the actors. Activities take place in urban rehabilitation centres and special schools. While historical institution-based rehabilitation is currently seen as contrary to contemporary notions of rehabilitation needs, there is an awareness of the potential of appropriate and complementary institution-based services.
- *Networking*: the model emphasizes the co-ordination of services and programmes and looks to optimize the use of available resources, ensure access to services and the avoidance of duplication and of competition for scarce resources.
- *Outreach*: provision of therapeutic and/or medical services at clinics, community centres and the homes of people with disabilities.[9] In such programmes strong emphasis is placed on accessibility and contextualization of the given intervention.
- *Non-service programmes*: those that facilitate CBR but may not themselves offer direct clinical services – manpower training, awareness raising and community mobilization programmes; preventive and promotive activities, vocational training programmes of people with disabilities, strengthening of support groups.
- *Resource-centre based*[15,18]: an approach that acknowledges the importance of user-friendly community-centred or community-based institutions.[19] People with disabilities and their families and skilled persons are the actors. Werner in Projecto Projimo in Mexico mobilized local people, many of them disabled, to start a – now famous – villager-run rehabilitation programme for children with disabilities in the western part of Mexico.[14]
- *Home-based rehabilitation*: emphasizing that rehabilitation starts and takes place in the individual's home and within the community. Traditionally, women already provide care to their disabled relatives regardless of any CBR scheme. The challenge of home-based rehabilitation is to offer knowledge and skills to enhance the effectiveness of what they (already) do, and perhaps to remove the necessity for them to do most of it. Financial and economic implications are not well documented and raise questions as to sustainability of this model in lesser-developed countries.

ORGANIZATIONAL AND PROGRAMME ISSUES

- *Principles*: the fundamental principles incorporated in the mission statement or constitution of the organization will have a direct bearing on the project. The manner in which these principles are applied in daily activities needs to be scrutinized and their impact on programmes understood.
- *Human resources*: Periquet[20] describes CBR in terms of human resources and the roles of non-professional, semi-professional and professional workers. Effective decision making, accountability, responsibility and control are directly related to the human resource base available within the project.
- *Origin*: Kisanji[21] classified CBR according to the origin of the programme, whether it is a national or regional government programme, a programme developed by a non-governmental organization whether national or international, or a community or individual

(grassroots, persons with disabilities). Community-owned programmes can have an empowering aim and role, though this is not exclusively the domain of such programmes. NGOs may follow the aims and activities set by national government rehabilitation policies. There is always a risk that successful local initiatives will lose important aspects of CBR (community participation and ownership) in the process of scaling-up through community-based organizations or NGOs.

- *Geography*: another way of classifying CBR could be by viewing the geographical situation in which CBR takes place. Urban CBR programmes require different approaches then rural or semi-rural ones. Some CBR programmes are implemented in slum areas with mobile populations constantly in search for work and shelter, where maintaining contacts with individuals is difficult.
- *Target group*: some programmes address special needs, such as children with disabilities or restrict their scope to people with specific disabilities, such as visual disabilities, children with mental handicaps, those affected by leprosy etc.

TOWARDS A MULTIDIMENSIONAL CONCEPT OF CBR

It is clear from the preceding brief discussion of issues and models that CBR is a diverse and complex subject. Peat[3] attempted to identify different project types and recognized a total of 20 CBR models. McColl and Paterson[22] describe the shortcomings of unidimensional conceptualizations of CBR and suggest a multidimensional framework for CBR classification. On the basis of qualitative information obtained from key informants, they identify six thematic descriptors of CBR programmes, divided in two sets: those that define programmes (aims, beneficiaries and strategies), and those that support programmes (human resources, structural resources and attitudes). These six dimensions (each with individual and community oriented aspects) are then used to define two, three-dimensional spaces, in which CBR programmes may be plotted and compared: the Defining Model and the Support Model. Miles,[9] though recognizing the merits of this cuboid classification, states that the complexity of this multidimensional model illustrates the difficulty of constructing a convincing classification. He argues that the information based approach leaves ample space for valuing each model in the context of history, culture and development.

In our view, a continuum exists on which distinct CBR models can be positioned on the basis of their philosophical starting points and subsequent approaches: at one end the *individual model* and at the other end the *social model*. These two ‘contrasting’ models will provide us with insight into a number of characteristics, which in turn will be essential in determining broad categories of CBR models. It should be noted that although the social model is nowadays viewed by many – mainly western academics - as the most desirable and optimal model of CBR, the various mixed models and the individual model have significant value as well. In fact, within the social model several characteristics/principles of the individual model should be incorporated if it is to have any serious meaning for people with disabilities. We recognize, therefore, an element of complementarity within the apparently ‘contrasting’ models and a development from one to the other.

CBR amongst people affected by leprosy

In the past, the emphasis in dealing with people affected by leprosy was on shelter and segregation – feeding and caring for people with leprosy, but protecting society from them.

Any serious rehabilitative effort came comparatively recently. The availability of an effective treatment has moved the focus for rehabilitation activities away from institutions and into the community. Programmes now recognize the need to match treatment and control activities with appropriate rehabilitation interventions.

The impact of leprosy is such that, even after discharge from treatment, those affected are at continuing risk of impairment and resulting disability. Programme managers are therefore concerned with the continuing prevention of disabilities of hands, feet, and eyes, as well as overcoming negative attitudes on the part of the community and working for the psychological, social and economic rehabilitation of those affected. Typical rehabilitation programmes include vocational training, placement in mainstream employment and the facilitation of micro-enterprises. Such activities fall very much within ILO's mandate of CBR development,[23] which includes a strong focus on socio-economic rehabilitation.

Vocational training and job placement form a strong entry point for integration into society. They provide a mechanism for breaking the 'disability cycle' of isolation, dependence and profound poverty.[24] Through income generation, people with disabilities become partners in the earning of family income and thereby gain respect, giving them a larger stake in family decision making processes. Large gains in social role and status in both the family and the community at large are expected to take place. The effects of this process on personality will open ways to become more self-determined. Thus empowered, the person needing help may now be able to help others in the community.

While the ultimate rehabilitation aim 'integration into mainstream society' is often achieved through employment activities, there is a risk within such a model that too much value is placed on economic activity alone. Rehabilitation efforts should focus on the creation of a supportive environment that stimulates people with disabilities to be whole persons whose lives are not solely determined by their disability but who can also enjoy relationships and contribute meaningfully to the lives of their families or communities. Such an approach avoids the continuing stigmatization of those who cannot become economically active, the elderly, the young and those who have such profound/multiple disabilities.

CBR focusing on the specific needs of those affected by leprosy is faced with an anomaly in that it continues to make a special case of leprosy. This carries the risk of further stigmatizing those involved in such programmes. This is one reason why TLMI seeks to address the needs of people affected by leprosy as well as their communities. The emergence of national programmes defining the nature of services to those with disabilities will increase pressure to address the issue of integration further.

A working classification

Our present purpose is to identify common themes and underlying dimensions which may be used to focus programme evaluations and identify families of indicators which will support the evaluation process. We have identified the following dimensions or principles which are central to CBR (cf. Figure 1).

OBJECTIVE 1: CONTINUUM *RESTORATION OF QUALITY OF LIFE*: 'FROM NORMALIZATION OF FUNCTION TO EQUAL OPPORTUNITIES'

Projects on the left side of the continuum refer to 'normal' functioning within the community and the process of rehabilitation is geared towards normalization of physical function.

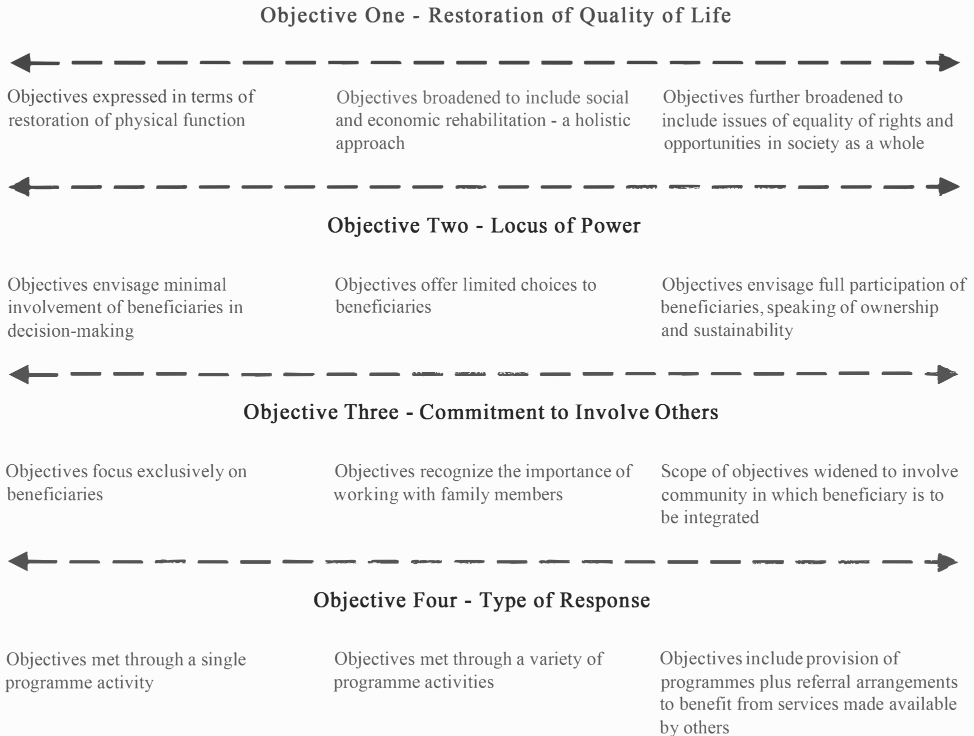

Figure 1. Four dimensions characterizing rehabilitation projects according to their objectives

Restoration of impaired function is seen as the end-product of rehabilitation (e.g. surgical intervention). The focus of interventions is on the alleviation of the restriction of activity or inability rather than on the need to focus on social consequences of impairment and restriction of activities. The full dimension of development in both the process and the outcome of rehabilitation is missing.

Another class of projects refer to social and/or economic rehabilitation and to physical and psychological well-being; they enable beneficiaries to overcome the impact of their disability and stimulate/facilitate the return to an earlier or develop a new, appropriate lifestyle within the community. Recognizing the importance of a full range of life skills is an aspect of holistic programmes, which work for an overall wholeness of life.

On the far right side of the continuum are projects which go beyond the care for the disabled person and address society as a whole, speaking out for the rights and acceptance of people with disabilities (advocacy) and seeking to address knowledge, attitudes and behaviour towards them. It may extend to issues of rights, legal constraints and access of public facilities. Equalization of opportunity is seen as an outcome.

OBJECTIVE 2: CONTINUUM *LOCUS OF POWER*: 'FROM COMPLIANCE TO EMPOWERMENT/ SELF DIRECTION'

Within the individual model the professional dominates decision making about rehabilitation objectives, plans and interventions and requires from the beneficiary compliance. The

beneficiary is told what to do or not do and receives protocol-like instructions. The WHO statement, however, refers to self-reliance and self-sufficiency. Effective empowerment requires that clients participate in all aspects of the process so that ownership is achieved and benefits are sustainable, providing solutions that are manageable and affordable. Equality of access to local resources and services is a common objective. In many instances empowerment is realized through (in-)formal education, (vocational) training and paid employment, but may equally take place through participation in self-help groups, community based organizations and through processes of active participation in the development of co-operatives.[25]

OBJECTIVE 3: CONTINUUM *COMMITMENT TO INVOLVE OTHERS*: 'FROM INDIVIDUAL FOCUS VIA FAMILY INVOLVEMENT TO COMMUNITY PARTICIPATION'

Within the rehabilitation process relatives of people with disabilities will be involved in the process of rehabilitation. However, in individual models there is the risk that relatives become only 'the extra pair of hands' of rehabilitation personnel. It is not uncommon that motivation of relatives to become even more involved in the life of their disabled family member is lacking. Expectations of professionals in this regard are often too high and unrealistic given that in fact not only the person with a disability, but the whole family should be seen as disabled: the burden of caring for the disabled family member should not unnecessarily be increased. On the other hand, as stated earlier, the family forms a powerful resource if rightfully involved in the rehabilitation process.

Integrating previously stigmatized or excluded individuals in the community demands a level of community involvement, though this may vary from acknowledgement or mere tolerance through to active encouragement, participation and ownership. Community participation is seen as indispensable to empowerment since only through community participation social, economic and political changes will take place; changes which are imperative in the process of enabling people with disabilities to become integrated into mainstream society.

OBJECTIVE 4: CONTINUUM *TYPE OF RESONSE*: 'FROM PROVISION OF A SINGLE RESOURCE OR SERVICE VIA MULTIPLE SERVICES TO INFORMATION SHARING'

At one end of this scale, projects offer one particular form of rehabilitation such as physiotherapy, a computer course, or an interest-free loan. Other projects offer a range of services within their own organization, while yet another approach is to act as a broker, assisting clients to find what they need in other existing (development) programmes, resources and facilities within the community that are not necessarily explicitly focussed on the rehabilitation of people with disabilities (multisectoral collaboration).

Within the individual model the focus of rehabilitation is usually only on specific disabling conditions that require (specific forms of) rehabilitation, e.g. the improvement of locomotion through physical therapy, or the prevention of disabilities by making appropriate footwear available. In the social model the focus is more on the person as an individual with specific needs and demands: on individuals who live in society and want to live a life in dignity.

Applications

Having proposed these four dimensions of CBR, the focus moves to describe how these may be used to develop a typology of projects. Projects may be classified by assessing their objectives against each of the four dimensions using an agreed scoring or marking system. This involves assessing the level of emphasis placed on the characteristics described in the available project documentation. For each characteristic the scoring system needs to allow three scores, for example 1, 2 and 3. Besides purely individual models (e.g. score up to 6) or entirely social models (e.g. score 10–12), there are various mixed models which will be labelled as such when they score between 7 and 9.

Application of such a scoring procedure to a set of project documents will in theory produce 81 types of similar projects based on the four dimensions described here. In addition, we expect to identify outliers, projects that differ from all others, and non-existent groups, i.e. potential project types where no such projects exist. Each of these outcomes will be of interest. The existence of some groups may be predicted and confirmed. The absence of certain project types may raise questions of policy and funding decisions. The presence of some unexpected types may lead to analysis of local priorities and decision-making.

The following case studies illustrate the result of applying this scoring method to selected CBR projects:

1. *Project amongst disabled children of the Winterveld community, South Africa.* Project aims are to assess the extent of the problem, build the capacity of those providing care (mothers) and enable carers to fulfil a leadership role in providing advocacy in the community on behalf of those with disabilities. Also to work directly for the development of appropriate facilities for severely disabled children. Scoring for this project is as follows:

Dimension	Comment from project outline	Score
Restoration of quality of life	Advocacy . . . for rights	3
Locus of power	Limited mention of shared decision-making	2
Commitment to involve others	Focus on mothers of disabled children	2
Type of response	Work with mothers, plus direct advocacy role	2

2. *CBR in 45 villages of Tamil Nadu, India.* Project addresses needs of children and adults with many different forms of disability in 45 villages, providing appliances and aids, scholarships for schooling and vocational training.[27] This results in the following scores:

Dimension	Comment from project outline	Score
Restoration of quality of life	Provide aids and appliances, health education and vocational training	2
Locus of power	Some involvement in planning of activities	2
Commitment to involve others	Focus on disabled children and their parents but as beneficiaries rather than partners	1
Type of response	Variety of activities targeted at people with a variety of disabilities	3

3. *CBR in five rural areas of Bangladesh.* Project[28] aims to make the disabled independent, to create awareness in the community, the transfer rehabilitation skills to the community, to raise level of community participation and to mobilize all available resources. Scores can be assigned as follows:

Dimension	Comment from project outline	Score
Restoration of quality of life	To make disabled independent and self-reliant	2
Locus of power	To provide services with intention to raise levels of community participation	2
Commitment to involve others	To transfer rehabilitation skills to community and withdraw services subsequently	3
Type of response	To provide required services, to make programme sustainable	2

From these three case studies some interesting contrasts emerge. For example:

- Only the Winterveld project has a specifically stated objective of advocacy.
- None of the projects put the decision making power firmly in the hands of the beneficiaries.
- The three projects are all different in their commitment to involve others.
- Though the Indian and Bangladeshi projects both define the desired outcome in social and economic terms and agree that a variety of services should be made available, the Bangladesh project appears to have the stronger community dimension.

Application of the proposed CBR model in the context of leprosy

The following section presents an example of a CBR project focusing on the needs of people affected by leprosy and further illustrates the use of the proposed classification method.

In India, TLM is planning to open a series of information centres for people with disabilities, to be known as New Life Centres. The centres will act as meeting places and resource centres for people with any form of disability. Activities will include family or community support, an information centre, occupational therapy and physiotherapy, counselling and vocational guidance, job and training placements. There will also be an advocacy role.

Dimension	Comment from project outline	Score
Restoration of quality of life	counselling, building self-confidence, vocational guidance, some advocacy	2–3
Locus of power	offering options, making information available; interaction between beneficiaries	2
Commitment to involve others	limited community outreach	2–3
Type of response	information about and referral to other services	3

The focus is the centre where beneficiaries meet and are stimulated to make use of the wide range of possibilities presented to them. The involvement of the community is limited but may grow from this work as it becomes more firmly established.

Discussion

We have presented four dimensions that in our opinion permit a characterization of rehabilitation projects based on their objectives. First, we considered whether the desired outcome of project interventions for the beneficiaries was defined in terms of physical function, social integration or in terms of the acceptance of disabled people in society. Second, we asked how power was distributed between providers and beneficiaries. Third, we considered whether target groups were limited to disabled persons themselves or widened to include relatives and/or the community. Finally, we asked what range of services was offered to the beneficiaries, as an indication to what extent solutions could be tailored to their needs.

We believe this method is a useful tool to analyse rehabilitation projects and discuss its strengths and weaknesses. It may be used to help define policy or to guide debates in the project planning stage. For us, it provides a starting point for evaluation of projects as it will guide the formulation of questions relevant to the type of project that is being evaluated.

It is clear that more detailed work is needed on definitions and in describing the criteria used in classifying projects. The reliability and validity of this classification system will eventually need to be checked by arranging for an independent assessment of a set of project proposals and other supporting documents.

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