PARTICIPATORY EVALUATION

KIBWEZI CBR-PROJECT
(MAKINDU, KIBWEZI AND MTITO ANDEI DIVISIONS)

24 AUGUST - 3 SEPTEMBER 1997

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ACKNOWLEDGEMENT

We were invited by AMREF to serve as external facilitators for a participatory evaluation exercise of Kibwezi CBR-programme. Twenty four persons, from a variety of backgrounds were trained to gather the evaluation data. In the process they interviewed over 120 persons, and held 5 focus group discussions to gather a wide cross-section of perspectives on the achievements and challenges of Kibwezi CBR-programme.

This report is therefore a collective vision of a number of persons. The Kibwezi Evaluation Team was comprised of experienced and gifted individuals. Mr David Kariuki, Urbanus Ndivo, Samson Thuo, Nguli Mutisya and Phitalis Were all from Kibwezi CBR-project not only provided key insights from the backgrounds of their own professions but also were indefatigable field workers in gathering the data.

The evaluation team also benefitted significantly from Dr Sam Kazibwe of AMREF who in his capacity as an internal consultant guided the team in shaping the future vision of the project in respect to its structure, goals and needs of the people it is serving.

The team was more greatly enhanced by the presence of Mrs Isabella Chege from AMREF who constantly challenged the evaluators to appreciate the perspectives of PWDs.

The evaluation report could not have been possible to compile without the cheerful hard work of the Local Evaluation Team composed of 8 young girls and boys identified by Kibwezi Evaluation team to supplement its work. It was also greatly enhance by a team of three persons Mr P.N. Kaguthi, Paul Ndeto and Ms Goretta Mutisya who carried out Focus Group Discussions.

We also wish to recognize Ms Anne Mwikali's secretarial abilities and her willingness to work far beyond normal hours to ensure that each day's work was very well documented. Mr John Saa, the CBR attendant made sure that materials for evaluators were available when needed and of course Patrick Mwaura, Ndivo Mwoloi and Nicholas Kimeu drivers who took the groups in the field to gather data and who made sure that there were no logistical problems in pursuing the evaluation.

Lastly, we wish to recognize the surmountable assistance given to the team by the Project Manager Ms Shaya Asindua. She was a gracious host who put all the resources of her project at the disposal of the evaluation team.

To all of you, we owe a real debt of gratitude and as external evaluators we are greatful to AMREF for having been given us the opportunity to participate in this evaluation exercise.

1.0 INTRODUCTION AND EVALUATION EXERCISE

1.1 INTRODUCTION

The main thrust of Kibwezi CBR-programme since 1994 has been the promotion of community participation in the development and provision of basic services. As a result Kibwezi CBR-programme has put in place various strategies to achieve the desired goals.

At inception, the Kibwezi CBR project as part of a Rural Health scheme had a leaning towards the individual model of service provision. This meant a focus on the individual disabled person's impairments and attempting to correct and normalise the disabled person. AMREF as a health oriented organisation and the partnership with the Ministry of Health may have enhanced this factor.

The Kibwezi CBR Programme over time have shifted from the individual approach to a more social and comprehensive development approach which focuses on removing environmental barriers that are restrictive and disabling. These environmental barriers may include; negative attitudes, lack of accessibility, inadequate opportunities for education, employment, democratisation process and participation.

The broad theme of the evaluation was to assess the project's move from the individual focus to a more social and developement model.

The evaluation was carried out in Kibwezi area which encompass Mtito Andei (Kambu), Makindu and Kibwezi Divisions of Makueni District, Eastern province of Kenya where the CBR programme operates.

1.2 PURPOSE OF THE EVALUATION AND TERMS OF REFERENCE

Evaluation exercise

Purpose of the evaluation

The exercise was an end-of-project-term evaluation and was aimed at assessing the level of achievement of the stated project objectives and the impact the project interventions had made on the quality of life for the individual PWD. Among the items to be assessed were changes the project had brought on the social cultural and economic environment for the various target groups in the community.

On the project processes, the evaluation aimed at identifying strengths and weaknesses in strategy design, project organization and implementation in efforts to bring about positive attitudes, capacity building, community empowerment and service accessibility.

undamental to the evaluation objective was an assessment of how the project evolved from a conventional approach focusing on enabling an individual person with a disability to fit in a 'restrictive and obstructive' environment to a social development model that emphasizes equalization of opportunities in an environment free of barriers.

Specifically the evaluation focussed on:

1. Assessing to what degree the objectives of the CBR programme had been met
2. Assessing whether IGAs had benefited PWDs
3. Assessing whether PWDs had attained improved access to social services

At the end, the evaluation team was to come up with pertinent conclusions, elucidate lessons learned and make appropriate recommendations for a proposed future phase of the project.

1.3. Evaluation questions focused on the following issues:

A. Individual PWD level

- Who and how many had benefited from the programme.
- What impact had the CBR-programme made on PWDs in terms of:
  (I) Economic empowerment.
  (ii) Social services' accessibility.

B. Community level

- In what ways had the local community been mobilized e.g CHWs, TBAs, family members and community based organizations.
- What were the attitudes within the community towards PWDs.
- What was the role and level of participation of the Sub-locational Development Committees (sub-loc DDC) in the project.
- What was the degree and nature of the participation of DPOs.
- What was the degree of family involvement.
- What role had been played by NGOs.
- What type of resources has the local authority put in the CBR programme.
- Nature and timeliness of project response to the community's felt needs.

C. District level

- What had been the role of the DDC.
  What level of cooperation existed at the district level between the various. sectoral departments (collaboration).
  What political and financial commitment had been extended to the project by the Government.

D. Staff

- Expectations and incentives
- Contribution to the CBR projects
- Their perceptions on the project strength, weaknesses, opportunities and external threats to the project
- Constraints

E. Collaborators

- Support to CBR project
- Participation
- Networking

F. CHWs

- Identification
- Training
- Service quality assurance
- Nature and adequacy of referral systems
- Follow-up

G. Line Ministries: MOH, MCSS, MOE

- Policy on disability
- Financial commitment to disability programmes
- Mechanisms for supervising
- Monitoring and Evaluation systems

1.4. Time schedule

The time schedule for the evaluation was as follows:

August 24th: Arrival of External Team.
Introductory meeting with members of Kibwezi CBR Project Team

August 25th: Meeting with Kibwezi Evaluation Team to formulate plan of action for the evaluation

August 26th: Development and production of questionnaire and training of Local Evaluation Team

August 27th:
- Making appointments to interview collaborators and pretesting the tools
- Data collection in Kibwezi, Mtito and Makindu for both PWDs and family members
- Data collection from IGA groups

August 28th:
- Data collection: Focus Group discussion at Makindu, CHWs at Kaunguni
- Data collection: PWDs and family members

August 29th:
- Focus Group Discussions at Ngomano
- Focus Group Discussions for CHWs at Muthingini
- Data collection: DDC-Makueni
- Data collection: PWDs and family members

August 30th:
- Focus Group Discussion: DPO; Mtito Andei, Kathekani, Wivia primary school
- Data collection: PWDs and family members

August 31st:
- Data analysis and organization

Sept. 1st:
- Report writing

Sept. 2nd:
- Feedback meeting with the Evaluation Team and departure to Nairobi.

Sept. 3rd
- Report writing by the Evaluation Team

Sept. 11th
- Feedback to AMREF team

1.5 PROJECT AREA

The evaluation was carried out in *Kibwezi, Mtito Andei and Makindu* Division of Makueni District, Eastern province of Kenya where the Kibwezi CBR programme operates.

Methodology

The evaluation was primarily summative, assessing level of achievements in respect to the stated objectives . However, it was also intended to evaluate the project processes and implementation systems employed to assist in the designing of a proposed project extension phase. The team comprised of two external consultants, two personnel from AMREF headquarters in Nairobi, a data systems analyst, the project manager and several members of the project field team.

Planning meetings were held on 25 and 26 August 1997 between the external facilitators and the project team including representatives of the DPOs and PAFODs to review the questionnaires to be used in gathering the data.

In each of three divisions, a sample of 20 PWDs and 20 CBR project trained family members, making a total of 120 persons, were randomly selected through a multistage sampling process to participate in interviews based on structured questionnaires. A 'Local Evaluation Team" comprising of 8 interviewers representing a wide range of background from both the programme and other areas not connected with the CBR programme was selected and trained to administer the questionnaires. Each interviewer was made aware of the evaluation objectives and given specific instructions on data collection and the targets to be met. Each was given a stipend for participating in the evaluation exercise.

Focus group discussions were carried out by another set of 3 persons and included PWDs, CHWs/TBAs/Volunteers and Sub-locational Development Committees.

The Kibwezi Evaluation Team had a two fold task of supporting the work of the 'Local Evaluation Team' and carrying out random cross- checks to ensure reliability and validity of the data collected. This was done by re-interviewing a random sample of the same persons that had been interviewed by the Local Evaluation Team to compare the results. The Local Evaluation Team was however unaware of which persons were to be interviewed twice in this way. The validity of data was found to be acceptable.

Data analysis was carried out through a process that included coding of each possible answer on the questionnaire, data entry and frequency generation using EPI Info statistical package. The planning of the evaluation, designing of the tools, data collection, analysis and interpretation were carried out through a participatory process, amalgamating individual and collective points of view through discussions, making it a learning experience for all the participants involved.

2.0 HISTORY OF KIBWEZI CBR PROJECT

2.1 BACKGROUND INFORMATION

The general geographical area under review is the former Kibwezi Division of the Machakos District in Eastern Province of Kenya which has since changed with the recent sub-divisions of the District into Machakos and Makueni. The former Kibwezi Division which now falls under Makueni District has further been sub-divided into three Divisions namely; Makindu, Kambu and Kibwezi. The three Divisions cover an area of approximately 3,400 square kilometers stretching from Hunters Lodge to the north to Mtito Andei in the South along Nairobi-Mombasa road and Chulu Hills to the West to the Athi River eastwards. The Divisions comprise of 16 locations sub-divided into 46 sub-locations and several villages forming the administrative structure in the area.

The greater part of Kibwezi is semi-arid with unreliable rainfall patterns that are marked with long intervals of droughts which often result into poor or no harvest at all. In recent time including the years 1994/95, the drought was so severe that literally every activity in the whole area was directed to provision of relief food. The majority of the people are essentially subsistence farmers although a small proportion benefit from irrigation scheme along the Athi River where horticultural crop farming for export is thriving.

The settlement pattern of the area is characterized with scattered homesteads with approximate population density of 150 people per square kilometer. Due to the recent settlement in Muuni sub-location, the population of the whole area is estimated to have risen to about 190,000, a majority of whom are of Akamba ethinical group.

2.2 AMREF-KIBWEZI RURAL HEALTH SCHEME

Kibwezi CBR project is a component of the larger Kibwezi Rural Health Scheme which is a joint local community, GOK and AMREF PROGRAMME established way back in 1978.

The scheme runs a comprehensive health and development PROGRAMME covering the whole area of water and nutrition, family planning and community based health care, a communication programme for women and of course the CBR project. The above activities are carried out through six intertwined projects namely; Community Based Health Care, Applied nutrition project, Water and sanitation project, Women's reproductive health project and finally the Community-Based Rehabilitation project.

2.3 THE ORIGINS OF KIBWEZI CBR

CBR programme was first established in Kibwezi in 1982 by Action -Aid-Kenya through initiation of a project referred to as Disabled Assistance Scheme (DAS). The scheme was aimed at providing services to children under the age of 15 years as an intervention

mechanism. The DAS had a team of 6 field workers one of whom was a supervisor. The field workers were trained to recognize disability among children of age 0-15 and with assistance of families and community health workers (CHWs) already in place. And to assist in referral to Assessment centers, Special schools and or to Corrective Surgery facilities. They were equally trained in production of low-cost aids using local materials, mobilize children with disabilities and assist them in daily living activities. Within the above arrangements, AMREF's role all along was the provision of surgical intervention which were held at Mutomo Hospital through AMREF's Clinical Department.

Following the problems experienced due to inadequate follow-up into the community in 1987 it was found appropriate to harmonize a joint CBR programme run by Action-Aid-Kenya and AMREF both of whom were already involved in health care delivery services in Kibwezi since 1980's. The project attracted the support of Save the Children Fund of U.K. A project coordinator was appointed under this new scheme. In 1988, the GOK seconded two officers, a Physiotherapist and Occupational therapist, adding another dimension to the programme.

Earlier in 1970's, the Association for the Physically Disabled of Kenya (APDK) had established monthly Mobile children's Orthopaedic clinics in the area for fitting and providing walking aids produced in their workshop in Nairobi.

The Kenya Association for the Welfare of Epileptics (KAWE) on the other hand had been visiting Kibwezi Health Center since 1984 providing treatment for epilepsy. KAWE appointed a social worker and attached her to the health center from where she made follow-up of children and adults to their homes and sensitized the families on acceptance at all levels including schools and communities.

The above was the collaborational network that grew into the present CBR programme.

2.4 MAJOR ACTIVITIES OF THE CBR PROJECT

The initial activities of the joint CBR programme included;

(i) Home visits for assessment and follow-up.
(ii) Play groups for children and their parents.
(iii) Integration of children with disabilities into regular schools and at times enrolment to special schools.
iv) Child-to Child programme for primary schools on disability awareness.
(v) Parents and community leaders workshops on disability and the management of the disabled persons.
(vi) Referral of children for surgery, physiotherapy, further assessment and provision of Orthopaedic aids.
vii) Production of low-cost aids.

By 1990 the CBR programme had grown with an increased staff of 10 excluding CHWs and TBAs who were already in place before the initiation of the joint programme.
Presently the CBR programme has not only increased its skilled human resources to 15 staff, but has also opened up to more activities which include establishment of Disabled Peoples Organization which have necessitated additional activities among others;

(i) Training of DPO Committee members on enterpreneual skills including financial and business management and leadership skills.
(ii) Exchange visits to well established micro-credit projects run by DPOs and PWDs.
(iii) Accessing credit facilities (Revolving fund) to families of children with disabilities, DPOs and PWDs
(iv) Organizing awareness raising workshops for community and leaders on needs and the potential of people with disabilities.

2.5 The identified needs to the set objectives

To be able to establish as to whether the project had shown signs of transformation from medical to social model, the evaluating team opted to reflect on the set objectives of the project and co-relate the same with the identified needs of PWDs.

(a) Project goal

Improved quality of life of children , youth and persons with disability (PWDS) and thus enhance their integration into society.

(b) Project objectives

At the end of the project period the project implementors planned to have:-

- Screened children for early identification and intervention on disabilities
- Strengthened Parents and Friends of the Disabled Peoples Association (PAFODA) and the Disabled Peoples' Organization (DPO) to enable them lobby and advocate for increased support to the persons with disability in their communities.
- Conducted applied research to determine;-

(i) The most appropriate design of a wheelchair for the area and therefore more appropriate technology.

(ii) Feasible and appropriate income generation activities for the people with disabilities.

(iii) The causes and reasons for high incidence of epilepsy in the area.

(iv) Aspects that would promote the sustainability of the CBR projects .

(v) Assisted the PAFODA and DPO to initiate and manage income generating projects .

(vi) Promoted networking both within and outside the country.

(vii) Assisted at least 20 youth with disabilities every year to acquire skills

(viii) Established four community based integrated Day Care centers

(ix) Established a spacious hostel for CBR trainees within the region.

(x) Provided an expansion of the present resource centre and workshop to accommodate more people.

(c) Needs of the PWDS in Kibwezi CBR Project

(i) **Equalization of opportunities to acquire:-**
- Love and attention (care)
- Basic Health promotion prevention and services delivery
- Equal access to education-special needs
- Social interaction
- Vocational training
- Employment

(ii) **Access to utilities** such as recreational, transport, buildings, information, water points and infrastructural facilities

(iii) **Acceptance,** appreciation, recognition and promotion of self-esteem

(iv) **Socialization** - relating to others, friendships, marriage and procreation

(v) **Rights and obligations** - leadership

(vi) **Independence** making own decisions

(vii) **Increase capacity** for enhanced participation and development

Needs of PWDs vis-vis set objectives

1. **Equalization of opportunities**
Under the above needs, the programme set the following objectives to address the need.

(i) Early identification of persons with disability and intervention through facilitating access to basic human requirements.

(ii) Establishing and strengthening PAFODAs and DPOs in an attempt to enhance increased intervention opportunities and support mechanisms.

(iii) Development and laying out of approaches that would create income in an effort to strengthening the capacity of individuals and or their organization.

(iv) Setting up research activities in effort to designing appropriate technology, mechanisms for income generating activities and identifying causes of most frequent type of disability with special reference to epilepsy.

(v) Promotion of networking in attempt to accelerate creation of equal opportunities for PWDS within their own environment.

(vi) Targeting specific people with disability that require specific skills and needs.

2. **Access to utilities**

(i) Through establishment of four community based integrated Day care centres

(ii) Construction of a training centre for CBR trainers in the region suitably designed for PWDs

(iii) Access information through establishment and expansion of the Resource Centre

3. **Acceptance**

Through income generating programme initiatives to make PWDs less dependant and therefore enhance self-esteem and self-reliance

4. **Socialization**

(i) Through creation of Day-care centres which enable parents/guardians to interact and exchange information and in the process attain self acceptance.

(ii) Through the organization of DPOs, in an attempt to creating an opportunity for interacting and sharing.

5. **Rights and obligations**

(i) Through DPOs, the capacity for PWDs to be strengthened to advocate and lobby for their rights

(ii) Create opportunities for DPOS and PWDS to learn about leadership skills and obligations among themselves and therefore be able to influence society's perception of them

(iii) Attempt to influence development policies of the area by high-lighting their needs and demands

6. **Independence**

(i) Through feasible vocational training programmes, impact skills in an effort to be less dependant

(ii) Through organization of DPOs, strengthen capacities to plan and make their own decisions and manage their organizations

7. **Capacity building**

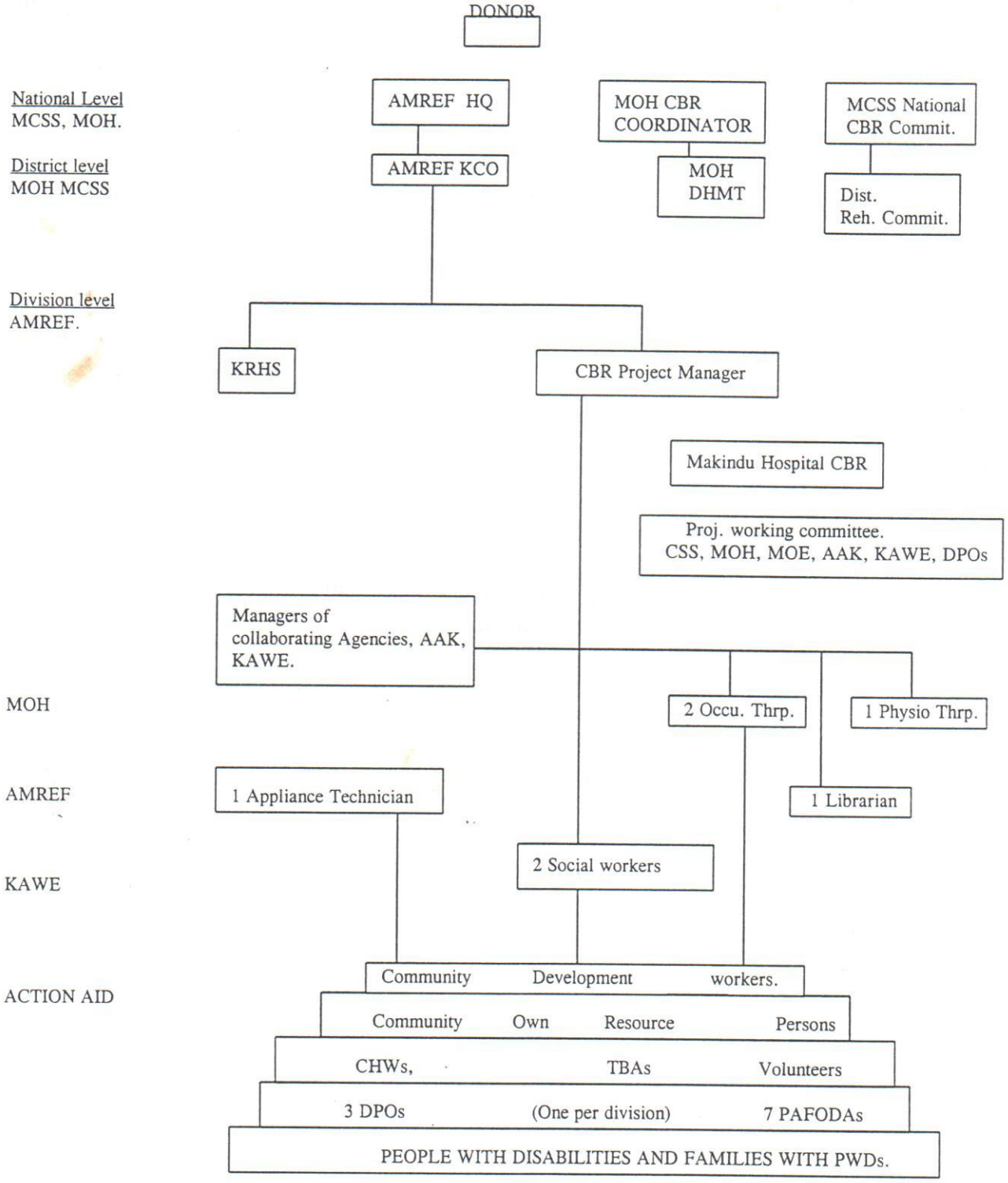
(i) With the establishment of a training facility, the hostel for CBR trainers from the region, be able to design a training curriculum suitable for PWDs.

(ii) The accessing vocational training for 20 youth with disabilities every year will ensure enhanced strength for individuals and their organizations

(iii) The expansion of the workshop and Resource centre will enable increased intake and participation and accessing of information

(iv) Through research, identify appropriate technology and realistic income generating activities for PWDs to strengthen their involvement in the community activities.

2.6. KIBWEZI CBR PROJECT ORGANIZATIONAL PROFILE



Project Organization and Management

1. Definition of catchment area and population covered by project interventions.

The project has defined its catchment area as the administrative boundaries of the three divisions; Kibwezi, Mtito Andei and Kambu with an estimated population of 190,000 of which an estimated 6% or 9600 people do have one form of disability. These figures are, however, based on outdated rates and are very rough estimates.

A number of disability surveys have been carried out in Kibwezi beginning as early as 1983. The first one in 1983 which was part of the " International Pilot Study of Severe Childhood Disability' was limited to children 3-9 years and covered only one sub-location. The Kibwezi Integrated Survey in 1985 and the Kibwezi Health Risk Study in 1986 were limited in coverage and in scope. The 1990 Survey of Childhood Disability was limited to only children under 15 years, which was then the target age group for the project. The Kibwezi Rural Health Scheme, project population census of 1996, investigated disability in all age groups but was confined to three locations only. All the surveys do indicate that disability is a major problem but none has provided a comprehensive disability profile. With its wide spread network of community based and field workers, the project should be able to establish a comprehensive and complete inventory of disability in its catchment area. Such an inventory would provide information for better planning, especially in identifying the most needy and most vulnerable.

2. Definition and clarification of roles and responsibilities for the various project partners

The project has had several *de facto* and potential levels of collaboration. Historically AMREF in Kibwezi has been in partnership with Ministry of Health since the Kibwezi Rural health Scheme was started. Specifically for this project, in accordance with its social development focus, AMREF has gradually been drawn into the domain of the Ministry of Culture and Social Services. MOH has indicated its commitment to this partnership by posting a number of technical staff to the project. This commitment has encouraged the project manager to further incorporate more staff from Makindu Sub-district Hospital to share the project principles and to participate in the activities. Although it is understood that MCSS has limited provisions for disability, its important role in institutionalizing the project strategies, and likewise, the potential for the project to contribute to technological development in those areas of the ministry's concern, should be acknowledged. The opportunities the project offers should not be missed. A clear framework of association which defines avenues and nature of collaboration should be established from national to grassroots linkages. A forum for reviewing the changing responsibilities as the project matures is an urgent need.

At the operational level, AMREF entered into a joint undertaking when the CBR project inherited the operations of the Disabled Assistance Scheme (DAS) that was then operated by Action Aid. Action Aid continued its financial inputs by paying salaries of its former field

staff participating in the CBR project.

The collaboration has been mutually supportive and has demonstrated an excellent relationship between agents which , although deferent in technical focus, converged for a common goal. Due to a fundamental change in its operations and programme structuring, Action Aid is weaning its involvement in the project. Again its phased withdrawal has demonstrated a gradual transfer of responsibility without hampering operations.

Kenya Association for the Welfare of Epileptics established its ties with AMREF when it initiated its monthly clinics at the Kibwezi Health Centre in 1984. It appreciated the value of the project and let its two resident social workers operate from within the CBR project, while their activities have continued to centre around epilepsy they are an invaluable resource and participate in the other CBR interventions. Higher than this level, however, KAWE has remained distant and there is little shared between the partners.

CBR in-house collaboration with the other projects under the Kibwezi Rural Health Scheme needs to be more fundamental and systematic. In previous years there was a forum through which the teams undertook strategic planning jointly and came up with an annual semi-integrated plan. The team spirit was facilitated by an un-official recognition of KRHS as being under one leadership. This perception among the team members has over the time been eroded, partly because Kibwezi leadership has never been formalized and perhaps needs strengthening, secondary, as a consequence of the fall-out from the restructuring at AMREF headquarters. It is apparent from all the project proposals originating from Kibwezi and the programme documentation at various times in KRHS's history that it was intended to be an entity designed to demonstrate certain critical aspects of health service development in a specified geo-physical and demographic environment. If that philosophy still holds then fragmentation of KRHS should be avoided, but equally seen against the changing circumstances and dynamics.

3. Project Formulation Planning and Implementation.

The relevancy of the Childhood Disabilities survey carried out in 1990 as a baseline to establish benchmark values for the CBR project was gradually eroded as the project transformed it main thrust to highlight social and behavioral change themes. The project scope also widened to include disability at all ages.

Activity planning has been undertaken annually and reviewed every six months. The schedules indicate what activity to be undertaken, when, for how long, where and who is responsible.

Notably absent, however, were output indicators and targets for the various activities. Without such indicators that can be monitored, assessing project progress would be difficult. It would also be difficult to link resource use to project performance and productivity. Consistency in scheduling could also have been improved by aggregating activities under a particular strategy and relating it to a particular objective.

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The project received a no-extra-cost extension when, at the end of the scheduled project period in March 1997 there was a balance of UK Pounds 51,787. Two major project interventions; support for income generation and establishment of a CBR training centre for the East African Region had lagged behind. The extension was, therefore, intended to redirect efforts towards achieving objectives relevant to these components. Accordingly, the work plan for the remaining period should reflect this emphasis.

Assignment of responsibility has been based on a staff member's basic technical ability rather than geographical allocation among the team. This arrangement has the advantage that individuals deal with issues for which they have basic training. The disadvantage is that staff are centralized at the project office and each requires a great amount of travel to cover the entire project area. Since the project is de-emphasizing focus on medical attention to a social approach all staff could be trained to meet this need and be decentralized to cover different geographical areas.

The project has operated independently from the National CBR Committee of MCSS, the MOH CBR Co-ordinator and the Makueni District Health Management Team. While the project's efforts in networking has reached out to other countries in the region and beyond, it is still yet to consolidate efforts in developing a collaboration mechanism with other national bodies charged with the development of activities for people with disabilities in the country. AMREF as an organisation has not adequately integrated disability issues in their wider strategic plans. The expected function of the AMREF KCO to provide technical back-stopping, monitoring and guidance to the field projects also appears to have been less than optimal. At operational level there have been regular forums for the team to review activities. However, to be able to supervise and ensure service quality in such an area, wide both in scope and nature of operations, the team should develop supervisor's checklists to be used at the various levels and for the different programme implementors.

4. Participation in Project Development and Governance

MOH, MCSS, MOE are principal stake holders in the project. They are responsible for policy formulation at national level and service planning at the grassroots. At the operational level were AAK and KAWE in collaboration with AMREF as already explained. At the grassroots are the beneficiaries; PWDs, DPOs and PAFODAs. The local administration provides the political and administrative environment for the operations.

All these parties have deep interests in the project and ordinarily, a project steering committee would have been the body to bring them together and facilitate their participation in the project governance. The operational partners would have participated in strategic planning and operations monitoring through a project working committee. These committees were established at the initial stages of the project, but meetings have been irregular.

5. Framework for technical development and backstopping

The CBR project was conceived as a model to engage in operations research and systems development to benefit CBR application and development. This aspect of the project is hardly visible. The project team has lacked assistance in articulating research needs, developing appropriate protocols, designing research methods and tools, collecting the necessary data, critical analysis and documentation. This capacity has not been accessed and AMREF KCO, MOH, MCSS, MOE or other specialist agencies and institutions could play a proactive role to maximize benefits from the opportunities this project offers.

6. Developing and marketing the project as a social development model

In spite of the constraint mentioned above, the team in Kibwezi have done well on networking. Since 1990 the project manager has participated in, at least, 5 national and 9 international forums varying from curriculum development to sharing CBR experiences in which lessons from Kibwezi have provided valuable references. The project has featured in donor sponsored video films which have been used for fund raising overseas. Also various members of the team have had opportunity to share experiences with colleagues from within the country and in overseas forums. These initiatives, however, have not been backed by professionally documented material made available for publication. The project's linkage with the national organs responsible for policy formulation and strategic planning for CBR have some what been minimal.

The project Resource Centre at Kibwezi occupies an essential position in information dissemination, CBR technology display and programme documentation. However, its current organization and management need some improvement to enable it live up to this important role. The resource centre functions could also be augmented by regular technical meetings and presentations to bridge the communication gap between the project, AMREF KCO and the line ministries.

7. Management Information System

Information and communication are the nerve centre of project management as the project traverses the phases of planning, implementing, evaluating and replanning. It is information that enables a manager to monitor, control and direct. The project requires assistance to develop suitable methods and tools for data collection.

An attempt was made to monitor progress of each individual PWD using duplicated cards on which progress was recorded. One card was kept at home while the other was kept at the project office. This process turned out to be expensive, tedious and was discarded. The home card was replaced by record books provided by the clients. Keeping progress information at the office was abandoned. The project has computers which, with minimal staff training and the right information management packages, can be put to good use.

Progress Reports have been regular and timely, however, they have tended to be in form of story telling and less analytical. Activities have been reported with no reference to the degree of achievement and with no evaluation of the effectiveness of the strategies employed. Internal reviews are very commendable, especially the one that relates to the 1990 evaluation findings and recommendations, but it was done five years after the evaluation, hence, its usefulness in guiding the project to respond to the issues raised in the evaluation is questionable.

8. Resource Management

To facilitate transportation, the project has a 4 wheel-drive sedan and four motorcycles. The budget for vehicle running had by June 1997 been overrun by 81%. This might call for a closer look at the management of transport especially the motor cycles. AMREF has an elaborate system of monitoring vehicle use, but it has not been enforced on the motor cycles. Worthy noting was the fact that although the motor cycles are quite old, their maintenance has not been overtly expensive which makes them a suitable mode of transport in the difficult terrain found in Kibwezi.

9. Financial Management and Accounting

Financial management and reporting has been done in accordance with AMREF accounting systems. Reports have been regular and comprehensive. As of 30th June 1997, there was a budget balance of Pounds Sterling 30,828 to take the project through to March 1998. At the current average expenditure of Pounds 6580 per month, and the cost of this evaluation, the remaining funds can last to, latest, October 1997. Budget allocations for some line-items like; Office and vehicle running appear to have been grossly overspent, while Vocational Training, which, it is understood, has been taking place, shows nil expenditure. A plausible explanation is that expenditure allocations have not been done accurately. Whatever the case, project management needs to review the work plan for the remaining period in view of the restrictions imposed by the balance of funds.

2.8 STAFF OF KIBWEZI CBR-PROGRAMME

It is a very well known fact that programmes fail or succeed depending on the support professionals provide. The questionnaires encouraged members of staff to reflect on the following:-

- their understanding of their role in the programme
- how well the management structure is working in practice
- Whether they understand clearly the objectives of the programme
- strength, weaknesses and threats of the programme
  their expectation
- what is needed to motivate various cadres of CBR workers
- their interactions with other agencies
- how the programme could be improved

The CBR Programme Manager

The Kibwezi CBR-programme Manager is Ms Shaya Asindua who has played a key role in the development of the programme since its inception 10 years ago. She has been prepared for her role in that she attended the Post Diploma course at the Institute of Child Health at the university of London and recently completed a Masters programme in Social, Community and Rural Development at Manchester university. This training has been complimented by field trips to a number of other CBR programmes within Eastern Africa and overseas. She is a full-time employee of AMREF.

Physiotherapist

The CBR-programme Physiotherapist is Mr David Kariuki who holds a Diploma from the Kenya Medical Training College (KMTC). He was seconded to the programme by the Ministry Of Health to mainly carry out medical interventions. He has never received any formal training in CBR despite the fact that he has attended many workshops.

Occupational therapist

There are two occupational therapists in the names of Mr S. C. Thuo and Mr F. Njoroge who are both holders of a Diploma from KMTC and were also seconded to the programme by the Ministry of Health. They have never received any formal training in CBR despite the fact that they have attended seminars and workshops in the same.

Social workers

There are two social workers in the names of Ms Esther Nzinga and Ms Winnie Mwethya. They were seconded to the programme by the Kenya Association for the Welfare of the Epileptics (KAWE). Despite the fact that their background is in Social Studies, have never received any formal training in CBR.

Project Officer

The project officer is Mr Phitalis Were Masakhwe. He is on a short term contract with AMREF and is responsible for the development of DPOs and PAFODAs and documentation of project activities. He holds a BA (Hons) degree in sociology and philosophy from the university of Nairobi. Mr Were himself is a person with a disability.

Project Technician

The project technician is Mr M. Nguli (also a person with a disability), is responsible for designing, fabricating and fitting appliances that are given to PWDs under cost-sharing

arrangements. He has taken long without going for any refresher course and cannot produce artificial limbs nor flat bar calipers with joints.

All the above officers, small in number compared to the area of coverage carry out the following roles:-

- Overall supervision of CBR programme and rehabilitation activities
- Training of parents, PWDs, DPOs and PAFODAs
- Screening of children for early identification and intervention
- Increasing community awareness through social mobilization and sensitization
- Production and supply of assistive devices to PWDs
- Research and documentation and
- General service delivery

The general feeling of the staff is that they have shifted from an individual model to a social and development model. This means focusing on the removal of environmental barriers, other then the focus on the individual's impairments. Staff are emphasizing awareness raising, training of PWDs and parents, training of DPOs and PAFODAs in areas of income generating activities, counselling, lobby and advocacy methods.

The team wanted to know the strength and weaknesses of the programme and they responded:

(a) Strength: These included among others:

- Good working relationship between the staff and the community. They are therefore respected.
- Community as a resource
- Collaboration with other NGO's
- Good inter-personal relations among staff members

(b) Weaknesses: These included among others:

- Traditional beliefs on disability which are still strong
- Illiteracy still high amongst catchment area
- Lack of government commitment (the project belongs to AMREF)
- Defection of members from DPOs and PAFODAs
- Lack of staff development programme
- A structure which does not provide promotional outlets.

The staff also commented on what they thought was the most rewarding aspects of the programme and their responses included:

- Signs of progress in PWDs
- Appreciation by family members
- Change of negative attitudes
- Increased personal respect

When asked what had been their major constraints, their responses included:

- Poverty among families of disabled persons and therefore little allocation of time to disability issues
- Inadequate CBR skills and therefore demand for formal training
- Wide area coverage and therefore need from more staff
- High expectations of PWDs from the project
- Lack of enough funding to IGAs
- Transport: some officers have no motorcycles and even those who have are very old.

On the question of "what motivation(s) would you prefer in your responsibilities all staff numbers who answered this questionnaire singled out "TRAINING IN CBR". The staff also rated CBR programme as very helpful in respect to service delivery.

In response to the question "how could the CBR programme be improved" they stated :

- More training and refresher courses
- Improved transport
- Increased funding for IGAs
- Improved supply of appliances and production by training local artisans.

Although the CHWs are not staff under this programme, the team was very interested in knowing their views since they are in constant touch with PWDs and their parents. Their complaints to the programme were in areas of transport (bicycles) and requested that these be included in the Income-generating activity programmes.

TABLE 1 SUMMARY OF PROJECT OBJECTIVES AND ACHIEVEMENTS

STATED OBJECTIVES	ITEMIZED OUTPUTS	ASSESSED OUTCOMES OR IMPACT	DEGREE OF ACHIEVEMENT	REMARKS
Goal				
Improved quality of life of disabled persons and enhanced social integration into main stream of society	*Community awareness campaigns carried out * More than 3000 persons with disabilities identified and assisted in one way or another by the project	* Community acceptance, and inclusion in the decision making organ of the community * Improvement in income at household levels * Access to social services such as education	A small level of integration has been achieved	A lesson learnt is that it is difficult to achieve much improvements in the quality of life of PWDs without targeting poverty eradication in the general community
Specific Objectives				
1. To screen children for early identification and intervention of disabilities	198 persons with disabilities were identified and assessed 80% of these were children	* 19 children integrated in schools * 3 benefitted from vocational training * home-programme developed for 128 persons * 58 benefited from corrective surgery *92 received appliances	Assessments were carried out in 4 sub-locations out of 46	Some of the PWDS benefited from more than one intervention
2. Strengthen Parents and Friends of the Disabled Associations (PAFODA) and the Disabled People's Organizations (DPO) to enable them to effectively lobby and advocate for increased support for the disabled population	3 DPOs and 7 PAFODA groups have been formed and registered with the Ministry of social services * The groups have been trained in group formation, leadership, management, lobbying and advocacy and entrepreneurship * 3 exchange visits were facilitated for the DPOs to enable them learn from other similar groups elsewhere. * groups have accessed loans (Makindu & Darajani)	Kibwezi and Mtito Andei DPOs are now represented at the locational DDC * A federation of the 3 DPOs have been formed and seeking representation in the DDC * Linkages have been made with the UDPK- The federation is a member of UDPK * Makindu have establish a formal office in the division	Despite the outputs and outcomes, the groups are still quite weak in many areas	Some of the constraints to the group's developments have been frequent local administrative changes The result is new group formations and membership drives. *Illiteracy hinders the groups ability to conceptualize issues. * Poverty affects the groups resource base
3. Conduct applied research to find out:-				

a) The most appropriate design of wheelchair for the area	A research on appropriate design of a wheelchair was carried out in collaborations with the DELFT University in the Netherlands	The prototype wheelchair exist awaiting operationalization	100% achievement	
b) Feasible and appropriate income generation activities for disabled persons in the area	Not done but replanned			
c) The causes and reasons for the high incidence of epilepsy in the area	Not done but replanned			A concept paper was developed for seeking supplementary funding for this research which was envisaged to require a bit detailed scientific investigations
d) Aspects that would promote the sustainability of CBR projects	Not done and replanned			A research protocol has been developed
4. Assist the PAFODAs and DPOs to initiate and manage income generating projects	2 DPOs have accessed loans (Makindu and Darajani) 4 PAFODA members have benefited from loans and materials 112 DPO and PAFODA members have been trained on business entrepreneur-ship	35 people have started small scale IGAs such as: maize selling, shops/vendors, selling bicycle spare parts, watch repairing, horticulture etc.	There is a lot of demand for this but much needs to be done	A loan scheme has been established but there is need to conduct an in-depth study in the area of IGAs
5. Promotion of networking both within and outside the country	1 National & 2 regional workshops held	An interim regional committee has been established	Much more still needs to be done in this area	National and regional cooperation requires adequate funding

6. Assist at least 20 disabled youths every year to acquire feasible vocational training giving priority to young disabled women	77 disabled youths have acquired vocational skills training	20% have been able to start their own IGA activities	More needs to be done to support "the out of vocational training youths"	A rapid assessment of the vocational training was conducted the results indicated that the majority of the disabled youths were unable to start activities due to start-up capital and/or tools. Traditional skills taught at the polytechnic have affected the viability of businesses
7. Establishment of four community based integrated day care centres	1 integrated day care centre established	12 mothers are accessing the day care centre for temporary custody of their children * Opportunity for playground for all children provided		The Ministry of education have posted a teacher to the day care centre
8. Establishment of a specious hostel for CBR trainees from the region	4 roomed hostel has been constructed- a kitchen, dinning and laundry rooms	* A curriculum has been developed for regional training in CBR	50% achievement	*Seeking funds for 2nd phase of the construction
9. Expansion of the present workshop to accommodate more people	Not done			*Funds for this was diverted to the construction of the hostel with the objective of putting up a resource centre at the training site during the 2nd phase

Observation

Having synchronized the set objectives to the identified needs of PWDs, it was now necessary to get feed-back from the service recipients and the stake-holders in efforts to evaluate the project.

3.0 FOCUS GROUP DISCUSSIONS

3.1 Community health workers (CHWS) Traditional Birth Attendants (TBAS) AND Volunteers

The cadre in reference are among the various Community Own Resource Persons(CORPS) commonly referred as the key actors in CBHC. They basically work on voluntarily basis and have multiple responsibilities in the community all related to Health and development

(i) Roles of CHWs, TBAs and volunteers in CBR

Information was sought to determine the roles of this team of actors in CBR and their involvement based on their own perception. From the interaction it was noted that CHWS TBAS and volunteers main task in CBR includes identification of PWDS and their families, counselling and referral, follow up sessions for PWDS for routine follow up and specific skills development. This is very important role because it helps PWDS come to term with their reality. The community health workers had good knowledge of the PWDs in their area.

Information was sought to determine how the CHWs access the PWDs in their area . The responses indicate that most of the times the group identify PWDS when conducting their routine work in the community or people report to them, other times they make observations during home visits and through referrals from community member conducting village survey. Most common form of disability as perceived by CHWs were as follows; epilepsy, physical, speech, seeing, hearing and mental handicap.

(ii) Approach used to identify PWDs

On trying to find out how the group approaches the PWDS/families they explained how a group of CHWs visits the family and explain their role in CBR. They specifically mentioned how they do climate setting to solicited acceptance before explaining their roles. Asked about their experience in carrying out this role the group responded as follows:-

- Find it difficult to change peoples attitude, for example CHWs may visit a home and recommend some measures to be taken just to come later and find that nothing has been done

- Expectations from the PWDs because " once you visit they expect help."

- The area of coverage is big which makes the work difficult in an attempt to reach the PWDs.(each CHW covers an avareage 16-20 homesteads). They felt the area should be reviewed for better coverage and effective service delivery

(iii) Follow up

Asked about follow up they explained how they refer to health institutions and then visit the home after a while to get feedback.

- CHW's constraints are; lack of essential drugs, lack of transport, extreme poverty within the community therefore little support from the community.

When asked what kind of follow-up activities they conducted, the responses were as follows: home visits once per week, organization of the play groups, organize specific activities for the play groups.
This also gives them an opportunity to identify new cases for referral.

(iv) Training for specific skills

Skilled rehabilitation is an activity carried out by this cadre, information was sought to determine what kind of training the group has undertaken to facilitate this activity. The training areas mentioned includes handling PWDS during an epileptic fit, counselling skills, identification skills and making of various appliances using available materials and how to use them

Regarding the situations that need counselling in the respective areas include PWDS requiring to be sent to school or vocational training, helping the PWDS and family members accept the reality and start doing something to improve their situation for particular type of disability and for sexual and reproductive concerns of the PWDs.

(v) Other trainings

Regarding other trainings ,CHWS are trained as CBDS, Nutrition, Growth Monitoring while others are trained TBAS. The training has been organized by AMREF CBR Project and other AMREF Projects. Asked how they integrate CBR into other activities in their day to day work, the team responded that when they visit a homestead they look into all the needs of that home and if their initial mission was not CBR, they address issues and concerns related to CBR.

(vi) WHO Package

It is important to note that the Focus Groups targets included CHWs, TBAs and Volunteers. Other than being the main actors in the identification counselling and referral process, they formed the main training team for PWDs and their families in the community.

The project uses the WHO Packages which are translated into local language for use by this cadre of personnel. The evaluation team sought the views of the above groups regarding the sustainability of the WHO training Packages and the following were their observations:

- The manual is composed of a range of packages with different themes representing

specific skills and needs.

- The training package are quite popular and those interviewed said they were useful. However, they had the following comments:

(i) Some wordings in the manual are not correctly phrased in local language

(ii) Interpretation of pictures is difficult.

(iii) Pictures need to be simplified and made relevant to the local situation copies are few for the users. Most used and needed books are numbers 21,7,2,4,5,19,12, 17 in order of demand, i.e. (21. - Training package for a family member of a person who has fit, 7.-Training package for a family member of a child who has difficulty speaking and moving but can hear, 2.-Training package for a family member of a person who has difficult seeing.- Difficulty hearing or speaking, 5.- Difficulty hearing and has not learnt to speak, 19.-Adult who shows strange behavior.

Constraints when using packages

- Some of the essential packages may not be available when needed
- Few books

General comments

- The group is well versed on CBR activities and with more training and supervision of their activities, it can do better.
- Poverty appear to be a major concern especially during the droughts and thus could interfere with the spirit of volunteerism.
- The team noted a crucial need to introduce IGAs for these groups as a monitoring factor and further observed a need to prioritize the concept of volunteerism.
- Other than reviewing of the local languages in translations, there is a need to redesign the pictures to reflect the local situations and therefore relevancy.

3.2 TABLE SHOWING Disabled Peoples Organization (DPOs) and Parents and Friends of the Disabled Associations (PAFODAs)

LOCATION	MALE	FEMALE	TOTAL
Ngomano	2	10	12
Makindu	8	4	12
Kathekani	3	12	15
Mtito Andei	13	26	39

Age range
- under 15 - none
- Between 16-20 - 1
- Between 21-30 - 3
- " 31-40 - 5
- " over 41- 7

The major aim of forming DPOS and PAFODAS is to bring together PWDs and parents in order to uplift their standard of living as well:-

- To fight for their rights
- To help improve their income and general wellbeing
- To be recognized by other organizations, community, GOK

Asked how their objectives were met, the following observations were recorded:

The group was well conversant with their objectives and their legal requirements for registration. All groups reported to be registered or are in the process of being registered. Asked how one becomes a member, they indicated that one is required to pay membership fee, agree with the constitution before being accepted by the group.

Group activities

Activities carried out by the group include selling and buying of maize and paraffin, giving credit to members among others. The groups have a number of projects such as IGAs, assisting other members construct houses, including making bricks for members in need, communal work, awareness raising, revolving fund out of which members can be given funds and Identifying and referring other PWDs

Asked about the needs of members in the groups; recognition and acceptance within the community was identified as well as improved income and appliances.

Information was sought to determine what CBR programme had done to address those needs. The following were sited :

- conducting workshops
- seminars to increase knowledge which has changed peoples attitudes towards PWDs
- has promoted self esteem
- brought confidence to members so that they can feel part of the community
- Training on prevention and corrective surgery, provision of exchange visits to see other disability projects in other parts of the country and in the region
- Training in developing appliances within the community.
- Supply of drugs for epileptic patients
- Assisted in construction of Day care centers and special units for children with disability.
- Lobbying for education opportunities for children with disabilities

Constraints

The group indicated that they have multiple responsibilities and therefore there is need for establishing a community center where PWDs can be accommodated to relieve the families off

the pressure of work.

Other constrains mentioned include;

- Low income
- delay in surgery
- poor mobility when attending meetings
- lack of essential drugs,

Information was sought to determine whether the PWDs are integrated into various community groups. The PWDS indicated that their participation is based on the nature of disability in relation to the scope and nature of work.

For example, Merry-go-round, acceptance is more based on capacity rather than the disability issues.

Helping each other in agricultural activities such as digging terraces and planting. One was discriminated upon if they could not do the work or pay money to compensate for the work not done.

- Those with Mental handicap are mostly avoided by the groups.

Role of DPOs and PAFODAs

Asked how they participate in activities, the DPOs indicated that they mobilize PWDs and refer them to CBR, they also carry out community sensitization at individual levels, assists PWDs in initiating IGAs especially in accessing loans to PWDs.

Assists in CBR activities in the grassroots mainly implements what CBR has requested them to do like organizing workshops and providing support during training, identifying and referral of PWDs as well as conducting follow up visits.

The DPOs indicated that they have benefited from the CBR programmes and cited skills acquired in making appliances, attending seminars and workshops on better leadership and management skills. CBR programme has assisted to mobilize group members. Some DPOs have benefited from IGA loans. Some DPO members have undergone reconstructive surgery. Those with epileptic fits have been supplied with drugs.

As regards to the day care center situated in NGOMANO the role of PAFODA in establishment of the day care center included mobilizing children, providing materials like bricks and manpower for construction while the CBR provided the rest of the materials and technical support.

Sustainability

Asked about their views about the way forward for the CBR project, one group felt that they" were not yet ready to carry on with CBR activities in absence of AMREF. Their structures are still weak and they require support from AMREF to develop these structures and integrate them within the community decision making organs"

Other comments/concerns

- Lack of a plot or an office to house DPOs or where to operate from.

These groups have potential for developing into strong support groups but their major constraints need to be addressed.

Training undertaken by CBR Project

The project undertakes the following training as part of capacity building endeavors.

1. Community health workers/Traditional birth attendants. This is normally an awareness training on disabilities, causes, management, identification and referral. A curriculum has been developed for this.

2. Extension workers. These are government workers in Agriculture, Livestock, health, social services etc.

   The training orientate them on disability as part of development issues. They are then expected to incooperate disability work in their day to day activities and organize community support for the same. A curriculum for this cadre is available.

3. Support groups - DPOs and PAFODAs. This training is geared to assisting the groups of Disabled People's Organizations and Parents and friends of the Children with disability have capacity to lobby and advocate for support and service for PWDs.

These trainings also involve community leaders like village elders, chiefs and even religious leaders. Those community leaders are basically trained on awareness of disability and how they can involve PWDs in community development and how they can mobilize and facilitate community support and contribution (moral and material) on disability issues.

Observations

1. The move from the individual medical model to a social model has been attained as evidenced by the following; project started with focusing on individual persons, but now the involvement of community groupings such as in play groups, DPOs, IGAs, Child to child programmes and other awareness seminars for groups form major project activities.

   Division of political boundaries has had an effect on the cohesion of the structures because of the new administrative boundaries.

- Lack of documentation especially in area of marketing.
- Ownership greatly appear to be AMREF driven
- AMREF should design a strategy of influencing the government to take ownerships throw the relevant Ministries
- Need for advocacy to integrate disability in the development agenda in line with other sectors. PWDs require more training for them and their families.
- Irregular home visits were cited. There is need for structured home visit plans.
- Those sponsored to polytechnics and other trainings should be guided or given tools to start them off.
- IGAs appear to be a big problem and it need to be reviewed in effort to providing clear guidelines about the entire operation. More efforts should be directed towards changing communities attitude about disability.
- People have not been fully reached in terms of changing attitude about the causes of disability.
- Need for clear demonstration about the roles and responsibility of DPOs and PAFODAs.
- The project should ensure gender balance in training programme, facilitation and management of the structure at all levels.

3.3. Mainstreaming the project into the government development planning - (District Focus for Rural Development)

During the evaluation planning sessions, it was found necessary and of paramount importance to find out the structures developed and/or existing within the Government system that would accommodation the project.

Towards this end, the evaluation team decided to interview one of the sub-locational development committees which is chaired by the Assistant Chief. This forms the grass-root governmental structure in the community. We also decided to talk to relevant departmental heads who sit onto and form the District Development Committee (DDC). This effort was aimed at establishing the level the government prioritized programmes that benefit PWDs within its planning mechanism and system.

Sub-locational development committee structure

The team visited Makindu Division and had an interview with the Chief of Makindu Location and the Assistant Chief of Manyatta Sub-Location.

The chief expressed regret that he might not be very conversant with the CBR project as he had newly been posted to the Location barely five months back. He had however been visited by the officials of the DPO in Makindu Division.

For reasons cited above the chief did not have the number of DPOs in the location at his finger tips, neither did he know much about registration process. He however recalled clearly how the DPO had contributed K shs. 10,000 towards the planned national harambee for the women to be presided over by the president of Kenya.

Among other roles he had played for PWDs had been signing of application forms for the DPOs members applying for grants from the National Trust Fund for the Disabled Persons (NTFD).

Twenty such cases requiring his forwarding stamp and remarks had passed through his hands. The office of the chief did not however have any records from which one could determine the number of PWDs in his area of jurisdiction and cases handled.

As much as the chief could enumerate some of the needs of PWDs which included skills training like tailoring, capital injection into PWDs enterprises and technical aids, like wheelchairs, he couldn't relate the above with CBR projection in Kibwezi.

It was therefore not possible to establish whether there was any formalized services in government development programme at that level though it was vivid in the chief's mind that some individual PWDs had initiated IGAs including small shops and watch repairs in the area and that they had opened bank accounts. But there was no linkage between the individual activities, the community and the government development programmes. Neither did they have any disabled person on the Locational development committee. The chief on the other hand advised PWDs and CBR to identify problems and channel them through the sub-locational development committee which in turn would forward them to his committee.

He promised that on issues where he could assist including allocation of land, plots and or premises to start a project, he would offer full assistance and further requested PWDs, DPOs or CBR to organize harambee through his office for that course.

The Assistant Chief of Manyatta Sub-location, on the other hand expressed opinion that the CBR programme had not involved his office as much. He remembered to have assisted PWDs get relief food and also identified and placed two disabled children in schools.

Assistant Chief of Manyatta was conversant with CBR project but lamented lack of proper collaboration with his office. He was aware of families that neglected their disabled members, but did not know what steps to be taken. He requested the project and DPOs to develop a mechanism through which women with disabilities would benefit from the fourth-coming national harambee for women to strengthen their IGAs.

3.4 District Development Committee (DDC) structure

Having established whether there was linkages in the government structure from the

community upwards, the team decided to visit Makueni District headquarters at Wote, the seat of the District Development Committee.

Due to logistical problems, appointments which had been arranged with some of the members for Friday 29 August could not be honored and the visit had to be rescheduled for Monday 1 September 1997. Most of the officers were not available. Only the District Education Officer (DEO) and the officer in charge of EARS programme were present.

Both the DEO and the officer in charge of EARS were totally conversant with the CBR project in Kibwezi. Incidentally, their homes are in Kibwezi Division so we could not tell whether their knowledge of the programme was because of its impact or just familiarity since it was a home project. They cited previous interactions in seminars on special education and collaboration in sports for the disabled children. They also explained that their officers including teachers at division level were involved in CBR project.

The Ministry of Education, it was reported had policy guidelines on special education from the top to the grass-root. There was a department of special education at the headquarters headed by an Assistant Director of Education. The only problem was the minimal allocation to special education due to general scarcity of funding in the whole Ministry.

Whereas there was a certain level of activity in the area of education especially more so due to the support from DANIDA with EARS programme and the CBR project, at the DDC level, issues of disability hardly featured. The only time probably was when discussing the vulnerable groups under the Social Dimension of Development (SDD) programme which is yet to be implemented.

There is no allocation of funding towards issues of disability at DDC level but a few grants and donations come through. They however cannot be quantified into percentages.

The CBR project has not as yet influenced prioritization at district level. Those interviewed requested for more sensitization of the DDC system on the importance of disability programme in the development of the district. They suggested awareness meetings and workshops involving the relevant members of the DDC to influence the thinking of the DDC to lean towards disability issues.

Asked whether the government was ready to take over the CBR project, they answered that the CBR project must stay on and assist in initiating the process in that direction and where need be facilitate with transportation to ensure a coordination.

Observations

Having failed to meet the heads of other departments including; health, social services under whose department issues on vocational training, employment, sports and recreation could have been discussed, it was difficult to assess the DDC structures and how it could relate to

disability issues.

Some of the areas that require attention could include issues ranging from, sensitization to coordination.

(i). CBR project should initiate dialogue between PWDs and the administration in mobilizing resources to develop disability programme particularly the human resource.

(ii). Coordination is major gap in the whole process. The project should workout some mechanism that will as much as it decentralizes services to other divisions, ensure centralization of policy issues to develop a coordinating process.

(iii). More and more involvement of the community could influence the government administrations concern and pressure must come from PWDs through the communities to the administration to ensure that there is movement from charity to demanding for rights. Sustainability can only be strengthened with more commitment from the government.

(iv) A mechanism for top-down need to be established right from the DC to the Assistant Chief or from District Development Committee to sub-location Development committees in order to deal with disability issues effectively.

(v) As much as there is assumed partnership in ownership of the programme among GOK, AMREF and the community, there is no clear-cut systems and commitment on take over.

4.0 RESULTS

4.1 Participatory evaluation

Out of 25 persons who were involved in the exercise, 24 (96%) persons attended the feedback meeting to discuss the results of the evaluation and analyze the effectiveness of the evaluation experience.

On a four point scale of highly significant, useful, not useful and poor a total of 18 rated high significance while the remaining 6 said useful. When asked to rate the one day workshop and construction of the questionnaire, 16 persons stated it was very-highly useful, 6 persons stated useful.

A total of 23 persons felt the questionnaire they administered in homes were well understood by respondents because they were in Kikamba.

The team therefore felt confident that the responses elicited from homes through the interviews were reliable indicators of what may exist. It can therefore be said that the evaluation team members were positive about being in this exercise.

4.2 The persons with disabilities

The programme has achieved notable progress in the areas of community sensitization and mobilization as many PWDs agreed that they have been accepted in the community. "We are now known by even the sub-district development committee and the entire leadership in Makindu division" said Ms Anastasia Kalunde one of the PWD whom the team interviewed. The project has also made a lot of impact in placing individual disabled children to schools and providing appropriate appliances.

4.3 Family involvement

A total of 60 family members were interviewed as part of this evaluation exercise.
Many of the family member interviewed were very positive about CBR-programme. On answering "How would you rate the assistance you have received from CBR?" 65% said it was useful in terms of managing impairment, daily living activities, business skills and use of locally available materials. The interview data provided information on issues of training, group formation, community meetings, participation and contact with CBR workers. The aim was to assess family's knowledge, skill and practices in the absence of a CBR worker. Moreover, it should be noted that in the absence of the CBR programme, very few of those interviewed would have received any service for their relative with a disability.
The programme should ensure that families/parents do not develop unrealistic expectations of the programme especially financial support. It was also encouraging to note that parents do not now expect the CBR programme to take responsibility for their family members.

The team noted that since one of the goals of the training programme is to try and raise up resource persons from amongst the family member "Community known as Volunteers" to work with other families, it may be necessary to introduce some form of selection criteria for those family members attending the training courses to ensure places for most motivated persons and those with a perceived capacity to pass on their skills to others. It was also of great interest during Focus Group Discussions to note that in addition to working with their own PWDs in their family, they also assist in other homes. A good foundation therefore exists on which an expansion of the programme could be established. Simplified version of training materials could be prepared for the family members so that they have some simple, illustrated teaching materials to share with the families when they visit. Case studies of successful cases could also be documented and used as training materials in families.

We recommend that a curriculum for families concerned with aspects of a social model approach i.e. attitudes and attitude change, strengthening household incomes, democratization process, family participation, cultural norms and sustainability be developed in addition to families using WHO Training manual.

4.4 Community involvement

The involvement and sense of ownership by the community are integral to the success of any CBR programme. The following people in the programme attempt to respond to this challenge. Community volunteers, CHWs, local DPOs, Extension workers, PAFODAs and members of the general public.

The focus group discussions confirmed community involvement through construction of community play-grounds where people meet with disabled persons for play and meetings. The groups confirmed raising of funds, material through community "Harambees" for the purpose of constructing houses/huts for disabled persons; provision of poles, reeds, mud, labour, sisal to construct appliances and in the training of other parents.

4.5 Collaboration with PWDs and PAFODAs

(a) PWDs

The Rapid Appraisal Report of 1996 reports a number of positive outcomes on the part of individual PWDs including: linking PWDs to appropriate technical institutions to learn skills, provision of commercial materials and equipment for economic independence. Such positive findings were confirmed by this evaluation.

The illustrations provided in the results section on PWDs support collaboration between PWDs and the programme. Although the project has not yet employed PWDs in key positions they play an important role as resource persons on the CBR training courses in sensitizing other persons to the needs of PWDs.

(b) **DPOs**

The formation of strong independent DPOs in management of income generating activities was sighted in annual report of 1996/97 as a main objective among others. It is also at the core on issue of Sustainability of the programme. There is a need for sensitization and training in areas of management, record keeping and marketability of skills for economic independence of PWDs and their families. The problems of low incomes and literacy levels together with lack of any form of transport have in many cases affected the functioning of PWDs or DPOs .

(c) **Collaboration with other NGOs**

As a key to Sustainability, CBR programme may be conceived in terms of an integrated model of development. The challenge for the CBR workers or PWDs would then be to place disability issues on the agendas of all other agencies working in the development field. The CBR programme has established effective links with ActionAid- Kenya, APDK, KAWE so that PWDs are able to benefit from whatever services these organizations offer.

4.6 Collaboration between project and ministries

Since the inception of the programme, much effort was made to bring together all bodies working in the field of disability be it government or non-governmental. This was however temporarily shelved as it proved very cumbersome and slow as majority of agencies are based in Nairobi, about 200 km from Kibwezi. Collaboration between the line ministries and Association for the physically Disabled of Kenya was maintained despite the fact that meetings are not regular and the roles of members are not explicit.

The evaluation team therefore noted the importance of the above committee in areas of drawing up broad policy guidelines, developing a comprehensive disability programme and be a means of sharing information between the key agencies. The team again noted that the contribution from Ministry of Culture and Social Services to the development of CBR programme is minimal at all levels.

At locational levels extension workers have identified themselves with the empowering of PWDs economically, socially and politically.

4.7 Income generating activities

It is a known fact that few IGAs under CBR programmes all over the world have succeeded. This does not mean that income generating activities for PWDs and their families should be discouraged as they improve household incomes and focus on financial independence.

The evaluation team noted that among other objectives, Kibwezi CBR-project aims at improving incomes for persons with disabilities and their families through provision of starting materials and training in the field of business skills and marketability among others.
There exists a saving and credit guidelines for the target groups which include PWDs, parents and guardians with disabled children, parents and guardians of persons who cannot advocate for themselves but who are members of DPO or PAFODA, women, CHWs and TBAs. In order to ensure the Sustainability of the scheme and encourage seriousness on the part of PWDs an interest rate of 18% per year has been put in place.

The 1996/97 annual report says "The development of the component for IGA has been slow due to the development of the loan guidelines". This has been because the DPOs and PAFODA members have taken time to understand the loaning scheme. The loan disbursements have therefore just started.

Secondly, the report continues, "in a hard hit community like Kibwezi, income generation opportunities are scarce, the community's buying power is low due to the vicious cycle of poverty attributed to frequent drought and famine. The project therefore has had to be selective and firm in its support and only support viable activities."

It is against this background that out of 16 income generating groups identified the project has supported 11 groups representing 69% of what the project has done. Of the 11 members supported, 10 were interviewed and rated CBR project "very useful". They also responded that they were trained by the project and that 60% had bank accounts. They also responded that CBR had provided start up materials rather than loans or grants.

The income generating activities offer a path towards greater independence for PWDs. This is especially important as few (or no jobs) are available for PWDs in rural ares like Kibwezi. Very well executed IGA activities can be effective means of motivating a number of key players in the programme (i.e. parents, PWDs, DPOs and volunteers).

The income generating activities therefore need assistance in these major areas;

- **Funding**: In the future, more money needs to be made available to the credit scheme in order to increase the out-put. Friendly credit scheme guidelines in respect to re-payment should be negotiated as the aim is not for the project to be in business but to improve financial status of PWDs.
- **Technical support**: The project should identify small scale entrepreneurs, improve your business skills to guide communities in identifying planning and marketing IGAs.
- **Training of PDOs so as to train their members**: That the project should identify relevant persons to train DPOs in areas of financial management, leadership skills and consultation skills.

The team also recommends that:

- A new training package on IGA that suits the country's needs be developed for DPO and PAFODA.
- The CBR programme should consider employing a full time person with business skills to promote IGA especially as this aspect of the programme will assume greater importance in the future. This person would focus on training needs, providing business advisory services to PWDs and facilitating the development of business plans and loan applications.

4.8 Referral services

The evaluation team was requested to assess the effectiveness of the existing community structure for identification and referral of people with disabilities and to assess to what extend the project has supported other medical interventions.

(a) Existing structures for identification and referral to social services

As we had reported before, the following structures in the community do exist:

- The government extension workers
- The community health workers who serve on voluntary basis
- The family members who serve on voluntary basis
- The PWDs through their DPOs
- The parents organizations (PAFODAs)
- The employees of the CBR project
- The chiefs
- The sub-location development committees

The above categories of people are trained to identify and refer PWDs for medical care in the fields of assessment, diagnosis and treatment of epilepsy. The annual reports of 1995/96 have it that a total of 450 cases of epilepsy were recorded in all the clinics while 2124 cases were reported in 1996/97 report. The interpretation of this big increase could have been that nobody was reporting on earlier cases. The idea of researching into the causes has been planned but nobody has carried it out. We recommend that research be carried out in this CBR project area so that the outcomes can assist other areas in the country.

Other referrals and accessibility to social services include, referrals to rehabilitation services i.e. village polytechnics, vocational training centers where PWDs acquire functional skills in leather craft, carpentry, tailoring and metal work. It is reported that since 1994, 19 PWDs graduated from these institutions and only 4 have established themselves in small businesses in their respective villages.

Other areas include integrating children into regular schools that have been running Child-to-Child programmes or to units attached to regular schools. The above community structures have also identified and accessed PWDs to social services in the community such as placing

PWDs in employment. There exists DPOs whose main thrust is lobbying and advocacy for the acceptance and human rights and for the development of IGA for the financial independence of its members.

The CHWs and TBAs identify and carry out home visits and to an extend do counselling services.

This team believes that in as far as identification and referral to medical and social services is concerned, the expected outcomes in the CBR programme were achieved. However, it is the feeling of the group that we cannot ascertain the degree of success as we were not availed the figures of follow-up and resettlement of persons identified and referred.

(b) Support to other medical interventions e.g., surgery, orthopaedic and neuro-surgery

The Annual Reports of 1995/96 reports that a total of 74 PWDs received reconstructive surgery. The impairments range from Congenital Constructure of the fingers, club feet, post burns and cleft lips and palates. The same annual reports has it that 87 appliances were produced and supplied to PWDs.

On the side of reconstructive surgery, the team feels that the expected out-puts in the CBR programme were achieved. Considering the problems of referral were lack of medical experts at location, division and district levels, limited capacity of the regional hospitals and transportation problems.

It is recommended that the CBR programme strengthen operational theaters of the nearest hospitals so PWDs can take preference. The team also feels that production of aids and appliances should be stepped up. Focus Groups have complained of delays in production and supply.

We recommend that an activity for training local artisans, PWDs, DPOs and PAFODAs in the production of aids and appliances be developed to avoid long distances and reliability to the programme. The programme should introduce in their activities services that cover all impairments and not to concentrate on physical disabilities only.

4.9. SUSTAINABILITY: ISSUES IN DPOs AND PAFODAs

One of the objectives of evaluation was to assess how the project has developed the capacity of the DPOs and PAFODAs and their active participation in the decision making processes of the project.

Sustainable development of the CBR programme at the local level is possible only when there is effective, innovative and responsible leadership and effective involvement of PWDs and

their families. There is evidence to show that the project carried out leadership training, exposure visits, provided revolving loans for the income generation and involved DPOs and PAFODAs in staff meetings. This shows that planning, implementation, monitoring and evaluation has been done together. The project has carried out training in fund-raising preparing both DPOs and PAFODAs to sustain their activities should the donor pull out.
The 1996/97 annual report says that all the above efforts were put to waste when greater Kibwezi was sub-divided into three smaller divisions. "The solidarity that had developed within the original group of the DPOs and PAFODAs was however interrupted by the sub-division of Kibwezi administratively into three smaller divisions." This meant the split of the original one into three units for the purpose of administration and registration. It was observed that Makindu DPO has a strong and good leadership as it was not affected by the above administrative division. There is need for the programme to start afresh in shaping the leadership and membership of DPOs in Kibwezi and Mtito-Andei which at present look fragile for any progressive work. The team observed that there were no clear cut structures for the DPOs. The programme should assist DPOs to establish structures through which government, especially DDC and other agencies can channel assistance. The grassroot groups should affiliate to a sub-location leadership then to a location, a division, and to a district etc.

The programme put a lot of effort in developing and strengthening PAFODAs through training in order to build their emotional, spiritual and physical support to PWDs. The political divisions of greater Kibwezi did not disrupt efforts put in place by the programme. PAFODAs provide a forum for mutual understanding, acceptance and information sharing. However, it was noted that they lack capacity to sustain the programme due to high levels of poverty. Members simply do not have enough time to devote to activities that would sustain a CBR programme.

It is our considered view that the programme should re-visit this area with a view to starting or strengthening the DPOs and PAFODA structures from grassroots with an in built component on Sustainability strategies. However, there is evidence of awareness creatied by the project through training sessions that have been carried out.

Through training workshops, Chiefs and Sub-Location Development Committees informed the team that they know the programme and its objectives and have supported it by providing accommodation and food and have involved PWDs in their developmental meetings.
The extension workers, CHWs and volunteers have strengthened referral system through identification and training and training of enrolled nurses have assisted the programme in catering for the families and persons with epilepsy.

The PWDs still depict a sense of inferiority complex and they have not yet attained a high level of empowerment. The programme should carry out refresher courses with an in-built component on sustainability.

The team was also requested to assess the effectiveness of the WHO model of training at the

community level. The team interviewed staff that trains parents using the WHO manual. There were divergent feelings. The general feelings however, were that the manual is too expensive to interpret in various local languages. It was repetitive and had no respect to parents as it assumes that parents had never taken care of their children.

That it is inhibitive as trainers do not care to learn about the experiences of parents with their PWDs. That it has no respect to traditional appliances. It was felt that a local manual depicting traditional methods used should be developed so as to be used alongside WHO manual. There is a need to provide WHO manual to some members of DPOs and PAFODAs who can read in order to train their colleagues.

5.0. LESSONS LEARNT FROM THE EVALUATION

The following are some of the lessons learnt from Kibwezi CBR experience.

- No one agency can effectively deal with the challenges of disability and therefore a multi-sectoral response is essential.

- That the responsible Ministries should work hand in hand on a daily basis with the NGOs that supplement government efforts.

- An inter-Ministerial Committee together with AMREF is essential in terms of policy , budgeting, supervision and collaboration in order to use scarce resources available to CBR sector.

- A system of voluntary workers in Kibwezi CBR programme provides challenges to other CBR projects in the region.

- While many volunteers are doing a good job the project should address how this cadre of workers can be properly motivated to curb defection.

- CBR-programme tends to concentrate on persons with movement difficulties, attention should also be turned to persons with learning, seeing and hearing difficulties.

- That it is advantageous to the project to have a very well developed structure in government e.g., Ministry of Health, for eventual take over of the programme.

- The chiefs and sub-location development committees have the potential to play a key role in the consolidation of the programme. However, they need further training and support to maintain their motivation

- That CBR programme is a cross-cutting issue and therefore must be sustained in all concerned Ministries. Government has the responsibility of providing services to all

citizens, PWDs included.

6.0. USE OF THIS EVALUATION

One of the goals of this evaluation was to assess the project approach from the individual medical orientation to a social development approach. We examined the strength and weaknesses and the challenges which have yet to be achieved.

The findings of the evaluation now need to be shared with as many key members of the CBR programme as follows.

Three day workshops should be held in each of the sub-locations to share the views of evaluation. The Kibwezi Evaluation Team should serve as facilitators of the workshops. The participants should include Chiefs, members of Sub-Location Development Committees, DPOs, PAFODAs, Extension workers, CHWs and Volunteers.

These workshops will help to promote a reflective approach within CBR-programme. They will also mark the beginning of the process of ownership by the community after the administrative divisions of greater Kibwezi.

7.0. CONCLUSION

The impression of the Evaluation Team was that the CBR programme exists at the grassroot but is not yet owned by the community. The approach from individual medical orientation to social development approach has taken place but is not yet consolidated. This philosophy is based on the promotion of self-help, community participation and equalization of opportunities in sharing of community resources. This will be pre-requisites for sustainable development.

The majority of community members interviewed stated that they found the programme valuable and useful. The PWDs, their DPOs and PAFODAs have been mobilized and are involved in various aspects of the programme despite acute poverty in catchment areas. In these and in many ways, a strong foundation has been established from where CBR programme can flourish. We feel that the programme would be more consolidated if it is to be appreciated as a cross-cutting developmental issue which should be handled by lead Ministries in terms of policy guidelines, budgets etc. We feel that CBR is a process which should be spearheaded by Government but call on NGOs like AMREF to supplement on its efforts. We again feel that disability issues should be included in all AMREF programmes.

In conclusion, the writers would like to express their sincere thanks to their very hard working colleagues of Kibwezi Evaluation Team and to the many equally dedicated members of the Local Evaluation Team who helped to gather the images of Kibwezi CBR-programme.

8.0. RECOMMENDATIONS

1. The project needs to decentralize its management structure in order to accomodate and run within the present new government administrative structure but maintain a central policy formulating organ at Kibwezi.

2. For sustainability, as the project continues to build, the capacities of the communities through DPOs and PAFODAs, it must establish and strengthen the linkages with the government Development System in an effort to develop a mechanism for gradual transfer of ownership.

3. The Coordinating Committee should be reviewed and strengthened to encompass all partners, stake holders and community leadership.

4. IGAs being a major tool in transformation and empowerment of PWDs, there is a need for the programme to be properly planned, designed and managed. A management training component of IGAs is therefore pre-requisite. There will be equally a need to develop a water-tight loan recovery mechanism to check on defaulting.

5. Recognising the fact that disability is a cross-cutting issue, AMREF is advised to integrate the CBR programmes in all its other existing programme so that the project does not seem to run in isolation.

6. There is a need for the project to do a case study of PWDs who have benefitted from the project since its inception in order to assess the success of transformation from medical to social.

7. Kibwezi CBR project is internationally renown but there is very little scientific documentation of the project other than progress reports and evaluations. There is need for the experiences and the lessons learnt to be documented for reference.

8. In view of the fact that families find the WHO manual useful, there is need to review the translation into proper language and redesigning of the pictures to reflect local images in order to make it more relevant to the local situation.

9. While appreciating the commitment of the project staff, opportunities should be availed for professional training on CBR. With this kind of training, it will be easier to establish a management team within the proposed decentralized set up

10. The National Trust Fund for Disabled (NTFD) is by and large one of the key financial resource from PWDs. In collaboration with stake holders, the project should endeavor to develop a lobbying mechanism to influence change in the Fund management and focus.

11. In the process of deciding which programme to put in place for the benefit of PWDs efforts must be made to involve them in the decision making so that they are seen to be part and parcel of the whole process. What is priority for them should be given first consideration.The project should therefore assess the strengths and weaknesses of PWDs and their organizations vis a vis their needs to ascertain the real areas to invest in to ensure appreciation and fulfillment.

ABBREVIATIONS

AMREF	-	African Medical Research Foundation
KRHS	-	Kibwezi Rural Health Scheme
MOH	-	Ministry of Health
MCSS	-	Ministry of Culture and Social Services
MOE	-	Ministry of Education
NGO	-	Non-Governmental Organizations
PWDs	-	Persons with Disabilities
WHO	-	World Health Organization
DPOs	-	Disabled Peoples Organizations
PAFODAs	-	Parent and Friends of the Disabled Association
CHWs	-	Community Health Workers
GOK	-	Government of Kenya
TBAs	-	Traditional Birth Attendants.

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FOCUS GROUP DISCUSSION GUIDE FOR, TBAs,VOLUNTEERS

Type of Group .....
Sub Location .....
Village .....
Age (range) .....
Male/females

Introduction/climate setting

1. What are your roles in relation to CBR of disabled persons?
   Probing questions

2 a. What activities do you carry out to fulfil this roles? i.e.
   - Identification of PWDs
   - Referral
   - Follow-up
   - Rehabilitation services . specify
   - Counselling
   - Community sensitization about CBR
   - Counselling PWDs and their families

   b. Where do you refer the PWDs

3. How many PWDs are in your area?
   - How do you know them?
   - How many types/ most common form of disability?

4.a. How do you approach a family/individuals with disabilities?
   - family
   - individuals

b. What is your experience in carrying out this activity? e.g. problems encountered and how they are overcome.

5.a. What do you do with people with disability?

b. How do you get feedback about the people you have referred?

c. What constraints do you encounter?

d. What kind of follow-up do you carry out? how often do you carry out the follow-up?

6. What type of skilled rehabilitation services do you provide
   - What kind of training have you received on skills indicated?

7. What are the situation that need counselling in your area regarding disability?
   Probing
   - neglected persons
   - defaulters
   - abuse
   - sexual and reproductive health needs

8. What kind of training have you received?
   - Who organizes the training?
   - How did the training help you in your work?

9. How do you integrate CBR with other activities in your day to day work?

10. Who do you report to?

    - how often do you meet?

    - what do you do when you meet?

11. How has CBR Project helped the PWDs in your community?

12. In your opinion, how will the CBR Project be sustained in your community?

13. For CHWs using WHO Training packages, are you you aware of the WHO packages?
    If yes, Do you think the packages have helped you in carrying out your duties as regards disability work? If yes how?

14. What constraints have you encountered while using the packages?

QUESTIONNAIRE FOR THE LOCATIONAL DEVELOPMENT COMMITTEE

Name .....
Title .....
Gender ... Females/Males

1. Have you heard anything about Kibwezi CBR?

2. What do you know about it?

3. How many PWDs are in your area?

4. How many groups of PWDs are registered in your area? and how do you work together (role)?

5. What are the needs of these groups and how has CBR helped you to address them?

6. What are the needs of PWDs and how has CBR helped you to address them?

7. How have you integrated services for PWDs in the main stream development in your area?

8. Are PWDs represented on your committee? if yes - why?

9. How can the community participate in supporting CBR project?

   (a) Resources - funds

   (b) Training support

   (c) Food provision

   (d) Land allocation

10. What is the way-forward for the CBR programme in your location?

QUESTIONNAIRE FOR THE DDC

Name .....
Title .....

1. Have you heard anything about CBR? when and how did you know about it?

2. What do you know about it?

B 1. What is the role of the DDC in the activities of Kibwezi CBR project?

2. What policy guidelines are in place at district level that would cater for disability issues in:-

   (1) Education
   (2) Health
   (3) Vocational training
   (4) Employment
   (5) Accessibility; both physical and information
   (6) Sports and recreation

3. How has CBR as an approach influenced development prioritization at district level?

4. Are there budgetary provisions to cater for the disability services? if yes - what percentage of the ministry

QUESTIONNAIRE FOR PWDs

1. **Name..... village .....**

   sub-location ..... location.....

2. **Nature of disability: moving, seeing, hearing/speech, epilepsy, learning, no feeling. Others please specify.**

3. **Age .....**

4. **Sex: Male/female**

5. **What are the greatest needs faced by persons with disabilities in your area?**

   Circle one or more of the following:

   (a). **To be more independent financially**
   (b). **To be accepted within the community**
   (c). **To have access to specialised facilities**
   (d). **Others, please specify**

6. **What do you feel the CBR programme has done to respond to the above needs? (circle one or more of the following)**

   (a). **promotion of Income generating schemes**
   (b). **reduced barriers**
   (c). **access to education facilities**
   (d). **access to medical rehabilitation facilities**
   (e). **access to vocational rehabilitation**
   (f). **very little support has been offered**
   (g). **Others, please specify.**

7. **What support do you think the CBR programme could give to PWDs in your area? (circle one or more below)**
   (a). **extend training to family and community**
   (b). **develop employment opportunities**
   (c). **Lobby and advocate for human rights for PWDs?**
   (d). **Involve PWD's in planning implementation, monitoring and evaluation of communities activities.**

8. **List three changes that could be introduced to make CBR programme more beneficial in your area.**

9. How can the community participate in supporting CBR projects?

(a). Resources- funds
(b). Training support, provision of food, training support
(c). Provision of land

10. How would you rate CBR programme?
(a). Very helpful
(b). helpful
(c). unhelpful

11. How has CBR enabled your family to support you?

(a). training (b). counselling
(c). home visits (d). others

QUESTIONNAIRE FOR CBR STAFF

Name

- Professional status .....
- Brief description of your role in CBR project
- How long have you been in the project?
- How did you get into the project?

1. Describe your work with the following:
   (a). DPOs/PAFODAs

   (b). Ministry of education

   (c). Ministry of culture and social services

   (d). other NGOs if any

2. What are the objectives of this programme?

3. What are the strengths weaknesses/ opportunities and threats of this programme?

4. In your own assessment, have you achieved your objectives? give reasons

5. What have been your major constraints to the programme implementation?

6. What do you suggest can be done to overcome the constraints?

7. What are your expectations in the programme?

8. Do you think that the programme meets the needs of PWDs? Give comments
   To what degree has the programme been able to meet the needs of PWDs.

9. What are your frustrations ? if any.

10. How could the CBR programme be improved in terms of organizational and technological aspects in the design of the programme?

11. In your opinion, do you think CBR is an answer to PWDs?

12. How do you rate CBR programme in respect to service delivery?

- very helpful
- helpful
- unhelpful

13. What motivation(s) would you prefer in your responsibilities?

14. How could this CBR programme be sustained?

QUESTIONNAIRE FOR DPO/PAFODA

Name of the group.....

Responsibilities of participants .....
.....

Age .....

Gender .....

1. What are the objectives of the group?
   probe for lobbying and advocacy.
   - how
   - when
   - why

2. How many are you in your group?

3. Is the group registered?

4. How does one become a member?

5. What activities does your group carry out?

6. What are the needs of members in this group?

7. How has CBR programme assisted the group to address the above needs?
   probe for constraints

8. How do DPOs participate in CBR activities?

9. How have you benefited from the CBR programme?

10. What has been your role in establishment of day care centre unit-(PAFODA) (NGOMANO)

QUESTIONNAIRE FOR COLLABORATORS

Name of Agency .....

Name of Respondent .....

Title .....

1. Are you familiar with CBR programme?

2. In what ways has your office supported the CBR programme? probe:
   (a). financial support
   (b). land
   (c). policies
   (d). curriculum
   (e). transport

3. In what ways has the CBR project supported your office? probe:
   (a) training staff
   (b) resource persons

4. Has your office participated in the activities of CBR activities?
   - production and supply of activities
   - CBR-guidelines
   - Meetings

5. Do you think that CBR project has influenced other CBR projects in the region? (Eastern)
   probe: in what ways
   - workshops
   - seminars
   - research
   - evaluations
   - resource persons

6. How has your office participated in the management/governance of CBR project?

7. 7. What would you suggest the way forward in case of external assistance stopping/stopped?