TRANSITION FROM CBR TO CBID:
A SITUATION ANALYSIS OF COMMUNITY BASED REHABILITATION (CBR) AND COMMUNITY BASED INCLUSIVE DEVELOPMENT (CBID) IN AFRICA

By
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Executive Summary

Community Based Rehabilitation (CBR) has been implemented in many parts of Africa for over four decades. Since the declaration of the sustainable development goals, Community Based Inclusive Development (CBID) has been popularized for disability inclusion. Although each stakeholder is aware of contribution of CBR and CBID in empowering and enabling persons with disabilities, there seems to be confusion since many do not understand the difference they have.

In 2020, Rehabilitation International supported CBR Africa Network to establish the nature of interventions implemented by the various organizations for persons with disabilities to improve the lives of persons with disabilities and explore how this could inform the transition from CBR and CBID. The study was implemented in four countries of Africa that is Uganda and Zambia which are Anglophone and Francophone to allow room for comparison. Uganda and Zambia (Anglophone) and Cameroon and Togo (Francophone).

The study involved policy makers, education specialists, health personnel, personnel from organizations of and for persons with disabilities, human rights activities, leaders of persons with disabilities at different levels as well as persons with disabilities, family members and some community members. Information was collected using document review, some questionnaires, focus group discussions, interviews and observation. Output of these has been triangulated to generate the following results:

A total of 260 organizations participated in this study. 24.6% were organizations working with persons with disabilities and organizations of persons with disabilities 23.5% while NGOs 1.5%, government 2.3% and CBOs 3.8% had the lowest representation. Use of both CBR and CBID was noticed in all four countries. However, the higher percentage (38.8%) of the organizations reported that they have retained CBR, 31.4% have shifted to CBID while 29.8% are still grappling with the two concepts possibly because they are failing to comprehend their difference. Despite adoption of CBID, most organizations continue to implement similar activities as they did under CBR.

Lack of disaggregated data on disability, limited knowledge on the difference between CBR and CBID, limited funding, negative attitude and lack of coordination between stakeholders were identified as key challenges in CBR/CBID.

To mitigate these, obtaining disaggregated data, research and documentation of the PWDs, existing resources and facilities to inform planning, economic empowerment of PWDs and families, lobbying and advocacy for harmonization of CBR and CBID,

Conclusions

Regardless of the name, persons with disabilities need empowerment and enablement to enhance their participation and inclusion. The launch of the CBR guidelines reflected in the CBR matrix clearly indicates that inclusive development is the ultimate goal for CBR interventions. Regardless of the approach, persons with disabilities need adoption of the twin-track approach for them to empower while creating an enabling system at the same time. Much as some changes are professed by some respondents adopting CBID, interventions to empower persons with disabilities should be encouraged for effective disability inclusion.

Recommendations

1. **Raising awareness:** Many people have always ben familiar with CBR. Advancement of CBID makes them expect and feel a difference in interventions yet the two are approaches which involve similar activities to promote participation and inclusion of people with disabilities. Awareness is therefore required to help individuals, families, communities and all other stakeholders in disability to help them understand the CBR/CBID for effective planning and implementation of activities.

2. **Networking and collaboration:** The effectiveness of CBR/CBID requires collaborative efforts from different stakeholders. Government departments like MOH, MOES, MOGLSD and MOLG should work together with communities and Civil Society Organizations in the planning and implementation of activities for persons with disabilities.

3. **Education and training:** Effective planning and implementation of interventions requires sufficient capacity

development. Regardless of the name of the approach, education and training of individuals, families, project/ program implementers and all other stakeholders is required in needs identification, intervention planning and implementation to promote participation and inclusion of persons with disabilities at the different levels which is the ultimate goal.

4. Lobbying and Advocacy: Most interventions for persons with disabilities are supported by civil society organizations and development partners which is not sustainable. Effort should be made to lobby and advocate for government commitment and deliberate investment in CBR/CBID interventions at the different levels.

5. Promote use of locally available resources: CBR/CBID being community based emphasizes use of locally available resources for ownership and sustainability of interventions however, this has been significantly lost in many communities. Effort should be made to promote identification and use of locally available resources at individual, family and community level since it helps to reduce costs and demystify disability to promote participation and inclusion of persons with disabilities.

6. Promote research: In all most countries like the four countries of study, there is a general lack of disaggregated data on persons with disabilities, existing resources and interventions in communities. This calls for research at the different levels to inform effective advocacy, planning and budgeting for effective service delivery.

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Abbreviations

CBID	Community-Based Inclusive Development
CBR	Community-Based Rehabilitation
DPO	Disabled Persons Organisation
WHO	World Health Organisation
OPD	Organization of People with Disabilities
CSO	Civil Society Organization
MCDSS	Ministry of Community Development and Social Services
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UN	United Nations
ZAPCD	Zambia Association of Parents of Children with Disabilities
ILO	International Labour Organizations
UNESCO	United Nations Educational, Scientific and Cultural Organization
IDDC	International Disability and Development Consortium
SDGs	Sustainable Development Goals
MDGs	Millennium Development Goals

INTRODUCTION

1.1 Background

Persons with disabilities need interventions to empower them and mitigate barriers to their participation. Disability as a concept has evolved over the years. In the 19th and 20th centuries, advancement in science and medicine led to a perception of disability as a health condition that requires medical intervention. It was therefore perceived to be an impairment which restricts one's functional ability; and intervention focused on cure and the provision of medical care by professionals (WHO, 2010).

In the 1960s and 1970s persons with disabilities emerged with their own view that disability is attributed to barriers that exist in society; hence shifting from the medical perspective. Disability was redefined as a societal rather than individual problem; hence focusing on mitigation of barriers and social change that goes beyond the medical intervention. In the 1990s, disability advocates popularized the well-known slogan of "Nothing about us without us" to emphasize the desire for persons with disabilities to achieve full participation and equalization of opportunities for, by and with persons with disabilities. This greatly contributed to developing the Convention on the Rights of Persons with Disabilities (CRPD), which promotes a shift towards a human rights model of disability.

The UN Convention on the Rights of Persons with Disabilities (CRPD) describes persons with disabilities to include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (Article1). 'This is based on observation that the concept of disability is evolving and that disability results from the interaction between persons with impairments and the barriers that hinder their full and effective participation in society on an equal basis with others'(UN,2006).

Comprehensive rehabilitation services focusing on health, employment, education and social services are needed to enable Persons with disabilities attain and maintain maximum independence, full physical, mental, social and vocational ability for participation and inclusion in all aspects of life (UN, 2008).

Community-Based Rehabilitation (CBR) was introduced by the World Health Organization to improve access to rehabilitation services for Persons with disabilities in developing countries. The primary principle of CBR is to provide primary health care and rehabilitative assistance to persons with disabilities, by using human and other resources available in their communities. CBR is a community development strategy that is used to improve the lives of persons with disabilities within the community, emphasizing utilization of locally available resources including beneficiaries, their families and the community to widen their opportunities. It is a strategy for rehabilitation, equalization of opportunities, poverty reduction and social inclusion of people with disabilities (ILO, UNESCO&WHO, 2004). CBR is implemented through the combined efforts of persons with disabilities, their families, communities, relevant government and non-governmental health, education, vocational, social and other services. It involves activities to empower persons with disabilities with skills development, emphasizing the use of remnant abilities and creating an enabling environment to ensure their engagement in all individual, family and community undertakings in contribution to inclusive development.

Evolution of CBR into a broader multi-sectoral development strategy, led to development of a matrix to provide a common framework for CBR programmes. The matrix consists of five key components – the health, education, livelihood, social and empowerment components. The first four components relate to key development sectors, reflecting the multi sectoral focus of CBR. The final component relates to the empowerment of persons with disabilities, their families and communities, which is fundamental for ensuring access to each development sectors and improving the quality of life and enjoyment of human rights for the persons with disabilities. Each of the

components of the CBR matrix forms a model for implementation of CBR.

The CBR guidelines launched in 2010 in Abuja – Nigeria, provide direction for effective development of CBR programs with the ultimate goal of attaining inclusive development. Inclusive development is where all people regardless of their differences engage in all activities with all their needs equally met. It is about ensuring that persons with disabilities are part and parcel of community development. The UN defines community development as "a process where community members come together to take collective action and generate solutions to common problems."

Recent development has introduced the concept of Community Based Inclusive Development (CBID), a person-centered approach where community members and community-based organizations take collective action for achieving disability inclusion within their communities. Today many stakeholders use the concepts CBR and CBID interchangeably. After the declaration of the sustainable development goals (SDGs) with their overarching principle of "leaving no one behind", many development partners and funding agencies insist on CBID and sometimes disregard CBR - associating it more with the medical intervention. Although each stakeholder is aware of their respective contributions in empowering and enabling people with disabilities, there is need for clarity in informing effective programming and service delivery.

CBR Africa Network (CAN) brings together stakeholders in disability; rehabilitation and inclusive development from different parts of Africa to share information, learn and document experiences. Being one of the stakeholder in CBR/CBID networking launched a study to establish the nature of interventions undertaken by the different stakeholders working with persons with disabilities in different countries of Africa. In 2020, Rehabilitation International supported CBR Africa Network to establish the nature of interventions implemented by the various organizations for persons with disabilities to improve the lives of persons with disabilities and explore how this could inform the transition from CBR and CBID. This study was successfully completed despite the disruptions of the Covid-19 pandemic.

1.2 Statement of the Problem

CBR has been implemented in many rural communities of Africa for over four decades. The CBR guidelines launched in Abuja Nigeria in 2010 detail the key components of the CBR matrix which relate to key development sectors and reflect the multi-sectoral focus of CBR. The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and Sustainable Development Goals (SGDs) have led to increased advocacy for disability inclusion hence CBID.

Globally, stakeholders are grappling with the "CBR-CBID transition" however, no study has been conducted on what is being implemented by stakeholders to inform the transition from CBR to CBID.

1.3.1 Purpose

The study sought to establish the CBR/CBID interventions implemented by the different organizations for persons with disabilities to guide the transition from CBR to CBID.

1.3.2 Objectives

1. To establish the nature of interventions and services provided by different organizations for persons with disabilities in the different countries of Africa.
2. To establish the changes realized by the different stakeholders since the declaration of the transition from CBR to CBID
3. To identify needs, benefits and challenges associated with the transition from CBR to CBID in Africa.
4. To propose appropriate strategies to facilitate harmonization of service provision to persons with disabilities during the transition from CBR to

CBID.

1.3.3 Study Questions

- What is the nature of interventions and services provided by different stakeholders implementing CBR or CBID in the countries under study?
- How are the interventions implemented?
- Who are the stakeholders engaged in the interventions and what is their respective stake?
- What are the challenges and benefits associated with the transition from CBR to CBID in Africa?
- What are the changes realized by the different stakeholders since the declaration of the transition from CBR to CBID?
- What strategies can be proposed for facilitating harmonization of service provision to persons with disabilities?

1.4 Scope of the project

The study was conducted in four countries of Africa with consideration of Anglophone and Francophone to allow room for comparison. Uganda and Zambia represented the Anglophone while Cameroon and Togo represented the Francophone countries of Africa.

Organizations providing services to persons with disabilities were identified to participate in the study, guided by the CBR Matrix. Despite the Covid-19 pandemic, effort was made to reach programs/organizations in the different regions of each of the respective countries of study with consideration of rural and urban settings which allowed room for effective comparison. In the respective countries, the study involved both government programs and those implemented by civil society.

In terms of time, the study focused on the trend of interventions stretching from 2000 to-date, identified the changes realized over time in relation to the changing development agenda and the global effort to ensure participation and inclusion of persons with disabilities.

2.0 REVIEW OF RELATED LITERATURE

Introduction

The review focused on the concept and evolution of the community-based rehabilitation (CBR) and community based inclusive development (CBID) approaches as viable strategies for the rehabilitation of persons with disabilities. The approaches were separately explained and then their strengths and weaknesses compared.

2.1 CBR and CBID: Conceptual background

On realizing the gap in rehabilitation services, inadequate national planning and co-ordination of medical, educational, vocational and social services among others, the challenges in institutional care, in 1974, WHO began to shift focus towards increasing access to rehabilitation. Recognizing that rehabilitation was a component of primary health care, CBR was initiated by WHO following the1978 International Conference on Primary Health Care and the Alma-Ata declaration (Helander, 2007). It involved measures undertaken at community level to improve the lives of persons with disabilities, their families and community using locally available resources.

In the 1980s, WHO published and field-tested the first CBR training manual for persons with disabilities in the community (Helander, 2007). In 2004, a joint position paper by the International Labor Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO) and WHO redefined CBR as "A strategy within general community development for the rehabilitation, equalization of opportunities and social inclusion of all children and adults with disabilities. CBR is implemented through the combined effort of persons with disabilities and the appropriate health, education, vocational and social services." Following the UNCRPD in 2006, WHO published the CBR guidelines in 2010 to guide stakeholders in developing and strengthening CBR programs in line with the CBR joint position paper and the UNCRPD. The CBR matrix in the CBR guidelines demonstration the multidimensional efforts to improve the lives of persons with disabilities.

The evolution of CBR, the UNCRPD and the declaration of the SDGs in 2015 have caused a change in the understanding and practice of CBR. Today it is a comprehensive, multi-sectoral, rights-based approach encompassing services within Health, Education, Livelihood, and Social development sectors (WHO, 2010). Furthermore, cognizance of the fact that persons with disabilities have the same rights and need access to the same services and opportunities as others in their communities is paramount (UN, 2008).

The launch of the SDGs in 2015 intensified advocacy for disability inclusion hence CBID. The ultimate goal of CBR is disability inclusive development. CBID it is considered as making communities and society inclusive of all marginalized groups and their concerns, including persons with disabilities (WHO, ILO, UNESCO & IDDC, 2010; IDDC, 2012). The assumption of CBID is that persons with disabilities are included in all aspects of community life and given full access to all facilities and services. To achieve this twin track approach: focusing on society to remove barriers to exclusion of persons with disabilities; and focusing on persons with disabilities to build their capacity and supporting them to promote their inclusion is recommended (IDDC, 2012).

As we all grapple the name change from CBR to CBID, this study sought to explore the details, in the two strategies and the respective gaps in each to inform decision making.

2.2 Service provision under CBR and CBID in Africa

CBR is today a comprehensive, multi-sectoral, rights-based approach (Karen, 2013); although at its inception it was medical orientated and often single sector (dominated by the medical model) service delivery approach (ILO, UNESCO &WHO, 2004). It is today practiced

in over 90 countries and is increasingly seen as an effective strategy for inclusive development and, more recently, as a means of implementing the Convention on the Rights of Persons with Disabilities (Karen, 2013). The approach encompasses many strategies which are often unique to a particular country, region or service provider (WHO, 2003). This flexibility makes CBR adaptable to local needs, but hinders comparison across interventions (Mitchell, 1999). The CBR Matrix (WHO, 2010) provides a way to depict the diversity of strategies, and to understand and compare CBR interventions. The matrix consists of five key components four of which: Health, Education, Livelihood and Social - relate to key development sectors. Empowerment, the final component, addresses sustainable access to development sectors for people with disabilities and their families (WHO, 2010). To implement its multi-sectoral goals, CBR calls for full and coordinated involvement of all levels of society, community, district, and national (Helander &Mendis, 1991; Sharma M, 2007; ILO, UNESCO &WHO, 2004).

CBR programs support persons with disabilities by providing rehabilitation services within their communities. The key activities of the CBR program comprise organizing training sessions for the welfare of family and community members on disability; providing educational assistance and improving physical access; setting up referral services; providing assistance (namely, financial support, assistive devices); arranging employment opportunities; and extending social and recreational support (Díaz-Aristizabal et al, CienSaude Colet, 2012; Mannan &Turnbull, 2007). CBR activities are not only cost-effective, but have delivered encouraging results in increasing independence; enhancing mobility, improving communication skills; augmenting educational/vocational opportunities; influencing community attitudes positively; and in facilitating social inclusion of disabled people (ILO, UNESCO & WHO, 2004).

It is evident that CBR and CBID are multisectoral in nature and aim at improving the quality of life of the persons with disabilities, their families and community. It is however not clear what difference changes come with the name choice hence this study.

2.3 Benefits of the CBR Approach

There is empirical evidence of the benefit of CBR research in low-income countries (35). Based on published reviews of CBR research and other literature, rather than individual studies, the following can be noted:

CBR-type programs have been identified as effective (Mitchell, 1999; Mannan &Turnbull, 2007) and even highly effective (Velema, Ebenso&Fuzikawa, 2008). Outcomes include increased independence, enhanced mobility, and greater communication skills of people with disabilities (Velema, Ebenso&Fuzikawa, 2008). There are also anecdotal indications of the cost-effectiveness of CBR (Mitchell,1999; Mannan &Turnbull, 2007).

Systematic reviews of research on community-based approaches in brain injury rehabilitation in high-income countries indicate that such approaches are at least as effective or more effective than traditional approaches, and have greater psychosocial outcomes and a higher degree of acceptance by people with disabilities and their families (Barnes & Radermacher, 2001; Chard, 2006).

Livelihood interventions associated with CBR have resulted in increased income for people with disabilities and their families (39) and are linked to increased self-esteem and greater social inclusion (De Klerk, 2008).

In educational settings, CBR has been found to assist in the adjustment and integration of children and adults with disabilities (Mannan, & Turnbull, 2007; Velema &Ebenso, 2008). The CBR approach has been found to constructively facilitate the training of community workers in the delivery of services (Mannan, & Turnbull, 2007). nAs similar research in high-income countries has shown, CBR activities have positive social outcomes, to influence community attitudes, and to positively enhance social inclusion and adjustment of people with disabilities (Mannan, & Turnbull, 2007, Velema & Ebenso,, 2008).

Although CBR programs, are reported to be associated with remarkable benefits, evaluation studies have revealed a wide range of challenges in the execution of CBR (Kendall, Muenchberger& Catalano, 2009). Among the challenges are high poverty levels among communities and families of Persons with disabilities, leading to diversion of CBR programme resources to poverty alleviation in Persons with disabilities' families (Hartley et al & Were, 2010); limited availability of resources (Hartley et al., &Were, 2010); minimal participation of community owing to negative attitudes and culturally- insensitive nature of the programmes (Pollard, Sakellariou, 2008); shortage of healthcare workers to exercise CBR (Mannan et al. 2012); untrained CBR workers (Mannan et al, 2012); non-employment of multi-disciplinary teams (Hartley et al & Were, 2010); and poor coordination among health care providers and systems of delivery (La Cour&Cutchin, 2013).

According to WHO (2017), barriers to consolidation of rehabilitation services in developing countries include: under-prioritization by government amongst competing priorities, absence of rehabilitation policies and planning at national and sub-national levels, limited coordination between ministries of health and social affairs where both are involved in rehabilitation governance, non-existent or inadequate funding, a dearth of evidence of met and unmet rehabilitation needs, insufficient numbers and skills of rehabilitation professionals, absence of rehabilitation facilities and equipment, and lack of integration into health systems. These challenges have significantly threatened the implementation and the sustainability of CBR programs. Which all needed to be explored in the countries of study to inform further planning and intervention especially as we ponder over the possibility of transitioning.

2.4 The CBID approach

CBID is a useful tool for realizing the Millennium Development Goals (MDGs) and poverty reduction strategies for all people irrespective of geographical location, disability, gender, ethnicity, or sexual orientation (Khasnabis, 2010; WHO, UNESCO, ILO & IDDC, 2010). Community based inclusive development is an aim or an end result to be achieved – of making communities and society at large inclusive of all marginalized groups and their concerns (IDDC, 2012). The ideal is that no one should be excluded from development for any reason, be it gender, disability, ethnicity, refugee status, sexual orientation, aging or any other issue. CBR is the tool or strategy to achieve the goal of community based inclusive development for persons with disabilities by using a 'twin-track' approach:

1) Working with persons with disabilities to develop their capacity, address their specific needs, ensure equal opportunities and rights, and facilitate them to become self-advocates.

2) Working with the community and society at large to remove barriers that exclude persons with disabilities, and ensuring the full and effective participation of all persons with disabilities in all development areas, on an equal basis with others (IDDC, 2012).

The CBID approach is popularized by donors as the approach to enable disability inclusive development. It "brings change in lives of people with disabilities at community level, working with and through local groups and institutions. It enhances and strengthens earlier work described as CBR". The advocates of CBID are majorly NGOs and agencies which for a long time have been at the helm of rehabilitation service provision by offering financial, medical and technical support (Lorenzo & Cramm, 2012). CBID ideally addresses the limitations of CBR to effectively resolve challenges of offering rehabilitation services to persons with disabilities, their families and their organizations. For example, initially CBR in some countries and communities was implemented as a single sector. With CBID that is comprehensive, multi-sectoral and human rights-based encompassing services within Health, Education, Livelihood and Social development sectors (WHO, 2010), most needs of Persons with disabilities should be met. CBID is implemented at individual, community and society levels to ensure services (such as health, education, livelihood

and social) are accessible to all persons with disabilities; thus ensuring all people with disabilities participate in their community life and fully enjoy their rights like other members (IDDC, 2012). CBID gives persons with disabilities opportunity to join community based self-help groups and livelihood activities to enhance inclusive development and promotes the participation and voice of people with disabilities in decision-making processes at the local level. In brief, the CBID strategy encourages inclusive, resilient and equitable communities where people with disabilities are empowered to exercise their rights, aligning with the idea of an inclusive world.

In spite of WHO effort to sensitize states on the importance of CBR guidelines and support to member states to initiate CBR and/or strengthen existing CBR programs (WHO & World Bank, 2012), many countries in Africa and elsewhere are yet to embrace the CBR strategy, let alone CBID. In some countries, rehabilitation services are still institution-based or form part of active outreach services to rural communities, supported by international agencies (Persson, 2014). In many other developing countries CBR programs are yet to take off (Tinney et al, 2007). Considering the consequences of civil wars in some countries like South Sudan, Somalia, the Central Africa Republic and Democratic Republic of Congo, a workable CBR model that is compatible with specific African countries is needed to suit their peculiar circumstances. Much as this may be inform of CBR or CBID, it is important for planners and implementers to have an informed decision on the nature of interventions required.

2.5 Transition from CBR to CBID: changes and challenges on the African Continent

Literature on the changes realized in Africa after the CBID concept came into focus with the endorsement of the CBR Guidelines of WHO, ILO, UNESCO and IDDC (2010) is hardly available. However, the success of CBR/CBID depends on collaboration with host governments, both local and national, because they plan and implement development programs. Considering the meagre resources at the disposal of many countries in Africa, especially those torn up by civil wars, issues of persons with disabilities and other marginalized groups are often pushed to the periphery of priorities. Diversity in community values and culture, poverty, differing priorities, mindset and expectations of the community which are evident in most developing countries often restrict development.

Furthermore, persons with disabilities often lack a voice in the public discourse, and their interests and needs are frequently neglected. The negative interaction between persons with impairments and functional limitations and attitudinal and other environmental barriers creates disability and hinders their participation in social and economic life. These barriers to inclusion have profound social and economic effects not only on individuals with disabilities but also on their families and/or caregivers who often forego economically productive activities to stay at home and provide care (WHO, 2010).

Currently the sustainability of CBR programs and projects in Africa depends on donor funding of mainstreaming economic, social, educational and medical programs for persons with disabilities. On the other hand, Community based inclusive development in essence requires that responsibility of offering rehabilitation services to Persons with disabilities should be considered within the mainstream local and national government planning and programs. While there is no empirical data to show the success (or lack of it) of the transition, anecdotal evidence shows the difficulty of pushing the onus of meeting special needs of persons with disabilities to mainstream planning and budgeting on government and community. In Uganda for example, there is no specific budgetary provision for disability issues. Budgetary allocations go in line ministries, which often push disability issues to the periphery. There is need for further efforts to promote the use of CBR guidelines with the goal of facilitating inclusion and equal participation before the complete shift from CBR to CBID

3.0 METHODOLOGY

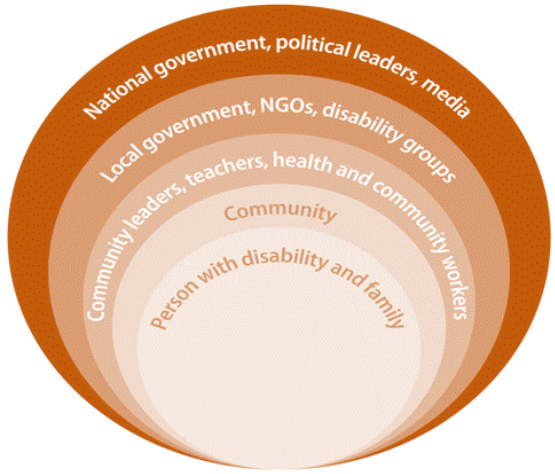
3.1 Study Design

The study used a descriptive research design that included both qualitative and quantitative research data. The quantitative research approach was used to establish the nature of interventions undertaken by the different organizations, challenges experienced and appropriate strategies for transition while qualitative methods were used to assess the changes realized over time to inform the transition.

3.2 Population

Study participants included policy makers, the line ministries based on the components of the CBR matrix, the community development officers at national and district/provincial levels, program managers for the respective programs of study, implementing officers, program beneficiaries by age, sex and disability. All these were perceived to have had adequate information which facilitated effective identification of the needs, interventions, changes realized, challenges and strategies which informed the final deliberation on the name change and the transition.

3.3 Sample and Sampling techniques



A heterogeneous sample was selected for the study. Using the list of programs/organizations registered by the community development department, a sample of 5 programs for each of the components of the CBR matrix was randomly selected from each country to participate in the study. Effort were made to include government programs and those implemented by civil society working in the different regions of the four countries with consideration of rural and urban settings; hence allowing room for comparison.

From each program, the Program Manager and Program Officers in the different satellite offices were purposively selected to participate in the study. A sample of 10-20% of the program beneficiaries from the various interventions in the respective programs were selected using stratified random sampling with consideration of age, sex and impairment to participate in the study. However due to the Covid 19 pandemic, it was not easy for the entire sample to be accessed due to travel restrictions in all the countries of the study.

Government Personnel in the relevant ministries, policy makers and community development officers were selected using purposive sampling that included only those engaged in disability inclusive development and mainstream community development programs to inform the study. As summarized below, this sample was replicated in the four countries of the study; although with some slight variations depending on prevailing circumstances.

Nature of respondent	Category of respondents	Number of Respondents
Policy Implementers	National and Local level Policy Implementers in line ministries and districts/provinces	10
Inclusive Education	Inclusive Schools	20
Health	Health facilities	20
Livelihood	NGOs / CBOs involved in Income Generating Projects and those giving loans to persons with disabilities	20
Social and Empowerment	Human rights-based organizations involved in disability work	20
Persons with disabilities	Beneficiaries of various CBR/CBID interventions	9 FGDs

3.4 Data Collection instruments

Information for the study was collected using a variety of data collection tools to allow triangulation, validation and comprehensive conclusion of the study. The following data collection tools were used:

Document Review: Review of records from the community development department and the respective programs involved in the study was done to obtain information on the interventions undertaken, the beneficiaries, changes realized and challenges. This was very instrumental for effective sampling of study participants.

Questionnaires: A semi structured questionnaire was administered to the respective program beneficiaries and detailed information was obtained on their needs, items/services received, changes realized and challenges which informed recommendations and facilitated deliberation on the name change.

Interview guide: In-depth interviews were administered to Policy Makers and implementers (Ministry Personnel, Community Development Officers, Program Managers and Program Officers) to obtain detailed information on the existing policies, nature of interventions, beneficiaries and the existing social, economic and political environment to inform recommendations on the final deliberations on CBR-CBID.

Focus Group Discussions (FGDs) guide: A minimum of six FGDs (one in each region/ district of study) were conducted with members of Organisations of Persons with Disabilities (OPDs) that generated their opinions on the current needs of Persons with disabilities, the interventions availed and challenges realized. Each of these was concluded with development of an appropriate strategy for change.

3.5 Study Procedure

- A team of experts was identified to undertake literature review and develop research instruments.
- Pre-testing of the study instruments was conducted in a number of selected institutions in Uganda involved in CBR/CBID work. Based on the pre-test, necessary amendments were made prior to data collection.
- A letter was designed by CBR Africa Network (CAN) to introduce the research teams in the four countries to places wherever data was to be collected from.
- In consultation with the project supervisors in the four countries, the research teams selected the study participants. For easy mobilisation of participants, contact persons in

respective regions of the four countries were identified.

- Contact was made with study participants in order to make appointments for interviews.
- Data collection was carried out by the research teams using a range of data-collection tools.
- Data organisation and analysis was done immediately its collection commenced
- Thereafter four country reports were compiled by the study teams.
- A validation meeting was organised in each of the four countries, where a presentation of the draft country report was made to a group of stakeholders.
- Country reports were finalised and submitted to CAN for merging into this report.

3.6 Data Analysis

Information from the questionnaire was edited, coded and entered using the Statistical Package for Social Sciences (SPSS). Information from the interviews and FGDs was compiled, transcribed and arranged in line with emerging themes and descriptively analyzed alongside that generated from the document reviews at national level.

Information obtained from all the data collection methods was analyzed by the data management team at the CAN secretariat. It was harmonized into a single data set for comprehensive analysis in which comparisons were made by country and region. Information from the questionnaires were descriptively presented in response to study objectives. Information from the interviews, FGDs and document review was used to complement that from the questionnaire. All the information was triangulated for validation of findings to inform comprehensive conclusions on CBR-CBID.

3.7 Quality control:

Validity and reliability of instruments, data collection process and the output have been assured through the following measures that were undertaken:

- Use of a variety of study samples that included; policy makers, ministry personnel, community development officers, program/organizational staff and beneficiaries.
- Utilization of a variety of data collection methods and instruments which was triangulated to effectively inform the study.
- Careful construction of data collection instruments that was validated by research experts in consultation with stakeholders in disability, rehabilitation and inclusive development.
- Translation of research instruments in the languages of the local people specifically for those who could not effectively communicate in English.
- Data collection was undertaken by teams of trained personnel. The training was further harmonized by the entire study team through Skype interactions.
- Throughout the data collection process, the study teams scheduled meetings and shared details on progress that ensured effective harmonization of the entire study.

3.8 Ethical Considerations

- Throughout the study, participants' consent was sought. They were assured of confidentiality and anonymity of all information shared during the study.

Informed Consent

- All data collection instruments were translated into the local languages for the program beneficiaries.
- Research assistants were identified from each of the countries of study

with consideration of ability to effectively communicate and translate in the native languages used in the countries. In places where more than one native language was utilized, effort was made to ensure representation of the languages accordingly.

- No names were recorded in the hard copies of questionnaires and interview schedules as well as electronic recordings. Instead, an identification number was assigned to each of the respondent for organizational purposes only.
- A consent form (translated in accessible formats such as easy read, large print or braille) was given to potential respondents to read by themselves. In cases where the potential respondents were illiterate, research assistants read to them a version of the consent form that was translated in a suitable local language.

3.9 Benefits of the Study

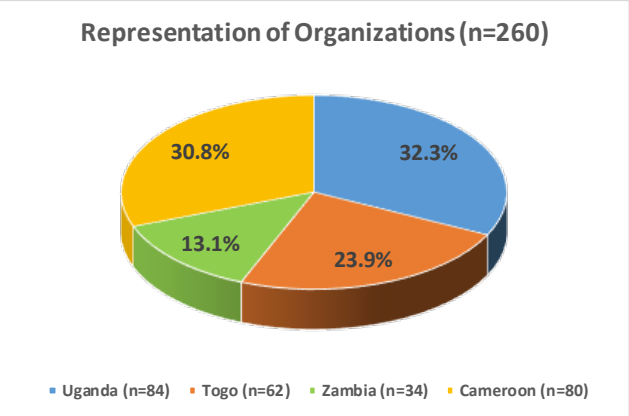
- Data collection was undertaken using interactive methods to ensure freedom of expression and shared learning to provide the details required to inform the study.
- During the focus group discussions, a basic transport refund equivalent to five to 10 US Dollars was availed to all participants depending on the distance from their respective homes. In cases where the meetings were prolonged, simple refreshments were provided to all people in the discussion groups to keep them motivated into effective contribution.
- In cases where children and persons with severe disabilities were involved, consent was sought (especially for those who could communicate) from their respective parents or guardians prior to inclusion in the study.

4.0 FINDINGS

4.1 Introduction

This chapter presents key findings from the situational analysis carried out in four countries of Africa – Cameroon, Uganda, Togo and Zambia. The study was set out to establish; the nature of interventions and services provided by different stakeholders implementing CBR or CBID, the changes realized by the different stakeholders since the declaration of the transition from CBR to CBID, challenges and benefits associated with the transition from CBR to CBID in Africa and appropriate strategies to facilitate harmonization of service provision to persons with disabilities.

4.2 Types and Description of Respondents



In all the four countries, organizations were identified to provide information based on the study objectives. A total of 260 organizations participated in this study. Country representation of these organizations is indicated in chart 1:

Chart 1: Representation of Organizations by country.

As observed above, Uganda and Cameroon had the highest representation of organizations while Zambia had the lowest representation of organizations. Below is the breakdown of organizational representation for the study:

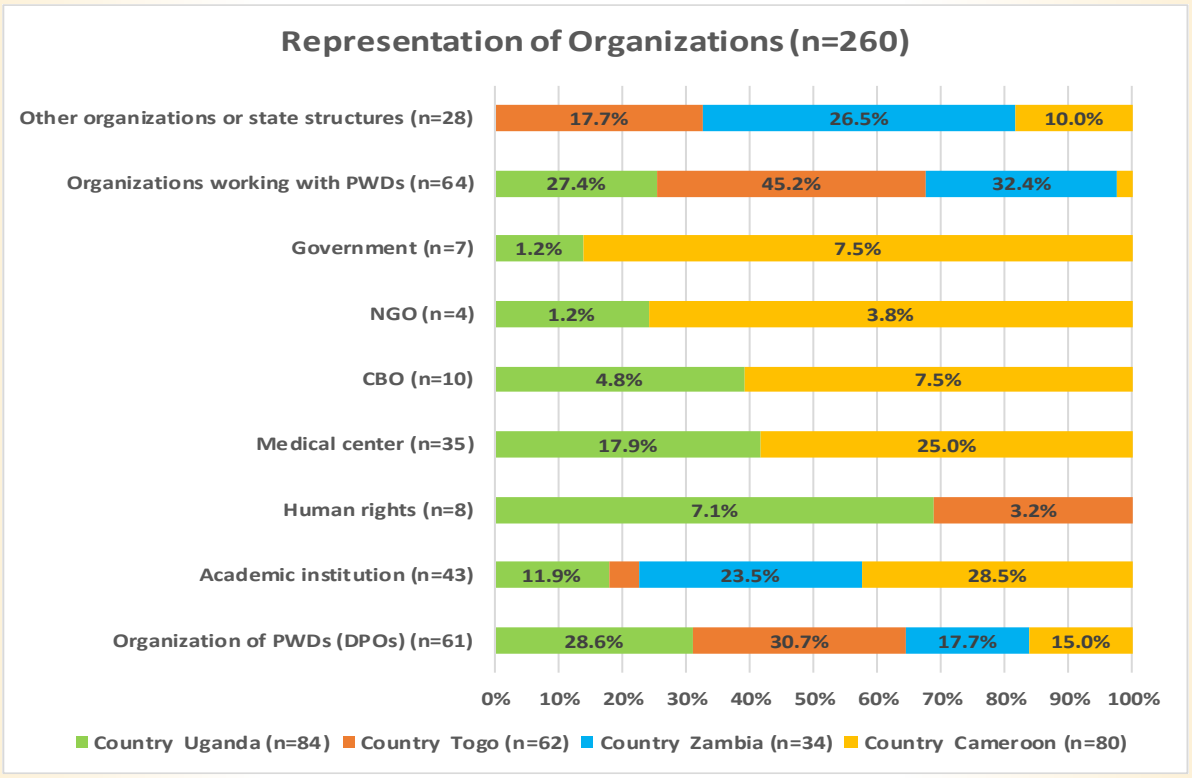


Chart 2: *Breakdown of organizational representation for the study.*

Effort was made to get representation for the different categories of organizations for effective assessment of the various aspects of study. The higher percentage (24.6%) were organizations working with persons with disabilities and organizations of persons with disabilities (23.5%) while NGOs (1.5%), government (2.3%) and CBOs (3.8%) had the lowest representation.

In Togo, the higher representation was of organizations working with persons with disabilities (45.2%) and organizations of persons with disabilities (30.7%).

Zambia registered a balanced representation of organizations that is academic institutions, organizations working with persons with disabilities, and organizations of persons with disabilities and other organizations that occasionally engage persons with disabilities. However, the team failed to access representation from government, NGOs, CBOs, medical centers and human rights organizations due to the Covid restrictions and the political climate at the time since the country was preparing for elections.

Cameroon had representation from all categories but registered more academic institutions (university and schools), medical facilities and DPOs. In Cameroon, most of the activities relating to disability are implemented and supported by Cameroon Baptist Convention Health Services (CBCHS). This institution has a strong structure with academic institutions, medical facilities and support for community based work.

CBR has been used in many rural communities for over four decades however, recent developments have popularized CBID making many organizations, projects and programs grapple with shifting or retaining CBR. The study sought to establish the approach currently used by the organizations that participated in the study.

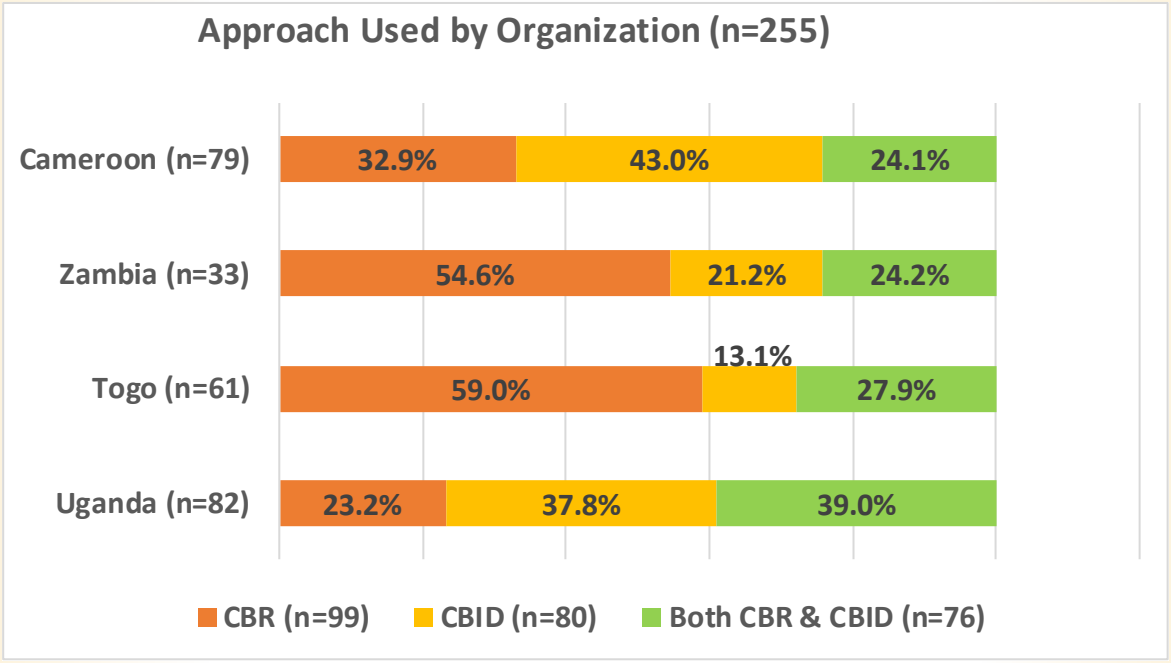


Chart 3: *Approach Used by Organizations in the Countries of study*

Use of both CBR and CBID was noticed in all four countries. However, the higher percentage (38.8%) of the organizations reported that they have retained CBR, 31.4% have shifted to CBID while 29.8% are still grappling with the two concepts possibly because they are failing to comprehend their difference. Most of the organizations that shifted attributed the change to donor influence.

"You people keep on confusing us. We know that all we do in this organization is offer

services to improve the lives of persons with disabilities. Some donors indicate that their funding is for CBID so we simply indicate that to access such support for activity implementation." personnel from one of the organizations in Cameroon.

Majority of the organizations in Togo and Zambia reported use of the CBR approach. CBR became popular in Togo in the early 1990s and since then, organizations have got support from various donors to implement activities. Currently, Togo is one of the countries reported to have a strong CBR network.

In Cameroon, the higher percentage (43%) of the organizations reported that they use the CBID approach while in Uganda, most of the organizations grapple between the two approaches depending on the source of funding available for a particular project.

4.3 Nature of Interventions and Services Provided by Stakeholders Implementing CBR/CBID

The study sought to establish the nature of services or intervention provided by the organizations. Information on this aspect was obtained from beneficiaries. Unlike Uganda and Cameroon, information from Togo and Zambia did not yield statistics on the nature of interventions/services provided by the organizations. They instead obtain qualitative extracts on the services provided by organizations based on the CBR matrix while Uganda and Cameroon availed details on the nature of services/interventions provided by the organizations. Below is the output on the nature of services availed by the organizations in Cameroon and Uganda:

Table 1: Nature of Interventions/Services provided by the CBR/CBID Organizations

Type of Services	Cameroon (n=78)	Uganda (n=76)
Educational support	**10**	**12**
Medical support	**11**	**9**
Provision of rehabilitation services	**7**	**6**
Provision of assistive devices	**18**	**3**
Skills development	**12**	**36**
Livelihood support	**25**	**2**
Counselling		**4**
Human rights Advocacy		**16**

Multiple responses

In Cameroon, most organizations reported provision of livelihood support, assistive devices and skills development while in Uganda, skills development, human rights advocacy and educational support stood out as the most popular interventions provided by the CBR/CBID organizations.

In Togo, a personnel from an organization working with persons with disabilities reported:

> "Much as we would like to do so much, we cannot offer all services to exhaust all the needs of persons with disabilities. Most times we focus on capacity building and skills development for our staff and persons with disabilities"

While an officer from a civil society organization working with persons with disabilities in Togo

said:

> "Due to budgetary constraints, we are able to provide assistive devices such as wheelchairs and hearing aids to only a few persons with disabilities. A number of our activities involve identification and mobilization of persons with disabilities, sensitization about their rights and trainings on financial literacy."

In one of the participating organizations of Uganda, the following was shared:

> "We empower persons with disabilities through rehabilitation, physiotherapy, corrective surgery, livelihood support and education. The support we offer through vocational training in various disciplines like carpentry, bricklaying, social and communication skills have enabled a number of persons with disabilities in Lango Sub-region acquire the relevant skills to live full and productive lives." Project officer in an organization working in Northern Uganda

Another organization reported that:

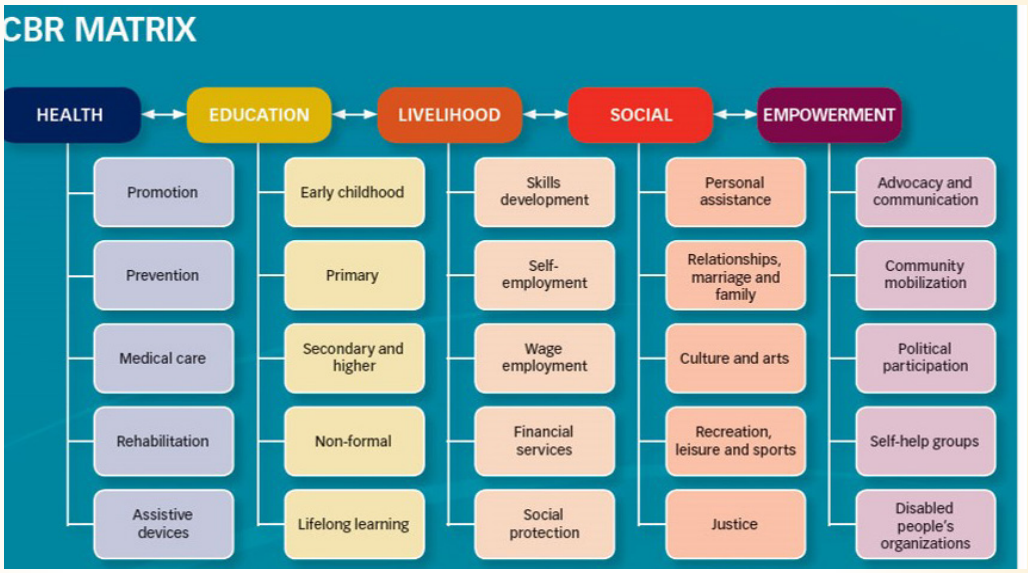
> "Sensitization workshops are frequently organized with the district leadership to share experiences and sensitize the local council leadership on the rights of persons with disabilities. Through these interactions, the community is able to better understand us and offer the appropriate assistance when required to do so." personnel from an organization of persons with disabilities in Uganda.

In Zambia, the following services/interventions were provided by respondents:

- Constructing ramps on buildings to ensure accessibility for persons with disabilities.
- Advocacy for people with disabilities to participate in politics, benefit from affirmative action in employment especially in civil service.
- Training in livelihood skills such as agriculture and catering.
- Collaboration with government to promote inclusive saving groups for small grants and provision of microfinance.
- Promotion of inclusive education in government schools and colleges.
- Promotion of free primary education in addition to benefit from loans and bursaries for tertiary education.

Changes Realized from the CBR/CBID Interventions

Information of the changes realized by the beneficiaries of the CBR/CBID interventions was sought from beneficiaries identified from each organization. This was assessed in reference to the CBR matrix below:



The CBR matrix consists of five components (Health, Education, Livelihood, Social and Empowerment) and their associated elements. It provides a basic framework which may guide classification of the various interventions for people with disabilities.

Health Domain

As mentioned early, CBCHS is a key player in disability management and disability inclusion in Nigeria, their structure spreads to the different regions of the country through their health service facilities. One of the key aspects handled by CBCHS is capacity development in inclusive healthcare through which persons with disabilities like all other people benefit from diagnosis, treatment and provision of medicines. Below is what was shared by a health worker in CBCHS health facility in Bamenda, North Western Cameroon:

> "As a result of the training we had on inclusive healthcare, persons with disabilities are currently assessed better than was the case before. At first we thought disability was an illness that needed specialized services and we never gave them much attention. Today, we are able to provide them with better healthcare because we know their disability needs and try to meet them."

An administrator in a hospital in the Bafoussam 1 council of the West region of Cameroon mentioned increase in knowledge as shared below:

> "CBID has enlightened us on the plight of persons with disabilities and the difficulties they face accessing our services. With CBID we are making efforts to make our services accessible to all, especially persons with disabilities."

During an FGD in Bamenda, Cameroon one of the participants reported:

> "I used to rely on traditional medicine because the health center is far from here. With the outreach programs the medical personnel come to our communities, making it possible for us to consult. It is now easy for us who have disabilities to benefit from health services."

CBID has strengthened the referral systems and this has led to more persons with disabilities accessing rehabilitation and health services, with the costs at times subsidized by some organizations. More persons with disabilities are frequently referred to orthopedic and physiotherapy services. A health worker in Ngousso (the Centre Cameroon) reported:

> "Our services reach more people with disabilities than before, thanks to the field workers who refer them to us."

The field workers have also received training in the early detection of disability in the communities and this is done with effective collaboration with other stakeholders. This early detection ensures that some deformities are corrected early and easily. A good example is the case of clubfoot in Cameroon where treatment is highly subsidized as shared by a parent in Santa council of the Northwest region:

> "I thought my child's legs were due to witchcraft but when the CBR worker came to my compound and informed me that his legs can be corrected, I was happy and today, I am thankful to God because we followed what we were told after the operation. The boy walks normally"

During the FGDs, some people with disabilities also reported that they received assistive devices such as eyeglasses, crutches, white canes, hearing aids and wheelchairs. Accessibility modifications were also reported in most health centers and other public facilities to increase access to healthcare by persons with movement challenges. Accessibility audits was also mentioned as a change realized over the years.

Education Domain

In Zambia, the following were identified as changes in the education domain:

> "Government is promoting inclusive education in government schools and colleges. There is provision of

education support through free primary education and loans and bursaries for tertiary education" personnel in an organization supporting inclusive education in Lusaka Zambia.

> "Organizations working with persons with disabilities have worked together but a lot of support for advocacy has come from NAD programs in Livingstone. Many changes are now evident in education. We provide sensitization through office of the special education department and now even the examinations are suitable for learners with disabilities" representative of an organization of persons with disabilities in Zambia.

One of the parents interviewed mentioned that:

> "Children with disabilities now go to school and stay in school because there have been changes made to accommodate them in the educational setting.

In Bafoussam (West region of Cameroon) a school administrator had this to say:

> "Students with disabilities are consulted on how to make the school environment accessible to them and now they can easily move around the premises with little support from their peers"

However, in Cameroon, some respondents mentioned a change arising from the transition from CBR to CBID as shared below:

> "When it was CBR, people with disabilities were receiving individual attention. This was helpful to those who got the help but still many were missing education due to resource constraints. With the CBID campaign of inclusion, government is being made to help a lot and as a result, many children access education"; official of the Ministry of Secondary Education Yaoundé, Centre region.

As observed earlier, CBID is the popular approach used in Cameroon. Some participants mentioned that with the transition from CBR to CBID, emphasis is placed on building the capacity of teachers and making the school environment accessible to all. Teachers have acquired skills in inclusive teaching and they can now effectively teach and monitor children with disabilities. Sign language interpreters in some schools enable children with hearing impairment to access and benefit from education. Interaction between children has also improved as the learners without disabilities have been enlightened to be receptive and supportive to their counterparts with disabilities.

In all four countries, beneficiaries reported increased school attendance for children with disabilities since accessibility has improved, teachers and learners are receptive and sign language is provided to ensure education for all.

Livelihood Domain

Among the changes highlighted in the livelihood domain is affirmative action in Zambia. Some persons with disabilities are given certain employment opportunities in civil service as indicated by one participant:

> "Persons with disabilities have been given a certain percentage to be reserved for them in recruitment of teachers and nurses etc." representative of PWDs in Zambia.

In an FGD in Zambia, some PWDs also reported that they have become more active in agriculture and catering service provision thanks to the survival skills acquired through training. Persons with disabilities are also encouraged and recruited for entrepreneurship programs and in addition, government of Zambia promotes inclusive saving groups for small grants and provision of microfinance.

In Cameroon, more people with disabilities are now engaged in livelihood activities though on a small scale in their communities due to the skills and assistance acquired as a result of the transition from CBR to CBID. People with disabilities have acquired skills in gardening, weaving, poultry and business. From the focus group discussion with people with disabilities

in Garoua (North region), the respondents confirmed that they can now take care of their basic needs as shared below:

> "Because of the vocational training and other skills acquisition workshops organized by some NGOs, we now carryout income generating activities".

Many also reported earning from the variety of livelihood skills acquired as shared below:

> "Before now I could only weave traditional dresses but with skills acquired in soap making, I now weave traditional dresses and make soap."

Social Domain

In the social domain, a lot was mentioned on improving accessibility. With the great advocacy for disability inclusion, local governments play a critical role in ensuring that infrastructure is built to accommodate the needs of people with disabilities.

During the FGDs in Cameroon, people with disabilities affirmed that CBID programs have changed the attitude of community members towards them. Community members now relate better with people with disabilities and are gradually consulting them in community activities as shared by a respondent in Yaoundé:

> "Few people call me by my disability as was the case before. Now my neighbors call me by my name and I am happy"

In Zambia and Uganda, sign language provisions are made in public broadcast and news.

Empowerment Domain

In the empowerment domain, parents' support groups were reported in all the countries of study. Parents of children with disabilities come together to share their experiences and learn from each other. They have acquired skills and now some even assist their children with their homework. Consequently, more children with disabilities now enroll and stay in schools as shared by a parent with a child with disability in Cameroon:

> "I can now assist my child do his homework as other parents share experiences on how they assist their children at home and also from the skills we acquire during the trainings we receive from some NGOs"

In Uganda, most of the respondents agreed that CBID programs help in improving attitudes of the community towards Persons with disabilities and also encourage the implementation of disability laws and guidelines. Community members are now awareness of PWDs' rights and change in community attitudes to PWDs.

Some of the beneficiaries who received assistive devices reported the following:

> "Since I received a wheelchair from Adina Foundation Uganda, my mobility is easier although at times I experience difficulty due to poor accessibility in the community. Our roads have many potholes and it is worse during rainy seasons as most of the roads become impassable" male wheel chair user in Lira district, Uganda.

> "With this wheel chair, I endeavor to attend important community gatherings and also actively contribute to the development of my parish" female wheel chair user in Apac district, Uganda.

While in Zambia and Cameroon, effort is made to ensure that people with disabilities participate in elections.

> "From the trainings we have been having with NGOs, our members have acquired skills that have enabled us elect competent leaders who work for our benefit." Councilor in an FGD in Bamenda 1, Cameroon

In all four countries, beneficiaries reported that PWDs now join groups in the community, share views and have respect like all other people in the community.

In all four countries beneficiaries reported that PWDs also participate in planning at family and community level as a result of the empowerment which has given them increased participation. In Uganda, the following was

shared by an official from Ministry of Gender, Labor and Social Development and affirmed by a personnel from the National Council for Disability:

"During formulation of the national budget, lower local governments are involved in all categories to identify their key priority activities for funding. During the planning phase, gender, equity and other crosscutting issues have been mainstreamed into the budgets right from the grassroots. People with disabilities are represented by local councilors (male and female) at all these levels to ensure that the needs and interests of people with disabilities are considered."

And later verified in the focus group discussions with the people with disabilities in the different districts of study.

Challenges Associated with the transition from CBR to CBID

Major challenges related with the transition from CBR to CBID were identified through FGDs, Key informant interviews and questionnaires. In all four countries, the following were identified as challenges experienced during the transition:

Limited knowledge on the relationship between CBR and CBID

Lack of collaborations between organizations since some use different approaches and are so rigid possibly because they of limited understanding of the difference between CBR and CBID.

Disaggregated data on disability has always been a challenge. This greatly affected effective advocacy for disability inclusion and it is hard to validate progress and yet the problem seems to be persistent.

Limited funding for effective implementation of activities since some funder are so strict with the approach to fund and yet an organization may have different backgrounds and funders for different projects. This often leaves the organizations struggling to adjust to the demands of funders which worsens the confusion of what to actually consider; CBR or CBID.

> "These days there is limited financial contribution from the government and other international DPOs for a national CBR response." Response from Zambia.

> "Personally, I have failed to understand the difference between the two approaches because we are all working with people with disabilities to improve their wellbeing. However, some funders insist on us defining what approach we are using and this makes it hard for us; "administrator for an NGO in Uganda.

> "Sometimes you people come with a lot of confusion. As a government we are aware of CBR and we have been implementing activities together with civil society but then you bring in CBID. Presenting such concepts to cabinet often cause confusion and yet I also do not know how to explain the difference. Does it mean CBR is dying out and CBID is the new things? It is all confusing." Ministry official in Uganda.

Negative attitude was also reported in all four countries from the community and people with disabilities as shared below:

> "Disability inclusion is difficult to obtain since some people with disabilities are too rigid, with high expectations and stuck with the charity model where they expect to be given everything. This often frustrates service providers and the community and as a result, exclusion continues. Such people need to be helped to understand their role and responsibility for us to succeed with disability inclusion" respondent from Zambia.

4.6 Strategies to facilitate harmonization of service provision to persons with disabilities.

Research and documentation of the PWDs, existing resources and facilities to inform planning.

Economic empowerment of PWDs and families

Lobbying and advocacy for harmonization of CBR and CBID

Implementers of the different programs and projects in all four countries mentioned need for disaggregated data on disability to inform advocacy, planning, intervention and validation of effectiveness of whatever is done to help people with disabilities.

To offset some of the challenges of transitioning from CBR to CBID, stakeholders need to work in synergy to enhance their resource for maximum impact. Increased collaboration among the stakeholders was proposed in all four countries of study.

> "If organizations can collaborate more in the field, there will be fewer duplication of services as is the case now. Currently you notice more than one organization doing the same activities in a community with almost the same group of people thereby wasting scarce resources."

> "Collaboration between implementers of interventions for people with disabilities will enable identification of the areas that need more attention and those that other organizations have been working in"

A respondent with a disability in Guider council of North Cameroon suggested that:

> "Capacity building in the area of CBID should be continuous as implementers for continuous interventions to help people with disabilities"

In all four countries, respondents mentioned need for awareness raising to the different stakeholders on the difference and similarities between CBR and CBID to mitigate the confusion in which funders, implementers, beneficiaries and all other stakeholders have on the two approaches. This will help to demystify CBR and CBID to facilitate effective service provision to people with disabilities.

> "All institutions and organizations in the country must be made aware of existing services and resources to be utilized by the people with disabilities as well as awareness on the rights of people with disabilities" respondent from Zambia.

> "Since attitudes have remain a continuous challenge to effective participation and inclusion of people with disabilities, all stakeholders should strengthen it to facilitate change of attitudes and promote disability inclusion" respondent from Togo.

> "Awareness creation is essential to inform the public of the needs of people with disabilities and existing policies so that accessibility is improved for increased access to services and facilities" PWD in Uganda.

One of the respondents in Uganda expressed need to review the CBR guidelines to inform the transition or help to streamline the two approaches since they greatly contributed to the concept of inclusive development.

"We need to revise guidelines to serve a national or globally acceptable development framework to include SDGs and ensure clarity of the CBR-CBID approaches. This may help countries and stakeholders to develop and implement a national disability mainstreaming strategy that suits their context."

In Zambia, one of the respondents mentioned the need to needs assessment of people with disabilities and ensure their effective fulfillment to inform appropriate approaches to suit them accordingly as shared below:

This transition being one of them. This will ensure that Persons with disabilities will be able to bring out issues that affect them both at community and national level to inform interventions for the actual disability inclusion that is desirable and beneficial to all."

In Togo, program implementers emphasized need to strengthen the resource base for effective interventions in disability inclusion as shared below:

> "With the frustration we get from donors, there is great need to strengthen and increase resource mobilization efforts for continuous intervention. Many people with disabilities are very poor and vulnerable yet funding to implement interventions is becoming harder with the CBR-CBID confusion."

Another respondents added:

> "Robust local mobilization of resources and advocacy is required so that government could be more proactive and ensure sustainability."

Discussion and recommendations

In all the four countries of study, CBID has been introduced however, its adoption is at different levels. In Zambia, the CBR Program was barely starting. It had not yet spread to the different parts of the country when CBID emerged making it difficult for programs to access funding due to the contest between CBR-CBID. According to Huib and Khondowe (2017), CBR Zambia is a large and comprehensive program that seeks to set up public structures and systems but at the same time offers essential services to children and adults with disabilities. The CBR program in Zambia is mainly funded by the Zambian government and NAD but because of its breadth, a lot is needed and funding is instrumental. The current wave of transition to CBID is outing a strain on the CBR activities for most programs in Zambia and all other countries.

5.0 CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

One important conclusion is that ten years after its inception, the factual basis of the CBID concept is still weak. Most of the actions implemented and the documents consulted speak more of CBR. There has been no change in policy since the declaration of the transition from CBR to CBID. Practice has not changed either. However, although the use of the CBID concept is limited, the notion of inclusion of PEOPLE WITH DISABILITIES is integrated into projects and programmes of interventions in the field as well as in policy and strategy documents.

The study further established that majority of respondents lacked the requisite knowledge about CBR and CBID and were unable to distinguish between the two concepts. One observation from Togo was such that despite the nuance in practice, CBR and CBID are approaches that have the same purpose of improving the quality of life for people with disabilities and their families by including them in all aspects of life. It should be noted that these two approaches have brought about enormous changes not only to people with disabilities themselves but also to the issue of disability.

CBR is considered fundamental in improving the wellbeing of persons with disabilities and for fostering their participation in the community and society at large through inclusive development and equalization of opportunities (WHO, 2010). In light of this argument, the study established that CBR interventions by the different stakeholders have delivered remarkable positive outcomes to persons with disabilities and assisted to transform them to active roles within their communities. The local communities, government and civil society organizations through a number of deliberate activities in support of Persons with disabilities have empowered them to live meaningful and productive lives. Therefore, the programme has been successful in reaching people with disabilities. This has been possible through making their daily lives better with practical skills, assistive devices, creating social integration and reducing discrimination by influencing community attitudes.

However, the issue of resource availability for CBR programmes against other competing priorities in a community with limited resources was an important area of focus in this study. Although local councils were mainstreaming equity and other cross cutting issues into their yearly budgets, there was insufficient commitment of funds into disability activities since issues of disability were not taken as a priority owing to the marginal population group that they affect.

Another conclusion is that the transition from CBR to CBID has heavily relied on funding from international donor agencies, which is short term and unreliable with fears that reduction in funding will disrupt the continuity of the programme. Interviews with the different stakeholders implementing disability activities confirmed that their disability activities were largely funded by donor agencies whose support did not exhaustively meet the many needs of People with disabilities. Budgetary allocations and funding by government towards disability programmes has also not been prioritized, which has greatly limited the scope of programmes that directly benefit Persons with disabilities.

The KIIs and FGDs conducted in this study established that involvement of persons with disabilities in decision-making, planning and implementation of disability activities was primarily driven by the CSOs and government stakeholders with little or no contribution of resources from the community. This inadequate participation and involvement of local communities in the implementation of CBID projects threatens the sustainability of CBID programmes. Therefore, it was necessary for CBR and CBID programmes to actively collaborate across government departments, NGOs, local organisations and communities to enhance skills and secure funding. The programme needed to incorporate local capacity building and encourage community

members to make contributions of resources in order to increase community ownership and sustainability.

5.2 Recommendations

5.2.2 Recommendations

Based on the study findings, the following recommendations have been made:

Effective collaboration and networking among all stakeholders. For CBID to succeed there is need for effective collaboration among all the stakeholders. Both government departments and the civil society organizations should work in synergy in the design and planning of activities for people with disabilities. The Ministry of Social Affairs which is the tutelage ministry of people with disabilities should take the lead and coordinate the activities of all stakeholders. The staffs of these government ministries should trained by competent organizations to ensure they acquire the skills for effective technical assistance. Training of government workers is key in enabling them provide the necessary technical skills for training families and children in physiotherapy in their homes and disseminating important information to the community. District councils will need to ensure that equity issues are addressed in their budgets and resources allocated for deliberate interventions targeting Persons with disabilities.

Twin track approach.For effective implementation of CBID, the "Twin track" approach should be used. This guarantee that projects can effectively take a twin-track to disability inclusive development. Needs for disability specific interventions will be identified and addressed at the same time with what the broader community and government can do to be inclusive of people with disabilities in their programs and services. For example, where the projects involve improving inclusion of children with disability in education, there should a focus on early detection and intervention through community workers and family members and development of individual learning plans. At the same time some teachers should be trained in inclusive teaching methods and community members engage in understanding the basic features and benefits of inclusive development and education. Efforts should also be made towards inclusive healthcare involving healthcare professionals and the community to ensure people with disabilities benefit from appropriate diagnosis and treatment. This means that efforts for inclusion are understood and supported from within the community rather than being initiated from outside forces.

Engage community leaders.

Traditional leaders and other community leaders have proven effective in mobilizing community members for other community activities. For CBID to be anchored in our communities, the people need to be mobilized for action. Using these groups of persons as change agents will facilitate the transition from CBR to CBID. The capacity of these leaders should be built for them to have the appropriate skills and knowledge to effectively mobilize the people.

Government funding.

The funding allocated for disability issues by the government is negligible and needs to be increased. Most disability related projects are funded by international NGOs and faith-based organizations. NGOs and other civil society organizations should partner with organizations of people with disabilities to advocate and lobby with government authorities for Parliament to vote a separate budget for disability related activities. To can cause the government to increase the amount of money allocated to disability issue.

Capacity building.

There is lack of trained professionals in the field of rehabilitation making the quality of services rendered low and causing people with disabilities to wait for long before attended to. The government should create more schools to train rehabilitation professionals. There is need for more professionals in rehabilitation to be trained as the number of people with disabilities keeps increasing due to illness and old age.

Advocacy and sensitisation. People and organizations are still ignorant of the abilities of people with disabilities leading to their

exclusion. There should be continuous sensitization by people with disabilities and other stakeholders about the benefits of inclusive development and of engaging people with disabilities in their work. Stakeholders with the active participation of people with disabilities should organize "open days" and other activities to showcase the potentials of people with disabilities. During cultural and other community activities, disability related issues should always be included on the program and implemented by both people with disabilities and those without disabilities. .

Need to conduct further research.From the findings of the study some of the respondents even those in disability related organizations did not understand the concept of CBR not to talk of CBID. There is need to do an effective sensitisation and advocacy campaign among the various stakeholders and after then do another research on the two approaches.

5.3 Recommendations

Based on the study findings, the following recommendations have been made:

i. **Utilize local resources.** The effectiveness of CBID requires collaborative efforts from different stakeholders. Government departments like MOH, MOES, MOGLSD and MOLG should work together with communities and Civil Society Organizations in the planning and implementation of activities for persons with disabilities. Training of government workers is key in enabling them provide the necessary technical skills for training families and children in physiotherapy in their homes and disseminating important information to the community. District councils will need to ensure that equity issues are addressed in their budgets and resources allocated for deliberate interventions targeting Persons with disabilities.

ii. **Stakeholder engagement.** Involvement of local community leaders and structures is key in ensuring effective mobilization and participation of communities. Engagement of community leaders in mobilization of community is instrumental for the success of CBID programmes in their respective areas of jurisdiction. These are regarded as opinion leaders and respected in the society as they act as custodians of knowledge in the area. It is imperative that the local communities and persons with disabilities are actively involved in the design, planning and implementation of CBID programmes for it to be a success.

iii. **Capacity building.** Rehabilitation services are less than optimal due to the lack of trained professionals in the provision of appropriate rehabilitation services for Persons with disabilities. Inclusion of disability and rehabilitation curricula is also limited in most formal training institutions. Deliberate training interventions should therefore be targeted towards social workers and caregivers to improve access to disability inclusive health care, assistive devices and rehabilitation services. Building these capacities is of great importance in light of the increasing number of people living with the consequences of disability either as a result of birth or injury.

iv. **Government funding.** The issue of funding disability-related activities should not be left solely in the hands of civil society organisations. Policies alone are not enough to meet the many needs of persons with disabilities. Sufficient funds should be specifically allocated to Persons with disabilities during the national budgeting process as a deliberate strategy to bridge the funding gaps that the programme is currently facing.

v. **Advocacy and sensitisation.** There is need to further raise awareness about persons with disabilities as a number of people and institutions are unaware of the value persons with disabilities can add to their organisation and the communities. Stakeholders should therefore actively engage in supporting activities and services that bring both employers and

communities closer to persons with disabilities. For persons with disabilities to live active and productive lives, they require support and services which at most times is inadequate since government funded projects are biased towards funding institutional services as opposed to home and community based services. Although a number of legislations have been passed in support of persons with disabilities, enforcement of the disability rights laws still leaves a lot to be desired. Without the active enforcement of these laws, persons with disabilities will continue to be neglected. Disability stakeholders will therefore, need to actively engage with government stakeholders to ensure these laws are enforced and also advocate for additional budgetary allocations for disability activities.

vi. **Collaboration and Networking.** Multi-stakeholder partnerships and collaborations with other organisations giving support to persons with disability is extremely important in adding value to persons with disabilities. Disability activities should not be carried out in isolation but in collaboration with government agencies and ministries, academic institutions, vocational training institutions, NGOs and most importantly with persons with disabilities and their organisations. These partnerships should clearly define roles for each of the stakeholders with emphasis on involving persons with disabilities and their organisations in planning and implementation of their activities. Disabled people organisations and NGOs specifically targeting persons with disabilities should be empowered to serve as advisors or partners by providing special disability expertise in implementation of special initiatives. Therefore, not only is connecting with other disability providers important, but collaborative efforts through meaningful partnerships is critical for persons with disabilities to fully realise the benefits of CBR.

vii. Need to conduct further research. With the findings discussed above, there still exists gaps about the two approaches i.e. CBR and CBID. Many of the respondents were unfamiliar with CBR. As suggested above, there is need for further research after carrying out an effective sensitisation and advocacy campaign among the various stakeholders about the two approaches.

Based on the study findings, the following recommendations have been made:

i. The shift from CBR to CBID needs to be included in policy to ensure its implementation. The policy should be made known to stakeholders and persons with disabilities and all ministries must be guided on inclusion of persons with disabilities in various programmes and projects. Allocation of funding for services must be increased and presented at parliamentary level. In the planning and provision of services, persons with disabilities must be involved.

ii. It is imperative that local communities and persons with disabilities are actively involved in the design, planning and implementation of CBID programmes for them to be a success.

iii. Deliberate training interventions should be targeted towards social workers and caregivers to improve access to disability inclusive health care, assistive devices and rehabilitation services. Building these capacities is of great importance in light of the increasing number of people living with the consequences of disability either as a result of birth or injury.

iv. Sufficient funds should be specifically allocated to Persons with disabilities during the national budgeting process as a deliberate

strategy to bridge the funding gaps that CBR and CBID programmes are currently facing in several countries of Africa.

v. There is need to continue raising awareness about persons with disabilities and their potential as a number of people and institutions are unaware of the value these can add to their organisation and the communities. Stakeholders should therefore actively engage in supporting activities and services that bring both employers and communities closer to persons with disabilities.

vi. Collaboration and Networking. Multi-stakeholder partnerships and collaborations with other organisations giving support to persons with disability is extremely important in adding value to persons with disabilities. Disability activities should not be carried out in isolation but in collaboration with government agencies and ministries, academic institutions, vocational training institutions, NGOs and most importantly with persons with disabilities and their organisations. These partnerships should clearly define roles for each of the stakeholders with emphasis on involving persons with disabilities and their organisations in planning and implementation of their activities.

vii. With the findings discussed above, there still exist gaps about the two approaches i.e. CBR and CBID. There is therefore need for further research after carrying out an effective sensitisation and advocacy campaign among the various stakeholders about the two approaches.

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