

GUEST EDITORIAL

**STAKEHOLDERS' INFLUENCES IN CBR PROJECTS
IN SOUTHERN AFRICA**

Harry Finkenflügel *

ABSTRACT

This paper explores and analyses the characteristics of the different stakeholders and their roles in influencing and achieving the objectives of CBR projects. Documentation of CBR projects in Southern Africa has been reviewed. Ten projects out of the more than 30 projects identified were studied. For these ten CBR projects, the stakeholders have been identified, and the objectives of the project have been analysed. Subsequently, the objectives of the project have been related to the interventions made by the different stakeholders involved, and the role of the Intermediate Local Supervisor or Rehabilitation Technician is emphasised. In the projects studied, this cadre played a dominant role in CBR as the most decentralised and community-oriented rehabilitation worker. In fact, CBR appears to rely completely on the involvement of this type of rehabilitation worker. It is concluded that, with such a strong emphasis on this cadre, and its inclusion in a professional rehabilitation system, the influence of other stakeholders (i.e. the non-professional stakeholders) stays unfocused.

INTRODUCTION

CBR builds on the active involvement of people with disabilities, volunteers, community rehabilitation workers, trainers, and planners. These six 'stakeholders' can be described in terms of their role and position in the process, their contributions to the project objectives, and their ability to influence the CBR process. This article assesses the available documentation on the roles and positions of stakeholders in 'real life' CBR projects. To reduce error due to the cultural diversity and socio-economic variables, the study had to be limited to CBR projects conducted within a specific region. An extensive literature review

(1) revealed that, with 35 articles (of a total of 127 articles), Sub-Saharan Africa was relatively well documented. Since 29 of these articles concern the ten countries in the Southern African region (Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, Zimbabwe), a further reduction of the study area could be made.

IDENTIFYING CBR PROJECTS IN SOUTHERN AFRICA

The basis of this study was thus formed by the 29 CBR studies conducted in Southern Africa. In order to study the interests, and influence of the stakeholders involved in these CBR projects more comprehensively, these studies were complemented with 'grey literature' such as progress and evaluation reports, brochures, electronic resources, annual reports, newsletters, theses, chapters in books, and articles published in journals which did not meet the inclusion criteria used in the literature review.

Limiting the study to countries in the Southern African region will aid the interpretation of the findings. However, it also limits the ability to generalise results with those of CBR projects in other regions. It is also important to note that the selected region is still very diverse in many aspects such as population groups, languages, income, health status, cultural and political backgrounds. For practical reasons, this study relies on literature written in English and therefore does not include studies written in other languages (e.g. Portuguese, Afrikaans, Shona, Setswana, Bantu, Ndebele).

A literature search was carried out using MEDLINE (The keywords: 'disability', 'disablement', 'rehabilitation', 'Community-based rehabilitation' were used in different combinations and also combined with 'developing countries', 'Southern Africa', and the names of the countries in Southern Africa.), SOURCE (<http://www.ids.ac.uk/data/source/source.htm>), and bibliographies made available by organisations (such as EENET (U.K.), DART (South Africa).) or researchers. This was combined with evaluation reports, articles in non-scientific journals, (electronic) newsletters (e.g. 'CBR news'/'Disability Dialogue', 'Disability World'. 'ICACBR update', 'HealthWrights'), and information available on the Internet, using the Google search engine and the same keywords as those used for the MEDLINE search. Studies about conditions not commonly accepted as part of the domain of community-based rehabilitation (for example, people with epilepsy, people who are malnourished, or people who are considered socially deviant (e.g. because of infertility, ugliness, illegitimate birth)), were not included in this study.

A total of 97 documents, covering approximately 35 projects were found. Six studies could not be linked to a CBR project (2-7) Also, some projects appeared to be known under different names or as part of another project, and these were not necessarily a CBR project. It is assumed that the number of projects identified in this study presents an under-reporting of the total CBR projects since reports on rehabilitation projects are not distributed widely and are not easily available to people outside the project, organisation, or country. This fact was illustrated by experiences at a conference on CBR in Southern Africa in Harare in 1998 (8). At this conference, all participants presented a brief review of the CBR projects in their country. Not only were these projects often unknown to people in neighbouring countries, they were sometimes even unknown to colleagues in the country itself. Vanneste (9) estimated the number of projects in Sub-Saharan Africa (excluding South Africa) to range from 200 to 220 (or approximately six projects per country). Although the identified projects do not present a full picture of CBR projects in Southern Africa, the number of projects that could be identified is assumed to be sufficient for the current study. The level of documentation per project differed greatly between projects. Some projects were covered relatively well and could be located by name or region, but some projects were only found based on references made to it in policy documents, annual reports (10) or reports about other projects. For example, Serpell and Nabuzoka (11) referred to “three or four” other CBR projects and Kathleli, Mariga, Phachaka and Stubbs (12) mentioned three projects in Lesotho. The projects identified and the documentation used are presented in table 1.

Table 1. Overview of CBR projects and available literature

<i>CBR projects</i>	Research studies	Reports and other documentation
Angola		
1. Center for community-oriented rehabilitation (Medico International)	---	(30)
2. Social Integration project with disabled people (Handicap International)	---	(31)
Botswana		
3. Botswana Red Cross CBR programme	(23)	(17)
<i>Kweneng</i> (project South) and Tutume	(32)	(35), (36)
(project North)	(33)	(25, 37-39)
	(34)	

4. Ministry of Health (SSU) CBR programme	(40)	(41) (28,42) (25,37-39)
5. Mogoditshane Rehabilitation Centre CBR-programme	(43)	
Lesotho		
6. “three CBR programmes”	---	(12)
7. Scott CBR project		(44) (45)
Malawi		
8. Malawi Against Polio (MAP)	---	(46), (47) (48) (49)
9. MACOHA	---	(48)
Mozambique		
10. Ministry of Social Welfare (MIMUCAS): pilot CBR projects: ABC programme Maputo Ministry for Social Action: Community based support programme		(28), (50) (51) (52)
Namibia		
11. National CBR pilot (Tsandi division) Ministry of Land Resettlement and Rehabilitation (MLRR)	---	(28), (53)
South Africa		
12. Western Cape : SACLA Health Project	---	(54, 55)
13. Alexandra Health Centre: Institute of Urban Primary Health Care (IUPHC):Gauteng	(56)	(58) (59)
Alexandra CBR programme	---	(60, 61)
Winterveldt / Oukasie: Odi district	(57)	(62), (63)
Mpumalanga : Botshabelo	---	---
North West province: Ditsobotla	---	---
14. Wits-Tinswalo Community Rehabilitation Worker Training Programme (CRWTP):		
Free State: Bushbuckridge	(64)	---
Mpumalanga : Mhala / Gazankulu	(65)	---
Northern Province	(66)	---

15. Kwa Zulu Natal Maputaland / Manguzi Thuhukani CBR programme Emtshezi / Okhahamba (1989) Amawoti	--- ---	(67, 68) (69) (70) (6)
Swaziland		
16. National CBR Ministry of Health (supported by SCF)	---	(28), (71) (44)
Zambia		
17. Zambia National Campaign to reach Disabled Children (ZNCRDC) Katete district (Vulamkoko ward) Zambezi districts b) CBR project: Kasama district	(72) --- ---	(11) (73) (74) (75), (76)
18. CBR project in Mense	---	(75)
19. Ministry of Health Chipata district CBR Programme	---	(77), (28)
Zimbabwe		
20. Zimcare	(15)	(78) (79) (80)
21. Ministry of Health CBR programme pilot projects in eight districts, later expanding to 31 districts.	(81) (82, 83) (84) (85)	(86), (87) (88) (89) (90), (91) (21), (28)
22. Zimbabwe Red Cross CBR programme: Mutoko district (1982), Gutu district (1986), Beitbridge (1990)	(92)	(19, 20, 93), (14), (94) (25)
23. Ministry of Health Zimuto (Masvingo province) (1987)		(95), (21)
24. TOSE Respite Care Home		(10)
25. Rural membership development programme: National Council of Disabled People of Zimbabwe (NCDPZ)		(96), (97) (98), (99)
26. Children's rehabilitation unit: Community based parents' groups (CBPGs)	(18)	(100) (101)

The search comprised a time period of two decades. It is unknown how many, and what type, of projects exist at any given time. Little is known about the 'life-cycle' of CBR projects, and concerns about their sustainability have been expressed (13). Riße (14), for example, mentioned in her study that the 'Zimcare home based programme' (15), one of the projects included in this study, had stopped due to lack of funding. MacLachlan (16) argued that "an increasing number of 'third world' health development projects are proving to be unsustainable once foreign aid has been withdrawn".

The terms 'CBR-programme' and 'CBR-project' are both commonly used in the documentation studied. Although these are often used interchangeably, it appears that 'projects' generally refer to the practical implementation of CBR and 'programme' is mainly used at the planning and policy levels. As such, a 'CBR programme' can include more than one project (e.g. the Botswana Red Cross CBR programme comprised projects in Kweneng and Tutume (17)). In this chapter, both of the terms 'projects' and 'programmes' are included and all are referred to as CBR projects.

The CBR projects differed greatly with regard to the number of people assisted and the area covered. Some projects were run by one or two people who had been assigned to the project by, for example, the hospital, health centre, school, or social welfare department, who besides their regular obligations, worked on the project for one or two days per week. Other projects were staffed by a team of rehabilitation workers, clerks, drivers and other personnel working full-time. The amount of time and staff devoted to the project will definitely have implications for the roles the different stakeholders are expected to fulfil. In this study, autonomous CBR projects (with their own organisational structure) as well as CBR projects attached to other (institutional) projects are included (e.g. 18).

Whereas projects may have faded, others were incorporated into other CBR projects (for example, the CBR projects run by the Zimbabwe Red Cross (19, 20) were later handed over to the Ministry of Health and incorporated into their CBR projects), or they were incorporated into more general development programmes and thus became invisible as a separate or specific CBR project.

Some CBR projects aimed explicitly at the expansion of the project and used an approach whereby expansion was dependent upon the (increasing) availability of manpower, transport,

and other resources. An example of this approach was found in the Ministry of Health projects in Zimbabwe. The Ministry began its nation-wide CBR initiative by setting up eight pilot projects. With the experience gained from these early projects, and by training more Rehabilitation Technicians, the project had expanded to 31 of the 55 districts by 1997 (21). Some of these projects already cover the whole district, but most are currently covering only part of it and are gradually expected to expand to cover the whole district.

STAKEHOLDERS IDENTIFIED IN THE CBR PROJECTS

In the articles reviewed many names were used to describe the stakeholders involved in CBR projects. Twenty seven different names were found in the reports of CBR projects in the Southern African region and, without a doubt, the list would increase if CBR projects from other regions (i.e. Asia) were included. In table 2 an overview of the various names used for CBR workers is given at four levels. It is important to note that a range of labels such as 'disabled people', 'people with disablements', 'clients' and, 'people with disabilities' was used. To be consistent, the term 'people with disabilities' is used in both the text and the tables in this paper, even if a different name was used in the documentation studied. As a result, the reasons that authors might have had to use a specific terminology were ignored. For other stakeholders, there was no strict preference for use of a given set of names.

Table 2. Names used for CBR workers

Stakeholder	Name used and references
First level CBR workers Community level CRW / LS	Local Facilitators (21) Village Health workers (20) Auxiliary workers (67) Village Community Workers (21) Red Cross Volunteers (33) Family Welfare Educators (37, 41) Health Surveillance Assistants (HSAs) (102) Community-based (contraceptive) distributors (20) Health Assistant (75) Development officer (75)

<p>Second level CBR workers County / District level ILS / RA</p>	<p>Social Welfare Officer (SWO) for the Handicapped (41) (25, 37) Red Cross Field Officers (37) (93) Community Based Rehabilitation Worker (CBRW) (3) Community Rehabilitation Facilitator (CRF) (60, 65) Community Speech and Hearing worker (CSHW) (3) * MAP physiotherapy assistant (47) Rehabilitation Assistant (65, 68, 82, 98) Rehabilitation therapist (68)</p>
<p>Third level CBR workers Provincial level Trainer</p>	<p>Occupational therapist Physiotherapist Senior Welfare Officers (37) Regional Field coordinator (Red Cross Z.) Speech therapist (3)</p>
<p>Fourth level CBR workers National level Specialists</p>	<p>Commissioner (37) Orthopaedic Surgeon (46) Control therapy post (68) Flying doctor service (75)</p>
<p>* The Community Speech and Hearing Worker (CSHW) receives a training similar to the CBRWs but their training is specialised on communication impairments. Bortz et al place the CSHW between the CBRW and the speech therapist. The initial identification is done by the CBRW who refers to the CSHW (3).</p>	

People who are responsible for an exclusive task in CBR and who are specifically educated in CBR or other forms of rehabilitation were included in the four levels of CBR workers in addition to stakeholders who have been trained in other disciplines (e.g. nursing, Social Welfare) and those who have other tasks on top of - and sometimes competing with - CBR duties. A specific example of CBR workers combining different duties is the use of 'Community-based contraceptive distributors' in CBR projects in Zimbabwe. In these projects, workers had the regular task of providing information about and distributing contraceptive devices even though there was no obvious overlap between this task and CBR work. These CBR workers were most likely chosen for this unrelated task because they are already known in the community and had access to the families.

OBJECTIVES OF CBR PROJECTS

In order to analyse and discuss the roles of stakeholders in CBR projects, the types of objectives that have been assigned to the different stakeholders need to be clarified. The available documentation for ten CBR projects included both the objectives and a record of the stakeholders involved. This covered a limited, but varied, number of projects in five different countries (Botswana, Lesotho, Malawi, Zambia, and Zimbabwe), and were either run by NGOs (Red Cross, Malawi Against Polio, Zimcare) or by Governments (Ministry of Health, Ministry of Social Welfare). The 'exclusion' of South Africa is noticeable. As shown in table 1 a number of projects in South Africa were identified, but the documentation available was fragmented and focused on the training of Community rehabilitation workers. Thus, they only described CBR projects marginally. Also, the only project in table 1 that was run by people with disabilities (Rural Membership Development Programme) failed to meet the criteria for inclusion in this study. This is unfortunate since this project demonstrated how people with disabilities themselves were able to form the structure through which the awareness and development of people with disabilities was promoted.

In table 3 the objectives and the stakeholders for each CBR project have been listed. The objectives are expected to a large extent to determine the interventions made by, and the perceived roles of, the different stakeholders. Commonly, the main objectives in CBR aim directly at improving the quality of life of the person with a disability. In some practices objectives that specifically aimed at changes within the different stakeholders (increasing the knowledge of Local Supervisors) were formulated. This implies that stakeholders are not only the 'agents of change' but also 'objects of change'.

Project objectives are described as 'statements of specific outcomes that are to be achieved' (22) and as such mark the difference between an existing situation and a desired situation. However, none of the CBR projects studied presented an accurate description of the actual situation, the needs of people with disabilities, the requested support by the families, and so on. Objectives set in a CBR project seem to be entirely based on a common notion of a desired situation. Lundgren-Lindquist and Nordholm (23), for example, started with a general description of the perceived disadvantaged position of people with disabilities in developing countries. This is followed by a description of the problems such as; "mortality rate among children with disability is higher", "children with disabilities have less opportunities to attend

school”, “adults with disabilities have lower incomes”, and “people with disabilities are not represented in the planning and decision making in their societies”. These problems were not based on a factual analysis of the situation of people with disabilities in the project area, and were thus not reflected in the objectives of the projects. Consequently, these general problems could not be directly connected to the expected interventions of specific stakeholders. Although the study of Lundgren-Lindquist and Nordholm (23) is mentioned here as a typical example of applying a broad and general perspective on people with disabilities to a specific project, this approach appears to be common in all of the studies that were included in this analysis.

Table 3. Overview of objectives of CBR projects and stakeholders involved

Country, Organisation, Project title, Objectives	Stakeholders involved
Botswana: Botswana Red Cross CBR programme for the disabled: Kweneng (project South) and Tutume (project North)	
1.0 To promote community based health care and rehabilitation of disabled persons with full participation of their families and the community. Specific objectives include: 1.1 To identify and register all disabled persons, 1.2 To assess and programme disabled persons for rehabilitation and improved quality of life, 1.3 To provide appropriate appliances, 1.4 To promote placement in schools, workplaces etc., 1.5 To educate communities and motivate them to take an active part in CBR, 1.6 To develop a system for reporting, monitoring and evaluation of the programme.	People with disabilities Red Cross volunteers Family Welfare Educators (WFE) Rehabilitation Assistants Community members / representatives Teachers Rehabilitation Social Welfare officer Trainer (expatriate OT) Chief training officer (headquarters)
Botswana: Ministry of Health: Special Services Unit for the Handicapped	
2.1 To coordinate policy and ensure that every section dealing with the handicapped is aware of the official line of approach 2.2 To liase closely with local organizations for the handicapped	People with disabilities Family Family Welfare Educators (WFE) Social Welfare Officer (SWO) for the handicapped Organisations,

2.3	To maintain intimate contact with people with disabilities and caregivers	Government
2.4	To maintain a register of people with disabilities	
Lesotho: Scott CBR project		
3.1	To establish a CBR programme in Scott Hospital service area over a period of three years	People with disabilities Local support groups, Village health committees
3.1.1	To introduce the concept of CBR to PHC management	
3.1.2	Train 16 people who will train CBR-worker in the villages	CBR-workers
3.1.3	Support and supervise training of CBR-workers	CBR trainers
3.1.4	Establish a managerial supervision structure to establish the effective function of the programme in each area	CBR coordinator
3.2	To motivate and assist communities in the establishment of local support groups	(CBR structure is integrated within PHC structure)
3.3	To establish an information and monitoring system	
Malawi: Malawi Against Polio (MAP): Outreach programme		
4.1	To provide medical assistance and appliances for the victims of polio and other disabling conditions and to adopt all possible measures for their welfare	MAP physiotherapy assistant Physiotherapist / occupational therapist Orthopaedic technician
4.2	In association with other voluntary and statutory bodies to take any other measures for their welfare	MAP Unit (4) Orthopaedic surgeon Map Head Office / director
Zambia: Zambia National Campaign to Reach Disabled Children (ZNCRDC): projects in Zambezi, Katete and Kasama		
5.1	To enable the disabled and their families to co-exist and participate fully in the family and community activities. Seven specific objectives are given.	Health Assistants
5.2	To identify disabled children and stimulate rehabilitation activities within the community	District Rehabilitation Team
5.3	To promote delivery of supportive and specialist services to community efforts	Physiotherapist (expatriates)

5.4	To function as part of Primary Health Care emphasising prevention and early intervention	Special teacher
5.5	To increase knowledge on impairment and disability prevention	Clinical officer of psychiatry
5.6	To increase materials for reference and training	Clinical officer TB and
5.7	To promote social acceptance of disabled children and avoid stigma	leprosy control
5.8	To co-ordinate rehabilitation activities concerned with disabled children	
Zambia: CBR programme Chipata district (1996)		
6.1	To sensitise and educate the communities on disability issues	CBR implementing team
6.2	To empower disabled people in the home villages	(CBR co-ordinator,
6.3	To encourage the social integration of disabled people within the community	Physiotherapist,
6.4	To train CBR workers and Rural Health Centre staff on disability issues and implementing the programme	Social Worker, special teacher) -
6.5	To provide rehabilitation services near community members	do outreach visits Volunteers
6.6	To join the efforts and resources with others in the field of rehabilitation	(many of them with a disability or relatives): Local CBR committees
Zimbabwe: Zimcare home-based learning programme for mentally handicapped people		
7.0	To help families living in rural areas with a home-based learning scheme for mentally handicapped people	People with a mental handicap
		Caregivers (mothers /
		grandmothers) Family Support
		Workers Zimcare staff
Zimbabwe: Ministry of Health CBR programme		
8.1	To increase awareness, educate the community	VCWs / volunteers / local facilitator
8.2	To implement rehabilitation programmes at home	Rehabilitation Assistants
8.3	To stimulate involvement of community members and to use community resources	Therapists Rehabilitation Officer,
		Ministry of Health Referral
		structure: District / Provincial /
		Specialised centres (see Zimbabwe
		Red Cross)
Zimbabwe: Zimbabwe Red Cross: projects in Mutoko (1982) and Gutu (1986) district		
9.1	To promote awareness, self reliance and responsibility of rehabilitation in the community	PHC cadre: VHWs, Health
		Assistants, Community Advisers,

9.2	To mobilise, motivate and train community members including the disabled themselves to take an active part in the training	CB distributors VIDCO / local government Schoolteachers
9.3	To encourage the use of simple methods and techniques which are acceptable, affordable, effective and appropriate in the local setting	Field coordinators Red Cross volunteers Rehabilitation Assistant
9.4	To use existing local organisation especially primary health care agencies to help deliver services.	Regional field coordinator Red Cross Headquarters Referral structure:
9.5	To consider economic resources and gradual take-over by Government	District hospital: RA Provincial hospital: therapists / RAs Specialised centres
Zimbabwe: Children's rehabilitation Unit: Community based parents' groups		
10.1	To educate parents on the causes, prognosis and management of their children's disability	Volunteers Rehabilitation Technicians
10.2	To encourage the growth of group autonomy and action independent of professional participation	Therapist Specialised institution Paediatrician
10.3	To encourage the growth of friendship and support among the parents	
10.4	To monitor the progress of the children, assist the parents in carrying out treatment programmes	
10.5	To refer back to the central facility for specialist attention as necessary	
10.6	To ensure follow-up of all children with disabilities in these areas through the assistance of volunteers	

ANALYSIS OF OBJECTIVES

In analysing the objectives given in table 3, a few (methodological) problems become apparent. These problems are identified and discussed below. The numbers between brackets refer to the objectives listed in table 3.

Objectives are not specific

Objectives like 'to increase knowledge' (5.4), 'to encourage the social integration' (6.3), and 'to increase awareness' (8.1, 9.1) are indistinct as they do not specify what aspects

need to be addressed and which stakeholders would be involved. Furthermore, it implies that knowledge about the baseline is available, and assumes that the means to attain the objective, and what an 'attained objective' looks like is known. None of the studies mentioned includes an actual analysis, or even a description, of awareness level, education level, and quality of life of people with disabilities or motivation to change.

Objectives are formulated as preconditions

In the process of achieving objectives, it is common and necessary to bring about appropriate preconditions and to develop procedures. These preconditions and procedures are not an objective in its own right but are to be seen as means to attain an objective. Although the difference between 'means' and 'objectives' will often be debatable, it is important that objectives be formulated as a functional or meaningful change of the situation as a result of the intervention. For example, the involvement of stakeholders (including organisations formed by people with disabilities) has been listed as a project objective frequently. In one or two projects, this seems to be a genuine objective (6.0, 9.1) but in most situations this objective is part of establishing 'prior conditions' or 'using resources' (1.1, 2.2, 4.2, 9.5). Another example is the objective that aims to 'provide appliances' (1.3, 4.1). Most likely the actual objective behind it aims to 'improve mobility'. To make it even more specific it could be phrased as 'to enable the child to walk from home to school'. Also the 'establishment of an information and monitoring system' (3.3) is a means rather than an objective. In this example the objective could be rephrased as 'the development of a responsive and accountable management system to support and inform the different stakeholders'.

Objectives are not phrased in a way that they can be evaluated

Some objectives have been phrased in a way that makes it impossible to determine whether objectives have been reached, to what extent and when. An objective such as 'to identify and register all disabled persons' (1.1) would be impossible to achieve due to definition problems and practical impossibilities. Objectives such as 'to promote placement in schools...' (1.4) and 'to educate communities and motivate them to take an active part in CBR' (1.5) refer to 'actions-to-be-taken' more than 'objectives-to-be-achieved'.

Objectives do not reflect or cover the contents of the project

Arnold (24) commented in the evaluation of the Scott CBR project that the objectives did not fully reflect the project. In addition to the set of formal objectives agreed to at the start of the project, and there are other, informal, objectives. For example, in the Scott CBR project the objective 'to improve the status of disabled people within the community' is not listed in the formal objectives but came up frequently in the discussions with the project staff. Also, specific objectives set within different intervention levels might not be included in the formal objectives of the project as a whole.

To add to the criticism that many project objectives have been based on a general idea about the position and needs of people with disabilities and other stakeholders, it is mentioned here that CBR projects also introduce new objectives to communities by changing peoples' perceptions on their situation or by just becoming part of their life. This results in the creation of other demands, and increases the impact of a disability on daily life by setting expectations that cannot be fully met. Not one of the projects studied here, monitored such trends or accounted for this effect.

STAKEHOLDERS' CONTRIBUTION IN ACHIEVING OBJECTIVES

In all CBR projects described, people with no professional training in rehabilitation, education, nursing, and so on. have explicitly been made responsible for the training of people with disabilities. Trainers and therapists have changed from providing hands-on therapy or training to the people with disabilities, to roles that provide instruction to Intermediate Level Supervisors. However, this was only possible due to the introduction of 'second level' CBR workers (see table 2). In a comparison between CBR in Botswana and Zimbabwe, Ingstad (25) focussed on the availability of Rehabilitation Technicians. She observed that only a few Rehabilitation Technicians were working in Botswana whereas in Zimbabwe Rehabilitation Technicians were employed in every district. According to her, the number of Rehabilitation Technicians makes the difference between a 'struggling' CBR programme (Botswana) and a 'thriving' one (Zimbabwe).

As a result of the indistinctiveness of CBR project objectives, understanding the roles of the stakeholders involved is complex. Questions such as 'who is going to sensitise and educate

the communities about disability issues' need to be answered. Are objectives that focus on the community the responsibility of the stakeholders living in that community? Or is it the second level rehabilitation worker who supports the Community Rehabilitation Worker or

Table 4. Project objectives assigned to stakeholders in CBR

Summarised objectives	Objectives (see table 3)	People with disabilities	Family / family trainer	CBR workers			
				1 st level: CRW / LS	2 nd level: ILS / RA	3 rd level: trainer	4 th level: specialist / coordinator
To identify, assess, register people with disabilities	1.1, 1.2, 2.4, 5.1			+++	+++	+	
To train person with disabilities	4.1, 5.1, 8.2			+++	++	+	
To support families	7.1, 10.4			+++	+++		
To empower stakeholders, form support groups	6.2, 3.2, 10.3				+	+	
To provide appliances	1.3, 4.1				+	++	+++
To increase awareness / knowledge / information	1.5, 5.4, 6.1, 8.1, 9.1, 10.1			++	++		
To increase participation / integration	1.4, 5.0, 5.1, 5.6, 6.3			+++	++		
Community involvement / resources	6.4, 8.3, 9.1, 9.2, 9.3, 10.2			++			
To train 1 st level CBR workers	3.1.2, 3.1.3				++		
To improve coordination between sectors	2.2, 4.2, 5.7, 6.6, 9.4				++	++	++
To develop and maintain service system	1.6, 2.3, 3.1, 5.2, 6.5, 10.5, 10.6					+++	
To influence / coordinate policy level	2.1, 9.5						+++

the Local Supervisor? And, if so, does she have the knowledge to accept this responsibility and will her authority be well received in the community?

In table 4, the different objectives are grouped and assigned to the appropriate stakeholders. The symbols + (minor), ++ (moderate), and +++ (major) stand for the extent of the involvement of the stakeholders required to reach the objectives as presented in the ten projects analysed.

Looking at the project objectives and how they have been assigned to the stakeholders, it is noticeable that the +'s are placed more to the right than would have been expected on the basis of general CBR literature (26, 27). This indicates that, in 'real-life' CBR projects, the responsibility for objectives is held by a higher level of stakeholders. It is also noteworthy that very few objectives are assigned to the person the disability, to the family and family trainer.

A few comments about documentation

- The study has been limited to CBR projects in Southern Africa. The choice to only include documentation in English might have affected the inclusion of CBR projects in the non-English speaking countries Mozambique and Angola. References to CBR projects in these countries have been found, but no reports or studies that could contribute to this study could be obtained. This is regrettable, especially since these countries are, due to their recent history of (civil) war, confronted with many land-mine (and other violence-related) victims. As indicated by Ingstad (25) and others, war can be a forceful drive to set up rehabilitation services. If and how this works out for Mozambique and Angola is unknown and therefore not included in this study.
- The documentation on quite a number of CBR projects has been disappointingly minimal. It sometimes consisted of no more than a reference made in WHO's review (28) or in other documents. It is therefore very hard for people interested in CBR to assess and become familiar with their projects unless they are directly involved in that specific project. This not only hampers sharing information and learning from each other, it also neglects the question of whether or not the chosen approach met the expectations of the people with disabilities as well as other stakeholders in the project.

- The inclusion of 'grey literature' made it possible to study CBR projects in more detail than would have been feasible if only peer-reviewed articles were included. However, the quality of 'grey literature' is difficult to assess because the methodology is often not robust.
- Twenty-nine articles about CBR in the Southern African region formed the basis of this study. Twenty-three articles could be related to a specific CBR project, and 14 of these could be related to seven selected projects (for two projects no related articles could be found). In fact, nine articles stemmed from two projects (Botswana Red Cross CBR programme and Zimbabwe Ministry of Health CBR programme). Although these two projects were reasonably covered (in combination with the 'grey literature'), the overall picture was that documentation on CBR projects is scarce and fragmented and the basis for analysing the roles of stakeholders in specific projects is still small.

DISCUSSION

The CBR projects studied have emphasised 2nd level rehabilitation workers (Intermediate Level Supervisor or Rehabilitation Assistant/Technician). Interestingly, the two projects in which they were not included recommended the introduction of a 'mid-level' rehabilitation worker in their concluding statements. The objectives and tasks of this level are very much derived from the 3rd level rehabilitation worker: the trainer. This 2nd level cadre fits well in the professional rehabilitation network and can be seen as the most community-oriented rehabilitation worker. In practice, the 2nd level Rehabilitation Workers often work directly with people with disabilities and will involve 1st level rehabilitation workers (Local Supervisors) to assist them and to continue the training in their absence.

Although the names of stakeholders differed (table 3), the CBR projects described here share a very similar structure. The hierarchical pyramid of stakeholders and services in all of these projects is characterised by a clear co-ordinating structure headed by professionals residing in Head Offices. This managerial structure is basically identical to the ones existing in hospitals, rehabilitation centres, special education, etc., and it also conforms to the CBR structure proposed by Helander (26, 29). All of the projects involved referral centres (hospitals and specialised centres) at the district, provincial, and national level. None of the articles presented a negative picture or judgement on institution-based services. These services

were very much used complementarily to the assistance that could be offered by CBR projects. Thus, the dichotomy between institution-based and community-based services appears to be non-existent or irrelevant in 'real life' CBR projects.

First and second level of CBR workers were emphasised to be the stakeholders most responsible for project objectives. In some projects the second level CBR worker was not included. In these cases the third level CBR worker (often a therapist) appears to step into the role assigned to the second level and then takes the responsibility to work directly with the person with a disability and her family. In most projects the third level CBR worker basically supervises the second level and organises CBR at the district and provincial level. It is quite distinguishable that when finances or other resources are involved (such as in the provision of appliances), these objectives 'belong' to the third level CBR workers. None of the projects outlined a (decentralised) budget structure in which parts of the budget were made available to first or second CBR workers or even to families or the people with disabilities.

The objectives of the projects are apparently based on assumptions and on an implicit and shared, understanding of 'what needs to be done'. At the level of the person with a disability, the starting point appears to be the development of her full physical capacities regardless of the type of activities that she wants to do. At the community level, the assumption is that low levels of awareness, knowledge, and self-reliance restrain the person with a disability from living their life like anybody else. However, without a prior assessment of the actual situation and a description of the desired situation, setting project objectives is not only an incomplete but also insecure process. It is not only difficult to determine when the desired situation has been achieved, it is also unknown whether or not the right objectives were chosen and how relevant and effective they were in influencing the different stakeholders.

Only one of the projects listed 'empowerment of stakeholders' as an explicit objective (table 3: objective 6.2). However, what this implicated and what type of interventions were carried out to actually empower this group was not made clear in this project. Looking at the objectives listed, it appears that most objectives do aim at increasing the competence levels of the different stakeholders involved in CBR. However, better fulfilment of roles as a result of an increased competence level does not necessarily give stakeholders the authority to influence the project. In the projects studied, the control of resources and the power to

make changes within the project stays very much with the programme implementers and the trainers and it is not handed over to the other stakeholders such as stakeholders in the community.

It can be concluded that, although strengthening stakeholders is part of the objectives of CBR projects, the influence of stakeholders in the rehabilitation process is fairly limited, and goal-setting in addition to the allocation of resources and power occurs at the level of the programme planners.

* Institute for Health Policy and Management
Erasmus Medical Centre, PO Box 1738
3000 DR Rotterdam, The Netherlands
Tel. + 31 10 408 9701
Fax + 31 10 408 9094
e-mail: h.finkenflugel@erasmusmc.nl

Acknowledgement

The author thanks M. Miles, B. O'Toole, A. Vreede, P. McLaren and SCF UK for providing bibliographies and documentation for the literature search.

REFERENCES

1. Finkenflugel H, Wolffers I, Huisman R. *The evidence base for community-based rehabilitation: a literature review*. International Journal of Rehabilitation Research 2005. (in press)
2. Brodin J, Molosiwa S. *Support for families with children with mental retardation in Botswana, Southern Africa*. International Journal of Rehabilitation Research 2000;23:163-167.
3. Bortz MA, Jardine CA, Tshule M. *Training to meet the needs of the communicatively impaired population of South Africa: a project of the University of Witwatersrand*. European Journal of Disorders of Communication 1996;31:465-475.
4. Coetzee D, Kemp R. *Community-based rehabilitation in the service area of Stikland Hospital-The problem defined*. South African Medical Journal 1982;61(20):751-4.
5. McConkey R, Mphole P. *Training needs in developing countries: experiences from Lesotho*. International Journal of Rehabilitation Research 2000;23(2):119-123.
6. Miles S. *Engaging with the Disability Rights Movement: the experience of community-based rehabilitation in southern Africa*. Disability & Society 1996;11(4):501-517.

7. Whyte SR, Ingstad B. *Help for people with disabilities: Do cultural differences matter?* World Health Forum 1998;19:42-46.
8. Cornielje H, Jelsma J, Moyo A. *Proceedings of the workshop on disability and rehabilitation systems research* (Harare, June 29 - July 3, 1998).
9. Vanneste G. *Currents status of CBR in Africa: a review*. Asia Pacific disability rehabilitation journal 2000; Selected Readings in Community Based Rehabilitation. Series 1: CBR in transition: 127-135.
10. APSO. Annual Report 1999; 1999.
11. Serpell R, Nabuzoka D. *Assessment as a guide to meeting the needs of rural Zambian families with a disabled child*. In: Socio-cultural context and childhood disability; 9-13 July 1989; Jyväskylä, Finland.
12. Khatleli P, Mariga L, Phachaka L, Stubbs S. *Schools for all: National planning in Lesotho*. In Brian O'Toole and Roy McConky (Eds.) *Innovations in Developing Countries for People with Disabilities*. Lisieux Hall, 1995.
13. Ager A. *The importance of sustainability in the design of culturally appropriate programs of early intervention*. International Disability Studies 1990;12(2):89-92.
14. Riße M. *The Community based rehabilitation programme of the Zimbabwe Red Cross Society*. Mainz, Germany; 1991.
15. Mariga L, McConkey R. *Home-based learning programmes for mentally handicapped people in rural areas of Zimbabwe*. International Journal of Rehabilitation Research 1987;10(2):175-183.
16. MacLachlan M. *Sustaining Health Service Developments in the 'Third World'*. J.Roy.Soc.Health 1993(June).
17. Botswana Red Cross. *Mid-term evaluation report of the Botswana Red Cross society's community based rehabilitation programme for the disabled*. Gaborone, Botswana; 1988.
18. Jelsma J, Cortes-Meldrum D, Moyo A, Powell G. *The Children's Rehabilitation Unit, Harare, Zimbabwe: an integrated model of rehabilitation*. Pediatric Physical Therapy 1995.
19. Zimbabwe Red Cross Society. *Rehabilitation services Mutoko district: 1st November - 1st December 1982*. Harare, Zimbabwe; 1982.
20. Zimbabwe Red Cross Society. *Evaluation report of the Zimbabwe Red Cross Society's community-based rehabilitation programme in Gutu district, Zimbabwe*. Harare, Zimbabwe; 1987.
21. Chidyausiku S, Munandi J, Marasha M, Mbadzo D, Mhuri F, Ooppelstrop H, et al. *Community-based rehabilitation programme in Zimbabwe. evaluation report*. Stockholm, Sweden: SIDA; 1998. Report No.: Sida Evaluation 98/15.
22. Johnson G, Scholes K. *Exploring corporate strategy*. Harlow, U.K.: Financial Times, Prentice Hall; 2002.

23. Lundgren-Lindquist B, Nordholm L. *Community-based rehabilitation-a survey of disabled in a village in Botswana*. Disability and rehabilitation 1993;15(2):83-9.
24. Arnold C. *Evaluation of the Scott CBR project*: SCF; 1995.
25. Ingstad B. *Disability in the Developing World*. In: Albrecht G, Seelman KG, Bury M, (ed). Handbook of Disability Studies. London, UK: Sage Publications; 2001. p. 772-792.
26. Helander E. *Prejudice and dignity. An introduction to Community-based rehabilitation*: United Nations Development Programme; 1999.
27. Helander E, Mendis P, Nelson G, Goerdts A. *Training in the community for people with disabilities*. Geneva: WHO; 1989.
28. WHO. *Disability and rehabilitation Status, review of disability issues and rehabilitation services in 26 African countries*. Geneva, Switzerland: 2003.
29. Helander E. *Prejudice and dignity. An introduction to Community-based rehabilitation*: United Nations Development Programme; 1993.
30. Tietze U. *Possibilities for working with cultural knowledge in the rehabilitation of mine victims in Luena, Angola*. In: Weigt G, (ed). Disability in different cultures. Reflections on local concepts. Bielefeld, Germany; 1999.
31. Harknett S. *From talk into action in Angola*. Disability Dialogue 2000(1):10.
32. Lundgren-Lindquist B, Nordholm L. *The impact of community-based rehabilitation as perceived by disabled people in a village in Botswana*. Disability and rehabilitation 1996;18(7):329-334.
33. Nordholm L, Lundgren-Lindquist B. *Community-based rehabilitation in Moshupa village, Botswana*. Disability and rehabilitation 1999;21(10-11):515-521.
34. Ingstad B. *The disabled person in the community: social and cultural aspects*. International Journal of Rehabilitation Research 1990;13:187-194.
35. Gabanameko C. *Botswana Red Cross Society and Community-based rehabilitation*. African Regional Conference on CBR; 3-16 April 1989; Harare.
36. Waaler S. *CBH&R project North 1986-1991 Botswana Red Cross - statistical results project villages Mandunyane, Shashe Mooko, Tonota and Shashe Station. Francistown, Botswana*: Botswana Red Cross; 1991.
37. Ingstad B. *Community-based rehabilitation in Botswana. The myth of the hidden disabled*. Lewiston, New York, USA: The Edwin Mellen Press; 1997.
38. Ingstad B. *Mpho ya Modimo - A gift from God: perspectives on "Attitudes" toward disabled persons*. In: Ingstad B, Whyte SR, (ed). Disability and Culture. Berkeley: University of California Press; 1995.
39. Ingstad B. *Problems with community mobilization and participation in CBR: a case from Botswana*. In: Laevitt RL, (ed). Cross-cultural rehabilitation, an international perspective. London, UK: W.B. Saunders; 1999.

40. Kibria KG. *Childhood disabilities in Botswana: problems and priorities for special education and habilitation*. International Journal of Special Education 1989;4(2):183-188.
41. Sebina DB, Kgosidintsi AD. *Disability Prevention and Rehabilitation*. Assignment Children 1981;53/54:135-152.
42. WHO. *Community Based Rehabilitation. Report of a WHO Interregional Consultation Colombo, Sri Lanka, 28 June - 3 July 1982*; Report No.: RHB/IR/82.1.
43. Popovich JM. *Rehabilitation nursing in Botswana*. Rehabilitation Nursing 2001;26(5):168-171.
44. Miles S. *Disability as a catalyst for sustainable development*. 1995.
45. Arnold C. *Evaluation Save the Children Fund (UK) Scott CBR project*. Lesotho; 1995.
46. Hyde KAL. *Malawi against polio programme evaluation, final report*. Malawi: University of Malawi, centre for social research; 1992.
47. Chipofya E. *Rehabilitation of the patient with poliomyelitis. The Malawi experience*. Tropical and Geographical Medicine 1993;45(5):206-210.
48. Maanen V van. *Rehabilitation-services for disabled people in Malawi*. Memisa Medisch 1999(2):57-59.
49. Davies M, Finkenflügel H. *Joint Evaluation of Malawi Against Polio, part 1 Main Report: Christoffel Blindenmission, Memisa*; 1995.
50. Heinonen T. *Report on trip to Mozambique*. 2000.
51. Miles S, Medi E. *Disabled children in post-war Mozambique: Developing community based support*. Disasters 1994;18(3):284-291.
52. Medi E. *Primary education booklet "theme paper": How can a disability programme based in the Ministry for Social Action help disabled children's education?*; 1997.
53. United Nations. Johannesburg Summit 2002: Namibia, country report; 2002.
54. Loveday M. *Community-based rehabilitation workers, a South African training manual.*: SACLA Health Project; 1990.
55. Loveday M. *Is CBR a second rate service?* In: Finkenflügel H, (ed). The Handicapped Community. The relation between primary health care and community based rehabilitation. Amsterdam: VU University Press; 1993. p. 95-98.
56. Ferrinho P, Robb D, Cornielje H, Rex G. *Primary health care in support of community development*. World Health Forum 1993;14(158-162).
57. Taukobong N. *The role of the Community based rehabilitation worker within the primary health care service of the Odi district*. South African Journal of Physiotherapy 1999;55(1):19-22.
58. Cornielje H, Ferrinho P, Fernandes A. *Report of an evaluation of the community based rehabilitation programme at the institute of urban primary health care, Alexandra*. Johannesburg, South Africa: Institute of Urban Primary Health Care; 1994.

59. Cornielje H, Ferrinho P. *The sociopolitical context of CBR developments in South Africa*. In: Leavitt RL, (ed). Cross-cultural rehabilitation, an international perspective. London, UK: Saunders WB; 1999.
60. Cornielje H, Ferrinho P. *Development of a community based rehabilitation programme for a poor urban area in South Africa*. CHASA Journal of Comprehensive Health 1993;4(2):56-57.
61. Cornielje H, Ferrinho P. *Community development skills: Essential component in the training of community rehabilitation facilitators at the Institute of urban primary health care in South Africa*. CHASA Journal of Comprehensive Health 1995;6(1):16-17.
62. Deetlefs L. *The establishment of a CBR service and training program in Alexandra, South Africa*. ActionAid Disability News 1995;6(1):16-17.
63. Cornielje H. *A local disability movement as part of a Community based rehabilitation programme*. In: Finkenflügel H, (ed). The Handicapped Community. The relation between primary health care and community based rehabilitation. 7 ed. Amsterdam: VU University Press; 1993. p. 17-21.
64. Lorenzo T. *The identification of continuing education needs for community rehabilitation workers in a rural health district in the Republic of South Africa*. International Journal of Rehabilitation Research 1994;17:241-250.
65. Dolan C, Concha ME, Nyathi E. *Community Rehabilitation workers: do they offer hope to disabled people in South Africa's rural areas?* International Journal of Rehabilitation Research 1995;18(3):187-200.
66. Petrick M, Sichangwa K, Collinson M, Pickford K. *Supervision of Qualified Community Rehabilitation Workers*. South African Journal of Physiotherapy 2001;57(1).
67. McLaren P. *Community intervention in Maputaland Kwa Zulu. What is successful community intervention?* S.A. Federal Council for the Rehabilitation of the Disabled; Johannesburg, South Africa; 1981.
68. McLaren P. *Is rehabilitation of the rural disabled a realistic objective?* The South African Journal of Physiotherapy/Die Suid Afrikaanse tydskrif fisioterapie 1986;42(2):51-55.
69. Fenenga C. *The role of Community Based Rehabilitation Cadre* [dissertation Master in Community Health]. Liverpool: University of Liverpool; 1997.
70. McLaren P, Phillipott S, Mdunyelwa M. *Report of the Disability Information Project (DIP) in the Emtshezi / Okhahlamba district*: Disability Action Research Team (DART); 2000.
71. Save the Children UK. Country Report: Swaziland 2000.
72. Serpell R. *Specialized centres and the local home community: children with disabilities need them both*. International Journal of Special Education 1986;1(2):107-127.
73. Serpell R, Nabuzoka D. Zambia: *Community-based rehabilitation for disabled children in Vulankoko ward: a follow-up study*: Institute for African Studies; 1985.

74. Nabuzoka D. *How to define, involve and assess the care unit? Experiences and research from a CBR programme in Zambia*. In: Finkenflügel H, (ed). *The Handicapped Community. The relation between primary health care and community based rehabilitation*. Amsterdam: VU University Press; 1993. p. 73-88.
75. Nabuzoka D. *Community-based rehabilitation activities for disabled children in Kasama district: an evaluative report*. Lusaka: Institute for African Studies, University of Zambia; 1988. Report No.: IAS Commissioned Studies Reports, No. 3.
76. Vermeulen D. *A policy paper for Zambia on Community Based Rehabilitation (CBR), with the case of Western province*. Lusaka, Zambia; 1989.
77. Payne H, Simwanza F. *Mid-term review report Chipata district Community-based rehabilitation programme - Eastern province, Zambia*. Zambia: Healthlink Worldwide; 1998.
78. McConkey R, Templer S. *More than care, a videocourse on nurturing the development of severely retarded and multiply handicapped children*. Course handbook. Harare, Zimbabwe; 1986.
79. McConkey R. *Out of Africa: an alternative style of services for people with mental handicaps and their families*. *Mental handicap* 1988;16:23-26.
80. Mariga L. *Technical aids for training developmentally retarded children in rural areas*. In: Lagerwall T, (ed). *Appropriate Aids and Equipment for disabled people in Africa*; Harare, Zimbabwe: ICTA Information Centre; 1988.
81. McAllister M. *Community based rehabilitation in Zimbabwe*. *Physiotherapy* 1986;75(7):432-434.
82. Finkenflügel H. *Help for the disabled - in hospital and at home*. *World Health Forum* 1991;12:325-330.
83. Finkenflügel H. *Identifying people in need of rehabilitation in rural Zimbabwe*. *The Central African Journal of Medicine* 1991;37(4):105-10.
84. Finkenflügel H, Maanen Vv, Schut W, Vermeer A, Jelsma J, Moyo A. *Appreciation of community-based rehabilitation by caregivers of children with a disability*. *Disability and Rehabilitation* 1996;18(5):255-60.
85. Rottier MJN, Broer RW, Vermeer A, Finkenflügel H. *A study of follow up of clients in community-based rehabilitation projects in Zimbabwe*. *Journal of Rehabilitation Sciences* 1993;6(2):35-41.
86. Tiroler G, Rubenson B. *Establishing rehabilitation services in Zimbabwe's communities. A project identification study in Community Based Rehabilitation*. Harare, Zimbabwe: International Child Health Unit, Uppsala, Sweden; 1985.
87. CIIR. *Zimbabwe Steps Ahead. Community rehabilitation & people with disabilities*. London, UK: Catholic Institute for International Relations (CIIR); 1990.
88. Ministry of Health Zimbabwe. *A report on eight community-based rehabilitation (CBR) pilot projects*. Harare, Zimbabwe: Rehabilitation Unit; 1990.

89. Njini L, Goerdts A, Hanekom J, Lagerkvist B. *Evaluation of rehabilitation services in Zimbabwe*. Report from a mission jointly commissioned by the Ministry of Health, Zimbabwe and SIDA. Harare; 1991.
90. Hulst G van der. *Negotiating the role of the rehabilitation worker in rural communities: outreach work in Zimbabwe*. In: Finkenflügel H, (ed). *The Handicapped Community. The relation between primary health care and community based rehabilitation*. Amsterdam: VU University Press; 1993. p. 106-123.
91. Mpala F. *Das programm zur prävention von behinderungen in Zimbabwe. Die perspektive eines distriktkrankenhauses*. *Behinderung und dritte welt* 1998;9(1):4-15.
92. Lagerkvist B. *Community-based rehabilitation—outcome for the disabled in the Philippines and Zimbabwe*. *Disability and Rehabilitation* 1992;14(1):44-50.
93. Zimbabwe Red Cross Society. *Project memorandum development of Zimbabwe Red Cross services for the disabled*. 1981.
94. Rumano N. *Community based rehabilitation run by the Zimbabwe Red Cross Society*. In: Lagerwall T, (ed). *Appropriate Aids and Equipment for disabled people in Africa*; Harare, Zimbabwe: ICTA Information Centre; 1988.
95. Munandi J. *Zimuto community based rehabilitation programme*. In: *Community based rehabilitation*; Harare, Zimbabwe; 1988.
96. NCDPZ. *Report of the participatory evaluation exercise of the NCDPZ rural membership development programme (24th October - 11th November 1988)*: National Council of Disabled People of Zimbabwe.
97. CBR-News. *From inmates to Rebels*. 1990(5):8-10.
98. Csapo M. *Zimbabwe: emerging problems of education and special education*. *International Journal of Special Education* 1986;1(2):141-160.
99. Coleridge P. *Zimbabwe: forming a disability movement*. In: Coleridge P, (ed). *Disability, Liberation, and Development*. Oxford UK: OXFAM; 1993.
100. Hanekom J. *A survey of children attending a rehabilitation centre in Harare, Implications for rehabilitation*. *Central African Journal of Medicine* 1988;34(7):149-153.
101. Hanekom-Jelsma J, Cortus-Meldrum D. *Working with parents: the experience of the Children's Rehabilitation Unit*. In H. Finkenflügel (ed.) *The handicapped community: The relation between Primary Health Care and Community based rehabilitation*. VU University Press, Amsterdam 1993.
102. Malawi Against Polio. *Annual report 1997*. Blantyre, Malawi: 1998.