

# COMMUNITY BASED REHABILITATION IN CHINA: A COMMENTARY

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## ABSTRACT

*Through fifteen years of extraordinary effort, China has set in motion a nation-wide programme for preventing disability and improving the quality of life of people with disability. A strong and comprehensive framework for rehabilitation efforts is now in place. In an attempt to reach those most in need and least able to access services, China has adopted a community based approach to rehabilitation. However, considering the more than sixty million disabled children and adults and the size of the country, it is truly a challenge to establish viable and sustainable programmes. This chapter describes the current strategies to provide rehabilitation services and consider ways to strengthen the community based rehabilitation (CBR) work in China. Starting with a brief review of disability in China and of CBR internationally, the author goes on to discuss the factors favouring CBR programming in the Chinese context, such as the existing administrative system, the national rehabilitation plan which includes CBR, multi-sectoral endorsement of the plan and of CBR, and the establishment of referral centres for rehabilitation. However, many challenges still remain, related to community participation, sustainability, the role of disabled people, and training of personnel.*

## A. INTRODUCTION

Through fifteen years of extraordinary effort, China has set in motion a nation-wide programme for preventing disability and improving the quality of life of people with disability. A strong and comprehensive framework for rehabilitation efforts is now in place. In an attempt to reach those most in need and least able to access services, China has adopted a community based approach to rehabilitation. Zhao (1) reports that more than 62 counties are now testing community based rehabilitation services. However, considering the more than sixty million disabled children and adults and the size of the country, it is truly a challenge to establish viable and sustainable programmes.

This chapter will describe the current strategies to provide rehabilitation services and consider ways to strengthen the community based rehabilitation work.

## B. DISABILITY IN CHINA

Until recently, disabled children and adults in China were usually confined to their homes. In some cases the extended family or village co-operative systems were able to find suitable productive work (2). However, in the vast majority of cases, even in major cities, no rehabilitation expertise was available to help disabled people improve their abilities. Families with disabled members often used all their resources in seeking cures, quickly becoming marginalised in both the economic and social spheres.

The situation changed remarkably in the early 1980's with the formation of a national welfare organisation for the disabled led by Deng Pufang, himself newly disabled and son of China's then paramount leader, Deng Xiaoping. After his father's return to power, Deng Pufang was invited to visit Canada for medical care and rehabilitation. The visit opened a world of opportunity, which he then made every effort to offer to China's disabled people. He set up a new organisation, which became the China Disabled Persons Federation. It raised funds, instigated a national sample census of disabled people and pushed through a national work plan for the disabled. This movement was legitimised by Deng's leadership, was strongly promoted and was paralleled by an explosion of rehabilitation activity in other government sectors. The conjunction of these developments with the United Nations International Year of the Disabled (1981) and the World Programme of Action for Disabled Persons (1983-1992) was fortuitous.

In 1987 China announced the results of its vast national sample survey of disabled people. The survey reported 4.9% of the population, 51.64 million people, as disabled in 1987 and that 18.1% of households had a member with a disability (3). Guo and Meng (4) report that if people with leprosy, dwarfism and visceral disability had been included in the survey, the disabled population would have totalled about 91 million, or 8.6% of the total population. Although many difficulties arise in comparing prevalence studies because of differences in methodology and in definitions of disability, the Chinese data are very similar to estimates for other developing countries. Helander (5) arrives at a global prevalence estimate for moderate and severely disabled individuals of 5.5% in the year 2000, with 8.5% in the more developed regions and 4.8% in less developed regions.

In addition, China has also to consider the impact of improved standard of living, changing lifestyles and an ageing population. In its 1992 report on China's health status, the World Bank reports that the country is already well into the health transition: "... in all parts of China, including the poorest areas, infectious diseases have decreased to a point where the chief causes of premature death and disability that remain are the various chronic diseases" (6). The report points out that China has yet to develop appropriate plans to cope with chronic illness and the resulting morbidity and disability. At the same time, the report recommends that China must avoid the costs and problems of the high technology approaches adopted in developed countries.

National rehabilitation planning requires this sort of country wide data, but specific programmes can only be designed with a more detailed understanding of the needs and situation of disabled individuals, their families and communities in which they live. Although every Chinese city and county has reports on disability numbers, there are few studies documenting the expressed and real needs of disabled individuals.

Chen and Simeonsson (7) looked at the needs of families with a disabled child living in rural and urban sites in Hubei Province. In addition to schooling, the expressed needs were similar and not unfamiliar to parents of disabled children elsewhere. Parents primarily needed more information about their child's condition and about available services. They wanted "... knowledge on how to teach their child and how to handle behaviour. Related areas of need were for financial help for therapy, special services and special equipment, locating a doctor who understood the child and family..".

Kleinman and co-workers (8) studied epilepsy in urban and rural communities in Shanxi and Ningxia Provinces, documenting the effect of this chronic illness on the individual and the family. Families perceived emotional, financial and family and marital burdens as extensive. Suffering was shared by the whole family. The authors emphasise the significance of the family not only as a source of nurture and assistance but as a potential source of over-control, in an effort to maintain the family's status in an unfriendly and ignorant environment.

Phillips and Pearson (9) discuss society's desire for visible social control of people with mental illness. They suggest using the promise of improved control and reduced social unrest as an approach to strengthening community and official support for community programmes. They also identify work programmes as central to community rehabilitation efforts because of the significance of work for social identity and welfare in the Chinese situation. An article describing CBR stations in Shenyang City clearly demonstrates the high value given by local officials, families and the authors to social control and the visible productivity of the disabled people (10).

A paper by Zhao (11) looks at socio-economic status of disabled women in Beijing in 1990 and 1995. While noting recent improvements, the authors describe generally lower education levels and increased unemployment among disabled women, and document the prejudice and discrimination they face from both their families and from the community. They conclude "attention should be paid to the work for disabled women at grass roots levels, especially to those .. below the poverty line."

As elsewhere in the developing world, the majority of people with disabilities in China still lack comprehensive family-oriented services, easily accessible, financially affordable and appropriate to the immediate community and its culture.

C.

#### **D. COMMUNITY BASED REHABILITATION IN THE INTERNATIONAL CONTEXT**

In recent decades it has become clear that institutions can neither provide services for all who need them nor provide the appropriate training for community living. These problems of accessibility and appropriateness are exacerbated in rural areas and among the very poor. Most families either do not know of the existence of rehabilitation or expend all their resources in travelling and gaining admission to urban institutions, which are then unable to give them the hoped-for cure and indeed, often give them inappropriate treatment and assistive devices. In fact, most basic needs of disabled people can be met in their own homes and communities, given simple and practical methods and a mentor or coach (5).

Community based rehabilitation (CBR) programming uses existing community structures; uses local manpower; and includes a working referral system for complicated problems. CBR works as follows. A community, often led by a non-governmental group, recognises its responsibility for helping disabled people attain health care, schooling and jobs, and forms a rehabilitation committee. The committee, which includes disabled people, family members, representatives of the concerned sectors and usually influential leaders, selects and supports several local people to become local community workers. They are trained in identifying, assessing and helping disabled people in their own homes and environment. Initially this may include training in mobility and daily activities, followed by helping a disabled child to join a play-group or go to school, or perhaps helping an

adult contribute to the family productivity, attain employment and participate in social activities. The over-riding goal of CBR is social integration and equal opportunities both within the family and the community at large.

Often a higher level co-ordinating body, professional group or rehabilitation resource centre at a district or county level may have spear-headed the awareness of disability and rehabilitation services. That resource centre may provide the technical expertise for training of community workers and a channel for referrals, as well as motivation and monitoring. In CBR, the main focus is on the home and community, but a referral network, a viable management structure and visible, documented outcomes are essential for sustainability.

Describing a successful CBR programme in the Philippines, Estrella (12) discusses the empowering aspects. As a disabled person develops increased independence, self-confidence and motivation in his home and community, he also gains an “increased sensitivity about the difficulties he is experiencing.. he seeks out other disabled persons. He now starts to make demands; he does not wish to be perceived as a client of welfare anymore.” She reports that now many self-help organisations have formed and they are not only initiating their own CBR programmes, but are involved in political lobbying for their rights. The ability to be self-sufficient and self-reliant would be invaluable in China’s current situation, although political lobbying remains problematic (13)

### **(1) Factors Favoring Community Based Programming in the Chinese Context**

Faced with a vast population of disabled people, the large proportion in rural areas, and with the goal of extending care to all in a reasonably equitable way, China’s central planners concur with international authorities that community based rehabilitation (CBR) is a promising strategy. Indeed, in light of China’s highly structured administrative system, the country’s achievements in improving health status, the policy of household responsibility and the tradition of extended family support networks, community-based rehabilitation appears made-to-measure for China.

In 1978 China decided to decentralise many administrative functions to provincial, city and county authorities reaching even to the district and township levels in some aspects.

In urban areas each city is divided into districts. These districts are further divided into “streets” and then into neighbourhoods. The district government has full authority to handle day-to-day affairs within its boundaries. Its decisions are implemented through the street offices. Each street usually has a first-referral hospital or clinic, and a selection of social welfare centres. Examples of these are an elderly home or activity centre, a school for children with mental handicap, a work station for people with mentally illness and a welfare factory for those who are blind or deaf (14). The neighbourhood residents’ committees are mandated by national ordinance as a means for mass mobilisation and self-government. They co-ordinate and monitor local efforts in social welfare, public hygiene and family planning. They also mediate disputes and ensure local security. This work is all reported back to the street office (15).

In rural areas, the urban structure is paralleled by the counties which are divided into townships and then into villages. Again, each level has an administrative committee. The township level offers a hospital, a junior high school and a variety of economic enterprises, often owned co-operatively by the township. The civil affairs sector of the provincial government has strong ties with the township

government and is concerned with social welfare activities such as providing for those who are indigent (14). At village level, the village committee may be made up of 3-5 officials comprising a party secretary, a labour (agricultural) representative, a social welfare representative and a woman representing the women's federation and involved mainly in family planning. Most villages have a primary school and health clinic. The village teacher and doctor usually have about one year of training in their respective fields, originate from that village and work as farmers in addition to their teaching or medical responsibilities (16). Clearly, both in urban and rural areas, these are infrastructures highly suitable for initiating community based rehabilitation programmes.

In 1988 the top-down endorsement necessary for CBR materialised. The "National Five Year Work Programme for the Disabled" was passed, which mandated the formation of "leading groups" at provincial, city and county levels to oversee its implementation. Three ministries — Civil Affairs, Public Health and Labour — together with the China Disabled Persons Federation drafted this first national plan, which was endorsed by the State Council. In expanded form, it was later incorporated into China's Eighth-Five Year National Development Plan (1991-1995):

"This work programme was drafted by the State Planning Commission and fifteen other relevant ministries and agencies.. [it] sets the general goals and guiding principles for the work for disabled persons.. The Work Programme stipulates that at least one community based rehabilitation station should be set up in each county or district. Publications on rehabilitation of disabled persons shall be compiled to guide their home based training with professional training" (17).

On May 15, 1991, China promulgated "The Law of the People's Republic of China on Disabled Persons" (18) seeking not only to protect the rights of the disabled but also to promote services for them. CBR was again identified as a national strategy:

"the work of rehabilitation shall, proceeding from the actual conditions, combine modern rehabilitation techniques with traditional Chinese techniques, with rehabilitation institutions as the core and community based rehabilitation as the basis and relying on the families of disabled persons for support. Emphasis shall be laid on rehabilitation projects which are practical, easy to realise and widely beneficial...." (Article 14)

"The people's government and departments concerned should at various levels, organise and guide urban and rural community service networks, medical prevention and health care networks, organisations and families of disabled persons and other social forces in carrying out community based rehabilitation work" (Article 15)

China thus has a national rehabilitation plan, which is a multi-sectoral, co-ordinated effort. It includes implementation directions and is officially endorsed as part of the National Development Plan. It has been disseminated to each level and officials are obligated to acknowledge it and report their part in implementing it.

In addition to the comprehensive work of the China Disabled Persons Federation, several ministries have very actively developed expertise in rehabilitation and services for particular groups of disabled people. The Ministry of Civil Affairs, as well as providing welfare services, runs prosthesis/orthosis-making factories, of which there is at least one in every province and region. They also

manage many welfare factories and vocational training centres and run rehabilitation centres for children linked with several key orphanages. They have actively promoted neighbourhood community service centres, as well as institutional and community networks caring for disabled elderly and people with mental illness. The Ministry of Education has developed courses for training teachers of special education. The 1996 Provisions on Education of Disabled Persons promote inclusive education and there are some rural schools are presently involved in pilot schemes.

The Ministry of Labour has developed the Provisions on Employment of Disabled Persons and the China Disabled Persons Federation (CDPF) is actively monitoring the quota system for employment in some cities, promoting opportunities on the open market whenever possible.

The Ministry of Public Health, for its part, has sparked the development of modern rehabilitation medicine through its hospital accreditation procedures. Many hospitals have long had small departments delivering electrical therapies and traditional rehabilitation therapies such as massage and acupuncture. In 1991, new hospital accreditation standards were issued which required higher level hospitals to add exercise therapy, occupational therapy and other such specialities based on the western practice. Several centres have developed training programmes to upgrade staff to take on these new rehabilitation tasks.

So the framework necessary for country-wide CBR programming exists: an administrative system, a national rehabilitation plan which includes CBR, multi-sectoral endorsement of the plan and of CBR, and referral centres for rehabilitation. In the context of China's family-oriented society, all the structural elements are in place.

## **E. CHALLENGES FACING COMMUNITY BASED PROGRAMMING**

A major dilemma in China is how to achieve sustainable community participation in programmes. Certainly, mass mobilisation for top-down targets is accomplished with ease. However, cultivating community awareness and responsibility takes time, while recruiting committed volunteers and promoting their ownership of programmes may cause undesirable power plays within a community which officials can well do without.

Notwithstanding many changes in recent years, most officials in China still have an intense suspicion of grassroots organisation of the kind required to support CBR (14). This suspicion sustains a fear among the people of organising themselves for any reason apart from private family matters. As a result, developing CBR through community organising techniques is not the natural approach in China that it would be in many other countries.

While it might seem that this should not unduly inhibit the formation of social and non-governmental groups, in reality it means that, even in the social service sector, private initiatives face many unexpected barriers and carry a low status in their interactions with officialdom. So, while there are examples in every province, where private rehabilitation efforts have come from individuals, these remain few, considering China's vast population. Where such initiatives prove successful they usually are co-opted promptly by an official programme. In most cases this leaves both sides happier. Indeed, new regulations for the formation of social organisations and non-profit groups, state that all such groups must be sponsored by a government department, which accepts responsibility for supervision and annual audit. They must comply with specific rules regarding

minimum membership and financial assets. Significantly, there is a limit to any duplication of similar organisations at each administrative level, which allows for little dissension (19).

A second factor delaying the development of CBR is the strong, central direction of the rehabilitation movement, even within the disabled persons movement itself. This may seem to be contradictory. Surely, the capacity to put disability and rehabilitation on the national agenda is enviable as is the national endorsement of the CBR approach?

The China Disabled Persons Federation (CDPF) certainly speaks for disabled people. Many of its officials, at all levels, are disabled themselves or are parents of disabled children. However, the CDPF was initially established as an off-shoot of the Ministry of Civil Affairs with offices and parallel positions at each administrative level. Today, the CDPF is a separate semi-governmental organisation, but it has kept the same lines of authority. The benefits of this power structure are the strength and visibility the CDPF has attained through having its own “person” at each level. On the other hand competition has been created between the sectors and there is duplication of services in many areas.

In fact, many activities of the concerned Ministries and the CDPF seem to draw resources away from the community level. Despite the professed emphasis on CBR, visits by officials and professionals to other countries have left impressions of large institutions, well equipped and well manned, serving disabled people. This has tempted leaders to invest in building centres of expertise which contribute little to the development of CBR. Indeed, raising money to build the China Rehabilitation Research Centre, which opened in Beijing in 1988 proved relatively easy. This first national centre is very impressive, acting both as a direct service centre, as a training centre and as a model. But it has little positive impact on community based rehabilitation. On the contrary, visitors and trainees from other parts of the country and from other sectors, invariably come away determined to establish similar high-tech centres.

In the last few years, much time and effort has been spent raising money to build these rehabilitation institutions. By committing most of its resources to a highly visible rehabilitation centre a local bureau limits itself to serving only the disabled people in its area who are able to access and pay for the services provided. The local bureau argues that it needs to develop a solid base, experience and a strong reputation before it can achieve other goals which may be as important but have less appeal in the competitive bureaucratic world. They further argue that effective community programmes require an institution to provide a resource centre as backup. The controversy lies in the level of sophistication and finances necessary for such a resource centre.

Sadly, too often there is little funding, time, manpower or enthusiasm left over for community programming, which anyway is seen as having little status. Although the local bureau is able to report on community surveys and take visitors to homes of disabled people, in most cases the institution neglects its role as a resource centre serving a community based network, and concentrates instead on building up its visibility.

Another strategy distracting attention away from CBR is the issue of using quantifiable, national targets to jump-start disability prevention and rehabilitation work. As a general rule, such targets tend to focus the efforts of officials and experts on quick in-and-out solutions via massive campaigns.

These, while, without doubt, of benefit to a large number of persons, have not yet addressed the daily problems of disabled people in their communities.

The first Five Year National Workplan for the Disabled launched such a campaign called “three rehabilitation targets”. The three targets were: to perform 500,000 cataract surgeries, to perform 300,000 surgeries for poliomyelitis deformities, and to give speech training to 30,000 hearing impaired children. As is typical of such nation-wide mobilisations in China, a truly remarkable job was done and the numbers surpassed the five-year target figures before the end of 1992. Intersectoral committees were formed at each administrative level to organise and co-ordinate the project. Medical teams were identified to go out to county and township hospitals where they would find patients awaiting them for surgery. The costs were divided between the different sectors, levels of government and patients. Training courses were held to improve surgical techniques, audiological testing skills and teaching of deaf children. Central government funded equipment, personnel, the building of classrooms for the deaf and associated research.

There is no doubt that this target strategy, a traditional and well-defined process in China, achieved its goals in treating three highly prevalent disabilities. In addition, there were ancillary benefits in increasing awareness of disability and rehabilitation, and in spreading the realisation that China already has technical knowledge and skills and lacks only a delivery system. But the strategy could never be characterised as anything but a top-down approach, with little input from individual communities. It has left some officials with the impression that helping disabled people is a matter of resources and is amenable to a one-time solution.

While “the three targets plan” was never planned as community based rehabilitation, it would have made an excellent springboard for CBR initiatives. Unfortunately, that did not occur.

Finally, training programmes for rehabilitation personnel have concentrated on professionals and virtually ignored the community level. The Ministry of Public Health set up a partnership with the Hong Kong Society for Rehabilitation and a key medical school, Tongji Medical University in Wuhan, to train doctors in a one year intensive rehabilitation course. The course was endorsed by the Western Pacific Region of the World Health Organisation, the Ministry of Civil Affairs and the China Disabled Persons Federation, with the latter giving start-up funds to the university. It was expected that the graduates would be the seeds for CBR and rehabilitation in general (20).

Once again a top-down metaphor came into play with the assumption that these young doctors would be able to initiate community based rehabilitation projects in their own localities. In fact, about 70% of the graduates have responded to their hospitals’ needs to establish rehabilitation medicine departments. Some are involved in community based work peripherally, a few in teaching CBR courses or writing training materials, and a handful have taken part in monitoring work (21). The training course seems to be another example of a well-intentioned programme, with good results, but has yet to evolve into something which can be described as CBR.

#### **A) CBR Development Projects**

In fact there are many CBR projects reported as operating in China, but most seem to be isolated activities rather than programmes. The Jin Hua Street Project was established in the southern city of Guangzhou as long ago as 1986. It constitutes a worthwhile demonstration of CBR in the

Chinese context, but it remains a street project that has not been extended to other streets or districts. Another example is a rural project in Pi County, Jiangsu Province, which targets a large number of children and adolescents with polio deformities. The project has developed medical, educational and prevocational aspects for the children, but there are, as yet, no plans to serve children with disabilities other than polio sequelae.

There are many similar small projects started by local social welfare bureaux or the local disabled persons association. In some cases, they don't get much further than a survey and a training course. A World Bank health project in three different regions ostensibly included a CBR component, but in fact accomplished little more than surveys of disabled people and a few training courses. In other cases, disabled children or adults with a particular type of disability are receiving training and assistance, but mainly using an outreach model. These are often initiated by hospitals or welfare institutes. The staff go out to villages or districts to visit selected individuals and conduct training. But there is little time spent developing local community workers and both decisions are taken and funds are controlled by the responsible institution. Those private initiatives which get started have almost all been in urban areas. They have been absorbed into the system, but have not been extended or replicated.

Community organising with disabled people in urban areas appears to be relatively straightforward. The most obvious entry point for rehabilitation is the civil affairs sector with its organisation of street offices, neighbourhood residents' committees and its reputation for mass mobilisation and mutual help. However, staff of the street offices and neighbourhood committees are overworked and underpaid, yet responsible for implementing a wide variety of directives from above, many of which involved exerting control and making demands on residents( 14). Chan (15), in her book, *The Myth of the Neighbourhood Mutual Help*, describes an increasing lack of interest in participating in communal activities among residents of Beijing and Guangzhou, although the rate remains higher than in urban areas in other countries.

Some large cities have welfare systems funded by street and district-owned enterprises. Poorer districts and cities cannot boast the same facilities. Chan (15) feels there are many opportunities for community-based social welfare services using the neighbourhood and street system, but that they require something other than the authoritarian approaches used heretofore. At present many community stations (small centres for disabled persons) are passive, time-occupying services as opposed to short-stay training centres or truly productive work centres. While there is no doubt that some disabled people need caretakers, special schools or sheltered work places, others should be included or integrated when appropriate into regular schools or open employment. In order to better use the potential for community based work in urban areas, an increased understanding of the needs and abilities of the disabled people of the district is essential, together with more training and support for the crucial front-line workers and volunteers. Finally, it is essential that the community plans and takes responsibility for the work.

In rural areas, primary health care appears the obvious entry point for CBR. Unfortunately, the system has disintegrated in many parts of the country since the central government's decision in the late 1970s to reform agricultural production, introduce the household responsibility scheme and abandon the communes. Co-operative medical schemes, which covered 90% of villages in 1976,

covered only 5% in 1985. Village doctors, once paid by communal funds, now rely on fee-for-service and drug mark-ups to earn a living. Preventive health services are neglected because doctors are not usually paid for this work and mobilising community participation is difficult since people don't want to lose time from their work (22). The once-proud, three tier referral system has dissolved as county hospitals or private practitioners become more attractive to families with income. Tormented by a substantial decrease in subsidies from government, township and county health services find themselves in competition for patient fees (23).

For better-off communities able to establish village and township enterprises, and thus re-establish a co-operative fund for social services, co-operative health care schemes are again becoming more common.(22). However, for poor communities with few communal resources it is impossible to subsidise health services. Liu and Hsiao (23) cite a survey in the 1980's of poor households where almost 50% reported that their poverty resulted primarily from the expenses of health care when a family member became ill.

In spite of the disintegration of the primary health care system, several counties have attempted to use it as a vehicle for CBR. In all of these official approval was given, funding was allocated, an intersectoral committee was established either at county or township level, a survey of disabled people in the villages was carried out and village doctors were called in to attend lectures on the training of the disabled.

However, when one of these sites was followed up, the results were disappointing. While the village doctors knew each household with a disabled member, it was obvious that any training given the doctors had been unsuccessful in transferring skills. The village doctors were fascinated by a few useful techniques demonstrated by the visiting students and enjoyed making simple and useful technical aids from local materials. Nevertheless, they reported that most of the villagers couldn't pay them for such services, and anyway didn't want to pay for non-curative interventions. The villagers, for their part, said the doctors charged too much. Village leaders knew little about the project or about rehabilitation. The CBR committee at township level, lacked representation from the villages, let alone from disabled people. In addition, any understanding of rehabilitation was from the medical viewpoint, neglecting the primacy of schooling, productive activity and social involvement (24).

Thus the expectation that a mandate from the centre, together with funding, a committee and a training course, would produce a community-based project was unrealistic. It was assumed that the village doctors were able to cope with problems of which they had little experience and were also enthusiastic to do so. They were expected to do this without regular support, without referral resources and with no show of interest from the centre until the time came to make the annual reports. The villages were given no say in designing the programme, in stating their interests or in managing the funds allocated. With the recent government-approved movement towards village democracy, this situation may change rapidly.

## **STRENGTHENING CBR IN CHINA**

China has established a national rehabilitation structure within which community based rehabilitation can flourish. During the past fifteen years, the Chinese have channeled their resources

and efforts into promoting awareness of disability, developing expertise and specialist centres, particularly at tertiary levels and establishing a voice for the disabled in government and administration. But it is now time to devote more effort and resources to community based programming. Crucial is to find ways to link up officials and national planning with individuals who have reason to care about disability, who are willing to actively work in their own community, ensuring that disabled children and adults are not neglected.

In other countries, non-governmental organisations and disabled people and their carers, have been at the forefront of CBR programming. They have often worked for years in the voluntary sector before gaining government and professional support. In China, government endorsement is already guaranteed and a well-designed plan should be able to secure district and county support. However, there are few groups initiating services at the primary level unless they have been planned and funded from higher levels. The majority of families with disabled members are still searching for help as individuals and, outside of welfare, there is seldom neighbourhood or community networking to support and direct families to services and opportunities.

Certainly, CBR in China needs to use the top-down approach to legitimise and validate programmes in the eyes not only of local officials but also in the eyes of the public. Community rehabilitation services should be easily grafted onto the established networks of health and social welfare and indeed, there are many examples of this. However, officials in developing countries seldom see rehabilitation as a priority measure. Projects initiated from above will collapse when official attention is distracted to new targets and official funding is exhausted. Any top-down project needs to include the involvement of those community-level individuals who care about disability and have a stake in the rehabilitation work. They must be involved as planners and managers themselves. Officials and professionals have to give up some decision-making power and funding decisions to community rehabilitation committees at the lower levels. It will also require that front-line workers are supported and motivated in a variety of simple and effective ways.

More emphasis on sustainability is required in initial planning stages instead of designing projects around targets. If results are measured in qualitative and well as the usual quantitative terms, and if these results are seen to be the result of local actions, community pride and satisfaction will enhance sustainability. It is crucial that community-level indicators of success are defined in terms of increased functional abilities, opportunities and social interactions of disabled people and their families, not only in terms of numbers, buildings and staffing (25).

It would be of great value to developing sustainable CBR programmes if several full-time CBR co-ordinators were recruited for each province. Since they will act as consultants, they should receive training in disability concepts, values and attitudes, rehabilitation measures and CBR planning and management, including participatory methodology for community development and strategies for local awareness and fund-raising issues. They should have a broad job description, which includes substantial travelling, and formal and informal liaison with different players at varying levels. They also should have control of a budget to use for training and consultative activities, as well as small funds for special items and have responsibility for recommending funding requests for CBR seed money and other requirements.

The question, however, immediately arises: under which sector should these co-ordinators be employed? A thorny question indeed, which is often solved in other countries by contracting the job out to NGOs or research institutes.

In addition, it would be beneficial to pilot-test some management elements of CBR, which are neglected in many of the existing projects. These include: a rapid needs assessment, appropriate community-level training, a community level reporting system, and a monitoring system that provides guidance, continuing education and support to front-line workers and community rehabilitation committees as well as report analysis and evaluation. These elements will be vital to the extension and replication of projects. In addition, they will demonstrate the commitment of the project to the achievement of results at the front-line.

China is making every effort to establish equitable rehabilitation services reaching all those in need. It is now necessary to purposefully allocate funds and other resources into promoting, extending and replicating community initiatives, making a concerted effort to encourage and support local inventiveness and leadership.

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