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A PARTICIPATORY EVALUATION OF COMMUNITY-BASED REHABILITATION PROGRAM IN NORTH CENTRAL VIETNAM

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ABSTRACT

Community-based rehabilitation (CBR) as an approach for meeting the needs of persons with disabilities (PWD) has been developed by the World Health Organization (WHO) for implementation in developing countries. In 1992, for the first time a non-governmental organization (NGO) was formed locally in North Central Vietnam to plan and implement the CBR approach. The program is currently being implemented in ten districts and has been able to affect 24.6 percent of PWD in this region. The purpose of this study was to evaluate the efficacy of this approach being implemented in North Central Vietnam using participatory methods. A collective framework of identifying strengths, weaknesses, opportunities, and threats (SWOT) analysis was used in this study. Participatory data collection was done at village, commune, district, provincial, and central levels using semi-structured interviews and focus group discussions. The data were examined against the five principles of the WHO approach: utilization of available resources, transfer of knowledge, community participation, utilization and strengthening of referral services, and multisectoral coordination. Specific strengths were found in three of these five areas.

INTRODUCTION

Vietnam is among the poorest nations in the world with a per capita GNP of US$ 320.[1] Vietnam is also a densely populated country with a present population of 79.3 million and a growth rate of 2.3 percent.[1] The health indicators of Vietnam are very similar to those of many developing countries. Thirty five percent of the population is less than 14 years of age, life expectancy at birth is 67.74 years, infant mortality ratio is 36 deaths per 1000 live births, and total fertility rate is 2.5 children born per woman.[2] Literacy rates in Vietnam are surprisingly high at 91.9 %. Population that has access to safe water is 43 % (urban 47%, rural 42%) and access to sanitation is 21% (urban 43%, rural 15%).[3] Besides ensuring family planning, safe water and sanitation, the major health issues in the country are control of infectious diseases (malaria, leprosy, tuberculosis, HIV/AIDS, STDs, acute respiratory infections in childhood, meningitis, encephalitis, dengue fever and water borne diseases), universal immunisation, prevention of malnutrition and iodine deficiency disorders. The health budget accounts for 3.1% of the total budget.[4]

In such a situation it is easy to imagine that the needs of persons with disability (PWD) can easily be disdained. In 1976, World Health Organization (WHO) estimated that 90% of persons with disabilities were totally neglected in developing countries and introduced the community-based rehabilitation (CBR) strategy as part of its goal to accomplish “Health for All by the year 2000.” [5] Since the populations in developing countries were (and are) largely rural and without

access to institutional rehabilitation facilities, therefore, WHO developed the CBR approach designed to integrate with the primary health care (PHC) approach. A training manual was produced in 1980[6] that was revised in 1989[7] and has now been translated in several languages for use at the village level. The goals of CBR are that a PWD should be able to look after himself or herself, move around the house and village, attend school, do a job and carry out household activities, enjoy family life and take part in community activities.[7] The five basic principles of CBR strategy include:

- Utilization of available resources in the community.
- Transfer of knowledge about disabilities and skills in rehabilitation to people with disabilities, families and communities.
- Community involvement in planning, decision making, and evaluation.
- Utilization and strengthening of referral services at district, provincial, and national levels that are able to perform skilled assessments with increasing sophistication, make rehabilitation plans, participate in training, and supervision.
- Utilization of a co-ordinated, multisectoral approach.

In essence, the primary tenet of CBR is to provide primary care and rehabilitative assistance to persons with disabilities by using human and other resources already available in their communities. In CBR approach, rehabilitation work can be carried out safely and effectively by lay persons, such as family

members, significant community members, or by persons with disabilities themselves.

CBR methodology (*Phuc Hoi Chuc Nang Dua Vao Cong Dong*) was introduced in Vietnam in 1987.[8] By 1992 CBR program was extended to 10 provinces including Ho Chi Minh City and Tien Giang Province in South, Hai Duong, Vinh Phuc, Ha Tay, Hanoi and Quang Tri provinces in North. It was found that for PWD the highest needs were in the area of self-care, followed by mobility and then socialisation. Nine of these provinces received funding from *Radda Barnen* (Swedish Save the Children) and one from World Vision.[9] Today, CBR program exists in 31 out of 61 provinces covering 75 districts and 980 communes. It is envisaged that by the year 2010, CBR program will be extended to all 10,300 communes in Vietnam. In 1992, AIFO was invited by WHO to support CBR in North-Central Vietnam through a new non-governmental organisation, VIet NAm REHabilitation Association (VINAREHA). The acronym in *Kinh* means "victory for the persons with disability." This arrangement was done to reduce bureaucratic difficulties and explore the feasibility of an association to serve as "the long arm of the government." Since the needs were highest in the area of self-care and mobility, a three-year pilot project based on WHO model was designed for implementation through VINAREHA focusing exclusively on medical aspects in the province of Thai Binh. In June 1996, a full-scale three-year project co-funded by European Union became functional in five North-Central provinces: Ha Nam,

Nam Dinh (in the initial part of the project these two districts were administratively under the name of Nam Ha), Thai Binh, Hoa Binh, and Ninh Binh. The specific aims of the CBR program that was started in June 1996 in the five provinces of North-Central Vietnam through VINAREHA were:

- Training of a nucleus of trainers that would train the peripheral level staff as well as volunteers.
- Promotion of a multisectoral approach through the formation of CBR committees in the provinces for the planning and implementation of the program activities.
- Transfer of knowledge from the rehabilitation workers to the PWD and their families about disabilities and rehabilitation.
- Use of appropriate technology for the production of simple orthopaedic appliances, utilising the locally available raw materials.
- Improving the referral services for rehabilitation at district and province levels.
- Promoting the integration of children with disabilities in normal schools.
- Enhancing the role of organisations of PWD for promoting activities for protection of their human rights.
- Promoting economic self-sufficiency for PWD through creation of rotating credit funds, professional training, and employment.

The purpose of this study was to conduct a participatory evaluation to ascertain the extent of success with the WHO model during the past three years by the program.

METHODS

Participatory approach used in this evaluation has its roots based on the principles of liberation theology,[11] social activism,[12] community psychology, and rural development.[13] The approach builds on accepting the potential of the people, focusing on the reality of experiences rather than thrusting knowledge, respecting the views of the community rather than pushing outside ideas, and working from a mutually shared terrain rather than imposing theoretical ideas onto the community.[14-16] The approach utilised in this evaluation is based on postmodernist paradigm that discards the notion of objective reality and emphasises value on meaning and interpretation.[17]

For this evaluation a collective framework was chosen that of Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis.[18] Since the purpose of this evaluation was to reflect on past accomplishments and plan for future, it was collectively decided that this framework would be well suited. For understanding the strengths, the primary question posed for reflection was "*What are some of the strong aspects of the program that you think the program has been able to accomplish in the past three years?"* For understanding the weaknesses, the primary question posed for reflection was *"What are some of the difficulties that you think the program has encountered in the past three years?"* For understanding the opportunities, the primary question posed was *"What are some of the areas that that you think the program can consolidate and augment over the*

next three years?" For understanding the threats, the primary question posed was "*What are some of the areas that that you think the program will face difficulties in over the next three years?"* Discussion was conducted around these questions, probing was done where needed, and participant initiated directions were diligently pursued.

Participatory data collection was done at village level, commune level, district level, provincial level, and central level. Due to the constraints imposed by time, travel, and resources, for making this plan feasible, the village and commune levels were combined and semi-structured interviews were conducted at this level in three provinces. The program personnel selected the communes. The district and province levels were combined and focus group discussions were facilitated involving participants from all ten districts and all five provinces of the program. At the central level, both semi-structured interviews and focus group discussions were conducted. At the central level, communication in English posed almost no difficulty. However, at all levels below the provincial level, since the primary language of communication is *Kinh*, the method of translation-retranslation was utilised. The facilitator posed questions that were translated in *Kinh* and the responses were translated in English. At the end of the session, the transcript was then relayed back to the participants for ensuring accuracy, sometimes with the help of another translator and sometimes with the help of the same translator. Data from the village and commune level was collected through a total of twenty semi-

structured interviews. Data about provincial and district level functioning was collected through six focus group discussions. One focus group discussion was done exclusively with province level personnel; one exclusively with district level personnel and four had combined participants from district and provincial levels. Data from the central level was collected individually and collectively from six key informants.

RESULTS

At commune and village levels the SWOT analysis revealed the following self-identified strengths:

- Identification of PWDs through house-to-house surveys.
- Community mapping at each commune (rough community map depicting location of houses of persons with disabilities in the commune).
- On an average a CBR worker was found to be dealing with 2-4 PWDs.
- Integration of children with moving difficulty in schools.
- Production of simple prosthetic, orthotic and orthopedic devices.
- Emotional support to PWDs.

At commune and village levels the SWOT analysis revealed the following self-identified weaknesses:

- Income generation by PWDs.
- Children with severe learning disabilities have been difficult to integrate in the school system.

- Needed supplementation and reinforcements in CBR worker training.

At commune and village levels the SWOT analysis revealed the following self-identified opportunities:

- Skill building activities need to be included in CBR workers and CBR supervisors training.
- The best CBR workers are family members of PWDs and efforts in future programming needs to be made to recruit such people.
- Some CBR workers felt that there should be a periodic newsletter sent to them after training to increase their knowledge, provide them with new ideas, and keep their interests in rehabilitation-related issues alive.

At commune and village levels the SWOT analysis revealed the following self-identified threats:

- CBR supervisors and workers felt that there are numerous difficulties in extending rehabilitation beyond medical work particularly due to lack of training.
- In most interviews, those CBR workers mentioned performing several duties in different areas such as family planning, immunization, teaching etc.

At the province and district levels the SWOT analysis revealed the following self-identified strengths:

- Collection and availability of assessment data about PWDs in 8 categories of disabilities at the village, commune, district and provincial levels.

- The medical referral system utilised by the CBR program.
- Formation of steering committees from PWDs, families of PWDs, Peoples Committee, Hamlet chiefs, Women's Union, Youth Union, Fatherland Front, Veterans Association, and Red Cross.
- System of cross assessment between one commune and another commune utilising pre-established criteria in the areas of:
  (a) Management including follow-up at commune level, community mapping of the commune, regularity of steering committee meetings, and maintenance of CBR monitoring book at commune level.
  (b) Indicators of PWD including documentation of proportion of PWD showing improvement by total number of PWD who need rehabilitation, proportion of PWD integrated in the community by total number of PWD who need rehabilitation, proportion of families involved in CBR by number of families with PWD.
- System of cross assessment between one district and another district utilising pre-established criteria in the areas of:
  (a) proportion of communes in the district implementing CBR
  (b) regularity of steering committee meetings
  (c) length of primary training according to standardised curriculum
  (d) replacement training courses
  (e) annual upgrade training courses

(f) funds allocated by local authorities

- Change in people's attitude towards PWD and attitudes of PWD. Some of the comments in this regard were: "there is less stigma," "they feel equal to other people."

At the province and district levels the SWOT analysis revealed the following self-identified weaknesses:

- Multiplicity of tasks from several vertical programs such as family planning program, immunisation program, infectious diseases control programs, iodine deficiency disorders programs, and others.
- Centralised planning.
- The active members of steering committees are mainly people involved in the medical system.
- Income generation activities for PWDs being weak.
- Integration of children with disabilities remains a challenge.
- Medical budget remains low; for example, Ninh Binh has a budget of 20,000 dongs per person per year (about US$ 2) and Ha Nam 5,000 dongs per person per year (about US$ 0.50).
- Still there is need among members in the community to become aware about the needs of persons with disabilities and need for CBR programs.

At the province and district levels the SWOT analysis revealed the following self-identified opportunities:

- There is a need to sustain the interest of participants of steering committees to continue with regular meetings.
- Expansion of the program to all communes in the district and not just a few.
- A need to enhance the participation of all members at the commune, district and provincial levels in the steering committees was expressed.
- A need to enhance number of PWDs in the composition of steering committees. At present the number of PWD varies between 1-2 people (10-20%) in most of the committees.
- The training of steering committee members in CBR is purely "content-based" and steering committee members need to learn more about management processes, activity planning, conducting meetings, problem solving, and follow-up skills.
- Need to enhance firm commitment from Peoples Committee chairpersons and vice chairperson to provide support for local funding.

At the province and district levels the SWOT analysis revealed the following self-identified threats:

- The approach as laid out in the WHO manual is very theoretical.
- Co-operation with other programs and other sectors was mentioned as a major challenge in the coming years.
- Issues pertaining to funding, availability of trainers, and availability of participants without incentives were pointed out as potential threats to training.

- Self-sufficiency of the program still remains illusive.
- Motivation of the CBR worker through incentives or monetary reimbursement as an issue was brought up at almost all focus group discussions

At the central level the SWOT analysis revealed the following self-identified strengths:

- The method of house-to-house survey in the program was an identified strength. The mean disability rate from this data was found to be 8.6% (with a range of 5.6 % in Kim Bang to 12.3% in Binh Luc).
- The CBR program has assisted several PWDs in making progress towards their rehabilitation goals. In gauging progress of PWDs, the program follows 23 criteria that include performance of activities of daily living (ADL), self care, playing, schooling, taking part in family activities, taking part in social activities, and taking part in income generation activities. The program has been able to demonstrate progress in 25 percent of those needing rehabilitation and integrate another 19 percent of those needing rehabilitation.
- Translation of the WHO manual in *Kinh* and printing of 10,000 copies.
- Conducting the planned seminars for province and district leaders, CBR supervisor training, and CBR worker training at district and commune levels. Up to 2,235 CBR workers have been trained.
- The CBR program has been able to link with the medical referral system.

- Creation of a nucleus of trainers well versed in CBR methodology at the provincial level who in turn can train commune level supervisors and workers.

At the central level the SWOT analysis revealed the following self-identified weaknesses:

- Limited co-operation from people other than Ministry of Health.
- Irregularity of Steering Committee Meetings.
- Modest documentation.
- Mobilisation of local funding.
- Training of theoretical nature.
- Lack of funding due to CBR not being a national priority.

At the central level the SWOT analysis revealed the following self-identified opportunities:

- Need for reaching all communes in the five provinces
- Retraining for trained CBR workers.
- Phased training of CBR workers in future.
- CBR leaders training needs to include more specific information about involving political leaders, ways of ensuring participation in steering committee meetings, and ways to mobilise local funding.

At the central level the SWOT analysis revealed the following self-identified threats:

- Eliciting participation from other sectors at all levels continues to be a challenge particularly at central and provincial levels.
- The situation with local funding remains temporary.
- Some of the members of the team were humble enough to admit that they had limited knowledge and expertise with regard to aspects other than medical.

DISCUSSION

The purpose of this participatory evaluation was to establish a summarisation of accomplishments across different levels of program while examining the findings against the WHO principles of CBR and developing implications for future CBR programming. The first component of the WHO model is utilization of available resources. Findings from across the levels seem to suggest that for the CBR program in North Central Vietnam this is indeed a strong component. Resources in the community include both human and material resources. The CBR workers were selected and trained locally. The rehabilitation materials used at the village level were locally available. Examples of such materials included crutches and exercise aids made of bamboo. Furthermore, after training, a cadre of local trainers has been created who have the potential to continue training and retraining in the future. Also efforts have been initiated to mobilise some local funding. In future, perhaps it could be more beneficial if firm and regular local funding can be harnessed.

The second component of the WHO model is transfer of knowledge about disabilities. This component again seems to be an area of strength. Across all levels, identification of PWD using house-to-house survey was acclaimed as being a strong component of this program. Collection and reporting of data in this regard also supports this notion. This collected data can serve useful purpose for persons with disability as the data provides the capacity to discuss with local authorities the need to allocate regular funding. Several groups in other countries have used such strategies. For example, in the slums in Bombay city (Mumbai, India), Society for Promotion of Area Resource Centres (SPARC), facilitated a cluster profiling during Census that besides providing useful data, enabled women to become aware of their community, initiated a process of reflection (since this was designed with women requiring consultation with each other), and provided basis for asking for more funds from local authorities.[19] Mapping the community at village level and using it for tracking persons with disability is again an excellent example of an effective tool. Further, in some focus groups especially at the village level it was mentioned how importantly the program has been able to change attitudes about PWD in the community and also the attitudes of people with disability. However, there is a need to obtain more information about which attitudes have been influenced and which attitudes have been resistant to change, so that those can be targeted using focused strategies. With regard to transfer of knowledge about skills in rehabilitation it seems that skills pertaining to activities of daily living (ADL), self-care, and

mobility-related exercises seem to have been done well, especially at the village level. Another very significant progress that has been made has been the development of a cadre of trainers at province and district levels. This core group of trainers will be very useful in future expansion of the program. In future, however, there is need to improve skills further in CBR workers with regard to learning disability, hearing disability, speech disability, seeing disability, strange behaviour, and multiple disabilities. Besides addressing the "content" needs in training, "process" needs in training will also have to be addressed. Experimentation with techniques that develop skill transfer and not merely knowledge transfer will be mandatory for future programs. Such measures will also ensure retention of skills for longer periods of time. Allowing for more practice sessions, breaking down the skills into small steps, facilitating observational learning, incorporating simulations, presentation of actual problems and group exploration of ways to deal with those would be helpful techniques in developing actual skills.[20-21] Some form of refresher training of trainers in training methodology would be useful investment for improving skill-developing training in future. Such training may include aspects of adult learning principles, roles and responsibilities of trainers, facilitating small group discussion, conducting structured experiences, introduction to "self-efficacy" building techniques.[20] Also, the suggestion in some focus groups with regard to conducting CBR worker training in a phased manner (twice a year) with appropriate timing linked to after the harvest will go a long way in strengthening this aspect.

The WHO model's third component of community involvement in planning and decision making, has clearly been one of the challenges in this program, as has been pointed out in focus groups at all levels. There are several factors inherent in the cultural milieu and system-wide constraints that impede maximisation of participation. Sometimes, while working in the field one experiences the acme of what Freire[10] talked about as the "culture of silence." However, being a non-governmental organisation offers unique advantage to VINAREHA that can be judiciously invoked to enunciate the voice of PWD. At present the process of refinement of WHO manual is done by "experts" in the central and some provincial level people. Involvement of CBR workers and PWDs in this exercise will benefit a great deal. With regard to community involvement in evaluation, while reporting of monitoring data is a regular practice and needs to continue. The idea of cross-assessments has lot of merits. However, it can benefit from greater rigour. What can be added is to critically and continually reflect on problems, discard irrelevant issues, focus on pertinent concerns, identify several ways of dealing with those, discussing the pros and cons of different ways, and then experimenting with innovative solutions. Incorporating this practice as a routine in all steering committee meetings would also help in rejuvenating these important structures. It may also be worthwhile to translate and share this report at all levels and critically examine all the issues raised.

The fourth component of the WHO model of utilization and strengthening of referral services is again identified as a strong component of the CBR program at all levels. Vietnam has a good primary health care system and an effective referral chain. The AIFO-VINAREHA partnership has made useful strides in utilising this chain and deserves unequivocal kudos.

The final component of the WHO model of utilization of a co-ordinated multisectoral approach has again been a challenge for this program. With this issue there are no easy answers. Centralised administration, bureaucracy, diverse mandates and reporting regulations make establishing collaboration between agencies a very slow and challenging process.

This evaluation study had several limitations. For a reader, coming from a purely quantitative, modernist paradigm expecting an immaculate, objective, scientific evaluation, this evaluation would pose some difficulty in comprehension. For qualitative, postmodernist evaluators also many of the aspects may be unpalatable. It is evident in this evaluation that an attempt was made to utilise participatory methods. Participatory approach is a process on a continuum. The circumstances in the CBR program posed several challenges that prevented maximisation of participation. Language was a major constraint that was addressed partially by using translators and applying translation-retranslation method. However, this method poses several inherent weaknesses such as the quality of translation, loss of accurate meaning, and misinterpretation. It is my hope that in

future, perhaps, using the same method some local person(s) would be able to facilitate a better process. The other limitation was the method of recording that was done by note taking. Ideally, it would have been desirable to record conversations and then transcribe the transcripts using translation-retranslation method. However, limitations of resources and other factors precluded such an approach. Then, the translators chosen for this evaluation were members of the central team. Again this poses threat in terms of honest and free expression of thoughts. On the other hand, it offers advantage in terms of introducing a person that the people already know and feel more comfortable with. It also reduces the time entailed in establishing rapport. Another limitation was that the communes and evaluation processes were selected by the program personnel. Random selection of which communes needed to be visited was not done. Clearly random selection would have added objectivity to the data collection. However, the purpose of this evaluation was to collectively understand the processes and not to maximise objectivity – therefore selection by the program staff provided definitive advantages. Further no specific training was given to translators. Again this was in consonance with the participatory philosophy of having "faith" in the inherent potential of people. Further, it was possible to conduct only twenty semi-structured interviews at village and commune level, six focus groups with province and district level people and one focus group at central level with six individual discussions at central level. Clearly, if more time was available more data could have been

collected. However, there was substantial repetition of themes that would indicate that not much more would have been gained by carrying on with the process any further. It can be safely assumed that the data gathered and presented here has been fairly representative of the entire program area. Another limitation was in terms of lack of prior familiarity of the facilitator with the country, people, or the program. Besides posing problems this also offers some advantage by providing the ability to look at the situation with a clean slate. Political, cultural and historical location of the program was also not very conducive to classical participatory "dialogue" and can be considered in the limitations. Limited amount of time availability was another major constraint. This was addressed by tapping and relying extensively on the potential of the people involved in the program who provided all the insights.

In conclusion, it can be stated that out of the five principles of CBR as established in WHO manual, the CBR program In North Central Vietnam has been able to do remarkably well in three areas in the ten districts that this program has implemented its activities over the last three years. The program would benefit by consolidating on these aspects in the coming years and extending the program to all communes. The program can also begin to explore ways of improving upon the remaining two areas.

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