

## ***Changing CBR Concepts in Indonesia: Learning from Programme Evaluation***

**Handojo Tjandrakusuma, Douglas Krefting  
and Laura Krefting**

CBR programmes are founded on basic ideas or concepts that vary significantly between countries and organizations. These ideas and concepts change through time as new information is obtained. Often trial-and-error experiences prove that the initial ideas were wrong. One of the best ways of examining the effectiveness of CBR programmes, and the concepts on which they are based, is through evaluation.

This chapter draws on our experiences in Solo, Indonesia at the Community Based Rehabilitation Development and Training Centre (CBRDTC) to describe a process where changes in programmes and concepts have resulted from evaluation. This will hopefully help others to learn ways to change their own ideas, concepts and CBR programmes.

CBRDTC is a not-for-profit, non-governmental organisation (NGO) that is part of Yayasan Pembinaan Anak Cacat (YPAC), which is the Indonesian Society for the Care of Disabled Children. CBRDTC's mission statement is:

*Improving the quality of life of people with disabilities in their own families, communities, and countries by developing, implementing and sharing knowledge about community action programmes that focus on disability issues.*

CBRDTC is primarily an applied research and development organisation who, in order to learn how to do CBR, has established CBR community development projects in Indonesia (Central Java and North Sulawesi) and Bangladesh.

Other facets of their work includes the production of training manuals and organising international workshops for CBR initiators.

Their work is funded on an individual basis by a number of different international donor organisations while funds for core operations are raised locally.

The chapter is divided into four main sections.

In Section 1 we present a summary of the evaluators' understanding of what CBR was and could be. This provided the 'standards' against which the projects were then judged.

Section 2 describes the formal evaluation process which was used to systematically obtain information about the outcomes and results of four CBR programmes started by CBRDTC in Central Java.

In Section 3 we describe the concepts on which CBRDTC's new CBR programmes are based. We explore some of the hidden problems that were brought to light by the evaluation and examine their underlying causal factors.

Finally in Section 4 the general conclusions reached as a result of this complete evaluation process are described.

First though a word about the evaluation team. This consisted of personnel from Yayasan Indonesia Sejahtera (YIS), an NGO that works in the field of community development in Indonesia, along with staff from the Faculty of Rehabilitation Medicine, University of Alberta, Canada. The University had helped to develop the first Indonesia Academy of Occupational Therapy and had gained an understanding of disability and rehabilitation in the country. Part of their Canadian aid funding had been ear-marked for CBR and they chose to use it in the evaluation of CBRDTC's projects in Central Java. The University also selected the appropriate Indonesian evaluation consultant, thereby ensuring that this partnership was completely independent of CBRDTC.

### ***Section 1: Evaluators' Understanding of CBR***

Before beginning the evaluation, the team had to first learn what CBRDTC's concept of Community Based Rehabilitation was and what it could be. The following information describes the evaluators' understanding of CBR after they reviewed existing documents and they had interviewed staff and others involved in the development of the CBR field programmes.

The basic CBR concept underlying the implementation of the field programmes was to change the community's perception about the problems; the socioeconomic, sociocultural, medical and psychological problems of people with disabilities.

CBR sought also to encourage the community to provide an atmosphere in which people with disabilities could solve their problems and improve their lives. The larger idea behind it involved giving authority to community members to collectively make decisions about their future.

The seven key strategies that were considered necessary for CBR implementation were:

1. **Integrating CBR into Community Activities:** In order to

minimize the funding required, CBR activities should be integrated with existing services wherever possible.

2. **Entry Point:** The best way to enter a community was through demonstrating how it was possible to help people with disabilities in a way that motivated the community to get involved from the beginning.
3. **Maintenance:** It was important to encourage community members to take responsibility for CBR's continuation.
4. **Realization of Goals:** It was impossible to simultaneously achieve all of the goals CBR set for itself. But success in early detection of disabilities was an immediate CBR priority because it would reduce future demands on related services.
5. **Spectrum of CBR Activities:** The types of *community activities* that should be included in the CBR field projects are:

- Helping an existing community organization develop activities to improve the welfare of people with disabilities.
- Financing field activities.
- Encouraging proper attitudes among people with disabilities.
- Undertaking disability prevention.
- Providing home treatment.
- Detecting and reporting disabilities.
- Conducting community training.

The *Rehabilitation activities* that could be conducted by specially-trained community members were thought to be:

- Simple rehabilitation, such as walking exercises, making tripods, and explaining their use.
- Providing information and motivation, as well as illustrating various types of exercises to community members.
- Organizing continuity of service.
- Monitoring, recording and reporting.

The *Supportive activities* which health care professionals or institutions could provide would include:

- Supporting the technical and managerial aspects of CBR services.
- Providing referral services for medical intervention and

complex medical rehabilitation services.

- Organizing and conducting research activities, developing CBR implementation, etc.
- Developing a general understanding of the health aspects of disabilities.
- Teaching of disability prevention.

6. **Economic Aspects:** CBR did not limit itself to vocational rehabilitation, but took income generation as one of its starting points. It was envisaged that the activities related to the economy and to income generation should include:

- Supporting the family economy.
- Training by local community members in business skills.
- Encouraging new initiatives in the village economy.
- Training in micro-economy management.
- Developing effective marketing techniques.
- Initiating a cooperative economic enterprise.
- Providing local jobs for people with disabilities.

7. **Involving People With Disabilities In the Programme:** It was envisaged that community members and people with disabilities would all be involved in the managing of CBR so that they could become the programme's subjects, not simply its targets.

### ***Section 2: Evaluation Methods***

Data were collected through a series of interviews (both informal and guided) with key personnel and through direct observation of all CBR activities. Detailed sampling techniques focused on two villages in each regency. The data were validated by:

- **Triangulation:** Data were collected from different people and from different perspectives. Information from one source was thoroughly compared with information from other sources.
- **Key Informant Review:** Key informants were asked to review the information in the draft report.

In order to understand CBR's strengths and weaknesses, the evaluation considered the following key issues:

- The number and diversity of field activities in relation to the programme's overall goals.
- CBR's effectiveness as perceived by all those involved with it and who were affected by it.
- Village volunteer training activities in the community.
- Existing community mechanisms relating to CBR programmes.
- The extent and nature of community knowledge of, and participation in, CBR at the village level.
- The community's perception of CBR's achievements.
- The extent of government awareness of the CBR approach.
- Whether an NGO such as CBRDTC was better equipped than a government development project to become a catalyst for community-based development.
- The determination of objective indicators for future research.

The main model of analysis was interactive, where the activity of data collection interacted with the three main analytical techniques (data reduction, data display and conclusion drawing). This model was applied to each case or unit of analysis.

### ***Evaluation Results***

Evaluations were carried out in four regencies (districts) in the province of Central Java where CBR programmes had been established by CBRDTC. The findings for each regency are summarised in separate sections. Further details are available (see Note at end of chapter).

#### **1. BANJARNEGARA REGENCY**

**Background:** The 1980 census revealed 1056 people with disabilities in the regency's 278 villages but data obtained later from social workers increased that number to 4,134. Early detection in 4,000 children under the age of 5 revealed that 142 (3.43%) had disabilities. To coordinate all activities for people with disabilities, the BANJARNEGARA local government founded the Supervising Board of Rehabilitation for People with Disabilities which involved 30 institutions and offices related to disabled people.

**CBR Programme Initiation Process:** The Rehabilitation Board soon after its founding, cooperated with CBRDTC to draft a plan of activities, known as the Disabled Rehabilitation Development Project. The plan called for activities in 10 villages in four locations: two valley sub-districts and two in the mountainous area.

Evaluation was conducted in two valley villages which became the project locations between 1986 and 1989. Initially CBRDTC was dominant but its visits then decreased, the last one taking place in June 1990. This influenced the development of the programme and in one of the two villages selected for the evaluation, the CBR programme came to a halt after June 1990.

The training given to local volunteers created a local work force to nurture community enthusiasm and to undertake both the initial census of people with disabilities and the early detection efforts. The training was also to enable the volunteers to spread the idea that people with disabilities were not simply the responsibility of the government.

In April 1986, a CBR team was founded in the village of Medayu. Funds were derived from the re-sale of community-donated rice and from sources such as divorce fees paid to the government. But according to both the village head and a village volunteer, once the initial project finished, the activities stopped.

In two other valley villages there was training in early detection. Yet the head of one village said he had never heard of CBR and that none of its activities were carried out there. There was not a single document about CBR in the village office.

The Rehabilitation Board's activities at the sub-district level were similarly unorganized. In addition, the CBR team felt it had little involvement in the project because CBRDTC went directly to the field without coordinating with the subdistrict CBR team. This direct handling from CBRDTC in Solo meant that once the project was finished there could be little coordination among the village and subdistrict teams and their supervisors in the regency. It was also clear that the people in the community, who it was hoped would handle the treatment of people with disabilities, could not do so without outside assistance.

**Present Condition of the Programme:** Although the CBR programme ran well between 1986 and 1989, informants said it ceased to function after that point.

**Conclusions:** During the term of the project, trained village volunteers performed as expected.

Community leaders and village volunteers thought the programme dealt effectively and quickly with disabled people. On the other hand, programme planners and government officials thought the programme was ineffective.

CBR was handled by only one institution and did not fully involve

the community. People became involved because of the village head's decree, without necessarily knowing what CBR was. They were volunteered rather than volunteering through their own interest.

Government involvement needed improvement. Many Rehabilitation Board members neither knew about nor became involved in the programme. There was little coordination between the levels of authority.

## **2. SUKOHARJO REGENCY**

**Background:** Sukoharjo Regency's 676,482 inhabitants live in 167 villages. According to 1989 statistics, there were 5,462 people with disabilities in the regency; 0.8% of the population. Of those, only 1,938 (0.3%) had been medically or vocationally handled by either government or non-government agencies.

**Programme Initiation Process:** Discussions between CBRDTC, local governments and the District Head led to the choice of three villages as CBR try-out areas. Each had a great number of people with disabilities, and in each the village heads and staff from the Women's Family Welfare Movement were already active in a variety of development activities.

The CBR team, formed after a 1987 decree from the subdistrict head, involved subdistrict agencies and the Departments of Education and Culture. The village volunteers worked in their communities with funding and direct supervision from CBRDTC. Between 1987 and 1990, 17 (14%) people with disabilities in the three villages underwent medical rehabilitation while 36 (29%) underwent thorough medical, educational and vocational rehabilitation.

Financial contributions for CBR came from a variety of sources: local communities in which people with disabilities live; the families of people with disabilities; related agencies such as the district government, the Department of Social Welfare and the Department of Health and from private sector sources such as CBRDTC and the Disabled Children's Foundation. Although increased community funding was a goal, CBR activities still depended on outside sources (in this case CBRDTC). Related institutions had little identifiable role, simply following the recommendations of the implementation team.

There was a great degree of highly dedicated village volunteer involvement in the implementation. All levels of government acted to support their work but it was felt that coordination between various government sectors could have been improved, especially at the regency level.

**Present Condition of the Programme:** The rehabilitation statistics

reported above, led to the start-up of CBR activities in a further twelve villages. Activity in the three try-out villages, however, decreased significantly. Between 1990 and 1993 only one person was medically rehabilitated.

**Conclusions:** The work done by the village volunteers in early detection and fund-raising was successful. But, because of the limited nature of the funds that came from the community (even if fund-raising was successful) the desired level of rehabilitation could not be undertaken without the involvement of CBRDTC or other external financial resources.

In general, those involved in CBR at all levels agreed that the programme was effective. The Government was enthusiastic because the private sector had become involved. Informants using three different yardsticks (the level of community involvement, the amount of funds raised and the village volunteer activities) all stated that the programme ran well during the try-out phase. Doubts about the programme's sustainability seemed borne out by the later disintegration of coordination and the drying-up of funding.

Village volunteer activities were varied and, on the whole, effective because they were conducted by people already involved in community health activities and because they were incorporated into existing health programmes. Community involvement was good, especially in so far as it marshalled the support of existing community agencies for CBR activities. However, it was felt that community involvement in CBR activities had decreased because CBR was fully understood only by a few members of the community, most notably those actively involved in it.

At the institutional level, the understanding of CBR was weak. At the regency level, some government employees cited the lack of a standard curriculum as an obstacle. There was a better understanding at the subdistrict level, where people were more intimately acquainted with the day-to-day work of the programme.

CBR activities declined for a number of reasons, among them the loss of the person who was the key motivator for the programme and a reduction in the involvement of related institutions and the private sector.

**Suggested Improvements:** In order to increase the probability of success in developing CBR programmes in the future, interested parties at both the regency and sub-district level, among others, made the following suggestions:



- The roles and functions of relevant institutions needed to be clearly defined and a routine meeting schedule should have been established.
- Private sector, non-organizational funding should have been more energetically pursued.
- There was a need for more skilled and qualified field workers at the village level.
- The mass media should have been employed to spread information about CBR across Indonesia.
- CBRDTC should have allocated more funds for the management and motivating of teams.
- Top leaders should have offered more encouragement and provided better examples for those below them.
- There should have been more monitoring of people with disabilities after they left the programme.

### **3. SRAGEN REGENCY**

**Background:** Sragen Regency's 207 communities (all primarily agricultural) were found to contain 44,707 children under the age of five. Of these nearly half had undergone screening for the early detection of disabilities at over 1,000 of the regency's 1,136 Integrated Health Service Posts. It was found that 182 of these children (0.8%) had some form of disability. The early detection programme, which later developed into the CBR programme, was coordinated by the Women's Family Welfare Movement which dominated CBR implementation in the regency. Both local government and CBRDTC became involved when it developed into a full CBR programme.

**Programme Initiation Process:** Four villages were chosen as try-out areas, in part because all were easily reached from the regency capital. Evaluation of CBR programming took place only in two villages; those with the highest number of people with disabilities.

Early detection activities in the regency took place between 1987 and 1990, following a CBRDTC training attended by people from a variety of relevant agencies.

After training, early detection activities were undertaken with the full support of the District head and the Women's Family Welfare Movement. The latter organisation trained village volunteers at the subdistrict level in early detection techniques, conducted early detection every three months at the Integrated Health Service Posts and sent those found to have disabilities to the Community Health Centre for examination and classification. Data about disabilities was recorded at, and reported to, all levels of government.

**Present Condition of the Programme:** There are currently no CBR programme activities being carried out in this district. All activities ceased as soon as CBRDTC withdrew from the programme area.

**Conclusions:** According to an informant, 61 people with disabilities were detected in one village in 1990 and 77 in another. Due to limited funds from the regency and from CBRDTC, the number of people rehabilitated medically, educationally or vocationally was very low. Those who were treated were handled by the government sector; that is, sent to institutions related to their disabilities.

After data was compiled and reported, and people with disabilities were examined, there was little effort on the part of the community members or the CBR team to impart skills to them. Only skilled village volunteers carried out the disability detection and intervention activities, because untrained village volunteers were afraid of making mistakes. Trained village volunteers found they still had problems motivating and organizing the community. Many parents of people with disabilities still felt ashamed of their children.

Among community leaders and village volunteers, there were differing opinions about the programme. The head of the CBR team in one village felt that CBR was an effort to give people with disabilities the same status as people without disabilities. The secretary of CBR activities in another village felt that CBR was an effort by non-disabled people to help people with disabilities enhance their self-image. A subdistrict official understood CBR to be an effort to motivate community members to take part in the handling and treatment of its people with disabilities.

Village volunteers were involved in the programme but village leaders were often otherwise occupied with their own duties. Agencies involved in CBR handled only those aspects of the programme relevant to their previous duties. This suggests that the division of tasks for CBR team members was not explicitly stated.

Community members in general, and people with disabilities in particular, did not receive much benefit from the programme. The level of medical rehabilitation was low, while educational and vocational rehabilitation was not carried out at all.

From the point of view of services received, Institutional Based Rehabilitation was superior because people with disabilities were placed in institutions with complete facilities. CBR, on the other hand, suffered from poor funding and a consequent poor level of service. On a social level, CBR was considered superior because people with disabilities could stay with their own families.

#### **4. WONOSOBO REGENCY**

**Background:** Most of the 670,000 people in Wonosobo's 263 villages are farmers whose income is low by Central Java standards. In 1990, the Regional Office of Social Service reported 2,182 people with disabilities, mainly in rural areas. Few of them had been served by any related programme.

**Programme Initiation Process:** CBR teams at all levels started their work after a training session in November 1988. The CBR teams visited villages and Community Health Centres, usually accompanied by Social Service officials. Their initial commitment, and that of CBRDTC, were not matched by a commitment from other institutions.

Wonosobo's CBR programme started in 1990. A series of meetings was held, during which relevant Wonosobo institutions and leaders were addressed by CBRDTC and by those who had implemented CBR programmes in other regencies. Three villages were later selected as try-out areas.

CBR village volunteers, carrying out early detection discovered 181 people with disabilities. The detected disabilities were reported to the Community Health Centre. Of the total, five persons were rehabilitated; four medically and one vocationally.

**Present Condition of the Programme:** The CBR motivator team conducted public education sessions with the village volunteers, a process enhanced by periodic visits by a CBRDTC team. At the beginning of the programme, this and other activities ran efficiently, even though lack of equipment was a chronic problem. Over time, however, activities slackened.

**Conclusions:** The CBR programme was introduced to participants at all levels, using discussions, information meetings and comparative studies. However, the involvement at all levels was not uniformly intense and this greatly influenced the programme's success.

Only one coordination meeting was held, seven months after the issuing of the decree calling for the formation of the CBR supervisor team. Supervisor team members felt insufficiently informed about their positions on the team, even though some had been intimately involved in the programme's start-up stage. Misunderstanding arose about an appropriate level of involvement. Some personnel from related government agencies, for instance, still felt that primary responsibility for the programme should belong to the Department of Social Welfare. Another team member, who had been asked to provide instructors and conduct training for people with disabilities,

was nonetheless entirely unaware that the government agency for whom he worked, was involved in the programme.

Because the team members responsible for motivating the community were expected to have more contact with the community, more preparation was made on their behalf. They held discussions and informal meetings, and helped to introduce the CBR idea to the community. As a result, they had a significantly higher degree of understanding about CBR and their roles in it. Yet they faced some of the same stumbling blocks encountered by the supervisor team. Some agencies were more active than others. Also, there were widely differing perceptions about the programme among the team members.

Despite their small size, the village-level implementation teams had more success in understanding the programme and increasing community awareness. Some members fully comprehended CBR as an effort to make people with disabilities fully self-supporting. Others continued to see CBR only as an attempt to medically rehabilitate people with disabilities.

The only activities included in the outline of the CBR programme that were never carried out, were the programme evaluation and the educational rehabilitation. These activities occurred only at the preparation stage and at the programme start-up. The only activities that remained were early detection and the collecting of funds, which were considered inadequate for the programme's needs.

So far, there has been a noticeable attitudinal shift in the community. Some have begun to see disability not as a curse, but as something that could happen to anyone. People with disabilities have become more a part of daily life. Some community members now employ people with disabilities or purchase products made by them. But the community members saw CBR as involving little more than early detection and medical rehabilitation. It was more difficult to change the attitudes of people with disabilities themselves, as well as those of their families.

The CBR mechanism, from early detection and identification through to the eventual handling of the cases by the Community Health Centres or by CBRDTC, took a long time. Activities were constrained by lack of funding and lack of equipment. Technically, most of the village volunteers were capable of performing the tasks for which they had been trained. They could do early detection and give recovery training to people with disabilities, both without awkwardness. But they felt they had not been adequately prepared for activities that involved informing and motivating the community, both of which are important for the programme's success.

It was clear that all related institutions had to be consistently

involved in CBR if it was to reach all its short- and long-term objectives. This did not happen, in part because leaders delegated responsibility to unprepared subordinates. It was also clear that the intervention programme did not fully succeed in making people with disabilities self-supporting. This suggested there were still weaknesses in CBRDTC's attempts to prepare people with disabilities for full economic participation in the community.

### ***Evaluation Conclusions***

Village volunteer activities, such as early detection and intervention, and the collection of funds, were the most consistently maintained activities in the CBR programmes. Village volunteers still report their findings to the villages.

Government staff from related institutions found the programme largely ineffective. They felt that medical rehabilitation had been insufficient and the CBR mechanism in general had not been implemented.

The programme was found to be most effective while still in the try-out stage. When CBRDTC staff were no longer involved, CBR activities declined. This suggests that the community never felt it owned the programme or had responsibility for developing it. In part, this was because village volunteers were not given the kinds of training that would keep the programme healthy.

Community members had few opinions about the programme because they knew little about it and had not been noticeably involved. Village volunteers felt the programme was effective in so far as it led to better early detection of disabilities.

Although village-level programmes still existed, at the regency level, related bodies carried out their own programmes with little coordination.

Community knowledge about CBR, even among those involved in it, seemed limited to the feeling that CBR was an attempt to serve only people with disabilities. Most people saw CBR as an attempt to help people with disabilities live more normal lives. Negative perceptions were held by those who did not yet understand CBR's aims. The highest degree of understanding about CBR came from the staff of the local government welfare office. Elsewhere, awareness was lower.

People living in districts surrounding the project areas, especially in Sragen regency, expressed a desire for CBR programming but activities were limited to early detection, without formal organizing along CBR lines.

CBRDTC, an NGO, had some advantages over government

institutions for carrying out CBR programmes. It is more flexible, better able to tap a wide variety of funding sources and can work more effectively at the grassroots level to help people develop an awareness of sustainable development.

In general, it can be said that the sequence of CBR activities was in line with the strategy outlined in the CBR concept. Good use was made of parallel activities in the local Integrated Health Service Posts.

There was misunderstanding about the role of the regency-level supervisors. They, not the community, were expected to develop the programme, an idea that ran counter to the CBR philosophy. This misunderstanding had a great impact on the sustainability of the programme.

The programme's biggest problems concerned funding and community support. Most efforts to collect public funds resulted in only small amounts of support. Alliances with other NGOs in more imaginative funding campaigns, and a more thorough canvassing of private sector sources, were felt to be necessary.

The decrease in field activities tended to limit the programme to its medical aspects and stopped it short of its ultimate goal of encouraging both financial self-sufficiency in people with disabilities and an overall community development.

Another important problem was thought to be inadequate monitoring and evaluation of the programme by CBRDTC.

A final point of discussion involved the top-down nature of CBR implementation. Most of the efforts on the part of the CBR organisers seemed aimed at forming structures removed from the overall communities. A more appropriate approach would have been a participatory approach that allowed ideas and perceptions to rise up from the bottom.

In conclusion, the problems associated with CBR implementation in the four regencies included:

- Decreasing intensity of programme activities;
- Lack of organizational coordination at the subdistrict and regency levels;
- Limited knowledge and understanding about CBR;
- Insufficient development of people's attitudes, knowledge and skills;
- Insufficient community funds available for CBR;
- A limited number of services available for people with disabilities;
- The passive role of people with disabilities;
- Insufficient monitoring and evaluation.

**Recommendations**

The following suggestions were offered by the evaluators, although some may present problems when they are implemented in the field that make them inappropriate or in need of rethinking.

- There is a need for a guide book to CBR implementation, which could be divided into three parts:

- Part 1: A guide for organizations to be used by agencies at the subdistrict and regency levels.* It would include information on CBR concepts and strategies, suggested organizational structure (including the number, roles and responsibilities of involved personnel) and a working mechanism for coordinating the various teams, with job descriptions and suggested activities for all participants.
- Part 2 - A guide for village volunteers and all village-level participants.* This section should include job descriptions for village volunteers, village office staff and community leaders and suggestions for fund raising.
- Part 3 - A training manual.* The information in this section should be geared towards encouraging the development and passing on of skills without the need for a specific team of outside experts.

- A complete system for monitoring and evaluating CBR activities in a community should be created. It should include:

- A system for regular registration and reporting.
- Strategies for reporting feedback.
- A strategy for internal programme evaluation.

- CBRDTC needs to develop liaisons with other NGOs involved in community development to exchange information and encourage mutual support. It is not enough for CBRDTC to work simply with government institutions or with the local Health Service Posts.

- Some consideration must be given to modifying the implementation strategy to allow for more bottom-up planning, that is from the village level, rather than coming down from the subdistrict and regency levels. Well-known techniques of "Participatory Rural Appraisal" might be useful in this regard.

- Training should be more frequent and better material should be developed for that training.

- A firmer organization is needed to encourage the proper training of CBR staff. For instance "field care-takers" should be created to oversee implementation, and further staff should be appointed to handle monitoring and evaluation.

### ***Section 3: Changing the Concepts of CBR***

This evaluation indicated that there was something seriously wrong with the CBR concept proposed by CBRDTC and the reality of the evaluation came as a shock. The outcomes were not at first accepted or acknowledged.

Previously evaluation at CBRDTC was simple and very informal. Usually villagers would make casual comments or tell stories to visitors who would pass them on to the staff or sometimes the staff would make casual comments about what was happening in the field. These informal evaluations were not based on a systematic process of data collection which would allow managers to determine what objectives were not being met and the changes in concept which might help to meet these objectives. Nevertheless these informal evaluations did lead to the formal evaluation.

Of particular concern was the large difference between the description of what the evaluation team had learnt CBR was supposed to be (as summarized in Section 1) and what had actually been done in the field (the reports by programme recipients given to the evaluators and summarised in Section 2). To address this, a secondary analysis was necessary in terms of the overall work of CBRDTC. This would identify any intangible benefits that would not be apparent at the local level where the first evaluation had been carried out. The main conclusions reached are described below.

After completing this, the changes needed in CBRDTC's concept of CBR, and CBR programme design, could be considered so as to address the major recommendations of the evaluations.

### **Putting evaluation into context**

The development of CBR programmes needs to be looked at in the larger context of the overall development of CBR itself. CBRDTC develops CBR programmes in order to learn how to do CBR. Implicit in this major objective was the secondary objective of sharing what was learnt with as many others as possible, mainly through international workshops which started in 1992 and international networks of organizations to which CBRDTC belongs.

One example of the changing of CBR concepts in the greater context is the development of CBR by the World Health Organization



(WHO). Because CBRDTC were testing their concept in the field programmes, they were able to make some contribution to bringing about a changed point of view. Their major focus was advocating that CBR should be seen as a community development programme rather than as a rehabilitation programme. In 1994, WHO changed their definition of CBR to a "*...strategy within community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities*" (see Note 2).

Another indicator of CBRDTC's influence is the inclusion in the current national, five year plan, by the Indonesian Department of Health, of CBR as a national strategy for providing rehabilitation assistance at the community level. CBRDTC staff are often requested to advise the Department of Health on community level rehabilitation problems and have frequently used these opportunities to advocate for CBR as a national strategy.

### **Implications for the CBR Programmes**

In this section we attempt to analyse some of the underlying causes for the problems identified in the evaluation, and to outline the changes in concept or process that have been adopted to overcome them.

**Aims of CBR:** The evaluations teams's description of the concept of CBR was fairly accurate. However there were several areas where the description did not match with CBRDTC's concept. The most important aspect of CBRDTC's concept that was not considered by the evaluators was the idea of trying to find a way of doing CBR on a large-scale; the macro approach.

Also a comparison of the evaluator's description and what they found in the field, indicated that there was an even greater difference between what was being said and what actually was done. Subsequent discussions with some of CBRDTC's staff indicated that this mismatch happened because not all staff were aware of the concept being promoted. In a few cases, staff members did not agree with the CBRDTC concept and had described to the evaluators what they thought CBR should be, rather than the CBRDTC concept.

In order to try and solve this problem, CBRDTC tried to get more of the staff involved in programme design. Another approach was to replace some of the staff who would not change their ideas. This difference in opinion is, to a certain extent healthy, and is still present in CBRDTC. However when the difference is too great, it decreases the overall effectiveness of the organisation and the programme.

Latterly, CBRDTC have found that this emphasis on focusing on the community, while very important, is not sufficient. They have

recently changed their concept to include a double focus which first emphasises the focus on community, in terms of changing the environment in which people with disabilities live, and second, emphasises the focus on people with disabilities themselves, in order to decrease the effects of their impairments on their lives and on those who support them (i.e. families) thereby minimizing their handicaps.

**Government Involvement:** One of the major problems indicated by this evaluation was lack of coordination with and/or involvement of government employees. The underlying problem is government employee job descriptions and rates of pay. At the community level, most government employees are under-paid and over-worked. To expect them to take on extra work, without additional pay, at the request of an NGO or the community is unrealistic. In some cases, it has been found that they will not attend CBR coordination meetings unless they are paid transportation money. It seems that achieving the levels of cooperation required to make this type of CBR programme workable and sustainable is not possible unless the national government changes job descriptions and adds additional staff at the local level. With the current state of the economy this does not appear to be possible.

Nevertheless it is important to note that many government employees, usually at lower levels, were willing to cooperate and worked very hard with no expectations of extra pay or benefits. However, there were not enough of them to ensure sustainability.

To try and overcome this problem at a community level, CBRDTC have placed full-time paid field workers in the target villages. One of the tasks of these field workers is to try and get more government employees interested and involved in the CBR programme. Experience indicates that this approach is somewhat more successful.

Another significant factor in programme sustainability is continuity of service by staff. Often CBRDTC have found that the government people who get trained in CBR are later transferred, then the programme has to start all over again. Again the solution is to have government employees officially designated as CBR workers with a government programme to train them and their replacements when they get moved. All CBRDTC can do in this regard is to continue to try and lobby the government to change their approach.

The lack of government involvement and concern presents a major problem if CBR is to be developed for an entire population. In a country like Indonesia, it is impossible for NGOs to do this. Fortunately government services are starting to move in this direction

and in order to further shift opinion, CBRDTC are now trying to develop a model of CBR, as well as the necessary training materials, that could be adopted by the Government on a larger scale.

**Funding:** In several places in the evaluation, there are references to the dilemma of finding funds in the villages for needed medical rehabilitation. These are not only one-off funds needed to solve current problems but also include funds that will be required for the foreseeable future as the occurrence of disability will not stop once a CBR programme starts.

The finding of funds is not only a problem for the villagers, it is also a problem for the NGOs, like CBRDTC. If we pay for the rehabilitation this time who will pay next time? If it is always to be CBRDTC, how long will we be committed to this obligation? CBRDTC have no immediate solution to this problem and are still trying to find ways to overcome it.

The other aspect of medical rehabilitation is the cost and availability of referral services. Medical services are not free and they are not always available close to villages. What do you do when there are no services or people cannot afford them?

As noted above, CBRDTC now recognize that this problem is as important as the involvement of the community and will soon be including in their CBR programme, a second type of paid field worker who will be trained specifically for rehabilitation rather than community development.

**Programme failure:** The evaluation noted that the effectiveness of the programme declined after the try-out stage. This phenomena could be a function of human nature - new project, new ideas which equals lots of interest as opposed to, old project, old ideas and a problem that never goes away, which results in boredom and a desire to go on to something else.

The evaluation further noted that after three years of project time, the programmes had failed in all of the villages examined. CBRDTC have given serious consideration to project duration and now feel, after looking at similar programs in other areas of community development, that a much longer time period will be required to firmly establish a programme so that it will be more sustainable without external NGO support.

#### ***Section 4: General Conclusions***

The basic evaluation design, field work, and analysis were completed by a team of Indonesians. The input of staff from the University of Alberta consisted of a general review of, and comment on, the

methodology and editing of the final report.

It was a big advantage having an evaluation team that were familiar with the local scene. During the course of the evaluation they were able to maintain their independence from CBRDTC as they could obtain all of the permits required to do this research on their own and were able to talk directly with the relevant government officials and community members in their own language without using interpreters. The team's awareness of and their ability to understand local needs and conditions, was considered to be the primary attribute.

One consideration regarding the team's effectiveness was their unfamiliarity with any aspect of rehabilitation. Given the terms of this evaluation this unfamiliarity was seen to be an advantage as the team focused on, what was to CBRDTC, the most important parts of the evaluation, namely the effects of the programme on the community and the programme design itself. However, the lack of knowledge about rehabilitation had a disadvantage in that the evaluation did not consider the direct effect of the programme on the individual lives of people with disabilities.

Overall the team did an excellent job in a relatively short time. They found the major problems and clearly stated them without reservation, both of which are essential if an evaluation is to be of any use.

CBRDTC's experience of non-formal evaluation had proved inadequate for properly designing and implementing programmes. A formal process of evaluation at key points in time, for example evaluating old programmes before starting new ones, can result in development of new CBR concepts and models. However, model changes will only happen if close attention is paid to the evaluation itself, and time and effort is taken to put the evaluation into its proper context in terms of the overall activities of the organization.

The final, and most important conclusion reached by CBRDTC as a result of this evaluation process, is that CBR projects must have a much longer time frame than the three years used in the programmes that were the subject of this evaluation. In fact, there is now considerable doubt as to whether a CBR programme can ever be fully self-sustainable. External inputs in terms of funds, training and monitoring will be required long after the programme has been implemented. This is an important area where solutions will only be found through close cooperation between governments and NGO's.

## **Notes**

1. A fuller account of the evaluation and its outcomes is given in the report: *An Evaluation of Community Based Rehabilitation in Banjarnegara, Sukoharjo, Sragen and Wonosobo, Central Java, Indonesia*, prepared by Heribertus Sutopo of Yayasan Indonesia Sejahtera (YIS) in cooperation with the University of Alberta, Canada. The evaluation was conducted between March and October 1993 and the funding was provided by the Government of Canada through a grant from the Canadian International Development Association (CIDA).

2. *Community-Based Rehabilitation For and With People with Disabilities*, 1994 Joint Position Paper, International Labour Organization (ILO), United Nations Educational, Scientific and Cultural Organization (UNESCO) and World Health Organization (WHO).

**Dr. Handojo Tjandrakusuma** has been the founder Director of CBRDTC since 1989. On graduating from medical school, he became involved in rehabilitation, joining YPAC in 1967 as a volunteer. By 1975 he realised the limitations of institutional based rehabilitation for people with disabilities in rural areas and he started to organize a community development approach. In 1992 he was awarded the Sasakawa Health Award by the World Health Organisation (WHO) for his contribution to the conceptual development of CBR.

**Douglas Krefting** is a medical anthropologist, working for CBRDTC as a CBR Management Consultant. He has been a colleague of Dr. Handojo since 1986 when he first learnt about CBR. Since 1992 he has lived in Solo and has managed the development of CBR projects in Java and Bangladesh. He assists with the development of new concepts, ideas and proposals, including the organisation and management of international CBR workshops.

**Dr. Laura Krefting** is an occupational therapist who has used her background in medical anthropology to specialise in cross-cultural disability. She has been involved in the development of CBR since she learnt of it from Dr. Handojo in 1986 and moved to Solo to work with CBRDTC as a volunteer in 1992. She coordinates the development of training manuals, trains the field workers in all CBRDTC projects and facilitates and directs the international CBR workshops. She is a consultant to UNICEF and WHO.

**Contact Address**

CBR Development and Training Centre  
JL. Adisucipto KM 7,  
Colomadu, Solo 57176, Indonesia