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Full Length Research Paper

Community Based Rehabilitation of persons with Special Needs in Mberengwa, Zimbabwe: Quality or Mere Formality?

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Abstract

This study examined the impact of Community Based Rehabilitation (CBR) programmes in the two purposively selected communities (Mposi and Chegato) in Mberengwa district, Zimbabwe. The study was informed by Urie Bronfenbrenners' ecological theory. A qualitative phenomenological case study design was used with two focus group discussions and interviews as data collection instruments. The sample comprised eight parents, four teachers, six persons with different disabilities and four pastors resident in the two communities. The Tesch's open coding method of data analysis was used to identify the major themes and the main categories that emerged from the findings. The study established that self-esteem, empowerment, self-reliance, social inclusion and interpersonal relations were enhanced due to CBR. On the other hand, broad geographical dispersion and varying socio-economic conditions of those with special needs, wide heterogeneity of impairment and disability characteristics, as well as the impact of stigma on persons with disabilities affected CBR implementation in Mberengwa. The study established that the successful adjustment of people with special needs to community living depends on the availability of vocational opportunities, continuing education programmes, adequate housing, medical service, support systems, and access to public transportation and buildings. This study also recommends an ecological approach in solving the problems of persons with disability in a community.

Keywords: CBR, heterogeneity, disability, special needs, social inclusion, severity of disability, marginalization, integration

Introduction

The World Disability Report estimates that there are over one billion people with disabilities in the world, of who between 110-190 million experience very significant difficulties (WHO, 2011). According to the Zimbabwe Population Census (2013), approximately 900 000 People with Disabilities (PWDs) were identified in Zimbabwe, a figure which equates to about 3 % of the national population. This figure is further validated by the Poverty Assessment Study Survey (PASS) (2013) which showed that nationally 3,2 percent of people were disabled. In Zimbabwe, the rural areas had a slightly higher prevalence of persons with disability than urban areas (Chinyoka and Ganga, 2010). It is also widely reported that PWD are excluded from education, health, and employment and other aspects of society and that this can potentially lead to or exacerbate poverty (WHO, 2011). This exclusion is contrary to the essence of the United Nations (UN) Convention on the Rights of Persons with Disabilities, which is an international human rights instrument of the UN intended to protect the rights and dignities of PWD (UN, 2008). This Convention calls upon all countries to respect and ensure the equal rights and participation of all PWD to education, health care, employment and inclusion in all aspects of society hence the need to come up with Community-based rehabilitation (CBR) programmes.

Community-based rehabilitation (CBR) is a multi-sectoral approach to meeting the health, education, vocational skills and livelihood needs of children, youth and adults with disabilities, primarily in developing countries (WHO & World Bank, 2011). CBR is defined in a joint statement by ILO, UNESCO and WHO (1994 & 2004) as 'a strategy within general community development for the rehabilitation, equalisation of opportunities and social inclusion of all people with disabilities. Lysack and Kaufert, (2014) also believe that CBR is a strategy for enhancing

the quality of life of people with disability by improving service delivery, by providing more equitable opportunities and by promoting and protecting their human rights. In addition, Werner (2008) asserts that CBR is an approach that seeks to actively involve the efforts of members of the community in the rehabilitation process. As a result, power is therefore restored to those who were initially marginalised. Given the above definitions, CBR therefore touches all facets of a person with special needs such as education, health, physical and emotional needs, employment, recreational and social needs and is therefore, an innovative approach to the rehabilitation of people with disabilities.

CBR is implemented through the combined efforts of people with disabilities themselves, their families, organisations and communities, and the relevant governmental and non-governmental health education, vocational, social and other services (Chakuchichi and Mutamiswa, 2014). CBR is the strategy endorsed by WHO (WHO, 2010) for general community development for the rehabilitation, poverty reduction, equalisation of opportunities, and social inclusion of all PWD. This goal was however never met and will continue to be a pipe dream as long as the economic and political situation remains unstable in Zimbabwe. CBR may be viewed as opposing conventional, expert driven and institutionally based medical models of rehabilitation which focus primarily on impairment and disability (Helander, 2013). Njimba (2015) argues that the idea of implementing CBR is to avoid as much as possible institutional rehabilitation. In support, Anderson (2002) posits that institutional Rehabilitation is a barrier to the integration of people with disabilities. Studies in Sweden, the United Kingdom, and the United States have demonstrated that home-based rehabilitation for people with stroke enables early discharge from hospital and a reduction in hospitalisation costs (Maulik, Darmstadt, 2017; Mayo, Wood-Dauphinee, Cote, Gayton, Carlton & Buttery, 2010). The other rationale for CBR is derived therefore from WHO estimates indicating that institutional based approaches to rehabilitation were only responding to 2 to 3% of rehabilitation needs (Chinyoka and Ganga, 2010). The reasons underlying this decision were both financial and philosophical. Zimbabwe could not afford the cost of providing institutional care for its people with special needs and institutional care would in the long run only lead to social segregation of persons with disabilities (Chakuchichi & Mutamiswa, 2014). Thus CBR is trying to do away with this as it advocates for rehabilitation in the home. The family members, friends and relatives should all participate. In agreement, Chakuchichi and Mutamiswa (2014) contend that the day to day activities of rehabilitation should be the responsibility of the family. Mariga and McConkey, (2002) also posit that in Zimbabwe and other developing nations, CBR programmes appear to take the form of outreach programmes from established rehabilitation institutions. Technically, these might be viewed as extensions of institutionally based rehabilitation forms as there is direct link with mother rehabilitation institutions. St Giles Rehabilitation center and Jairos Jiri Association in Zimbabwe provide successful CBR programmes in areas that are situated some distance away from their institutions (Mariga and MaConkey, 2002).

The concept of CBR in Zimbabwe has met both criticism and praise from many sectors. CBR is especially meant to bring more affordable and sustainable services to the economically disadvantaged rural communities in remote areas. In Zimbabwe, the development and spread of CBR programmes has often been credited to its being a culturally sensitive and low cost approach to disability because of the use of the Indigenous Knowledge Systems (IKS) (Chinyoka and Ganga, 2010). The CBR also complimented and reinforced the philosophy and practice of Primary Health Care as described in the WHO'S Alma Ata Declaration of 1978. The Alma-Ata Declaration affirmed health as a fundamental human right and called for transformation of conventional health care systems and for broad intersectoral collaboration and community organizing (Kuipers, Wirz & Hartley, 2008).

Studies have established that CBR projects in developing countries are linked to positive social outcomes, enhanced social inclusion, and greater adjustment of people with disabilities (Helander, 2013 & Njimba 2015). Where livelihood interventions have been integrated into CBR, this has resulted in increased income for people with disabilities and their families, and consequently increased self-esteem and greater social inclusion (WHO, UNESCO, ILO, & IDDC, 2010). In educational settings, CBR has assisted in the adjustment and integration of children and adults with disabilities (Hartley, et al., 2009). Of late, the Zimbabwean government has made efforts in spearheading Community Based Rehabilitation (CBR) programmes. Whilst this is so, most of these projects have died a natural death due to financial constraints and due to lack of sense of ownership by some communities (Njimba 2015).

Although CBR is currently implemented in over 90 countries, in reality only 2% of PWD are estimated to have access even to basic health and rehabilitation services (Helander, 2013). The scaling up of CBR is therefore urgently needed, but there is also a need for a stronger evidence base on the efficacy and effectiveness of CBR programs (Finkenflugel 2005; Hartley 2009; WHO, 2011) to support the expansion in coverage of CBR. Most of the evaluations of CBR programmes to date have been performed in several countries most using quantitative impact assessment methods with a focus on service provision levels. This study therefore hopes to close the gap in research by exploring the impact of CBD programmes in the two purposively selected communities (Mposi and Chegato) in Mberengwa district, Zimbabwe using only a qualitative methodology in order to gain an understanding of social phenomena from participants' perspectives in their natural settings.

Theoretical Framework

This study is informed by Bronfenbrenner's ecological systems theory which suggests that a person's surroundings including their home, school, work, church,

neighbourhood, culture and government have an influence on the way an individual develops (Donald, Lazarus, & Lolwana, 2010). The ecological model states that human development occurs within an interactive system of nested influences between the child and the environment. The ecological environment consists of the following five nested structures: microsystems, mesosystem, exosystem, macrosystem and chronosystem (Chinyoka, 2013; Rathus 2006; Donald et al, 2010). Children's microsystems include any immediate relationships or organisations they interact with, such as their immediate family, school, peers, neighbours and caregivers.

A key strength of the community-based rehabilitation model is the enhanced opportunity for provision of education and training of others (that is, family, support workers) and skill sharing with those in the immediate social network surrounding the client. This social 'ecology' of the person includes their family, friends, and work colleagues, as well as the community and services supporting the person. Greater collaboration with the community and empowerment of the support network of people and services surrounding the client is possible in a CBR model and enables the client to make sustainable gains. For example, family members may be involved in rehabilitation sessions for the purposes of education and training (about disability, empowerment, therapy, goal setting, support services, independence, and the provision of practical advice). Furthermore, collaboration with others (work colleagues, friends, and paid support workers) that may be in a position to help the client to achieve their goals is also possible in a CBR model.

Bronfenbrenner's next level, the mesosystem describes how the different aspects of a PWD's microsystem work together for the sake of the child (Donald et al, 2010). The exosystem level includes the other people and places that the PWD may not interact with often but still have a large effect on her/him, such as parents' work places, extended family members and the neighbourhood. Bronfenbrenner describes the macrosystem as the one that involves dominant social and economic structures as well as values, beliefs and practices that influence all other social systems. Finally, the chronosystem involves development over time that affects the interactions between these systems as well as their influences on the academic and intellectual development of PWDs (Donald et al, 2010).

Purpose of the Study

This study examined the impact of CBR programmes in the two purposively selected communities (Mposi and Chegato) in Mberengwa district, Zimbabwe, with the aim of successful adjustment of people with special needs enhancing them to reach their highest potential.

Major research Questions

- What are the effects of CBR programmes in Mposi and Chegato in Mberengwa district, Zimbabwe?
- To what extent is CBR effectively implemented in Mberengwa?
- What recommendations can be made to enhance the effective implementation of CBR in Mberengwa, Zimbabwe?

Methodology

Research design

The study adopted a qualitative phenomenological case study design to explore and present the impact of CBR programmes in Mposi and Chegato in Mberengwa district, Zimbabwe, with the aim of successful adjustment of people with special needs, enhancing them to become asserts rather than liabilities in their communities. Qualitative phenomenological case study approach is used to highlight the specifics and to identify phenomena through how they are perceived by the actors in the situation. A case study design was developed in order to gain insights into not only what was happening to PWD, but also why events might be happening in that way (Yin, 2012; White, 2012). One of the advantages of this approach is that it allows the researcher to gain an understanding of social phenomena from participants' perspectives in their natural settings (McMillan and Schumacher, 2010).

Sampling

The study was carried out in two communities (Mposi and Chegato) in Mberengwa district, Zimbabwe. These two were chosen because of their accessibility to the researchers. The target sample comprised eight parents (four women and four men), four teachers (one female and one male teacher from each of the two communities), six persons (four girls and two boys) with different disabilities and four pastors (one female and three men) who reside in the two communities. The participants were purposively chosen by the researchers.

Ethical Considerations

Permission to conduct the study was secured from Mberengwa rural council, chiefs (Chegato and Mposi), respective participants, parents or community members, four teachers from Chegato High school and Magavakava primary in Mposi, Danga area and four pastors who reside in the community. Consent was also sought from people with special needs interviewed in this study. Assent forms were also filled before interviewing six minors with disability. Permission was also sought from their parents. The participants were informed that their involvement in the study is voluntary and that they were free to withdraw at any stage of the interviews if they were not comfortable. Participants were also assured of anonymity in the research report.

Data collection

Data were collected through interviews and focus group discussions. These techniques increased the quality and richness of data, much more than one-on-one interviewing could have done (McMillan and Schumacher, 2010). The research instruments were validated using a pilot study and trustworthiness of data was ascertained.

Trustworthiness of data collected

The interviews were to be audio-taped and the researcher made observations and copious notes during the interviews. This strategy helped to eliminate the problem of inaccuracy or incompleteness of the data which, according to Maxwell (2006) in Chinyoka (2013) is the main threat to the valid description of what the researchers saw or heard.

Data analysis

An inductive approach to analysing the responses was undertaken to allow patterns, themes, and categories to emerge rather than being imposed prior to data collection and analysis (Patton 2012). This identification of themes provided depth to the insights about understanding the impact of Community Based Rehabilitation (CBR) programmes in the two purposively selected communities (Mposi and Chegato) in Mberengwa district, Zimbabwe.

Findings and Discussion

The major findings of the study are illustrated by the diagram below:

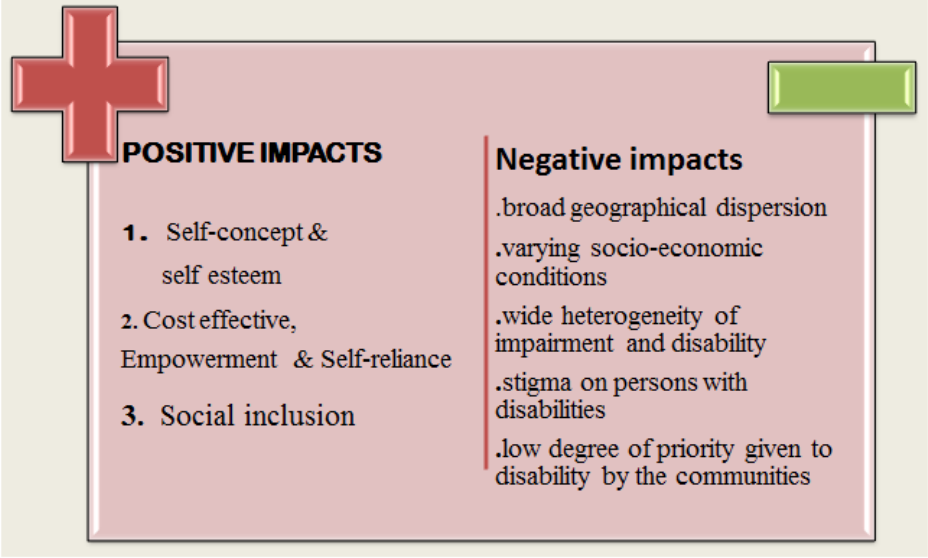

Fig 1: Field data, (2017), Showing themes derived from the study

As shown by fig 1 above, mixed feelings among participants were recorded on the impact of Community Based Rehabilitation programmes in the two purposively selected communities Mposi and Chegato in Mberengwa district, Zimbabwe. Positive and negative effects of CBR were noted.

Positive impacts of CBR on people with special needs

Self-concept and self esteem

The current study established that in both Mposi and Chegato communities in Mberengwa and other parts of the country in Zimbabwe where CBR has been practiced, the use of local chiefs, family members and volunteers from the community is of paramount importance. Research shows that the utilization of such indigenous personnel has a distinct advantage. This is because the help agent is part of the people with disabilities' culture. They are more likely to have a better understanding of the problem from the people with needs' point of view and are prone be accepted by the people with disabilities. It was established in the current study that before the CBR Programme was launched in these two villages, PWDs were teased and humiliated by the local people. These activities made them hesitate to go outside so they had no choice other than to sit at home idly. One parent who took part in the current study lamented:

> *But since the CBR Programme started in this village there has been drastic change in the life of persons with disabilities. This has also enhanced the self-concept and self-esteem of those with disabilities in the communities.*

The study shows that CBR programmes have increased self-esteem as reported by persons with disabilities and parents of children with disabilities. Disabled people have

become visible; they have shown that they can contribute to family life and in the community, irrespective of the type of disability. Typical statements were raised by PWDs are:

- *Previously, I felt very inferior but after I joined the CBR Program…I have been able to overcome that feeling… I can now assess myself with others and say that I can perform certain activities and tasks better than the able bodied.*
- *I used to be a very shy girl and felt hesitant to speak a word in front of other people. This was because of the discrimination and the way non-disabled persons looked upon me.*
- *Since the programme was launched in this village we came to know about disability and learn to support ourselves through different trainings. Now I have confidence in me and I'm able to introduce myself at school and at church confidently speaking my mind. I see myself as a role model for other persons with disabilities.*

In support of the above, the findings from the parents established that they become proud when their children improve their social behaviour, develop new skills and communicate better. In addition, they become proud when they are able to use their experience to help other parents.

Participants also responded with favourable comments regarding increased parental knowledge and understanding, expanding interest within families and communities, positive attitudes, appreciation that CBR suited the needs of rural people and parents becoming less worried and more confident. It is also said that mothers expressed less feelings of sadness and anxiety, more confidence in them as they received more support from community. Awareness becomes an important aspect in the programme especially when working with community at large where there is a high level of misunderstanding about disabilities (Chakuchichi and Mutamiswa, 2014). Studies show people's lack of knowledge and misunderstanding about disabilities which has led them to perceive a person with special needs in a family as due to sin committed by their ancestors (Chinyoka ad Ganga, 2010).

Cost effective and Empowerment/ Self-reliance

The Lutheran church through the Lutheran Development Services (LDS) to a large extent was successful in implementing CBR for people with disability in Chegato and Mposi communal areas in Mberengwa. This study established that nursing sisters on rotational basis from Mnene and Musume hospitals worked in the district. They were assisted with about 60 volunteers, including pre-school teachers, home economics teachers, community development workers, a rehabilitation assistant, Red Cross volunteers together with LDS members and community advisors who helped with the identification of cases, the training of family members on how to help their children with disabilities or relatives with follow up home visits. Findings from this research supported by Lagerkvist, (1992) cited in (Chinyoka and Ganga, 2010) suggest that interventions which are provided within the home will have more merit and better meet individual needs. From the above analysis, because the disabilities are identified early and interventions are provided, the children have greater chances for improvement.

The caregivers were given training and motivations regularly and continuously to encourage them attend the camps and have a follow up from the initial stages to reap maximum benefits. Given the above, the CBR services are cost effective, and by their very nature help to bring about social integration of people with special needs in their community. Simple, low cost aids are either bought by the LDS or made locally or and given to needy patients who are taught how to use them. People with disabilities are encouraged to participate in activities in their home area, such as going to church, to school and getting involved in self-skills like gardening, basket making, shoe repairing, carpentry and pottery. Finding from this study also established that the families of the young children are encouraged to send them to the mainstream school and vocational training centers in their communities. The LDS workers, in the CBR programme therefore work with people involved at grass roots level. Such people are community health workers, Community Advisors, Health Assistants and others. Other CBR advocates point out that CBR meets family needs by eliminating transportation problems (Chinyoka and Ganga, 2010). Long journeys to urban centres are often difficult or impossible when families must rely on expensive and unreliable public transportation, especially if the trip involves taking an older child or adult with mobility problems (Chakuchichi and Mutamiswa, 2014).

Social inclusion and integration

At Magavakava primary, school age children attend daily and are taught self-help skills, communication, academic skills and some occupational skills, as well as being involved in behaviour modification programmes when appropriate. Parents of pre-school age children bring their children once a week and are trained on how to provide community based education for them. It is important to note that the individual is not isolated from the community, family members and community volunteers are part of the rehabilitative process. All participants can see what the people with special needs have achieved. This can help integrate the person into the community, a community which values the unique contribution which the person is able to make. The Mberengwa Blind Women's CBR projects funded by the Norwegian Association of the blind and Partially Sighted (NABP) were reported to have done well in 1998 and 2014 respectively. The visually impaired women in these areas continued to receive training from the specialised teacher in the following areas, activities of daily living such as independent living skills like walking, cooking and self-hygiene, literacy introduction (Braille) and income generating projects such as knitting, weaving, soap and basket making. This is an advantage to the people with special needs because it promotes

sustenance among people as commented by one teacher at Chegato high school.

The CBR programmes therefore impart knowledge on problems and need for treatment, provide training to people with special needs, help to eliminate the stigma and misconception regarding people with special needs, motivate the people to attend mainstream schools, and to create awareness about the importance of family and the community involvement in the process of rehabilitation of people with special needs. Community leaders and members have been informed about disabilities, their causes and the way to support children and adults with disabilities. It should be noted that the single most effective tool to change social norms and values is through successful role models.

Negative impacts of CBR

While CBR in Zimbabwe continued to be implemented with limited success, its negative aspects in Mberengwa, Zimbabwe should be put into consideration. Those who participated in focus group discussions highlighted that to a less extent CBR was not as successful as purported by some participants. The issues which make the development of CBR programmes by isolated groups problematic includes broad geographical dispersion and varying socio-economic conditions of those with special needs, wide heterogeneity of impairment and disability characteristics, as well as variety of handicapping conditions in the physical, social and political environment, impact of stigma on persons with disabilities, low degree of priority given to disability by the communities and difficulties in distinguishing needs due to ageing and other marginalising experiences.

During interviews and focus group discussions, majority of participants highlighted that CBR programmes in both Mposi and Chegato areas are affected by the low priority given to rehabilitation by some communities especially if empirical evidence suggests a significant need. What is important is not to understand the CBR programmes but to accept them. Rehabilitation projects will be of little value if communities do not want them and do not feel they need them. In these two communities, people rather pursue their day to day activities which reward them fully at the expense of CBR workshops. This research also found out that some people in the two communities out rightly refused to co-operate in particular when they realised that they had to carry the brunt of the burden. Betseranai home-based care in Chivi, Gwapa in Gweru, Ruvheneko in Chirumanzu and many more CBR programmes in Zimbabwe have failed because the initiative for the project had more to do with the desire of the developers (top down) (Chinyoka and Ganga, 2010). It should be noted that in most cases most of the donor funds to promote CBR in the communities is given with strings attached. They often dictate how the project should be carried out which in some instances is not exactly what the people in the community want. Communities should therefore be allowed to participate in their programmes and to share in important decisions which do affect them.

Economic restrictions are but one of the hindrances making CBR impractical in Mberengwa, Zimbabwe. Some NGOs, especially Lutheran Development Services (LDS), God's Garden (GG) and CARE International indicated that dependence on outside resources was high and that they received the largest proportion of their funding from national governments (22%) and to a lesser extent from local donor agencies (16%). Other funding sources were regional and provincial governments, 13%, and foreign non-profit organisations or donor agencies (41%). From the above statistics, it is therefore reasonable for these researchers to conclude that in CBR, there is nothing like 100% use of local resources for it also depends largely on foreign funding. One teacher posits that some of the resources and support systems used are imported from other countries making CBR expensive. In the case of LDS, they receive about 90% of the funds from the Western donors and less than 5% from the country Christian members of the Lutheran church (Chakuchichi and Mutamiswa, 2014).

Findings of this study also revealed that CBR in Mposi and Chegato communities failed because of poor communication or lack of openness between partners, and that differences in communication methods, leadership styles and decision making approaches between CBR organisations often affected the success of their collaboration. Rural areas are isolated and difficult to access. In many of these villages, daily activities for survival are remarkably time and energy consuming leaving very little time to devote to the needs of those with special needs. In some instances, schools are more than 10km from the community. This worsens the plight of the people with disabilities in rural areas. There is often lack of transport and fuel to enable home visits to be made regularly to far away communities. This was noted to be a drawback as community visiting is thought to be particularly valuable among facilitators. It is the only way of monitoring the inclusion of the people with disabilities in their home environment with the aim of helping them to adjust.

Misconceptions about disability

CBR in Mberengwa, Zimbabwe was not always welcome by all the people because of people's misconceptions about disability. Participants in this study revealed that even after awareness campaigns, some people continued to hide children with special needs. The reasons for this seem various. Initially, a family may not acknowledge the fact that a child shows signs of disabling condition probably hoping that the situation will improve. Also a family may be ashamed of such a member and unwilling to acknowledge the problem. Traditionally, a woman who bears a child with disability is one who is suspected of having been promiscuous in her behaviour while pregnant. The following are some of the phrases made by people in the Mberengwa community depicting the attitude of the people which was recorded through informal interviews by

the researchers. “We feel ashamed of this child,” “If God is willing to give us children he must give us good children” “The families in the neighbourhood do not allow their children to play with my child” “My husband deserted me because of my mentally ill child” The above said statements reveal the misconception that the people have about persons with special needs and attitude towards these people. Labelling and stigmatisation continued even after awareness campaigns in Mposi and Danga communities.

On various occasions, when outreach teams are known to be in communal area, it is reported that they have received requests to come and collect people with disabilities. The following remarks have been made by paraplegic patients, “We live far away from clinics and it’s hard for me to stay at home”, “There is no one to look after me at home” “I intend to live at either Jairos Jiri home or Betseranai home in Masase for a long time”. This shows that people with disabilities also have not accepted to live in their communities and would therefore prefer to live at institutions.

Lack of trained personnel and Severity of disability

Zimbabwe often lacks trained personnel and technology, both of which are fundamentally ingrained at institutions. Most of the buildings in the communities are not user friendly; classrooms for example were built without the people with special needs in mind. Modifying the buildings to meet the needs of those with disabilities is very expensive.

It was also observed in the current study that the success of CBR in Zimbabwe depends also on the severity of disability. Only those of mild disability can be rehabilitated easily. Those with multiple disability and also severe disability need to be referred to specialists in institutional rehabilitation centers for further assessment and treatment and for operative and corrective surgery. It is important to note that they cannot be rehabilitated in their communities’ especially rural communities which are remote. People with multiple disability and severe disability need medical attention more regularly hence the need to house them at institutions.

Conclusion

The concept of CBR is a noble proposition in Mberengwa, Zimbabwe promoting self-concept, empowerment, social inclusion and self-reliance of PWDs. It has however been affected by numerous problems. Some of the issues raised remain unsolved. It was observed that CBR when put into practice not only bring dignity into the lives of people with disabilities and a sense of satisfaction of having contributed in the rehabilitation process, to the family and community involved but also brings a sensitisation and awareness amidst the community regarding various myths and stigma attached to it. In practice however the success of CBR programmes in Zimbabwe has often been questioned due to broad geographical dispersion, varying socio-economic conditions of those with disabilities, wide heterogeneity of impairment and disability characteristics and low degree of priority given to disability by both communities and the government. Many factors operate at the macro, meso, and micro levels of educational systems (that is, the level of the school system, the classroom, and the individual learner) and are closely nested around learners with disabilities. Therefore, active involvement of all stakeholders and positive interaction between multiple systems are important for successful implementation of CBR.

Recommendations

On the basis of the findings of this study, the following recommendations were made:

- CBR initiative should redirect their energies from providing services to proving answers. With current economic restrictions and scarce resources it may be difficult for the CBR enthusiasts to justify allocation of funds to research projects which on the surface, do not cause immediate action, however, it is only through such research projects that constructive efforts will ever be accomplished.
- Objective evaluations on CBR should be made regularly. Future evaluations must aim to provide true measures of the status of CBR projects and must therefore be completed by individuals who do not have a vested interest in evaluation results. Evaluation needs to address, effectiveness of CBR as a viable alternative to other methods of rehabilitation, community perceptions of CBR, family perceptions of CBR and effectiveness of local supervisors, both paid and volunteer, in CBR projects.
- Future and current CBR projects must seek support from local government. CBR initiatives must include eventual sustainability as part of their planning process. Communication between persons involved in or interested in rehabilitation endeavors in Zimbabwe needs to be improved.Many individuals are involved in rehabilitation projects; however most remain largely unaware of efforts outside their realm
- There is need for continuing programme to create awareness of the importance of bringing forward people, and especially children, who show signs of disabling conditions for treatment. This may be through the media. There is as yet no register of people with disability in the country. It could be done through the organizations of people with special needs, training institution, sheltered workshops, outreach eams, hospitals and clinics. Coordination of the exercise should be in the hands of the Department of Social Services.

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