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ORIGINAL RESEARCH

# Adaptation of the global frameworks for community based rehabilitation in southern Africa: a proof of concept

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## ABSTRACT

**Introduction:** Community based rehabilitation (CBR) has evolved over the last 30 years and now focuses on empowering persons with disabilities to access and benefit from a wide range of services. The essence and ethos of CBR is captured in several global frameworks, such as the UN Convention on the Rights of People with Disabilities (2006) and the *CBR guidelines* (2010). The latter contains the CBR matrix. All 15 countries in southern Africa are implementing CBR mostly in rural areas, but the policy framework to guide CBR in the region is unknown. The purpose of the study was to determine to what extent countries in southern Africa have adapted the global frameworks available for CBR.

**Methods:** A CBR policy analysis using proof-of-concept methodology was undertaken. Policy documents on CBR were sought from relevant government departments or agencies. Multiple methods and media, including web searches, searches for grey literature, social media and contact through an elaborate network of colleagues working in the region, were employed to execute the search strategy. Data were organized using NVivo software, and three independent raters coded the emergent themes using the CBR matrix.

**Results:** Only Namibia, South Africa, Tanzania and Zimbabwe have specific policy content for CBR. These, however, lacked structure; the content was predominantly aligned to health. Inclusion of key international concepts such as mainstreaming and empowerment were superfluous when present.

**Conclusions:** The CBR policy environment in southern Africa appears inadequate. Contingent factors that preclude adaptation of the global frameworks available for CBR appear to be at play. These warrant further investigation.

**Key words:** CBR strategy and guidelines, community based rehabilitation, policy, proof of concept, southern Africa.

# Introduction

Community based rehabilitation (CBR) was initiated in the mid-1980s by the WHO and over the years has evolved to become a multi-sectoral strategy that empowers persons with disabilities to access and benefit from a wide range of services.

CBR is a strategy for enhancing the quality of life of persons with disabilities, improving service delivery by providing more equitable opportunities and social integration, and promoting and protecting their human rights[1]. Although the origins of CBR are rooted in facilitating primary rehabilitation in low-income countries[2], it is now a response, in both developed and developing countries, to the need for adequate and appropriate rehabilitation services, to be available to a greater proportion of the disabled population. Because CBR addresses the issues of access, it is largely implemented in remote areas where rehabilitation personnel and infrastructure are otherwise absent. Its development and practice as a needs-based approach has evolved from a biomedical approach to a biopsychosocial approach[3-5]. In order to achieve its goals, CBR calls for the full and coordinated involvement of all levels of society: community, intermediate and national[3,6,7].

The development of CBR was influenced by the human rights movement. Notable human rights events were the Alma Ata Declaration of 1978, the 1981 UN International Year for Disabled Persons, the UN Decade of Disabled Persons 1983–1993, the UN Standard Rules[8] and the UN Convention on the Rights of People with Disabilities (UNCRPD)[9].

Cumulatively these frameworks seek to promote effective measures; for prevention of disability, rehabilitation and the realization of the goals of 'full participation' of people with disability in social life and development, and of 'equality'[10], as well as, specifically, to commit countries to meet minimum requirements for ensuring the rights of persons with disabilities are accommodated in legislation, policy and practical ways[11]. Ensuring that persons with disabilities enjoy all aspects of human rights is embedded in international and country level legislation 'to empower PWDs [persons with disabilities] and to ensure their participation in political, economic, social and cultural life'[5]. The *CBR guidelines*[12] capture the essence of participation of persons with disabilities as a rights-based approach. These guidelines describe a CBR matrix (Fig1) that consists of five key development areas: health, education, livelihood, social and empowerment[12].

Each column includes five areas of activity, which are potentially part of CBR. The key focus of the guidelines is mainstreaming and empowerment of persons with disabilities and their family members, and sustainability of CBR[12].

In southern Africa, CBR was introduced to Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe[4,13-16]. Most often CBR programs are implemented at subdistrict levels, in rural and remote locations where rehabilitation personnel and infrastructure are non-existent. In a few cases CBR has been implemented in peri-urban areas. Some programs were introduced via a socially oriented paradigm while others used a medical entry point. CBR provided the opportunity for training personnel that can respond to pressing community needs[4]. In conflict and post-conflict countries such as Angola and Mozambique, CBR was implemented to provide essential rehabilitation services to the affected populations[6].

In many countries, CBR at a community level is part of an integrated community development program that relies on the mobilization of local resources[7,12]. At the national level, CBR seeks the involvement of the government in the leading managerial role[2]. Although, planning, implementing, coordinating and evaluating the CBR system takes place at all levels of the system, and although the persuasion is for participatory approaches, government is expected to take the lead managerial role in CBR.

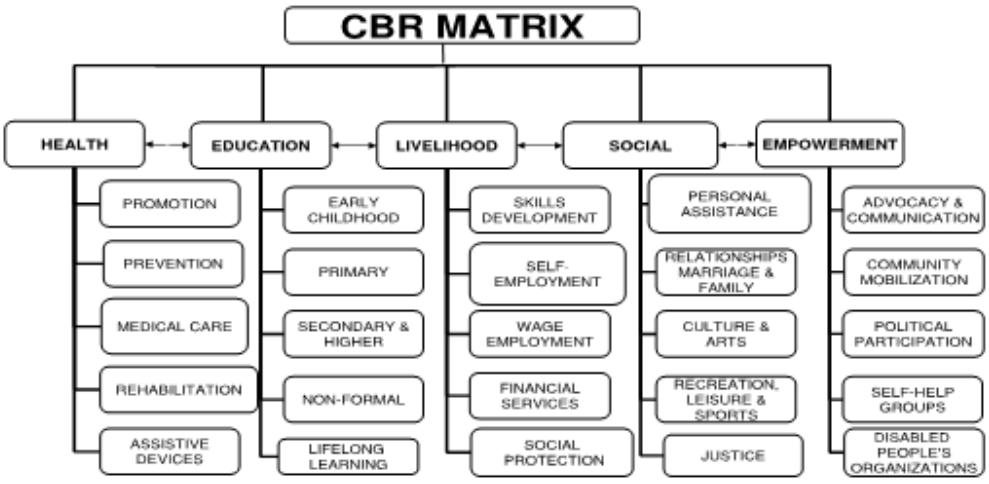


**Figure 1: The community based rehabilitation matrix.**

### *Purpose and significance*

Against this background, an evaluation of the policy framework and content for CBR in southern Africa was sought. Governments are expected to take the lead in shaping such programs by developing policies and guidelines, and planning for CBR at country level. These processes can be influenced by existing global frameworks or instruments. Unpacking the global frameworks such as the UNCRPD and *CBR guidelines* into CBR policies at the country level could be an astute consideration to unlock resources for CBR and enhance its delivery in the region.

## Methods

### *Study setting*

In this study, southern Africa was defined as all countries belonging to the southern African Development Community (SADC). These countries are located in the southern-most part of the African continent and share one or more borders with at least one of the other member states.

The SADC was established in 1980 in Lusaka, Zambia as a loose alliance of nine majority-ruled states in southern Africa known as the Southern African Development Coordination Conference (SADCC). The transformation of the organization from a coordinating conference into a development community took place in 1992 in Windhoek, Namibia when the declaration and treaty gave the organization a legal character. This **treaty** sets out the main objectives of SADC: to achieve development and economic growth, alleviate poverty, enhance the standard and quality of life of the peoples of southern Africa (population approximately 310 million) and support the socially disadvantaged through regional integration[17].The member states are shown in Table 1.

### *Proof-of-concept study*

A proof-of-concept method was undertaken to discern the themes that characterize the understanding of CBR at the level of central government in each of the15 countries (Table 1). This methodology enables a 'systematic, largely qualitative synthesis', and although Kuipers and colleagues used the method to explore themes in CBR evaluation reports, we anticipated that the process would generate evidence representative of country-level priorities for CBR in southern Africa. The proof-of-concept method has been reported to be 'potentially beneficial for research in CBR' and in international development research where the primary source of evidence is not formal research evidence[18].

**Table 1: Southern African Development Community countries**

| Country | Population estimate (UN, 2012) (millions) | Working language(s) |
|---|---|---|
| Angola | 20.2 | Portuguese |
| Botswana | 2 | English |
| Democratic Republic of Congo | 69.6 | French |
| Lesotho | 2.3 | English |
| Madagascar | 23.2 | French |
| Malawi | 15.4 | English |
| Mauritius | 1.2 | French/English |
| Mozambique | 24.5 | Portuguese |
| Namibia | 2.4 | English |
| Seychelles | 0.090024 | French |
| South Africa | 51.7 | English |
| Swaziland | 1.2 | English |
| Tanzania | 47.6 | English |
| Zambia | 38 | English |
| Zimbabwe | 15 | English |

The source of these data was an appropriate policy document or guidelines for CBR at the country level. This was obtained from the relevant government department or a non-governmental agency delegated the CBR function by the government.

The officer responsible for the CBR program in each of the countries in the region was identified and designated a key informant. Multiple media, methods and informants were employed to identify, locate and contact the appropriate CBR officer and/or CBR policy source document. Early in the study serious challenges in contacting the identified key informants and in obtaining information on CBR policy were encountered. The response to this challenge was to identify and contact a network of rehabilitation professionals working in the region. This strategy was instrumental in Botswana, Democratic Republic of Congo, Lesotho, Malawi, Mauritius, Seychelles, Swaziland and Tanzania. The scope of the search was extended to include strategic plans and guidelines. It had been noted that these are used to guide CBR in other countries, particularly in the Asia-Pacific region. The time for data collection for this phase of the study was extended to 12 months to allow sufficient time for the search. The search strategy is outlined in Figure 2.

The purpose of the study was shared in writing, informed consent obtained and the source document for the required policy or guideline requested. All communications were done electronically. The data required were extracted from the source documents using a pre-designed extraction guide. Thematic content analysis of the data was done by two independent raters as well as the principal investigator (VM) for reliability. The raters were selected for their training and experience in CBR, and were all from southern Africa. The principal investigator first read the source documents and facilitated their translation into English where necessary. Sections from the source documents containing CBR policy positions were entered into, and organized using NVivo v9 qualitative data analysis software (QSR International; http://www.qsrinternational.com/nvivo-product). Raters received a single file of this electronic copy of the data. Themes and corresponding codes (categories and labels) were identified. Recurring themes were noted in the text and allocated a 'node'. These nodes or emerging themes were labelled broadly using the five key components contained in the CBR matrix (Fig1). A second phase of analysis allocated the themes into the specific CBR activity described under each column of the matrix. Identified codes were also summarized according to their level of priority or prominence in the source document.

The electronic text of the data was read to identify key international concepts that characterize CBR, and are contained in the global frameworks, such as mainstreaming, empowerment and sustainability.

The three summaries were compared by the principal investigator and the results shared with the two independent raters. A discussion was scheduled between the three raters to obtain consensus on the final concepts contained in CBR country policies or guidelines, and their ranking.

### *Ethics approval*

Ethical clearance was obtained from the University of the Witwatersrand, South Africa, Human Research Ethics Committee (certificate number:130593) and the College of Medicine Research and Ethics Committee in Malawi (certificate number: P.03/14/1545).

## Results

### *Availability and location of CBR policy in southern Africa*

Only four countries in southern Africa had a policy or guideline on CBR. There were no standalone or dedicated CBR policies in any of the countries in southern Africa. Table 2 summarizes the CBR policies that were available in the region.

With the exception of Botswana, Lesotho and Mauritius, all the other countries that did not have a CBR policy/guideline had the CBR program in that country administered by development agencies such as GTZ (Deutsche Gesellschaft fur Technische Zusammenarbeit GmbH, a German government agency involved in health development), non-governmental organizations (NGOs) such as Cheshire Homes, the Leprosy Mission, various church organizations; or by organizations or individuals with an interest in the welfare of persons with disabilities. In all these cases, identifying, locating and contacting the key informant was an arduous process and in some cases unsuccessful, owing to unavailable or outdated contact information.

### *CBR policy content and alignment to the CBR matrix*

Analysis of the policy content available from Namibia, South Africa, Tanzania and Zimbabwe revealed that this was brief and generalized. Frequent policy content alluded to the 'government being responsible' to ensure that CBR is adopted' (Tanzania's National Policy on Development and Services to People with Disabilities, 2004), and in all four countries the objectives of 'social integration' and 'all services at all levels' for persons with disabilities were recurring themes. Table 3 illustrates the CBR activities that were contained in the CBR policies and guidelines. Health was overwhelmingly aligned to the CBR matrix, and to a lesser extent education. The social column was least aligned to the CBR matrix.

Only the policy from South Africa contained principles and strategies. The principles included:

- 'people centred, people driven'
- 'address equalization of opportunity'
- 'address social integration'
- 'espouse dignity and respect'.

The strategies for the CBR policy included:

- reorienting service providers to the principles listed above
- developing partnerships with NGOs
- raising awareness about CBR.

### *Key international concepts*

Table 4 illustrates the inclusion of key international concepts in the CBR policies. 'Integration' was featured in all policy documents.

The following information was sought from each southern African country:

1. CBR policy; disability and rehabilitation policy, health policy and or CBR Guidelines
2. Government department or NGO responsible for CBR and the national CBR officer (contact).

A systematic and sequential search included:

a) Google search
b) WHO website and CBR Africa Network (CAN)
c) email contacts of key informants – WHO DAR, CAN, national CBR officers, World Confederation of Physical Therapy Africa (WCPT-A), World Federation of Occupational Therapy–Africa (WFOT)
d) collegial contacts in the region via email, mobile phone, Skype or SMS
e) social media – an appeal message was posted on two Facebook pages hosted for physiotherapists and occupational therapists in the region
f) grey literature.

**Figure 2: Search strategy**

**Table 2: Community based rehabilitation policy availability in southern Africa**

| Country† | Nature of policy | Date of publication | Document type | Department/agency source |
|---|---|---|---|---|
| Namibia | Brief statement | December 2004 | National Disability Council Act | Ministry of Health and Social Services; Community Based Rehabilitation Directorate, Windhoek |
| South Africa | Brief statement | November 2000 | National Rehabilitation Policy | Department of Health, Pretoria |
| Tanzania | Brief statement | July 2004 | National Policy on Development and Services to People with Disabilities (*available in Swahili)* | Department of Social Development Ministry of Works Youth Development and Sports, Dar Es Salaam |
| Zimbabwe | Brief statement | 2009–2013 | National Health Strategy | Ministry of Health and Child Welfare, Rehabilitation Unit, Harare |
| | Comprehensive guidelines | 1990 | Guidelines for Implementing Community Based Rehabilitation in Communal Areas in Zimbabwe | |

† No policies for Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Seychelles, Swaziland, Zambia.

### *CBR priorities*

Only the broad areas of health and education were analysed further to ascertain how specific activities in each column were prioritized in the policy document. The other areas were excluded from analysis because they were either not identified in the preliminary analysis or identified codes and themes were too few to be ranked meaningfully. Overall health was most prominent in the policy content. Only those activities that were present in the CBR policy according to the CBR matrix (Table 4) were ranked.

Hence the rankings were:

- health – 1. Rehabilitation, 2. Assistive devices, 3. Prevention
- education – 1. Primary, 2. Secondary and higher, 3. Early childhood.

## Discussion

The search for CBR policies and/or guidelines yielded only four policy documents depicting policy positions out of the

 

15 countries in southern Africa. A report on the CBR status in 11 African Countries (eight countries were from southern Africa), conducted by Mji, Myezwa and Statham in the late 1990s (unpublished) on behalf of the World Confederation for Physical Therapy Africa Region, reported, contrary to the present study's findings that Botswana had a CBR policy. This could not be obtained despite repeated efforts. Several key sources within Botswana were of the opinion that a CBR policy does not exist. In-depth analysis of the policies obtained demonstrated that when the policy or guideline for CBR was contained in a document specifically for CBR, it tended to have more specific and detailed content. Hence Zimbabwe performed well in this aspect owing to its comprehensive *CBR guidelines*. This was followed by South Africa's National Rehabilitation Policy. Key outcomes (policy content) were informed principally by the CBR matrix and ascertainment of inclusion of key international principles contained broadly in the CBR Guidelines. This provided the framework of the concept and the standard against which the CBR policies were evaluated.

The policies lacked structure and did not provide for financial specificity. Both of these elements could aid in ensuring that the policy addresses certain critical issues critical to the success of CBR[19] such as empowerment of the participants (in particular, persons with disabilities and their families), mainstreaming of disability issues into development and key programs, and sustainability. Integration was the dominant concept contained in all policies, while empowerment and mainstreaming featured in the policy for South Africa and Zimbabwe respectively. In general the content for South Africa performed better than the other three countries on inclusion of key concepts, but these were often transferred verbatim from the global frameworks, and sustainability was absent from all documents. Faydi et al[19] used a WHO Mental Health Policy Checklist to assess whether key policy processes had been followed that could lead to the successful adoption and implementation of the policy, as well as whether the content addressed certain critical issues in four countries in Africa. Such a checklist could be developed for CBR, which could aid inclusion of key concepts in CBR policy. The policy framework tended to have a biomedical bias with the content aligned to health. This may be a response to the expressed needs of persons with disabilities (ie the need for health interventions), but it may also be influenced by perceptions regarding what disability is. The underlying reasons why CBR policy responds mostly to health requires further investigation. A scoping review of how disability is viewed and how this view influences disability measurement is under way as work towards this recommendation.

The proof-of-concept approach was successful in identifying the themes and subthemes in the policy evaluated against the CBR matrix. However, policy analysis draws on concepts from a number of disciplines[20]. We therefore had elected to proceed further by way of health policy analysis because the source and content of our data reflected a bias towards a health paradigm. In this study it was however not possible to subject the CBR policies obtained to a comprehensive policy analysis framework because the content was very lean, the policies were silent on process and the context (geography, politics, economics, culture and organization of the health system) was not defined. Walt and Gilson[20] outlined such a framework for health policy analysis in which, for instance, events taking place at the time the policy was developed were considered in the way in which they shape the policy (context – situational). In the case of the present study, such illustrations may not apply because, apart from the guidelines from Zimbabwe (1990), the other sources of CBR policy statements are not focussed on CBR, hence the contextual factors may not speak directly to CBR but rather to the focus of the source document (eg *National Disability Council Act for Namibia* (2004)).

The findings of this study also demonstrate that all the countries that had a CBR policy or guideline used English as one of the main languages for conducting business. It is possible that the electronic search strategy performed in English may have excluded the non-English sources available for Angola, Democratic Republic of Congo, Seychelles, Mozambique, Madagascar and Mauritius. To minimize this limitation, a diverse search strategy (as shown in the methodology) was used, which was also aided by contacting a network of colleagues in the region who could physically search for information and/or key informants locally, and in turn through their networks. It was not possible to find a policy, plan or guideline in all the countries where English is not one of the main business languages. Thus, it is speculated that in addition to particular competencies that would be required to adapt global

 

instruments to suit a local setting, some countries may experience an overlying challenge in adapting frameworks available only in certain languages. The *CBR guidelines* are available in four languages: English, Spanish, French and Chinese. Many member countries of Disabled People's International expressed their lack of fluency in these languages. Hence, reading and analyzing the guidelines was difficult for them[21]. Angola, Malawi, Namibia, Tanzania, Zambia and Zimbabwe were among the 84 countries involved in this survey. On the other hand the UNCRPD, which has been around for longer, is available in 29 translations including French, Portuguese, Spanish and Kiswahili, which one might expect to cater for the countries in southern Africa. However, on the basis of the report by DPI[21], these translations may still be inadequate. The availability of the UNCRPD in Kiswahili may extend the ease of adaptability for Tanzania and parts of the Democratic Republic of Congo where it is in use.

Although the CBR matrix was the basis for the analysis, a determination of the extent to which key international concepts contained in the UNCRPD that characterize the current knowledge of disability and rehabilitation (such as mainstreaming and empowerment were integrated) was explored. Wholesale use of the key concepts, without a further unpacking, description or illustration of their meaning, was observed. This was particularly true for the policy statement on CBR obtained from the National Rehabilitation Policy for South Africa (2000). It was therefore concluded that, when present, inclusion of these concepts was superfluous. This finding may illustrate the difficulty in understanding and adapting the global frameworks that practitioners may face, lack of technical support in adapting the frameworks, lack of political will[2] or may illustrate processes that were undertaken to serve political expediency more than anything else. A feature of the CBR Framework for Samoa (2014) contains sections that explore the rationale as well as the international guidance that informs the framework. In these sections the salient characteristics of CBR are explored and the key concepts are described and illustrated.

Policies are essential tools for setting strategic priorities, coordinating action and reducing fragmentation of services and resources[19]. This is especially relevant for CBR where the scope of activities and the number of service providers and stakeholders is particularly diverse. Duplication of service has previously been observed in Namibia where the mandate for CBR has traditionally been shared by two government departments. CBR programs implemented predominantly in rural areas lack real guidance because of the inadequacies in the CBR policy environment. People with disabilities who are already marginalized may continue to be in this position as they fail to realise the full benefits of CBR.

The Asia-Pacific region has taken the lead in demonstrating how the global frameworks could be adapted to suit a specific situation. This is illustrated in Papua New Guinea, Samoa and the Solomon Islands, among others. The Papua New Guinea CBR Network Strategy and Action Plan (2013–2016) as well as the Samoa CBR Network (2014) propose a vision, mission and an action plan based on strategic objectives. The Papua New Guinea CBR Network Strategy and Action Plan (2013–2016) illustrates the coordination and reference point for national and provincial government policies. This demonstrates an approach that could be used to achieve mainstreaming issues related to disability and the wellbeing of persons with disabilities. On the other hand, the Samoa CBR Network makes provision for monitoring the action plans; it offers some indicators and allocates responsibilities as a means of 'verification' of progress towards meeting the strategic objectives[22].

### *What can be done?*

While lessons may be drawn from other country examples, policies can be influenced in many ways. According to the Association of Faculties of Medicine, Canada, common influences (and all are applicable to CBR policy) include[23]:

- political parties or individual politicians
- lobbying decision makers in government
- voluntary organizations
- community groups
- public opinion
- public consultations
- media and publicity
- research.

 

**Table 3: Alignment of community based rehabilitation (CBR) activities to CBR matrix**

| | Key development area and active country(ies) | | | | |
|---|---|---|---|---|---|
| | **Health** | **Education** | **Livelihood** | **Social** | **Empowerment** |
| | *Namibia, South Africa, Zimbabwe* | *Zimbabwe* | *Namibia, Zimbabwe* | *South Africa* | *Zimbabwe* |
| **Area of activity**[†] | Promotion | Early childhood | Skills development | Personal assistance | Advocacy and communication |
| | Prevention | Primary | Self-employment | Relationships, marriage and family | Community mobilization |
| | Medical care | Secondary and higher | Wage employment | Culture and arts | Political participation |
| | Rehabilitation | Non-formal | Financial services | Recreation, leisure and sports | Self-help groups |
| | Assistive devices | Lifelong learning | Social protection | Justice | Disabled people's organizations |

[†] Presence of CBR activity in policy/guideline is indicated by underline.

**Table 4: Key international concepts included in community based rehabilitation policies**

| Country | Concept(s) included | Example quotation |
|---|---|---|
| Namibia | Integration | 'Part of the national development programs' |
| South Africa | Integration<br>Equalisation of opportunity<br>Empowerment | 'CBR should ensure the empowerment of people with disabilities …' |
| Tanzania | Integration | 'Ontegrates the non-disabled' |
| Zimbabwe | Integration<br>Mainstreaming | 'The focus of care is integration, focussing on mainstreaming management' |

CBR, community based rehabilitation.

The CBR literature often bemoans the paucity of evidence in the field. Evidence is necessary to augment the understanding of CBR. Lack of empirical evidence for policy development or evaluation of existing policy is recognized as one of the factors for a weak policy environment[18,19,24], as well as failure to translate research findings into policy – the evidence–policy gap[25] –and these could be factors contributing to the findings presented in this paper. A systematic review is currently underway to ascertain the veracity of this criticism regarding CBR literature in southern Africa. Grimshaw et al[25] recommend systematic reviews as a method of synthesizing evidence and therefore the basic unit of knowledge translation. A study of the 'perceived effectiveness and consequences' of policy is recommended by Ditlopo et al[24]. This will be done for CBR policy in southern Africa using more participatory approaches during field visits to CBR programs in selected countries in the region, and this is planned as a follow-up study.

Meanwhile, knowledge translation platforms that fashion 'policy briefs'[25] adapted from the global frameworks and containing key messages targeted at policy makers could be useful to improve the CBR policy framework in southern Africa. The UNCRPD and the CBR Guidelines are large documents and could be summarized into a 'brief'. Printed educational materials[26] , educational meetings[27] and educational outreach[28] are other strategies that have variable effectiveness[25], but could be employed among CBR stakeholders to improve CBR policy in the region.

Faydi et al[19] also identify that the capacity of key stakeholders, including policy makers be strengthened. The WHO, through its regional Disability and Rehabilitation technical leads, could play a facilitator role to ensure that the intent of the global frameworks is understood prior to local adaptation. Governments should also put in place

 

mechanisms to review policies periodically[24] and evaluate their ability to meet new needs.

Finally, the establishment of a CBR community of practice in southern Africa is recommended[29]. There are two conditions that need to be met for 'community of practice' to work: shared experience over time and a commitment to shared understanding[29]. It is believed that the actors (practitioners, researcher, policy makers) in CBR in the region could establish a community of practice to enhance the understanding of the global frameworks, as it is rooted in social learning theory. Shared experiences that arise from a common history, geographical proximity and a common vision as expressed in the SADC Treaty provide an opportunity to take advantage of this strategy. Together with knowledge translation platforms, such strategies could be instrumental in building into policy the vision, key, values and objectives of CBR policy. Communities of practice could also be strategic in addressing the policy language capacity challenges described in this article.

It must be noted that all four countries that had a policy on CBR do have CBR programs running across the countries in the various regions and provinces. This may be attributed to the existence of the policy direction. In South Africa, Tanzania and Zimbabwe, CBR programs are mixed: some are operated by a government ministry, whilst others are operated by NGOs (eg CREATE in South Africa, Jairos Jiri in Zimbabwe). In Namibia, however, the CBR programs are operated by a government department. The impact of CBR in South Africa has been reported to be greater on individuals rather than whole communities[30]. Similar individual impacts in the area of health and empowerment were reported by Shumba[31] in Namibia. In Tanzania the impact on children has been significant, especially with regards to the provision of aids and appliances. For a long time the CBR program in Zimbabwe was funded by the Swedish International Development Cooperation Agency, but when they exited the country the scope and intensity of CBR activities became lean, and in some districts stopped all together. Currently, government through the Ministry of Health and Child Welfare has taken over the funding of CBR, and activity is on the increase.

### *Implications*

All strategies to strengthen CBR policy must be as an inclusive process[20]. Whether the state should play a central role in policy making appears to be a contentious issue in the literature. The findings of this study support a position where the state plays a leading role. In all countries where the government did not play a leading role in CBR, there was no policy available; in other words, a poor CBR policy environment appears to be related to situations where the mandate for CBR lay with an NGO or other agency or entity. Although certain rights would be protected constitutionally, a lack of CBR policy means there are no mechanisms or measures in place to meet obligations to protect the rights and provide services for persons with disabilities using the CBR approach. Grimshaw et al[25] appear to concur with this view with regard to public policy, in their assertion that organizations of government officials may be the 'most credible messengers'. Leaving the strategic direction and implementation of national programs to individual NGOs as the frontrunners may result in fragmented, unsustainable, albeit effective in the short term, CBR programs. Once funding is limited, the program, its history and documentation is not noticeable.

## Conclusions

A discrepancy between the global frameworks and the CBR policy environment in southern Africa was observed. The reasons for this are unclear, but preliminary and potential observations point to inadequate evidence to inform local policy, challenges in technical policy development skills and policy language capacity to adapt and sometimes translate the global frameworks. Corneilje and Bogopane-Zulu[32] remarked that, 'It may be that the hesitation to accept CBR as a national policy for rehabilitation is based on a lack of evidence that CBR has the desired effect in terms of coverage, effect and impact on the [quality of] lives of disabled people. Without

 

this evidence there is a tendency for the policy makers to assume that CBR has low coverage and high costs per person.' Whichever the case, the contingent factors, Grimshaw et al[25] refers to these as 'barriers to knowledge translation' that preclude adaptation of the global frameworks available for CBR appear to be at play in southern Africa. These warrant further investigation.

The adaptation of global CBR frameworks by countries in southern Africa appears inadequate. Both the content and structure of policy to guide CBR in southern Africa is weak. Policies are mostly not available or difficult to locate. The scope of the content is narrow, preoccupied with health interventions and when present takes a superficial tone to the key international concepts contained in the global frameworks for CBR. These findings may lead to inadequate funding for CBR. This could frustrate CBR practitioners and could account for a waning of interest in CBR, and consequently under-servicing of persons with disabilities using this approach. In particular, it disadvantages persons with disabilities living in rural and remote communities in countries in southern Africa.

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