

CHAPTER TWELVE: GOVERNMENTS AND CBR: POLICYMAKING, PLANNING, COST CALCULATIONS.

Services and other interventions in favour of disabled people must be permanent, and they should aim at eventually covering the needs of persons with disabilities in every part of the country. This will not be possible without competent personnel and a proper organisational structure. Only governments can provide such organisation, and it is necessary that they become interested in this role and assume their responsibilities for policy-making, planning and execution of the CBR programme.

1. HOW TO CONVINCING GOVERNMENTS

When we present ideas to governments and try to convince them to change policies, it is not enough to argue that disabled people are a neglected group and deserve their attention. A more substantive and structured argument is needed. In this chapter I will discuss how we might influence governments to make the priority decisions necessary for the CBR programme. Three methods will be described: the cost-benefit and the cost-effectiveness approaches, and the analytical system for deciding human services priorities.

Cost-benefit method

After the Second World War, this method started to be used to promote rehabilitation, primarily in the USA. There were arguments, such as: "a disabled person who works will pay back the costs of rehabilitation several-fold. Just the taxes he or she pays will suffice to generate US\$3 for US\$1 invested."¹

More scientific methods to calculate cost-benefits were developed in the 1950s and 1960s, and became fashionable at that time. By putting an economic price tag on everything, one would in theory be able to find out where the highest benefits at the lowest costs could be expected, and so allocate government funds in an optimal way. The cost-benefit method started to be widely applied², but the implication for human service projects was that someone had to decide the price of the non-monetary benefits. Some of those were not market but political prices. How, for instance, do we compare the benefits of having 500 more teachers with having 500 more policemen? How do we compare the benefits of having a football stadium with those of having a district hospital, or of having a place of worship?

This method seemed especially controversial when applied to the human services field such as rehabilitation programmes.³ The mathematical techniques to calculate production benefits, for example, are highly questionable in countries with high unemployment. Would the addition of work performed by disabled people substitute for that of the able-bodied, who would become unemployed? Or would it, and this was doubtful, contribute to an increase in national production? Promoting services for disabled people to governments by using a profit motive of this nature was theoretically and practically dishonest and morally questionable, since it deprived the rehabilitation concept of its primary humanitarian content. However, it is clear that, when successful rehabilitation leads to a decreased dependency on others, family members will be free to undertake other, in many cases income-generating, activities. This indirect benefit is of great importance.

Cost-effectiveness method

The cost-effectiveness method is a completely different approach.⁴ If a certain rehabilitation result is sought, can it be achieved at a lower cost, by employing an alternative technology and/or service delivery system?

A question to face in the developing countries is whether or not we believe that a certain type of rehabilitation results can be achieved at a lower cost while maintaining the same quality. A study of low-

cost approaches, which forms part of the evaluation of the CBR technology, will be helpful in convincing governments that this is possible.

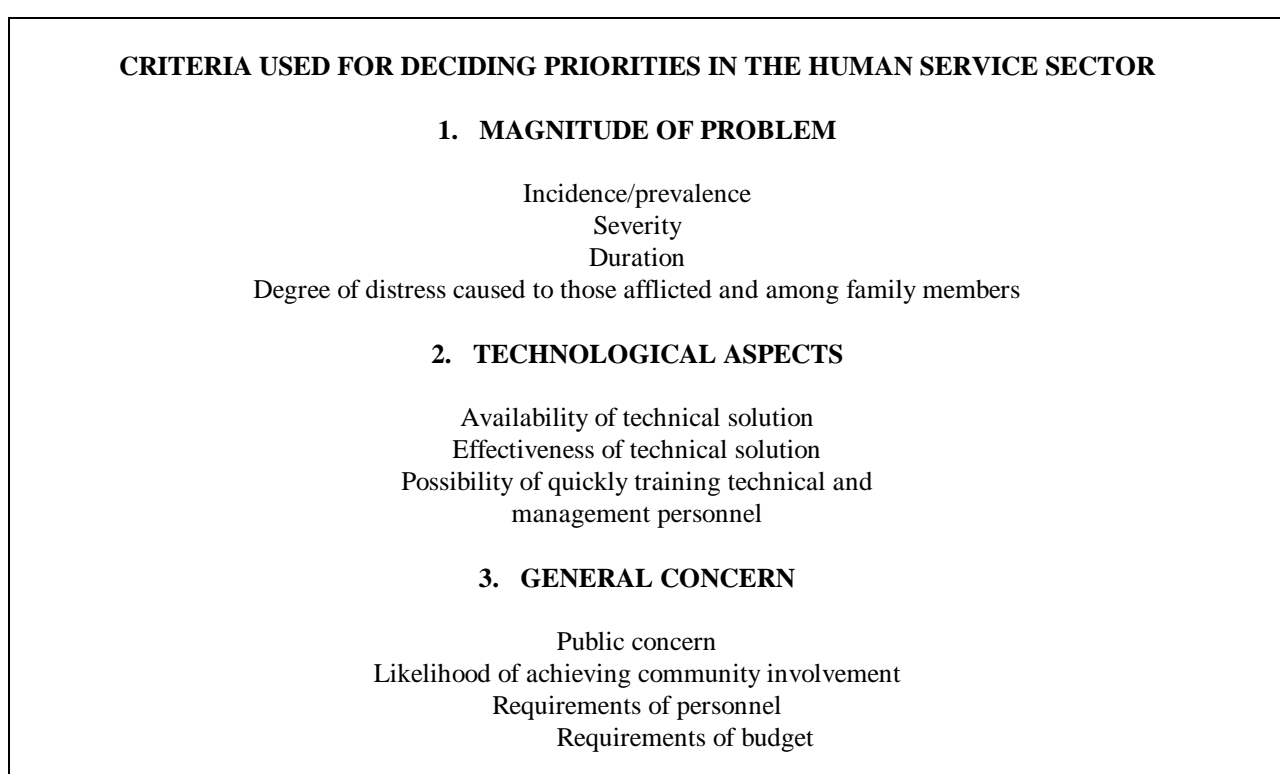
Using generally accepted criteria to set priorities in the human service sector

The governments facing a variety of choices for priority action must establish a reasonable methodology to guide their political decisions. This applies to the human service sector, where it has become accepted that what is done has not only economic and political implications but also humanitarian ones.

The following approach has been applied and accepted in many developing countries as part of the country health programming exercises.

As a first step, those who want to convince a government should gather all the information relevant to a specific problem, in this case concerning disability. The second step is to review the situation in the light of predetermined criteria. A set of such criteria⁵ is seen in Fig. 12.1. These can be used as the basis for a presentation to be submitted to a government.

FIG. 12 1. CRITERIA USED FOR DECIDING PRIORITIES IN THE HUMAN SERVICES SECTOR



I will start with the **first group of criteria** related to the **magnitude of the problem**. It should be useful to point out to the government that the incidence of disability is high and that the prevalence of moderate and severe disability in the developing countries is generally about five per cent. This is a very high proportion. Very few serious health conditions, will arrive at this prevalence. Consequently one would expect about every fourth family to have a disabled member. Most of these are dependent on help from others for self-care or economically, at an age when they should be self-supporting. For many of these people, the difficulties start at an early age and are life-long. The degree of distress in those afflicted is high. Some of them can be seen “walking” across the street on their hands and knees, yet they do a normal job. Many have complications: as deformities caused by severe contractures, pressure sores, pain or problems with communication: they do not participate in normal family or social life, and are excluded from opportunities such as education and jobs. The burden on the family is large, as they have to give daily care to their disabled members, and there are many psychological and economic consequences causing distress.

This can be illustrated by statistics resulting from a small-scale national study of the prevalence, the rates of dependency, the age at the start of the disabling condition, the degree of complications, and the time required by relatives for daily care. No government can claim that disability is a problem of no importance or to be ignored; it is large-scale, severe, long-term, causes a lot of distress, and the price for a policy of non-intervention is high.

Let us now look at the **second group of criteria**: those related to the **technological aspects**. Governments are often under the impression that services can only be provided by professionals in institutions. It should be pointed out that there exists an alternative CBR technology. Simple examples from the TCPD Manual could be shown. Family member can carry out a large number of interventions at home, with the same (or better) effectiveness than those achieved by personnel working in institutions (see Chapter Fourteen).

Regarding **technical and managerial personnel**, there are alternative ways in which it will be possible to train and supervise community workers; provide in-service training or supplementary courses. The system for providing rehabilitation at home and in the community should be described. The conclusion should be that there are certainly effective solutions, which can easily be applied, and that competent personnel can be trained in a reasonable time.

Let us now look into the **third group of criteria**. Governments are more likely to take action if it is apparent that disability is a problem of **general concern** to the public. All governments are also concerned about the requirements for personnel and want to know whether the costs for a programme are maintainable within their present frame of resources.

As about every fourth family has a disabled member, there will indeed be enough public concern. Since most people perceive disability as intractable and because there is a lot of prejudice, this public concern may not be adequately expressed. Once the facts are better known and people have become aware of the progress that is possible, this concern will grow. As it will take some time to build up services, it would be a positive move to start a programme ahead of an expected increasing public demand. Each government will have its own experience from integrated community development projects and should see the CBR programme in this light. Success is related to the quality of community leadership and the degree of community participation. It is necessary to foster local management and sustainable self-financing systems, similar to those applied to other community-initiated development projects.

The requirements for personnel salaried by the government are small. The total costs to the government are small, compared to those associated with the alternative of closed institutional and outreach programmes. It is assumed in our model that there is financing on three levels: the communities will compensate their own local worker and contribute to the costs for helping those of their members who need contributions to meet their costs for education, apprenticeships, and so on. The second level is the government, which will provide the salaries for the intermediate level supervision and maintain referral services. Donors and development agencies, which could contribute, represent the third level to the training and start-up costs and managerial capacity building.

The conclusion is that this programme should be able to attract community participation, that the requirements of personnel are small and that the programme budget can be tailored to a cost level that is maintainable by national resources. Furthermore it might be useful for a government to see this effort for disabled people as part of a human development programme and accepted as an integral component of the socio-economic development sought by all.

A government will now - using the above or similar criteria for decision-making - compare the case for a CBR programme with other projects presented to them. It is to be hoped that a detailed presentation along these lines, supported by available information and data, will be convincing and that the government will decide to become involved in the management and provision of community-based rehabilitation services.

2. POLICY-MAKING

The next item on the agenda, once a government has decided to become involved, concerns the formulation of appropriate and detailed policies. It is most common to find that ministries and governments rarely formulate any specific policy documents.⁶ Where documents exist, they are mainly for a single sector. For instance, the Ministry of Education would have a policy on special education. Only in isolated cases does there exist a multi-sectoral policy formulation that is issued by the government as the outcome of inter-ministerial consultations and decisions. This is one of the reasons why national co-ordination often is poorly developed.

Policy review

All governments have some general policies that are applicable to disabled people. Such policies are laid down in instruments such as the Constitution or the Bill of Rights of a country, or in the U.N. Declaration on Human Rights and the U.N. Standard Rules on the Equalization of Opportunities for Persons with Disabilities, among others⁷.

Besides, there may exist specific policies formulated as decrees, legislation, administrative rules and regulations, statements in a five-year country plan and so forth.

All existing policies should be reviewed and evaluated with two questions in mind:

- (1) Have these policies been fully implemented or not? If not, how can one promote their application?
- (2) Are these policies adequate or not? If not, what amendments are needed?

Promoting existing policies

Many of the existing policies concern human rights or are of a general nature and were not formulated specifically with disabled people in mind. Examples are: the rights to public services, to education and to work.

In the developing countries, systems concerned with these sectors are only partly in place. So, any deficiencies in sectors such as health services, schooling, employment opportunities and others will affect disabled people and able-bodied people alike. When it comes to using what is there, however, disabled people are often up against an added difficulty - discrimination.

Too little is being done to implement specific policies concerning disabled people. Legislation, decrees, etc. related to positive discrimination is not enforced. But these may not be required if a sufficient effort is made to enforce existing legislation and policies in favour of **all** citizens.

Formulating new policies.

If a government decides to implement a CBR programme, one of the first steps could be to formulate a detailed policy statement, outlining how the programme will be carried out. An example of such a policy that covers all aspects is presented in Box 12.1. It should be noted that the body that formulated the statement (in our example, the Congress) ensured that the document included reference to the following:

- **what** is going to be achieved
- **how** to implement a change
- **who** is going to be responsible for the change
- **when** can such a change be made, and
- a **commitment to provide the resources** needed for the change.

In this way, no false hopes were raised. Apparently, the government in our example had been briefed about the situation and given an analysis of alternative strategies, objectives, programmes and requirements of resources before this statement was issued.

Box 12.1. EXAMPLE OF A DETAILED POLICY STATEMENT

STEPS	SUMMARY OF THE TEXT
1 Who makes the policy statement (degree of authority)	The Congress has issued a statement explaining the policies adopted with respect to services for disabled people.
2 Describe the problem and why a change is needed	Five per cent of the population of our country is estimated to have a moderate or severe disability. Disabled people are not fully integrated in our society; they are socially and economically disadvantaged. The quality of life of disabled people is lower than that of the average population. Current government policies on human rights, equality, security, and dignity for disadvantaged groups have not been sufficiently applied. Rehabilitation services fail to reach 97 per cent of the disabled people who need them.
3 State the objectives (what is to be achieved)	In order to achieve full social integration of disabled people, rehabilitation services, and opportunities for education and jobs should be provided for all and changes in the environment should be made to ease the daily life of disabled people.
4 Describe the strategy (how to achieve the objective)	In order to achieve this change, a community-based rehabilitation strategy will be applied, employing effective rehabilitation methods and technology. The services will be integrated into the health educational and social service systems. A procedure for referrals and supervision will be established. Already existing institutions for disabled people will be adapted to meet specialised referral needs. Other public services now used mainly by the non-disabled will be more effectively opened up to disabled people. As rehabilitation methods relate to several sectors - education, health, labour, social services, etc. - a multi-sectoral, co-ordinated approach will be used. At the community level, an approach including local decision-making, cost-sharing and management will be employed.
5 Indicate the time perspective (when)	Implementation will begin (date) and full coverage will be reached in (date).
6 Commit the resources needed (personnel, materials, money)	All personnel needed for this new programme will be trained; basic facilities for referral services will be set up; supervision and equipment will be provided through budgetary allocations made by the government. Community resources will be mobilised to meet the local costs. The government has included an amount (...) in the next five-year-plan in order to meet its part of the costs. The necessary funding will also be provided for the subsequent planning periods.
7 Who is responsible?	The Ministry of Health and Social Welfare will co-ordinate all action taken to implement the programme. For this, a new post of Director of Services for Disabled People will be created. The Ministries of Education, Justice, and Labour will co-operate with provincial and district administrations, and with communities which have decided to adopt the programme. For this purpose there will be co-ordination committees at the national, province and district levels. Disabled people and their organisations will be asked to become active members of these committees, and a special procedure will be established in order to seek their continuous advice.
8 Monitoring	The Congress will review the results of the programme at its session in (year), based on the reports received from the Ministry of Health and Social Welfare.

3. *PREPARING A GOVERNMENT PLAN*

As stated above⁸, very few countries have formal government plans for how to deliver services, etc. to their disabled people. Existing plans are almost always made for a single ministry, as are policies. Also, they do not apply a multi-sectoral approach. Nor do they provide for sufficient national co-ordination. It is certainly desirable to have a well co-ordinated plan that outlines who is responsible for what and describes the mechanisms for consultations and co-operation.

It is the governments' role to decide if, when and how they would like to produce a plan. Of course, allowance will have to be made for the particular pattern of a country's planning process, particularly the established procedures for inter-ministerial plans.

There are many ways to prepare a formal government plan for rehabilitation. Some of these are fairly sophisticated, with their techniques targeted at high-level management courses or described in complex planning manuals. There are few opportunities for learning the specific planning of a community-based rehabilitation programme. A national plan for a developing country need not be very complex. (See Box 12.2. The Chapter numbers quoted refer to this book.)

BOX 12.2. EXAMPLE OF THE CONTENTS OF A GOVERNMENT PLAN

1 Introduction	<p>1. Background: Who took this initiative for planning? Were there any guidelines given, if so, quote? Who participated in the planning; which ministry(ies), representatives of political bodies, professions, representatives of organisations (e.g. of disabled people or their parents)? Did the planners undertake any particular studies: surveys, questionnaires, studies of development projects, study tours to other countries, seminars and so on?</p>
2 Situation Analysis	<p>2. (a) estimate the prevalence of disabled people, the causes of disability, the expected future development (See Chapter Two.) (b) review existing policies, decrees, legislation and specific measures to assist disabled people. Evaluate the impact of these policies. (c) describe existing specific services for disabled people (government, NGO, etc.): their programmes, number of disabled people admitted or served in one year, annual intake, costs, quality and long-term results (if known). Finally, estimate the proportion of needs met through existing services; (See Chapters Three and Four.) (d) estimate the extent to which disabled people are using ordinary public services: health, education, vocational training, transportation, etc., as well as the number of disabled people finding employment in the open market; (e) estimate the social and the economic situation of disabled people (economy, existing prejudice, degree of social integration); (f) assess the importance of various environmental factors that influence the quality of life of disabled people;</p>
3 Problem Definition	<p>3. A short account of the problems disabled people are facing, especially their low quality of life. Almost all of them have no access to services. They have next to no opportunities for schooling, ability training or employment. They face a number of environmental constraints. Their human rights are not well protected. They lack organisations representing their interests, as well as adequate political representation. (See Chapter Seven.)</p>
4 Strategies	<p>Discuss various options of resolving the problems listed above, such as an expansion of the present system, and the alternative of community-based rehabilitation. Analyse the potential achievements of each alternative. Then calculate the relevant inputs needed for the implementation of each in terms of personnel, equipment, budget and so forth, and discuss the constraints that are liable to delay the implementation of individual programme components. Finally, propose a strategy that has the potential to solve the problems defined above at a minimum of constraints and within a reasonable time limit.</p>

<p>5 Objectives and Targets</p>	<p>Formulate the objective: a general description of what the programme seeks to achieve. Then specify the objectives of each programme component, including services providing functional training, inclusive education, ability training and income-generation, environmental interventions, legal protection and representation. Mainstream programmes should be given priority; special services should be proposed only when necessary. As a next step, formulate the targets: specific quantitative results to be achieved within a period of 5 to 10 years. Formulate such targets separately for each programme component and revise them on completion of the entire planning document so as to make sure they are realistic. (See Chapter Eight.)</p>
<p>6 Programme Design and Description</p>	<p>Describe the activities that should be carried out concerning services and management at the various levels. Start with the family and the community: what will be their roles in the planning/implementation/evaluation processes of the programme? Who will do what (the community committee, the community worker, the teacher, etc.)? How can this become a people's programme? How will the various activities be financed at the community level? Then describe the activities at the intermediate level: which are the tasks to be done by the intermediate level supervisor, and how many of these will be needed? Will there be a mobile resource teacher? How will he/she work? How many are needed? How will disabled young people undergo preparation for income generation and ability training? How will jobs be sought for them? Discuss means of transport to reach the communities. Then review the present network of referral services in the various sectors, and outline how these can be used in an integrated system. Finally, outline the government's role in management, development of personnel, financing and evaluation. (See Chapters Nine, Ten, Eleven.)</p>
<p>7 Personnel</p>	<p>Describe how the training of local facilitators will be carried out: by whom, duration, where, learning material, costs. Then discuss the various options for choosing an existing group of intermediate level supervisors or - if need be - how to train a new profession for this purpose. Decide on the best alternative. Define the educational objectives of the training, outline the detailed contents of the various courses, and propose a timetable for the courses, including for those related to maintenance and upgrading of knowledge and skills. Describe all inputs needed: teachers of all the personnel; how are they going to be trained; school facilities, pedagogic material, equipment, transport, teachers' and students' accommodation, etc. (See Chapter Ten.)</p>
<p>8 Time Plan</p>	<p>Make a time plan, listing all action to be taken, dates for start and for completion, and who is responsible. The time plan for the short-term period (1-2 years) needs to be detailed; for the following years an outline is normally sufficient.</p>

It is useful to set up an Advisory Committee to assist in the formulation of the plan and in reaching a consensus among those representing disabled people and their families, professionals, administrators and representatives of communities.

All plans should be flexible and should be revised from time to time in the light of the realities. A checklist for how to scale-up a small project to a national programme is shown in Box. 12.3.

BOX12.3. SCALING UP SMALL PROJECTS INTO LARGER PROGRAMMES

It is common to see that NGOs or Governments have set up some small CBR projects in order to familiarise themselves with the concept and to find out both the benefits and the constraints.

Such projects could either be multi-sectoral or concern only one group of disabled people such as children with learning difficulties.

Sometimes there are several such projects; these might be different in concept and execution. The Government would seek a unified approach.

Below some guidance about the process to scale up smaller projects to create a national multi-sectoral, multi-level CBR programme, which will eventually cover all the population. This could be done in the frame of a national policy and plan for rehabilitation. Before the scaling up process starts make an evaluation system that will allow monitoring of its progress. For this purpose it should be useful to make flow-charts of all events, time plans and indicate the responsible person for each of the events.

CHECKLIST OF EVENTS

1. Evaluate preferably through an outside expert the ongoing projects¹⁵. Such evaluation may take one year, including the assessment of outcomes, degree and nature of community participation and costs.
2. Design on this basis a sustainable, future programme¹⁶.
3. Survey the interest of the community participation in a nation-wide programme.
4. Estimate the financial contributions that are needed for the long-term implementation of a CBR programme. These costs must be approved for at least a medium-term period.
5. Make a plan for the training of the teachers of ILSs. Recruit and train them.
6. Decide on a strategy for the recruitment of ILSs. What educational background is needed, how can one make sure that they are interested in working as mobile resource persons in rural communities or urban marginal settings? Should they be recruited locally, so they will be familiar with the local language, culture and social conditions? Which gender?
7. Analyse transport conditions. What transport will the ILS and LFs use, and at what cost?
8. Prepare all learning materials for the courses for ILS and for LFs.
9. A decision is now needed on the number of ILS to train each year. It may be preferable to set up a permanent training center, with regular annual intake of trainees. This will be more effective and efficient and less costly on the long run. Calculate the requirements for this training center and make a cost analysis.
10. Prepare the facilities and equipment for a training center for the ILS.
11. Recruit trainees for the ILS course and start the course.
12. When the ILS course is finished organise the training of the LFs through the ILS.
13. Service delivery can start as soon as the communities decide to get involved. It will be extended annually until full population coverage is reached. Never implement quicker than the resources allow.
14. Prepare a plan for how to arrange referral services for disabled persons, in order to provide inputs that can not be made at the community level. Negotiate with the appropriate authorities how these referrals can be organised and eventually scaled up to meet the needs. Please note that referrals should be made using mainstream public services, not by the setting up of (and perhaps even building) segregated specialised units. For many services, mobile consultants can be used.
15. Review the arrangements for schooling of disabled children. Plan for inputs into the training at teacher's colleges, and for the supplementary training of existing teachers, so they can take care of disabled children in regular classes.
16. Undertake the training for multi-disability resource teachers (MRT). These will prepare the disabled children for entrance in regular schools and then support the teachers. Plan for how MRTs will be working with the teachers, the parents and children.
17. Include the training of MRTs in the teacher's colleges.
18. Employ the MRTs and extend their services until full coverage.
19. Prepare for an educational referral system.
20. Review all mainstream human and economic development programmes and make plans for how to include disabled persons into these.
21. Create local systems for the protection and promotion of rights, including the empowerment process.
22. Review arrangements for the creation of awareness and conveying information to the general public. Consider a distance education programme.

4. ISSUING GOVERNMENT GUIDELINES

Such guidelines should be issued formally by the government and will be built on the details of the national plan. They should concern:

- International NGOs: advising them of the government strategies, policies and plans, and requesting them to work along those lines. Or, if such organisations are already present, help them to reorient their services accordingly, so they can become Self-reliance Promoting Organisations (SPOs).

Their co-operation is welcome and could help to advance the activities planned by the government, or the NGOs could supplement the latter with inputs that may serve to broaden the skills and knowledge of national staff, such as fellowships abroad, training courses, research grants, etc.

- National NGOs: since these have been involved in the policy-making and planning efforts, the government plans should be known to them. They should receive guidance on how to advance the activities in the government's plan.

- Other donors, such as bilateral or multilateral development agencies: these organisations will deal directly with the authorities and will therefore have advance knowledge of the government's policies and plans in the field of rehabilitation.

5. COSTING OF A CBR SYSTEM

CBR is not a low-cost system *per se*

There are many misunderstandings about CBR and some relate to its costs. The alternative of CBR has **not** been proposed to provide a "low-cost solution using second-rate technology" for poor countries which cannot afford "real rehabilitation".

CBR is an alternative for giving quality rehabilitation. It is built on modern principles no different from those existing in the industrialised countries. It aims at achieving the goal of full social integration and self-realisation.

Keeping disabled people in institutions cannot bring about social integration. The community needs to be mobilised, to rid itself of the ever-present prejudice, to break the patterns of injustice and to open itself up to full acceptance of its disabled members. Co-operation with the families gives the best results, both in the industrialised and in the developing countries.

To give families a chance of becoming partners in rehabilitation they have to acquire knowledge of disabilities. They must also learn skills to apply a technology built on their experience and adapted to their background. This means - just as it does in the industrialised countries, where families also are involved - that the technology has to be simplified and demystified. This does not in any way make it less effective or a second-rate technology.

CBR is proposed as an alternative to a mostly ineffective and costly system that has contributed to segregation, to a concentration on the few instead of trying to do something for all. The conventional system has tried in vain to operate on a single service level. It remains inaccessible for most people, requiring resources out of proportion to its results. Usually it operates in isolation from the surrounding community.

CBR is not necessarily low-cost, as will be demonstrated below. Its cost level can be tailored

to any level desired - but the end product should always be a system that is economically sustainable while relying on government and community resources, without outside funding.

Cost alternatives for the functioning of the programme

Below are some examples of cost calculations for a CBR programme. A general example appears in Box 12.4. and a local example from Bangalore, India in Box 2.5. These will facilitate the understanding of the problems related to budgeting and give an idea of national and local costs alike. The numbers given are indicative and build on the experience of field studies⁹.

Before entering into details, we will assume, in these examples, that in country X there will be one LF per each village (or groups of villages) or city block, and that the average population is about 5,000. Among them we expect to find 250 people (five per cent) moderately or severely disabled. For some of these there will be a need to provide rehabilitation. The indicative number is about 1.5 per cent (See Chapter 3). Disabled people of all ages will be included in functional training, children in inclusive educational and adults in income-generation. Most young disabled people need to receive consecutively all three types of service. At the time a CBR programme is started, there are large accumulated needs, these will gradually decrease as needs are being met. Permanent services will eventually be established when the accumulated needs have been met.

We assume that the LF will start providing services gradually, and will work full time. The alternative is to have a part time LF. Then the training costs are higher.

At the district level, which in these examples is assumed to have a population of 100,000, there will be one or several ILSs (Intermediate-Level Supervisors) and MRTs (Mobile Resource Teachers). These will have no other duties than those directly related to the fieldwork.

Some disabled people will be referred for services that cannot be provided by the community personnel. Some referrals will be to the general health care system for diagnose and treatment. I have chosen to exclude the costs for this in our calculations. The health care system is set up for all, and its costs are borne elsewhere in the system of public services. Similarly, the costs for general education, vocational training, etc. are not included in the budget presented here. In each community, some funds are needed for support, especially for disabled members of poor families and, these should apply to disabled members also.

I have excluded the costs related to the work carried out by the family trainer. This is a difficult and controversial subject. First of all it should be an act of solidarity. Also, many family members are under-employed - how do we estimate the cost of their free time? On the other hand, families who train their disabled members to a higher degree of independence will in the long run perhaps gain more time than they used to spend on training them, thus reducing future costs.

Below are given some examples of costs; these are all estimates for a district of 100,000 people, assuming that permanently there will be about 1,500 disabled people in the CBR programme. (Chapter 3). Costs for transportation of the district-level personnel (ILS and MRT) are included in the support costs. Support costs at the community level include, for instance, assistance to produce walking devices and other aids, subventions for appliances produced in orthopaedic workshops, school uniforms, books, assistance for apprentices and trainees, seminars/workshops for leading members of organisations of disabled people, funds to provide legal protection, and travel costs. The per capita cost and the cost per disabled person have been calculated. (see Chapter 15 for explanations, why this should be part on the managerial monitoring process). The cost levels below may be typical of certain countries, but not of others. For each country the appropriate numbers have to be introduced.

There may also be external contributions from donor and development agencies. Then the salaries and other expenditure for expatriates, administration etc. should be calculated separately. These costs are

normally not part of the “regular delivery system”, but the financing of the functions carried out may have to be included in the future budget.

Once included in a CBR programme, disabled people may remain under observation for several years. The most intensive training will be done in the beginning, but later on the skills and abilities acquired will need to be maintained, and after functional training other components, such as schooling, assessment, ability training, and a job may follow. Human rights and empowerment processes will be in focus all the time for all persons with disabilities. Newly disabled people will also be identified by regular re-surveys.

National NGOs. There are several types of such organisations. Most NGOs provide services for a single - sector project, mainly in urban areas. NGOs can play an important role in referral system, in training of personnel and/or as mobile consultants. Another type of NGOs is the community rehabilitation committee. The CBR programme is a programme by the people. It is important that all people especially disabled people and their families get involved. Their involvement is not only as service-providers, but also for the management of the programme. This includes planning, decision making, implementation and evaluation. Their guidance should be sought at all levels. A fully democratic system should be established to ensure their true participation.

BOX 12.4. EXAMPLES OF COST CALCULATIONS

(1) Service delivery

In this example the service delivery system personnel consists (see Chapter 10) of LFs at the community level and ILSs at the intermediate level. Using realistic examples (which have been checked in about 30 countries), - including making of local maps - it is estimated that - with “normal” terrain and road system, and a population density of about 30 per sq. km - one full-time LF can undertake the necessary CBR tasks in a population of 5,000. The LFs in this example will have no other duties, and will be assisted by and under the management of the Community Rehabilitation Committee. The committee will be especially engaged in tasks related to ability training (social and technical components) and identification of income generating activities. For functional training, care and security issues, there will be self-help groups. The teachers of the regular school will be in charge of all education for disabled children; MRTs will give preparation before and assistance during the phase of inclusive education.

The LF will need the TCPD manual (preferably translated to the local language and with adapted drawings), some equipment (such as tools for making walking aids, small repairs, etc.) and a bicycle for transportation (in more densely populated areas, e.g. urban marginal settings, walking by foot is feasible).

At the intermediate level an ILS will be in charge of the technical supervision of the LFs, the in-service training, contacts with referral facilities, authorities, reporting system, monitoring outcomes etc.) In the circumstances mentioned above, one ILS can supervise about 20 LFs. For this reason it is in this example calculated to employ one ILS for a population of 100,000.

In the example below, salaries for the LFs are calculated to be about 50% of the local service delivery costs, an equal amount has been set aside to cover the costs for transport, manuals, tools etc. For the intermediate level, the salary represents 35 % of the costs, and the remaining 65 % are for other costs.

Annual costs for CBR service delivery in a population of 100,000	US \$
20 LFs, salary US \$ 400 x 20	8,000
Other costs (transport, manuals and other written material, equipment) US \$ 400 x 20	8,000
1 ILS, salary US\$ 700	700
Other costs US \$ 1,300	1,300
TOTAL	18,000
Cost per capita of population	0.18

Cost per disabled person	12
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(2) Costs for inclusive education

In an area with a population of 100,000, there will in a developing country be about 20,000 children of primary school age. Out of these, about 2 % or some 400 will have a disability. This implies that each year we might expect 50 to 70 such children to enter the primary school. Half of them may have a moving disability (with no other difficulties) and they will require some physical assistance (e.g. with transportation to the school) and adaptation in the school (such as of the toilet/latrine). To better accommodate them, the local teacher could benefit from an orientation seminar, but a MRT will not be needed. For the other 25 to 35 new disabled children each year it is recommended to have 3 full-time MRTs. They will prepare the new children for inclusive education, and assist those, who are already in school. The MRTs will need transportation by motorcycle, some equipment, the salary levels and other costs are calculated in the example as for ILSs.

Annual costs for inclusive education in a population of 100,000	US \$
3 MRTs, salary US\$ 700 x 3	2,100
Other costs US\$ 1,300 x 3	3,900
Total	6,000
Costs per capita	0,06
Cost per disabled child (400 beneficiaries)	15

(3) Training of ILSs

The costs for training of the ILSs depends on the length of training, and on local costs, if students receive a stipend etc. It will be most practical to locate an ILS training centre in a small town, close to a rural area with access to a nearby CBR programme (see also Ch. 11 regarding the scaling up of small projects to national programmes). Alternatively a “rehabilitation village” can be built. Such a village will have some of houses built in the traditional style. Persons with disabilities are invited to stay, while the students carry out the preparatory part of their training at the training centre. About one third of the period for an ILS should be spent in direct contact with a CBR field programme so the students understand the role of the community leadership, the CBR committee, the school, income-generation, access to community development programmes, interventions in the environment, empowerment of disabled persons, human rights problem etc.

Below follows a budget example of an 18-month course developed for the State of Karnataka in India. The costs have been translated to US \$, using a rate of 1 US\$ to 40 Indian Rs. In the Indian budget system costs are increased each year by 5 to 10 % to take care of automatic salary increases and inflation.

Students are admitted once a year, the first and second year below there are 30 students admitted, during the third year 60. Note that both capital and current expenditure are included.

Example of annual cost calculations in US \$ for an ILS course in Bangalore, India

A. Personnel

Budget Heads	Basis	Year 1	Year 2	Year 3
1 Course Director	2,250 + 5% a.i.	2,250	2,360	2,481
3 Master Trainers	1,875 + 5% a.i.	5,625	5,906	6,202
Resource persons for teaching	Cat. 1: 10 p.d. Cat 2 : 30 p.d.	2,500	5,000	5,000
1 Hostel warden	1,200 + 10% a.i.	1,200	1,320	1,452
1 Assistant Hostel warden	600 + 10% a.i.	-	600	660
1 Manager	900 + 10% a.i.	900	990	1,089
1 Secretary	600 + 10% a.i.	600	660	726

1 Driver	600 + 10% a.i.	600	660	726
1 Cook	540 + 10% a.i.	540	594	653
2 Kitchen helpers	360 + 10% a.i.	600	660	726
2 Watchmen	360 + 10% a.i.	720	792	871
2 Office boys	450 + 10% a.i.	900	990	1,089
Subtotal		16,435	20,535	21,675

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B. Stipends, Canteen Expenses, Infrastructure and Equipment

Stipends	25p.m + 10% a.i	9,000	14,850	21,780
Canteen expenses		10,125	16,875	24,750
Rent of Buildings		7,500	-	-
Construction of Hostel buildings		25,000	37,500	-
Furnit: class rooms		2,500	2,500	-
Training aids and equipment				
Hostel furniture				
Bus, purchase		-	5,000	-
Bus. Maintenance		12,500	-	-
cost/diesel/ insurance etc.	2,750 p.a + 10% a.i	-	2,750	3,025
Subtotal		66,625	79,475	49,555

C. Training materials and library

Training materials development		5,000	5,000	5,000
Library furniture		2,500	2,500	1,513
Books and journals	1,250 p.a + 10% a.i	1,250	1,375	
Subtotal		8,750	8,875	6,513

D. Utilities, stationary, and miscellaneous

Utilities Telephone Fax, Email, Water, Electricity, etc.	1,800 p.a +10% a.i	1,800	1,980	2,178
Stationary, post5age etc.	2,500 p.a + 10% a.i	2,500	2,750	3,025
Miscellaneous		2,500	2,500	2,500
Subtotal		6,800	7,230	7,703

TOTAL COSTS

Year	1	Year 2	Year 3
	103,650	118,615	85,445

The budgets for the first two years include some capital costs. During the third year, where there are no capital costs, the total for training of 60 students are annually US\$ 85,445, equivalent to US\$ 1,424 per student per year. The cost for training one ILS for a period of 18 months is about US \$ 2,100.

It will be seen from the tables above that the highest costs during the third year is for stipends and canteen, which represent 54 % of the total. Teaching staff on the other hand only costs 16% of the total. I might be useful to increase this staff; the added cost is small and will have a positive effect on the quality.

(4) Costs for the training of MRTs

If one assumes that the MRTs are already trained as schoolteachers, the subsequent training period to become a MRT could be about one year.

The costs for this training are likely to be similar to the annual costs for training an ILS or in example, or about US\$ 1,400.

(5) Costs for the training of LFs

Realistic budget calculations of alternative approaches to this type of training have been made for some 30 countries. These all show that the most cost-effective approach is to training 3-5 LFs in the area, where they live and are going to work. The ILS undertakes the training. Other alternatives, such as using a training centre, or individual training are more costly; using a training centre is the most costly and likely to produce lower quality.

Budget calculations have to be made locally, and should for a 10-week course include, as an example

	US\$
Salary for ILS trainer, 10 weeks	170
Per diem (US\$ 5 x 50 days) and travel, the ILS/trainer	280
Lunches for the trainees (4 x US\$ 1 x 50 days)	200
Total	650

To this should be added miscellaneous costs: manuals and other written instruction materials, report and assessment forms, equipment etc. These costs are included in the service delivery costs above. In the above example the cost for training one LF is US \$ 163.

(6) Costs for referrals

As stated above, costs for referrals to public services, open to all citizens, are not part of the CBR budget. For instance: health care (including primary health care, immunisations, nutrition and women and child programmes, treatment of infectious or non-communicable diseases, surgery for cataract, contractures and so on), schooling in regular schools, literacy, participation in development programmes, such as ability/vocational training, jobs and other income-generation, security and law enforcement etc.

Some specific services for disabled people are needed, and their budget should be included. Examples of these are: appliances and aids from orthopaedic workshops, tricycles and wheelchairs, provision of eyeglasses for severe sight impairment, hearing aids etc.

It should be noted that 80% to 90% of the production of appliances in orthopaedic workshops in some countries are now aimed at victims of polio. As polio is soon to be eradicated, a cautious approach to the building up of such workshops is recommended.

Wheelchairs and tricycles of very good quality are now manufactured at a cost of US\$ 50 to 100 in some countries. Smaller countries should preferably import these items, rather than setting up their own manufacture. Eyeglasses now cost less than US \$ 5 and hearing aids can be made for some US\$ 25 to 50.

In each country, specific calculations have to be made to find out the costs for the referrals mentioned.

SUMMARY

The above examples are chosen to illustrate how costs calculations can be made. The examples have to be recalculated to each country, and then the total costs estimated. The total costs for training and service delivery can be divided up in increments, over a longer period of implementation, such as 10 to 15 years.

Each country should undertake a cost estimation of several alternatives to service delivery, e.g. with those provided in institutions. An example of cost calculations from Argentina is shown in Box 12.5¹⁰. It is clear from the examples that it may "pay" to provide more competence and more funds at the peripheral level of the system.

Box 12.5. EXAMPLE OF COST ESTIMATE FROM LA RIOJA, ARGENTINA

The report from La Rioja, Argentina contains some interesting comparisons of very different approaches to providing rehabilitation and of the relevant costs. As far as the CBR alternative is concerned, the estimate includes salaries, transport of personnel, office and telephone costs expenses for secretarial assistance, equipment and printed material.

COSTS/MONTH/DISABLED PERSON	US\$
<i>Community (CBR) programme</i>	2.53
<i>Comparison costs</i>	
Institutional programme	
Ambulatory care	50.00
Hospital care (government hospital)	810.00
Hospital care (social security hospital)	3,690.00

Then the country can choose a level of service provision and of costs that is maintainable using national resources. While planning for the expansion, it might be useful to consider the Checklist for how to expand small-scale project into national programmes, see in Box 12.3.

Each country should undertake a cost estimation of several alternatives to service delivery, e.g. with those provided in institutions. An example of cost calculations from Argentina is shown in Box 12.4¹⁰. It is clear from the examples that it may "pay" to provide more competence and more funds at the peripheral level of the system.

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Total cost estimates and financing

The total costs may sometimes be shared as follows:

- ***by the Government***

The Government will decide on the frame of resources to be finally allocated to the CBR programme. Financing can be phased in over a period of 10 to 15 years. This should facilitate the financing from government funds, as well as allowing for some evaluation and adaptation during that same period.

- ***by the community***

In the examples above, the per capita cost for the community is low. It may be phased in over a period of several years. As indicated above, communities are unlikely to commit themselves to a CBR programme unless their own funds are spent locally under the control of their own people. (see Chapter 15).

- ***by external donors and development agencies***

Basically external donors and development -agencies may contribute in two different ways:

(a) by assistance to the developmental costs and capacity-building

This could include training of technical and managerial personnel during an initial period, pedagogic material and equipment, by providing transportation, equipment and facilities during the early period of the programme, by fellowships, seminars, giving assistance to evaluation and research, etc. Direct funding of the service delivery costs, such as field personnel should not be included, as this will impede the sustainability of the programme. One approach that is to be avoided is to pay extra salaries to Government employees on top of what the Government provides. This will always eventually fail.

(b) by assistance to referral services.

International NGOs are already involved in a number of institutions which could form part of a referral

system. It is preferable to have long-term commitments, possibly for 10-20 years, so the government can avoid costly surprises.

It is appropriate to add a few words of criticism of the way technical co-operation financed by external contributions has been carried out in the past.¹¹ The present system as a whole is under fire, for several reasons. These are related to poor co-ordination¹² and "hasty and poor design of technical assistance projects"¹³.

Other problems concern insufficient quality of expatriate technical personnel, who are not equipped for the task, and "[who are] mixing policy, institution-building, and technical and operating responsibilities ... [are showing] lack of knowledge ... and insensitivity to local cultures."¹⁴ Their efforts seldom lead to sufficient build-up of indigenous capacity, or to the intended self-reliance of the national institutions.

It will be necessary to seriously review the purpose and real sustainability of external support to programmes for disabled people provided by external organisations, such as the UN system, bilateral agencies and NGOs (see Chapter 15).

Redistribution of costs in countries with transitional economies

In some countries, the process of industrialisation has started and the economy may grow rapidly, say between six and ten per cent annually. In such countries, the government revenues increase quickly, and there may then be more funds available to pay for programmes concerning disabled people. It is then common to see that the government starts paying costs previously met through community resources. For instance, the government may start to pay the salaries for local facilitators, take over all the support costs at the community level and so forth.

This assistance from a central Government poses the risk of community involvement being curtailed. The CBR Committees may consider themselves unnecessary and resign themselves to the government delivering all the services. The result will be the top-down programme that is contrary to the CBR strategy. Whenever the government has more funds available for the provision of services for disabled people, it should not seek to take over the management of the programme or the many initiatives and responsibilities, which derive from the community. It is important to promote and maintain the local initiatives and involvement. The community spirit must survive because no government will ever have the resources needed to maintain a system of cradle-to-grave care for their disabled citizens.

Instead of starting to take over existing and locally funded services, **the government may seek to become a Self-reliance Promoting Organisation** and to develop a partnership with its communities. This might mean that the government could subsidise certain costs and might, for example, make a contract with a community rehabilitation committee about the maintenance of services. In this way the local management will be kept in place and will continue to play an important role; contrary to what has happened in Western countries, the community spirit will not be lost.

The calculations made above are meant to give a rough idea of the costs of a CBR programme. There are many cost alternatives. Each country should seek to tailor its programme to its needs and resources.

CONCLUSION

The trend in recent international policies is that governments should get involved in programmes for their disabled citizens. The involvement has to be built on long-term political commitment, adequate planning and resources; a CBR programme can be designed to fit each situation.

COMMENTS AND REFERENCES

¹Built on not more than anecdotal evidence, this statement was yet quoted in the United States Congress and in a large number of publications.

²For a review of the literature, see Health Care Cost-Benefit and Cost-Effectiveness Analysis. Medical Care, Vol. 31, 7, 1993E. Klarman: The Road to Cost-Effectiveness analysis, Health and Society, 60.4, 1982.

³For a review see e.g. B. Jonsson: Cost-Benefit analysis in public health and medical care. Economic studies No. 112, University of Lund, Sweden, 1976.

⁴E. Helander: "Enquete economic a propos de la readaptation", In Readaptation, No. 264, C.I.P.E.S., Paris, France, 1979. S. Eastaugh: Cost-Effectiveness and Cost-Benefit Analysis in Health Economics Efficiency, Quality and Equity, Westport (USA), Auburn House, 1992. A. Williams: Cost-Effectiveness analysis: is it Technical. J. Med. Ethics, 18, 7, 1992

⁵This set of criteria has been provided by Dr. S. Moday, WHO. It has been slightly abridged. These criteria have been formulated on the basis of discussions with the authorities in over 40 developing countries and have then widely used in workshops related to national health programming.

⁶See Chapter 4 and 16

⁷See Annex I

⁸See Chapter 4. A detailed review is available in E. Helander: "National Planning of Rehabilitation", Geneva, 1996.

⁹E. Helander, *ibid*, 1998.

¹⁰A. Guzman Loza et al., *ibid*.

¹¹E. J. Berg: Rethinking Technical Cooperation, UNDP, New York, USA, 1993.

¹²UNDP and World Bank, "Somalia: Report of a Joint Technical Cooperation Assessment Mission." New York and Washington, USA, 1995.

¹³B. Buuyck: "The Bank's Use of Technical Assistance for Institutional Development." Working Paper Series No. 578, The World Bank, Washington, USA, 1991.

¹⁴Technical Cooperation in African Development. An assessment of its Effectiveness in Support of the UN Programme of Action for African Economic Recovery and Development 1986-90, UNPAAERD, UNDP, 1989.

¹⁵E. Helander: A Guide on the Analysis of Costs, Effectiveness and Efficiency of Rehabilitation Programmes UNDP, Geneva and T Jonsson: OMAR, Operations Monitoring and Assessment of Results in Rehabilitation. UNDP, Geneva

¹⁶See E. Helander: Guide on National Planning of Rehabilitation, 1996, UNDP, Geneva