Gains and losses of structured information collection in the evaluation of 'rehabilitation in the community' programmes: Ten lessons learnt during actual evaluations

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REHABILITATION IN PRACTICE

Gains and losses of structured information collection in the evaluation of ‘rehabilitation in the community’ programmes: Ten lessons learnt during actual evaluations

JOHAN P. VELEMA¹, HARRY J. M. FINKENFLÜGEL² & HUIB CORNIELJE³


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Abstract

Purpose. Previously we have explored definitions of community-based rehabilitation (CBR) and proposed a way of classifying rehabilitation programmes by describing their essential characteristics. As the next step, we proposed two flow charts that guide the evaluator through a characterization of the programme and then indicate the information that should be collected. The present paper describes the application of this methodology in five actual evaluations of programmes aiming at socio-economic rehabilitation of persons affected by leprosy.

Method. We compared the information as required by the flow charts to the information presented in the evaluation reports and asked: “Does this methodology adequately describe and reveal all relevant aspects of the rehabilitation programme?”

Results. Use of the flow charts led to discussion between evaluators and programme staff about how each would characterize the programme; this was a valuable step in the evaluation process and provided insight to the staff into their current practices and aspirations. The rehabilitation services as such were always well-described in the evaluation reports. More attention could have been given to the programme environment and provider-client relationships. More or more explicit attention than required by the flow charts could be given to linkages with other rehabilitation programmes and community organizations; questions of organizational capacity; systems to maintain and increase the quality of services; and conditions and constraints imposed by donor organizations. In order to show their effectiveness, rehabilitation programmes need to develop simple information systems which show progress of clients towards the rehabilitation goals defined for them, with them or by them. Impact can be demonstrated by an assessment one year after ending the intervention. This should include assessments of clients’ psychological and social status.

Conclusions. The original theoretical framework has proven its value in evaluation practice. The flow charts accommodate a variety of programmes and address the specific aims, contexts and developmental stages of the programmes evaluated. Taking the lessons learnt here into account will further improve the usefulness and practical relevance of the methodology we proposed.

Keywords: Leprosy, rehabilitation, programme evaluation, socioeconomic factors, India, Nigeria, Bangladesh

Introduction

The involvement of people with disabilities, community members and working with local resources and through local organizations are key elements of community-based rehabilitation (CBR) and other ‘rehabilitation in the community’ programmes. Whilst these programmes share a common ideology of providing support to people with disabilities, the programmes differ to a great extent. Not only do living standards of people with disabilities differ greatly but also the objectives of the programmes [1]. Where some programmes focus on providing treatment to people with disabilities, others focus on socio-economic rehabilitation or aim to involve people with disabilities in advocacy movements. Classification models have been developed, e.g., [1,2], covering the different types of rehabilitation programmes and to make an assessment and comparison of these programmes possible. Finkenflügel, Cornielje & Velemma [3] reviewed these classification models and concluded that these
models have so far very rarely been used in evaluation or research.

Based on these theoretical considerations, Velema & Cornielje have proposed a methodology for the evaluation of ‘rehabilitation in the community’ programmes [4]. They presented two flow charts (Figures 1 & 2) and sets of questions to guide the evaluators through an assessment of the programme.

Flow-chart A is used to assess the relation of the programme with the environment and flow-chart B to assess the rehabilitation process and the services offered. Eighteen different sets of ‘key questions’ were compiled with suggestions for corresponding ‘indicators’ and ‘sources of information’ to be used as appropriate to the programme under consideration. The instrument developed by Velema & Cornielje [4] accommodates a variety of programmes within one theoretical framework and provides a structured approach to evaluation, permitting the definition and use of agreed sets of indicators.

The present paper describes the application of this methodology in five actual evaluations. The potential of the instrument was explored by comparing the required information as shown in the flowcharts with the information presented in evaluation reports of ‘rehabilitation in the community’ programmes. The research question posed here was: does the instrument adequately describe and reveal all relevant aspects of ‘rehabilitation in the community’ programmes? We then present the lessons that have emerged from the experience.

Methods

The methods – as they were developing – were tested in the practice of actual evaluations. Five evaluations [5–9] (Table I) were carried out between 2000 and 2002 by the authors or by evaluators who were aware of their ideas. All evaluations concerned programmes for socio-economic rehabilitation of people affected by leprosy implemented by The Leprosy Mission. One was a vocational training centre [5] which enrolled a mix of students, some directly or indirectly affected by leprosy, some disabled through other causes and some who were marginalized but not disabled. One was a scholarship programme [9] for children personally affected by leprosy or indirectly through their parents. The three remaining programmes provided support financially or in kind to leprosy affected persons who were thus stimulated to generate income and improve their socio-economic position. The five reports evaluated projects in different localities within the same national programme (LMI, LMN, CTY).

The authors independently screened the reports for information on the issues presented in the boxes in the flow charts. Additional notes were taken on the extent to which the flow charts addressed the relevant issues in the reports and on information covered in the reports that did not correspond to any box in the flow charts. Subsequently the initial discrepancies between authors in coding the reports were discussed and consensus reached.

Results

First, flow-chart A was used to assess to what extent evaluations had adequately described the programme environment and the relationships between the programme and the environment. The first box of flow-chart A focuses on the occurrence of disability, the resources available to persons with disability, the socio-economic participation of people with
disabilities and the engagement of the community with community members who face limitations in physical, sensory or cognitive functioning (cf. Table 1 in reference [4]). These four aspects of the programme environment were not all covered to the same extent in the five evaluation reports (Table II). In two reports this information was covered in some detail but in the other three reports the information was incomplete or absent. Looking at ‘descriptive epidemiology’ it can be noted that in all evaluation reports some information was given on the number of people involved in the programme but little information was collected on the overall prevalence of people with disabilities in the

Figure 2. Flow chart B: Assessment of the rehabilitation process and services offered.
programme environment. In one report (LMI), coverage was estimated by comparing the number of clients in the socio-economic programme to the number of leprosy-affected persons registered in the disease control programme covering the same geographical area.

Most evaluation reports paid attention to ‘resource mobilization’, i.e., the number and type of rehabilitation programmes and the staff available but little information was given on Disabled People’s Organisations (DPOs) and also factual information on rehabilitation budgets in the project area was missing.

Subsequently, information on the relationship between the programme and the environment was extracted from the reports. Flow-chart A focused specifically on assessing advocacy, referral to and from other services, and the level of community support for the programme. Also, the flow chart aimed to explore if the programme staff was open for new ideas and advice. The results of this exercise are presented in Table III.

Screening of the evaluation reports showed that ‘Community support’ was covered in all reports but ‘Advocacy’ and ‘Referral’ were only described in a few projects. This probably reflected the true nature of most of the projects: mainly operating within a medical paradigm and slowly moving in the direction of a social paradigm of viewing disability. Only two evaluation reports had addressed the ways in which staff kept up to date with current developments.

We then considered how the reports described the rehabilitation services of the programmes evaluated (flow-chart B). The different elements of these services i.e., the type of services offered, the quality of these services and their utilisation (cf. Table 3 in reference [4]) were well recognized in all evaluation reports (Table IV).

Next, continuing through flow-chart B, it was considered whether evaluation reports paid attention to the relationship between service provider and client and what role the client played in the choices that were made concerning his/her rehabilitation. As can be seen in Table V, four reports paid some attention to this question. Questions concerned

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**Table I. Evaluation reports used in the study.**

<table>
<thead>
<tr>
<th>Evaluators</th>
<th>Title</th>
<th>Evaluation report</th>
<th>Country</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Velema et al. [6]</td>
<td>Nashik</td>
<td>Evaluation of the Nashik Vocational Training Centre in India</td>
<td>India</td>
<td>2000</td>
</tr>
<tr>
<td>Mahato et al. [10]</td>
<td>CTY</td>
<td>Evaluation of the Catch Them Young (CTY) Programme, TLM India</td>
<td>India</td>
<td>2002</td>
</tr>
</tbody>
</table>

**Table II. Assessing the programme environment (flow-chart A).**

<table>
<thead>
<tr>
<th>Issues</th>
<th>Nashik</th>
<th>DBLM</th>
<th>LMI</th>
<th>LMN</th>
<th>CTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descriptive epidemiology</td>
<td>+/−</td>
<td>+</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Resource mobilization</td>
<td>+</td>
<td>+/−</td>
<td>+/−</td>
<td>+</td>
<td>−</td>
</tr>
<tr>
<td>Socio-economic</td>
<td>+</td>
<td>+/−</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>participation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eco-social variables</td>
<td>+/−</td>
<td>+/−</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
</tbody>
</table>

+, extensively covered in the evaluation report. +/−, some information given in the evaluation report. −, not covered in the evaluation report.

**Table III. Relation programme and programme environment (flow-chart A).**

<table>
<thead>
<tr>
<th>Evaluation reports</th>
<th>Nashik</th>
<th>DBLM</th>
<th>LMI</th>
<th>LMN</th>
<th>CTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy</td>
<td>−</td>
<td>+</td>
<td>+/−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Referral</td>
<td>+/−</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Community support</td>
<td>+</td>
<td>+</td>
<td>+/−</td>
<td>+/−</td>
<td>+</td>
</tr>
<tr>
<td>Influx of new ideas</td>
<td>+/−</td>
<td>+</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
</tbody>
</table>

+, the issue is extensively covered in the evaluation report; +/−, some information given in the evaluation report; −, not covered in the evaluation report.

**Table IV. Assessing the services offered (flow-chart B).**

<table>
<thead>
<tr>
<th>Evaluation report</th>
<th>Nashik</th>
<th>DBLM</th>
<th>LMI</th>
<th>LMN</th>
<th>CTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Utilization</td>
<td>+</td>
<td>+/−</td>
<td>+/−</td>
<td>+/−</td>
<td>+</td>
</tr>
<tr>
<td>Quality</td>
<td>+/−</td>
<td>+/−</td>
<td>+</td>
<td>+</td>
<td>+/−</td>
</tr>
</tbody>
</table>

+, extensively covered in the evaluation report; +/−, some information given in the evaluation report; −, not covered in the evaluation report.

whether a recipient of a loan could choose the income generating activity s/he undertook, whether parents could choose the school their children would attend when sponsored by the programme or whether students at a vocational training centre were assigned to the type of training (trade) they preferred. Beyond this, the DBLM evaluation paid attention to
whether the programme was taking initiatives to help person’s with disability (PWDs) to organize themselves, whether leadership among clients was encouraged, whether clients had a possibility to influence the policies of the programme or propose interventions not previously explored and whether clients felt ownership of the programme. Finally, evaluation reports were screened for information whether the programme focused exclusively on the client as a beneficiary or whether relatives and neighbours/community members were also included. To this issue, three reports paid adequate attention while the two other reports mentioned it in passing.

### Discussion

The results showed that not all issues included in the flow charts were addressed in the evaluation reports and that, conversely, evaluators included some issues in their reports even though these were not suggested by the flow charts. As mentioned above, the number of reports is limited and these reports have not been chosen randomly. It should also be noted that the programmes that featured in the evaluation reports were programmes that could not be sustained on locally generated funds and were financially supported by donor organisations. The fact that large sums of money are spent is often the impetus for an evaluation to be done. Thus a publication bias exists through which we seldom hear of fruitful community initiatives that provide much needed service at low cost. In the present study we merely assessed whether specific issues, derived from the theoretical framework we developed, were adequately addressed in the evaluation reports. No attempt was made to put a value on the programmes evaluated. For example, in the five evaluation reports studied, little information was presented on ‘socio-economic participation’ and hardly any on ‘eco-social variables’. It could be argued that this is a serious shortcoming, probably reflecting a lack of attention for this type of information in the programmes evaluated. It could, however, equally be argued that the evaluator should look for this information whether or not his terms of reference required him to do so. Evaluators should not blindly follow the terms of reference handed to them but independently reflect on what is needed in an evaluation. The flow charts in Figures 1 and 2 form an aid to help the evaluator think through the vital aspects of a ‘rehabilitation in the community’ programme. Of course, depending on the purpose of the evaluation, i.e., the decisions that need to be taken for the programme, some issues can be given more or less attention than others during a specific evaluation. The evaluator will usually negotiate with the agency commissioning the work about the choices to be made and agree how much time is needed to complete the task.

Thus we conclude that, starting from a theoretical framework, there were good reasons to include data on ‘socio-economic participation’ and ‘eco-social variables’ in the evaluation reports but that the relevance of these issues is not (yet) recognized or supported in many real-life evaluations. This conclusion we believe to be valid, in spite of the limitations inherent in the present study.

### Using flow charts to classify programmes

When ‘providing structure to the evaluation of rehabilitation programmes’ [4], we built on our earlier work [1,2] but did not rigidly stick to our initial system to classify rehabilitation programmes. In fact, a new raster (defining the programme environment, the relation between programme and environment, and the services offered) was introduced to provide a structure for a guided evaluation based on the classification.

One potential shortcoming of the new raster is that for the evaluation of a programme which puts all its focus on advocacy and does not provide direct rehabilitation services to clients, flow-chart B will not be relevant. As a consequence, questions concerning the relationships within the programme – the roles of PWDs, their relatives and others – might be neglected. Yet all would agree these questions are important, particularly in that situation.

### Differences in classifications made by the evaluator and programme staff

The flow charts include ‘choice boxes’ which require the user to give a characterisation or classification of the programme that is being evaluated. Field experiences as presented in the evaluation report of the Nigeria programme (LMN in Table I) showed that differences occurred in characterizations made by the evaluator and by the programme staff. Based on the available documentation of the programme, including the terms of reference, the lead evaluator classified the role of the client as choosing from a limited set of options and concluded that clients were...
not referred to other services to benefit from interventions not available within the programme itself. The programme staff, however, had another opinion and classified the programme as offering full participation of the beneficiaries (envisaged as empowerment); they also felt that the programme was having a multisectoral approach, making optimal use of other existing resources and facilities. In fact, the staff felt that the programme was operating from within a social paradigm, while the lead evaluator felt that only some aspects of a social paradigm could be identified. Subsequent discussions concentrated largely on the issue of reality versus aspiration.

Similar experiences were observed during the evaluation of the socio-economic rehabilitation programme of the Danish Bangladesh Leprosy Mission [6]. During the staff meeting prior to the evaluation the classification was explained in some detail and staff were asked to give their opinions. Again, staff categorized their programme more towards the categories that fitted the social model than the evaluators had done. This issue was also reported by Thomas, Thomas, Babu & Velema [10]. They presented the choices in the flow charts to project managers of 36 evaluated programmes in India and asked them to classify their own programmes. They observed that the managers had ‘rated the questions based on what they aspired for the future rather than where they were at present’.

Differences in the classification of a project would result in different sets of questions being asked during the evaluation. In the Nigeria evaluation it was decided to use the evaluators’ opinion as a starting point but, where appropriate, also use the questions focusing on empowerment and on multisectoral collaboration (as these issues were brought in by the programme staff). During the evaluation itself it then became obvious that the aspiration of the staff was different from the reality. During the discussions at the end of the evaluation, some staff members clearly expressed that the social model was the better model and that still a lot could be done to realise it in the programme. The added value of the classification process and related discussions (prior to and at the end of the evaluation) was that it provided the staff of the programme with insight both in their current practice and their aspirations.

Problems in collection of data

Information systems. When collecting data guided by the flow charts, the evaluators necessarily relied on the information available within national statistics, health management systems, the projects etc. However, it was observed that evaluation studies were frequently hampered by lack of both baseline data and consequent record keeping, i.e., by the lack of simple but effective management information systems.

Usually, programmes could provide some information on employment, income or literacy status but paid little attention to issues such as intensity of social ties, marriage prospects, participation in community activities and in decision-making in the household or in community affairs. Information on changes in the psychological and social status of the clients was usually fully absent. Yet, we believe that issues of self-esteem, motivation, dignity and worth – to name a few – play an important role in determining the success of rehabilitation interventions. In general, lack of relevant baseline data requires a lot of creative solutions from the side of the evaluators when they try to document the changes that have taken place during the project period. In order to cope with the lack of essential baseline data, evaluators frequently made use of retrospective questions about, for example, the disability status or socio-economic status of clients before the interventions [cf. 6,8,11 – 14]. By doing so, evaluators rely on the memory of clients, their relatives, and service providers and at best complement this information with some patient or client records. While information about the physical status prior to interventions may reliably be produced, it is in our experience far more complex to ask questions about the social and psychological status of the client before interventions were started. Where well-documented individual rehabilitation plans are lacking, assessing the types and effects of interventions becomes almost impossible. This eventually leaves the reader with the impression that evaluation results are not sufficiently well substantiated/validated.

Discharge & follow-up. It is noted that very few clients in rehabilitation programmes are ever discharged. Rather, clients continue to be in contact with the programme with the type of interventions changing. When assessing the outcomes of interventions (services), it is of crucial importance to define when a client was enrolled in the programme or started on a particular intervention and at what point in time the intervention was or should be considered ended. This discharge could take place after a certain amount of time has passed or when certain ‘milestones’ have been passed in the rehabilitation process, e.g., when all inputs have been provided or when a client is transferred to other services. At discharge the status of the client should be reassessed in terms similar to the ones used at enrolment. In a programme emphasising physical rehabilitation, assessments will be in terms of improvement of physical status; in a programme emphasising socio-economic interventions, indicators of social status will be measured.
Individual outcomes as a measure for both the result of individual rehabilitation and programme achievement would provide both programme managers and policymakers with essential information. Additionally, we would argue that an important indicator of impact of rehabilitation is the status of the client, in terms of the original aims and expectations at enrolment, one year after the support has ended. This will demonstrate that improvements in status were sustained and that the programme has had a lasting impact on clients’ lives. The evaluation of the Nashik vocational training centre included a follow-up of persons who graduated more than one year ago. However, most rehabilitation programmes do not make the resources available for a systematic follow-up of all clients.

Provider-client relationship

An important issue in the flow charts is the relationship between the provider and the client. However, information on this relationship was lacking in the reports. Only in two reports (Nashik & DBLM) adequate attention was given to this issue of balances of power. This may mean that most of the evaluated programmes were provider-oriented: i.e., the clients were often given no or only a limited choice in terms of setting their own rehabilitation goals. This suggests that most of the studied programmes still operated within the medical or individual paradigm, in spite of the aspirations of most programmes to shift their focus to a more social paradigm. Perhaps the evaluator(s) were also biased towards the conventional role of the service provider and tended to take this traditional role, which is evident in the medical model, for granted. In the years 2004–2006, The Leprosy Mission India has since developed new programme concepts in which these aspects were given much more attention, working with self-help groups of PWDs and supporting clients to benefit from the rights granted to them under the 1995 disability act.

Information not picked up by the flow charts

The flow charts were developed to guide the evaluation process, to reduce the number of questions and to select the relevant indicators. A few areas where information was included by the evaluators even though this was not suggested by the flow charts, are discussed below.

Organizational capacity. In the evaluation reports many problems were identified with regards to the organizational capacity of the rehabilitation programme, for example lack of a clear vision for the work (DBLM), problems in the organizational structure (DBLM, LMI, LMN), lack of staff or lack of staff competence (LMI, LMN), and lack of awareness on the part of the staff of existing policies (LMI, CTY). However, the flow charts did not propose questions on organizational issues.

Linkages with vertical and horizontal programmes.

Although the flow charts addressed the interaction between the rehabilitation programme and its environment, they did not encompass the many and varied forms that linkages and partnerships may take. These include, for example, linkages with other rehabilitation programmes, with which experiences can be shared, a division of roles may be agreed and joint advocacy campaigns may be organised; linkages with the authorities, which may provide material, manpower and political support and legal recognition; linkages with government health services to ensure smooth referral of patients to the specialized services offered; linkages with community organisations, including religious groups, to gain support and which may aid in the integration of disabled people in society. In this study we noted that, except in Nashik, referrals of clients were mostly ‘vertical’ referrals within the rehabilitation service system (i.e., referrals made to hospitals for surgery or to specialized centres) and not ‘horizontal’ to organizations working in the programme environment (local schools, social welfare, co-operatives etc.). These ‘vertical’ referrals can hardly be seen as a ‘social orientation’ of the programme. In fact, referring clients to specialized centres can be seen as rolling off the responsibilities of the community to a centre and the professionals working there.

Quality of services. Issues of quality in the flow charts are usually present implicitly rather than explicitly. Flow-chart B starts with questions on the ‘services offered’ and these questions include a section on ‘quality of services’. Assessment of the outcome of rehabilitation should include an assessment of client satisfaction with the outcome. Also ‘influx of new ideas and advice’ in flow-chart A is a section that includes items related to quality (for example external consultants coming to the programme). There is a place, however, for being more explicit about quality than is obvious from the flow charts. A comprehensive evaluation should assess how quality is defined within a programme and what activities and procedures are carried out to reach and maintain a certain quality level.

Sources of income. Finally, the flow charts did not include questions addressing the sources of income of a programme. In practice, programmes will have to remain in the favour of their donors. Donations
may be accompanied with specific demands concerning the inclusion of target groups, the choice of interventions, the implementation of administrative processes, the conduct of evaluations etc. and consequently guide the evaluation process. This may lead to an influx of new ideas and provide opportunities for further development. Confronted with discrepancies between donor expectations and local realities, the evaluator is in a unique position to verbalize felt difficulties and tension and to facilitate the discussion.

Conclusions: Lessons learnt

In this paper, we report our experiences of applying a structured approach to evaluation of rehabilitation programmes, based on the theoretical framework developed by Velema & Cornielje [4], in five actual evaluations of programmes which were all aiming to improve the socio-economic condition of marginalized clients, many of which were affected by leprosy.

We draw the following ten ‘lessons learnt’ resulting from this exercise:

(1) If we are ever to show the effectiveness of ‘rehabilitation in the community’ programmes, we need to develop appropriately simple information systems which show progress of clients towards the goals of the rehabilitation process defined for them, with them or by them. This implies assessment of clients’ status at the beginning and end of a rehabilitation process. This in turn implies that a beginning and an end of that process must be defined in practical, operational terms.

(2) An important step in showing the effectiveness of rehabilitation interventions is to organize a follow-up of clients one year after they have ended or completed the rehabilitation process (after they have been ‘discharged’) and assess their status at that time, again in terms of the goals defined by them or for them.

(3) The flow charts necessitate the characterization of the rehabilitation programme to be evaluated on a number of essential issues. Discussion between evaluators and programme staff about how each would characterize the programme is a valuable step in the evaluation process and provides insight to the staff into their current practice and aspirations.

(4) It is apparently not customary to assess clients’ psychological and social status at the beginning and end of the rehabilitation process and we believe this is an area that needs further exploration.

(5) Asking questions about provider-client relationships is easily neglected in the evaluation of programmes which operate within a medical or individual paradigm, yet is essential to the long-term development of the programme.

(6) If the purpose of a programme is purely oriented towards changing community attitudes, the flow charts published by Velema & Cornielje [4] bypass questions concerning locus of power and involvement of others. Such questions concerning the relationships among the people operating the programme may, of course, be highly relevant and should be included if the purpose of the evaluation demanded it.

(7) The flow-charts give only limited attention to linkages between the programme evaluated and other rehabilitation programmes, services, interest groups, community organizations etc. This is a vital area for any rehabilitation programme as it relates to its environment and it therefore deserves adequate attention in any evaluation.

(8) Questions of organizational capacity have not been addressed in the flow charts as these were considered of a more general nature, not directly related to rehabilitation. Of course, any development programme needs from time to time to be evaluated in these terms and rehabilitation programmes are no exception.

(9) ‘Quality of services’ needs to be addressed more explicitly. Key questions and indicators on quality as well as on a system within the programme to maintain and increase the quality of services should be formulated. This includes issues like information management, management of processes, staff development and training, client satisfaction, training materials, and the response of the environment to the programme.

(10) As income streams and the constraints they impose are an important determinant of how development programmes function, these should be considered in evaluations.

The present exercise has shown that the flow charts can be a powerful instrument to evaluate ‘rehabilitation in the community’ programmes. It accommodates a variety of programmes and at the same time addresses the specific aims, contexts and developmental stages of the programmes evaluated. The original theoretical framework has proven its value in evaluation practice. Trying out these
methods in practice has resulted in ten lessons learnt. Taking these into account will further improve the usefulness and practical relevance of the methodology we proposed.

A consistent use of this methodology will result in a comprehensive ‘state of the art’ of the programmes evaluated and will make it possible not only to describe the essential characteristics of a programme but also to compare the processes and outcomes of programmes and generate a body of knowledge on ‘rehabilitation in the community’ programmes.

References