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DEVELOPMENT NEEDS OF PEOPLE WITH PHYSICAL
DISABILITIES IN LEBANON

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ABSTRACT

This thesis is concerned with people who are physically disabled and are living in Lebanon. The discussion focuses on what development has occurred for these people, how their households manage their lives within their local and national environment, what their needs are, and which service providers are attempting to address these needs. The national environment in which these people live and the situation of disabled people in developing countries is also considered. The thesis question asks if the service providers are meeting the development needs of the people with physical disabilities. The needs of the disabled people fall into two broad categories: practical and social. The Lebanese state is not active in addressing these needs and this role falls to the non-governmental organisations. It is shown that the non-governmental organisation services are in some way meeting the development needs of the people with physical disabilities. But both the non-governmental organisations and the people with physical disabilities identify weaknesses in the non-governmental organisation service provision. The physically disabled people experience improvements in their quality of life through their own efforts or with the support of the non-governmental organisations and/or their families.

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CHAPTER 1

INTRODUCTION

INTRODUCTION

This thesis is concerned with people who are physically disabled and may or may not be dependent on special services in order to meet their development needs. These services may be provided either by non-governmental organisations (NGOs) or the state. The purpose of this thesis is to consider how these people with physical disabilities manage their lives, what development means to them, what their needs are, and if service providers are meeting their needs. These issues are considered with regard to the situation in Lebanon.

This chapter will identify my interest in this topic and justify why I think this topic deserves further study, explain the key issues of the study, describe the conceptual framework on which these issues and the relationship between them may be considered, present the structure of the thesis, and discuss the aims of the thesis.

CHOICE OF TOPIC

My previous study, a research paper in 1992 for a Diploma in Development Studies, was concerned with rehabilitation workers and what they thought about their work. This field work was conducted at a rehabilitation centre in Cairo, Egypt. After this study I worked as a physiotherapist in the West Bank, and then in Lebanon for three years from 1993. I was involved with rehabilitation projects in both these countries.

The work in Lebanon was offered to me as a doctor had recognised a need amongst her patients for some type of rehabilitation service. I went to Lebanon with the brief "to assess the needs of the disabled people and to do something with these people". There were no details available as to the numbers of disabled people, the types of disabilities, the resources available, or the facilities for the disabled people.

Once this rehabilitation service was established, it was overwhelmed by people needing advice, equipment, rehabilitation, and treatment for acute conditions. The problems of the latter cases were usually resolved after some visits. But the people requiring long term rehabilitation appeared to be on the programme caseload for the rest of their lives, as there were few other services available to meet their needs. The scope of this rehabilitation work widened especially with regard to the children who progressed with their mobility and functional skills, but were unable to attend school due to their physical and/or intellectual disabilities. This rehabilitation process took time, at times more than two years, and it concerned me that when these improvements had occurred the child was still at home. A similar problem occurred with adults who were unable to join the work force and have some degree of economic independence.

Had we wasted these people's time with the rehabilitation and the effort it involved? The answers in some small surveys we carried out in 1994 and 1995 were favourable towards the rehabilitation work but I felt the honesty in the answers was doubtful. If the answers were not positive the people may have thought the service would be withdrawn. This study will attempt to look at the needs of the disabled people and the services provided for them in a more formal manner without the constraint of being attached to a service provider.

Beyond my personal and professional interest in this relationship between the expectations and the needs of disabled people and the opportunities available to them to participate in their society, I feel this study is justified for two reasons. Firstly, there is a limited amount of information available about people with physical disabilities in developing countries, and about the types of services which are available for them. Secondly, there are no studies from Lebanon which attempt to understand how the people who are disabled manage their lives or about the services which are provided for them.

It is suggested that people who are physically weak are often ignored when studies are conducted about the needs of people in developing countries (Chambers 1995:20). Sick people will access health care services. Therefore, they are visible and able to be counted. Disabled people may be unable to reach services, or there may not be services for them. Therefore they may remain in their homes, invisible and unable to be counted. The 1993 United Nations Development Programme Report does not include disability in any of its

tables (Chambers 1995:20).

The World Health Organisation (WHO) (WHO 1987, WHO 1988) and various United Nations bodies (Periquet 1984, United Nations 1994) have set objectives and established guidelines for the implementation of programmes concerning people who are disabled. These international organisations may provide overall guidelines for individual country initiatives, but no demand is made on the member states of these organisations to implement policies which may achieve these objectives.

A comprehensive study of Third World health delivery systems mentions physically disabled people, in brackets, in a paragraph about mentally ill people (Phillips 1990:273). Harpham and Tanner (1995) and Phillips and Verhasselt (1994) present ideas as to how maternal and child health services may be improved in developing countries. Until these services are improved or optimal, there will be mothers and children who are deprived of good health care and consequently there may be a higher percentage of disability amongst children where services are less than satisfactory, than in places where the services are optimal. There is no consideration either of what may be happening to these children until these services are improved, or of the rehabilitation services which are currently available to them.

The literature which is concerned with Third World household economies, how the poor survive, the value of a healthy body as a resource, and the cost of having a disabled person in the household (Bloom 1991, Chambers and Conway 1992, Lipton and Maxwell 1992, Colclough 1993, Chambers 1995), addresses the issue of disability in developing countries and the difficulties associated with disability. If these households are in a developing country which promotes neo-liberal economic policy it is suggested that the difficulties may be more acute as the state may not provide services for these people (Bloom 1991:222, Chambers 1991:274).

There is very little information available about the situation in Lebanon. There has not been a census since 1932 (McDowall 1986). A recent WHO publication (Murray and Lopez 1994) concerned with the international disease burden, expenditure and intervention packages does not include any figures or examples from Lebanon in its analysis of the Middle Eastern countries. It is suggested that Third World government policy concerning disabled people is

minimal and that formal state-operated and funded services are almost non-existent and that this role is left to the NGOs (Mallory 1993:9). Due to the absence of any objective information about the Lebanese policy concerning disabled people, this study will consider if this idea is relevant to the Lebanese situation.

KEY ISSUES OF THE THESIS

There are three key issues in this study: the role of the Lebanese state; the lives of and the needs of the people with physical disabilities in Lebanon; and the work the NGOs may be doing in relation to the needs of these disabled people.

The role of the state and its relationship with, and influence on, the lives and the work of the disabled people and the NGOs within the Lebanese society is important. The issues which are relevant to this discussion include an understanding of the current political situation in Lebanon, the economic policy of the state, the socio-economic situation within the country, state provision of education, health, and welfare services, and the policy it has specifically in relation to people with physical disabilities. As Lebanon has experienced twenty years of conflict, and for almost fifty years the country has had Palestinian refugees living in uncertain circumstances, the possible influence of these factors on the current situation must also be considered. The main issue concerning the role of the state is to find out if the state promotes and implements a social policy which is conducive towards the development needs of the disabled people.

If the state is not active in its social policy, this role may fall to the NGOs. The issues which are considered in relation to the work of the NGOs in Lebanon include an understanding of the type of NGOs which are working with disabled people, what are their guiding principles and policies, how are these policies implemented, are the NGOs able to influence government policy concerning disabled people, and how do they see their work progressing in the future?

The main issue concerning the NGOs is to find out if their service provision is meeting the needs identified by the people who are physically disabled.

The issues concerning disabled people in Lebanon are their experiences, how they manage their lives, and what their specific needs are. These include an understanding of matters

which are important to them, the improvements which have occurred in their lives, the opinions they have regarding their circumstances and the services which are provided for them, their expectations for the future, the support networks they have, and the good and the difficult things in their lives. Literature both from the West and developing countries regarding disabled people suggests that disabled people are at the "bottom of the pile" regarding social rights, education, and vocational training and that they are usually denied any opportunity for advancement. Two key questions arise in relation to people with physical disabilities in Lebanon: are they able to use their potential and take an active part in their society or are they denied opportunities to participate? and are their needs being met to allow this for participation and if they are, who is helping them to meet these needs?

Two supplementary issues are relevant to this study. The first issue is concerned with basic issues regarding disability (the facts and definitions of physical disability), the situation of physically disabled people in developing countries, the international and national initiatives which are attempting to address the causes of and the problems associated with disability, and research methods which may be applied within the context of this study. The second issue is concerned with development theory and the development models which may be applied to the three key issues of this study. These key issues cover different levels of Lebanese society. Therefore it is necessary to consider development models which are appropriate to these levels of society and allow for analysis of these issues.

The conceptual framework of the thesis is based on the issues described in this section. It allows for each issue to be considered independently, and also for the relationships between the various issues to be considered.

CONCEPTUAL FRAMEWORK OF THE THESIS

Figure 1.1 depicts the conceptual framework for this thesis and places the disabled people at the centre of the model, and these people are situated within the environment of a developing country. This model is transected by the situation in Lebanon. In order that needs of the people with physical disabilities may be met, the possible service providers are considered. The options for this service provision are the state or the NGOs. The role of the state is considered within the existing model, and the NGOs are added to this framework. They are

placed across this model from the external environment, through the developing country environment to the people with physical disabilities at the centre of the model.

This conceptual framework provides the basis for this study and the key questions which are considered in relation to the components are: how are the people's needs met? are the disabled people at the "bottom of the heap"? what are their basic needs? are they able to be empowered? and is there any participatory development?

The components of this conceptual framework provide the framework on which to discuss the key issues of the thesis. The thesis will consider the practical application of these concepts within the structure as described in the following section.

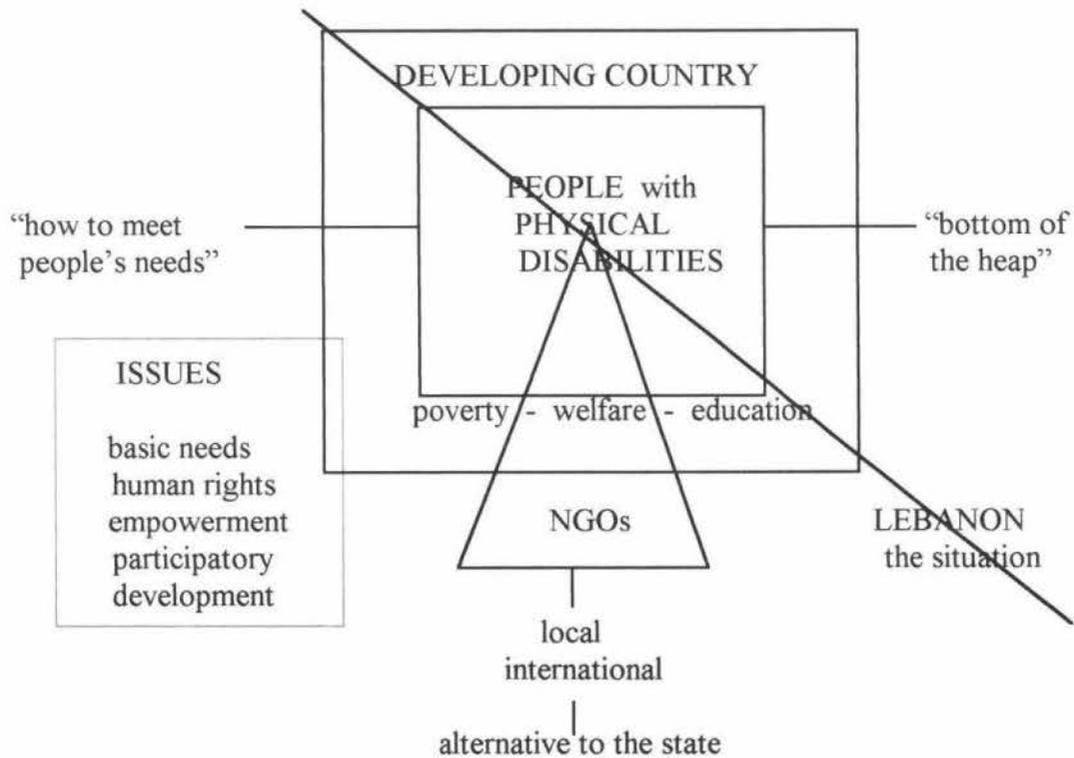


Figure 1.1 Conceptual framework of the thesis

STRUCTURE OF THE THESIS

The structure of the thesis moves from considering the peripheral components of the framework to analysing the relationship between the components at the centre of the conceptual framework. Each chapter of the thesis considers a component of the framework in relation to an appropriate development model.

The initial chapters (two and three) will consider the peripheral components which provide the foundation for the thesis discussion. Chapter two describes how the information may be collected about the key issues of the study. The methods used are interviews with the disabled people and their families based on the "emancipatory research paradigm" (Oliver 1992:110), a questionnaire to survey the work of NGOs, and discussions with key people concerning the current situation in Lebanon. The information from this field work provides the material which is analysed in subsequent chapters.

Chapter three is concerned with development theory, and concepts and practical models which may be applied in relation to the issues of the thesis. Concepts are used to provide an understanding of development and what it may mean to an individual who is physically disabled, and also to explain the circumstances of the households with disabled people. The models include one which explains the current situation within the state of Lebanon and also explains changes which have occurred within the state, one which analyses the work of the NGOs, one which helps to understand how households with disabled people manage their lives, and one which links these concepts and models.

The application of these models from development theory allows for the key issues of the thesis to be considered, beginning with the role of the state in Lebanon. The purpose of this discussion is to understand how the state functions and how this function influences the circumstances for the people who are physically disabled and their families, and the work of the NGOs. The analysis of the state is based on the framework of the "four domains of social practice" (the state, the corporate economy, the political community and the civil society) (Friedman 1992:26). This analysis provides some insight into the current Lebanese situation, and how it has changed since independence. The "counter-ideology of reversals" (Chambers 1991:264) identifies whether or not the state is active in meeting the needs of the people with

physical disabilities and it provides the link between the role of the state, the disabled people and the work of the NGOs.

Within any society a number of people will be physically disabled and they will have needs which are possibly greater than the able bodied people in the society. How other developing countries manage these issues will be considered before the discussion specifically related to the needs of disabled people, and the work of the NGOs in Lebanon.

The second key issue of the thesis is concerned with the work of NGOs in Lebanon. Are these NGOs meeting the development needs as identified by the people who are physically disabled? The framework of "generational analysis" as described by Korten (Korten 1990:114) is used to analyse the information from the field work concerning the types of NGOs which are involved with service provision for people who are physically disabled.

The final key issue of the thesis is concerned with two particular aspects of the lives of people with physical disabilities and their households: what development has occurred for these people and who has assisted with this development? and how do these people manage their lives? The concept of "good change" meaning "development" (Chambers 1995:vi), and the model of "sustainable livelihoods" (Chambers and Conway 1992:6, Chambers 1995:23) provide the frameworks for this discussion and analysis. This discussion is summarised using the concept of "dimensions of deprivation" (Chambers 1995:18).

The final chapter summarises the thesis and makes concluding comments regarding the key issues raised in the thesis.

AIMS OF THE THESIS

The thesis has four aims specifically related to the key issues of the study. The first is to learn about the experiences of the people who are physically disabled and their families. The second is to find out about the work of NGOs in Lebanon which are providing services for people who are physically disabled. The third is to find out about the current socio-economic and political situation in Lebanon. The fourth is to consider the information gained in meeting the aims stated above and to assess the relationship between the needs of the disabled people and

the work of the NGOs and the role of the state.

The additional aims of this thesis are concerned with complementary issues. The first is to find out about the situation of disabled people in developing countries and to consider any information concerning disabled people which may inform this discussion. The second is to identify a method of field work which is appropriate for the intended participants in the field work. The third is to review theories related to development and to apply the appropriate theories to this discussion. The fourth is to make recommendations, if this is appropriate, to service providers and other interested groups once the thesis has been completed. A final and personal aim is to increase my knowledge about and understanding of people who are physically disabled and living in a developing country.

The overall aim of this study is to answer the thesis question: are the development needs of the physically disabled people in Lebanon being met by the service providers? But before this thesis question can be answered it is necessary to find out which service providers are working with disabled people. Is it the NGOs or is it the state?

The circumstances of disabled people change. When I was working in Lebanon and considering the opportunities available to those disabled people who were relatively mobile and independent, their immediate needs regarding equipment, appliances, and wheelchairs were satisfied. However the children grow and their needs change, as do the needs of adults who are physically disabled. So at various times in their lives physically disabled people will have new needs and expectations. For a number of reasons, able bodied people will become disabled, and they too will have on-going needs. This study will attempt to understand the disabled people's needs and expectations at a specific time within the context of Lebanon in 1996-7, with the understanding that the circumstances, the needs, and the expectations of these people will change over time.

In summary, this study will attempt to find out about the lives and the particular needs of the disabled people within a specific developing country, Lebanon. It will consider the relationship of these people with the service providers who may be meeting their needs. The role of the possible service providers, the state and the NGOs will be considered independently and in relation to the needs of the disabled people. Various models, which

allow for these issues to be considered and analysed, will provide the framework for this discussion.

CHAPTER 2

METHODOLOGY

INTRODUCTION

This chapter will identify the purpose of the field work, describe how the field work was done (interviews, a questionnaire, observation, and informal contacts), and discuss the problems encountered during the field work in Lebanon. The information sheet for prospective interview participants, the consent form for the interview, the guidelines for the structure of the interview, and the questionnaire for the NGO survey are detailed in Appendix A, B, C, and D.

PURPOSE OF THE FIELD WORK

The field work was conducted to find out about the lives of some people with physical disabilities in Lebanon. How do they manage their lives (Chambers and Conway 1992, Chambers 1995), what are their needs, perceptions, and priorities (Chambers 1991, Chambers 1995), and what “good change” has occurred for them (Chambers 1995:vi)? The people with physical disabilities are the focus of this study and in the absence of comprehensive state services to help them meet their needs, the role of other service providers must be considered. Within the counter-ideology of reversals (Chambers 1991:264) the NGOs are seen as the complementary partner to the state.

Therefore, the second aspect of the field work was to find out about the work of NGOs who are concerned with service provision for people with physical disabilities in Lebanon.

As these NGOs and the people with physical disabilities are living and working in Lebanon the final aspect of the field work was to find out about the current situation in Lebanon.

METHODS USED TO ANSWER THE FIELD WORK QUESTIONS

Different methods were used to find out about the groups and the situations identified above. The disabled people and their families were interviewed, the situations in which these people were living were observed, the information about the work of the NGOs was collected in a questionnaire, and informal discussions were held with people working and living in Lebanon. The questionnaires were delivered in October 1996, and the interviews were conducted in January and February 1997.

I have previously worked in Lebanon, and three former colleagues assisted me with this field work. These people helped with the selection of NGOs, the delivery of the questionnaires, and with the translating. There is no central register of all the NGOs in Lebanon. The NGOs selected to take part in the field work were some of those working with people with physical disabilities, which were known to me or to the field assistants. The thirty NGOs selected were based along the coastal region of Lebanon (Tripoli, Beirut, Sidon, and Sour) and in the Mountain. No NGOs based in the Bekaa Valley were included as access was difficult, especially in the winter months. There was follow-up with nineteen of the NGOs. Seventeen NGOs completed the surveys and the staff expressed an interest in the receiving the information obtained during the field work once it had been collated. These NGOs also organised for me to visit their centres or to spend time with their field workers in the community.

Through a number of other contacts in Lebanon I was able to enlist the help of people to meet with participants for the interviews. These people also provided me with contacts to meet with some key people for informal discussions. All the people who were contacted through the local people agreed to take part in the interviews. The people with physical disabilities who were interviewed were living in Beirut, the Mountain, Sidon, and South Lebanon. The mothers of the young children agreed to be interviewed, and the families of the elderly people who were present in the home took part in the interviews.

The methods used to find out about the groups selected to take part in the field work are described in the following sections.

INTERVIEWS WITH PEOPLE WITH PHYSICAL DISABILITIES AND THEIR FAMILIES

People with physical disabilities and members of their families were interviewed using the emancipatory research paradigm (ERP) (Oliver 1992:110). The ERP is based on the work of Chambers regarding the situation of the rural poor in developing countries, and it has been adapted for use with people who are disabled (Oliver 1992). This research model attempts to understand about the lives of, and the practical and cultural needs of people who are physically disabled. It enables the people to talk about what they know, experience, need, and want (Appendix C).

The ERP is based on three fundamental elements: reciprocity, gain and empowerment (Oliver 1992:111). The researcher has the responsibility to discuss with the participant any issues raised during the interview and where necessary to follow up on matters and problems identified by the disabled people and their families.

The group of people (Appendix E) who participated in this field study included children and adults with physical and visual disabilities, any people with intellectual disabilities were excluded. After twenty three interviews the age groupings of the participants were reviewed. No elderly people had been interviewed, so through the local contacts some elderly people were asked if they wished to participate in the field work. The number of participants and their age groupings are listed in table 2.1.

Table 2.1 The participants in the interviews

Age Group	Number of Participants
pre-school and primary school children (interviews with the mothers)	5
4 - 8 years old	
school age children	5
9 -16 years old	
working age people	13
21 -46 years old	
elderly people	4
55 -76 years old	

All the interviews were pre-arranged through the contact people (NGO volunteers, community rehabilitation workers, the translators, NGO field workers, village and camp

leaders) who had explained the purpose of the field work to the prospective participants. This group included the mothers of the young children with physical disabilities, and the families of some adults with physical disabilities. A translator was used for all, except for three, of the interviews. These three participants spoke good English. The interviews were recorded on a dictaphone and they were transcribed on the day of the interview. In all cases the same translator was used for the interview and the transcription.

The rights of the participant and the responsibilities of the researcher and the translator were explained to the participants before the interview commenced (Appendix A). The elements of reciprocity, gain and empowerment within the research model place a responsibility on the researcher to follow up on any issues identified during the interviews. Permission was obtained from the participants to use their name if necessary when following up any issues raised during the interviews. The participant and the translator signed the consent form (Appendix B). In six situations verbal consent was obtained because of illiteracy or visual disability.

The length of the interview varied depending upon what the participant had to say. Four of the adolescent group had less to say than the other participants. Some participants identified problems which were discussed with the appropriate personnel, for example, NGO staff, kindergarten staff, village leaders, and community rehabilitation workers. The result of these discussions and the action implemented was discussed with the participants.

The information obtained in the interviews is used in the following ways:

- To find out what good changes have occurred for the individual person with a physical disability. "Good change" in this context meaning "development" (Chambers 1995:vi). This is discussed in chapter seven.
- To ascertain if the person with a physical disability and their household have the means to manage their lives in a positive manner, and if they do not have the means, where does the support come from? This is done using the model of sustainable livelihoods (Chambers and Conway 1992:6, Chambers 1995:23). This analysis is discussed in chapter seven.
- To identify the needs and problems of the disabled people and to compare these with the services provided by the NGOs. This comparison is discussed in chapter six.

- To feed back any relevant information to the NGOs who participated in the field work.

QUESTIONNAIRE FOR NON-GOVERNMENTAL ORGANISATIONS

A questionnaire which collected specific information about the policy, the guiding principles and the work of NGOs concerned with service provision for people with physical disabilities in Lebanon was completed in July 1996 (Appendix D).

An explanation regarding the purpose of the research and the contact details of the researcher were included on a cover sheet. The NGOs were given the option to meet with the researcher later, and also to receive a summary of the information collected in the survey. The questionnaire was translated into Arabic.

These questionnaires were delivered in October 1996 to thirty NGOs working in Lebanon, and involved with health care delivery, education, physical rehabilitation, special education, vocational training and the provision of equipment and supplies for people with physical disabilities.

Five completed questionnaires were returned by December 1996. During January and February 1997 I contacted another fourteen NGOs who had received the questionnaires but had not returned them. Of these fourteen, two had returned the questionnaires but they had been lost in the postal system so new questionnaires were sent and these were completed. One NGO declined to complete the questionnaire as it is not their policy to do so and another declined as it has no specific policy regarding physically disabled people. Five questionnaires were completed in Arabic. These were translated by a field assistant. Due to time constraints I did not contact the other eleven NGOs who had received the questionnaire.

I visited the seventeen NGOs (Appendix F) who had completed or agreed to complete the questionnaire and discussed the research with them. All the NGOs requested a summary of the information from the field work. This summary, which included the problems and good changes identified by the physically disabled people and their families during the interviews, was sent to the NGOs in February 1997 (Appendix G).

Thirty NGOs were given the questionnaires, further contact was made with nineteen of these NGOs and seventeen questionnaires were completed.

The information obtained in the questionnaires is used in the following ways:

- To find out what types of NGOs are concerned with service provision for people with physical disabilities. The method used for this analysis is based on the framework of generational analysis (Korten 1990:114). The results are presented in detail in chapter six.
- To find out if the services of these NGOs are meeting the needs and expectations identified by the people with physical disabilities. The information is analysed while considering the information obtained from the interviews with the people with physical disabilities and their families where they discussed their needs, expectations, and priorities. The comparisons between needs of the disabled people and the services provided by the NGOs are discussed in chapters six and seven.

OBSERVATIONS FROM THE FIELD WORK

The people with physical disabilities were interviewed in their homes or their shared institutional accommodation, with the exception of three school aged children, who were interviewed at their school. During the interviews observations were made of the living conditions of the household and the special facilities available in the home for the people who were disabled. Features of the local environment which affected the disabled person and their families were observed, discussed, and recorded at the time of each interview. These observations are presented in the chapter concerning the households of a physically disabled people in Lebanon (chapter seven).

INFORMAL DISCUSSIONS WITH PEOPLE IN LEBANON

Contact, either by chance or through organised appointments, was made with people who are working in different sectors of the Lebanese society (Appendix H). These people provided some insight into issues which are not presented in the media or discussed in the current literature available about Lebanon. The information from these informal discussions is presented throughout this paper.

PROBLEMS ENCOUNTERED DURING THE FIELD WORK

Overall the field work proceeded well but, due to both the methods used to find out about the selected groups and the environment where the field work was conducted, there were some problems. This section will discuss some specific problems related to the methodology and then consider the problems related to working in the field in Lebanon.

Two questions in the NGO questionnaire were not well understood or they did not translate well or they were inappropriate for the local conditions. They were question three regarding the NGO and its long term expectations for the people attending its programmes, and question fourteen regarding the methods of evaluating the NGO programmes. Question three was interpreted by the NGOs to mean their expectations of their programmes, rather than their expectations for the people who attended their programmes. The information from the questionnaires has been used in the way it was interpreted by the NGOs in the analysis of the NGO work (chapter six). Some NGOs may not have understood the difference between objective and subjective assessment. For example, an NGO which runs a school offering normal classes for physically disabled children who are denied access to normal schools identified subjective feedback as the method they use to assess their work. We interviewed some children at this school and found that they prepare for and sit normal school examinations and they are given marks and a placing in the class.

Some difficulties arose during the interviews with the disabled people and their families. Most people who were interviewed were very willing to talk about many different aspects of their lives and how they manage financially, but other people were not so forthcoming. The interviews did not consistently cover all the interview guidelines due to the differences we experienced with the participants.

During an interview with an adolescent girl her father returned to the house so the interview was stopped. After greetings and explanations the interview resumed and with the daughter's permission her father participated. The girl had earlier expressed an understanding about her disability and she accepted that this came from God. Her father then went on at length about the efforts he had made and would continue to make on his daughter's behalf to clear his conscience and ensure that she received the optimum treatment for her disability. The

situation was resolved by discussion between the girl, her father, the translator and myself. In this situation the lack of another room to continue the interview created a problem and also due to custom it would have been inappropriate to exclude the father.

The follow-up of the needs and the problems identified by disabled people and their families during the interviews created some initial confusion which was resolved by discussion with the people concerned. For example, in an attempt to solve a problem in one household I found that the husband and the wife had different ideas about how to manage the problem regarding their son's difficulty walking with crutches. However they talked through this issue and came up with some short term and long term options.

Some of the disabled people had practical needs which their local NGO staff could help them with. These needs were very basic and they were compromising the quality of the disabled person's daily life. I contacted the appropriate personnel and discussed these issues with them. This was sometimes quite difficult as it appeared to them that I was being critical of their work practices rather than trying to help them solve a problem which had been identified by the person with a physical disability.

There is a lack of published data regarding Lebanon. There has not been a census since 1932 (McDowall 1986), and there are no statistics regarding the number of people with physical disabilities (Murray and Lopez 1994).

The field work was also affected by political disturbance. The political situation in Lebanon is unstable and in January 1997 the situation was tense. The people, especially those in South Lebanon, were concerned about the political situation and their personal security. Some interviews were conducted with sound of war planes over head and shelling in the distance. The lack of security and the uncertainty of the situation makes both short term and long term planning difficult.

The poor infrastructure of Lebanon caused some problems. The internal communication systems are not reliable. The main roads have been reconstructed, which allows for greater speed on them and there is very little consideration of the road rules. This made commuting rather hazardous.

CONCLUSION

In summary, the co-operation of the field assistants, the interview participants, the NGOs and the local contacts allowed this field work to make good progress. Due to the variety of the people interviewed and the fact that two translators were used the interviews did not always cover the questions identified in the guidelines for the interviews. Some NGO questionnaires were completed in Arabic but the majority were in English. In both languages two questions were not answered as I had expected. All NGOs were interested in the field work and requested a summary of the results. The local situation created some difficulties but due to the co-operation of all the people I contacted and worked with the two months passed without any problems or delays.

The methods used in this field work found out about the lives and the needs of some people with physical disabilities in Lebanon, and the work of some NGOs in Lebanon who provide services for people with physical disabilities. The observations from the field work and the informal contacts with people from a variety of sectors in Lebanese society provided further insight into how people manage their lives and the circumstances which affect their lives.

The following chapter describes the models and theories which provide a framework so that this information from the field work may be considered and analysed within the context of the thesis question concerning the provision of service for the needs of the people with physical disabilities in Lebanon.

CHAPTER 3

DEVELOPMENT AND DEVELOPMENT THEORY

INTRODUCTION

The purpose of this chapter is to consider development and development theory with respect to people who are physically disabled. The needs of these people and how they manage their lives are the focus of this thesis. But it is inappropriate to consider them in isolation as they manage their lives in an environment which is influenced by actions and policies which occur outside their immediate environment. The conceptual framework of this thesis provides a basis for examining these issues within the context of the situation in Lebanon. This framework, which places the disabled people at the centre of the model within their national environment, is described in chapter one (figure 1.1). The components of this model are the disabled people and their household, the NGOs, and the Lebanese state.

This chapter will discuss the theoretical approaches and models which allow for the components of this conceptual framework to be applied, so that the thesis question concerning the needs of the people with physical disabilities and which service providers are meeting these needs may be considered in a practical manner. These theories and models are; the counter-ideology of reversals (Chambers 1991:264), the sustainable livelihood model (Chambers and Conway 1992:6, Chambers 1995:23), the four domains of social practice model (Friedman 1992:26), neo-liberal economic theory, and the framework of generational analysis (Korten 1990:114). For the purposes of this discussion, these general theories on development are adapted for analysis of people with physical disabilities, their environment, and the service providers.

The counter-ideology of reversals (reversal theory) is the pivotal theory as it provides the link between the people with physical disabilities and role of the state with regard to these people and their needs. If the state is not active in addressing these needs, the complementary role played by the NGOs is considered. The other models, which are supplementary to reversal theory, allow for analysis of the other components of the conceptual framework. The

sustainable livelihood model examines how disabled people and their families function at the household level of society. Neo-liberal economic theory provides some insight into the function of a state which promotes this policy. The four domains of social practice is used within this context to understand the make up and the function of the state and to consider changes which have occurred in the state over a certain period. The role the NGOs, which is complementary within the context of reversal theory, may be analysed independently in the generational analysis model.

This chapter will discuss the concept of development for an individual person with a physical disability, the sustainable livelihood model, the reversal theory, the neo-liberal economic theory, the role played by NGOs and a method of analysing the work of NGOs.

In this discussion “development” will mean “good change” (Chambers 1995:vi) for the individual disabled person. Good change is a subjective concept and it is dependent on the perceptions of the individual person and their household. This good change may include a variety of factors other than economic indices. It is linked with the concepts of illbeing, wellbeing, and the “dimensions of deprivation” (Chambers 1995:18), and it considers any improvements which may have occurred within these concepts.

THE PERSON WITH A PHYSICAL DISABILITY AND THE HOUSEHOLD

The sustainable livelihood model (Chambers and Conway 1992:6, Chambers 1995:23) provides a framework for understanding how individuals and households manage their daily lives. The interdependent components of a sustainable livelihood are livelihood capabilities, tangible assets, and intangible assets (Chambers and Conway 1992:9). A living, the gains or output, is the result of the interaction amongst these components (figure 3.1).

The capacity of people to use their skills, physical and intellectual capabilities, and creativity in a positive way is described as their livelihood capabilities. The manner in which people utilise these skills and the choices available to them may enhance their quality of life.

The tangible assets of a household include both its stores and resources. Stores are items seen to be of value and if possible they are purchased and held by the household. Stores may

include jewellery, gold, food stocks and cash savings. Resources are assets the household may have or buy, and use of these resources may help them to improve their situation. Resources include land, water, livestock, trees, and the equipment required to utilise these resources. Livestock and savings maybe considered as both stores and resources. A store may be sold to increase the resources of the household and vice versa.

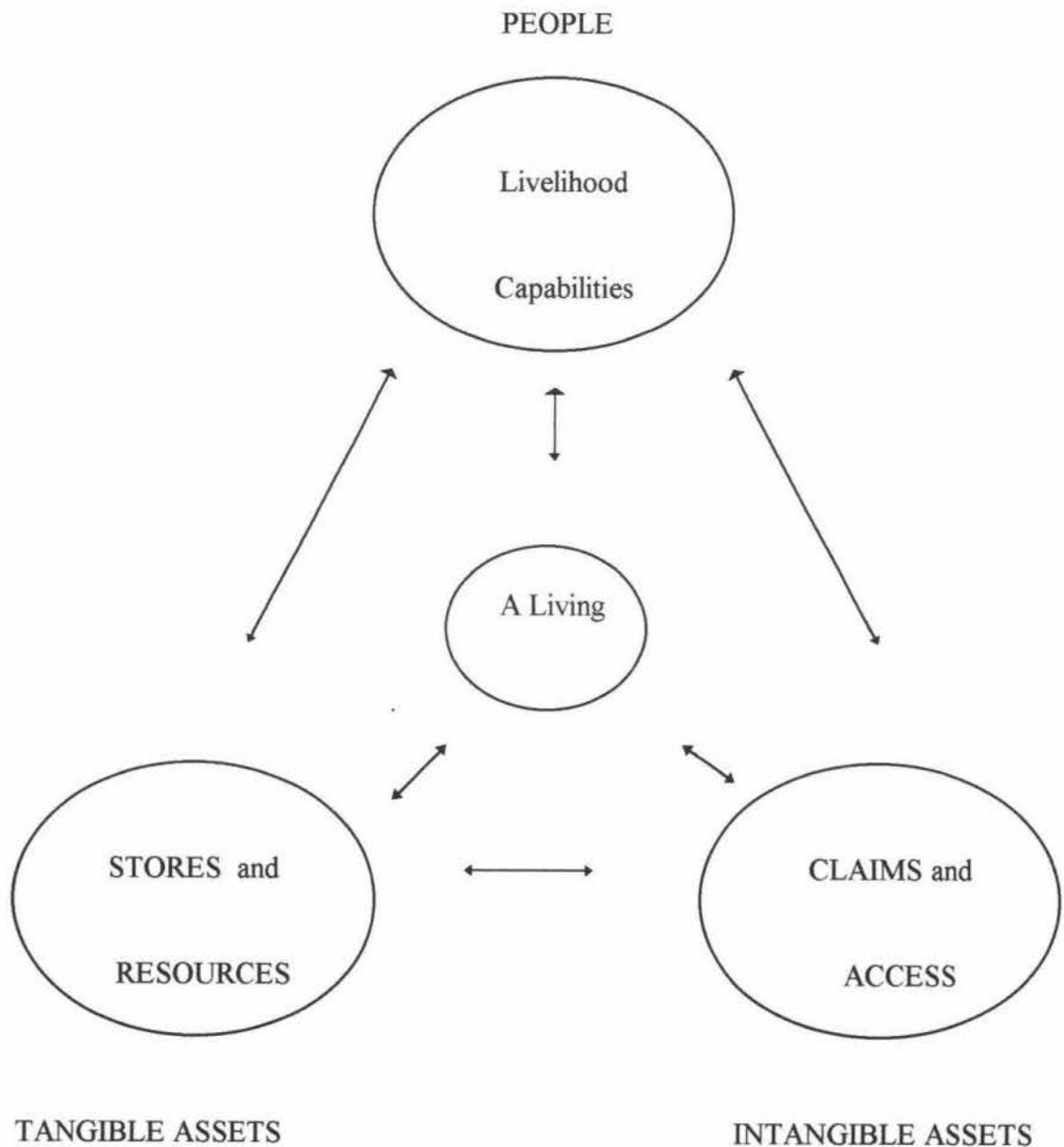


Figure 3.1 Components and flows in a livelihood
Source: Chambers and Conway 1992:10

The intangible assets are the resources which are available in community and they may or may not be utilised by a household. The ability of the household to claim and to gain access will determine if it is able to make use of the intangible assets.

Claims are:

"demands and appeals which can be made for material, moral or other practical support or access ... such as food, implements, loans, gifts, or work. ... Claims may be made on individuals or agencies, ... or on NGOs They are based on combinations of right, precedent, social convention, moral obligation and power" (Chambers and Conway 1992:11).

Access is described as the functional ability of an individual or the household either, to utilise a resource, store or service (for example, transport, education, health, or markets), or to obtain information, material, technology, employment, food or income.

The intangible assets are particularly relevant to the disabled person as without their ability to claim and gain access, their capacity to utilise the other two components may be limited and consequently their living (gains and output) will be compromised.

Chambers and Conway suggest that three fundamental concepts (capabilities, equity and sustainability), should be considered as an adjunct to this framework to further increase the understanding of how disabled people manage their lives and the opportunities available to them (1992:4). Capabilities are the ability of a person or household to cope with shocks and emergency situations and also the ability to discover and utilise positive situations which may enhance their quality of life. Sustainability is the ability to maintain and improve a livelihood without damaging or overusing the resources which maintain the livelihood. The concept of equity considers the distribution of resources and services. Are the resources and services reaching those most in need and if not, what is the reason behind this disparity of allocation? It also considers any biases within a society which may limit the opportunities and choices available for some groups of people within that society, for example, women, disabled people and children.

THE LINK BETWEEN THE HOUSEHOLD AND THE STATE

The "counter-ideology of reversals" (reversal theory) (Chambers 1991:264) offers a theoretical framework within which the perceptions, needs and priorities of the disabled person may be considered in relation to the role and action of the state and the possible complementary role of non-governmental organisations (figure 3.2). Chambers states that:

"one of the greatest unmet needs in rural development is a continuous, sensitive exercise to understand the conditions, strategies and priorities of the poorer" (1991:265).

In this discussion the poorer will be replaced by people with physical disabilities as there is no theoretical approach specific to understanding their situation within the Third World.

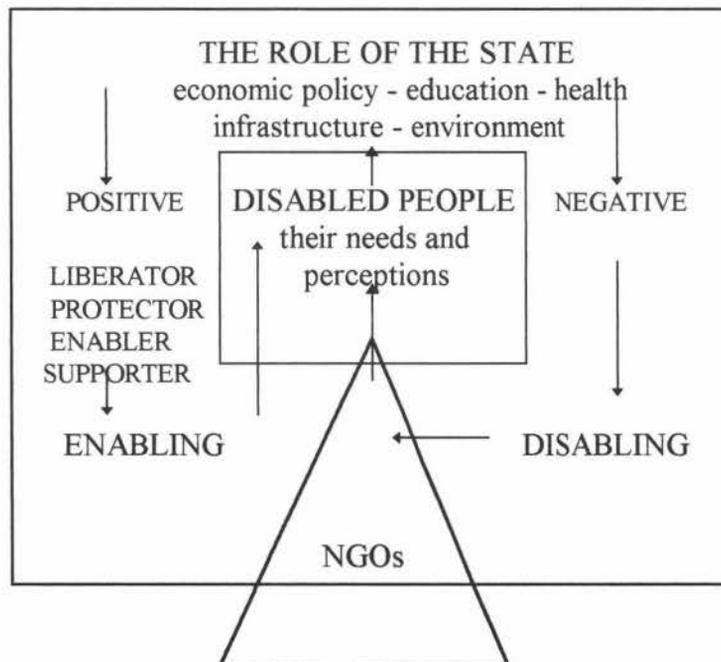


Figure 3.2 Components and flows in the counter-ideology of reversals
Source: adapted from Chambers 1991:264

Reversal theory contains three key points. Firstly, the priorities, problems and perceptions of the people with physical disabilities are the central focus, that is, some attempt is made to understand the daily realities of their lives within their local environment. Secondly, the interaction of the disabled people with field workers, local government staff and the services available to them provide the links beyond their immediate sphere: an understanding of the nature of these links and how they function is important. Thirdly, the role of the state is analysed in regard of its ability to meet the requirements stated by the people at the centre of the paradigm. Is the state disabling or enabling in its attempt to address these issues? If the state has a small commitment, what is the role of the NGOs (Chambers 1991)?

The problems, priorities and needs identified by the disabled person may cover any issues relevant to them and how they manage their lives on a day to day basis. Chambers acknowledges the diversity of these issues and has called them the "dimensions of deprivation" (1995:18). These dimensions will be "provisional and personal" (1995:19) and therefore change as some situations resolve and new problems and issues arise. However as a study takes place at a specific time it is these perceptions, problems and priorities which will be considered within the context of the role of the state and/or NGOs and their ability to address these issues.

Poverty, social inferiority, and isolation (geographical, physical, intellectual, and social) are identified by Chambers (1995:19) as being problems which are well recognised by development professionals and he offers five more dimensions of deprivation which deserve consideration and action if positive changes are to occur for the people at the centre of the model. These dimensions are physical weakness, vulnerability, seasonality, powerlessness, and humiliation.

All of the above dimensions are relevant to the disabled person. The severity of one or more of these conditions will compromise their ability for self development. For example, if a person is physically weak and immobile their ability to gain access to society will be compromised. This will in turn affect and compound the other dimensions.

The main concept of the reversal theory is to move the disabled person from the periphery of development policy to the centre by prioritising their perceptions into positive actions, that is,

to see how they may gain access to their society from their marginalised and deprived status. Chambers writes that the reversal theory, while seeking to see things from the view point of the poorer (disabled person):

"it is complementary to other ideologies, not an alternative. Macro analysis will always be needed as well as micro" (Chambers 1991:266).

Within the broader context, the macro, the issue of the state's capacity and ability to play a pro-active role in the development of a person with a physical disability, will be considered in the next section.

THE STATE

The method of analysis used to consider the role of a Third World state in relation to the features described in the reversal theory is the four domains of social practice as described by Friedman (1992:26). It provides a framework on which to answer the questions posed in reversal theory about the role of a Third World state with regard to disabled people.

Friedman (1992) identifies four interdependent areas of social practice: the state, the political community, the corporate economy and the civil society, all of which exist within the national life space. The overlap between these areas contains the informal economy, the church, the legislature, and interested organisations. The corporate economy borders with the global economic space, which is acknowledged and accepted as part of the influence on the nation (figure 3.3).

Each of these domains has "an autonomous core of institutions that governs its respective sphere" (Friedman 1992:28). These cores are the judicial and executive institutions of the state, the household of the civil society, the corporations of the corporate economy, and the independent political organisations and social movements of the political community.

Each sphere has a form of power which it may exercise depending upon the resources it is able to mobilise. This power may not be held by one group within these domains and the lack of co-ordination and co-operation between the various groups and factions may cause a

conflict of interests and tensions within that sphere. For example, the state has many centres of power, civil society is divided along many lines (class, gender, race, ethnicity, religion and caste), the people in the corporate economy are usually in competition unless it is in their collective interests to combine forces, and the political community is the sphere where the conflict occurs and this usually involves the other three groups who are drawn into this conflict.

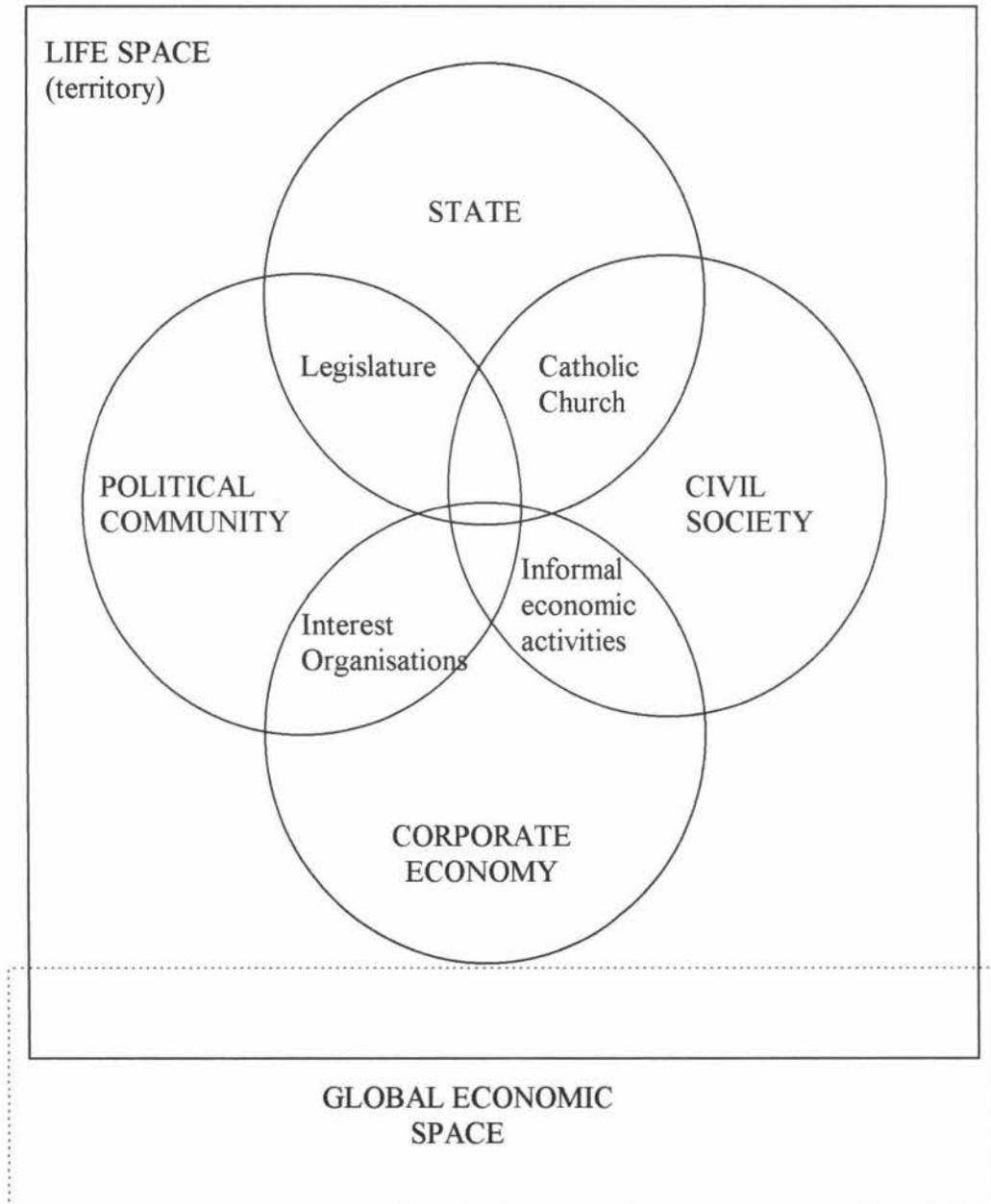


Figure 3.3 Four domains of social practice
Source: adapted from Friedman 1992:27

These domains all exist within the "life space" (Friedman 1992:29) of that country. This is the area where the political community and state claim their power. The corporate economy borders with the global economic space which also overlaps into the national life space. This space allows for consideration of the market relations of a country and to assess the flows of capital, the labour situation, and the production activities.

The relationships between these areas of social practice and the domination of one sphere over the others will determine the make up and functioning of that state. This concept functions with spirals looping out from the household level to the macro and then returning and linking in with the four domains of social practice. It allows for analysis of the different levels of society and the links are provided through the interaction of these four spheres. It offers a comprehensive analysis as all aspects and levels of society are included in the framework. This model is the framework for Friedman's 'alternative development theory' but the four domains of social practice and the interaction between them identify areas to consider when analysing state-society relationships and the changes which are occurring within individual Third World countries.

These four domains of social practice provide a framework within which the questions posed by Chambers (1991) may be answered. Is the role of the state enabling or disabling with regard to the perceptions and the needs of the disabled people? What is the state policy regarding participation, infrastructural support, security, justice, and democracy? It also meets the criteria demanded by reversal theory as the framework is dynamic, it allows for changes occurring over time to be considered and it can be applied in a practical manner.

If the role of the state is disabling towards the needs of the people with physical disabilities it may be due to the economic policy of that state. The next section will consider neo-liberal economic policy and the effects of this policy.

NEO-LIBERAL ECONOMIC THEORY

The Lebanese state, which is the focus of this discussion, has adopted neo-liberal economic policy. This discussion will consider the reasons why this policy is usually implemented, and the effects the promotion of this policy may have on the people within the state.

Neo-liberal economic theory is based on the premise that:

"long-run growth and development will proceed provided everything possible is done to achieve short-run allocative efficiency" (Colclough 1991a:6).

This theory, which has developed momentum since the 1970s, with its practical application, began in response to the problems of hyperinflation and increasing debt in the Third World countries (Schuurman 1993). The application challenged the structuralist packages of development of the early 1970s which promoted government intervention in Third World countries' development initiatives.

The aim of neo-liberal ideology is to promote economic growth. Within this context, it is believed that the failure of the Third World countries to achieve economic growth was caused by excessive and inefficient government intervention and the most efficient way to achieve economic growth was through competition in the market, not through government policy. The philosophy behind this approach is that an imperfect market is better than an imperfect state, and that government action generally has costs which exceed the benefits of their actions (Colclough 1991a).

The policy employed to promote this economic efficiency was to decrease state expenditure, to increase efficiency, to improve management skills, to increase the autonomy of the managers, and to increase competition (Shirley 1989). This was to be done by assessing the performance of state owned enterprises (SOEs) and if necessary, to sell them. This privatisation of the former SOEs would free them of politically motivated intervention and of the inefficiencies engendered by the weak accountability present within the state bureaucratic systems (Shirley 1989).

The practical application of this policy enjoyed some success in the West, and it was transferred to the Third World countries through conditions applied by the international lenders, the World Bank and the International Monetary Fund. The role of the state was to be limited with a liberal economy and a strict monetary policy which would be controlled by the international lenders and implemented through structural adjustment policies (Schuurman 1993).

With the privatisation of the SOEs, the welfare role of the state diminished. A feature of neo-liberal policy is that the individual or groups of individuals must take the responsibility for managing their lives within the market economy. It is not the role of the state to consider aspects of society which are the result of individual action and behaviour (Kabeer and Humphrey 1991).

Neo-liberal policy and its effect on health care delivery system is considered by Bloom (1991) to be unsatisfactory. Health care delivery is a complicated system and the responsibility of this should not rest with the market. The role of the government concerning legislation, standards of care, staff training and public health measures is important. Bloom (1991) also questions the ability of the market mechanism to allocate health care resources. The neo-liberal policy does not consider a household with vulnerable, sick or disabled people due to its policy of promoting individual responsibility. If the state does not maintain some safety net for people who are unable to care or provide for themselves, the NGOs may fill this role (Chambers 1991).

The emphasis of neo-liberal policy on economic development and wealth at all costs is criticised by Manor (1991). These policies which move everything from the public sphere to the private sector without any consideration of the strengths, weaknesses and balances within the existing systems do not provide solutions for all the population. Where does this leave the people discussed earlier and their various dimensions of deprivation who are unable to gain access to the market?

In spite of the criticisms directed at the neo-liberal approach, its policies have been implemented in many Third World nations. The extent to which a neo-liberal policy is implemented by a state will be revealed in a theoretical analysis of that state's economic policy and the degree to which it supports the various bureaucracies, for example, health, education, agriculture, tertiary education and training, infrastructure, and transport. The information from this analysis may be used to assess the role of the state with respect to reversal theory. Does the state have the capabilities to be supportive or protective towards the needs of the people with physical disabilities? Is it playing an enabling or disabling role?

In situations where the role of the state and its welfare responsibilities have diminished, it is important to consider who fills this gap. If the state has absolved itself of any responsibility towards the needs of people with physical disabilities, who may be unable in any way to compete in the market, this responsibility may rest with the NGOs.

THE COMPLEMENTARY PARTNER TO THE ROLE OF THE STATE

Reversal theory places the role of NGOs in a complementary position to that of the state (figure 3.2). This section will discuss NGOs and consider a method of analysis which is of value in understanding the type of work NGOs are doing.

Non-governmental organisations

NGOs have developed from a history of people assisting others seen to be less fortunate than themselves. This assistance has been given during emergency situations, for example, war, famine and natural disasters or in situations where people live in less than optimal circumstances, for example, with poverty, and where there is a lack of normally expected services and opportunities (Korten 1990, Theunis 1992a, OECD 1988).

NGOs were originally formed in Western countries. They were established on a voluntary basis and were driven by the values of the people who formed them. They usually function on a democratic basis with minimal hierarchical structures which allows for flexibility, innovation, and the ability to respond to and act within rapidly changing situations (Theunis 1992a, Fowler 1992).

NGOs which work both at home and abroad are identified as international NGOs (INGOs). People may be affiliated to an INGO as a volunteer, a financial supporter or as an employee. The NGOs which are formed and work within their own country are local NGOs (LNGOs). The members of these groups or their employees are people who may be affected by the reason for which the NGO was established. Organisations which work within a specific local area in their own country are grass roots organisations (GROs) (Korten 1990). The objective of GRO work is to improve the conditions within their own community. The membership of

these groups may be open to all people within a geographical area or they may have specific membership for example, a labour or professional group.

This charity and assistance type of work began, mainly through religious groups, in the seventeenth and the eighteenth centuries (Korten 1990). The International Red Cross was established in 1864. The provision of charitable services increased during World War One. The Save the Children Fund was founded in 1919 (Korten 1990). World War Two and the long term effects it had on populations prompted the formation of more relief and charitable groups, for example Oxfam (Stamp 1982), CARE (Theunis 1992a), and Catholic Relief Services (Korten 1990). Oxfam began its work as a political pressure group which campaigned against the blockade of Greece during and after the war, the other groups were also concerned with the situation in Europe. As the European situation resolved these groups turned their attentions to the Third World countries where people were living in less than optimal circumstances (Stamp 1982).

Events in the 1960s and 1970s, for example, the Food and Agriculture Organisation promotion of the Freedom from Hunger campaign, the war in Vietnam, the drought in Ethiopia and the number of refugees created by these situations, increased the demands on NGO services and subsequently the number of NGOs working in the Third World increased (Stamp 1982). The underlying issues of these and other emergency situations forced some NGOs to rethink their working strategies and also how to prevent these problems from recurring. The emphasis of the NGO work changed from charity to education so that people would be encouraged to develop a degree of self reliance (Theunis 1992a, Korten 1990). Initially the INGOs worked in co-operation with the Third World governments. The number of LINGOs increased as Third World countries gained their independence, and the INGOs began working with them also (Theunis 1992a).

Development NGOs are diverse but they do have features which distinguish them from governmental or private organisations. These features include their historic evolution, their commitment to the poor, and the relationship they have with people both in their country of origin and the host country, and with the government (OECD 1988). Theunis (1992b:307) is more specific about these features and he believes that for NGOs to function as NGOs they should be fundamentally independent from governments and donors, have a structural vision

about the problem of poverty, maintain human rights as their central issue, emphasise active participation of the marginalised people in the Third World, and display an affinity for cultural values in the development process.

As discussed earlier the emphasis of development work has moved from an economic orientation towards a process:

"by which the members of a society increase their personal and institutional capacities to mobilise and manage resources to produce sustainable and justly distributed improvements in their quality of life and consistent with their own aspirations" (Korten 1990:67).

The work of NGOs is usually orientated towards improving the circumstances of their intended beneficiaries. The NGO role may be to provide practical assistance, to advise, to educate, and/or to work as an advocate on behalf of the focus group to achieve the development objectives. In some situations the NGOs may provide services in the absence of any responsible government, for example during a conflict, a military occupation or a situation with displaced people. The manner in which this work is done will depend upon the philosophy and the policies of the NGO and its specific programme objectives.

Some NGOs are reluctant to work with local governments due to the implied constraints of this work or because of the political perspective of the NGO (Edwards and Hulme 1992, Theunis 1992c). In order to implement long term changes which may benefit the majority of the population NGOs may have no choice but to involve the local government in their work. Government action has a wide spread, for example, legislation, infrastructure, education and health care policies, and the effects of using governments to complement the work of NGOs can be beneficial in the long term. The utilisation of government networks and the fostering of a positive NGO-government relationship has been demonstrated by both INGOs and LNGOs (Edwards and Hulme 1992).

The money for the work of development NGOs comes from both public and private sources. The United Nations donation target for rich countries is for 0.7% of the GNP to be transferred for development and relief work (Elliot 1996). This money is transferred to the

Third World countries and NGOs through a variety of channels. For example, funds may be transferred from one government to another, from a Western government to an NGO, a Western or Third World umbrella organisation, or directly to a LNGO or GRO (OECD 1988, Smillie 1993a). LNGOs are often seen by Western donors as more efficient with the movement and allocation of money compared to their governments with their top heavy bureaucracies and they are increasingly utilised as the front line recipient for funds from abroad (Theunis 1992a). Individual countries, the United Nations and the World Bank have specific arrangements for disbursing funds to the Third World.

Most Western countries give a large percentage of their development funding towards disaster relief, for example Britain 48% (Smillie 1993b:281) and Australia 40% (Smillie 1993c:83). The European Community has established a special body, the European Community Humanitarian Office to deal specifically with disaster relief (Attanasio 1993).

The "almost three billion US dollars" (Clarke in Edwards and Hulme 1992:13) which are dispersed to the Third World via NGOs do not come without problems for the recipients. The development objectives of the NGOs may be compromised if the funder demands specific criteria for the use of the money without a comprehensive understanding of the role and the institutional needs of the NGO. At times NGOs may be required to use their funds quickly, Theunis (1992c) believes that this may lead to a poor use of the money and that it may foster the growth of entrepreneurial NGOs rather than those with a commitment to development.

Governments and NGOs have created a dependence and interdependence with regard to funding. Most NGOs are dependent on governments for funding and some governments are dependent on NGOs to implement programmes either supplementary to their work or independently to meet a need it is not addressing (Smillie 1993a). Smillie (1993a:27) wonders if the NGOs have lost their autonomy due to their dependence on governments for funding. Whether or not this occurs will depend upon the ability of the NGO to remain clear about the underlying philosophy of its work.

The money needed by NGOs for meeting immediate needs for example, natural disasters, areas of conflict, newly displaced refugees, and human suffering from epidemic illnesses and

poverty often supersede the priorities of the NGOs with long term development programmes. In order to maintain the necessary funds these NGOs have a responsibility to evaluate their programmes, and also to educate the public and the funders about their work so that the value and the results of this work can be assessed in an objective manner (Fowler 1992). The funders and also the public are then able to make an informed decision regarding their donations.

The lack of funds is one factor which limits the work of NGOs (Fisher 1993). NGOs also face other constraints in their attempt to realise their objectives. External constraints may include political factors (conflicts, changes of government and government policy), negative working relationships which may exacerbate as the programmes proceed, and the difficulties of working in a different environment (Edwards and Hulme 1992). Internal constraints are problems which may arise from within the institutional structure of the NGO itself. NGOs were often established by a charismatic leader and when this person moves on the NGO may become dysfunctional without their leadership (Theunis 1992d). There are very few formal NGO training programmes for staff development, employees may have expertise in specific areas of development but not be skilled managers. This creates problems regarding staff development, promotion and leadership (Fowler 1992). INGOs may experience a conflict of interests between field staff and office staff due to the pressures placed on these people either from the intended beneficiaries of the NGO programme or from the funders and their expectations for the programmes.

The value and the role of NGOs is accepted in the developed world as large sums of money are allocated for them to disburse in the Third World (Edwards and Hulme 1992). The reasons behind the evolution of NGOs, for example, poverty, communal violence, environmental degradation (Korten 1990), a population explosion (Fisher 1993), and a debt crisis and hunger (Edwards and Hulme 1992) are still evident today. Governments in the Third World are currently being forced into adopting a neo-liberal economic policy (Colclough 1991a, Korten 1990). This policy decreases the role of the state with respect to its welfare role. In the future the primary responsibility for addressing some of the problems in the Third World countries may fall to the NGOs.

A model for analysing the work of non-governmental organisations

Korten in his discussion about NGOs and their work uses the concept of generational analysis to describe their:

"definite pattern of evolution ... away from more traditional relief activities and toward greater involvement in catalysing larger institutional and policy changes" (Korten 1990:115).

This evolution and the changes within the NGO will be dependent on the commitment, focus and function of each NGO. Korten states that this movement may depend "on the extent to which the NGO:

- Is clearly focused on trying to make a sustainable difference in the lives of the people it is assisting;
 - Has attempted to make explicit the theory underlying its intervention aimed at improving their lives; and
 - Engages in the regular and critical assessment of its own performance"
- (Korten 1990:122).

The original framework identified three generations which broadly describe the type and focus of the NGO work. They are relief and welfare, small scale, self reliant local development, and sustainable systems development. In response to the question "where do NGOs go from here? (from the third generation)" (Korten 1990:123), a fourth generation has been identified. This generation remains untitled.

Generation one NGOs are concerned with relief and welfare (Korten 1990:115). The focus of this work is to provide humanitarian assistance. The NGO function is to deliver a service to those in need during an emergency, for example, in a conflict situation, as the result of a physical catastrophe (earthquake, flood or typhoon), or for refugees and displaced people. The services provided are to help those people dislocated from their normal environment begin to meet their basic food, health and shelter requirements.

In generation one work the NGO is the active partner and the beneficiary the "passive" (Korten 1990:116) recipient of the services provided. The management role of the NGO is that of logistics. They are responsible for organising a service to meet an immediate need. The funding for this work comes from government emergency relief allocations and from the public response to emergency appeals. The fund raising approach used in the West for these appeals is generally emotive appealing to the public to assist those poor people much worse off than themselves. There is no attempt made to educate the public.

Generation one activities are temporary. There are no long term development effects in this assistance work although NGOs working in this field may feel that they are helping the people get back on their feet and subsequently able to resume their pre-emergency life independently. Sometimes NGOs involved in first generation work realise their emergency aid is not enough to meet the long term requirements of the beneficiaries. They may progress to second generation work which has an emphasis on encouraging self reliance.

Generation two NGOs are attempting to encourage a degree of sustainability through small scale, self reliant local development (Korten 1990:118). This work of NGOs is developmental in concept. The orientation of the NGO work is to encourage and to develop "the capabilities of the people to better meet their own needs through self-reliant local action" (Korten 1990:118).

The philosophy behind this NGO work is that the community will consolidate and continue the development work once the NGO withdraws its support. The idea is that the community will be empowered by their learning experience while working in co-operation with the NGO. The NGO role is that of a mobiliser to encourage community action. The orientation of this work is local and small scale, for example, village health initiatives, local water and environmental problems, and infrastructure improvements. This work may have a specific focus or target group within a local community.

Korten makes the point that the reason why the community have not done this work themselves is because of "local inertia" (1990:119). The NGO role is to act as a catalyst to assist the community in realising its potentials "through education, organisation,

consciousness raising, small loans and the introduction of simple new technologies" (1990:119).

Fund raising for this work will depend on the NGO. Some NGOs may move beyond the emotive approach and begin to educate the donating public about where and how their money is being used.

The goal of generation two work is that the local partners will become self reliant. Some NGOs recognise that the power structures within the locality may inhibit this self reliance as the problems they are attempting to solve with their development initiatives may be perpetuated by this structure. A generation two NGO may be powerless to address these issues and it may broaden the scope of its work to rectify these inhibiting factors. This change of emphasis classifies the NGO as a generation three NGO.

Generation three NGOs have moved beyond the local to the national and international levels in an effort to develop sustainable systems (Korten 1990:120). This movement occurs because they are attempting to find and to establish a supportive policy environment so that their development work and strategies may be self sustaining in the long term.

Generation three work may include policy changes. The NGO must act as an advocate for change and take a leadership role in supporting these changes. This work takes place at two levels simultaneously. At the local level the NGO builds on the capacity of the people to make demands on the local system so their needs may be met. On a broader scale the NGO moves beyond the local scene to work with the elite and the power holders to encourage them to make positive changes so that systems are more responsive to the needs of the people.

The generation three NGO becomes an advocate and lobbyist on behalf of the local people. Funding and support for this work may come from a variety of sources, for example, the public or Western governments or interested INGOs may provide political, financial and technical support. Development education with the reasons for the specific lobbying and advocacy work of the NGO may be the focus of the fund raising campaigns.

Generation four work moves beyond a national level to an international level (Korten 1990:123). The focus changes from "repair work" (Korten 1990:124) to look at the components which make up the interdependent global systems and how they may be used in a positive manner to address the problems of development. This generation of NGO work remains untitled.

The NGO role is that of a facilitator of the global people's movement. The idea is to use NGOs to assist with the work of an international movement of coalitions and networks. The international perspective of this movement and its work would remove the problems of having to transform Third World nations sector by sector as they implement their development projects. NGOs would also work in countering the negative effects of international forces which prevent third generation work from meeting its objectives. This work will be driven by social movements with a vision of a better world.

SUMMARY

Development is a subjective evaluation by individuals related to good changes which have occurred for them. The theoretical models discussed above provide the links necessary to examine the needs of the people with a physical disability within their local and national environment. The model of sustainable livelihood assesses how the household manages its life on a day to day basis. The counter-ideology of reversals provides the link between the household, the state, and the complementary role which may be played by the NGOs. The situation within a state and the policies and the action of that state are analysed in the four domains of social practice. If the state promotes a neo-liberal economic policy the NGOs may play a valuable role in alleviating the needs identified by the people with physical disabilities. The model of generational analysis considers the type of work these NGOs are doing.

The thesis will look in detail at the needs of the people with physical disabilities and consider the good changes which have occurred for them. It will also examine how they manage their lives within the context of the sustainable livelihood model (chapter seven). Reversal theory places the NGOs as the complementary partner to the state, if the state in Lebanon is not active in meeting the needs identified by the people with physical disabilities. The work of the

NGOs is discussed in chapter six. But first it is necessary to examine the context of Lebanon with regard to reversal theory, neo-liberal economic theory and the four domains of social practice. The analysis of the situation in Lebanon within the four domains of social practice will provide some understanding of the make up and the function of the Lebanese state, and the influence this has on the lives of the people with physical disabilities and the work of the NGOs in Lebanon.

CHAPTER 4

LEBANON

INTRODUCTION

People with physical disabilities in Lebanon are the focus of this study but, in order to understand how they manage their lives and which service providers are meeting their needs, it is necessary to consider the circumstances in which they live and to understand how these circumstances affect their lives. The purpose of this chapter is to provide some background to and understanding of the current situation in Lebanon.

This chapter will present a history of Lebanon, and then discuss the role of the state, the economic development of the country, the provision of health, education and welfare services in Lebanon, and the current situation of the population groups in Lebanon. The summary will analyse the make up and function of the state and consider the changes which have occurred in state-society relationships during three periods following independence in 1943.

This analysis of the situation in Lebanon within the four domains of social practice model (Friedman 1992:26) will provide some understanding of how the state functions. One of the domains is the civil society, and it is presumed that the majority of the people with physical disabilities in Lebanon belong to this sector of the Lebanese society. This examination regarding the function of the state provides the link with the counter-ideology of reversals (Chambers 1991:264) which is concerned with the specific needs and priorities of the people with physical disabilities and the service providers responsible for meeting their needs. If the state in Lebanon is not active on behalf of the physically disabled people, the role of the other service provider, the NGOs, must be considered.

THE HISTORY OF LEBANON

The nation of Greater Lebanon was created after World War One under the terms of the Sykes-Picot Agreement of 1916 (Cobban 1985) (figure 4.1). France held mandate over



Figure 4.1 Lebanon

Source: McDowall 1996:iii

Lebanon and Syria, and Britain held mandate over Palestine and Iraq. At this time the Emirate of Mount Lebanon, which had been under Ottoman control from 1516 until 1920, was enlarged to include the Shia Muslims from Jebel Amal in the South and the Bekaa Valley, and the Sunni Muslims from the coastal regions of Beirut, Sidon, and Tripoli. Mount Lebanon was inhabited mainly by the Druze and the Maronite Christians with small numbers of the other Christian groups, Sunni and Shia Muslims (Cobban 1985, McDowall 1986).

During Ottoman times the Mountain had enjoyed a degree of independence with its own Emir. This was due to the support it had given to the Ottomans in their conflict with the Marmelukes for control of the area. The Mountain was not stable during this time with internal tension between the feudal Druze and Maronite families. The peasant uprisings which began in the 1820s were largely influenced by the Maronite church (Baaklini 1976). The final uprising of 1858 finished the feudal system. Many Christians were massacred at this time and this prompted the first Maronite migration from the Mountain to Beirut (Baaklini 1976, Cobban 1985). The Egyptian Pasha, assisted by the Maronites, had attempted to gain control of the Mountain in 1830s. Britain, France and the United States of America became involved in this conflict. The Pasha was defeated in 1840 (Cobban 1985).

In 1860 the Provincial Governorship was established as a local government to control the Mountain. The governor was a Catholic Christian and the Central Advisory Council (CAC) had representatives from the different religious groups (Baaklini 1976). The Mountain became politicised with this miniature government formation, but as the leader was not Lebanese the issue of control remained open. The Maronite church had intentions to create a secular state under their control and this issue was problematic for its leaders (Salem 1993a).

During the last period of the Ottoman rule the Mountain became linked with the coastal cities and especially Beirut as trading began, the economy improved, and infrastructural development increased. This was largely due to the influences of the large numbers of Europeans who had arrived following 1860 (Baaklini 1976).

Under the French mandate rule the CAC was dissolved but a larger advisory committee with representatives from all religions was established (Baaklini 1976). Groups within the country were divided over the political future of Lebanon. The options were a union with either Syria

or the Arab states, or independence for Lebanon. In 1926 the first constitution of modern Lebanon was written. There was to be a president assisted by a council of ministers including a prime minister of his choice. The constitution acknowledged the different religious groups in Lebanon and that the state was to:

"respect the personal and family laws of each sect, since those sects had been administering their laws for the past 600 years. ... The state is secular and non ecclesiastical ... the system was committed to the preservation of ethnic and communal identity" (Baaklini 1976:91).

With the advent of World War Two and the subsequent decline of France's military strength a pro-independence movement was able to force the French into granting independence in 1943. Elections were held that year. The Chamber had a ratio of six Christians to five Muslims. The National Pact which had evolved during the mandate became the guiding force for the post independence government (Baaklini 1976). The National Pact identified the value of the general assembly to acknowledge the religious diversity within the country. Other features of the National Pact included a free economic system, and there was to be minimal government interference in personal and communal life and the press (Baaklini 1976).

During and after this time there were various regional and internal factors which influenced the stability and the development of the Lebanese state. The creation of the state of Israel, which began with the Balfour Declaration in 1917, gained momentum during the British mandate in Palestine, and was completed in 1948 (Mallison and Mallison 1986). Many Palestinians fled to Lebanon during the conflicts prior to 1948 and again after the partition of Palestine. The Palestine Liberation Organisation (PLO) was formed in 1964 and it was recognised by the Arab League. In 1970 the PLO was forced to move its headquarters from Jordan to Lebanon (Cobban 1985).

Israel, since its inception, had plans to ally with a Christian government in Lebanon. The diary of the first Prime Minister David Ben Gurion on the 21 May 1948 states that:

"The Achilles heel of the Arab coalition is Lebanon. Muslim supremacy is artificial and can easily be overthrown. A Christian State ought to be set up

here, with its Southern frontier on the river Litani. We would sign a treaty of alliance with this State ... " (Mallison and Mallison 1986:280).

Israel subsequently made many attacks on Lebanon and in 1978 Resolution 425, calling for its withdrawal from South Lebanon, was passed at the United Nations (Cobban 1985). Israel did not withdraw completely and it created a self declared security zone which it handed over to the Israeli sponsored militia, the South Lebanese Army (SLA) (United Nations 1985).

External influences also came from Egypt and Syria. In Egypt Gamal Abdul Nasser promoted a Pan-Arabic socialist ideology. This ideology appealed to the Sunni population who were disaffected by the liberal economic policy in Lebanon (Cobban 1985, Khalaf 1993). The idea of union with Syria was considered to be an option for some Lebanese who felt it was necessary to belong to a larger state than Lebanon.

Inside Lebanon parties consolidated their ideologies and new parties were formed. The most influential of these were the Phalangist Party, the Progressive Socialist Party (PSP) and the Shia parties (Amal and Hizbollah).

The Phalangist Party was founded in 1936 (Cobban 1985) as an alternative to the other Maronite parties who were prepared to form coalitions with the French or Muslims at the time of independence. This hard line Christian Nationalist approach re-established the ideology begun after the Druze-Christian wars in the Mountain which saw the need for Christian security against Muslim domination (Salem 1993a). The armed wing of this party was the Lebanese Forces (New Internationalist 1994).

The PSP, with its secular socialist ideology, was formed by the Druze leader Walid Jumblatt in 1949 (Cobban 1985). It became the main opposition to the Christian dominated political system. Jumblatt was assassinated in 1979 and as the conflict progressed this coalition disintegrated (Salem 1993a).

The Shia constituency was under-represented in the post-1948 government. The Shia Muslim community in South Lebanon was destabilised by the Israeli-Palestinian conflict and many migrated to Beirut's southern suburbs. In the 1970s Imam Moussa Sadr launched the

Movement of the Deprived, to fill the void created by the disproportionate Shia representation in Parliament (Hamzeh and Dekmejian 1994). Sadr disappeared in Libya in 1978. His role was filled by Berri, a lawyer. During the war, the military wing of this group, Amal, became a sectarian political movement and it was alienated from the Iranian hierarchy which had previously supported it. Another Shia group, the Party of God (Hizbollah), had begun in Iraq in the 1960s and it expanded following the success of the Iranian revolution. Hizbollah gained a large Shia constituency in Lebanon following the 1982 Israeli invasion (Hamzeh and Dekmejian 1994).

Lebanon in the 1950s and 1960s continued with economic and infrastructural development and the ideology of the National Pact was condoned and enjoyed by the upper class and the majority of the middle class. Tensions began to rise with the influx of Shia refugees to Beirut, the continued presence of Palestinians living in refugee camps and the arrival of the PLO militia from Jordan (Cobban 1985, Khalaf 1993). The 1958 civil war resulted from these socio-economic tensions and the resistance of the Pan-Arab Nasserist supporters to the Western policy of President Chamoun's government. The government supported the Eisenhower Doctrine of 1957 which intended to contain the spread of leftist ideologies in the Middle East (Khalaf 1993).

In 1975 the Nasserist Sunni leader Maarouf Saad led fishermen in a demonstration against the former president Chamoun and his new fishing company in Sidon. Saad was killed during this event. Demonstrations followed in Beirut and on April 13 1975 Phalangist gunmen massacred Palestinians in East Beirut. This was followed by fighting between various factions which led to the creation of the Green Line and the city of Beirut was divided (Gilmour 1983, Cobban 1985). In 1976 the gradual breakdown of the army began as factional militias fought for control of areas. During the following years conflicts continued amongst civil factions and international forces including Syria, Israel, France and the United States of America (Cobban 1985).

In 1978 Israel invaded to the Litani River, this was followed by an incomplete withdrawal from South Lebanon (United Nations 1985). In 1982 it again invaded Lebanon and in collaboration with the Phalangist forces massacred the residents of the Sabra and Shatila areas of Beirut (Gilmour 1983). The Syrian and Israeli armies and the PLO left Beirut later in

1982.

In 1987 the Syrian army returned. They did so to limit the control by Amal in West Beirut, and also they wanted authority in Lebanon (McDowall 1996). The President appointed General Aoun, the commander in chief of the predominately Maronite Lebanese army, as his Prime Minister in 1988 (Alamuddin 1993). This created a de facto partition of Lebanon. Aoun wanted a Lebanese state with the Christians in control. The final conflicts of the war were the Aounists against the remaining Lebanese Forces, then against the Muslims for control of Beirut and a War of Liberation against the Syrians. These conflicts also involved Iraq, supporting the Aounists, and Iran, supporting the Shia militias (Salem 1993a, Alamuddin 1993). Many Christians emigrated during this conflict and following the war as their dream of living in a Christian controlled Lebanon vanished (Khalaf 1993). Aoun is currently in exile in France (Jansen 1996b).

In October 1989 a political settlement for Lebanon was decided at Taif in Saudi Arabia. A fifty:fifty Muslim:Christian power sharing formula for the general assembly was established. Elias Hrawi was appointed President after Rene Moawwad was shot immediately after his appointment. Hariri was appointed Prime Minister in 1992. Most of the warlords, except for some of the Maronites, have joined the post-Taif government. Syrian troops control various areas of Lebanon in co-operation with the Lebanese army which has been re-formed. UNIFIL (United Nations Interim Forces in Lebanon) patrols the pseudo border with Israel. The military wing of Hizbollah is the only active and armed militia. It continues to resist the military occupation by the SLA and the Israeli army in South Lebanon. This conflict has escalated twice (1993 and 1996) with Israeli bombardments of Lebanon (Jansen 1996b, Gellman and Lancaster 1996). Currently the April 1996 Committee is monitoring this conflict.

ROLE OF THE STATE

The ideology of the National Pact provided the framework for the role of the state in Lebanon following independence. The composition of the government assembly acknowledged the pluralistic religious make up of the country and the assembly was:

"to be the meeting place and centre of unity for those communities with a view to exercising joint control over the nation's political life" (Cheha 1966 cited in Baaklini 1976:106).

Following independence the government's responsibility was to develop a cohesive secular state by redistributing the authority amongst the various religious groups. It was presumed that this distribution of power would encourage regional development, through the vested interests of the leaders in their own areas (Baaklini 1976). There was minimal state interference in business, trading, the press, personal and communal life which was intended to encourage political and religious freedoms. The state adopted a liberal economic policy, and assisted the economic situation by severing monetary relations with France in 1940 and with Syria in 1950 (Labaki 1993).

Between 1943 and 1964 there was some public service expenditure, for example, the development of the airport, the Lebanese universities, and telecommunications, and state-owned enterprises were established, for example, the Silk Bureau and the Independent Fund for Energy. The government also provided subsidies to the agricultural, tourist and health sectors to encourage economic growth (Labaki 1993).

The following years were characterised by periods of the state attempting to cope with the conflict situation and also maintain the Lebanese economy. The state tried to prevent an economic crisis by protecting the oil and banking industries through increasing its control and protection of them. It also provided loans to sectors damaged by the economic downturn, for example, the tourist and health sectors (Labaki 1993). From 1988 to 1990 the militias were in control of the country and the activity and the effectiveness of state action was minimal.

The Taif Agreement re-established the presidency and the country returned to the ideology of the National Pact under a new constitution. The administration of the country is centralised. There have not been local body elections for thirty years (Young 1996a).

The state has begun a reconstruction programme, it is supporting some public infrastructure projects, for example, the redevelopment of the airport, the roads and the telephone network, and it is actively encouraging private sector development, for example, the rebuilding of the

central business area in Beirut (Hamdan 1994). The social policy is limited, but a Ministry and Fund for the Displaced has been established and the Ministry of Social Affairs has begun a registration programme for disabled people (Taowq 1995, P1¹). The President is attempting to alter the laws concerning marriage and the control the religious groups have over the provision of education (Young 1996a).

At an international diplomatic level the activity of the state is limited due to the post-war agreement with Syria. Any agreement with Israel about the occupation of South Lebanon is dependent on Syria reaching an agreement over the control of the Golan Heights (Jansen 1996a).

The post-war government is not tolerating personal and other freedoms in the same manner as the post-independence government. Some examples of this are: the state attempt to control the television stations in 1996 by proposing the introduction of a media law where only four channels would be licensed; the state and the political class control of the judicial system, (for example it disbanded the Lebanese Forces even though their leader Gaga was cleared of the crime which forced their break up); its reluctance to hold local body elections; and in its quest for rapid economic development many homes are destroyed and the temporary homes of the displaced people are re-possessed for reconstruction without these displaced people being offered alternative accommodation by the state (Young 1996a).

This state control is a response to the following factors. The regional influences which are affecting the stability of Lebanon, the commitment of the state to economic development, and the fact that the political class has the economic control (Young 1996a).

There is criticism within the country regarding the economic policy of the Hariri-Hrawi government but the majority of the people accept the government policy as they can see some gains for example, improved roads, and an increase in the supply of electricity and telephones (Jansen 1996a). If the economic situation within the household has not improved there have

¹ These references refer to interviews and informal discussions which were conducted in Lebanon. They are detailed in Appendix E, F, and H.

been some improvements in their quality of life. The government demonstrated its political strength during the 1996 bombardment of Lebanon and it continues to support the resistance movement in South Lebanon. This policy provides it with much support (N3, N4).

ECONOMIC DEVELOPMENT

Lebanon is currently experiencing a real per capita income growth rate of six percent per annum. It is predicted, using these figures as a baseline that Lebanon will return to its 1974 pre-war level of per capita income by the year 2006. The 1993 minimum wage levels were eight hundred and thirteen American (US) dollars per annum. This was fifty seven percent of the 1974 level (Eken et al 1995). In 1993, for the first time in twenty years, the government submitted a proposed budget (Salem 1993b).

Prior to 1975 the Lebanese economy was dynamic with low inflation, high rates of growth, a large balance of payments surplus, light tax burdens and a stable convertible domestic economy. Lebanese businesses and banks acted as the third party in transactions between Europe and other Middle Eastern countries (Eken et al 1995). This growth was possible due to the liberal economic policy of the state and the consolidation of businesses and industries after World War Two when the difficulty of obtaining imported goods created an incentive for local industrial development (Labaki 1993).

Despite these conditions which allowed for economic growth the system was not perfect. The economy had an external orientation, the agricultural sector did not expand, and there was a poor distribution of income (Labaki 1993). The war exacerbated these flaws in the system. With the loss of internal security Lebanon lost its role as a service trading centre and the militia control of the ports and airport denied the government its revenue from import and export duties (Labaki 1993).

The total damage to physical assets during the conflict was estimated to be twenty five billion US dollars (Eken et al 1995). Large amounts of money were deposited outside Lebanon, these deposits peaked during 1990. The increasing inflation and the exchange rate devaluation led to a currency substitution with the dollarisation of the economy. In 1993 thirty two percent of the bank deposits were in Lebanese lira (LL), and less than ten percent

of the currency in use was LL (Eken et al 1995). It is estimated that over two hundred thousand professionals and skilled workers sought employment outside Lebanon (Eken et al 1995).

The government currently has the responsibility to stabilise the economy so that investor confidence may be renewed, and to implement reconstruction programmes. The major constraints to this economic development are the poor infrastructure, the weak infrastructural framework of the government with its poor system of taxation and a superfluous and inefficient civil service staff, and the lack of trained personnel in all areas (Labaki 1993, Eken et al 1995). The unequal distribution of wealth is a major problem in Lebanon. The legal minimum salary, one hundred and sixty US dollars per month (Young 1996a:22), is not always honoured by employers. The poor financial state of many people is the main reason why they wish to leave Lebanon (P3, P6, N4).

THE PROVISION OF EDUCATION, HEALTH, AND WELFARE SERVICES

The liberal economic policy adopted by the Lebanese government following independence has placed the responsibility for the majority of education, health and welfare services outside the realm of the government. Various charitable and philanthropic foundations, religious groups, and secular organisations have always provided these services in Lebanon, and the independent state did not encourage these providers to relinquish their role. The state provides some health and education services.

Lebanon has a long history of sectarian provision of education. For example, the Maronite church began education programmes in the early 1800s, the Druze School for Boys was established in 1864, in 1866 the Syrian Protestant College, now the American University of Beirut, was established by American missionaries (Alamuddin 1993), and the Cheraffeddine family, who are Shia Muslims, built the first school in Sour in 1938 (P1). The Lebanese Universities were established by the Shihab government in the late 1950s (Labaki 1993).

In 1982 fifty percent of the schools were privately organised (New Internationalist 1993:19), by 1994 this figure had risen to an average of seventy percent from pre-school level through to tertiary education (MECC 1994). The fees at these institutions vary. Kindergarten fees are

more than five hundred US dollars per year (N4), and the fees for a post graduate Masters degree at the American University of Beirut are ten thousand US dollars (P3).

Health and rehabilitation services are provided by a myriad of NGOs, the private sector and the government. The government has a hospital in each of the main centres outside Beirut. It is currently building a hospital in Beirut. Other tertiary health care is provided in private hospitals. These hospitals may be organised by a doctor, a group of doctors, a business company, or an NGO. All hospitals charge a fee for service and this fee varies. The government costs are approximately ten to fifteen US dollars per night whilst NGO hospital fees depend upon the philosophy of the organisation and the consultant fees, which are sometimes as much as in the private hospitals.

Many of these private hospitals have state of the art medical technology which is only of value when used in conjunction with the appropriate medical assessment, referral and follow up. Often both the value of the technology, and the financial costs to the patient are wasted due to the inadequate support services and the lack of a primary professional to co-ordinate the service for the patient (M1, M2, M4). Bloom (1991) believes that the market approach to medicine does not ensure quality control. The medical services in Lebanon are a good example of this lack of quality control.

Doctors in Lebanon practice as specialists, and patients consult them independently as there is not a general practitioner system. The primary health care role, including rehabilitation services, is filled by NGOs.

There is a large demand on these NGOs due to the general medical needs of the population, and also due to the long term effects from the years of conflict when health care was orientated towards emergency relief and other problems were neglected (N1). The nature of the war injuries and the disabilities caused by these injuries places an added burden on the NGO providers over and above the usual needs in any population group (N2, N3). The lack of early intervention in most cases of congenital abnormalities and newly acquired disability complicates the primary disability. This makes the rehabilitation process more difficult and it also compounds the needs of the disabled person and their family (N5).

If a family requires financial support for a specific need or a medical emergency they are often dependent on money from outside their immediate family. This support may be given by their local community or the family may approach various charitable and welfare organisations or seek assistance from wealthy individuals. Some political groups provide financial support for their supporters and families who were injured during the conflict (W1, W2), and they may (W12), or may not (W13) provide ongoing support for opposition people who were injured by them. The people are resourceful in their quests for financial support (P5). For example, one woman who needed money for medical care visited twenty organisations hoping for financial assistance (P6).

Most religious communities collect and donate money on a regular basis to people who live in very poor situations (E1). Regular and erratic remittances from family members working abroad are accepted as a normal income supplement in many families (W7, E3). This money may be used for a variety of purposes, for example, for day to day survival, to manage emergency situations, to purchase large items for the household, to assist with the costs of building a home or to help with the extra costs incurred with celebrations and feast times.

The United Nations Relief and Works Agency (UNRWA) is the main provider of health, education and welfare services for the Palestinians in Lebanon. This organisation was established in 1949 as a temporary body to provide relief services for the Palestinians. Its mandate is extended annually by the United Nations. The focus of the UNRWA work changed from relief to development as the Palestinians became settled in Lebanon with no prospect of returning to their homeland (United Nations 1985).

POPULATION GROUPS IN LEBANON TODAY

There has not been a census since 1932, but it is estimated that there are approximately 3.500.000 Lebanese and 325.000 Palestinians (McDowall 1986). The following percentages are approximate. The Muslims are the majority, making up 56 percent of the population, the Christians 36 percent (Maronites 22 percent, and other Christian groups 14 percent), and the Druze 8 percent (Khalaf 1993). The years of conflict altered the areas controlled and owned by the various groups and currently 80 percent of the Christians occupy 17 percent of the land (Khalaf 1993), while the Druze with only 8 percent of the population control a

disproportional amount of the land (Salem 1993a).

The Shia Muslims live mainly in the Bekaa Valley, the South and the southern suburbs of Beirut. Those living in the rural South are generally poor and this situation is compounded by the constant conflict they experience due to their proximity to the security zone. Many families have migrated to Beirut and some who cannot afford to migrate commute to the cities daily for work and education. In the Arab region most areas are under Sunni control, so the Shia Muslims are happy with the confessional Lebanese system which accommodates them. Shia strength has been consolidated with the increased Muslim representation in Parliament and with the tacit agreement and acceptance that Hizbollah continues its activity in the South (Hamzeh and Dekmejian 1994).

The Sunni Muslim population has urban and trading traditions from their continuous residence of the three coastal cities of Sidon, Beirut and Tripoli. During the war the Sunni Muslims allowed the armed Palestinian forces to take the armed initiative on behalf of the Sunni population. Their strength diminished in Beirut and Tripoli where they were surrounded by Syrians of the Alawi sect and in Sidon by the Shias. However since Taif they have been reinstated to a position of influence by their neighbouring Sunnis who brokered the Taif Agreement (Salem 1993a).

The Druze have not succumbed to urban migration and they remain in the Mountain where they have consolidated their own political and social institutions. At the beginning of the war with Jumblatt as their leader, and also the leader of the leftist coalition, they were in a strong position. But then they fought alone against the Lebanese Forces and their American support in the Mountain, and against the Shia militias for control of the city and the area south of the city (Salem 1993a).

The Christian Maronites began their migration to Beirut from the Mountain in the 1860s (Cobban 1985). After this time their numbers in the city were greater than the Muslims. They consolidated their power during mandate times and following independence. A second migration occurred in the 1980s and by the late 1980s their numbers in the South Mountain had shrunk to five percent of the population from fifty five percent (Khalaf 1993). With General Aoun's final War of Liberation failing many Christians left the country with the belief

that if their country could not be controlled by Christians they should live elsewhere (Salem 1993a). Today the Patriarch and some politicians boycott the political system, and many Maronites who stayed are unhappy with the Syrian-Muslim control in Lebanon (Jansen 1996b).

Other Christian groups include the Greek or Arab Orthodox, the Greek Catholics, the Protestants, the Roman Catholics and the Armenians (McDowall 1986). The Armenians are refugees from various conflicts over the past one hundred years. They were granted citizenship in 1924 to increase the percentage of Christians inside Lebanon (McDowall 1986).

The Palestinians are predominantly Sunni Muslims. The majority of them live in refugee camps around the cities of Tripoli, Beirut, Sidon and Sour (McDowall 1986). Their future remains uncertain as the Oslo Accord and the Gaza-Jericho First Agreement of 1993 does not include the repatriation of refugees from 1948 (Salem 1993c). In 1994 the Lebanese government offered citizenship to some families who had lived in seven villages along the current Israeli-Lebanese border. Wealthy Palestinians are able to buy Lebanese citizenship but the majority, after nearly fifty years as refugees, remain stateless and marginalised. They live in appalling circumstances with few chances of economic and social improvement (Sayigh 1995).

Syrian immigrants currently hold two seats in the Lebanese Parliament, there are one and a half million Syrian workers and possibly forty thousand Syrian troops in Lebanon (Jansen 1996a). The average income of the workers is five US dollars per day, most of which is repatriated to their families in Syria, and some is paid in tax to the Syrian government. There are no travel restrictions for Syrians entering Lebanon.

The following section considers some features which may explain how these population groups manage to coexist in Lebanon following the years of civil conflict. The religious communities share many customs, for example, first cousins still marry, the males are circumcised, and elders and guests in the home are treated with great respect (Cobban 1985, Khalaf 1993), which creates some common ground amongst the various religious groups. All religious holidays are observed nationally, and the national television channels focus on the various religious festivals and events as they arise.

Every family suffered in the conflict through the death of family members and friends, and with the loss of their homes and displacement. For example, 150.000 people died, 300.000 people were wounded or disabled, 700.000 people were displaced, and 9.000 thousand homes were destroyed (Khalaf 1993:94). Khalaf (1993) believes that this human loss and physical destruction is a unifying force within Lebanon, a recognition of what has happened and a need to move on with hope for the future.

The partition of Beirut with the formation of the Green Line did not successfully divide the Christians and the Muslims (P2, P3). A complete breakdown between east and west Beirut was:

"staved off by those sullen people who stubbornly cross[ed] over, day after day by the thousands, some to go to work, some to visit friends and relatives, and many just to make a point" (Makdisi in Khalaf 1993:154).

The majority of the population in Lebanon is not well off and the life is not easy for them (N1, N2, N5). The people may be critical of the government (P6), or they may accept it (N4, P1) and get on with their lives with the hope that peace, economic stability and prosperity will eventuate (Salem 1993a).

SUMMARY - THE ANALYSIS OF THE FUNCTION OF THE STATE

This section will attempt to analyse the make up and the function of the Lebanese state. It will consider changes which have occurred in state-society relationships in three periods since independence in 1943 (1943 - early 1970s, late 1970s and 1980s, and 1989 - 1996), and show how these changes have influenced the function of the state.

The analysis is based on a model adapted from the four domains of social practice (Friedman 1992:26-31). This model which is discussed in chapter three describes four interdependent areas of social practice: the state, the corporate economy, the civil society and the political community. Some components of this model have been adapted for this discussion about Lebanon (figure 4.2). For example, the life space is not only influenced by the local political community and the state but also by the regional political forces; the church is replaced by the

religious community which includes the different Christian groups, the Sunni and Shia Muslim groups, and the Druze; and the civil society in this context includes the people with physical disabilities, and people from all religious groups who are not connected with the corporate society and/or the state. These are the people who may experience difficulties gaining access to and benefiting from the market economy due to their low income. The civil society is presumed to be the lowest twenty percent of income earners who receive four percent of the private income in Lebanon and the majority of the sixty percent of the population who receive forty one percent of the private income (New Internationalist 1993:18).

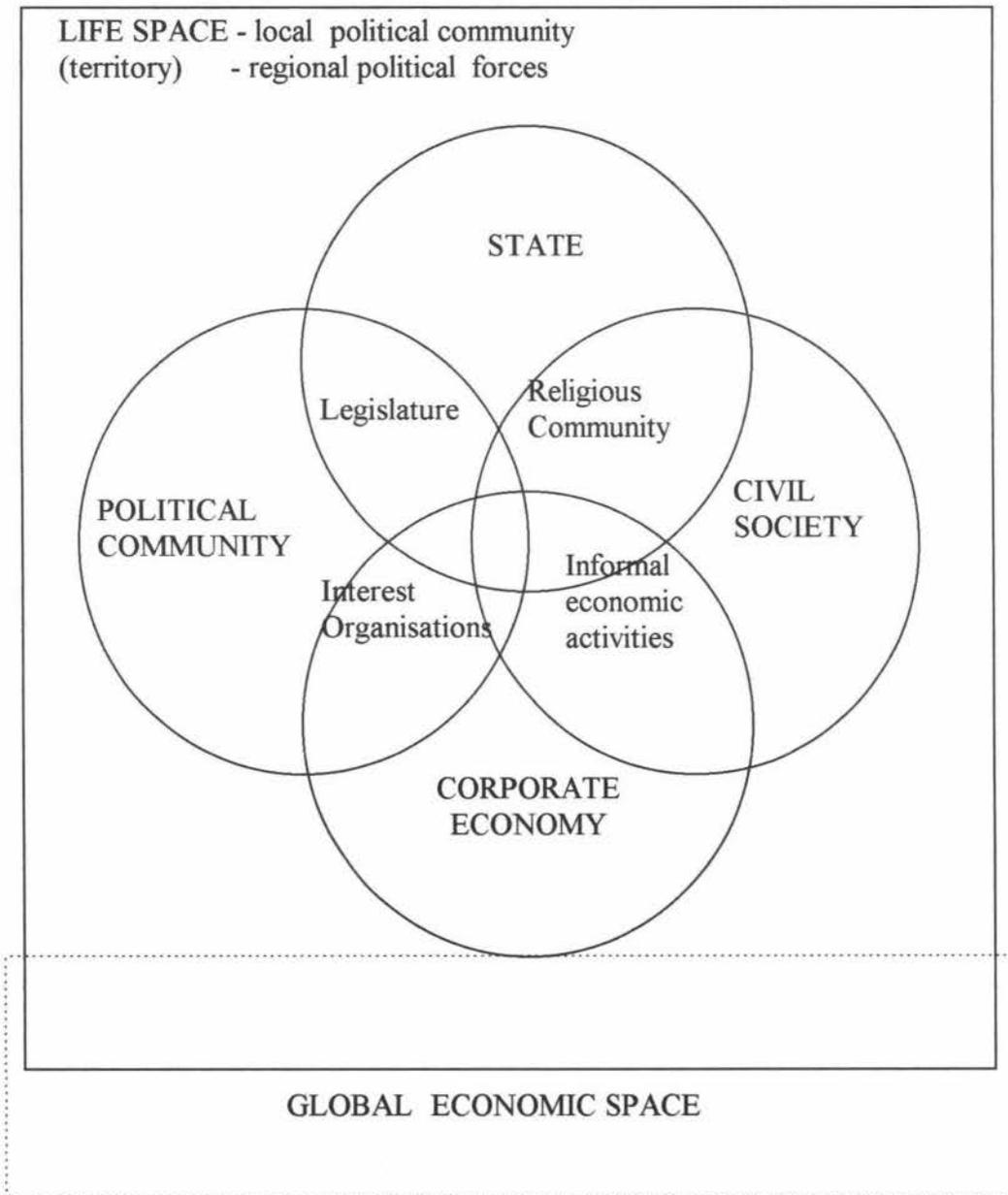


Figure 4.2 Four domains of social practice: adapted model
 Source: adapted from Friedman 1992:27

1943 until the early 1970s

Lebanon began its post independent phase with a relatively equitable distribution of power and responsibility throughout the four spheres of society (figure 4.3). The national life space was to be one where religious, political, economic and social freedoms were tolerated (Baaklini 1976).

The role of the government was to encourage political and religious freedoms with the general assembly to be the "meeting place and centre of unity" (Cheha 1966 in Baaklini 1976:106). There was minimal state control through its policies regarding the economy, the lack of interference in personal and communal life, the freedom it gave the press and the political groups, and the lack of state responsibility for and interest in providing education, welfare and health services (Baaklini 1976). The state did establish some bureaucracies which controlled public works, financial administration and some public health services (Labaki 1993).

The need to develop services and an infrastructure for the rural areas was acknowledged by the government. It hoped to include the outlying areas of Lebanon into the new state structure by divesting power to the religious and local leaders who in turn would become responsible, through their vested interests, for regional development (Baaklini 1976). This development did not eventuate. This neglect by the government in some areas prompted local leaders into action on behalf of their people and new political groups, some of which were connected with the religious community, were formed (Hamzeh and Dekmejian 1994).

The role of the different religious communities in Lebanese society was recognised by the state. The religious authorities were left with their historical responsibilities for education, personal laws and properties (Baaklini 1976, Cobban 1985). This mandate by the state to the religious community to maintain their control over some aspects of civil society allowed the various religious groups to increase their influence over the civil society and the state (Salem 1993a, Hamzeh and Dekmejian 1994). The religious groups subsequently became more powerful, and, rather than occupying a socio-political space between the state and civil society, merged with the political community.

The corporate economy flourished during the post-independence years and Lebanon became the trading and banking centre of the Middle East. The corporate sector also developed strong international links (Labaki 1993). The upper class and some of the middle class benefited from this corporate economy growth at the expense of the lower class. This caused tensions among the disaffected groups and eventually the conflicts of the early 1970s which escalated into civil war (Khalaf 1993).

The political and religious freedoms tolerated by the new government allowed the political parties to expand and new ones were formed (Salem 1993a, Hamzeh and Dekmejian 1994). The different groups within the political community gained strength in the first thirty years after independence. The arrival of the PLO from Jordan added to and complicated the political and religious community activity. Tensions increased amongst the groups within the political community. There was also conflict between some political groups and the government regarding its lack of action concerning the welfare of the civil society (Cobban 1985, Khalaf 1993, Hamzeh and Dekmejian 1994). Civil society became marginalised for the reasons mentioned above. In the 1970s it became weaker as the other sections of society became more powerful.

The state was frequently destabilised. This was due to external factors, for example, Israeli incursions into Lebanon, and the influences from Syria and from Egypt, and from internal tensions arising from various causes, for example, economic disparities, and the political and religious problems caused by the presence of the Palestinian refugees and the PLO (Gilmour 1983, Cobban 1985, al Khazan 1993).

In summary, this period began with relatively equitable spheres with the state divesting responsibilities to the various communities within the Lebanese society. Its policy to encourage economic growth and regional development with minimal state involvement was not successful. Activities within the other spheres of Lebanese society, due to state inactivity and outside influences, and the tensions this caused within and between these spheres altered the structure of the balance of power within the state. The size and influence of the political, religious, and corporate economy communities increased at the expense of state control and the welfare of civil society (figure 4.3 - dotted lines).

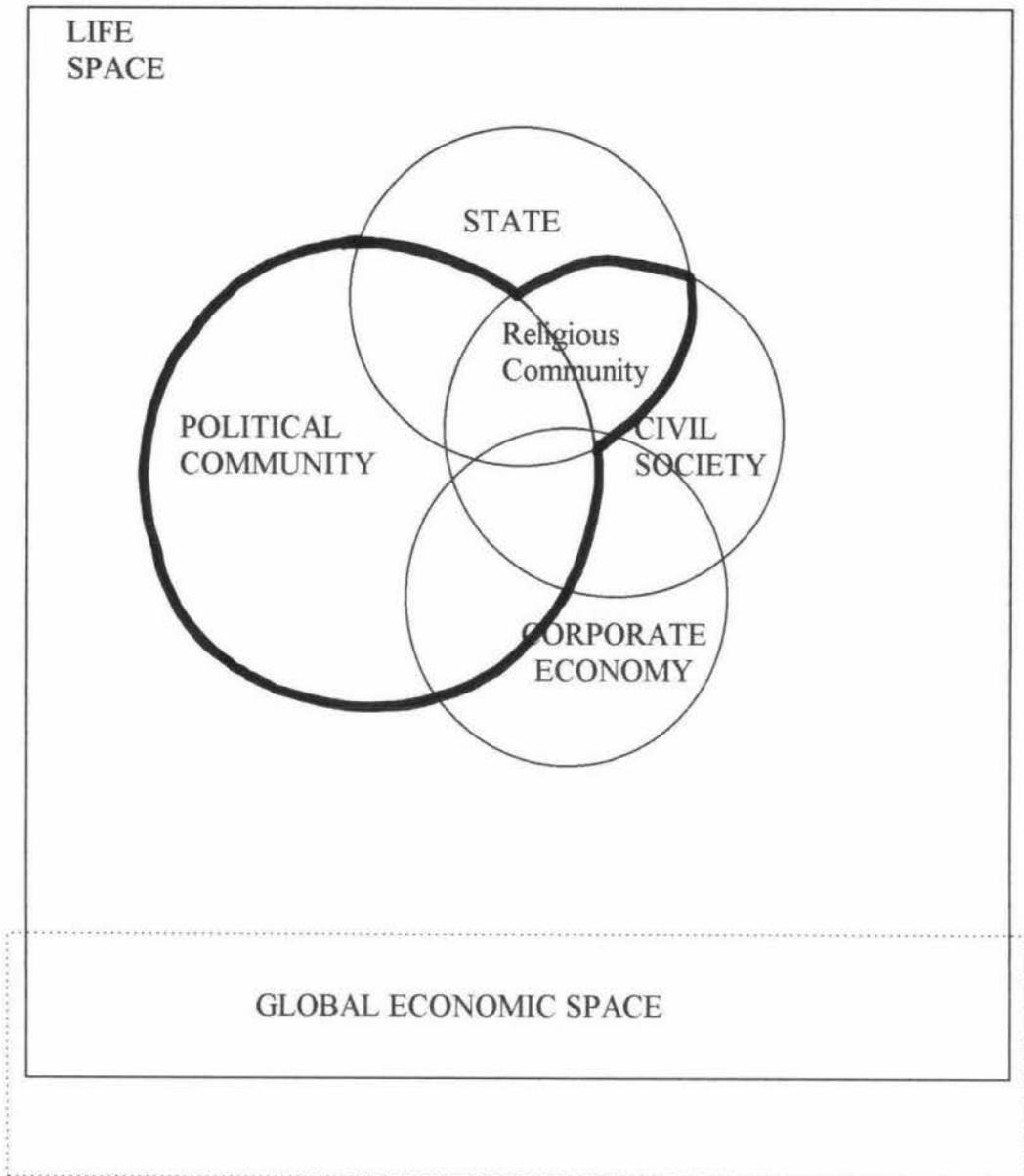


Figure 4.4 Four domains of social practice: late 1970s - 1980s
Source: adapted from Friedman 1992:27

and their opposition to the state and the corporate community escalated into civil war (Gilmour 1983, Cobban 1985, al Khazan 1993).

The political community factions, with their militias, began fighting for control over different parts, if not all, of Lebanon. At times the militias were assisted by armed forces from outside Lebanon, and this direct negotiation and action between the militias and these outside forces further compromised the role and the control of the state (Alamuddin 1993, Salem 1993a).

Within the political community the fortunes of the factions fluctuated and dominance was not maintained by one faction. In 1987 the Syrian army returned to Lebanon, and the Syrian presence has since then influenced the state (Jansen 1996a, McDowall 1996).

By 1988 the role of the state had diminished. The state lost the revenue from the international airport and the port as the militias controlled them. Its administrative powers, especially concerning foreign affairs and the defence sector, were weakened. Commercial deals were lost due to the absence of security (Labaki 1993). The state's ability to protect and support the corporate sector was lost and the corporate sector collapsed. Lebanon lost its position as the broker between the Middle Eastern countries and the international markets.

The dominance of the militias within the political community and their struggle for control of Lebanon compromised the other three areas of Lebanese society. In 1982 the GDP had fallen by 36.79%, and in 1987 the minimum wage was three hundred and sixty US dollars, 27% of the 1974 level (Eken et al 1995).

Civil society, at the end of the years of conflict, was weak. The economic and social structures of most households had either been completely disrupted or compromised (Khalaf 1993).

The national life space during this time was a fluctuating one depending upon the conflicts and where these were occurring. At times the trauma and upheaval associated with conflict was prevalent and at other times attempts were made to carry on with life as normal, for example education, work, and social activities. Many events of the war were isolated and often unrelated events were occurring simultaneously in different parts of the country (Kassir 1994). The life space was unpredictable during the years of conflict.

During this period the tension between the various religio-political factions had become a divisive factor in Lebanon. The conflicts between these factions plus the international wars caused almost complete destruction of the state, the corporate economy, and civil society.

Following the Taif Agreement in 1989 until 1996

The War of Liberation was the final civil and international conflict and a agreement was brokered in Taif, Saudi Arabia, in 1989 (Alamuddin 1993). This agreement altered the spheres of dominance in Lebanon. The government was re-formed with a fifty:fifty Muslim:Christian membership in the general assembly. The militias were disbanded, except for the Lebanese Forces and Hizbollah, and the Lebanese Army was re-formed. Most of the former warlords joined the new government, returning the position of dominance to the state from the political community (Gellman and Lancaster 1996, Jansen 1996b).

Rafiq Hariri, a wealthy Sunni Muslim with international corporate interests, was appointed Prime Minister in 1992. It was hoped by his appointees that his wealth and influence would benefit Lebanon as it began post-war reconstruction and attempted to maintain a stable post war environment (Young 1996b). Hariri stood in the 1996 general election and he is currently an elected member of Parliament. Hariri and many of his Parliamentary colleagues have business interests in Lebanon. The emphasis on economic recovery and reconstruction in Lebanon has strengthened the link between the state and the corporate economy. These two spheres currently dominate all aspects of life in Lebanon (Figure 4.5).

Due to the unstable situation, both internally and regionally, the government is not displaying the tolerance and encouraging the freedoms of the post-independence government. The strength and the wealth of the political class gives them disproportionate access to control of the bureaucracies and services. Currently there are no checks and balances on their power and control. This is a problem especially in the administrative and judicial systems (Young 1996a).

The method of tax collection remains a problem, there is much tax evasion, enforcement is weak and consequently the revenues are low (Eken et al 1995).

Hariri expected that the benefits of his government's economic development, with the emphasis on corporate expansion, would "trickle-down" (Young 1996b:24) throughout Lebanese society as the economy expanded. However the government recognises that the people have been neglected due to this emphasis on economic development. It is now making some attempt to resolve this issue with the assistance of NGOs involved with social affairs and services for people with specific needs (Taowq 1995, Salem 1996). Civil society today is

weak and the economy of the average household is managed on a day to day basis with many households being dependent on an irregular income from within the informal sector (P6, N1, N4). It is estimated that one third of the population is poor (Salem 1996). Many people are still displaced and some risk being displaced again as the reconstruction programme progresses.

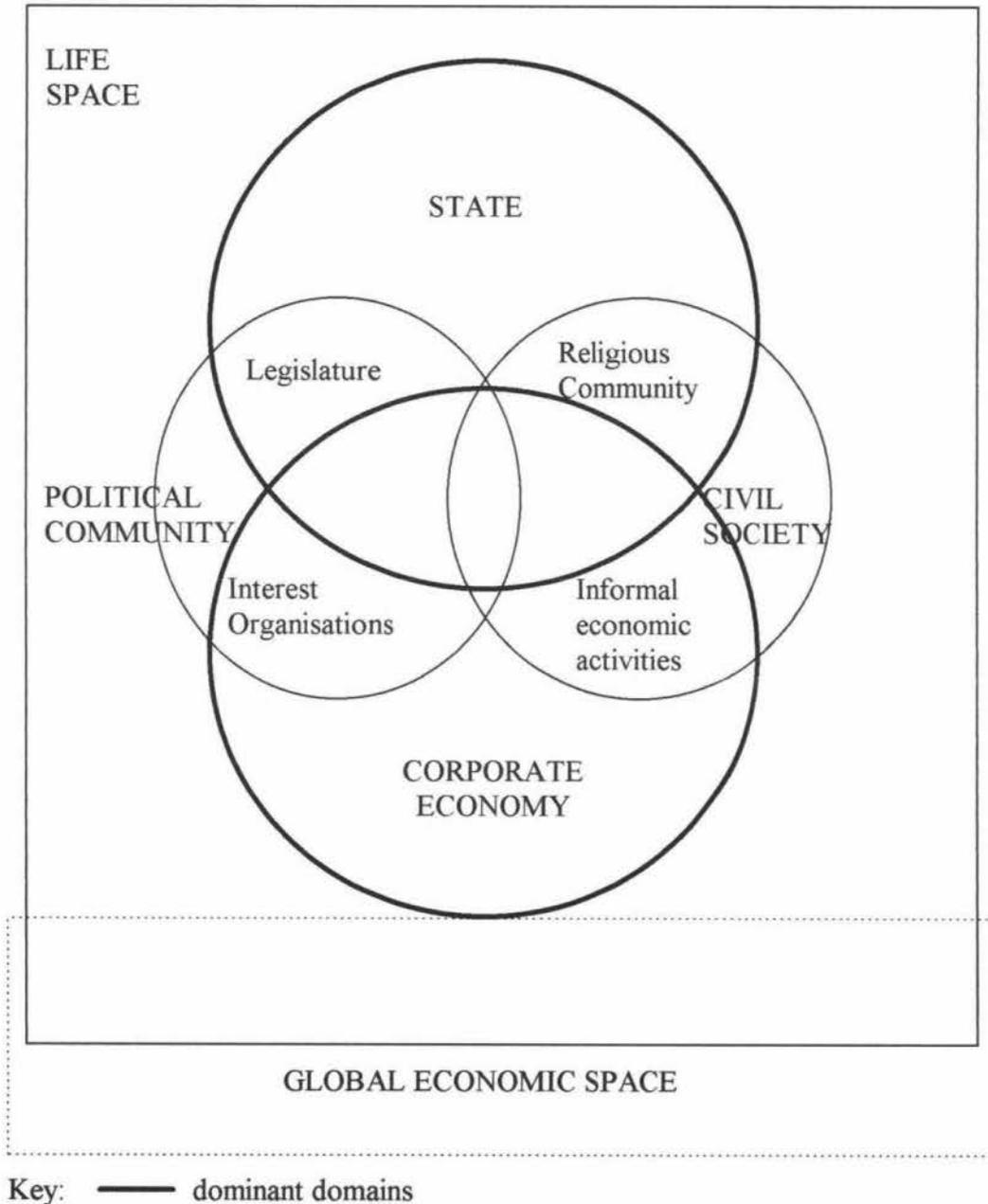


Figure 4.5 Four domains of social practice: 1990s
Source: adapted from Friedman 1992:27

Civil society has an ambivalent attitude towards the economic policies of the government. The financial situation of the household may not have improved but the household may have benefited from the infrastructural improvements made by the Hariri government. Due to the combined strength of the government and the corporations and the centralised nature of the administrative system, civil society is generally unable to influence any policy it may disagree with.

This lack of popular representation at a local level compounds the weakness of both the political community and the civil society (Salem 1996). The political community attempts to gain support from the civil society by providing welfare, health and education services in the absence of state provision (P6).

The national life space continues to be unpredictable due to the simmering conflict in South Lebanon which escalates from time to time, and the domestic tensions.

Currently, amongst the different spheres of society there are areas of disagreement and tension, for example, the religious community against the state regarding the revision of the marriage and education laws; the political community against the state regarding the local body elections; the church against the state over arrests and detainments; and the political community and interest organisations against the state regarding social policy and the media laws. The state has taken an aggressive approach to these disagreements and dissent against its policies is not tolerated (Young 1996a).

CONCLUSION

Throughout these periods of Lebanese history the civil society has been the weakest sphere of society. Despite the poor socio-economic situation of the civil society at the end of the conflict, the state has placed emphasis on the corporate sector and economic development. It hopes that the benefits of this economic development will trickle-down to those not directly involved in the corporate sector. The civil society remains marginalised due to this economic policy of the state.

The lack of state provision regarding health, welfare and education continues to be a problem for the majority of the population. The provision of these services has historically been the responsibility of interested organisations and individuals concerned with the welfare and the needs of the people, and this pattern is perpetuated by the government's current policy.

But the government is being forced to reconsider its lack of a social policy. There is some acknowledgement that it has been neglecting the needs of the people. It recognises the importance of the NGOs and accepts that any social policies will be implemented in co-operation with these organisations. Until any formal social policies are implemented the provision of education, welfare, and health services for people who cannot buy services at market rates will remain the responsibility of the NGOs.

NGOs are identified in reversal theory (Chambers 1991) as the complementary partner to the state, if the state is not addressing the needs of the people who are the focus of the model. This discussion has shown that the state in Lebanon does not provide services for the people with physical disabilities, and that the NGOs are active in this complementary role. Chapter six will consider if the NGOs are able to meet the needs identified by the people with physical disabilities in Lebanon. But before this analysis of the situation in Lebanon, it is necessary to consider what disability means, and to discuss general issues regarding disability and development for people who are physically disabled and live in developing countries.

Chapter 5

PHYSICAL DISABILITY AND DEVELOPMENT

INTRODUCTION

The previous chapter suggested that physically disabled people in Lebanon belong to a sector of Lebanese society (civil society) which has been compromised and marginalised by the other sectors of society (the state, the corporate economic sector, and the political community) since independence in 1943. Being physically disabled implies that these people may be less able, and possibly more compromised and marginalised, than the other people within this sector of society. This chapter will consider if physically disabled people in society do have needs which are greater than the people in society who are not disabled, and if being disabled limits their opportunities for development.

Issues which are relevant to this discussion include an understanding of why any society has people who are physically disabled, the impact these disabled people have on society, and how the disability impacts on the disabled people themselves. Are these people doubly disadvantaged by their disability due to the fact that they belong to a sector of society which is considered to be compromised and marginalised?

The chapter will define disability and handicap, and identify the factors which may cause disability, the types of disability which result from these causes, and the number of people who are affected by disability. It will then consider the impact that these numbers of disabled people have on international bodies and developing states, the impact of disability on the individual disabled person and their family, and discuss a method of research which increases the understanding of how these people manage their lives.

PHYSICAL DISABILITY

In 1994 the United Nations General Assembly presented the following definitions of disability and handicap:

"The term "disability" summarises a great number of different functional limitations occurring in any population ... People may be disabled by physical, intellectual or sensory impairment, medical conditions or mental illness. Such ... may be permanent or transitory in nature" (United Nations 1994 in Moore 1995:58).

"The term "handicap" means the loss or limitation of opportunities to take part in the life of the community on an equal level with others. It describes the encounter between the person with a disability and the environment. The purpose ... is to ... focus on the shortcomings in the environment which prevent persons with disabilities participating on equal terms" (United Nations 1994 in Moore 1995:58).

Being physically disabled means that a person may have functional limitations in carrying out one or more of the following activities: "recreation, education, procreation or occupation" (Murray 1990:12). If this functional limitation is considerable the person may require assistance with "instrumental activities of daily living such as meal preparation, shopping or housework, [and] with activities of daily living such as eating, personal hygiene or toilet use" (Murray 1990:12).

The reasons why people may become physically disabled, experience these functional limitations, and possibly denied the opportunity to take part in the life of their community on an equal level with others are presented in table 5.1. Some types of disability will result from an obvious cause, for example, poliomyelitis, but other types of disability may be caused by unknown factors. However these factors may contribute to either the disability of unknown origin and/or the secondary problems which may develop as a result of the primary physical disability.

The types of physical disability which are relatively common in developing countries are listed in table 5.2. The classification of a disability into a specific type is not an indication of the functional limitation a person with that disability may experience, as each type of disability will affect each person in a different manner. But the classification of disability into types is useful for understanding why a person experiences specific functional limitations and how to

Table 5.1 The causes of physical disability

Factor	Related Issues
Poverty	poor maternal health with inadequate diet and over work during pregnancy may cause low birth weight babies inability to breast feed predisposes the baby to infection and malnutrition to possibility of long term disability congenital defects overcrowded conditions lack of clean water with poor sanitation lack of food with dietary deficiencies
Inadequate primary health care	poor maternal and child health services lack of first aid in homes drug orientated health care delivery systems lack of information and co-ordinated care
Lack of and poor delivery of vaccinations	vaccines not available co-ordination of service delivery is poor techniques of delivery sub optimal
Poor environment	water, roads, transport, fuels, shelter all are factors if unsafe may cause disability pollution, fires, work place environment
War and conflict	injuries - traumatic and complicated may cause long term disabilities high percentages of civilians affected injuries exacerbated by conflict situation (inadequate care, shelter, sanitation) people affected may be displaced/refugees
Cultural habits	family marriages lack of counselling services
Government policy	inadequate provision of primary health care lack of national planning urban bias of government services neo-liberal economic policy

Source: adapted from Morley and Lovell 1986, Werner 1987, WHO 1988, Phillips 1990, Phillips and Verhasselt 1994, Harpham and Tanner 1995

manage the person's circumstances in an optimal manner.

It is difficult to find up to date statistics about the number of people who may be affected by these disabilities in developing countries, but the World Health Organisation (WHO)

Table 5.2 Primary physical and sensory disabilities and the secondary problems which may or may not occur

Primary Disability	Secondary Problems
poliomyelitis	contractures
cerebral palsy	abnormal spinal curvature
birth defects:	developmental delay
club feet	epileptic fits
cleft palate	visual problems
joined toes or fingers	hearing problems
incomplete limbs	speech problems
injuries	behavioural problems
burns	pressure sores
amputations	urine and bowel problems
spina bifida	
spinal cord injury:	
complete or partial	
quadriplegia	
paraplegia	
muscular dystrophy and atrophy	
juvenile arthritis and other joint pains	
bone infections:	
osteomyelitis	
tuberculosis of the spine	
hip problems:	
congenital dislocation	
Perthes disease	
leprosy	
arthrogryposis multiplex congenita	
cerebral-vascular accidents (strokes)	
fractures	
head injuries	
peripheral nerve injuries	
other problems:	
not fitting any pattern and/or undiagnosed	
Sensory Disability	Secondary Problems
speech	developmental delay
hearing	"a slow learner"
vision	

Source: adapted from Werner 1987

(1987) estimates that the number of physically, mentally or sensorially disabled persons in the world is between 340 and 480 million. This is about seven to ten percent of the world's population. It is stated that "[s]ome 35% of them live in developing countries where services are insufficient or not available at all, in particular in the rural areas and among the poorest social groups" (WHO 1987:25). Helander states that there maybe 200 million disabled people in the Third World and possibly another 200 million "adversely affected and

impoverished through having to support the disabled" (cited in Chambers 1995:20).

Werner (1987:A6) believes that the idea of one child in ten being disabled can be misleading as often the defects are so minor the children may live a normal life and it is better to ignore the non-disabling defect rather than draw attention to it. From his experience working with disabled people he estimates, "on the average, only 2 or 3 children in 100 are considered disabled by the community" (Werner 1987:A6).

There are no statistics from Lebanon regarding the number of disabled people. Due to the years of conflict in Lebanon, the percentage of disabled people may be higher than the international expectations due to a number of reasons. These include the injuries related to the conflict situation (Khalaf 1993), the lack of appropriate care, follow-up and rehabilitation of these injuries (N3, P2), the poor socio-economic situation of the people during the years of conflict, the large numbers of displaced people (Khalaf 1993), and the limited access of people to health and rehabilitation services due to the economic policy of the Lebanese state (N1, N5).

THE IMPACT OF PHYSICAL DISABILITY ON SOCIETIES

What is the impact that these disabled people have on different levels of society? The following section will discuss the preventative measures taken at the international level to prevent disability from occurring, the initiatives taken by international bodies and developing states to address the problems associated with disability, and consider the impact that the disability has on the individual person who is disabled and also their families and carers. These international and national initiatives have not always been well received by professionals working with disabled people, this discussion will consider their opinions on these initiatives.

International initiatives to prevent disability

The WHO, the United Nations International Children's Emergency Fund (UNICEF), and the World Bank have established international initiatives to prevent disabilities and to promote wellbeing and good health. One of the objectives of the 'Health for All by the Year 2000' strategy is to educate people so that further disability may be minimised (WHO 1988).

Preventative measures which were orientated towards improving the health of mothers and children and the standard of living for people in developing countries may limit the numbers of disabled people in a society. These programmes included primary health care initiatives for example, GOBI (growth monitoring, oral rehydration, breast feeding and immunisation) Programmes and FFF (food supplements, family planning, and female education) Programmes (Price 1994); the United Nations Decade for Women 1976-85 (Price 1994); and the Poverty Reduction Programme and Handbook 1992 (Hecht 1995).

In order to succeed, these initiatives require support and an ongoing commitment from the local governments, the NGOs, the grass roots organisations, and the local people (Ebrahim and Rankin 1993). In many Third World countries people are using survival strategies to manage their lives on a day to day basis. The negative consequences of living and working in an unhealthy environment and of using unsafe practices are not considered as risk taking behaviour as there may be no viable and affordable options (Morley and Lovell 1986). The prevention of disabilities at this local level is dependent on the work of the local health workers and their ability to educate and advise the local population as is appropriate for their circumstances (Werner 1977, Morley and Lovell 1986).

International initiatives to address the impact of disability

The WHO and the United Nations General Assembly have established specific objectives regarding intervention programmes for disabled people and they have also set up frameworks for implementing these programmes. In 1977 the World Health Assembly in resolution WHA 30.43 stated that the:

"target of governments and the World Health Organisation ... should be the attainment by all citizens ... by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (cited in Periquet 1984:11).

This objective was to be realised through the Primary Health Care approach which included two specific strategies for disabled people and the prevention of disability: to prevent disability through impairment reduction, and to provide rehabilitation services (Periquet

1984). In order to achieve the goal of service provision the WHO promoted the Community Based Rehabilitation concept, which is guided by the principles of equality, solidarity, and integration. The practical application of this concept is that rehabilitation is implemented at the community level by the disabled people, their families, and their community. A manual (Training Disabled People in the Community) for volunteer workers, supervisors and families was published as a resource specifically for this programme (Periquet 1984).

Werner (Periquet 1984) and Narasimhan and Mukherjee (1986) have identified weaknesses in the Community Based Rehabilitation approach and its manual. Werner (Periquet 1984:50) suggests that the manual is too authoritarian and generalised, and that some of the aids, devices and recommendations are overly simplified so they are unlikely to be effective and they may create new difficulties. He offers a problem solving approach to the problems associated with disability. This encourages thinking through problems and solving them with the resources available in the community rather than following the commands in the manual.

Narasimhan and Mukherjee state with reference to India that:

"there are several drawbacks in the community based rehabilitation programme ... it has not taken into consideration specific cultural and socio-economic differences ... family members of handicapped individuals find it difficult to comprehend the significance of many instructions and are unable to follow them" (1986:83).

In 1982 the United Nations General Assembly established the World Programme of Action concerning Disabled Persons (ILO 1985). The goal of this programme was to promote the equalisation of opportunity concept to ensure that disabled people received a share of the improvements in living conditions resulting from social and economic development. In 1987, the mid point of the decade for disabled persons, the guiding philosophy of the United Nations concerning disabled people was decided upon: the rights of disabled people were to be recognised. It was hoped that practical application of this philosophy through international guidelines and objectives would lead to the elimination of discriminating attitudes towards disabled people (United Nations 1994).

In 1994 the United Nations established the Standard Rules for the Equalisation of Opportunities for Disabled Persons. Due to the wide scope of the effects of impairment and disability many other conventions, bills and programmes were consulted and consolidated to form this document which promoted a multi-sectorial approach to addressing the problems experienced by disabled people. These rules were orientated towards improving the conditions of marginalised groups of society (women, children, the elderly, migrant workers, and refugees) who were also disabled (United Nations 1994).

Miles (1989) discusses the Asian experience regarding the implementation of WHO packages and the general "level of non-realism" (1989:117) of them. Miles is critical of the United Nations and UNICEF as six years after International Year of Disabled Persons there was only token provision of services for Asians with disabilities.

Developing states initiatives to address the impact of disability

The impact that the numbers of disabled people has on individual states appears to be minimal. Despite the frameworks supplied and the guidelines proposed by the international agencies for the implementation of programmes concerned with physically disabled people over the past twenty years many states do not have comprehensive, active and enabling policies towards people with disabilities.

This may be due to the fact that most developing countries have been forced to adopt neo-liberal economic policies by international lending agencies (Colclough 1991a). The strategy of neo-liberal policies is that people should take care of themselves in the market economy without the support of the state (Kabeer and Humphrey 1991). The World Bank view is that the poor do not benefit from state owned enterprises and that there should be less expensive ways to meet welfare needs than state provision (Shirley 1989). This neo-liberal ideology is contrary to the objectives of the WHO which suggests that a government should be responsible for improving the level of health within its country so that the citizens may lead socially and economically productive lives (Periquet 1984).

The market approach to health care and education has not enhanced opportunities for disabled people (Colclough 1991b, Bloom 1991), as it is difficult for a disabled person to

access education and other public services if they must pay for equipment and services which would improve their functional mobility. These costs are not incurred by able bodied people. It is suggested that the NGOs may be the providers who will enhance these opportunities (Chambers 1991:274, Mallory 1993:9).

However, some countries do have policies which may improve the situation of disabled people. In 1950 the Indian Government passed an Equal Rights Legislation for Disabled People and they do have the right to work but with high non-disabled unemployment their chances of employment are poor. The Government promoted the Community Based Rehabilitation concept in some areas, but as discussed earlier, the programme had drawbacks as it was not comprehensive and not easily transferable to all Third World nations. There are no reports of any success with this programme in India (Narasimhan and Mukherjee 1986).

The ILO (1985) gives examples of policy changes implemented by Third World governments (Indonesia, China, Pakistan, Oman, Philippines, India, Yemen and Bahrain) following the International Year of Disabled Persons and the World Programme of Action concerning disabled people. Reports of the success or failure of the policy changes were not found, the exception being Miles (1989) who criticised the application of international policies in Third World states.

In Lebanon the government is registering people with disabilities in a new programme organised through the Ministry of Social Affairs (Taowq 1995, P1). The government also contracts some service providers to supply equipment and treatment to people who are disabled (P1, P2).

Due to the economic policies of developing countries, future government policy and services for disabled people will probably continue to be minimal. The grass roots organisations, the NGOs and interested individuals may have the greatest influence on improving the opportunities for and the quality of life of disabled people.

THE IMPACT OF DISABILITY ON THE INDIVIDUAL PHYSICALLY DISABLED PERSON

Physical disability may limit a person's opportunity to take an active part in their community, this may include their lack of opportunity to be educated, to work, to marry and have children, and to enjoy social activities (Murray 1994). They may lack money (Berthoud et al 1993). Their physical environment and the social attitudes (Rioux and Bach 1994, Barton 1996) of their community may compound and exacerbate these limited opportunities. Before these issues are discussed it is necessary to consider the primary impact of physical disability which is functional limitation, and the possibility that the disabled person may need practical assistance with the normal activities of daily life (Murray 1994).

Many types of disability (table 5.2) may occur in a population and the manner in which the functional ability of a person is affected by these different disabilities will be variable. For example, a person with paraplegia may be unable to use both legs, a person with hemiplegia may have a mild or considerable loss of function on one side of their body, and other people may have a disability which affects less of their body, but it may compromise their functional abilities. Little is known about how people are affected by these functional limitations in developing countries. Chambers (1995:19-20) suggests that the reason why this is so, may be due to the physical weakness which causes the people to remain in their homes, and therefore they are unseen and ignored. This implies that they have not been assisted in overcoming the functional limitation they experience and that they are unable, due to the primary impact of their disability, to take advantage of any opportunities which may be available to them in their community. Special equipment, for example, wheelchairs, crutches, calipers, artificial limbs, and other aids, may help with decreasing or eliminating the functional limitation a person experiences.

Some people, due to the nature and severity of their disability, may require practical assistance, in addition to special equipment, to manage their normal daily activities. In developing countries, it is taken for granted that the family and the family network will provide this care (Miles 1989, Nicholls 1993). This functional limitation and practical dependence may have a negative impact on the household of the disabled person. This family carer will be denied the opportunity to work if the practical needs of the disabled person are

considerable. The family may not have the financial resources to buy the basic equipment which would allow the physically disabled person to become mobile and independent (Berthoud et al 1993). They are consequently denied access to their local community and its resources.

However, despite the negative impact of disability on the household, it is recognised that care of the disabled people by their families provides them with “food, shelter, company and hope” (Miles 1989:119). This may be the only support they receive as Miles (1989:117-119) believes that the international rehabilitation programmes do not provide any practical support for the disabled people in the Asian region. A study of the rural people in Nigeria suggests that social solidarity is of primary value to the people and that care of the disabled people by the extended family is accepted as normal (Nicholls 1993:28). In the absence of family carers this care is provided by charitable organisations which may be either religious, political or humanitarian (Narasimhan and Mukherjee 1986).

If a physically disabled person has overcome the impact of their physical limitations in the home, they may be able to take part in the life of their community. But they may face difficulties in being given equal opportunities due to the policies of the state and the attitudes of society. The physical environment may also influence their degree of participation in their society. The physical environment in Third World countries is not usually adapted to the needs of people with physical disabilities. As government policy in developing countries is not orientated towards providing services for disabled people, there is possibly no consideration of their mobility needs when public services are planned and implemented.

In a country with a neo-liberal economic policy Colclough (1991b:209) suggests that the non-bright poor may be doubly disadvantaged compared with the non-bright rich, who will be able to gain access to an education institute regardless of their learning abilities. The ability to pay is not equated with the ability to learn. The same principle may apply to the poor and rich disabled people and their chance of access to education.

Education policy regarding disabled people is in some countries being adapted to the needs of disabled individuals either through mainstreaming, provision of special schools or vocational training centres (Daunt 1991). This applies mainly to European countries and examples of

equal education opportunities in developing countries were not found.

Some form of education may be necessary before a person has the capability to work. In developing countries much of paid employment is manual labour and the nature of a person's disability may automatically exclude them from this type of employment (Chambers 1995). Therefore basic literacy and numeracy skills are useful for business or clerical work, which does not demand a strong healthy body.

The lack of employment opportunities for all people in developing countries decreases a disabled person's chances of employment although some may manage to find employment within the informal sector (Narasimhan and Mukherjee 1986). A study of disadvantage in physically disabled adults in Lebanon (Shaar et al 1994) found that they showed disadvantage in four areas: employment, work level, income, and marital status, and that one disadvantage may lead to another. "The disability had permeated the disabled persons' lives so that all their attributes were viewed in the light of its shortcomings ..." (Shaar et al 1994:412).

The value of employment is recognised as being an essential ingredient in developing the social and psychological wellbeing of an individual (Berthoud et al 1993). It provides social status and social contact, allows for personal development and for the accumulation and use of skills, plus an independent income. If people with physical disabilities are denied the opportunity to work, because of weak government enforcement of the Equal Employment Opportunity Act, if there is one, or because of employers' attitudes towards disabled people, or due to environmental barriers, they are excluded from these economic and social benefits.

The concept of double disadvantage is also discussed by Boylan (1991a:1) who suggests that women with disabilities in the Third World are doubly disadvantaged due to the fact that they have been born into a life of deprivation whether disabled or not, and that the disability will compound their deprivation. Boylan (1991a) discusses the role of women in a developing country society which includes supplying and cooking food, housework and reproduction. This role will be difficult for a woman who is disabled and consequently immobile and isolated in her community. A woman's chances of marrying due to these factors are seen to be limited (Boylan 1991a, 1991b).

A doctor in Lebanon, who had amputated the leg of a nine year old girl following an injury said:

"Can you imagine what this means? She is a girl, she will want to marry, and she has only one leg" (in Fisk 1990:621).

Shaar et al (1994) found that people with physical disabilities were less likely to marry than their able bodied contemporaries.

The limited ability to enjoy social activities and recreation (Murray 1994) may be applicable to the disabled and able bodied people alike in Lebanon. The disabled people were described as belonging to the civil society within the Lebanese society, their able bodied contemporaries are also probably denied access to social events for economic and social reasons. Television, and sometimes videos are the main form of entertainment for the majority of the population in Lebanon.

The cost of living for a disabled person is higher than a non disabled person (Berthoud et al 1993). As identified in the descriptions of disability and functional limitations (Murray 1994), disabled people may require practical assistance to carry out their daily living functions. This practical assistance either in the form of personal carers and/or special equipment costs money and also the carer is denied the opportunity to work outside the home.

The attitudes of non-disabled society create barriers which exclude disabled people from participating fully in their society (Rioux and Bach 1994, Barton 1996). This social exclusion is the product of the lack of understanding of the abilities and the needs of disabled people and the stigmatising image associated with disability. Post-modernist theory regarding disability and disabled people suggests that this exclusion from society is a major issue for disabled people and that it has a large impact on their lives (Morris 1993, Rioux and Bach 1994, Barton 1996). Disability in this context is a social construction as society creates a disabled person by the constraints and barriers it constructs. Society is considered to be disablist, and for the disabled people to gain their rights they must fight against this disablist attitude of their society (Abberley 1989, Morris 1993).

Schuurman suggests that this idea is irrelevant for the marginalised groups in developing countries as:

"the Third World does not consist of post-modern societies. Social movements (new and old) in the Third World are not expressions of resistance against modernity; rather, they are demands for access to it" (Schuurman 1993:27).

He believes that if people, who are excluded from mainstream society, form groups this is a survival strategy with the participants wanting access "to welfare and wellbeing. They are no longer prepared to be shifted to the sidelines" (Schuurman 1993:27).

In summary, the impact of disability on an individual person may compromise both their physical and social development. If a person's practical needs have not been met they will probably remain in their homes and will be dependent on their families for care and financial support. However if this need has been met they may take part in the life of their community. The disabled people may face problems in their community regarding their chances of being educated, able to work, and to enjoy recreational activities and social relationships. The state may not assist them in overcoming these problems, but they may receive support from the NGOs.

RESEARCH AND PEOPLE WITH PHYSICAL DISABILITIES

Research about disabled people has been criticised as not addressing their cultural and practical needs. The researchers have been seen as powerful academics or statisticians who interfere in or examine the lives of the disabled people and then fail to act positively on behalf of the disabled people with the information they have gleaned (Oliver 1992, Barnes 1992, Morris 1993, Rioux and Bach 1994).

This past research which has failed to improve the conditions of disabled people has been based on the positivist (medical) and interpretive (social science) models (Oliver 1992). An alternative research model is the emancipatory research paradigm (ERP). This model is based on the work of Becker who questioned the perspective and attitude of the researcher, and of

Chambers with respect to the aspirations and experiences of the rural poor in developing countries (Oliver 1992:101).

The basis of the ERP is to place the disabled people at the centre of the model rather than alienating them from the research process. For the ERP to meet its objectives and not fail where the other two models have, it should be based on three fundamental elements: reciprocity, gain, and empowerment (Oliver 1992). Oliver makes it clear that the researcher does not have the ability to empower the individual but through the process of discussing their aspirations, needs and expectations they may begin to realise how they may make some changes in their life. The role of the researcher is to facilitate and encourage these changes with whatever means are available to him or her, the reciprocal aspect of the ERP model.

In summary, a physically disabled person will experience some degree of functional limitation, and this may deny them the opportunity to take part in the life of their community on equal terms with others. Possibly ten percent of the world's population may be affected by disability. The reasons why these people are disabled may be easily identified or it may result from an unknown cause. International efforts to improve the circumstances of disabled people have not always been acted upon by individual states.

A lack of appropriate services and/or the lack of equipment may compound a person's physical disability. The opportunities available to a disabled person will depend on how they are able to manage their physical environment, the attitudes of their local community, and the resources which are available in their community. The families of disabled people do their best to support and care for them. This family care may be the only support they receive, but in some circumstances this care and assistance may be supplemented by the work of NGOs.

CONCLUSION

Being physically disabled means that these people may be compromised in two aspects of their lives: the practical aspect of limited function and the social aspect of being unable to participate in their community on equal terms. For the purposes of this study, people with physical disabilities in Lebanon were included in the 'civil society' category for the analysis of state-society relationships (Friedman 1992). Civil society in Lebanon was shown to have

been compromised and marginalised by the other sections of society in the three periods since independence. A person who is physically disabled may be further compromised due to their functional limitations and the lack of equipment which would allow them to participate in their society.

International bodies have attempted to address these issues of compromised function and inequality through various programmes, but the benefits of this work have yet to be realised. National efforts by individual developing states also appear to have been ineffectual if they were implemented, and some states have no active policy towards the issues associated with physical disability. The support the disabled people receive from their families has been recognised as being of value to them. However most families, due to their circumstances in developing countries, are unable to meet all the needs of the disabled person in their household. Unless these families and the disabled people themselves are able to access NGO services it would appear that they will be disadvantaged in many aspects of their lives and denied the opportunities which may be available to able bodied people.

The preceding chapter recognised that the Lebanese state did not act in an enabling manner towards the needs of disabled people. As identified in reversal theory (Chambers 1991:264) and also as suggested in this chapter the NGOs may be the service providers who are able to act in an enabling manner and assist in removing the inequalities and limitations faced by the disabled people in Lebanon. The following chapter will identify the work that some NGOs are doing in Lebanon with people who are physically disabled and consider if this work is meeting the needs of the disabled people and their families.

CHAPTER 6

NON-GOVERNMENTAL ORGANISATIONS IN LEBANON

INTRODUCTION

The counter-ideology of reversals (Chambers 1991:264) model places the NGOs as the complementary partner to the state in enabling and supporting the people, who are the focus of the model, to meet their needs and priorities. The Lebanese state following independence promoted a neo-liberal economic policy, and the NGOs were encouraged to retain their responsibility for health care, education and welfare services. Historically this role had been carried out by groups mainly from within the religious community, and as political groups developed after independence, they too began providing services. Since the Taif Agreement in 1989 the state has continued with a neo-liberal economic policy. Currently it places an emphasis on economic development at the expense of social policy and the provision of health, rehabilitation, education and welfare services. Therefore in the 1990s the NGOs continue to fill this complementary role to the state as identified in the counter-ideology of reversals. The purpose of this chapter is to discuss the work of some NGOs in Lebanon, and to consider if the needs identified by the people with physical disabilities are being met by the work of the NGOs.

This chapter will provide an overview of some local and international NGOs working in Lebanon, look at the functions of these NGOs (the type of work they are doing, why they are doing this work and how they carry out this work), analyse the work and the role of the NGOs, and examine why the NGOs fill these roles within the context of the thesis question concerning the needs of the people with physical disabilities.

The "Three Generations of Voluntary Development Action" model (Korten 1990:114) provides a framework for analysing the work of NGOs.

The information presented in this chapter was obtained from the NGOs, and the people with physical disabilities who participated in the field work. The reference codes refer to the

interviews and the survey conducted in Lebanon, and they are detailed in Appendix E and Appendix F.

AN OVERVIEW OF NON-GOVERNMENTAL ORGANISATIONS WORKING WITH PEOPLE WITH PHYSICAL DISABILITIES IN LEBANON

The following overview divides the seventeen NGOs who participated in the research into two groups, the local NGOs (LNGOs) and the international NGOs (INGOs) (Appendix F). All the NGOs, with the exception of one INGO, work with all people regardless of their nationality.

The local NGOs include Lebanese NGOs and other NGOs which were established in Lebanon by residents who are not Lebanese citizens. Nine LNGOs participated in the survey. Eight of these provide a variety of services for people with physical disabilities. These services include education, health care, rehabilitation, equipment provision and parental and/or family support. One LNGO does not offer specific services for people with physical disabilities but it accepts them into its community programmes.

All these LNGOs are staffed with local personnel. Many of these people are long term NGO staff and they have worked with one NGO throughout the years of conflict. The LNGOs offer their staff ongoing training. The type and pattern of this training is variable. The main problems these NGOs experience are due to a lack of funds, the poor access to and the limited space in their buildings, and a lack of equipment for the people with physical disabilities.

The international group of NGOs work in other countries besides Lebanon. Eight INGOs participated in the survey. Two of these INGOs provide rehabilitation services only, both of these are administered and staffed by transient staff from outside Lebanon. The constraints identified by these INGOs are orientated towards the difficulties of working in a different culture and environment.

One INGO offers integrated programmes in their kindergartens. This INGO was the first NGO to promote integration and it actively recruited children with physical disabilities to

attend its kindergartens. The other five INGOs offer mixed service provision as explained above with the LNGOs, two of these INGOs also offer financial support for starting work and business schemes, and education.

Except for the two rehabilitation INGOs, all the INGOs employ local staff, who work as field officers and/or local administrators. As with the LNGOs the majority of INGOs have long term employees. They appear to function at the field level on a relatively autonomous basis with funding and administrative support from abroad.

Twelve (both LNGOs and INGOs) of the NGOs which participated in the field work are registered with a Lebanese government authority. Of these twelve registered NGOs nine have some input into government policy concerning people with physical disabilities.

THE WORK OF THE NON-GOVERNMENTAL ORGANISATIONS

This section identifies the type of work the NGOs do, why they do this type of work, the policies they have to implement this work, the expectations they have for their work, the factors which limit this work, the plans they have for their future programmes and it describes how they carry out this work.

Fifteen NGOs have programmes specifically orientated towards people with physical disabilities. Two of these NGOs (both INGOs) are concerned only with physical rehabilitation and the provision of equipment. This work includes teaching the disabled person and their families how to manage at home, and guidance regarding occupational therapy and vocational training. Thirteen of these NGOs provide composite services for people with physical disabilities (table 6.1).

Two NGOs do not have specific programmes for people with physical disabilities but they include disabled people in their programmes. The work of one of these NGOs includes health care, the provision equipment and supplies, health education, social programmes including summer camps and environmental activities and the referral of people with physical disabilities on to the most appropriate agency if they require specialist care. This NGO may provide

Table 6.1 The different services provided by the 'composite' NGOs

Type of service		Number of NGOs
Education	pre-school	2
	primary	4
	secondary	2
Special education		5
Physical rehabilitation		11
Equipment and supplies		7
Vocational training		4
Health care		3
Referral to other agencies		3
Lending money		2
Parent awareness programmes		1

financial support for people requiring surgery if this is appropriate. The other NGO provides pre-school education and its programmes also include parent education, after school and summer programmes, and community education.

In summary, fifteen NGOs are providing services orientated to the needs of people with physical disabilities, two of these NGOs provide rehabilitation services only and the other thirteen NGOs provide a mixture of services. Two NGOs promote the integration of people with physical disabilities into the services they provide for the community.

The following section discusses the guiding principles behind the NGO work with people with physical disabilities. All the NGOs express an understanding that people with physical disabilities have needs which are greater than able bodied people and also that their individual right to live with an optimal quality of life is not always recognised by society.

The NGOs recognise the rights of the disabled person according to the Human Rights Convention. They believe that a disabled person has the right "to live with the best possible quality of life" (LN6) and that their work should offer "a humanitarian approach to ... the disabled person" (IN6) and attempt to "improve the quality of life of all people" (LN9).

The NGOs understand that each disabled person is different and that this difference will be reflected in the needs of each person with a physical disability. A disabled person is an individual and he or she should not be collectively categorised due to his or her disability. The services provided by the NGOs "should be good enough so that the disabled person can make

use of it in his life" (LN8). The NGO programmes should "satisfy their particular needs" (IN3) and "help them solve and overcome their problems" (LN1).

The NGOs recognise that a disabled person lives within a family unit and their local community and that work with the disabled people should involve both the family and the community. This principle implies that disabled people should be integrated and hopefully included into their society. NGOs working "for the equalisation of opportunity for the disabled person together with the community and its social infrastructure and the family members" (IN7) are attempting to realise this principle. NGOs believe they should "help the disabled person [to] cope with society as much as they can" (LN2) by providing "functional habilitation so that the disabled person can reach independence in his/her environment" (LN3). "Integration of the disabled child into regular schools" (LN3) and community education programmes "about accepting the disabled people" (LN1) move the sphere of NGO work beyond that of the family unit towards promoting the integration of people with physical disabilities into society.

The NGOs understand that currently the abilities and the skills of disabled people are undeveloped and under-utilised due to a variety of factors and that this situation could be improved upon. The underlying concept of this principle is to provide a person with a physical disability with some capacity and power so that he/she may use his/her abilities for self development. It is based on the belief that "disabled people can be self-sufficient and productive even on the national level if they are well treated and well trained" (LN8). The programmes should "help the disabled people reach an optimum level of function and thus provide him/her with the tools to change his/her life" (IN7).

The NGOs accept that some disabilities could be avoided and that the secondary problems which are created by a disability could be minimised with improved education in the community. The burden and the costs of disability could be reduced by "the primary prevention of disabilities from disease and injury through health education programmes" (IN7) and by "spreading awareness concerning disability issues" (LN1).

The NGOs acknowledge a need to improve the social policy of the government concerning disabled people and the lack of education, employment and social opportunities available to

them. An effort is being made "to improve government policy regarding disabled people to allow for work place integration" (LN7).

In order to carry out the guiding principles of their organisation the NGOs have implementation policies. Some NGOs work within one policy area only and other NGOs work in two or more policy areas. People with physical disabilities are accepted into the NGO programmes, with the exception of one INGO, "irrespective of [their] religion or nationality without any discrimination" (LN8).

The policy of most NGOs is to provide practical support to the disabled person and their family. This work includes; "rehabilitation" (IN8, LN2), "physiotherapy" (LN7, LN9, LN8, LN4, LN2), the supply of "wheelchairs" (IN4), "technical aids and other equipment" (IN6), the "making of orthotics and prosthetics" (IN6, LN8), "home adaptation" (IN6), the provision of "inpatient care if the person needs this" (LN8), "health care" (LN1, LN5, LN8) and the referral to other providers for "operations and medical assistance" (IN4) as required. These services may be provided in NGO centres, in some situations with "transportation to and from the centres" (IN6), or by NGOs who "visit in the homes" (LN2, IN8, IN1).

All NGOs include some form of education in their policy. The focus of this education varies according to the policy of the NGO. The rehabilitation NGOs orientate their work towards providing "information to the disabled ... and the family, [so they may] help improve the function of the disabled person to manage daily activities" (IN2, LN5). Some NGOs have more formal education policies which include "education and habilitation for multiply disabled children from age 2-5" (LN3), "education for people with visual disabilities" (LN4), "vocational training" (LN7, LN9, LN8, LN4, LN2), and "taking care of the disabled children according to the special programmes ... in our schools" (IN5). Community education programmes concerning "the prevention of disability" (IN7), and those "aiming towards Community Based Rehabilitation (CBR)" (IN1) are implemented either through established NGO programmes or new programmes. An NGO, which runs a community outreach programme, is "training local people to work with the disabled people" (IN8).

Some NGOs, concerned about the lack of opportunities available for people with physical disabilities, "promote the concept of the equalisation of opportunity" (IN7) within the local

and national environment. An NGO which accepts disabled people "does not have special programmes specialised for the disabled but ... integrate[s] them into the social programmes of the community" (LN1) and it also organises community education programmes which create an "awareness of the skills of disabled people" (LN1). Two NGOs "lend the disabled people money to encourage self sustainability and independence with business and work" (IN4).

The NGOs belong to formal and informal networks and "work with other NGOs involved in the area of rehabilitation so that the disabled people may benefit from these other services" (IN8). Individual disabled people may be "helped with equipment and operations according to their needs ... by contacting specialised organisations we co-operate with" (LN1). This referral will be dependent on the specific needs of the disabled person. An INGO "financially supports local NGOs" (IN8) which complement the services they provide.

Some NGOs provide recreational and social programmes. These programmes include "summer camps " (LN2, LN9, LN4), "recreational activities" (LN2, LN9, LN4, IN3), educational trips, and the development of hobbies and income generation skills.

Nine of the twelve NGOs which are registered with the Lebanese government have the opportunity to "influence policy decisions" (IN3) concerning the future plans for people with physical disabilities. The NGOs hope that they may achieve some lasting benefits for the people who attend their programmes and also to "make a reality of children's rights" (IN3).

The individual person with a physical disability, their family, and the community are identified by the NGOs as the intended beneficiaries of their work. The NGOs have expectations that their work with these people and groups, and the government of Lebanon will have some long term benefits. These expectations are presented in the following section.

The NGOs expect that the a person with a physical disability will "be as independent as their capabilities can provide" (LN3). This independence will vary depending on the type and severity of the disability and the aptitude and the ability of the person to cope with their disability. The individual person must learn to be "responsible and independent in their daily life" (IN5) and to "ask for support when they need it" (IN2). The NGO role is to "support

the disabled person to realise their maximum independence" (IN8).

From the community, the families of people with physical disabilities and the disabled people themselves the NGOs expect that an "increased knowledge about people with disabilities in the community will change attitudes towards the people with physical disabilities" (IN1). They expect a person with a physical disability to become "integrated into the society" (LN8, LN9, LN1) through the NGO work which "assists the disabled people as appropriate to cope with their communities" (LN2). They hope that physically disabled children will "be accepted into regular schools" (LN3) and that adults will become "economically independent through income generating projects" (IN7).

Some NGOs expect the government of Lebanon to "provide welfare cards ... for the disabled people to receive treatment" (IN4) and to "start taking care of the disabled people by [meeting] their needs and integrating them through employment in the governmental bodies" (IN6). The NGOs hope to work "with the government and social society to complete the rights of disabled people" (LN8).

The NGOs acknowledge the problems associated with running their existing programmes and introducing new programmes. Two examples of these problems are the mystification of physiotherapy, "in this society [there is] the idea that the rehabilitation should be done by the professional and that the disabled person, passively, should be treated by them" (IN1), and the concept of integrated programmes. This concept of integration is new to the parents and the community and the "people usually pity the disabled child without considering his abilities and needs" (IN3). Other factors which place limitations on the NGO work with the physically disabled people in Lebanon are presented in table 6.2.

Despite the uncertain national and regional circumstances in which the NGO work, they all identified plans for the future. Most of these plans involve an expansion of the current services, and in some cases the NGOs plan to diversify into new areas while maintaining their current services (Table 6.3).

Table 6.2 The factors which limit the work of the NGOs

Limiting Factor	Related Factors
Lack of money	the equipment is expensive a dependence on volunteers the fees do not cover costs inability to engage specialised personnel the centres are small the numbers of people attending are limited
Personnel problems	the lack of trained personnel communication difficulties with doctors a lack of professionals to co-operate with NGO staff have different expectations social and cultural restrictions
Physical barriers	access is difficult - no ramps or lifts NGO centre is on the first floor centres are ill-equipped for disabled children geographical isolation disabled people live far from the NGO centre unable to attend due to financial reasons
Poor services	the lack of a government strategy a decrease in UNRWA services for Palestinians the lack of co-ordination between NGOs * a duplication of services no regular follow up of disabled people the disabled people move about
Negative attitudes	lack of recognition of disabled people's skills lack of interest by families stigma and prejudice makes the work difficult

* nine NGOs who answered the questionnaires belong to a network with other NGOs and eight NGOs do not.

This section describes how these NGOs carry out their work in Lebanon. The NGOs are predominantly urban and all, except three of them, work from one of the main coastal cities in Lebanon. Some of the urban NGOs have centres in the villages. The NGOs use a variety of facilities for their work, for example, polyclinics, kindergartens, rehabilitation centres, vocational training centres, physiotherapy centres, technical workshops for making prosthetics and orthotics, occupational therapy assessment and treatment centres, and schools.

Table 6.3 The future plans of NGOs

Plan	Objectives
Same services	<ul style="list-style-type: none"> to carry on with the same services to become self sustainable to be run by the local partner
Improve and expand services	<ul style="list-style-type: none"> to promote registration of disabled people to increase the size and quality of services to upgrade the skills of disabled people to offer work placement for disabled people to establish income generating centres to improve the buildings and access to run an training programme for physiotherapists to build a multi-purpose education centre to increase the outreach activities to begin a rehabilitation outreach programme
Diversification of work	<ul style="list-style-type: none"> to run programmes concerned with young girls, slow learners, disabled, vulnerable, and street children to run education programmes concerning the prevention of child abuse to run health education programmes in the Palestinian refugee camps to establish a multi-purpose rehabilitation facility in South Lebanon
Improve co-operation between NGOs	<ul style="list-style-type: none"> to increase the NGO network to use local agencies as referral centres to strengthen the co-ordination between NGOs

The funding for the NGO work comes from a variety of sources. Six NGOs charge a fee for the services they provide but this income does not cover the costs of the work. Two NGOs receive funds from inside Lebanon only, five NGOs receive funds from both inside and outside Lebanon, and the other NGOs are funded by governments and NGOs outside the country. The majority of the people with physical disabilities and their families find out about these services through other disabled people.

The NGOs usually evaluate their work through subjective feedback. The NGO which has developed a CBR programme will have this programme assessed by a doctor and a person specialised in CBR methods.

Sixteen NGOs provide education for their staff. Some NGOs have regular teaching sessions

supplemented with practical training, and others offer short term courses. This training covers a variety of topics including; the theory and practice of rehabilitation (physiotherapy and occupational therapy), CBR concepts and methods, English language, pre-school work, social work, community education, administration, special education, counselling, and health education. These programmes are usually run in Lebanon but some NGOs in co-operation with other NGOs, send their staff overseas for specific training programmes, for example, to the CARITAS Rehabilitation Centre in Cairo, Egypt. On an informal basis, NGO staff visit other centres, meet with other NGOs working in a similar field and some NGOs receive current literature and journals.

ANALYSIS OF NGO ROLES

This information obtained from the questionnaires is summarised within the framework of generational analysis as described by Korten (1990:114-125) (Table 6.4).

Table 6.4 Generational analysis of the NGOs																	
G																	
4																	
G																	
3																	
G																	
2																	
G																	
1																	
	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8	9
	International NGOs								Local NGOs								
Key: G1 Generation one NGOs																	
G2 Generation two NGOs																	
G3 Generation three NGOs																	
G4 Generation four NGOs																	
Source: adapted from Korten 1990: 114																	

Generation one NGOs (Korten 1990:115) are concerned with providing immediate relief and welfare services to a community which has a shortage of its basic needs. The purpose of this work is to meet the needs of an individual or a family unit. The NGO is the active partner in this work while the beneficiary is a passive recipient. Fifteen NGOs are providing basic needs (practical support, the provision of equipment and supplies, and health care) to the physically disabled people to enable them to manage their lives in a more independent manner and to prevent complications developing as a result of their primary disability. Of these fifteen NGOs, fourteen also offer services which classifies them as generation two NGOs.

Generation two NGOs (Korten 1990:118) are concerned with stimulating the local community into action in order to improve the circumstances of the people within that community. The purpose of the work is to develop "the capacities of the people to better meet their own needs through self-reliant local action" (Korten,1990:118). The NGO works with the community to achieve the objectives of its work. Fourteen generation one NGOs meet the requirements of this category by providing some type of community, staff or family education, vocational training, financial support for education or work schemes and recreational activities in addition to their basic needs provision. Two more NGOs which provide education and vocational training for children and adolescents with physical disabilities also belong to the generation two group of NGOs. These two NGOs in addition to seven combined generation one and two NGOs move onto the third generation of NGO work.

Generation three NGOs (Korten 1990:120) are concerned with altering policies and institutional factors which may be hindering their work at either at a local or at the national level. This work is orientated towards improving the long term circumstances of the people they are working with. The nine NGOs in this generation all have some input into the government policy concerning the future plans for people with physical disabilities in Lebanon.

Generation four NGOs (Korten 1990:123) are described as those concerned with global issues and change through social movements. The NGO role is to act as an educator and activist to facilitate these changes on a global level. No NGOs fill the requirements of this generation although one INGO uses its international experience to improve its work. It is also

an active international advocate on behalf of children who live in less than optimal circumstances.

The role for generation three NGOs in Lebanon

The state of Lebanon, in the past, was not been actively concerned with the needs of people with physical disabilities. It is now beginning to address these issues and disabled people are encouraged to register with the Ministry of Social Affairs (Taowq 1995, P1). There is no formal state policy regarding the rights of disabled people or the equalisation of opportunity for them. Nine NGOs do have some input into government policy decisions concerning people with physical disabilities. These NGOs are also working with people "on the ground" so it is hoped that their practical experience, knowledge and input will be recognised and accepted when any policies are formalised in the future.

The role for generation two NGOs in Lebanon

Lebanon has a large private sector providing education from kindergarten to the tertiary level and the state is currently placing an emphasis on economic development by supporting the corporate sector. People with physical disabilities generally belong to the part of civil society which is compromised and marginalised by this orientation towards the market economy. The philosophy underlying the NGO work is that people with physical disabilities have needs which are greater than the able bodied people in the community. Therefore by providing education services, promoting the integration of disabled people into their programmes and the community, lending disabled people money to start up work schemes, and increasing the NGO community networking these generation two NGOs are assisting in some way to fill the gap between the market services and the neglect by the state of the needs of people with physical disabilities.

The role for generation one NGOs in Lebanon

People with physical disabilities have special needs as a result of their disability. They require practical support and advice (rehabilitation), and possibly specialised equipment to allow them to be mobile and function in a relatively independent manner. A rehabilitation service

orientated to the specific needs of the person with a physical disability will allow the person to reach their maximum level of independence and it will also prevent the possibility of secondary problems developing as a result of ignorance and neglect. The needs of the people change as they grow, make progress with their rehabilitation, or their situation alters in some way so these services are required on an ongoing basis by the person with a physical disability.

The equipment required by a person with a physical disability may be small, for example, special boots or splints or large, for example, a wheelchair. Regardless of the size or cost, these expenses are an extra financial cost for the family of the person with the disability and without this equipment the person will be unable to participate fully in his society. This equipment has a limited life span and children usually need their equipment replaced more frequently as they grow. Without generation one NGOs assisting (financially and practically) the families of the disabled people with rehabilitation and the provision of equipment the quality of the lives of many disabled people and their families would be less than satisfactory. For example, if a child did not have calipers so that he/she could attend school someone from the family would have to stay at home with him/her, when maybe they could be working outside the home, and also the child would miss his/her chance of being educated.

The health of people with physical disabilities may be compromised due to their disability, for example, there is a risk of renal failure or skin breakdown with paraplegic people, they therefore may require health care and follow up on a more regular basis than their able bodied contemporaries.

Generation one NGOs in Lebanon are essential if people with physical disabilities are to be given the chance for self development and to benefit from the work of generation two and three NGOs. Without these generation one services their lives and the lives of their families would be severely compromised.

WHAT ARE THE NEEDS OF THE PEOPLE WITH PHYSICAL DISABILITIES?

This section will present the needs identified by the people who participated in the interviews (Appendix E) and then consider them in relation to the roles of the NGOs. The first part will concern the needs which are relevant to most of the people with a physical disability and their families. The second part will look at the needs specific to the following groups, young children, school age children, working age people, and elderly people. The people are divided into these groups as their needs and problems are specific for that stage of their life, the expectations for or of the person with the physical disability and the capabilities of their carers. Some of the people with physical disabilities manage their lives in a reasonable manner and they had no specific needs. This discussion concerns the majority of the people who were interviewed.

The needs of people with physical disabilities are complex. They are linked between various economic, social, and physical factors which involve their families, their environment, the attitudes of the society in which they live, and the services available to them.

The people with physical disabilities are usually dependent on someone (a carer) to help them manage some, if not all of their normal daily activities. This need for a carer raises sensitive issues, for example, who will take care of the person with a physical disability when their carer is too old and/or physically unable to do this work, the lack of money to pay for a carer from outside the family, the siblings and children of the disabled person often have their own responsibilities and children to support and they are unable to support their family member who is physically disabled. Some daughters have given up their normal activities to care for their disabled parents, what will happen to them once the person they are caring for dies, and who will share the long term responsibility with the main carer?

Most of the people with physical disabilities have a need for special equipment to manage their daily lives in a reasonable and dignified manner. For example, they may require one or more of the following, a wheelchair, crutches, calipers, catheter condoms, pressure relief cushions and mattresses, an artificial limb, splints, and adaptations inside the home to assist with their basic daily activities.

People with physical disabilities have the need to live in an environment which helps them to manage their lives as independently as is possible. Many of the houses are unsuitable and require some modifications so that this independence may become a reality for them. The physical barriers in the local environment create more problems for people in wheelchairs or those people who have difficulty with walking. This situation is difficult to improve due to the lack of responsible people in the local communities and the poor condition of the infrastructure in Lebanon.

People with physical disabilities have needs which are specific to them and they may require special assistance to meet these needs. The problems associated with meeting these needs are often compounded by the lack of honesty from the medical profession regarding their diagnosis, treatment options and prognosis, the costs associated with receiving specialist care, the lack of a primary care provider who will follow up their progress and keep a record of their condition, and if they have managed to gain access to services appropriate for their needs there may not be co-ordination between the service providers. People in rural areas may know about services appropriate for their needs but they may have difficulty in gaining access due to their geographical isolation and the urban bias of some services.

Most families of the people with physical disability and the disabled people themselves are in a poor financial situation. They expressed a need for an increase in their income from whatever sources (employment opportunities, charity, remittances from abroad, the opportunity to travel abroad to work) may be available. This lack of money exacerbates many of the needs and problems identified above. For example, people with physical disabilities and their carers may not be able to afford the transport costs to utilise a service outside their immediate area, the cost of housing modifications may be too expensive for the family to afford, they may not be able to buy special equipment which would allow the person with a physical disability to become mobile and independent, and the cost of having a disabled person who may never have the chance to work will mean that another family member will have to work extra hours, (if this is possible), or beyond their retirement age due to the disabled person's long term inability to earn.

The mothers of young children with physical disabilities identified problems and needs which began in the perinatal period of their child's life. These children displayed abnormal

characteristics soon after they were born, and all the mothers had difficulty in obtaining a diagnosis concerning their child's abnormalities (M1, M2, M3, M4, M5). They all experienced some interference and advice from other mothers and friends regarding their child's disability and the possible treatment options, and given their lack of knowledge concerning the disability and the prognosis for their child this caused some confusion and anxiety.

The social needs regarding education and childhood socialising concern the mothers of these children. These children are past the "baby stage" and would normally be relatively independent and able to attend the local school. But three of the mothers are still left with a dependent child who they cannot send off to a school as they have done with their other children.

A mother was told there was "no hope" for her daughter and she was denied a place in a special school (M2). This mother is the primary carer for her daughter, the long term prospect of having her at home all day is difficult for the mother to accept. She would like her daughter to have the chance of an education and to meet and mix with children from outside the family.

One boy who attended an integrated kindergarten programme is now at a "normal" school (M4). He was accepted into this school because of family connections, rather than an integration policy of the school. His mother is concerned about how he will adapt to the new school and how his peers will accept him.

The needs identified by school age children with physical disabilities are associated with them realising they are different from their peers and about being accepted by their society. One girl was teased by her peers when she started school but she coped with this and is now accepted by them (S4). Some of the children are protected by their families and their chance for interaction with their peers outside school hours is limited.

The needs identified by working age people with physical disabilities are associated with their long term physical and financial dependence on their families and the lack of employment opportunities. Their physical needs, for example, being unable to manage an independent life style due to their home circumstances are often compounded by a mixture of factors. The

family does not know how to modify the house appropriately, there is often no money to make the changes, and if the outside environment is not accessible, what is the point of making the changes? The men who are paraplegic have special needs if they are to live their life in a dignified manner. They require catheter condoms as they do not have bladder control. These are supplied by some NGOs but not on a regular basis and they feel uncomfortable about asking for these supplies (W1, W8, W12, W13). One man has not been trained in bowel management and control (W12). This problem limits all aspects of his life as he is reluctant to leave the family home.

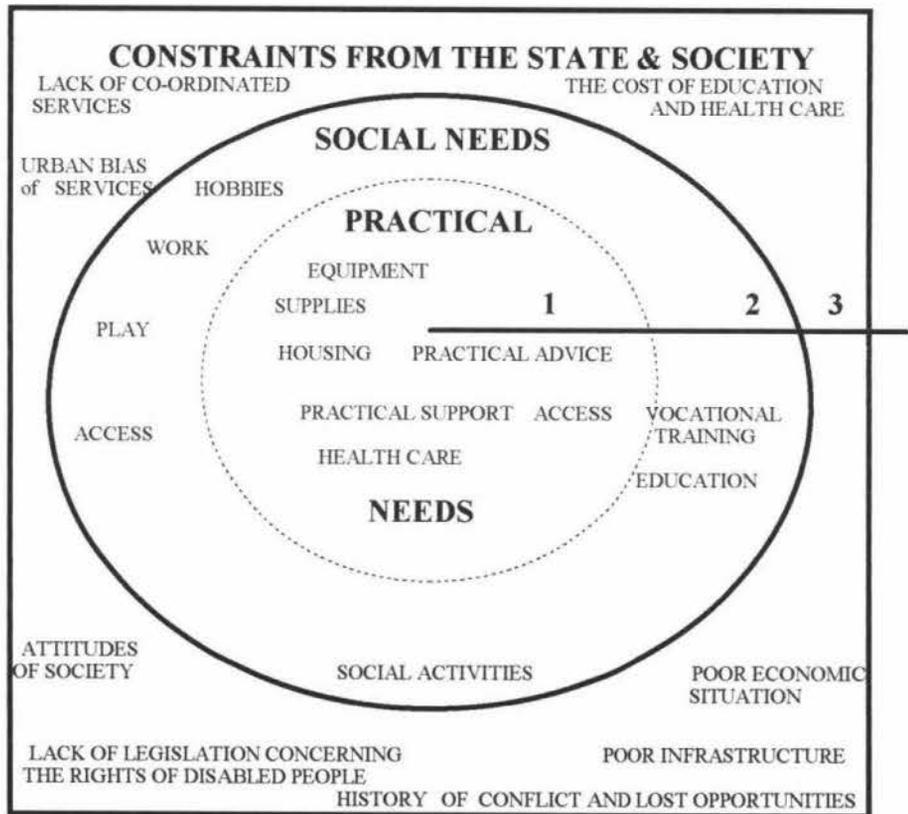
The social needs of these working age people are related to the life style choices which they are denied due to their physical disability. The life is boring, it is the same day after day, and there is no privacy in the home (W3, W8, W12, W13). There may be no chance to marry due to the attitudes towards people who are disabled and also the need for a marriage to produce children (W1, W13). There is no chance to go out to work and become financially independent. This is related to many issues, for example, being denied an education due to a physical disability and subsequently remaining illiterate (W2, W5), the lack of employment opportunities for all people and the disabled people are less likely to be employed (W3, W4, W8, W10, W13), the family lives in a farming area and there is no work for someone in a wheelchair (W13), physical access to any places of work is difficult (W3, W4, W10, W13), and the negative attitudes of prospective employees towards people with physical disabilities (W8, W10).

The needs identified by elderly people with physical disabilities and their carers are related to the requirements of having a continuous caregiver in the home with them due to their physical disability making them unsafe with daily living activities for example, dressing and cooking, and being unable to clean and care for the home as is expected in the society. Due to the nature and cause of their physical disability which is related to a decline in their general health they need regular medical care.

This section considers if the roles of the NGOs are meeting the needs of the people with physical disabilities.

The analysis of the NGO work shows that the type of work they are doing covers generations one, two and three (Korten 1990). The needs of the people with physical disabilities and their families may be loosely categorised as being either practical or social. These needs may be compounded by the constraints of their society and the lack of state legislation regarding their rights. Figure 6.1 is a diagrammatic representation of the needs of the disabled people, the constraints they experience, and the type of NGO work in relation to these needs. The boundaries between the physical and social needs are not definitive.

The needs of the people with physical disabilities may overlap and possibly exacerbate another need if there is not some intervention by an NGO somewhere in the chain of these



- key: 1 - generation one NGOs
 2 - generation two NGOs
 3 - generation three NGOs

Figure 6.1 The relationship between needs of disabled people, the NGO services, and the constraints of the state and society

Source : adapted from Korten 1990:114

interrelated needs. Some people may have requirements from generation one NGOs only and if these needs are satisfied, they may manage their lives in an independent manner (W1, W6, W7, W9, W11).

Other people with physical disabilities have mixed practical and social needs and they benefit from the composite generation one and two services provided by these NGOs. The degree to which these needs will be met depends on the approach of the NGO and its ability to consider the capabilities of the person with a physical disability, the environment in which the person lives, and the opportunities available to them once their practical needs have been realised.

The lack of any government strategy and legislation concerning the needs and rights of people with disabilities in Lebanon creates a role for the work of generation three NGOs.

There are some needs of the people with physical disabilities which are not met by the NGOs. There is an urban bias to their service provision, and the people often find out about the services by chance rather than through any formal system of advertising. The lack of co-ordination between the NGOs limits the efficacy and the efficiency of the services.

The attitudes of the disabled people themselves and of society in general may inhibit the individual person's ability to reach their maximum functional and economic independence. The NGOs cannot address this issue alone. This role of raising public awareness concerning the capabilities of the people with disabilities, their ability to be educated, to join the work force, and to be active in their community is the combined responsibility of the people with physical disabilities, the local community, the NGOs (generation one, two, and three) and the state.

CONCLUSION

Korten (1990:114-122) suggests that for NGOs to make long standing improvements in the lives of the intended beneficiaries of its work, they should progress through the generations. He believes that the progression will occur if the NGOs are clearly focused on trying to make a sustainable difference in the lives of the people they are working with, if the NGOs have an underlying theory for their work and if they assess their work on a regular basis (Korten

1990:122). All the NGOs display the first two factors. They all have guiding principles for their work and from these principles they have developed policies which allow these principles to be implemented. However the needs of the people with physical disabilities are not static and also the population of the intended beneficiaries will alter. For these reasons, even if the NGOs meet the requirements as Korten suggests for generational movement, there is a need for them to continue their work within one generation or across the generations and not to progress in some circumstances beyond generation one and/or two.

The assessment aspect appears to be neglected by most NGOs. However the NGOs do have expectations for their services and their policies are orientated towards meeting these expectations.

The work of the NGOs reviewed in this chapter, shows that the type of services they provide are appropriate for the needs identified by the people with physical disabilities. But the NGOs recognised aspects of their service provision which were less than satisfactory, and also the people with physical disabilities identified needs which were not satisfied by the NGO services. Due to both the diverse nature of the needs identified by the people with physical disabilities, and the lack of practical and legislative support from the state concerning disabled people, is not an unexpected outcome that some dissatisfaction is expressed by both the NGOs and the people with physical disabilities.

This chapter has been concerned with the relationship between the services provided by the NGOs and the needs of the people with physical disabilities. The following chapter will consider the good changes which have occurred for the people with physical disabilities in Lebanon, and examine how these people and their households manage their lives within their local environment.

Chapter 7

THE DISABLED PERSON AND THE HOUSEHOLD

INTRODUCTION

The purpose of this chapter is to provide some understanding of lives of disabled people and their families in Lebanon and to consider if these people have the ability or are assisted in developing their ability to experience good change and to manage their lives in a positive manner. The discussion will present the disabled peoples' experiences of good change and identify who instigated this process of good change. It will also consider how the households with disabled people manage their lives and the manner in which they utilise the resources which are available in their community. These issues will be analysed within the frameworks of good change meaning development, sustainable livelihoods, and the dimensions of deprivation. These frameworks are complementary to the central model of the thesis, the counter-ideology of reversals (Chambers 1991:264).

"Good change" in this context means "development" (Chambers 1995:vi). This is subjective and dependent on what the individual person has to say about their life and what they perceive to be good change which has occurred for them.

The components (livelihood capabilities, tangible assets, intangible assets, and a living) of the sustainable livelihood model (Chambers and Conway 1992:6, Chambers 1995:23) provide the framework for the analysis of how the households manage their lives. It considers whether the household is able or not to make positive use of their own capabilities and the community resources in order to sustain the household and the lives of the people in the household. The ability of a household to utilise the intangible assets, that is its ability to claim and to gain access, is particularly relevant to the people with physical disabilities. The disabled people in this study identified practical and social needs (chapter six) which required special services in order to manage their lives in a reasonable manner. Their ability to access these services and to make claims may assist them with meeting these needs.

Chambers (1995) suggests that for understanding the reality of the lives of the people who are disadvantaged, it is useful to consider them within the "dimensions of deprivation" (Chambers 1995:18). These dimensions (poverty, social inferiority, isolation, physical weakness, vulnerability, seasonality, powerlessness and humiliation) "attempt to capture some of poor people's reality" (Chambers 1995:19). The information about the disabled people in Lebanon and its relevance to these dimensions will be considered within this framework in the summary.

The needs of the disabled people, which were discussed in chapter six, were identified as being specific to that stage of their lives. This chapter will also consider the four age groups (the young children, the school age children, the working age people, and the elderly people), who took part in the interviews as these age groupings are relevant to this discussion. The information in this chapter was obtained from interviews with the people with physical disabilities and their families in Lebanon (Appendix E).

This chapter will present the good change identified by the people with physical disabilities and their families, discuss the good and the difficult things in the lives of these people, and consider how the households with disabled people manage their lives. The summary will consider these issues in relation to the dimensions of deprivation.

PRE-SCHOOL AND PRIMARY SCHOOL AGE CHILDREN

The needs identified by the mothers (M2, M3, M4, M5) of these children (4-8 years) were orientated towards the problems of learning how to cope with a growing disabled child who was not progressing and becoming independent as the other children in the family had done. This child was missing out on the normal chance to socialise and be educated. One child (M1) had been born with musculo-skeletal problems. His needs were slightly different as he required surgery to improve his functional skills. Due to the age and developmental stage of these children, the problems are usually on-going, and as the children grow and develop new problems may arise.

However the mothers did recognise that there had been some improvements with their children (Table 7.1), and also that their quality of life had improved with an increased

understanding of their child's condition and how to manage them in the best possible way. A mother had "accepted this problem now because [she is] better informed about it. ... H. has brought a new dimension to my life. In the beginning I thought how am I going to live my life with this boy, but I think I have accepted it. The progress I have seen with H. makes things easier" (M4). Another mother recognised that "only a miracle will change her [disabled daughter]" as she understood "more about [her] daughter now" (M2).

Table 7.1 Good change for the young children (identified by their mothers)

Good Change	Instigator of Change
attending an integrated kindergarten	NGO
accepted into the local school	family
trying to find a school	NGO
improved social skills	NGO
access to rehabilitation services	neighbours - family - a disabled person - NGO
improved functional skills	NGO
provision of equipment	NGO
increased understanding of disability	NGO
orthopaedic operations	family - NGO
speaking more since sitting up	NGO - self
learning how to manage the child	NGO
child walked at 1.5 years	self

The difficult things about having a disabled child in the family are considered in the following section. One aspect of these difficulties is related to the mothers and the families learning to cope with having a disabled child. "A doctor told us he was retarded ... we refused to believe this ... I was very depressed when he was little, I didn't know what to do with him and how to help him ... I didn't know anything about cerebral palsy until H. was 4 years old, I had never seen a spastic child before" (M4). A girl "lay on the floor for five years. I thought she would lie on the floor forever, I was afraid when she sat up because of the movement in her head" (M2).

The families experienced unwanted interference from the community. Their ignorance and the lack of professional advice often compounded these difficulties. "The people don't understand about cerebral palsy. They think it can be cured ... the people ask a lot, why is she like this? Why don't they treat her?" (M2). "The people are always asking what is wrong with him ... H. doesn't like to go out on the street when the school is getting out as he thinks the people will be looking at him" (M1).

The financial cost of having a child with special needs is exacerbated by the fact that "the government doesn't help with anything" (M2). One family spent \$US 8,000 on operations. "We went from doctor to doctor to find the cheapest [option] ... money is very difficult, there is no money now" (M1).

These mothers are the main care givers for their children and as the children grow the practical aspect of this caring is causing physical problems for the mothers. One mother is "suffering from lifting [her son] around. [I have] back pain ... he is too heavy for me now ... I have to undress him, bath him and take him to the toilet" (M4). Another mother has "to carry her [disabled daughter], I can't leave her at home with her brothers and sisters, she is big and heavy" (M2).

Three of the children are attending school or kindergarten. But two of the mothers have faced problems with finding a place for their children. "There is no school for her, [I have] been trying to put her into a school, but there was no way that the Randa Berri school would accept her as they said there was 'no hope' for improvement" (M2). A mother who lives in a rural area believes "it is difficult for [her son] to go to the local school. [It is] too far to walk, and the classes are too big" (M6).

Despite these difficulties of having a child with special needs these mothers talked about the good things in life with their children. H. is "a fine boy, he talks, he laughs, plays, loves going out in the car. He enjoys his meals ... and loves studying. He tells me 'take out my books for studying Arabic' ... a person who listens to him will think he is a normal child" (M4). One mother says "all things are good with H. but [there is] one bad thing, he is stubborn" (M3).

The mothers saw improvements in the social and physical development of their children. "H. can talk about everything ... he can tell me what he wants, his character is improving, his nature and his moods ... he may not be able to walk and do so much with his hands but he keeps me company ... the best part is that he can talk ... thank goodness he is the way he is" (M4). Another child is very keen on sport, " he plays football, he has friends and they play with him ... he likes music too" (M3).

These mothers are pleased that their children have a chance to be educated and they can see the benefits of this education. The boy who attends a normal school has not encountered any problems as "the children at the school are very friendly, loving and helpful ... wanting to help" (M4). The mother of the child with orthopaedic problems sent him to the local kindergarten and he will go the local school, "he is one year at the kindergarten now ... he is very clever ... I always knew that his mind was normal" (M1).

All of these children were living at home with their parents. The following section will consider how these households managed their lives and also how they coped with the extra needs associated with having a disabled child in relation to the components (livelihood capabilities, tangible assets, intangible assets, and a living) of the sustainable livelihood model (Chambers and Conway 1992:6, Chambers 1995:23).

The child with orthopaedic problems (M1) required operations which were expensive, and his parents shopped around the doctors to find the cheapest surgical option. The initial operations were not successful, and the boy required follow-up surgery. The family had sold their car and used their savings for the initial operations, so they borrowed money for the follow-up surgery. The final operations were done through an NGO, which the family had contact with. Before this final surgery the family was considering taking M. to Russia for surgical treatment as they were not happy with the treatment and the cost of this treatment in Lebanon. Currently the father is working in a small shop which makes about \$US 10 per day profit. There are six people in the family. This child is at a local kindergarten in their village, which he enjoys and he is making good progress. The family is optimistic that M. will continue his education in spite of his orthopaedic problems. Their ability to access the education system is due to their physical proximity to the school and kindergarten and M. is able to walk there.

One mother (M2) accessed the health care services once she realised her one year old daughter was disabled. She subsequently spent three and a half years taking her daughter to doctors until a doctor "told me to stop going from doctor to doctor, it is a waste of your money, she has cerebral palsy and will be like that" (M2). The doctor did not tell her about exercise and physiotherapy but a neighbour, who has a disabled daughter, eventually told her about a local rehabilitation service. The mother is trying to find a school which will accept her daughter but this is difficult. The long term needs of and the associated costs of having a

severely disabled child in the household are causing the family problems. The family is dependent on support from the NGOs as there is no assistance from the government. The father has seasonal work drilling for water. This family lives in basic rented accommodation with minimal facilities, but they are saving to buy a flat.

These two households had accessed health services on behalf of their children, but the information they obtained or the services they gained access to were not always appropriate or optimal for their children.

The following table 7.2 is an example of a household which has made good use of the local facilities so that their disabled child may benefit from the community resources.

Table 7.2 The livelihood of H. and his family (M4)

Component		Features
Livelihood Capabilities		speaks Arabic and English a student at local school sociable popular with his friends and adults able to consider options and choose "he has a mind of his own"
Tangible Assets		father works - engineer family home family car
Intangible Assets	Access:	information and technology kindergarten, school, health care, NGOs
	Claims:	on relatives for schooling
A Living: H. is dependent on his parents who are able to make good use of local resources following the information and advice they received from NGOs as to how to manage their son and the options available to assist with his development.		

H. (M5) lives with his family in an rural village in the South Lebanese hills. For five years he did not receive any treatment or rehabilitation. The family heard about a visiting NGO rehabilitation service through a disabled man who lives in their village. This NGO is currently trying to find a place in a school for him, as he cannot go the local school with his sisters, "it is too far for him to walk up there" (M5). His father works in the tobacco fields, and his mother works too when she can manage to leave her pre-school children with other carers. This family of seven is dependent on seasonal work in the tobacco fields for their income. This work may be disrupted at times due to the conflict situation in south Lebanon. This family has

been the passive recipient of claims made on their behalf. Due to their rural isolation their opportunities to access resources and services are limited.

In summary, the mothers of these children felt that they had made improvements in the practical aspects of their lives. The quality of life of the mothers had improved with increased information about their children and how to manage them. These changes were largely instigated through the work of the NGOs. Difficulties remained regarding the children's social needs as three children had uncertain education futures. This was due to the cost of education, the nature of the physical disability, and the fact that one child lived in a rural area. Households had wasted much time, energy, and money accessing services which were inappropriate for their children. Most of the households had few tangible assets and they did not have the financial resources to cope with the extra requirements of a disabled child. The services they received from the NGOs had been of value to them. The mothers had many positive things to say about their disabled child but they had many concerns about their futures, especially with regard to their education opportunities.

SCHOOL AGE CHILDREN

School children (9-18 years) are still dependent on their families but they had thoughts about their future and what they would like to do. They talked about their current situation at home and at school. The children identified improvements (table 7.3) in their ability to cope with their disability and to manage themselves in their society.

Table 7.3 Good change for the school children

Good Change	Instigator of Change
increased confidence at school	self
stopped feeling sorry for herself	self
acceptance of disability from God	self
independent at home and school	self
going to school (S1, S2, S3, S5)	NGO
(S4)	family
operations to help legs	family
walks without crutches	self
independent with daily living skills	self
was afraid and shy, not now	NGO and self
a wheelchair <i>helwah</i> (lovely)	NGO
learning to read, write and sew	NGO

These children acknowledged some difficult aspects of their lives which were related to their disability and social matters. A boy does not "know what is wrong, I have to wear this *jehaz* (brace) all the time and when I sleep too" (S1). Another boy knows that his "bones are not strong ... when I hit things I fall down" (S2). Because of this problem he is protected by his parents and he is not able to play with other children after school, but he has accepted this, "I have my books and toys and television at home" (S2).

An teenage girl (S3) is cared for by her father. "My mother died when I was little. Before she died I went to kindergarten and after that I stayed at home. ... It is difficult for me to dress, my father helps me with this, but people say this is *haram* (forbidden in Islam) for him to help, is this *haram*?" (S3). She is concerned about this criticism of her father helping her with her bathing and dressing. "My father doesn't let me out to visit other people, a child died on the streets, so he doesn't let me out. I am bored to death when I am at home ... I am thinking much ... I hear people calling their mother, I wish I had a mother" (S3). Despite the difficulties M. has without a mother and the problems she has with her father, she says he is a good factor in her life. "My father, yes he is my father, I trust him ... he is generous, he gives me money" (S3).

These children talked about many things which were good in their lives which were related to them coping with their disability, enjoying their education and managing in their society. Z. has "one hand and this is better than none. I can do everything myself but I don't play with the ball at school ... I can run with my friends in the playground" (S4). The children "like to study" (S4) and the "the school is good" (S1, S4). "I am happy at this school ... I want to be a teacher" (S5). A boy is happy as his mother "comes one time each month to help with the cooking" and his "sisters help with the homework" (S2). These children "go to the beach in the summertime" (S2), "play with friends on the street" (S1), and "talk with friends" (S3). At home M. has "dolls and [she makes] clothes for them with the machine" (S3) and she also watches television, "everything from all the different countries ... I would like to travel" (S3).

It was the Muslim Holy Month of Ramadan when these children were interviewed. All the children were fasting. "Ramadan is good, I am fasting and in the Feast I will have new clothes and we will go to Tripoli" (S5). M. reads the Koran and she "feel[s] comfortable when reading the Koran, [I] stop thinking of the bad things and [I] feel better" (S3).

How these children and their families manage their lives in their society is difficult to assess. Due to the nature of the interviews it was difficult to find out very much about the families of these children and how they managed. The children were developing their livelihood capabilities as they were all at educational institutions and enjoying this experience. They were planning for their futures and thinking about what they might do once they finished school: "to be a doctor" (S2), "a nurse" (S4), "a seamstress" (S3), and "a teacher" (S5). Table 7.4 identifies the features of the livelihood of M. (S3).

Table 7.4 The livelihood of M. (S3) and her father

Component		Features
Livelihood		keen to learn
Capabilities		happy to go out to school has friends and socialises overcoming fears of the outside beginning to make decisions technical skills compromised by father's attitudes
Tangible	Assets	father works - labourer family home - poor facilities poor access to street tin roof television wheelchair
Intangible	Access:	education - passive recipient equipment - passive recipient health care
Assets	Claims:	extended family NGO

A Living: M. is dependent on her father (functionally and financially) but she is becoming more independent in her thoughts and she is developing skills with the education opportunities provided by an NGO.

Four of these children were at special schools organised by NGOs for children with physical disabilities. One girl, who had a problem with the function in her right arm, was attending a normal school. All the families had made use of the medical and educational systems. Three children had received surgery in an attempt to correct their disability. How the boys' families paid for this surgery is unclear, but Z's father "borrowed a lot of money and sold both [his] cars so that Z. could have the physiotherapy and the medical treatment. I did my best for my daughter ... the doctor said that no treatment would help her, but I felt to clear my conscience, I must do my best for her" (father S4). There is conflicting opinion in this

household as Z. accepts that her disability is "from *Allah* (God)", and that she is able to manage her life well without further medical treatment (S4).

The livelihood of these children is dependent on their families. Four of the fathers are working. One father is living in Denmark and his son was not sure if he was working and/or sending any money home to the family.

In summary, these children felt that they had experienced improvements in their lives, most of which were related to their chance to attend school. Some good changes were also related to social changes with an increased confidence to cope with their disability. These changes were brought about by the children themselves, their families and/or the NGOs. Four children were attending special schools organised by NGOs. One teenager who lived with her father had some social problems at home, but the other children were happy with their home circumstances and the recreational life they had outside the school.

WORKING AGE PEOPLE

Working age people in Lebanon are expected to supplement their families' income, to marry and move from the family home, and to support their parents after they retire. Due to the generally poor economic situation of most families the opportunity and the ability to earn money and to support the elderly and dependent members of the family is an important issue. The physically disabled people may be denied this opportunity and they remain dependent. The good change (Table 7.5) these people experienced was related to the educational and social opportunities they had experienced when they were children and adults, and to their ability to work and have their own income.

The difficult things in the lives of these people were concerned with the lack of money, being disabled, housing, the lack of opportunity to work, and their local environment.

"The problem is the money" (W3). Most of the working age people discussed the problem they had regarding their financial dependence on other people and the financial commitments of their immediate family which precluded them from helping the person with a disability.

Table 7.5 Good change for the working age people

Good Change	Instigator of Change
neighbour made crutches	family and neighbour
able then to walk to school	family
course in radio and television repairs	self with political group support
started a rehabilitation centre	friends and political group support
works in a repair shop	self
organised work for a newly disabled person	self
confidence to be a public speaker	self
got a wheelchair when aged 14	NGO
physiotherapist came in 1982 to house	NGO
vocational training (met husband)	NGO
marriage and baby	self
accepted disability / gained confidence	self
went to primary school and vocational training	family and NGO
given sewing machine by an NGO	NGO
home adaptations to independent living	NGO
8 years at special boarding school	NGO
university for 2 years	family and self
special equipment for visual disability	NGO
visobraille (Braille to English) course	NGO
computer and typing courses	NGO
chance to work with disabled people	NGO
"foreigners" came during the war	NGO
started a business	self and family
car with hand controls/mobile phone	self
making dolls, picture frames/sells them	self and fiancée
at times has work and money	self
rehabilitation team home visiting	NGO
attending a vocational training centre	NGO
learned English	self and family
teaches relatives English	self
improved daily living skills	NGO and self
bought a car	family
artificial limb	NGO
changed work after disabled (self employed)	self
teaches people to drive	self
developed hobbies	self
Feast time activities for children	self

"My brother has his own family [which is] big. He can't help us, I have five sisters, my father is 76 years old and he works in the tobacco fields. The people make themselves poor, they have many children, they think the children help them to work" (W12). S. lives with her son and her husband "and we have his brother living with us. We don't have our own house and

money is always a problem. My father died in the war and my mother died 2 years ago, and Mohammed's family, except this brother who lives with us, died in the war in Shatila" (W2).

Being disabled means that "the year is like one day, always the same ... up, wash, breakfast, television, always like this, sometimes I am happy when I write a letter. There is no excitement in the life" (W12). Two men realise that they will have problems finding a wife as "it is difficult for a blind man" (W7) or a man "in a wheelchair to marry" (W1). Some of the men with spinal cord injuries talked of the difficulties associated with being injured and subsequently paralysed from the waist down. A man "realised that [he] was paralysed. The doctors didn't tell me this ... it was very difficult for the family especially my mother, she was very upset ... I felt that this [injury] is most difficult to my mother ... the others are not like my mother" (W12).

Some men chose not to live with their families after they were paralysed. A man who lives in an institution is unhappy with the situation. "We were moved here under the power of the gun ... it is like a prison ... there was another building for us, but they changed their mind ... I don't give up hope that we will leave. I won't go back to my family ... I left when I was 18, and my family didn't want me to be a fighter" (W8).

The lack of work opportunities for these people is problematic. A man with a partial paraplegia worked "in a shop in Saida [and he] tried to find a job like this in Sour. But the man didn't trust me because I was in a wheelchair" (W10). Another man worked after he had "learned the computer and typing. They only paid me fifty thousand Lebanese Lira a month so I left" (W8). Currently he is not working.

"It is difficult to live in the South, nothing is available, there are no schools ... people here live from farming tobacco and you need a healthy body for this work ... we need a chance to learn. The South is always aggrieved, the government doesn't support the South, the people always depend on themselves. Hizbollah are good support for the people. They sponsor orphans and help them. Hizbollah is very well organised, they have a good system" (W12). Another man believes it is not only the South that is difficult but "here in Lebanon with the government nothing is available, work is not available, there is no work for the people" (W3).

Two of the working age people felt there was "nothing good" (W8, W4) in their lives, but one of these people recognised that "in the past there were lots of good things but now there is nothing" (W4). The other eleven people of working age were more positive about various aspects of their lives.

A woman who spends most of her time in a wheelchair said her "son is the best thing in [her] life" (W2). Her mother and brothers did not want her to marry but her sister supported her. "I never thought I would marry and have a child ... I used to have some dreams when I was a teenager. ... The people here are kind to me, my neighbours help me with the work and the shopping ... some people found this house for us and a job for Mohammed" (W2).

Some of the people with disabilities were pleased that they were able to "live at home with [their] family" (W12). "My brother fixed the house so I can do things for myself in the house and I can make coffee... the house is good ... I live here with my mother and sister, but I have my own room with the television and video, thank God I am able to live at home" (W1).

One man, who is visually disabled, and his friends began "a centre for the handicapped in 1989. We got money from a political group ... but we only took thirty people and we refused fifteen people, so we needed a bigger space. In 1994 I went to UNICEF and they helped us. In 1994 we opened a new centre ... when we opened this centre the disabled people were glad. We organised a summer camp for the disabled people last summer ... fifty people went on this and had a holiday with some picnics and journeys ... we still have some money and will another one this year" (W7).

The people who became disabled when they were adults found some good things to say about how they had adjusted to their disability and began to manage their lives in a positive way after their injuries. "I made the changes myself [after the accident]. It was difficult at the beginning ... some people collapse after an accident and some are strong enough to continue their normal lives after they are discharged from hospital and have recovered a little bit. Sometimes I have problems but I don't talk about them ... I am always here with the people ... God willing, this is how it is" (W11).

"After the Israeli invasion in 1982, a lot of foreigners came to Lebanon. They helped us with the physiotherapy and took us out, they fixed the street to our house and also fixed the house, the floor was high with steps everywhere" (W4). "Since the end of the war the life has improved. The foreigners who came made a big difference, [they were] very good" (W1). "The best thing [in my life] is the visits from the Norwegians. They bought me a wheelchair and organised for me to go to the vocational training centre" (W12).

Some of the people were optimistic about their long term plans. A man is "thinking to build a home and get married, step by step, [I will] borrow the money and pay it back" (W7). Another man has hopes too that he may be able to live a more independent life but in the meantime "it is nice to have dreams, but difficult for them to be true ... wife, car, home ... if there is no hope there is no life" (W12).

The working age people live with different types of household arrangements. Some of the disabled people have not moved from their family home, some are in institutions, and some are married and live with their spouse and children. The contribution of the disabled person to the household and also the ability of the household to use the local community resources is variable.

S. (W2) is a wife and mother. Her husband has a slight limp as the result of childhood poliomyelitis but he is physically able and works (income \$US 100 per month). They live in rented accommodation (\$US 50 per month). They have no family support as all four parents are dead. Her family home is occupied by her siblings and her husband's family home was destroyed. Her husband's younger brother lives with them as he has no other relatives. S. has very little use of her legs and she needs either long leg calipers, special boots and crutches or a wheelchair to be mobile. She is dependent on an NGO to supply this equipment. S. sold her gold jewellery, which was an engagement present from her husband, except the ring, when they were short of money. Currently they have no stores or resources. Both S. and her husband are able to claim through the NGOs both for work and equipment. They have also contacted Islamic groups for financial support. They use the local NGO health care facilities and will use the education system for their child.

Three men live in institutions. Two of these men were dissatisfied with their domestic arrangements and they were totally dependent on charitable support. The other one is entrepreneurial and has a degree of financial and social independence. Six single men were living with their families. The livelihood of H. (table 7.6) shows how one of these single men manages his life.

Table 7.6 The livelihood of H. (W6)

Component		Features
Livelihood		works in radio and television shop
Capabilities		has small shop at home with friends set up a rehabilitation centre confident, capable and positive advocate for other disabled people active in community affairs
Tangible Assets		family home has money in bank has technical skills
Intangible Assets	Access:	used education system helped others into rehabilitation NGO and work uses market
	Claims:	through political group for vocational training

A Living: H. manages his life in a positive manner. He is active in his community, has a steady income and has savings in the bank. His life is well managed by the circumstances he has created for himself and the opportunities which he experienced when he was a child. His parents sent him "to school on the crutches. It was difficult at first, but after 1982 there were lots of people on crutches and disabled, it was OK ... the people were OK to me" (W6). He does not see himself as being disadvantaged through being disabled. "There is nothing bad in my life ... I have made my own life ... it is OK" (W6).

Of the other single men, who are living at home with their families, three of them had made good use of their community resources and they were all working. Two of these men have no tangible assets apart from those they share with their family (W1, W7), but the other has a car, a small business and equipment for the business (W9). Two men were dependent on their families for financial and practical support (W12, W13).

A female only household (W4 and W5) is totally dependent on its livelihood through its ability to make claims on NGOs and extended family members. Neither woman is working and their brothers are not able to provide them with any financial assistance. They have a small regular income from their father's political group which they use to buy regular supplies for the house. Their current use of local facilities and resources is limited due to the cost of

reaching these services. In the past one of the sisters had made good use of the local services for education and vocational training.

The livelihood of S. (table 7.7) shows how a father of four children manages his household. This man changed his work after he became disabled at the age of thirty three years.

Table 7.7 The livelihood of S. and his family (W11)

Component		Features
Livelihood Capabilities		changed work from tiler to joiner teaches people to drive rents land and charges people for car park built a merry-go-round for children recreational activity - wood carving active in his community
Tangible Assets		family home workshop/equipment for joinery business shop at home (run by wife) car
Intangible Assets	Access:	education for children health care market
	Claims:	NGOs for prosthesis

A Living: S. has adapted his life to cope with his above knee amputation, he changed his work and he supplements his income with part time jobs. His wife has a shop. He is well known in his community and is always prepared to help the people. He enjoys recreational activities and he has built playground equipment which he uses during the Feast times for children's entertainment. He uses the health care and education systems for his family, and the market for selling his products and for his wife's shop. His only claim is from an NGO for an artificial leg. The livelihood of S. and his family is positive due to the diversity of his activities and the manner in which he has adapted his life following the loss of his leg.

In summary, these working age people had experienced many good changes which, if they had been born with the disability, included their childhood experiences. The good change was concerned with practical improvements, social developments, the opportunity to be educated, and their ability to work and have their own income. Support and practical assistance for these changes came from their families, other disabled people, and the NGOs. Some disabled people made the changes themselves and two men started a rehabilitation and vocational training centre for other disabled people with the support of a political group.

Of the working age people who lived in their family homes, some were dependent on their families for meeting their practical and financial needs, and others were able to support themselves and to assist their families financially. Some people were totally dependent on their ability to make claims in order to manage their lives in a positive manner. One man was independent in all aspects of his life except for the claims he made on an NGO for his artificial limb. The women had no financial security but they were proud of their achievements. Two sisters lived together and they managed to maintain their household livelihood. Another woman, who was married and had a son, managed the practical arrangements of her household with financial assistance from her husband.

ELDERLY PEOPLE

These elderly people were all women. Prior to the onset of their disability three of them had been carrying out their normal domestic household responsibilities, the other woman had been working in the fields and supporting her household. The disabilities of these women, which were caused by medical problems, removed their livelihood capabilities and they subsequently became physically dependent on others. The interviews were conducted with the family and the disabled person, some of the views expressed here were those of the family members and not those of the disabled people themselves. The good change (Table 7.8) for these elderly people was related to functional improvements and their ability to maintain social contact with their society.

Table 7.8 Good change for the elderly people

Good Change	Instigator of Change
adapted environment & access to street	family with NGO
bought equipment to assist with daily living activities	family
started to walk again after stroke	self and NGO
physiotherapist comes to do exercises	NGO
returned to be with family	self
adaptations inside the home	NGO
going out to visit neighbours	self
remedies from Arabic doctor	family

Some of the difficult things in the households with the elderly disabled people were identified by their relatives. They were associated with that person being the main care giver for a dependent relative. The following example is from a thirty year old single woman who until

recently had cared for both her aged and frail parents. "I am looking after my mother myself, she had another stroke six months ago, before that she was going out to visit the neighbours and was able to get down the steps to the kitchen but now she is in this room and can't go anywhere ... also she is upset because her husband who was 91 years old died recently ... the family have come to visit but they will leave soon and I will be left with my mother again. Someone needs to be with her all the time ... she cannot do anything for herself ... she cannot stand up. ... I used to do embroidery for Najdi and sell it through them, but at the moment I cannot do anything ... my brothers give us money and I have to manage with this" (E4).

A woman who had returned to Lebanon to care for her mother talked about the difficulties in caring for her disabled mother. "It is difficult to find someone responsible to look after [my mother] ... I do not know how to make the food properly so my mother comes to the kitchen to tell me what to do ... I used to be a teacher in Abu Dhabi before I came back here to look after my parents ... they still have the same patterns in their life and it is difficult for me because I am not used to this life .. but it is my duty to care for my mother" (E2). Her mother is "frightened by the shelling she can hear in the hills, but she wants to stay here and not go to Sour with her sisters or to Abu Dhabi with her children ... this is her home" (E2).

A woman in her sixties who was severely disabled with a stroke is cared for by her aged, sick mother. "My mother has to look after me, I can't stand up ... this house is no good for a wheelchair ... I cannot get up off the floor ... my mother is old, she cannot help me" (E1). This woman spends most of her time on the floor indoors. She "used to work in the fields for eight thousand Lebanese Lira a day ... my brother in Beirut doesn't help ... my father died a long time ago, it is me and my mother" (E1).

The value of visits, socialising, and sharing coffee were identified as the good things in the lives of these elderly people. A woman who can "walk to visit the neighbours now" (E3) is pleased with her progress after her stroke. Two other women who cannot walk are happy when the "neighbours come to visit" (E2) and to "have coffee" (E4).

They also recognised that the help they received from their carers and the community improved their quality of life. A disabled woman lives with her "husband and his other wife. She is older but she helps, and also her (the first wife's) daughter comes to help me with some

things" (E3). S. and her mother receive financial help from "some people and the neighbours, and sometimes we get money from the mosque" (E1).

The three married women have families working outside Lebanon who supported them financially. They had all received some form of rehabilitation from an NGO. All the households used the local health care services. This was a mixture of NGO health care and private care. Two women had visited an Arab doctor in other villages for herbal remedies and massage treatments. One family, which had been living in the Gulf, went to Europe for rehabilitation. S. and her mother (table 7.9) are an example of a household whose livelihood is dependent on its ability to claim within their community.

Table 7.9 The livelihood of S. (E4) and her mother

Component		Features
Livelihood Capabilities		none - used to work now unable to due to disability
Tangible Assets		one room home courtyard and outside facilities garden and hens
Intangible Assets	Access: Claims:	doctors and health care extended family mosque neighbours NGOs

A Living: S. and her mother are dependent on financial and practical support from their community and their extended family to manage their lives.

In summary, the good change in the lives of these elderly people was related to the rehabilitation they had received which allowed them to maintain their functional skills, and to their ability to retain their social links within their communities. These good changes were brought about by family members, the NGOs and personal improvement. The quality of life of the family members who cared for these elderly people was compromised by their role as a carer. The households of these elderly people were dependent on support from outside the home to maintain a positive livelihood. Three households received financial support from their families which lived abroad, and the other household was dependent on support from the community groups and the NGOs.

This discussion has identified what the disabled people in this study considered to be the good change which had occurred for them. It also identified what they felt were the good and difficult features of their lives and it considered how these disabled people utilised their own skills and/or the resources of their community within the framework of sustainable livelihoods. The following discussion will consider the relevance of the "dimensions of deprivation" (Chambers 1995:18) in relation to these experiences of the disabled people and their households in Lebanon.

THE HOUSEHOLDS AND THE DIMENSIONS OF DEPRIVATION

Within the "counter-ideology of reversals" (Chambers 1991:264) model, Chambers acknowledges that the problems, priorities and experiences of the people and their households are diverse and relevant to them only. He suggests that the issues identified by the people who are the focus of the model may be considered within the "dimensions of deprivation" (Chambers 1995:18) so that the understanding of how they manage their lives may be improved. These dimensions are physical weakness, social inferiority, isolation, vulnerability, seasonality, powerlessness, humiliation, and poverty.

All of the households had a person with some degree of physical weakness (disability). The degree to which this disability affected the person was variable. For some people the disability was not a limiting factor in the way they managed their lives, and for others the disability was the focus of their lives and they were unable to participate in a productive way in their society. For the working age people who were unable to earn money and support their household in some way this was a problem. The physical disability meant that some disabled people were dependent on others, both inside and outside their household, for meeting their financial and functional needs. All of the households had in some way been adversely affected by the disability and they had required some form of assistance in order to improve the quality of their lives.

The fact that the people were physically disabled did not mean that they felt socially inferior. Some disabled men lobbied for and built a centre for disabled people, which they now run. They felt they were able to do more than able bodied people. Men with disabilities who were working felt better than their able bodied unemployed peers. The men of marrying age

acknowledged that their chances of marrying were limited by their disability. They live in a society where a man should provide economically for his wife and also be able to father children. This second issue creates problems for the men who are paraplegic. The men did not see themselves as inferior because of this, but rather the problem was with their society. This was difficult for them to accept, but a fact of their culture and environment.

Many of the disabled people saw themselves as being isolated and cut off in all aspects of the concept: geographically, intellectually, unable to access services and being denied access to services, social support and economic support. The long term conflict situation (1975-1990), when many of the working age disabled people were growing up, had affected the education opportunities for some of the adults and they were illiterate. Some people had been excluded from services which may have helped them due to the fact that services were not well advertised. They had eventually found out about them by chance. The isolation people experienced was compounded by the lack of a national government service for disabled people, the poor co-ordination and coverage of services by the NGOs, and the physical barriers which make access to some services difficult. The poor economic situation of most households, with few tangible assets, meant that the family was unable to provide much support for the disabled person to decrease their isolation and promote their inclusion into society. This provision became the responsibility of the NGOs.

Vulnerability is described as having two sides, internal and external. The internal side of defencelessness is the lack of means to cope without damaging loss. This loss has many forms, for example becoming physically weaker, economically impoverished, socially dependent or psychologically harmed. The men who live in an institution, were unhappy as they were moved to their current residence against their wishes. They are dependent for all their needs on charity and have no hope of establishing any positive means of a livelihood. Two families spent all their savings and borrowed money for surgery for their children. There was no guarantee that the surgery would succeed. For financial reasons they shopped around the surgeons so the children did not receive follow-up from the same doctor. One woman, who is disabled, sold all her gold in a period of hardship. She now has a child and no security for herself or her child. Some men who were disabled later in their life had the ability to adapt to their new circumstances. They do not see themselves as being vulnerable. Other people, who were disabled when they were teenagers, are unable to contribute to their household and

their own lives in any way due to their physical weakness and they are socially and financially dependent. Most households are vulnerable due to their economic impoverishment.

External vulnerability is the exposure to shocks, stresses and risks. All the households are vulnerable and particularly those in South Lebanon due to their proximity to the Israeli occupied zone. The conflict situation in South Lebanon causes disruption to the household life with the damage to homes, the inability to work, and the loss of income. In times of conflict it is difficult to move a disabled person from their home. Some of the rural households are dependent on the seasonal income from the tobacco fields and orange orchards. This income may be disrupted either by the weather or by the conflict situation. If there is shelling the people are unable to work in the fields.

The men who were moved by their institutional care providers were powerless to alter the situation. They were moved "under the power of the gun" (W8), and when they attempted to return to their previous residence the local Sheikh was dispatched to negotiate with them and they returned. They would like more recreation facilities and the chance to go out but this is denied them. They have no money or means to earn money. Many of the families or disabled people came upon services by chance. They were ignorant of services available in their community, they were powerless to help their disabled children, and they had no ability to access useful services. In some households the dimensions of powerlessness and isolation combine to increase the disadvantage of these households. Some people who are disabled are pro-active and positive, and they work on behalf of the disabled people who may be powerless.

The disabled people experienced the dimension of humiliation. They were able to accept negative comments from people who did not understand about their disability. But negative comments from people who should have a better understanding about the problems of being disabled were difficult to accept. The men who are paraplegic felt humiliated asking each month for their supplies from an NGO. They felt that the regular delivery of this recognised and accepted need would improve their lives. One person felt his work had been under-valued and he left that job, another felt he was not employed because he was in a wheelchair.

Poverty is described as a lack of physical necessities, assets, and income. All the working age people and most of the other disabled people were dependent on outside assistance, usually from NGOs, for maintaining their requirements to be mobile and physically independent. Some people were dependent on their families for meeting their basic daily needs. Once this immediate need had been satisfied the disabled people still faced constraints due to the physical barriers of their environment. The effects of these environmental constraints limiting their activities were variable. Some people manage well in their locality and others do not. For example, a blind person is able to travel independently to Beirut from the South in a shared taxi, another person is unable to move from his house, and a child has difficulty walking to school as there is no paving on the street. It is difficult to generalise about the household being in a situation of poverty, but most households are lacking in physical necessities over and above those required by the disabled person, and they also lack assets and a regular income.

In summary, the dimension of being physically weak (disabled) had affected the lives of all the disabled people who participated in this study and their households. The other dimensions which were common to most households were those of vulnerability and poverty. Many of the disabled people also experienced one or more aspects of isolation. This experience of being isolated was at times compounded by the disabled people being powerless to alter their circumstances. The households in the rural areas, which were most affected by these dimensions, were also affected by seasonality as the households were dependent on horticultural work for their income. The proximity of the households to the area of conflict in South Lebanon and economic, social, and environmental factors influenced the degree to which these dimensions of deprivation affected the households.

The men who lived in an institution were humiliated by the manner in which they were treated, and the paraplegic men felt humiliated as they had to ask the NGOs for regular supplies in order to meet their practical needs. None of the people felt they were socially inferior due to their disability. Some disabled people felt that they were managing their lives as well as their able bodied contemporaries as they were able to attend school, to work, to manage their household, to marry, to have children, and to provide services for other disabled people.

CONCLUSION

The households in rural South Lebanon experienced many dimensions of deprivation. These households were vulnerable, poor, isolated, and dependent on seasonal work for their income. They were powerless to address most of issues which placed them in this situation. However they had gained access to NGO services which were attempting to limit their isolation and to assist in meeting the practical and social needs associated with physical disability. The men in the institution were powerless to alter their circumstances due to the attitude of the organisation which ran the institution. The households which lived close to or in urban areas did not experience these dimensions so severely. Generally they were able to overcome the negative dimensions and build on their positive experiences to establish a life which satisfied them.

These disabled people who had established a life and livelihood which in some way met their expectations had been able to make good use of their own capabilities and the assets of their community. Most of these people had few tangible assets but they had been able to gain access to services which had assisted them in making some improvements in the quality of their life, and consequently they were able to manage their lives in a positive manner. Some people who also lacked tangible assets were unable to utilise their livelihood capabilities. This, in some circumstances, was due to the nature of their disability and in other circumstances they did not have the ability to take advantage of the resources which were available in their community. These people were dependent on their ability to make claims to supplement their livelihood. Some people did not have this ability to make claims and they were the passive recipients of financial support which sustained their livelihood.

The disabled people in this study had at some time experienced good change in their lives. This good change had been brought about by the work of the NGOs, the families of the disabled people, and the disabled people themselves. Some physically disabled people had been instigators of good change for other people who were disabled. This process of supported good change had given the majority of the people and their families the ability to progress, and consequently they became self motivated in making positive change in their lives.

Good change was dependent on the ability of the person to take advantage of the opportunities available to them in their community. Some people did not have this ability, and other people were able, but their community resources and the local environment did not provide them with the opportunity to improve their lives. In conclusion, good change is dependent on the interaction between two factors: a person having, or being assisted in developing, the ability to make improvements in their life and an environment which allows for these improvements to be utilised.

Chapter 8

CONCLUSION

INTRODUCTION

This thesis has been concerned with people with physical disabilities in Lebanon and it has considered their needs in relation to the services provided by the NGOs. The discussion has focused on what development has occurred for these people, how their households managed their lives within their local and national environment, what their needs were, and the service providers who are attempting to address these needs. The national environment in which these people live and the situation of disabled people in developing countries were also considered. The thesis question asked if the needs of the disabled people were being met by the NGOs, which have been identified as the service providers, in the absence of any comprehensive service provision by the state.

The purpose of this chapter is to provide a summary of the thesis and to make concluding comments about the issues and questions raised in the conceptual framework of the thesis: what are the basic needs of the physically disabled people? are these people able to be empowered to achieve some good change in their lives? who is assisting with this process? and what is the role played by the state in relation to these processes?

This discussion will present a summary of the thesis, consider the needs of disabled people in retrospect, discuss the concept of "good change" meaning "development" (Chambers 1995:vi), and discuss the role of service providers.

SUMMARY OF THE THESIS

The introduction identified the three key issues of the thesis: the role of the state in Lebanon, the lives and the needs of the people with physical disabilities in Lebanon, and the work of NGOs in relation to the needs of the disabled people. The relationship between these three issues is at the centre of the conceptual framework of the thesis.

The field work was conducted in Lebanon in January and February 1997. The purpose of this work was to find out how the people with physical disabilities managed their lives, what their needs were, and what good change had occurred for them, and also to question some NGOs concerned with service provision for these people. Twenty seven disabled people and their families were interviewed. The structure for these interviews was based on the "emancipatory research paradigm" (Oliver 1992:110). This is a western model but the concept for this research method was based on the work of Chambers which attempts to understand the experiences of people who live in deprived and marginalised circumstances (Oliver 1992). Thirty NGOs, which work with physically disabled people, were asked to participate in the field work. Seventeen of these NGOs completed the survey. Discussions were held with representatives from these NGOs.

Various development models were used as frameworks on which to consider the key issues of the thesis. These models, which are usually applied in relation to the rural poor or poor in developing countries, have been used for this discussion as there were no appropriate models specifically related to disabled people and their circumstances in developing countries. They included the concept of "good change" meaning "development" (Chambers 1995:vi), the sustainable livelihood model (Chambers and Conway 1992:6, Chambers 1995:23), the framework of "generational analysis" (Korten 1990:114), and an adaptation of the "alternative development" model (Friedman 1992:26). These models have been used in a supplementary manner to the "counter-ideology of reversals" (Chambers 1991:264) which is the pivotal and link model of the thesis.

Reversal theory (Chambers 1991:264) places the disabled people at the centre of the model, and their needs and perceptions were considered in relation to the role played by the Lebanese state. The discussion of the historical and the current situation in Lebanon showed that both the economic policy of the state and the historical provision of social services had placed the responsibility of service provision for people who are physically disabled with the NGOs. Within reversal theory the role of the state was therefore seen to be disabling towards the needs of disabled people. Analysis of the situation in Lebanon within the "alternative development" (Friedman 1992:26) model of the four domains of social practice identified that the civil society section of Lebanese society had been compromised and marginalised during three specific periods since Lebanese independence in 1943. The majority of the

disabled people were included in this section of Lebanese society. Currently in Lebanon the power and influence is held by the state and the corporate sector, and the state promotes a neo-liberal economic policy.

General issues relating to physical disability and disabled people within the Third World were considered. There was a shortage of information about disabled people and their situation, and service provision for them in developing countries. The current Western literature concerning disabled people is focused on the post-modernist theory of disabled people fighting the disablist attitudes of their society. This theory assumes that disabled people have had the capacity to gain access to their society, and consequently have the ability and will to engage in political activity. This concept was considered not relevant to this discussion.

Within reversal theory the NGOs are considered as the complementary partner to the state, if the state does not act in an enabling manner towards disabled people. It was identified that the Lebanese state was not enabling, therefore this complementary role of the NGOs and the type of work they were doing was considered. The information from the field work showed that some NGOs in Lebanon which work with disabled people were providing generation one, two, and three services as described by Kortén (Kortén 1990:114). The needs of the disabled people and their families fell into two broad categories: practical and social. The NGO services were considered in relation to these needs and it was found that there was some positive relationship between the needs of the disabled people and the services provided. But both the NGOs and the disabled people identified some weaknesses in the service provision.

The interviews with the disabled people and their families provided an understanding of how they managed their lives, what issues were important to them, and what they thought were the improvements they had experienced. This information was considered within specific age groups (young children, school age children, working age people, and elderly people), as the expectations and good change were relevant to that specific stage of their life.

The "good change" (Chambers 1995:vi) which disabled people and/or their families had experienced covered many different issues. Two people felt there was nothing positive happening in their lives but most of the people identified some small and/or large changes which had improved their quality of life in some way. The disabled people themselves, their

families and/or the NGOs were the instigators of these changes.

In order to understand how the households with disabled people manage their lives, the information was analysed within the components (tangible assets, intangible assets, livelihood capabilities) of sustainable livelihoods (Chambers and Conway 1992:6, Chambers 1995:23). The ability or not of the households to combine these components to make a positive living for the household was discussed. Many households were dependent on their ability to claim and gain access to services (intangible assets) in order to achieve some good change. Some households were totally dependent on their use of intangible assets to manage their lives in a positive manner. This analysis was summarised within the "dimensions of deprivation" (Chambers 1995:18) concept.

THE NEEDS OF DISABLED PEOPLE IN RETROSPECT

Physical weakness and being physically disabled affected people in different ways, consequently what they identified as their needs were specific to them only. However within the different age groups of physically disabled people (young children, school age children, working age adults, and elderly people), it was possible to identify types of needs which were relevant to these age groupings. The mothers of the children who were born with physical problems had to learn about their child and what was causing these problems. They then attempted to adjust their lives towards coping with a child who would not progress the way their other children had done and also they attempted to find the best solutions in order to help their child to develop and to be accepted into the local society. This physical disability denied the children access to schools and it also created some burden within the family due to worry and the time consumed with caring for the child. The mothers of these children were denied the opportunity to work. This situation is common across the age groups if the disabled person was not independent their carer lost the opportunity to seek work. This factor, along with the costs created by the extra needs of the disabled person compromised the economic situation of the households with a physically disabled person.

Adults who had become disabled in adolescence or later in their lives had different problems to cope with. They had to adjust to being disabled from their previous able bodied state, this created many problems for some of the men which they had not resolved, but others adapted

with time. The needs of these people were complex as they attempted to cope with their disability, the expectations of their society, and their own expectations that they should be contributing members of their households, and also be able to enjoy the social experiences of their able bodied contemporaries.

The elderly disabled people were attempting to maintain their social contacts within their society. This social aspect of their lives was important to them as they were dependent on family members for assistance with daily living activities and for financial support. This financial and practical dependence was accepted as normal, although their caregivers had some difficulties in adjusting to this role of care giving.

The needs of disabled people may be broadly categorised as being either practical and/or social. The practical needs were usually addressed by NGOs providing the first generation (relief and welfare) services (Korten 1990:115). The needs identified by the mothers of pre-school and primary school age children were dependent on the services of these NGOs to improve their quality of life and to make good change. Due to the changing needs of their children as they grow they were using the rehabilitation services of these NGOs on an on-going basis. The mothers also used these NGOs for advice regarding educational opportunities for their children and how to manage their children in the home. The medical staff they had consulted were not supportive in helping them to meet their basic needs nor did they refer them on to the appropriate service providers. The generation one NGOs were the only service providers who were helping the families to manage their children in an optimum manner.

Some of the working age people used the generation one NGOs on an intermittent basis for the supply of equipment, and consequently they were able to manage their lives in an independent manner. Other working age people were dependent on generation one NGOs on a long term basis due to the nature of their disability, their on-going needs, and the circumstances in which they lived. The elderly people had used generation one NGO services after they had become disabled but as their situation stabilised they were able to manage with the support of their family members and their community.

The social needs including education, vocational training, and recreational activities of the majority of the children and the working age people were met by NGOs providing generation two (community development) services (Korten 1990:118). Some of the working age disabled people themselves were involved in this service provision as they had recognised this need and had been pro-active in establishing and maintaining a generation two service. The elderly people had social needs which were usually addressed by their own families and their community network, but the other age groups were dependent on generation two NGO services to meet their needs.

The needs of the physically disabled people may be exacerbated by the circumstances of their household and their local environment. Whether or not these negative household and environmental factors limit the person's chances of overcoming their basic needs is dependent on many factors. These include the ability of the household to access services, their community network and support systems, the support of other disabled people, where they live, the provision of NGO services, and in some circumstances good luck, as households found out about services and facilities by chance.

In conclusion, some people had specific needs which once these were met, were able to ignore the deprivation created by their physical weakness. But some other people felt their physical disability was a large burden, and that the needs associated with their physical disability were not addressed. However, the majority of disabled people did experience some opportunities to overcome their needs. Consequently they were able to achieve good change, to improve their own and their household's quality of life, and to participate in the life of their society.

GOOD CHANGE

Development for people with physical disabilities and their families is based on their experiences of what they feel has been the good change which has improved their quality of life. What a person who is disabled and their family, carer or household perceives as good change is dependent on their own circumstances. What is relevant to one person may not be appropriate for another person. A small change may go unnoticed for a person with higher expectations than someone who has had a very poor and compromised life before any good

change occurred. Some people felt that an increased knowledge regarding their disability and advice on how to manage their lives was a good change. Other people thought the practical assistance they received from the NGOs had improved their life, as this practical assistance had given them the ability to move on and to organise their lives in the best possible way given the local circumstances. Other people required on-going support from their families and the NGOs in order to achieve good change.

Social factors influenced the development opportunities for the physically disabled people. A positive attitude of the disabled person and their families towards the disability and their ability to cope with the disability and its difficulties enhanced the development opportunities of individuals. Some disabled people themselves were the instigators of their own good change. In other situations either NGOs and/or family members were the catalysts for the disabled person experiencing good change. The ability of a family to access NGO services was shown to be an important factor in the development process for the disabled person in their household.

Development is an on-going process and as some progress is achieved often new obstacles will appear. The age and developmental stage of a person's life was relevant to what they perceived to be good change. The elderly people had quite different needs and expectations compared to the mothers of disabled children, consequently what they identified as good change was quite different. The mothers were trying to place their children in schools, to improve their child's physical abilities, to gain advice about how to manage their children and to cope with them growing. Therefore good change was related to improvements regarding these issues. But development for the elderly people, from their relatively new status of being disabled, was to maintain their social contacts developed over a life time and to regain or maintain some degree of functional independence.

Good change for working age people covered many social, practical, and economic aspects of their lives. Their hope for good change in some circumstances was compromised by constraints within their local environment and their inability to participate in their society due to financial, social, and access problems. A working age person's ability to achieve good change may be dependent on their own livelihood capabilities, rather than the support they received from their families and/or the NGOs. Good change came to an impasse for some

people once they reached a certain stage in their lives. As children and young disabled adults these people had made progress and improved their quality of life, but this progress had slowed or halted as they reached adulthood.

Good change was not only applicable to the disabled people but also to the members of their households. These people, particularly the carers, were affected by the difficulties associated with having a disabled and/or dependent person in the household. Any type of good change for the disabled person had also improved the quality of life for their caregivers and their families. The caregiver at times had experienced good change independently of the disabled person.

In conclusion, development for people with physical disabilities was dependent on what they perceived to be the good change which had occurred for them. This was a personal matter, although the instigators of this change may be from outside the personal sphere. The NGOs or a person's family may assist with making the good change, but this cannot be made and achieved without the co-operation of the disabled person themselves. Development is an on-going process, but the issues identified in this discussion were specific to that time in the person's life. All age groups had different ideas of what good change had meant for them. The use of good change as a method by which to consider development is useful as it is subjective and it is dependent on individual people expressing their thoughts about their experiences.

SERVICE PROVIDERS

The physically disabled people, due to their special needs and generally poor socio-economic situation, usually require some external support in order to manage their lives in a reasonable and dignified manner. The service providers who may provide them with the opportunity to achieve this may be the state and/or the NGOs. In this discussion it was shown that the state did not act in an enabling manner towards meeting the practical needs of physically disabled people, but it had begun to address some social issues related to disability.

A state may be precluded from addressing the practical needs of people with physical disabilities if it is committed to promoting neo-liberal economic policies. The application of

this policy expects that people will use the market for the services they require. However this expectation may be unreasonable for people who are physically disabled and have needs which are probably greater than the able bodied people in the society. The households with physically disabled people are possibly economically compromised by the fact that they have to cope with the extra requirements of a disabled person, and they may not have the financial resources to compete in the market. They are therefore dependent on services provided outside the market to meet their needs.

For some disabled people the NGOs were the only service providers which allowed them to make good change and to improve their quality of life. The members of households who had gained access to the NGO services were very positive about the benefits of the services they had received. Some households maintained a continuous relationship with the NGOs and they were dependent on their services to achieve good change. Other people used NGO services on a short term basis, but they retained their links with the NGOs, as they required the NGO services to meet their needs on an intermittent basis.

The links the disabled people were able to make with the NGOs were important to them. In some situations, disabled people felt that their relationship with the NGO field staff was a very important factor in improving their otherwise rather boring and compromised life. However some households were denied access to NGO services due to their location, and others were ignorant of NGO services in their area. Few of the NGOs advertise their services and access is usually gained through a word of mouth community network.

The NGOs were clear about their role and the type of services they were providing, but they faced many constraints in attempting to meet the practical and social needs of the disabled people. Analysis of the NGO work with disabled people in Lebanon showed that they were providing generation one, two, and three services (Korten 1990:114). Korten in his discussion of NGOs suggests for NGOs to make lasting improvements in the lives of people they are working with, they should move on from relief and welfare work (generation one) to community development (generation two), and then to sustainable systems development (generation three) (Korten 1990:115). This suggestion, that NGOs should progress through the generational framework in order that development may be achieved, is not appropriate for NGOs working with physically disabled people. As disabled people may have both practical

and social needs there is a place for NGOs working across the generations or by co-operation between NGOs which work within one generation only. It was identified by the NGOs that one of their main problems was the lack of co-operation between the NGOs, so this second option is not always viable.

Once a person's practical needs have been met by a generation one NGO, they may be able to manage their life in an independent manner without any support from a generation two NGO. However most of the people with physical disabilities will have either on-going needs or intermittent practical needs which require generation one services. Children will continue to be born with disabilities, and disability is a fact of life in any environment due to accidents and medical problems. These factors reinforce the need for generation one NGOs to remain as generation one NGOs.

Due to the reluctance of education authorities to accept disabled people and the lack of recognition of the community regarding the needs and abilities of disabled people there is a definite need for generation two NGOs. Some NGOs are promoting the integration of disabled people into the services they provide for non-disabled people. This approach provides a two pronged attack at addressing some of the social problems associated with disability in general: able bodied people are educated about disability which may remove some of the negative attitudes regarding disability in the society, and the disabled people are given the chance to use normal facilities and to mix with their able bodied peers.

The national environment, the attitudes of the society, and the reluctance of developing states to provide services for disabled people limit the opportunities available to disabled people. Until the state takes some responsibility regarding social policies, which ensure that the rights of the disabled people are recognised and that they receive opportunities to participate in state services which are available for able bodied people, the scope for the work of generation three NGOs is large.

In conclusion, there is a place for the work of NGOs across all generations. Generation one NGOs are particularly important, as without their practical assistance many disabled people would be forced to remain in their homes, possibly immobile, and unable to participate in the life of their communities. The services of generation two and three NGOs promote this

participation into society. There are problems with the co-ordination of NGO work and there are gaps in the provision of services but, due to the diversity of NGOs, the work done by them may be more responsive to the needs of disabled people than a uniform state approach might be. If the state takes an active role in the issues associated with disability, this role may be to implement policies regarding disability and disabled people. The state would then act in a complementary manner towards the NGOs which are the primary service provider for people with physical disabilities.

CONCLUSION

People who are physically disabled experience functional limitations. These people have normal intellectual capabilities but due to the practical problems associated with their functional limitations, they are often deprived of developing their social and intellectual capabilities. The secondary effects of their physical disability may therefore compromise their opportunities for development and they may remain marginalised within their society.

Some people with physical disabilities were able to meet their basic needs with the support of the service providers working in the capacity as a generation one NGOs. These disabled people, who saw themselves as being equal with the able bodied people in their society, were then able to make improvements in their lives in an independent manner. Other people were not able to do this, regardless of the support they received. Therefore in providing services for people who are physically disabled it is important to consider the capabilities and limitations of each person because, as with able bodied people, each person will have attributes and abilities which are particular to them only.

However it has been shown that age groups of physically disabled people do have features which are particular to that group. This grouping of needs, the good change which has occurred for them, and how these people manage their lives helps to understand some of the issues which are important to that age group of people who are physically disabled. This identification of needs, good change, and possible service problems may be acted on by the service providers, if they wish to be responsive to the needs of the disabled people.

If the economic policy of the state does not allow for the provision of practical services for people who are physically disabled, the state could exercise social concern for these people. It may promote their inclusion into society through policies which recognise the rights of disabled people and also encourage existing services to accept people with physical disabilities. In this way the marginalisation of physically disabled people may be lessened and their development opportunities may be enhanced.

Development is not a universal process with uniform outcomes but is subjective and related to the needs and situations of individuals. The state or the NGO may act as a catalyst for this process but without the will of the individual to make some personal improvement there will be no development. This argues for a different and diverse approach to meeting the development needs of an individual who is physically disabled. An overall plan from the state as to how these people should be managed may be inappropriate for this group of people within a society. But the state may play a role in ensuring that their rights are recognised, and that they are given the opportunity to participate on equal terms with people who are not disabled.

APPENDIX A**PEOPLE WITH PHYSICAL DISABILITIES IN LEBANON
INFORMATION SHEET FOR PEOPLE WITH A PHYSICAL DISABILITY**

I am Miranda Pittaway. I worked as a physiotherapist in Lebanon from 1993-95. Currently I am studying for a Master of Philosophy (Development Studies) in New Zealand. The study is about people with physical disabilities in Lebanon and the services provided for them by non-governmental organisations. For this study I would like to speak with some people who have a physical disability.

The purpose of the interview is to help with my understanding about how disabled people manage their lives, what their needs are and what expectations they have for the future.

If you would like to take part in this study, I would be pleased to talk with you. You may refuse if you do not wish to participate.

The interviews will not have any set questions. The interview will probably take about an hour, it may be shorter or longer than this. If you would like anyone from your family to take part, they are welcome.

A cassette recorder will be used to record the interview. A translator will help me with the interviews.

Your name will not be used when I write up the thesis. The translator and myself will be the only people who have this information and it will not be passed on to anyone else. However, if you do have the need for special services and a non-governmental organisation is providing this service, with your permission, I may need to use your name so that they can contact you.

If you are unhappy with the conversation at any time and wish to have any information removed or to stop the interview altogether please tell me. There is no need for you to continue.

You have the right:

- to decline to take part in the interview
- to refuse to answer any particular questions and to withdraw from the study
- to provide information on the understanding that your name will not be used unless you give your permission
- to be given access to a summary of the findings of the study when it is concluded.

If you have any questions at any time please ask me.

Miranda Pittaway 4a.145 Ohiro Road Brooklyn Wellington New Zealand tel 64.4.384.3355
fax 64.4.387.8362

Quasmeih Camp South Lebanon tel messages 03.232.817

APPENDIX B

PEOPLE WITH PHYSICAL DISABILITIES IN LEBANON

CONSENT FORM FOR INTERVIEW

I have had the information sheet and the details of the study explained to me.

I am happy to take part in the interview and I know that I can stop the interview at any time.

I agree that any information I give to the researchers will not mention my name unless I give permission.

I agree/do not agree to a cassette player being used to record the interview.

If I wish, the cassette player may be turned off at any time during the interview.

I agree to take part in this interview under the conditions set out in the information sheet.

I understand that a translator will be there too, and that he/she understands about the conditions of the research.

signed:

name:

translator:

name:

date:

APPENDIX C

GUIDELINES FOR THE STRUCTURE OF THE INTERVIEW

The history of the disability - what happened around this time, who helped, what medical care/rehabilitation/equipment was needed, support, advice, follow up, and the cost of this?

What has happened since then - what have you done, who has assisted if assistance needed?

The daily life - what happens, who helps with cares or independent, who provides the equipment needed to manage the daily life, education/employment/income?

The household - how many people, who is working, any people outside Lebanon, how they manage having a disabled person, who cares for the disabled person, income to the household?

What about being disabled or having a disabled person in the household in this society?

How the household manages in times of stress and uncertainty?

Opportunities - past, present and the future - education, rehabilitation, vocational training, employment, recreation and social life - self/family motivated or with support from outside the family

What changes/improvements have happened - how has this made a difference, if not, why?

What are the good things in life?

What are the bad things in life?

Any specific problems which limit activities - personal problems/environmental/geographical/financial/attitudes?

Social activities and relationships

What about the future? - expectations, priorities, needs

Any other specific issues to discuss?

Based on the work of Chambers and Conway (1992), Chambers (1995), and Oliver (1992).

APPENDIX D

SURVEY OF NON-GOVERNMENTAL ORGANISATIONS IN LEBANON

This survey is part of the research I am carrying out for my Master of Philosophy (Development Studies) thesis. The other part of the research will be to interview people with physical disabilities in Lebanon. This study is a continuation of the work I did in the Middle East and I hope that the information I gain from this survey and the interviews will be of practical value to both the non governmental organisations and the disabled people.

The information provided in these questionnaires will be confidential and organisations will not be mentioned by name in the thesis.

I would be grateful if you could take the time to answer these questions and then place the papers in the envelope provided.

If you agree to answer please could you sign below along with the person who has explained the reasons for this research to you.

On behalf of my organisation I agree to answer the survey questions.

.....

.....

I hope to be in Lebanon in December / January and would be happy to meet with you if you have any further questions about this research. I plan to have summarised the responses by April 1997, - if you would like a summary of them please put the details below.

I would like to see you in December

I would like a copy of the summary

NAME:

ADDRESS:

TEL:

FAX:

Thank you.

Miranda Pittaway

4a . 145 Ohiro Road Brooklyn Wellington New Zealand

Tel 64.4.384.3355 Fax 64.4.387.8362

July 1996

NAME OF NGO: -

**1. What is the policy of your organisation regarding disabled people?
(If possible please enclose a policy document.)**

.....
.....
.....
.....
.....

2. What are the guiding principles-philosophy regarding your work with disabled people?

.....
.....
.....
.....
.....

3. What plans for the future does your organisation have in Lebanon?

.....
.....
.....
.....
.....

4. What are the long term expectations of your organisation for the physically disabled people who attend your programmes?

.....
.....
.....
.....
.....

5. What factors limit your work with the physically disabled people?

.....
.....
.....
.....
.....

Please tick the appropriate boxes after the following questions:

6. Which areas of Lebanon do you work in ?

- | | |
|---|--|
| <input type="checkbox"/> The North | <input type="checkbox"/> Beirut |
| <input type="checkbox"/> The Bekaa Valley | <input type="checkbox"/> The Mountain |
| <input type="checkbox"/> Saida | <input type="checkbox"/> The South - Sour Area |

7. What type of work does your organisation carry out with physically disabled people?

- | | | | |
|--|--|---|------------------------------------|
| <input type="checkbox"/> education | <input type="checkbox"/> pre-school - KG | <input type="checkbox"/> primary | <input type="checkbox"/> secondary |
| <input type="checkbox"/> vocational training | | <input type="checkbox"/> special education | |
| <input type="checkbox"/> physical rehabilitation | | <input type="checkbox"/> health care | |
| <input type="checkbox"/> equipment and supplies | | <input type="checkbox"/> other - please specify | |

8. Does your organisation charge a fee for this work?

- Yes No

9. Does your funding come from

- | | |
|--|---|
| <input type="checkbox"/> self funding | |
| <input type="checkbox"/> outside Lebanon | <input type="checkbox"/> foreign governments |
| | <input type="checkbox"/> foreign non-governmental organisations |
| | <input type="checkbox"/> private funders |
| | <input type="checkbox"/> other funders |
| <input type="checkbox"/> inside Lebanon | <input type="checkbox"/> the government |
| | <input type="checkbox"/> local non-governmental organisations |
| | <input type="checkbox"/> private funders |
| | <input type="checkbox"/> other funders |

10. Does your organisation belong to a network of other similar organisations?

- Yes No

11. Is your organisation registered with a Lebanese Government authority?

- Yes No

12. Does your organisation have any input into government policy regarding disabled people?

- Yes No

13. How do the disabled people find out about your service?

- | | |
|---|---|
| <input type="checkbox"/> from their community network | <input type="checkbox"/> from advertisements |
| <input type="checkbox"/> from professional advisers | <input type="checkbox"/> other - please specify |
| <input type="checkbox"/> from other disabled people | |

14. How do you evaluate your work with the disabled people?

- | | |
|---|---|
| <input type="checkbox"/> subjective feedback | <input type="checkbox"/> objective assessments |
| <input type="checkbox"/> no formal evaluation | <input type="checkbox"/> other methods - please specify |

15. Do you provide ongoing training for your staff?

- Yes No

If Yes , what type of training?

Thank you.

APPENDIX E

PEOPLE WITH PHYSICAL DISABILITIES AND THEIR FAMILIES
REFERENCES FOR THE INTERVIEWS**GROUP M: the mothers of pre school and primary school children**

reference	age, sex, and diagnosis	interview date
M1	four year old male arthrogryposis	20.1.97
M2	eight year old female spastic quadriplegia with athetosis	13.1.97
M3	eight year old male spastic diplegia	13.1.97
M4	seven year old male spastic diplegia	6.1.97
M5	six year old male spastic quadriplegia	31.1.97

GROUP S: school age children

reference	age, sex, and diagnosis	interview date
S1	twelve year old male spinal curvature short stature	27.1.97
S2	ten year old male brittle bones	27.1.97
S3	sixteen year old female spastic diplegia	9.1.97
S4	eighteen year old female Erb's palsy	18.1.97
S5	nine year old female spastic diplegia	27.1.97

GROUP W: working age people

reference	age, sex, and diagnosis	interview date
W1	thirty five year old male paraplegia	27.1.97
W2	twenty eight year old female arthrogryposis	27.1.97

Group W continued

reference	age, sex, and diagnosis	interview date
W3	forty two year old male paraplegia	5.1.97
W4	twenty four year old female orthopaedic problems - fractures and dislocated hips	6.1.97
W5	twenty one year old female arthrogryposis	6.1.97
W6	twenty eight year old male poliomyelitis	9.1.97
W7	thirty one year old male visual disability	9.1.97
W8	twenty six year old male paraplegia	10.1.97
W9	thirty five year old male paraplegia	13.1.97
W10	twenty two year old male paraplegia	13.1.97
W11	forty six year old male amputation - above knee	18.1.97
W12	twenty four year old male paraplegia	31.1.97
W13	twenty four year old male paraplegia	31.1.97

GROUP E: elderly people and their families

reference	age, sex, and diagnosis	interview date
E1	fifty five year old female hemiplegia	11.2.97
E2	seventy three year old female hemiplegia	11.2.97
E3	age uncertain female hemiplegia	12.2.97
E4	seventy six year old female hemiplegia	12.2.97

APPENDIX F

REFERENCES FOR THE NON-GOVERNMENTAL ORGANISATIONS

INTERNATIONAL NGOS

reference	description of the NGO service	interview date
IN1	rehabilitation	23.1.97
IN2	rehabilitation	3.1.97
IN3	education with integrated programmes	10.1.97
IN4	mixed services	28.1.97
IN5	mixed services	27.1.97
IN6	mixed services	16.1.97
IN7	mixed services	29.1.97
IN8	mixed services	4.2.97

LEBANESE - LOCAL NGOS

reference	description of the NGO service	interview date
LN1	integrated and mixed services	10.1.97
LN2	mixed services	20.1.97
LN3	mixed services	16.1.97
LN4	mixed services	9.1.97
LN5	mixed services	30.1.97
LN6	mixed services	20.1.97
LN7	mixed services	20.1.97
LN8	mixed services	22.1.97
LN9	mixed services	29.1.97

APPENDIX G**SUMMARY OF THE FIELD WORK**

Beirut
February 1997

To:

Re: Survey of some Non-governmental Organisations in Lebanon who work with Physically Disabled People.

Thank you for agreeing to take part in this survey. The information from these surveys will be valuable for my thesis where I will use the framework of 'Generational Analysis' - a pattern of NGO work and philosophy presented by David Korten - to analyse this information. This will be considered within the context of Lebanon as a developing country. The relationships between the role of the state, the work of the NGOs and the needs and perceptions of disabled people will also be considered.

I have included a summary of the answers from the survey and also noted some of the problems disabled people and their families feel they are facing. As the thesis is concerned with development, in this context meaning 'good change' for the individual disabled person, some examples of what they consider to be good change, and how this was facilitated have also been included.

I hope some of the information is of use to your NGO. If you require any further information please contact me in New Zealand.

Thank you for taking part in this survey and good luck with your work.

With best wishes

Miranda Pittaway

4a.145 Ohiro Road
Brooklyn
Wellington
New Zealand
Fax: 00.64.4.387.8362

**SUMMARY OF RESULTS FROM NGO SURVEY
LEBANON FEBRUARY 1997**

The NGOs surveyed fall into 3 categories:

1. those providing rehabilitation services only - 2 NGOs
2. those providing rehabilitation and other services - eg physiotherapy, health care, vocational training, education and training programmes for rehabilitation workers - 13 NGOs
3. those who do not provide specific rehabilitation services but offer integrated programmes - 2 NGOs

1. WHAT IS THE POLICY OF THE NGOs REGARDING DISABLED PEOPLE?

The policies vary depending on the focus of the NGO.

Rehabilitation only NGOs - policy includes; equality and participation for people with disabilities, a CBR approach to rehabilitation, physical training and adjustment of equipment, information to the families of the disabled.

Rehabilitation and other service provision (mixed) NGOs - policy includes; rehabilitation, home visiting, vocational training, recreational activities, education, lending money for start up programmes to encourage self sufficiency and financial independence, medical assistance, wheelchairs, technical aids, home adaptation, making orthotics and prosthetics, transportation for patients to and from the centres, prevention of disability through education at the community level, referral of disabled people to specialist centres, buildings to have wheelchair access, to train and support local staff in their work with disabled people, to refer disabled people to other NGOs and their services so that they may have the most appropriate service to meet their needs, parental support groups, to provide needed and suitable services free of charge for poor and needy people, physiotherapy.

"Integration" NGOs - policy includes; long term benefits for children within their local communities by influencing policy, working to make a reality of children's rights, no specialised programmes for disabled people but they are integrated into medical and social programmes, provision of equipment and operations according to needs through co-operation with other NGOs.

2. WHAT ARE THE GUIDING PRINCIPLES REGARDING THE WORK WITH DISABLED PEOPLE?

These include:

- to follow the concepts of CBR to reach as many people as is possible
- to work for equalisation of opportunity for disabled people
- to include the family members and the community in the work
- to help the disabled people cope with their society
- to satisfy the particular needs of the disabled child
- to help in developing the skills of a disabled person, including self confidence, emotional and social relationships
- encouragement, education, and the ability to work
- a disabled person must have respect
- to utilise the energy and thoughts of the disabled person

- their rights according to the Human Rights convention and to allow them to live with the best possible quality of life
- to help the disabled people to solve their problems
- to educate the community about accepting disabled people
- to offer a humanitarian approach to the disabled people
- to motivate independence
- to prevent disability from disease and congenital abnormalities through education
- to improve government policy regarding disabled people
- to allow work place integration

3. WHAT PLANS FOR THE FUTURE DO THE NGOs HAVE IN LEBANON?

The plans include:

- extension of current services and where possible for them to be self sustainable without foreign NGO support
- work placement for disabled people
- to organise welfare cards for disabled people so they may receive free or reduced medical care
- to increase the work with young disabled women and vulnerable children
- to continue with the current services and/or increase them
- building programmes for better facilities and to improve access for disabled people
- to provide classes for children who are slow learners
- to increase the productivity of disabled people by giving them the appropriate skills
- to increase the outreach activities
- health education programmes in the Palestinian camps
- to begin a rehabilitation outreach service inside Ein el Helweh camp
- to improve the vocational training services
- a prevention of child abuse programme
- to strengthen the relations between NGOs so that they supplement each other

4. WHAT ARE THE LONG TERM EXPECTATIONS OF THE NGOs FOR THE PHYSICALLY DISABLED PEOPLE WHO ATTEND THE PROGRAMMES?

Expectations include:

- equality and participation in society
- from the community, an increased understanding about the abilities of disabled people
- a hope that the disabled people will get the things they want
- acceptance of disabled children into normal schools
- to be as independent as possible
- to get an insight into disability as that they manage their daily life as best they can
- to ask for help when they need it
- that the disabled people may be integrated into society
- that the disabled people may be employed eg in govt depts
- that the disabled people reach self sustainability through income generating projects so that they will be able to meet their basic needs
- to support the disabled people to reach their maximum independence

5. WHAT FACTORS LIMIT THE NGO WORK WITH THE PHYSICALLY DISABLED PEOPLE?

Rehabilitation NGOs: constraints include; negative attitudes, stigma and prejudice towards people with disabilities, difficulties with co-operation eg schools, the mystification of physiotherapy in this society with the idea that only professionals do physiotherapy and the patients should be the passive recipients of the treatment, communication difficulties with doctors and other co-operators, poor co-ordination between NGOs which leads to double the work, cultural and language problems, lack of equipment, the poor financial status of the disabled people.

"Mixed" NGOs: constraints include; lack of space in the current premises, funding, the psychological stress of the disabled person and the shame on his family due to his disability, access the centre as the building is on the first floor without a lift, carelessness and ignorance of the families that we deal with in taking care and educating their children, no money to assist the volunteers who help us, the lack of a government strategy concerning disabled people, a decrease in UNRWA services for Palestinians, lack of co-ordination between the NGOs, transport and accessibility problems, lack of trained personnel, the self sustainability of rehabilitation projects due to their nature and the financial situation of the disabled people, the abilities of the disabled people are not always recognised and many families are over protective, equipment (the availability and the cost of this), disabled people move about and there is little follow-up, rehabilitation centre is in the Mountain so access is difficult for disabled people, the attitudes of the disabled people themselves.

"Integration" NGOs: constraints include; the inability to engage specialised personnel due to economic constraints, the lack of facilities in the centres to receive children with physical disabilities, untrained staff, the concept of integration is new to the parents and the community, people usually pity the disabled child without considering his abilities and needs.

6. WHICH AREAS OF LEBANON DOES THE NGO WORK?

One NGO works in the North only, another in the Mountain, three work only in the South and the rest cover at least three geographical areas of Lebanon including three which have centres or provide services throughout Lebanon.

7. WHAT TYPE OF WORK DOES THE NGO CARRY OUT WITH PHYSICALLY DISABLED PEOPLE?

2 NGOs are providing physical rehabilitation and some provision of equipment, 13 NGOs provide mixed services including health care, vocational training, rehabilitation and special education, 2 NGOs do not offer specific programmes for disabled people but they offer integrated programmes - one for education and the other provides mixed services.

8. DOES THE NGO CHARGE A FEE FOR THIS WORK?

6 NGOs charge a fee for services - there are exemptions, eg; one NGO charges for out patient physiotherapy and health care but not for education; another does not charge disabled people or orphans.

9. WHERE DOES THE FUNDING COME FROM?

6 NGOs have an element of self funding - in all cases this is supplemented by funding from inside and outside Lebanon.

10 NGOs receive funds from outside Lebanon only - foreign NGOs are the main funders.

6 NGOs receive funds from both inside and outside Lebanon - within Lebanon 2 of these receive funding from the Lebanese government and the rest is from Lebanese NGOs and private funders.

1 NGO receives funding from inside Lebanon only - private funders, it also has an element of self funding.

10. DOES THE NGO BELONG TO A NETWORK OF OTHER SIMILAR NGOS?

9 NGOs belong to a network of other similar NGOs, 8 do not.

11. IS THE NGO REGISTERED WITH A LEBANESE GOVERNMENT AUTHORITY?

12 are registered, 5 are not.

12. DOES THE NGO HAVE ANY INPUT INTO GOVERNMENT POLICY REGARDING DISABLED PEOPLE?

Of the 12 NGOs registered with a government authority, 9 have input into government policy.

13. HOW DO THE DISABLED PEOPLE FIND OUT ABOUT THE NGO SERVICE?

The community network and other disabled people are the suppliers of information about NGO services, some people are told by professional advisers, five NGOs advertise their services.

14. HOW DO THE NGOS EVALUATE THEIR WORK?

16 NGOs depend on feed back from the people attending their programmes and of these 9 NGOs also have objective methods for evaluating their work.

15. DOES THE NGO PROVIDE ONGOING TRAINING FOR THEIR STAFF?

16 NGOs provide training - in-service education, short and long term courses, and some staff are sent abroad for specific training programmes. Some NGOs bring people to Lebanon to teach.

Training covers a variety of topics - English language, physiotherapy, occupational therapy, CBR concepts, social work, pre-school work, community development, administration, special education, habilitation, counselling, health education programmes, technical and scientific programmes.

PROBLEMS FACING DISABLED PEOPLE AND GOOD CHANGES WHICH HAVE OCCURRED

1. MOTHERS OF YOUNG CHILDREN WITH PHYSICAL DISABILITIES:

Problems:

- poor daily living skills eg not dressing, going to the toilet himself
- not walking well and falling over
- live in an isolated area and access to services and education difficult
- worry about changing schools and any new problems that may arise from these changes
- getting heavy and difficult to manage
- needs a wheelchair
- environmental access difficult
- lack of information about the child's disability especially in the post partum period
- denied entrance to school as told there was 'no hope'
- mother has to do all the caring herself and no facilities for the child to attend
- the extra costs of having a disabled child eg pampers, pushchair, new trousers as the knees wear out with crawling
- the child is stubborn and doesn't want to exercise
- some interference from other mothers and children
- needs new splints

Good changes:

- accepted into an integrated KG programme
- improved mobility and ADL with physiotherapy and rehabilitation programmes
- a doctor working with an NGO explained about CP and its effects
- provision of physiotherapy home visiting service
- a new dimension to the mother's life having a disabled child - highlighting the positive things about having a disabled child
- provision of a wheelchair/walking frame/pushchair /other equipment - leading to an improved quality of life for child and family
- operation on the child's legs to improve his mobility was a success
- disabled child walked at one and a half years
- NGO assistance in finding places in KGs and schools

Most of these changes were facilitated by someone working with an NGO - in one case a mother saw an advertisement on television and contacted the NGO for advice concerning her child's education.

2. SCHOOL AGE CHILDREN WITH PHYSICAL DISABILITIES:

Problems:

- no education from 5-13 years
- bored at home and not allowed onto the street with other children
- mother and grandmother both dead
- cannot manage own ADL
- when started school some children were teasing about the disability

- loss of hand function
- not accepted at normal school because of disability
- needed and will need corrective surgery for orthopaedic problems

Good changes:

- wheelchair supplied '*helwah*'
- accepted into a special education programme
- learning to sew, read and write
- visiting physiotherapist brought toys, games and books to the house
- friends at school
- go to school and do normal lessons
- able to accept that disability is from God
- thinking about the future - to be a teacher, doctor, seamstress, secretary

3. WORKING AGE PEOPLE WITH PHYSICAL DISABILITIES:

Problems:

- boring life, the same day after day
- no privacy
- lack of money
- doesn't walk
- doesn't speak English
- may not be able to marry
- illiterate
- no running water in the home (rented accommodation)
- shares home with husband's brother
- refused entrance to school because of physical disability
- father died in the war
- life in an institution with other physically disabled people - this causes many problems
- back pain
- no exercise facilities
- isolation - geographical, poor access to buildings, wheelchairs on the street difficult
- not many visitors and unable to go out
- no independence - physically and financially dependent on family
- family unable to support financially
- house leaks
- no parents
- brothers have their own families to support
- the future when carers can no longer provide financial and physical support
- no possibility to work - many reasons for this - lack of education, isolation, access, acceptance that disabled people can work, lack of employment opportunities for all people, lives in a farming area
- loss of bowel and bladder control (limits all other activities due to the problems this creates)
- needs new calipers
- the doctor was not honest about the extent of the initial injury which caused total paraplegia
- distress of mother due to the injuries and disability of her son

- unable to manage independently as home needs adaptations and there is no money for this
- uncomfortable about asking for regular supplies - provision from the NGO not consistent

Good changes:

- learned English and now teaches the children from extended family
- some operations have improved function
- physiotherapy and rehabilitation services
- vocational training
- equipment supplied
- education - accepted into a normal school using crutches
- home adaptations and running water inside house
- the street improved to allow wheelchair access
- able to live alone because of improvements to the home
- started a centre for disabled people with financial support from a political group within their community
- talked to a newly disabled man and encouraged his family to open a shop for him
- has the confidence and ability to be a public speaker
- UNRWA assistance to attend a special school for the visually disabled
- fiancee'
- newly disabled person changed his work which allowed him to function independently and support his family

One person from 13 said there had been no good changes, another said that changes had been positive in the past but now there was nothing happening.

4. OLDER PEOPLE WITH PHYSICAL DISABILITIES - interviews with the elderly people and their carers

Problems:

- long term care, daughter cared for by aged frail mother
- lack of money, daughter was working before she became disabled
- lack of family support
- house difficult, access, steps, bathroom facilities
- daughter - caregiver, given up her work to return to parental home - domestic duties new to her, problems with cooking, cleaning etc
- mother not keen to exercise
- mother needs constant supervision due to instability on her feet and when transferring
- loss of independence and inability to take part in the household activities - dependent on aged husband and his first wife
- daughter must bring food and help with the toilet etc
- heavy and difficult to manage
- unable to transfer to a toilet chair
- daughter, the only carer, her responsibility to care for mother, no income of her own - the future for the daughter uncertain, not married
- poor house with no windows, cold in the winter
- medical problems eg swollen feet, dry skin, bowel and bladder control

Good changes:

- some home improvements from an NGO
- some attempt at rehabilitation but difficult as mother not strong enough to help her daughter with exercises, mobility etc
- brought own wheelchair and adapted house so mother could go out
- visiting rehabilitation worker
- advice, exercises, equipment
- after two months function improved and able to go out, visit neighbours, walk to the shops
- improved with ADL, increased independence
- after first stroke mobility improved and quality of life, but now after second stroke confined to bed so good changes negated, but has hope to improve

APPENDIX H

REFERENCES FOR THE INFORMAL DISCUSSIONS

reference	the person interviewed	date of meeting
N1	LNGO director	10.1.97
N2	INGO field officer	14.1.97
N3	INGO director	10.1.97
N4	INGO field officer	17.1.97
N5	INGO director	10.1.97
N6	INGO director	9.1.97
P1	Doctor	15.1.97
P2	Orthotist and Prosthetist	21.1.97
P3	Nurse educator	22.1.97
P4	Diplomat	15.1.97
P5	Diplomatic staff	15.1.97
P6	Anthropologist and Author	16.1.97

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