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Original Article

Evaluating a Community-Based Rehabilitation Program Using Provus Discrepancy Evaluation Model

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Abstract

Background: *This study assessed the implementation of the Community-Based Rehabilitation (CBR) program in Cebu using the Provus Discrepancy Evaluation Model. The evaluation compared the actual program implementation with the ideal parameters set by the World Health Organization (WHO) CBR standards, identifying discrepancies.*

Methods: *A quantitative descriptive-evaluative research design was employed, with two respondent groups: program implementers and program clients, ensuring data triangulation. Data were gathered through one-on-one interviews, using WHO's 2004 standardized guidelines and indicators from the International Disability and Development Consortium (IDDC) as the evaluation framework. Key components assessed included health, education, livelihood, empowerment, and social aspects.*

Results: *The study identified discrepancies across these five CBR components, primarily attributed to limited resources and expertise available for service delivery. In the Philippine context, most indicators under health and education were effectively implemented, successfully enhancing the lives of persons with disabilities and their families. However, the livelihood, empowerment, and social components showed significant gaps, with several indicators or services yet to be fully implemented.*

Conclusion: *These findings underscore the need for resource allocation and capacity-building to improve these critical areas of the CBR program.*

Keywords

program evaluation, community-based rehabilitation, Provus discrepancy evaluation model, community health, Cebu Philippines

INTRODUCTION

World Health Organization (WHO) declared a pandemic due to the seriousness and health risks posed by Coronavirus disease (COVID-19). A lot of COVID-19 survivors can suffer a wide range of clinical, functional, and psychological impairments which may result in disabilities that require rehabilitation (Amatya, 2020). In the context of Physical Therapy (PT), community rehabilitation is a good treatment option for persons with functional disabilities, especially recently, going to a hospital setting poses more risks of infection transmission.

Community-based Rehabilitation (CBR) is a strategy developed in the community that enhances the lives of persons with disability (PWD) through rehabilitation, balancing the opportunities and integration of PWDs in the society. CBR was initiated by WHO to improve the quality of life of persons with disabilities together with their families to meet their basic needs and ensure inclusion, participation, and cooperation. Initially, this strategy was developed to increase accessibility to rehabilitation services in limited resources settings. However, now, CBR is a multi-sectoral approach working to improve the equalization of opportunities and social inclusion of PWD while combatting the perpetual cycle of poverty and disability (International Labour Organization et al., 2004).

There are more than 100 million people with disability globally, which is about 15% of the world's population or one in seven people. Of this number, between 110 million and 190 million adults experience significant difficulties in functioning. It is estimated that 93 million children – or one in twenty of those under 15 years of age – live with a moderate or severe disability. The number of people who experience disability will continue to rise as populations age, with the global increase in chronic health diseases. Global patterns of disability are influenced by trends in health conditions, environmental and other factors, including natural disasters and conflict, unhealthy diet, and substance abuse (World Health Organization [WHO], 2015b).

In the Philippines, the 2010 Census of Population and Housing (CPH, 2010) results show that of the household population of 92.1 million, 1.442 million Filipinos or 1.57% have a disability. There were more males, who accounted for 50.9% of the total PWD in 2010, compared to females, with 49.1% with disability. For every five PWD, one (18.9%) was aged 0 to 14 years, three (59%) were in the working age group (15-64 years old), and one (22.1%) was aged 65 years and above (National Statistics Office, 2013).

Because of its high incidence, the WHO developed a community-based rehabilitation matrix that visually represents the program. It illustrates the different sectors which make up the CBR strategy. It consists of five key components, which include Health, Education, Livelihood, Social and Empowerment and each is divided into five key elements. The matrix provides a basic framework that will be the basis for developing new CBR programs. Although a standard matrix from WHO exists now, each CBR program is still unique and has differences, which may be because of physical, socioeconomic, cultural, and political factors.

Following the call of WHO to enhance the quality of life for people with disabilities and their families, Velez College in Cebu City has developed a CBR program in line with its mission to develop competent professionals who are socially responsible and morally fit productive citizens of the world with a passion for service and lifelong learning. One of the partner Communities of Velez College is in Barangay Lorega San Miguel, Cebu City. This Community possesses the characteristics of parochial communities and is an ideal place for a CBR program since their economic status is generally low. Barangay Lorega-San Miguel is a populous community located in the heart of the city of Cebu. The barangay was named after the famous resident soldier, General Enrique Lorega, and its popular Sitio, Sitio San Miguel, where the old warehouse of San Miguel Brewery was located. The barangay is composed of 17 Sitios, namely Lorega Proper, Lawis, Creekside, Camansi, San Roque, Echavez Ext., Lomar, Laray, Canares, Itum Yuta, Riverside, Caimito, Sereas, San Miguel, Laguna, Phantom Lawis, and Quadrangle. Based on the 2015 Philippine Census, Lorega holds a population of 11,873 with a land area of 7.22 square kilometers.

In 2018, the Occupational Therapy Department started the Community-Based Health and Rehabilitation program in Barangay Lorega San Miguel, following the WHO standard (Velez College, Department of Occupational Therapy, n.d.). A survey was conducted by the Occupational Therapy Department at Velez College prior to establishing the CBR program. The study findings indicated that in terms of health status, the majority of the population does not attend regular check-ups. In terms of education, the majority of them have elementary as their highest educational attainment, and there are numbers of PWDs and their families also residing in these communities who do not have access to livelihood services.

In addition, the proponents would like to evaluate the CBR program implemented by the institution using the Provus Discrepancy evaluation model (DEM). The discrepancy evaluation model was utilized to assess the institution's CBR implementation in five categories based on the components of the WHO standard CBR matrix: health, education, livelihood, social, and empowerment. These indicators were evaluated by asking

questions relating to the program's relevance, efficiency, effectiveness, impact, and sustainability.

The Provus Discrepancy Model helps identify gaps between a CBR program's expected and actual outcomes, offering a systematic way to assess whether the program is meeting its objectives. By highlighting deficiencies, the model facilitates targeted improvements. When significant gaps are found, program structure, delivery methods, and resource allocation adjustments can be made to enhance effectiveness and service quality. Moreover, this model supports stakeholders, including program managers, funders, and policymakers, in making informed decisions on where resources, training, or support are most needed, ensuring more efficient and impactful interventions.

The model's iterative process of comparing expected outcomes with actual performance encourages continuous assessment, allowing the CBR program to adapt over time (for instance, in response to challenges like the COVID-19 pandemic) and stay relevant to the community's needs. Using the Provus Discrepancy Model is essential for diagnosing weaknesses, improving program effectiveness, optimizing resource allocation, and ensuring ongoing improvements. This structured approach helps CBR programs better serve people with disabilities, fostering their rehabilitation and integration into society.

Unlike some traditional evaluation models that primarily assess overall program outcomes, the DEM emphasizes comparing specific program standards with actual performance allowing for a more detailed and structured analysis that pinpoint exactly where the program deviates from its intended goals. Other evaluation methods, such as summative or formative evaluations, may focus on general successes or failures without diving into the underlying causes of discrepancies. By focusing on standards, DEM offers a clear framework for program improvement.

This study aims to evaluate the implementation of Velez College's community-based rehabilitation program in Cebu City, specifically in the affiliated CBR program implementation in Barangay Lorega San Miguel, Cebu City by utilizing the Provus discrepancy evaluation model. The identified gaps based on the WHO CBR program standards will become the objective basis for program enhancement strategies.

Review of Related Literature

This chapter is a collection of related literature and studies conducted by other researchers relevant to the presented research study. The results of these studies strengthen and support the entirety of the present research study.

Impact of Community-Based Rehabilitation Program

A study about the impact evaluation of the effectiveness of the CBR program in India, which provides a rigorous evaluation of its impact on people's well-being, specifically the well-being of persons with disabilities, found out that there is a significant and positive impact on the access to services, rights, and opportunities of persons with disabilities (Mauro et al., 2014).

Another study was conducted in South Africa about the impact of community-based rehabilitation (CBR) as implemented by mid-level rehabilitation workers known as community rehabilitation facilitators (CRFs) on people with disabilities (PWD), their families, and the communities. Although CRFs work with individuals, groups, families, and the community, CRFs appear to have had a more substantial impact on individuals with disabilities rather than the community at large. This study shows that there is a positive impact on individuals, but still, a number of issues need to be addressed. Part of the recommendations in the research is to have an intersectoral collaboration between the government to ensure a better future in CBR implementation (Chapell & Johannsmeier, 2009).

The community-based rehabilitation program also significantly impacts the "out-of-pocket" expenditure for PWDs, specifically for the mental illness beneficiaries and their families. In this study, the researcher found out that there is a dramatic fall in "out-of-pocket expenditure after switching and availing of community-based rehabilitation programs from personal treatment from the private sector. This study concluded that the provision of CBR in partnership with public health systems and non-government organizations leads to cost-effectiveness for the beneficiaries and their families (Sivakumar et al., 2019).

In the Philippines, a study was conducted to evaluate the implementation of the CBR program by the University of the Philippines (UP) Manila College of Allied Medical Profession and its impact on the stakeholders: persons with disabilities, students, and alumni. The program results show that the condition of PWDs has improved, and there were significant changes in their knowledge, skills, and attitude. Enhancement of student attitudes, skills, and values was noted, and the CBR program was considered a character builder for rehabilitation professionals. CBR implementers learned to appreciate the potential of PWDs and accept their limitations. Local leaders promised that they would sustain the CBR program for their constituents (Magallona & Datangel, 2012).

Evaluation of Community-Based Rehabilitation Program

A working definition of evaluation of CBR refers to a standard in making objective judgements on the activities and outcomes of the CBR program and rehabilitation efficacy of PWD in line with the goals, strategy, action plan, and implementation of the CBR program and the rehabilitation training scheme of the beneficiaries. Evaluation of CBR should take place in phases. Therefore, each phase of evaluation is an ongoing process. This phase is done to improve the program's work for the next phase and learn about the experiences and lessons to achieve the program's final goal. CBR programs can be evaluated monthly, every 3-6 months, mid-time evaluation, eventual evaluation, and follow-up evaluation (Zhao & Kwok, 1999).

Community-based rehabilitation interventions for stroke patients have shown significant improvement in terms of functional outcomes. A study was conducted to compare the functional status, leisure activity, and satisfaction in adult stroke survivors participating in a community rehabilitation program and compare these outcomes with stroke survivors not attending any program. The results revealed severe stroke impact and low functioning in activities of daily living in the participant group. However, participation in leisure activities improved significantly after attending the program. Stroke survivors participating in a community-based rehabilitation program did not show an advantage in terms of disability levels over non-participants. However, their activity level increased due to the program, and their satisfaction scores were higher than non-participants (Hartman-Maeir et al., 2007).

Another component of the community-based rehabilitation program is telerehabilitation (TR). This is defined as delivering rehabilitation services via information and telecommunication technologies. Telerehabilitation creates opportunities for underserved regions (e.g., rural communities) to access advanced rehabilitation expertise and services that would be otherwise inaccessible. The advances in Internet technologies and the availability of broadband connections have expanded TR applications that were previously too complicated or expensive to deliver (Parmanto & Saptono, 2009). Results showed in the study that there are generally high levels of usability in TR. Users commented that the telerehabilitation system improved communication, increased access to information, improved task completion speed, and had an appealing interface. Areas where users would like to see improvements, including ease of accessing/editing documents and searching for information (Schutte et al., 2012).

Community-based rehabilitation greatly impacts the lives of individuals availing the services in the community. The program enhances the lives of persons with disabilities and their families within their community. This program strategy is developed in the community through rehabilitation, balancing the opportunities and integration of PWD in society by following principles that involve inclusion, participation, sustainability, empowerment, and self-advocacy.

Framework of Evaluation

This study utilized the Provus Discrepancy Evaluation Model to evaluate a CBR program implemented in Cebu City. In the evaluation process, the proponent used the CBR WHO standards as the ideal parameters to compare to the actual program. Hence, this section will have two (2) important parts: 1) the Provus discrepancy model and 2) the WHO CBR standards.

The Provus Discrepancy Evaluation Model. Malcolm Provus developed the Discrepancy Evaluation Model in 1969 to provide information for program assessment and program improvement. It is the process

of agreeing upon program standards, determining whether discrepancies exist between some aspect of the program and the standards governing that aspect of that program, and using discrepancy information to identify weaknesses (Provus, 1969).

DEM identifies five specific stages of the program. 1.) Program definition stage, 2.) Program installation stage, 3.) Program process stage, 4.) Program product stage, and 5.) Cost benefit analysis. The program definition stage is where the purpose of the evaluation is to assess the program design by first defining the necessary inputs, processes, and outputs and then by evaluating the comprehensiveness and internal consistency of the designs. The program installation stage assesses the degree of program installation against stage 1 program standards. The program process stage checks the relationship between the variables to be changed and the process used to effect the change. The program product stage evaluates whether its design has achieved its major objectives. Finally, cost benefit analysis is where the evaluator compares the cost of similar programs with the same or similar end product.

CBR Standards are based on the World Health Organization. The WHO CBR matrix consists of five components: Health, Education, Livelihood, Social, and Empowerment, each divided into five elements (WHO, 2015b). The components and the elements should be interrelated, not discrete and separate. Several principles that inform all the work underpin the components and elements. The principles overlap, are complementary, are interdependent, and should not be separated. The following principles in the matrix are inclusion, participation, sustainability, empowerment, and self-advocacy.

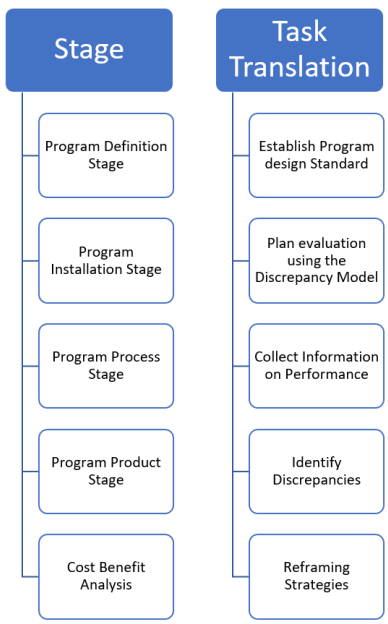

Figure 1. *Provus Discrepancy Evaluation Model (1969)*

Inclusion means the removal of all kinds of barriers that block people with disabilities from accessing the mainstream. It also includes all forms of impairment, may it be physical, sensory, communicative, mental health and illness, intellectual, and developmental disabilities. Participation means the involvement of disabled people as active contributors to the CBR program, from policy making to implementation and evaluation, because they know best what they need. Sustainability in which benefits of the program must be lasting. This means that the approach to poverty alleviation, where socio-economic gain lasts beyond the short term, benefits the present and future generations. Empowerment means local people and specifically PWD and their families, make the program decisions and control the resources. This means that PWD is taking

leadership roles within the programs. Self-advocacy means PWD's central and consistent involvement in defining the goals and processes for poverty alleviation. Family members will also play a key role as advocates.

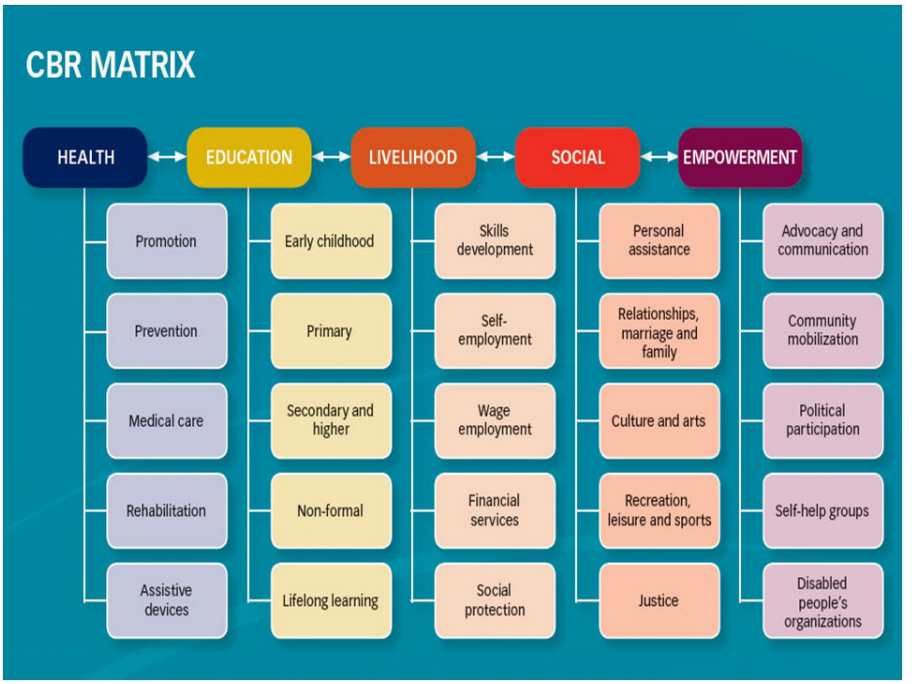

Figure 2 . *WHO CBR Matrix*

METHODS

Study Design, Population, Setting

This study utilized a quantitative descriptive-evaluative research design. Specifically, the Provus Discrepancy Evaluation Model was utilized to evaluate CBR implementation in one of the institutions in Cebu City, compared to the WHO standard CBR matrix. The Discrepancy Evaluation Model was developed in 1969 by Malcolm Provus to provide information for program assessment and program improvement. It is the process of agreeing upon program standards, determining whether discrepancies exist between some aspect of the program and the standards governing the aspect of that program, and using discrepancy information to identify weaknesses (Provus, 1969).

This study was conducted in the affiliated community of Velez College, particularly in Barangay Lorega San Miguel, Cebu City. This Community possesses the characteristics of parochial communities and is an ideal place for a CBR program since their economic status is generally low. In terms of health status, the majority of the population does not attend regular check-ups. In terms of education, the majority of them have elementary as their highest educational attainment, and there are numbers of PWDs and their families also residing in these communities who do not have access to livelihood services.

The respondents of the study involved two (2) groups: the program implementers and the program beneficiaries. Out of thirteen (13) total program implementers, ten (10) including the program director, Occupational therapists, Local Government Unit personnel – Barangay captain and councilors, GAD- Gender and Development focal person were mainly the source of program components and were validated and triangulated with the seven (7) clients who are/were recipients of the services. Inclusion criteria for the beneficiaries are as follows: able to read and understand the English language, a beneficiary or at least one

member of the family should be a beneficiary of the CBR program, and above 18 years old. All respondents who opted to withdraw from participating in the study were allowed.

Purposive sampling was utilized using the inclusion criteria. This study utilized total enumeration during the mentioned duration of data gathering to maximize the available respondents. Data saturation was reached.

Study tools, variables, data collection

The transmittal letter was forwarded to the Institution head for permission to conduct the study before the actual data gathering. Ethics clearance was sought prior to the data gathering. Thereafter, informed consent was explained and to be electronically signed by the respondents. Data privacy and confidentiality were maintained. After the data gathering through one-on-one interviews, if there are/were discrepancies noted in the answers of the implementers and beneficiaries, the proponents probed the respondents to check the gap and find out the possible reasons for the discrepancies noted. Narrative analysis of data was employed to identify patterns in meaning across the data.

The standardized guidelines by WHO, together with the International Disability and Development Consortium (IDDC) containing different indicators, were used in the evaluation. Components include health, education, livelihood, empowerment, and social aspects (World Health Organization, 2015a). The checklist measures the implementation or non-implementation of the indicators per component per element. Since WHO standards require all these indicators to be implemented in CBR, then non-implementation of any indicator can be an identified discrepancy and shall be considered in the enhancement of the program.

This research used a researcher-made interview guide for the narrative aspect of the data triangulation, which the content expert validated. The tool is composed of 2 parts. The first part contains the demographics of the informants. This includes age, number of years of being an implementer, and beneficiaries of the CBR program. Thereafter, warm-up questions followed that can gain the informant's trust in the researchers and build rapport that may be needed throughout the interview for the researchers to get the significant information. The second part focused on the main questions that would introduce us to the experiences/encounters of program implementers and beneficiaries in the CBR program. followed by needed follow-up questions or probing.

The researchers did not negate or agree with the informants' responses throughout the interviewing process to avoid any conflict of interest and biases that may affect the genuine context of the informants' responses.

Data analysis

Discrepancies between the standards and the actual program implementation were identified. Reasons for the gaps were deduced as a basis for program enhancement. Descriptive statistics, specifically frequency and percentage, were used to determine the extent of compliance in each indicator. Narrative analysis of data was utilized to identify patterns based on the supplemental interviews with the respondents.

Respondents were given a hard copy of the tool for them to access the questionnaires. Response monitoring was available for data processing in Google Drive. The interview file containing the interview questions was stored and protected using a password. When not in use, it was placed in a locked compartment at the principal researcher's residence.

Ethical considerations

The following institutional research materials in the study contain the respondents' confidentiality and propriety information. The information, data, and other materials embodied are strictly confidential and supplied on the understanding that they were done.

The researcher asked for consent from the Administrative Officer. The researcher asked the informants for a letter of informed consent requesting that the respondents participate. The decision to join or not to join was up to the informants.

Some informants may belong to vulnerable groups. The proponents discussed the study's objective thoroughly. They explained to the informants that they may be allowed to refuse or withdraw from the study if they feel any violations of the privacy and confidentiality. They were not forced to join and are capable of making those decisions themselves.

The recruitment process in this study was limited within the ethical boundaries required by the institution. It involved ocular inspection and verbal consent among the qualified subjects. There is no risk in this study. This study benefited the implementer by improving their services and identifying the discrepancies between the standard and actual implementation.

After completing the questionnaire, the respondents were given a token of appreciation in the form of a cellular phone load worth 100 pesos as a form of gratitude for their participation. The researcher noted no conflict of interest.

RESULTS AND DISCUSSION

This section presents the evaluation results comparing the standards of the WHO CBR program to the actual implementation of the community-based rehabilitation program facilitated by Velez College. To clearly focus on the identification of discrepancies between the various program components and elements with corresponding indicators, the findings are organized per program component: A. Health, B. Education, C. Livelihood, D. Empowerment, E. Social.

Health. This component tackles the elements of health promotion, prevention, medical care/curative, rehabilitation, and assistive devices. The healthcare needs of people with disabilities are often the same as those of non-disabled people–they need and are entitled to the same range of treatments. Health is a valuable resource that enables people to lead individually, socially, and economically productive lives, providing them with the freedom to work, learn, and engage actively in family and community life.

Table 1 . *Health Component*

Elements	Indicators	Implemented	Not Implemented	Discrepancy
Promotive	Access to information and promotion of personal and public health	✓		No discrepancies in all these indicators.
	Promotion of knowledge on health and staying healthy	✓		
	Health of personal assistants, parents, and siblings of children with disabilities	✓		
	Healthy environment	✓		
	Recognition of people with disability as a peer resource	✓		
Preventive	Primary prevention - Immunization	✓		No discrepancies in all these indicators.
	Early detection and intervention [especially children under 3 years old]	✓	**X(Recipient)**	
	Prevention of secondary conditions [e.g., depression, deformities, pressure sores, respiratory infections, etc.]	✓	**X(Recipient)**	
	Sexually transmitted diseases and appropriate preventive education and provision of protection	✓		
Curative	Health care for people with disabilities [e.g., Flu, high blood pressure, HIV/AIDS]	✓		Discrepancy was found. Specifically, service that offers corrective surgery and medical intervention
	Referral to specialized services	✓		
	Corrective surgery and medical intervention	✓	**X(Implementer and Recipient)**	

Table 1 . *continued*

Elements	Indicators	Implemented	Not Implemented	Discrepancy
Rehabilitative	Medical intervention	✓		No discrepancies in all these indicators based on the Implementers' answers
	Daily living skills support	✓		
	Therapeutic intervention	✓		
	Referral to specialist services	✓		
	Family and community support	✓		
	Return to work programs	✓		
Assistive devices	Access to devices, inc. mobility, vision, hearing, etc.	✓		No discrepancies in all these indicators
	Access to prosthetic and orthotic devices	✓		
	Education on their use; access to after-care	✓		
	Access to Information and Communication Technology	✓		
	Environmental adaptations	✓		

Based on the Evaluation of the Health component, discrepancies were identified. On the element of health promotion, rehabilitation, and assistive devices, all indicators in the WHO standard matrix were compliant with the actual implementation. This implies that the program managers were able to implement all these services. A 2008 evaluation conducted in Thailand concluded that the CBR program had been effective in providing a range of healthcare services for people with disabilities and their families, including early identification of people with disabilities and early intervention, health promotion, and rehabilitation, including functional training and provision of assistive devices. Overall, quality of life has been enhanced for all people with disabilities, with improvements in their independence, mobility, and communication skills. Parents of children with disabilities have also been provided with better support (World Health Organization, 2010).

Furthermore, as you can glean from the table, two elements were implemented according to the program managers. However, some clients were not aware of their existence (Early detection and intervention [especially children under 3 years old], Prevention of secondary conditions [e.g., depression, deformities, pressure sores, respiratory infections, etc.]. After validation, the possible reasons for this might be that the service is not very common, and the recipients may not be able to avail themselves since not all recipients have the same needs.

In the curative element of health, corrective surgery and medical intervention indicators were not also included in the implementation because of the lack of experts and resources. This supports the finding from WHO, (2010) that families may have limited knowledge and understanding regarding surgery, so they must be informed properly about the benefits and consequences. Surgical care is often costly, and without social security or health insurance, it will be difficult to access for poor people. As verbalized by the councilor who is in charge of health services, *"…wala mi doctor available para sa surgery. Igo ra namu irefer sa lain hospital"* (…we do not have an available doctor for surgical operations. We only refer clients to other hospitals).

Education. This component includes the elements of early childhood, primary, secondary, higher education, non-formal, and special education, and transitory/lifelong learning. This component recognizes the importance of mainstream education and the role of some specific or special educational provision. Education is about all people being able to learn what they need and want throughout their lives, according to their potential. It includes "learning to know, to do, and to live together.

Table 2 . *Education Component*

Elements	Indicators	Implemented	Not Implemented	Discrepancy
Early childhood development	Early identification	✓		No discrepancies in all these indicators
	Parent and family support	✓		
	Play and development	✓		
	Child development	✓		
	Recognition of people with disability as a peer resource	✓		
	Transition and readiness for formal education	✓		
Non-formal education	Home-based learning	✓		No discrepancies in all these indicators
	Adult literacy	✓		
	Community-based daycare centers	✓		
	Links with formal education	✓		
	Flexibility and adjustments/adaptations within formal education settings	✓		
	Religious-based supplementary education [e.g., Sunday schools, Madrasahs]	✓		
	Individual educational planning	✓		
	Creativity and sports	✓		
Basic education	Access to curriculum, technology, and medium and method of instruction	✓		No discrepancies in all these indicators
	Home / community / school links	✓		
	Child–to–child activities	✓		
	Orientation of school personnel	✓		
	Access to resources and learning materials	✓		
	Educational and technical support	✓		
Higher education	Advice, guidance, and enrolment	✓		No discrepancies in all these indicators
	Access to materials, methods, communication, and ICT	✓		
	Individual and family support	✓		
	Distance learning	✓		
	Flexible examination assessment methods	✓		
Special and transitory	Special education	✓		Discrepancies were found. Specifically, identification of work options and linkages to working life
	Identification of work options		**X (Implementer and Recipient)**	
	Linkages to working life		**X (Implementer and Recipient)**	
	Peer counseling	✓		
	Survival needs training -	✓		
	Citizenship and political awareness	✓		

All elements of the education component, particularly early childhood education, primary, secondary, non-formal, and higher education, were implemented. This is in compliance with UNESCO's call that education for all needs to be adopted in order to achieve the goals, with a special emphasis on those learners who are the most vulnerable to marginalization and exclusion (United Nations Educational, Scientific and Cultural Organization, 2003).

However, in the aspect of special education and transitory learning, these indicators involve the identification of work options and linkages to working life. Obviously, educational under-attainment and non-accessibility of the workplace are the leading causes. Because of the general unavailability and the prohibitive cost of technological advances designed to improve communication among PWDs, specifically, the hearing impaired, and the poor sign language interpretation, official documentation that is often required in qualifying for grants and funding for organizations is generally lacking (Kono, 2015)

This is supported by one of the implementers as follows:

"Magpa conduct ra mi ug trainings, pero wala mi partner companies na pwede mo hire nila after training" (We are offering trainings. However, we do not have any existing affiliated companies that can hire them afterward.)

Livelihood. This component includes financial services, employment, and social security benefits. It focuses on the importance of decent and fair employment, traditional skills, and services. It is essential to ensure that both youth and adults with disabilities have access to training and work opportunities at a community level.

All indicators in the skills training element were implemented. This is in accordance with the call of the United Nations Convention on the rights of persons with disabilities. By encouraging and facilitating work by women and men with disabilities, community-based rehabilitation programs can help individuals and their families to secure the necessities of life and improve their economic and social situations (WHO, 2010).

Table 3 . *Livelihood Component*

Elements	Indicators	Implemented	Not Implemented	Discrepancy
Skills training	Vocational – formal and informal/ traditional	✓		No discrepancies in all these indicators
	Skills transfer from home to work	✓		
	Life and work skills and orientation	✓		
	Vocational guidance	✓		
	Mainstream skills training	✓		
Access to capital	Guarantors and collateral		X (Implementer and Recipient)	Discrepancies were found. Specifically, providing guarantors and collateral
	Micro credit	✓	X (Recipient)	
	Access to mainstream capital and grants	✓		
	Knowledge of resources and sources of capital	✓		
	Linkage and possible merging with other mainstream groups	✓		
Income generating activities	Cooperatives	✓		Discrepancies were found. Specifically, providing a protected/ sheltered scheme
	Enterprises	✓		
	Protected [sheltered] schemes		X (Implementer and Recipient)	
	Focus on service sector	✓		
	On-going guidance support	✓		

Table 3 . *continued*

Elements	Indicators	Implemented	Not Implemented	Discrepancy
Open employment	Active lobbying	✓		Discrepancies were found. Specifically, providing legal obligations on employers, including affirmative action and quotas, providing reasonable adjustment by employers, and supporting employment, including job coaching and mentoring
	Legal obligations on employers inc. affirmative action and quotas		X (Implementer and Recipient)	
	Diversity awareness within organizations	✓		
	Equality of treatment at work for people with disabilities	✓		
	Reasonable adjustments by an employer, e.g., adaptations to the working environment,ways of working, etc.		X (Implementer and Recipient)	
	Supported employment [inc. job coaching, mentoring, etc.]		X (Implementer and Recipient)	
	Social capital and enterprise	✓		
Economic contribution and social protection	**For those working:**			
	As resource person, e.g., peer support, counselling		X (Implementer and Recipient)	Discrepancies were found. Specifically for those working individuals who provide peer support and counseling
	Skills training and role models	✓		
	Employment creation – services and goods to the community	✓		
	Contribution to the household	✓		
	Consumer role – services and goods	✓		
	For those who cannot get employment or have a decent income:			
	Social security		X (Implementer and Recipient)	Discrepancies were found. Specifically for those non-working individuals that provide social security, microinsurance schemes including pension, health and funeral expenses, and support from family.
	Mutual assistance in the community	✓		
	Micro insurance schemes, i.e., pension, health, and funeral expenses		X (Implementer and Recipient)	
	Support from family or official career/ guardian		X (Implementer and Recipient)	

However, some of the indicators in other elements under the livelihood component were not implemented, mainly in terms of access to capital, for which guarantors and collateral were not offered. There are many barriers to gaining access to microfinance institutions and financial services through banks and savings groups, such as a lack of physical access and the absence of sign language interpreters and Braille signage. Negative attitudes and misunderstanding on the part of both financial institutions and persons with disabilities can, however, be greater obstacles. For example, it can be difficult for persons with disabilities to become members of savings or loan groups because group members do not consider them creditworthy (Rule et al., 2017).

In the income-generating activities, only the protected/sheltered schemes were not implemented. For the open employment element, several indicators were not implemented, mainly providing legal obligations on employers incorporating affirmative action and quotas, allowing reasonable adjustments by an employer, such as adaptations to the working environment and ways of working, and providing support for employment, like job coaching and mentoring.

For the economic contribution and social protection element, these services were offered for those working and for those who could not get employment or a decent income. There are several indicators under

this element that were not implemented, particularly for those working individuals who offer services like a resource person which provide peer support and counseling, and for those who were not working which the actual implementation failed to provide social security, micro-insurance schemes like pension, health, funeral expenses, and support from family or official career/ guardian. The situation in low-income countries varies greatly depending on the strength of the economy and government resources, but in general, very few people have social protection. Those who have wage employment in the formal economy may have pensions and other forms of social protection. However, the great majority often struggle for survival in the informal economy where there is no formal protection against loss of income in old age, or through illness or disability (WHO, 2010). There are indicators in this component that contradict the answers from the implementers and recipients in terms of implementation–specifically, micro-credit and access to mainstream capital and grants. Validation was done, and the possible reason for this conflicting answer is that the service is limited only since funds in micro-credit and access to mainstream capital and grants are also limited in nature.

Discrepancies were further supported by the verbatim of the GAD implementer stating that:

> *"… naa mi livelihood trainings, pero lang, wala mi partner na agencies na pwede makahatag nila capital ug insurance" (We have livelihood trainings, but we do not have the capacity and even partner agencies that can provide their capital and insurance needs).*

Empowerment. The empowerment component focuses on the importance of empowering people with disabilities, their family members, and communities to facilitate the mainstreaming of disability across each sector and to ensure that everybody can access their rights and entitlements.

For the self-help groups (SHG) and disabled people's organizations element (DPO), all indicators were implemented. For the social mobilization element, campaigns led by people with disabilities, and campaigns on general issues, including those for people with disabilities, were also not implemented. In the political empowerment element, only one indicator, reservations, quotas, and affirmative action for elected and non-elected bodies at the national to local level, was not included in the implementation.

In language and communication, there were several indicators not implemented. Particularly communication needs incorporating sensory and communication impairments, internet, mobile phones, and tactile signing for deaf-blind communication. This is supported in the study about empowering women, including PWDs, whose findings confirm that economic SHG programs are a promising approach to achieve positive effects on women's empowerment and participation in SHGs led to a higher ability of women to exert control over resources (economic empowerment), participate in decision-making focused on access to resources, rights and entitlements within communities (political empowerment), make decisions about the reproductive health in the household and increased mobility (de Hoop & Tripathi, 2020). There are indicators in this component that contradict the answers from the implementers and recipients in terms of implementation–specifically, training political leaders and policy makers and specific language issues including literacy and translation. Validation was done, and the possible reason for this conflicting answer is that only a few recipients have availed this service since this is not very common, unpopular, and may need dissemination.

Social. Being actively included in the social life of one's family and community is important for personal development. The opportunity to participate in social activities has a strong impact on a person's identity, self-esteem, quality of life, and, ultimately, his/her social status. Because people with disabilities face many barriers in society, they often have fewer opportunities to participate in social activities.

GAD personnel confirmed these discrepancies, stating that:

> *"Kulang jud among mga serbisyo para sa mga PWDs. Wala mi aning kampanya nga pinanguluhan sa mga PWDs ug wala pud mi support para sa komunikasyon pareha anang internet ug celpon". (We really do not have enough services for PWDs. We do not have campaigns on general issues led by PWDs, and we do not provide support for their communication needs.)*

Table 4 . *Empowerment Component*

Elements	*Indicators*	*Implemented*	*Not Implemented*	*Discrepancy*
Self-help groups	Organizing people with disabilities and their family members	✓		No discrepancies in all these indicators
	Peer counseling and support, e.g., child to child, mother to mother	✓		
	Facilitate groups' leadership role in CBR processes	✓		
	Capacity-building	✓		
	Promote group activities for access to resources	✓		
Disabled people's organizations [DPO's]	Organizing people with disabilities	✓		No discrepancies in all these indicators
	Strengthening existing DPO's	✓		
	Promoting self-determination	✓		
	Capacity building	✓		
	Networking inc. agencies	✓		
	Umbrella organizations	✓		
	Resource to educate both people with disabilities and non-disabled people	✓		
	Partnership with local government	✓		
Social mobilization	Alliance building with representatives of society	✓		Discrepancies were found. Specifically, supporting campaigns on general issues led by PWDs
	Campaigns - led by people with disabilities		X (Implementer and Recipient)	
	Campaigns on general issues to include people with disabilities		X (Implementer and Recipient)	
	Access to local and community resources	✓		
	Involvement in any local committees	✓		
Political empowerment	Reservations, quotas, and affirmative action for elected and non-elected bodies at the national and local level		X (Implementer and Recipient)	Discrepancies were found. Specifically, providing reservations, quotas, and affirmative action for elected and non-elected bodies at national and local levels
	Access to voting and the right to a secret ballot	✓		
	Monitoring	✓		
	Lobbying	✓		
	Training political leaders and policymakers	✓	X (Recipient)	
Language and communication	Specific language issues, inc. literacy and translation	✓	X (Recipient)	Discrepancies were found. Specifically, providing communication needs for the deaf and blind and internet, mobile phones
	Communication needs, inc. sensory, and communication impairments		X (Implementer and Recipient)	
	ICT – Internet, mobile phones, etc.		X (Implementer and Recipient)	
	Tactile signing for deaf-blind communication		X (Implementer and Recipient)	

Table 5 . *Social Component*

Elements	Indicators	Implemented	Not Implemented	Discrepancy
Legal protection	Independent living	✓		No discrepancies in all these indicators
	Home working	✓		
	Sexual and reproductive rights	✓		
	Land and inheritance rights	✓		
	Protection of disabled children	✓		
	Financial support for legal advice	✓	**X (Recipient)**	
	Protection from negative cultural beliefs	✓		
Culture and religion	Participation in cultural and religious activities	✓		No discrepancies in all these indicators
	Participation in cultural and religious activities	✓		
	Society's attitudes to disability	✓		
	Religious attitudes to disability	✓		
	Resources and support from cultural and religious groups	✓		
	Using religious and cultural activities to remove stigma	✓		
Sports and leisure [social activities]	Integrating young people and adults into mainstream provision	✓		No discrepancies in all these indicators
	Physical activity for people with disabilities	✓		
	Parallel sports activities for people with disabilities	✓		
	Promotion of sports as a therapeutic measure	✓		
	Spectator roles in a range of sports	✓		
	Inclusion in public and family social gatherings	✓		
	Access to recreation facilities, e.g., cinema	✓		
	Technological – used for equipment adaptation and modification	✓		
	Marriage and family	✓		
Relationships, marriage, and family	Diverse relationships and sexualities, inc. lesbian, gay, and same-sex		**X (Implementer and Recipient)**	Discrepancies were found. Specifically, providing support to diverse relationships and sexualities, including lesbian, gay, and same-sex, provide counseling and capacity building for women with disabilities, and offering compensation in cases of divorce or separation
	Sex education and HIV/AIDS preventive education	✓		
	Sex and reproductive health issues	✓		
	Emotional issues	✓		
	Peer counseling among married and non-married people with disabilities	✓		
	Support for single mothers and mothers neglected and deserted by husbands after birth of a child with disabilities, or after the mother acquires disability	✓		
	Awareness work with religious communities on disability and relationships / marriage /sexual relations between people with disabilities and between a person with a disability and a non-disabled person	✓		
	Compensation in cases of divorce or separation		**X (Implementer and Recipient)**	
	Trauma and psychosocial counseling	✓		

Table 5 . *continued*

Elements	Indicators	Implemented	Not Implemented	Discrepancy
Personal assistance	Daily living skills	✓		Discrepancies were found. Specifically, providing interpretation services to all PWDs
	Protection of the young, older people, and those with severe communication impairments from exploitation and abuse	✓		
	Persons with disabilities using the programs have a decisive influence	✓		
	Interpretation services	✓	**X (Recipient)**	
	Access to information	✓		
	Training – supervised / provided by people with disabilities	✓		

In the Legal protection element, all indicators were implemented. All the indicators under the culture and religion element were included in the actual implementation. In sports and leisure social activities, all indicators were implemented. For relationships, marriage, and family elements, these indicators were not included in the implementation of providing support to diverse relationships and sexualities including lesbian, gay, and same-sex, providing counseling and capacity building for women with disabilities, and offering compensation in cases of divorce or separation. For personal assistance, all indicators were included in the actual implementation except providing interpretation services to all persons with disabilities. Even today, topics such as relationships, marriage, and parenting may be too sensitive or too difficult to address. At the same time, access to cultural, sporting, and recreational activities and justice is seen as unnecessary (WHO, 2010). There are indicators in this component that contradict the answers from the implementers and recipients in terms of implementation. Specifically, financial support for legal advice and interpretation services. After validation was made, the possible reasons for this conflicting answer are that only a few recipients have availed of this service since this is not very common and needs more dissemination.

GAD implementers said that they do not have services to support diverse relationships and sexualities, including lesbian, gay, and same-sex, provide counseling and capacity building for women with disabilities, and offer compensation in cases of divorce or separation.

Table 6 . *Summary*

Stages	Component									
	Health		Education		Livelihood		Empowerment		Social	
	# of indicators	Discrepancy		Discrepancy		Discrepancy		Discrepancy		Discrepancy
Program Definition Stage	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0
Program Installation Stage	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0
Program Process Stage	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0
Program Product Stage	23	1 (4%)	31	2 (6%)	32	9 (28%)	27	6 (22%)	38	2 (5%)
Cost Benefit Analysis	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0

Generally, all five program components and their corresponding elements were properly addressed. However, some specific indicators or services under some of the elements per component that were not implemented because of a lack of resources and expertise. Most of the not implemented services are those that are less sought after or less common. In addition, some of the residents were not aware of the services offered.

Table 7 . *Program Enhancement Recommendations*

Area/s of Concern	Program Objectives	Specific Innovative Strategies	Focal Person	Financial Allocation and Sources	Time Frame	Success Indicators
Lack of awareness of the services offered by the CBR program in the community	Delivery of the services of CBR program beneficiaries	Provision of information dissemination to all the services offered by the CBR program including posters, use of social media and referral.	Program implementers, including the program director of the CBR program, local government unit personnel	N/A	Annual	Implementer and Beneficiary Awareness of services offered by the CBR program
Lack of expertise in different services	To cater to more beneficiaries, especially needing services from experts	Participate in training and seminars to gain expertise in respective fields. To hire the lack of manpower	Program implementers, including local government unit personnel and Physical and Occupational therapist	Local Government unit funds	Annual	Increase number of experts and enhancement of services by the CBR program
Discrepancy of the actual CBR program implementation compared to the standard CBR program	To comply and enhance the actual CBR program implementation	Monitor and identify the discrepancies and implement based on standards	Program implementers, including local government unit personnel and Physical and Occupational therapist	N/A	Annual	100% compliance with the standard CBR and service satisfaction from the beneficiaries

CONCLUSION

Based on the findings, a conclusion was drawn that there exist discrepancies between the WHO standard CBR matrix and the actual implementation. These discrepancies from the five components of the CBR matrix are due to the limited resources and expertise available to offer the services. In the context of Community-Based Rehabilitation in the Philippine setting, the majority of indicators or services under health and education components were implemented, and it lives to its aim of enhancing the lives of persons with disabilities and their families within their community. On the other hand, livelihood, empowerment, and social components have several indicators or services that have yet to be implemented.

Therefore, it is recommended that awareness strategies be developed for the services offered in the community. Manpower training, especially expertise in different services and resource provision, is needed to offer the services that were reflected in the standards.

Specifically, it is recommended for the community to implement community-wide awareness strategies to inform residents about the services available through the CBR program. This can be achieved through local outreach initiatives such as informational sessions, community meetings, social media, and collaboration with

local leaders to ensure that the services are well-publicized and accessible to all community members.

Another is to prioritize training and capacity-building for program staff to enhance their expertise in key service areas. Specialized training should be provided in health, education, livelihood, empowerment, and social services to ensure that implementers have the necessary skills to deliver high-quality care. Ongoing professional development programs should also be introduced to keep staff updated on best practices and emerging trends.

The LGU must allocate sufficient resources, both manpower and financial and material, to meet the program standards. This includes investing in infrastructure, equipment, and educational materials necessary for the effective delivery of services. Additionally, funding should be directed toward enhancing the program's outreach, expanding service access, and ensuring that services are sustainable in the long term.

The program implementers need to foster partnerships with local governments, NGOs, and international organizations to access additional resources and expertise. These collaborations can help fill existing gaps in service delivery, provide training opportunities, and secure funding to address deficiencies in program implementation. By implementing these recommendations, the CBR program can strengthen its capacity to deliver comprehensive services, improve the quality of life for people with disabilities, and better align with WHO standards.

Lastly, another evaluation study should be conducted for future researchers to monitor the implementation and address discrepancies to enhance the program.

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Cutamora: Conceptualization, Methodology, Writing- Original draft preparation, Writing-Reviewing and Editing; **Leonardo:** Data curation, Data gathering; **Lagria:** Data gathering, Validation.

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Ethical Approval

Ethics clearance was given by Velez College Ethics Review Committee with protocol code: VCERC CODE: 2023-NON-001 dated 6/22/2021. Informed consent was obtained from all subjects involved in the study.

Competing interest

The authors declare no conflicts of interest.

Data Availability

Data will be made available by the corresponding author on request.

Declaration of Artificial Intelligence Use

In this work, the author(s) did not utilize any artificial intelligence (AI) tools and methodologies.

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REFERENCES

Amatya, B., & Khan, F. (2020). Rehabilitation response in pandemics. *American Journal of Physical Medicine & Rehabilitation, 99*(8), 663–668. https://doi.org/10.1097/PHM.0000000000001477

Chappell, P., & Johannsmeier, C. (2009). The impact of community based rehabilitation as implemented by community rehabilitation facilitators on people with disabilities, their families and communities within South Africa. Disability and Rehabilitation, 31(1), 7–13. https://doi.org/10.1080/09638280802280429

de Hoop, T., & Tripathi, S. (2020, March 8). Empowering women through self-help groups: Evidence of effectiveness, questions of scale. International Initiative for Impact Evaluation (3ie). https://www.3ieimpact.org/blogs/empowering-women-through-self-help-groups-evidence-effectiveness-questions-scale

Hartman-Maeir, A., Eliad, Y., Kizoni, R., Nahaloni, I., Kelberman, H., & Katz, N. (2007). Evaluation of a long-term community based rehabilitation program for adult stroke survivors. NeuroRehabilitation, 22(4), 295–301. https://doi.org/10.3233/nre-2007-22407

International Labour Organization, United Nations Educational, Scientific and Cultural Organization, & World Health Organization. (2004). CBR: A strategy for rehabilitation, equalization of opportunities, poverty reduction and social inclusion of people with disabilities: Joint position paper 2004. World Health Organization.

Kono, A. (2015). A glimpse of the employment status of persons with disabilities in the Philippines from a Cebuano perspective. Asia and Pacific Journal on Disability, 5(1). Disability Information Resources (DINF). https://www.dinf.ne.jp/doc/english/asia/resource/z00ap/vol5no1/glimpse.html

Magallona, M. L. M., & Datangel, J. P.-B. (2012). The community-based rehabilitation programme of the University of the Philippines Manila, College of Allied Medical Professions. Disability, CBR & Inclusive Development, 22(3), 39–61. https://doi.org/10.5463/dcid.v22i3.110

Mauro, V., Biggeri, M., Deepak, S., & Trani, J.-F. (2014). The effectiveness of community-based rehabilitation programmes: An impact evaluation of a quasi-randomised trial. Journal of Epidemiology and Community Health, 68(11), 1102–1108. https://doi.org/10.1136/jech-2013-203728

National Statistics Office. (2013). 2010 census of population and housing, report no. 2A: Demographic and housing characteristics (non-sample variables): Philippines. https://psa.gov.ph/system/files/main-publication/2010_PHILIPPINES_FINAL%2520PDF.pdf

Parmanto, B., & Saptono, A. (2009). Telerehabilitation: State-of-the-Art from an informatics perspective. International Journal of Telerehabilitation, 1(1), 73–84. https://doi.org/10.5195/ijt.2009.6015

Provus, M. M. (1969). The discrepancy evaluation model: An approach to local program improvement and development. U.S. Department of Health, Education & Welfare Office of Education.

Rule, S., Seifert, H., & Mbugua, P. K. (2017). No need to reinvent the wheel: Disability mainstreaming for poverty reduction. In A. B. Nganwa, M. C. Sserunkuma, & P. K. Mbugua (Eds.), CBR Guidelines: a Bridge to Inclusive Society beyond the 2015 Development Framework. CBR Africa Network.

Schutte, J. L., Gales, S., Filippone, A., Saptono, A., Bambang, P., & McCue, M. (2012). Evaluation of a telerehabilitation system for community-based rehabilitation. International Journal of Telerehabilitation, 4(1), 15–24. https://doi.org/10.5195/ijt.2012.6092

Sivakumar, T., James, J. W., Basavarajappa, C., Parthasarathy, R., Naveen Kumar, C., & Thirthalli, J. (2019). Impact of community-based rehabilitation for mental illness on "out of pocket" expenditure in rural South India. Asian Journal of Psychiatry, 44, 138–142. https://doi.org/10.1016/j.ajp.2019.07.029

United Nations Educational, Scientific and Cultural Organization. (2003). Overcoming exclusion through inclusive approaches in education: A challenge and a vision. UNESCO Digital Library. https://unesdoc.unesco.org/ark:/48223/pf0000134785

Velez College, Department of Occupational Therapy. (n.d.). Community based health and rehabilitation. https://sites.google.com/view/vcotcbhr/home

World Health Organization and International Labour Organization. (2004). CBR: a strategy for rehabilitation, equalization of opportunities, poverty reduction and social inclusion of people with disabilities; joint position paper 2004. UNESCO. Retrieved 2021, from https://unesdoc.unesco.org/ark:/48223/pf0000137716#:~:text=WHO%2C%20ILO%20and%20UNESCO%20view%20CBR%20as%20a,participation%20of%20people%20with%20disabilities%20and%20their%20organizations.

World Health Organization. (2010). Community-based rehabilitation: CBR guidelines. https://www.who.int/publications/i/item/9789241548052

World Health Organization. (2015a). Capturing the difference we make: community-based rehabilitation indicators manual. Retrieved 2021, from https://iris.who.int/bitstream/handle/10665/199524/9789241509855_eng.pdf

World Health Organization. (2015b). WHO global disability action plan 2014-2021: Better health for all people with disability. https://iris.who.int/handle/10665/199544

Zhao, T., & Kwok, J. K. F. (1999). Evaluating community based rehabilitation: Guidelines for accountable practice. Rehabilitation International Regional Secretariat for Asia and the Pacific.

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