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PAPER PRESENTED DURING THE COMMUNITY BASED REHABILITATION AWARENESS WORKSHOP HELD ON 21ST & 22ND DECEMBER 2005 AT COMMUNITY HALL IN BUSIA.

1. What is Community Based Rehabilitation (C.B.R)?

Community Based Rehabilitation is a strategy based on community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities themselves, their families and communities and the appropriate health, educational and social services.

Community Based Rehabilitation therefore empowers persons with disabilities to take action to improve their own lives, and contribute rather than drain or deplete whatever scarce resources that are available, and thereby benefiting the whole community

2. Background of Community Based Rehabilitation.

The Government of Uganda introduced its new strategy for rehabilitation and adopted the Community Based Rehabilitation (C.B.R) concept from the Norwegian Association of the Disabled (NAD) in 1992. the main focus of C.B.R is assisting PWDs within their own communities using locally available resources through "bottom up approach". It was introduced in the three districts of Mbarara, Bushenyi and Kabale in Western Uganda.

In a1994, the programme was introduced in the three districts of Iganga, Mbale and Tororo, in Eastern Uganda.

In 1997, after a major evaluation exercise conducted by the Government of Uganda in conjunction with the Government of Norway, the programme was reviewed and recommendations were made that the Government of Uganda takes up funding task and Norwegian Government offers technical guidance.
One of the funding problems, the programme was scaled down to one district (Tororo) which was retained to be supported by the NAD funding under special fund (PAF) purportedly to promote it as model district.
The report also recommended that a new board should be created to monitor and supervise the programme and the membership was to be appointed from key ministries i.e. Finance, Education, Gender Labour and Social Development, Health and NuDIPU (NGO).

In 2003, another review was conducted following countrywide district disability assessment which I was involved in and highly recommended that Busia be involved in the programme.

The MOU was signed between the District and the Ministry of Gender, Labour and Social Development, hence its official launch on 20th December, 2005.

3. Why Community Based Rehabilitation?

Community Based Rehabilitation is favoured due to:-

a) Coverage: It is intended to reach as many PWDs as possible compared to Institutional Rehabilitation.
b) Reduce occurrences / incidences of impairment (0.022%).
c) Manage prevalence of disability.
d) Promote community participation to bring about integration / inclusion.
e) Demystify disability issues from charity to development issues.
f) Promote human rights.
g) Promote independent living and reduce on dependence.
h) Promote income generating activities.
i) Make the environment disability friendly.
j) Promote confidence in the PWD as an individual.
k) Sustainability is assured because of its bottom up approach.

4. Advantages of Community Based Rehabilitation.

- Promotes independence of PWDs.
- Encourages participation of PWDs.
- It encourages PWDs to demand for services from professionals.
- It is cost effective.

5. Vision

"A fully integrated PWD Community, accessing equal opportunities and enjoying good quality life in society".

6. Mission

"Creation of an enabling environment for equalization of opportunities and services leading to improved quality of life of PWDs".

7. Goals of Vision Community Based Rehabilitation.

- Enhance the activities of daily living of disabled.
- Promote awareness in respect to disability issues.
- Promote community participation in order to encourage PWDs to participate in community activities.
- Promote community ownership of the programme to ensure sustainability.

8. Strategies

- Mainstreaming disability issues within sectors, districts, local levels, ministries, non-governmental organizations and the private sector.
- Equity and equality of services that promote equalization of opportunities.

- Participation of PWDs in service development, delivery, monitoring and evaluation.
- Recognition of the role communities play in service provision to PWDs.
- Recognition of obligations and responsibilities of PWDs.
- Collaboration and networking.

According to the 2002 Uganda population and housing census, PWDs in Busia were:-

-	Physical	3551
-	Hearing	1014
-	Sight	1810
-	Speech	262
-	Mental Retardation	231
-	Mental Illness	253
-	Others	972
	Total	8093

Out of the above, 2430 are pupils in schools within Busia district.

9. Small programmes / activities within Community Based Rehabilitation.

a) Public awareness:
   - Mobilization
   - Sensitization

   (Aimed at getting disability "fear" out of the people).

b) Training programmes targeting:
   - People with Disabilities (PWDs)
   - Parents / Guardians
   - Community.

c) Production / procurement and supply of appliances (assistive devices), compensatory appliances / Aids etc.
   - Home appliances (corner seats, raised frames, parallel bars, toilet seats, etc)
   - Work appliances (wheel chairs, clutches, tricycles, raised shoes, knee pads, etc).

d) Cultural programmes:
   - Songs
   - Role plays / drama.

e) Income generating activities (IGAs)

f) Referral services in the area of:
   - Health
   - Education
   - Vocational services - Shoe making
     - Carpentry
     - Tailoring
   - Drugs / treatment
   - Sheltered services
   - Personnel.

g) Relationship in Community Based Rehabilitation (CBR) programme:
   - Collaboration and networking
   - Lobbying and advocacy

   (Aimed at understanding the different tasks / roles played by different organs, organizations or agencies etc.)

10. Human right issues

i. Equality:
States that; human beings are inherent or of equal worth and entitled to human rights though we have different abilities.

ii. Social justice:
All the services in the community must belong to everybody and not numerical small groups. That social justice brings in the notion of equalization of opportunities e.g. self care, training, education, accessibility to employment as a result of promoting integration, independence and self actualization.

iii. Solidarity:
The principle of solidarity focuses on human life as is shared by all just as the African culture depends on the extended family.

iv. Integration / Inclusion:
All members of society should join in the community mainstreaming activities.

v. Family life:
PWDs accessing basic needs in a family and community through participation.

vi. Dignity:
Dignity means the equality of life that deserves or earns respect.

vii. Confidentiality:
One must first of all observe the principle of equity in that we all participate on equal terms in our community life.
That we encourage the development of group formation.

"The WHO study report on community development in health (1991)", suggested that participation can be categorized in three ways:-

a) Participation as a contribution where the community participates through contributions including labour, financial resources, material products;
b) Participation as organization where the community creates appropriate structures to facilitate participation.
c) Empowerment involves groups and communities, particularly those who are poor and marginalized, developing the power to make real choices and by having an effective voice and control.

11. Community participation and mobilization

Community mobilization is the process of bringing together all inter-sectoral social allies to raise people's awareness of and demand for a particular development programmme, to assist in delivery of resources and to strengthen the participation of people to achieve project sustainability and self reliance. Successful programmes are those in which a community is truly distinguished by a set of shared interests.

A community development programme depends on the mobilization and participation of those members key to the theme of the programme e.g. maternal and child health programmes are of more relevance to women than men.

Participation is key to all successful community development programmes.

12. Institutional Based Rehabilitation

Institutional Based Rehabilitation is an approach designed an controlled by professionals through removing people with disabilities from communities to specific centralized institutions who would in turn offer specialized vocational and medical services.

Institutional Based Rehabilitation approaches:

- Designed and controlled by professional groups.
- Delivered by professionals.
- Centralized
- Referral based
- Specialized
- Resources and technology intensive.

Limitations of Institutional Based Rehabilitation:

- Elimination – removing the disabled from the community.
- The "poor house" approach – removing them from view.
- Institutional care (segregation).
- Integration – the process denies them from full involvement in community programmes.
- Self actualization – denies them the ability to fulfill their need for living a life in dignified independence with self-esteem.

Examples of such Institutions:

1) Madera School for the blind (St. Francis).
2) Ruti in Mbarara.
3) Muni in Arua.
4) Kireka in Wakiso
5) Lweza in Kampala
6) Salama in Mukono
7) Buluba in Iganga
8) Ongino in Kumi
9) Nagongera in Tororo
10) Nabumali in Mbale.

Eight Rural Vocational Rehabilitation Centres in 1965;

1) Ruti in Mbarara.
2) Lweza in Kampala
3) Mpumudde at Nabumali in Mbale
4) Nagongera in Tororo
5) Ogur in Lira
6) Ocoko in West Nile
7) Muni in Arua.
8) Salama in Mukono

13. Conclusion

In conclusion, Community Based Rehabilitation is a successful approach to enhance the quality of life for a large percentage of the disabled population. It reflects the partnership between people with disabilities, the community and health professionals.

It is across cutting strategy as explained in its definition that examines other development factors influencing its design and implementation, such as planning, management, Education, research, evaluation and policy issues are also examined in details.

Thank you,

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