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Consultation Report on:

EQUAL OPPORTUNITIES FOR ALL: A COMMUNITY REHABILITATION PROJECT FOR SLUMS

WHO, Manila, Philippines
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Rehabilitation
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Foreword

Over the past 15 years, WHO has gained considerable experience of developing and implementing a Community-Based Rehabilitation (CBR) approach for and with people with disabilities. Recently, the Rehabilitation Unit, the Programme on Mental Health and the Programme on Substance Abuse of WHO have formed a partnership to attempt to apply what has been learned from the experience of CBR in predominantly rural areas to persons with disabilities and social disadvantage in urban slum communities. In particular, there has been a desire to focus on marginalized disabled groups and to include among them, not only persons with physical disabilities but also persons with mental disabilities and those with psychoactive substance use related difficulties. To further develop this possibility, a WHO consultation took place in Manila, Philippines, from 25 to 29 September 1995, to explore the issues and develop a proposed strategy. Participants came from nine slum communities around the world to share with WHO staff their experiences and develop a consensus strategy. This report summarizes the outcome of the consultation.

We would like to thank all the participants, Dr S.T. Han, Regional Director for his leadership and the staff of the Regional Office for the Western Pacific for their invaluable secretarial support. Thanks are also extended to Dr Brian O'Toole for preparing the background paper for the consultation and to Dr John Howard for drafting the final report of the meeting.

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1. Introduction

Over the past two decades, there has been a dramatic expansion of CBR programmes. However, the vast majority of these programmes are based in rural communities in developing countries. The potential for profound transformation as promised by CBR is as real for the unreached urban masses as it is for the rural villagers, who are currently the main players in CBR programmes.

This workshop was organized with the aim of exploring the relevance of the CBR philosophy to those impoverished in slum communities. The meeting sought to analyse the principles of CBR in the light of the reality presented by slum conditions and to formulate some principles which could guide intervention in this area.

Proposed objectives of the meeting were:

- To discuss community-based rehabilitation and slum communities.
- To discuss the introduction of the CBR programme to identified groups with social disadvantages in slum communities.
- To identify possible difficulties and to select and propose strategies for suitable approaches.
- To review the approaches with the participation of dwellers in a slum community in Manila.

Participants to the consultation came from nine slum communities located in different countries, including Brazil, India, Kenya, The Philippines, South Africa and the United States of America. The meeting elected Fr Norberto Carcellar as the Chair with Ms Pramila Balasundaram as Vice Chair. Mr Moshe More was elected Rapporteur, and Dr John Howard as Co-rapporteur.

Note: Throughout this report the acronym PWSD will be used for people/persons with social disadvantage, including persons with physical or mental disabilities, and persons with psychoactive substance use related difficulties.

2. Opening Session

Dr S.T. Han, Regional Director, WHO Regional Office for the Western Pacific (WPRO) welcomed participants and noted that it was fitting that this consultation was being held in Manila, "as the Philippines was among the first countries to encourage the development of community-based rehabilitation services within the context of primary health care". Dr Han went on to stress that the regional involvement was mainly focused on strengthening national capabilities in rehabilitation programming and management, training various categories of rehabilitation personnel and developing community-based programmes. He also informed

the consultation that six of the eleven WHO Collaborating Centres for Rehabilitation in the world are located in the Western Pacific Region.

Dr Han emphasized that experience has demonstrated that the individual, the family, the community and nations all have a growing role in making health a reality for all. In particular, he noted that the will and interest of the community must be supported by appropriate public policies, and that diversity between and among slum communities and countries need to be considered.

Other persons making presentations at the opening session were:

- Dr E. Pupulin, Chief, Rehabilitation Unit, WHO, Geneva;
- Dr M. Argandona, Chief, Treatment and Care, Programme on Substance Abuse, WHO, Geneva;
- Dr L. Ignacio, Department of Psychiatry, University of the Philippines, Manila; and
- Ms S. Yu Seapat, ILO, Manila.

A summary of these presentations can be seen under Annex 4.

3. Background Paper for Proposal for the Development of Community-Based Rehabilitation in Slum Communities

(1) The Challenge of Disability

At the beginning of the "Decade for Disabled Persons" a series of international reports stated that 10% of the world's population was disabled. Whilst we can debate the precise numbers and percentages, it is clear that a very significant portion of the world's population is in need of help. Moreover, as long as poverty and malnutrition, war and conflict, ignorance and superstition characterize huge areas of the globe, the numbers will continue to rise.

The great majority of persons with disability at present live their lives without dignity, in absolute poverty, victimized by beliefs that they are possessed by evil spirits or that their very presence in society is proof of divine punishment.

Whilst there have been some notable breakthroughs in these final days of this century, a great deal of time is still spent on examining the inadequacies of the existing service models in the area of rehabilitation rather than examining innovative and alternative strategies and approaches. It is clear, however, that the gap between need and provision in the area of rehabilitation cannot be closed by developing, or even expanding, conventional services. There is a need for a new pattern of services, characterized by fewer experts, less advanced forms of training, simplified methods of intervention, and above all the participation of those concerned in decisions about provision.

This challenge has been taken up by the WHO Rehabilitation Unit (RHB). A mandate was given to RHB by the World Health Assembly to develop and promote strategies for the rehabilitation of persons with disabilities. A significant priority within this global approach is to focus on the needs of the most vulnerable groups within the society.

WHO has been joined by its sister organizations, namely the ILO and UNESCO, in adopting Community-Based Rehabilitation (CBR) as the most viable strategy to meet the global challenge of disability. This partnership has now been formalized in a joint position paper on CBR (ILO/UNESCO/WHO, 1994).

(2) Community-Based Rehabilitation: A Response to the Challenge

The goal of Community-Based Rehabilitation (CBR) is to demystify the rehabilitation process and give responsibility back to the individual, family and community. Resource persons from the community are recruited and trained. Such persons could be health workers, teachers, social workers, volunteers or persons with disabilities themselves. The resource persons are trained and then show the person with a disability or someone within their home how to carry out the training programme. A simplified method of rehabilitation is therefore promoted which is described in a series of booklets (Helander, Mendis, Nelson and Goerdt, 1989). CBR attempts to use existing organizations and infrastructure for the provision of services. Simple tasks are delegated to auxiliaries or volunteers whose performance is monitored and supported by intermediate-level supervisors.

CBR attempts to involve the community in the planning, implementation and evaluation of the process. Links are established with higher referral services to cope with more specialized needs. CBR is an attempt to generate an exponential increase in appropriate skills, distributed to where the needs are by utilizing hitherto unexploited resources in the community. The goal is for rehabilitation to be perceived as part of community development whereby the community seeks to improve itself. Once the community takes on the responsibility for the rehabilitation for their persons with disabilities, then the process could truly be called community based. In such a process, rehabilitation becomes one element of a broader community integration effort.

The philosophy of CBR is immediately persuasive, but the challenge now is to translate philosophy into action. The immediate task is to examine how the principles of CBR can be enacted within the ethos of slum communities. Is community involvement in the area of rehabilitation realistic within impoverished urban communities? Is it possible to develop rehabilitation as a "process" in which a number of persons are involved, rather than as a "product" which is dispensed to others? Indeed can CBR prove to be a catalyst in the promotion of an integrated approach to development within slum communities?

The "Joint Position Paper on CBR" (ILO/UNESCO/WHO, 1994) presents the major objective of CBR:

To ensure that people with disabilities are able to maximize their physical and mental abilities, have access to regular services and opportunities and achieve full social integration within their communities and their societies.

CBR is therefore more a philosophy of care rather than any "one" form of service provision. Inevitably, therefore the term CBR encompasses a variety of experiences.

(3) The Relevance of CBR to the Urban Poor

The term "CBR" was first coined by WHO in 1978. The past two decades have seen a dramatic expansion of programmes labelled "CBR". The Rehabilitation Unit is informed of CBR initiatives in more than 65 of the Member States of the United Nations family. The great majority of these programmes however are based in rural areas in developing countries. Amidst such an experience it is easy to overlook the universality of the potential of CBR. The philosophy of CBR is as relevant to the affluent countries of the North as it is essential to the struggling nations of the South. The potential for profound transformation promised by CBR is as real for the unreached urban masses as it is to the rural villagers who are presently the major players in CBR programmes.

In reflecting on the Rehabilitation Unit's mandate to work with the most vulnerable elements of the society it is surely very timely to explore the relevance of the CBR philosophy to those impoverished in slum communities. It is the analysis of this process, the exploration of the philosophy of CBR in relation to the urban poor, that the Manila Workshop is focused.

This workshop therefore addresses the imbalance of the existing predominant CBR focus on rural communities. This meeting hopes to begin to articulate a strategy of how to proceed with a CBR philosophy within the context of slum communities. The meeting will analyse the principles of CBR in the light of the reality presented by slum conditions. The gathering will explore some of the difficulties which can be anticipated in entering such communities and will attempt to formulate some principles which could guide intervention in this area.

The Manila meeting will analyse the relevance of the principles against the reality of slum conditions. Amongst the issues which will be considered will be included:

- is disability a perceived priority within the slum community?
- is community involvement realistic when people are engulfed in poverty?
- do the settlements of the urban poor have the traditional community organizations and social support networks seen in rural communities?
- can community resources be mobilized to meet some of the needs of persons with disabilities? What are these resources in slums and how could such potential be mobilized?

- is the empowerment of persons with disabilities a realistic goal amidst the squalor of big city slums?
- how could awareness of the needs of persons with disabilities be created within such an environment?
- is the concept of working with volunteers any more than a romantic notion within slum communities?
- is cooperation with city authorities satisfactory, can this be further improved?
- what infrastructure in terms of health, education and labour exists within the community?
- how can the cooperation among public services in health, education and labour be reinforced?
- who are the leaders in these communities and are they likely to be altruistic enough to collaborate with a CBR initiative?
- how can the community, or sections of it, be mobilized to take responsibility for the prevention, rehabilitation and care of the socially disadvantaged within their particular community?
- how pervasive is the criminal ethos within the slum? Is the CBR intervention likely to be met with support or suspicion?
- how secure an environment can you promise your staff in which to work?
- is there a danger that the CBR programme will be dismissed as an irrelevance by a people who are more consumed by issues of survival?

The above questions illustrate the magnitude of the challenge to be faced by introducing CBR programmes within slum communities. It should however be remembered that similar questions were posed when it was suggested to introduce CBR into impoverished rural communities. Whilst there will undoubtedly be large sections of the rural community whose time is largely invested in survival, there are as many others, from comparable backgrounds, who have played very dramatic roles in CBR initiatives throughout the world. It may not therefore be unreasonable to believe that a similar scenario may develop in terms of the challenge of disability within the slum community.

(4) Existing Preparatory Work in this Area

During field visits to refugee camps and slum communities in Africa, Latin America and Asia, Dr E. Pupulin, Chief, WHO Rehabilitation Unit, consulted with a number of persons living under extreme conditions. When such persons were invited to reflect on the major challenges faced by their communities they highlighted the needs of the following groups:

- persons with physical or mental disabilities;
- persons with harmful or dependent substance use;
- unsupported mothers; and
- the elderly.

It was clear from the discussions however, that a simple focus on one or other form of disability would miss the major problems of these impoverished communities. Slum conditions, by definition, contain some of the most vulnerable and poorly serviced of any groups in society. It was clear therefore from these early discussions that slum dwellers warranted special attention. However, for any intervention to be effective it would need to be broadly based and not simply focused on the needs of individuals. Any intervention would need to be holistic and focus on the needs of the whole community.

(5) Evolving Partnerships to Respond to the Challenge

From the early consultations with slum dwellers and those working in this area it became clear that a narrow definition of disability would be irrelevant to such a population. To be meaningful a wider concept of disability needs to be formulated. A wider definition will attempt to respond to the broader challenges of Mental Health and Substance Use in addition to the more traditional conception of the domains of a "disability programme". It is clearly recognized therefore that a meaningful response to such diverse challenge cannot be solely addressed by the Rehabilitation Unit of WHO alone. A partnership has therefore been formed by the Rehabilitation Unit of WHO with the Mental Health Division and the Programme on Substance Use of WHO to develop a unified plan of action. It is further anticipated that other sections of WHO will become involved as the project expands. The essence of the partnership between the various WHO departments therefore is to learn from the experiences of other disciplines.

Moreover, each of the persons invited to attend this workshop was invited because of their particular experience in this area and for their ability to contribute towards a common understanding of developing Lines of Action for intervention in the CBR field within the slum community. Out of these various experiences the hope is to develop a strategy for the introduction of the CBR philosophy within slum communities.

(6) Holistic Approach

To impact on the lives of people surrounded by poverty a comprehensive intervention is required which envisages a true partnership between health and wider issues of development. Within such an approach the slum dweller becomes an actor rather than a spectator in the development process. Within such a model there are no "welfare recipients".

Riscos and de Ferranti (1988) suggest the following conditions as necessary for success in community-based projects:

- the communities must be involved in all stages of the project, not simply as unpaid labour;

- the roles and responsibilities of community and government agencies must be clearly defined at the outset and both parties must be prepared to fulfill their obligations;
- the facilitator agency must act as a supporter of the community, not as the owner or manager of the programme;
- the contact between the community and the facilitator agency should be through staff whose primary skills are in organizing and motivating communities rather than in technical matters;
- government agencies need to fulfill their limited but vital tasks of motivation, facilitation, training and technical assistance.

The hope therefore is that the Manila Workshop will attempt to address the above issues and challenges and will create an integrated model of intervention which emphasizes human rights, inclusion, appropriate, equitable and accessible health care, flexibility and individual and community involvement.

As we move closer to a new century, it becomes evident that the challenge of disability has yet to be met. It is however, quite clear that traditional approaches can do no more than scratch the surface. A radical reappraisal of our respective roles in the area of rehabilitation within the context of the slum community is required. CBR offers such a role. It is hoped that the Manila Workshop may help to articulate a coherent Plan of Action to develop strategies to put the CBR philosophy into practice amidst the demands of the slum community.

4. Presentations by Participants

In the presentations made by the participants about their respective projects/programmes, lessons learnt from their experiences were highlighted. The lessons identified are listed hereunder. (See Annex 5 for complete presentations).

4.1 Mrs Pramila Balasundaram - "Samadhan," New Delhi, India

- Many communities are very politically aware. Many communities are suspicious of new helpers.
- As many disabilities are seen to be fate or the result of the "evil eye" or bad blood, people may not seek professional services. Many try religion, faith healing, alternative medicines.
- Written material can be less useful than creative news media or puppetry.
- Use existing local trades to build up employment opportunities.

4.2 Mr James Billy - Harlem Independent Living Centre, New York, USA

- Some urban poor are "stuck" due to housing shortage - they cannot improve their situation in this respect. There is vast under-employment of persons with disabilities. Dealing drugs may be the only viable employment option.
- Widespread substance use can lead to injuries (through accidents, violence and gun shot wounds - e.g. spinal cord injuries).
- There are many layers of marginalization - e.g. class, colour and disability. Attention to one leaves the others.
- If laws exist (e.g. anti-discrimination legislation) using them can assist.
- African proverb "Nothing about me without me" suggests full participation by persons with disabilities in service delivery.

4.3 Fr Norberto Carcellar - Vincentian Missionaries Social Development Foundation Inc., Payatas Community, Quezon City, The Philippines

- There can be too many NGOs or too many migrants.
- Slums are dynamic.
- It is important to join a community and integrate into the community life.
- Service provision is needed in the slums (e.g. for the church - marriages, baptisms, funerals). This however takes time. Patience is needed, as well as listening and observing skills. Trust develops and then in collaboration with the community, targets can be identified.
- Participatory action research is a very useful means of designing interventions and determining the process.

4.4 Ms Cristina Firmo - Salvador, Brazil

- In some communities those with physical disabilities are tolerated and fully integrated. Those with mental disabilities may be less accepted, as different types of explanations are given for their disabilities. Substance users are least tolerated.
- Substance use is supported by both rich and poor. The rich need the poor to be involved in manufacture and supply.
- Raising awareness of services in the community which can be used, leads to understanding "the right to have rights" (i.e. citizenship).
- The law can be used to promote rights.
- Dividing the poorest of the poor into sub-groups can divide and destroy solidarity.
- Provision of services in the mainstream is important.

4.5 Ms Veronica Mendoza - NORFIL, Quezon City, The Philippines

- The growth of the community is dependent on the growth of the most disadvantaged member. Inclusion is important.
- "Rurbans" are emerging - urbanized rural communities.
- There is a need for focus on the individual, family and community.

4.6 Mr Moshe More - Work to Win, Johannesburg, South Africa

- Reconstruction and development are themes of significance, especially for reconciliation.
- Many youths drop out of formal schooling into 'the community".
- Capacities can be built for individuals which allow them to move into the formal and informal sectors. Housing, employment, education, social and welfare provision are areas to target.
- Training youths to be pioneers or leaders in their community can build a powerful resource.

4.7 Usha Nayar - TASH Foundation, Bombay, India.

- Slum communities are useful. They provide "muscle" for labour, political parties and employment for service providers.
- Community Advisory Committees are very important for advocacy and accessibility issues.
- The police are essential players who must be engaged.
- Partnerships need to be developed with GOs and NGOs in the areas of health, education, substance use, etc. Partnerships also need to be developed with universities for research and service provision. Partnerships need to be developed with medical schools. Partnerships need to be developed with youth groups and women.

4.8 Dr Eugenio Scannavino - Projecto Saude e Alegria, Santaren, Brazil

- A circus was created with input from doctors, nurses, video experts, education, etc. to focus on health and happiness. Professional and technical people worked with people from the broader community to develop the circus.
- People need training in self-management. People need to know what they are responsible for and what others are responsible for. Any time line/commitment must be clear.
- People can be helped to value their culture, store it and pass it on.

4.9 Fr Alex Zanotelli - Korogocho, Nairobi, Kenya

- Communities can be destroyed by governments or factions. There may be no "community".
- People often come to believe that there is no future, only now.
- People need to belong. Workers/service providers need to wait, be there and earn trust. Communities are dynamic - continually changing. Patience is needed. Trust takes time. Being around on site is important, to gain trust.
- There can be too many NGOs.
- Action research is helpful.
- Government help is not always positive. Land can get into the wrong hands.

4.10 Key Considerations

From the lessons highlighted in the presentations by the participants, some common elements to be taken into consideration when planning community action, were identified. These include:

- slum communities are dynamic
- substances users are often the least tolerated
- slums can be very useful to the elite and/or powerful
- external 'helpers' must earn trust and that this can take time
- creativity in approach is useful (e.g. puppets, a circus)
- action research strategies appear successful
- focus needs to be the individual, the family and the community
- use of any existing laws can provide leverage
- there needs to be clarity of roles and responsibilities
- building onto existing structures creates less tension, is more acceptable, and may require less resources
- participatory approaches are essential
- there can be too many NGOs and too much competition
- the development of networks and partnerships are essential

5. Workshop Sessions

5.1 Introduction to Workshop: Dr J. Howard, Macquarie University, Australia

Dr Howard introduced the workshop format which consisted of two small groups working concurrently on the same set of issues, then reconvening for plenaries. Available to the small groups were guiding questions (see Annex 2) to assist in focusing the discussions.

5.2 Summary of Workshop Discussions

Concerns and issues raised during the workshop sessions are presented in the summary of the discussions.

5.2.1 Community-Based Rehabilitation in Slum Communities

The concept of "slum communities" may differ from culture to culture, but the presence of poverty and marginalized groups are common features of these communities. It would appear that there are more similarities than differences in implementing CBR in either a rural or urban slum environment. The processes are essentially similar. The presence of diverse sub-cultures in the slum area may present more of a challenge in mobilizing broad support. Often it is only an external threat, or a community-wide recognition of a common internal threat which brings the community factions together.

Critical elements of CBR in slum communities include:

5.2.1.1 Disability as a Priority

- Disability is not a priority unless it is visible. It is not valid if not visible. It can disturb the entire economy of a place if visible and not understood.
- Disability can be a priority if prevalence/incidence is high.
- Many communities may not see disability as a priority. More often, basic needs for health, education, others are the priority. Unless one has a personal experience of disability, one may not find it important.
- If the government does not make disability a priority, it would be difficult to make the communities see it as such.
- Disability may not be viewed as a priority and is way down the list of community concerns.
- Cultures can define what and which is a disability (e.g. a physically disabled woman in India may not find it difficult to cook since this task is done on the floor).
- Priority does not necessarily lead to a positive response (can be suppression or punitive).
- Cultures perceive disability differently and give different explanations.
- There can be some solidarity when there is lack of awareness of 'special needs'.
- Divisions can occur over what is priority. Then, solidarity can be lost.
- "Handicaps" can be useful because they can give a role. When treated or rehabilitated the person may become neutral - no one.

5.2.1.2 Community Involvement

- People can be concerned, but how many may be willing to be involved in providing solutions is another matter.

- In a favela, disability is not a priority; but once this issue is pointed out to them as a valid concern, people may be more willing to become involved.
- People may be more sensitive to people in need, rather than individual sectors with needs (e.g. the disabled, substance users, and children involved in commercial sex, etc.). However, entry could be more acceptable if a wider target recipient group is selected (eg. the elderly, those with AIDS, and other disadvantaged groups).
- An outsider coming into a community may:

  - tend to identify for the community what its needs are and then 'dump in' packages of services, or
  - have the potential to see and describe a clearer image of a community situation and provide options for people.

- A "slum" creates its own discrimination; among the poor, there are degrees/levels and they may often discriminate against each other.
- A small amount of hope can grow. However, hope can be spoiled if linked to charity, and competition between NGOs.
- Projects need to wait and listen - the people will come.
- Some symbolic and strategic interventions can be useful (e.g. in India, people with disabilities were put in charge of public phones. This provided power, income and recognition for the disabled person).
- Use of existing resources and blending with the way of life of the people is a means of increasing involvement. Services which are more acceptable to the life-styles and traditions of people living in the slums will be more readily accepted and popular.
- Outside agencies find it difficult to get people out of the "dirty" profession (scavenging). Need to build on existing values and feelings of dignity. Build on what they have. Attempt to shift people out of illegal activities which may damage or devalue them.
- The community is those who live and work there, it is dynamic. All are important. A community can also be defined as the geographic location in which a group of people lives.

5.2.1.3 Empowerment of Persons with Disabilities

- This is seen as a realistic goal in any setting. The key to such is education (formal and/or informal) and access to information.
- Awareness of one's rights and the right to have those rights is a step towards empowerment.
- An empowered disabled person or group of disabled persons may be enough to bring to the attention of the community their needs and what should be done about them.
- The empowerment of a disabled person and his/her family is realized if education is made available and is used to advocate for issues.

- The passive roles that PWSDs typically play can be transformed to more active and valued roles.
- Recognize and value new/discovered abilities (e.g. drawing and dance).
- Women often bear the brunt of PWSDs. They require specific support.
- Rehabilitation should equal liberation and empowerment.
- Work with the abilities and not with the disabilities.
- Increase the visibility of PWSDs.

5.2.1.4 Relevance of CBR Programme

True, survival issues will be seen as more important, but if concern with disability can find its relation/connection with such issues, then it would be easier for people to take it in as part of their concerns (e.g., basic health care and disability prevention, child labour/prostitution and stunted growth, etc.). Again community education will play a vital role in this.

5.2.1.5 Social Support Networks in Slum Communities

Every community, regardless of feature/nature, has its traditional and non-traditional organizations, and support networks. The challenge is how to make use of them for implementing and sustaining a CBR programme.

5.2.2 Introduction of CBR into Slum Communities

Special attention must be given to a number of important points when introducing CBR into slum communities, namely:

5.2.2.1 Goals, Objectives, and Target Group for a CBR Project

It is the community who should decide the goals, objectives, the target population and the scope of the project. Objectives must be determined by the community if ownership and responsibility are to be fostered or later transferred.

5.2.2.2 Key Persons, Key Players/Stakeholders

- The best way to identify key players is by informally asking a wide range of representatives from the community to identify the key persons. People may be divided in loyalty. One person may be working for a political party while another may be emerging as a key person or leader. A variety of key persons may be identified from among the following: youth groups, youth leaders, political parties, elderly, religious groups. Disabled persons must also be seen as key persons.
- An outsider may be the key person in the social action, but, it would be better if the key person is found from within the community.

- School teachers are a good resource as well as health workers in the slums.
- Religious leaders may be controversial. Identification with one religious leader can alienate members of other religious affiliations.
- If you develop a political interest you may receive political help. However, many slum dwellers cannot vote because they are transients, and so political parties may be less interested in their vote than in their "muscles".
- Disabled people need to identify their own needs and it is the role of others to mobilize them for training.
- The key leaders will seek others to support their efforts and will avoid those who will follow their own agenda.
- The question of who should initiate or convene the meeting of the key persons with the view of developing a CBR programme is not so important, so long as the catalyst is acceptable to the majority of community members and so long as they foster as wide a representation as possible.
- A leader is ideally charismatic and can network among a wide range of services both within and outside the slum community. The leader should be from the marginalized group.
- By living in the community and observing, joining local groups and attending local meetings, key leaders/players as well as potential ones can be identified.

Seven Helpful Criteria in the Selection of Key Persons are:

(1) Identifiable by community members;
(2) Ability to speak for all the community;
(3) Ability to influence authorities in favour of the needs of the PWSDs;
(4) Should have voting rights to gain political response;
(5) Should not be puppets of a political system;
(6) Should not be controversial to community members or promote their own agenda; and
(7) The key persons should be from the community or have lived or are living in a similar condition or at least a similar area.

5.2.2.3 Access

- Entering into the slum requires knowing the politics of the slum to avoid problems from occurring. May not need to use the key persons initially, but at least one needs to be aware of them. Sometimes the opposing political party can also be mobilized for support. Who goes into the community is important.
- It is important to contact and elicit support from opinion makers. In places where multiple religious leaders influence opinion, all must be mobilized.
- Start with individual PWSDs and their families.
- There is a need to change the political will in some places.

- The external stimulus to CBR needs to be well accepted where bottom up meets top down.
- Provide services the people want, in line with what you can do (e.g. medicine, income generation, recreational, teaching, religious activities).
- Find common ground.
- The process can be seen to be similar to the engaging and joining strategies used in some family therapy approaches.

5.2.2.4 **Strategies for community mobilization** which have been found to be effective in maintaining involvement of the target population are as follows:

- Use multiple strategies - employment is only one need, but to be able to earn money is more important. Develop revolving credit and later cooperatives to assist income generation. Highlight and give media attention to these programmes.
- Intra-community assistance will probably emerge but initial stimulus nearly always comes from outside. The catalyst may be from outside the community.
- Use the multiplying factor - advocates recruiting other advocates e.g., teachers will sensitize other teachers.
- Building optimism is important and can be facilitated through rituals of celebration.
- Involve marginalized groups, e.g., women with AIDS, juvenile delinquents.
- Hold an event, e.g., deaf awareness week, a circus, a puppet show.
- Use existing events, celebrations, rituals, rallies to include awareness raising activities and mobilization.
- Tell stories of successful individuals and communities
- Education is required to change attitudes and then to provide services.
- The slum community residents should be considered subjects of change rather than objects of change.
- Find structures and linkages between people. However, nothing can unite all of them.
- Attempt to breakdown disadvantageous social structures.
- Bring people together who have the same problems.
- Enhance the image of the target group and encourage the community to see each member of this group as an individual.

5.2.2.5 **Organization of Committees**

- One of the key elements in community development is the steering/management committee. The success and sustainability of the CBR is often dependent on the quality and commitment of the CBR committee.
- There may need to be two types of committees: The grass roots interdisciplinary committee and the advocacy and access committee for networking and advising.
- An incentive can be to have the committee affiliated with or seen as a "WHO Consultative Committee".

- A danger can be that some influential people may not be representative of any group but may try to impose top down policies. Later they may become alienated and drop out when their ideas are not endorsed.
- Incentives such as status and high visibility identification can be given. One or two strategies may be used: an appeal to greed and ego, or an appeal to altruism (out of guilt or humanitarian reasons).

5.2.2.6 Multi-Focus versus Single Focus CBR?

All CBR workers and managers operate within their areas of strength. Therefore single disadvantage focus (vertical approach) in the initial stages may not necessarily be an inefficient approach, as long as there is an expressed commitment to expanding the coverage within a reasonable time-frame. Talented CBR workers who can do it all are rare to non-existent.

5.2.3 Identification of Possible Difficulties and Selection of Strategies:

5.2.3.1 Obstacles and Threats

- Difficulty in involving PWSDs and their families into a project.
- Politics that divide people.
- Governmental organizations interfering.
- Criminality as a threat (especially in relation to substance use).
- Traditional values, beliefs, karma.
- External agents implementing an intervention and not being adequately prepared for the actual work environment.
- Non-governmental organizations making themselves indispensable.
- Perception that non-governmental organizations involved in development work provide less quality service and that their workers are less skilled.
- Fragmentation among non-governmental organizations that breeds competition.
- Funding agencies imposing their views and therefore diverting project focus.
- International donors have different expectations in time and reporting than local non-governmental organizations. Many international non-governmental organizations are single disability or issue focused.
- Lack of support by government services.
- Dependence on funders for project implementation.
- Lack of trained person to do the work - knowledge can be transferred but ethics cannot be.
- People come from diverse cultures and are collected in one area. Outsiders come in and may not consider the values and traditions of the slum inhabitants. They can try to impose their expectations.

5.2.3.2 Strategies to address obstacles and threats

- Lobbying at all levels.
- Have clear policies and legislation.
- Show mutual respect for the work of GOs and NGOs.
- Inform GOs of activities, but attempt to ensure that they do not take over. At a later stage they may take over the project, but once it is established and clear in its interventions and impact.
- Support coalition or network that provides forum for consultation among NGOs who share a common vision or ensure that one can be developed.
- The concept of community development must be made clear by the NGOs to the community and vice versa.
- Strengthening CBOs and POs to be self-sufficient.
- The work being done by NGOs can be taken over by GOs.
- Sensitize GOs, politicians and media to disability issues.
- Training PWSDs, their families and communities, GOs and NGOs.
- Create opportunities for PWSDs and families to participate in all aspects of the project.
- Highlight small successes to encourage/motivate PWSDs.
- Offer another perspective or alternative to enable PWSDs to participate and to believe in themselves.
- Support potential leaders among PWSDs.
- Engage the support of popular music stars who are ex-drug users. Devise strategies that will create a better image of drug users.
- A mixture of strategies is required.
- Pathways or networks for the service delivery system need to be identified.
- An inter-sectoral approach needs to be taken within the context of general community development.
- Social support networks are vital - both traditional and non-traditional, formal and non-formal.

5.2.2.3 Eight Typical Phases for CBR development

(1) Planning: identifying needs, key people and resources; initiating management committees; and development of evaluation criteria - performance indicators.
(2) Training/organizing (re-organizing of committees) throughout.
(3) Launching the programme (public information).
(4) Piloting the programme for selected target group or groups.
(5) Replicating the programme based on experiences.
(6) Expanding the programme to other disadvantaged groups.
(7) Phasing over to specific agencies and the community in general the responsibility and ownership of the programmes.

(8) Evaluating and monitoring using the original indicators, and wide range reporting of successes and lessons learned.

5.2.2.4 Sustainability

- Networking with all resources and leaders.
- Choice of the "correct" leader, sensitizing future service users and community members, setting up an organizational structure, training in leadership for PWSDs, networking, focus groups, and building on successes.
- Creation of income generating schemes. For example, Taka collection in a slum community of Makuru, Nairobi, the slum dwellers now go to the city to collect refuse for recycling. The refuse there is of a "higher" quality and its sale generates a higher income.
- Celebrations are important in generating optimism and possible income, if done correctly. Talents can be tapped through these celebrations. The revelation of new talents to organize, can further contribute to the celebrations.
- The creation of a pool of trained, optimistic volunteers for the community.
- Parents and significant others trained to assist PWSDs rely on a "specialized" service only when appropriate.

5.3 Discussion on Visit to the Payatas Community

Listed below are some factors which were identified as being critical to the visit to the Payatas Community in Manila.

- Visitors must be sensitive to the needs of the community.
- Community needs to be informed about the visit.
- Should the visitors validate the group's strategy or should they simply listen to the concerns and ideas of the community - the latter was decided upon.
- How would the community perceive the "invasion"?
- Community members were shy by nature but they were empowered and political aware.
- The visit would provide an opportunity for the development of a reality-based strategy in the consultation.

6. Proposal from the Consultation Meeting

The consultation endorsed a number of statements which focussed on factors which should be considered in introducing CBR into slum communities.

6.1 Statements

(1) Urbanization is increasing all around the world.

(2) Increasing numbers of the world's urban population now live in slums.

(3) Poverty worldwide is increasing.

(4) Disability and social disadvantage are intimately associated with poverty.

(5) Available resources are declining and unevenly distributed: there is a gap.

(6) There is a need for a new approach which is based on multi-sectoral cooperation, equity and solidarity.

(7) The most disadvantaged of a community can be a catalyst for a change.

(8) Social advocacy and action are often led by marginalized groups. The actions of these groups to improve their conditions often benefit the community at large and increase the value and image of these groups.

(9) The challenge for all of us is to "bridge the gaps".

(10) Slum dwellers are citizens who have rights, though most are regarded as "illegally" occupying land.

(11) PWSDs in slums are citizens who have rights to services and their dignity.

(12) PWSDs in slums are subject to multiple layers of discrimination and marginalization; are often denied access to existing services and opportunities; are under-employed, unemployed and lack training for employment.

(13) Poverty is endemic in some communities and the physical conditions which are associated with poverty create and/or exacerbate problems.

(14) Slum communities around the world, and within the same country and city, will vary in many significant ways: e.g. social integration; mix of religions; type of work available; mix of disability; housing; infrastructure; migration in and out; ethnicity; etc.

(15) A collaborative, multi-sectoral approach between and among all these stakeholders must be encouraged as competition can reduce the capacity for service delivery.

(16) Policy makers and external and internal funders should be encouraged to see the benefits of comprehensive approaches to meeting the needs of PWSDs to avoid vertical projects.

(17) CBR has provided a model for meeting the needs of PWSDs in rural communities. "Community-Based Rehabilitation (CBR) is a strategy within the community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities. CBR is implemented through the combined efforts of disabled people themselves, their families and communities, and the appropriate health, education, vocational and social services".

(18) Participants believe that the CBR approach can be applied in urban slum communities.

(19) Participants also believe that people with disability and social disadvantage, including those with problems related to psychoactive substance use who live in slum communities, can have their needs met by an expanded CBR approach.

(20) PWSDs, their families and their communities should be empowered to better meet their needs through integration of service delivery and consumer involvement. CBR is one means of achieving this.

(21) PWSDs, their families and their communities, must be involved at all levels of CBR, i.e. administration, decision-making, planning, training, service delivery, plus monitoring and evaluation.

(22) Where a slum community has been identified by an external or internal initiative where CBR is narrow or does not exist, the following strategy is suggested by the Manila meeting.

The choice of the agency, person or persons to become the initial focus of the project is crucial to success. They should be acceptable to a broad range of factions within the community, i.e. they should be relatively neutral or, if belonging to a faction, respected and acceptable to the majority. Such persons may be identified by local contacts of the ILO, UNESCO or WHO. They may work for an NGO or another organization such as a religious group. They need to be more skilled in mobilizing communities and community organization and development, than in service provision.

6.2 A Strategy

(1) The initiator calls a meeting of all individuals, GOs, NGOs and other groups who are stakeholders in the identified community. PWSDs and representatives from the health, education, vocational, social welfare and labour/employment sectors, and community leaders should be included.

The stakeholders, other than PWSDs should be ones with influence and/or who provide services, and they may come from the formal or informal sectors. They should be identified on the basis that they represent the ethnic/cultural/ religious composition of the community, represent the key agencies (GO and NGO), can increase access, advocate, provide services, influence community attitudes and beliefs, network, transfer knowledge and technology, raise funds, or obstruct plans.

Objectives:

(a) To share experiences.
(b) To share concerns.
(c) To identify potential targets.
(d) To attempt to mobilize the group to action to better meet the needs of PWSDs.
(e) To receive any necessary training/information on disability and CBR.
(f) To increase the awareness of and visibility of PWSDs.
(g) To begin a multi-sectoral approach.

(2) An initial representative working committee is formed.

Objectives:

(a) To identify resources/assets both within and outside the community.
(b) To identify PWSDs and the means for doing so.
(c) To identify potential threats.
(d) To identify volunteers.
(e) To increase awareness of disability and social disadvantage.
(f) To identify possible links and development of networks.
(g) To receive any further training/information on disability and CBR.
(h) To develop a draft proposal for a comprehensive CBR approach.
(i) To prepare a draft strategy/plan.

This committee must include PWSDs who represent disability categories and family members/significant others.

(3) A means of consulting with the community needs to be developed such as a public meeting in order to:

(a) Share what has been identified and learned by the working committee.
(b) Test the willingness of the community to address the needs of PWSDs.
(c) Demystify both disability and the technology employed in some interventions.
(d) Further identify PWSDs.
(e) Discuss and modify any draft strategy/plan.
(f) Identify a means of further developing any strategy, such as establishing a steering committee.

Any steering committee would probably include members of the initial representative working committee. Any committee must include PWSDs and those who can assist with access and advocacy. Team building activities will need to be included to ensure that any group, such as a steering committee works in a cooperative manner. Any committee may develop sub-groups/committees to undertake specific tasks. For example, one sub-committee may be responsible for the organization of the community mobilization, another for any situation analysis, one for support and resourcing, one for advocacy, and yet another for developing any strategic plans.

Another consideration in forming the committee may be to have a two-tier system. One committee would contain community leaders and senior representatives of GOs and NGOs and representatives of PWSDs. This committee would focus more on advocacy, raising the profile of the issues affecting PWSDs, raising funds and providing an interface with the state.

The other committee would be more service/intervention focused, and contain people closer to the target populations, more known and acceptable to them, with skills in community development and service delivery.

To achieve what is required may take time and many meetings must be held throughout the different stages.

(4) Any strategy/plan should include attention to:

(a) Management:

- A statement of vision and goal, and setting of clear, achievable, measurable targets and objectives.
- Management structure.
- On-going information gathering. This may include a strategy for further, on-going rapid assessments (e.g. focus groups, key informant studies, etc.) to ensure continued relevance of any plan.
- Time frames.
- Financial Management.
- A mechanism for delivering any interventions.
- Documentation.
- Cultural relevance.
- Participation of PWSDs in all components.
- Sustainability.

(b) Education and Training/Transfer of Technology:

- Education and information sharing with the community.
- Training at all levels, technology transfer.
- Development of criteria for selection of workers and volunteers.
- Capacity to gain experiences from CBRs in other communities.
- Sharing of successes in and outside the community.
- Strategies to increase access to and participation in education, vocational training and employment.
- Strategies for non-formal education, especially remedial and based on adult learning principles.

(c) Community Activities:

- How to present the plan to the community.
- Increasing optimism in the community. This may be achieved by such activities as: public meetings, special group meetings, use of radio, T.V., street drama, any suitable cultural or religious events, rallies, etc.

- Use of celebrations, rituals and tradition.

(d) Referral Support Systems:

- Referral systems - health, vocational, training, education, social welfare, employment, etc.
- Ensuring medical back-up services.
- Availability of essential drugs.

(e) Capacity Building:

- Strategies to encourage creation of small enterprises.
- Strategies to involve unions to assist in advocacy for and inclusion of PWSDs, and creating safer workplaces.
- Strategies to develop and expand local income generating schemes.
- Strategies to provide for full access to credit facilities.
- Strategies for general community strengthening and capacity building.
- Development of a trained pool of volunteers.
- Effective transfer of technology.
- Maximising participation by PWSDs and their families and significant others.

(f) Partnerships and Networking:

- Networking, partnership and organizational development.
- Meeting points for the rich and poor.
- Means of active non-violent strategies aimed at reconciliation among any factions which exist.
- Strategies to develop more effective partnerships between any unions and employers to reduce stigma and exclusion by increasing employment possibilities, and to create more sensitive working environments.

(g) Monitoring and Evaluation:

- Participatory monitoring and evaluation. Performance indicators need to be agreed upon (e.g. 80% of identified persons with a mental disability regularly attending a support group, 3 self-help groups to be established by end of 1996, etc.).

(h) Advocacy:

- Advocacy, including training of PWSDs in self-advocacy.

Different strategies will be necessary to ensure that the needs of PWSDs, those working with the target groups, and broader government, international NGO, UN and private sector backers/funders are met. The reality of poverty and slum conditions will help in shaping any strategy.

Any plan which is developed must remain flexible and responsive to the particular needs of the community and the information gained from the monitoring process.

7. The Role of the World Health Organization

The role of WHO needs to be clarified. If projects are to survive they need to be self-sustaining. WHO can only play an advisory role and contribute technical support. There are at least six areas where WHO could be of assistance, which are as follows:

(1) Provision of technical support (i.e. methodology, and assistance in monitoring and evaluation).
(2) Assisting governments, GOs and NGOs to support the community develop their own solutions and strategies.
(3) Encouraging horizontal, rather than vertical service provision, in line with the principles of primary health care/community involvement in health.
(4) Encouraging INGOs and donors to give greater consideration to funding and developing comprehensive, non-vertical programmes and interventions.
(5) Encouraging greater links between prevention, treatment and rehabilitation.
(6) Coordination of inputs from education, vocational training and employment through the involvement of ILO and UNESCO.

ANNEX 1

Agenda

Monday, 25 September 1995

(1) Registration

(2) Opening Ceremony

- Welcome remarks by Dr S.T. Han, Regional Director ,WHO Regional Office for the Western Pacific
- Introduction of Participants
- Election of Officers

(3) Adoption of the Agenda

(4) Introduction - Dr E. Pupulin, Chief , WHO/HPR/RHB

- Working with People with Disabilities - Dr E. Pupulin
- Working with People with Substance Use Problems - Dr M. Argandona, Chief, WHO/PSA/TAC
- Working with People with Mental Disorders - Dr L. Ignacio, Department of Psychiatry, University of the Philippines, Manila
- Programmes on Training and Employment - Ms S. Yu Seapat, ILO, Manila

(5) Introduction to the Workshop - Dr J. Howard, Consultant

- Presentation by each Participant of their Work
- Identification of Key Persons to Access Slum Communities
- Identification of Target Groups
- Identification of Key Players/Stakeholders.

Tuesday, 26 September 1995

Continuation of the Workshop

- Discussion on Strategies for Community Mobilization
- Discussion on Maximizing Participation and Involvement by Target Persons/Groups
- Discussion on Establishing Community Committees

Wednesday, 27 September 1995

Continuation of the Workshop

- Preparation for Field Visit
- Identification of Resources/Assets
- Identification of Obstacles/Barriers/Threats to CBR Programmes
- Discussion on Strategies to ensure Sustainability of Programmes
- Formulation of Possible Strategies.

Thursday, 28 September 1995

(6) Field Visit to Payatas Community

- Consultation with Members of the Payatas Community

Friday, 29 September 1996

(7) Finalization of a Draft Strategy

(8) Adoption of a Draft Strategy

(9) Closing Ceremony

Guiding Questions for the Workshop

(1) Review and Initial Discussion of Draft Background Material

(a) Is disability a perceived priority within slum communities?
(b) Is community involvement realistic when people are engulfed in poverty?
(c) Is there a danger that the CBR programme will be dismissed as an irrelevance by a people who are more consumed by issues of survival?
(d) Is the empowerment of persons with disabilities a realistic goal in big city slums?
(e) Do the settlements of the urban poor have the traditional community organizations and social support networks seen in rural communities?
(f) Are there major differences in developing CBR interventions for use of illegal substances and those for mental and physical disability?

(2) Discussion on Objectives

(a) Given the previous discussion, is it worth developing a project?
(b) What is a suitable target population/group for a project?
(c) What is a suitable goal for a project?
(d) What are suitable objectives for a project?
(e) What are unsuitable objectives?
(f) What are the activities that need to be undertaken to meet the objectives, and, ultimately, the goal of a project?

(3) Strategies to Identify Key Persons to Access Slum Communities

(a) What are the best ways to identify key persons in slum communities or associated with slum communities?
(b) What are the major points of access to slum communities?
(c) What are the best means of obtaining access to slum communities?
(d) What has been found to be ineffective?

(4) Identification of Key Players

(a) What are the best ways to identify key players?
(b) What are the best ways to approach such persons?
(c) What are the best ways to gain and maintain the support of such persons?
(d) What are the best ways of dealing with the influence of unsupportive key players?

(e) Do key players need any specific training? If so, what and how could this be provided?

(5) Strategies for Community Mobilization

(a) What are some of the strategies which have been found to be effective in mobilizing communities and building optimism?
(b) What are some of the strategies which have been found to be ineffective?
(c) What strategies have been found to be effective in raising the profile of those with a disability?
(d) What are the best strategies for identifying the most vulnerable persons or groups in a community?
(e) What are some strategies to facilitate a process whereby the community comes to see the situation of its most vulnerable as worthy of special attention, when there are so many competing problems in slum communities?

(6) Maximizing Participation and Involvement by Target Persons/Groups

(a) What are some of the strategies which have been found to be effective in maximizing the participation and involvement of the target population(s)?
(b) What has been found to be ineffective?
(c) What are some of the strategies which have been found to be effective in maintaining involvement of the target population(s)?

(7) Establishing Community-Based (advisory) Committees

(a) What strategies might be effective in establishing representative community advisory committees?
(b) Does there need to be a two-tier system? If so, what differentiates the two tiers?
(c) What have been found to be effective mechanisms for committee operation?
(d) What has been found to be ineffective?
(e) Should sub-committees be formed? If so, on what basis?
(f) What strategies have been found to be effective in maintaining membership and enthusiasm?
(g) Do committee members need any specific training? If so, what and how could this be provided?

(8) Identification of Resources/Assets

(a) What are some of the actual and potential community resources that can be mobilized to meet some of the needs of persons with disabilities?
(b) What role can volunteers play?
(c) Is it realistic to expect that volunteers can be recruited in slum communities?

(d) What infrastructure, such as health, education and labour, exists within slum communities?

(e) What strategies have been found to be helpful in increasing cooperation with public services, such as health, education?

(f) What strategies have been found to be helpful in increasing cooperation with NGOs?

(9) Identification of Obstacles/Barriers/Threats

(a) What is the best means of identifying potential obstacles/barriers and threats to a project?

(b) What obstacles/barriers and threats have been identified in other projects?

(c) What strategies have been found useful in dealing with these, and/or turning them into opportunities?

(d) What has been found to be least useful?

(e) How have any criminal ethos or elements hindered or helped projects?

(10) Preparation for Field Visit

(a) Why has the particular community been chosen?

(b) What do we need to know about the community, if anything, before the visit?

(c) What tasks do we wish to achieve during the visit?

(d) How will we achieve these tasks?

WHO Consultation on "Community-Based Rehabilitation in Slum Communities"
25-29 September 1995, Manila, The Philippines

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Presentations made at the Opening Session

(1) Working with People with Disabilities: Dr E. Pupulin, Chief, Rehabilitation Unit, WHO, Geneva

Dr Pupulin reminded participants of the meanings of the terms: Impairment, Disability and Handicap. He stressed that impairment was related to the body, disability to the person and handicap to the society. Dr Pupulin noted that social disadvantage may be a better term than handicap, and that social disadvantages presented major difficulties in the rehabilitation process.

Dr Pupulin than distinguished rehabilitation (restoration of impairments and improvement of performance) from re-habilatare (the restoration of dignity). He pointed out how we can provide services and adapt environments, but not neglect community involvement.

Traditionally, services were centralized and institution or centre-based and may have incorporated some outreach from the centre. Services provided were specialized and mainstream. A true CBR approach is decentralized and community-based. CBR moves from sectoral to inter-sectoral service delivery, and from professional responsibility to consumer empowerment.

In more traditional approaches, PWSDs were "special cases" who often received "charity". In CBR, such people are regarded as citizens with particular needs, who can be empowered to gain their rights as citizens.

A charity approach reduces participation, and increases stigma and segregation. CBR can empower and integrate citizens with disabilities and social disadvantages into the community and enable full participation. They no longer have a suspended role, but are given valid roles by their community.

The tasks are:

- How to promote community responsibility;
- How to empower consumers; and
- How to obtain adequate services.

(2) Working with People with Substance Use Problems: Dr M. Argandona, Chief, Treatment and Care, Programme on Substance Abuse, WHO, Geneva

Dr Argandona pointed out that a debate is still required on how to integrate psychoactive substance use into Community-Based Rehabilitation Approaches.

He noted that substance use is a learned behaviour which is passed on. It is therefore contagious. The community is usually manipulated to respond to the problems, and the main response is often punitive, stigmatizing and marginalizing.

The whole community can become impaired, disabled and handicapped (disadvantaged) - all are affected. Continued substance use, especially the mode of administration, can lead to greater health and related problems (e.g. HIV, STDs, drunken driving, loss of work, money and relationships, accidents).

The community may also encourage substance use (e.g. tacit approval of alcohol use by young people for "fun") or tolerate it (violence to women and children by intoxicated men).

Substance use is a community as well as an individual problem. Focus on the individual can lead to greater stigmatization.

Rehabilitation can take years. On the individual's return from isolation and seclusion (e.g. prisons, t.c., hospitals, etc.) some problems can remain/re-emerge that were associated with substance use. These can lead to relapse. The community can ignore the individual while he/she is "away" but must face the issues when he/she returns.

A focus on the drug can ignore the individual's expectations and experience, the context in which drugs are used and the needs/ wants they meet.

When not rejected, substance users often function normally.

(3) Working with People with Mental Disorders: Dr L. Ignacio, Professor, Department of Psychiatry, University of the Philippines, Manila

Dr Ignacio noted that most CBR programmes have been implemented in rural communities. Community participation is essential for successful implementation of CBR.

Psychosocial interventions for mental health focus on the individual or patient needs support. The family receives education. The community seeks allies.

If the community is aware and mental illness is de-mythologised, the community can become more observant and helpful. Training of existing primary health care workers has been found to expand their capacity to deal with disabilities other than physical ones; for example, people

with mental disability/disorders. Interventions are at the level of the individual, the family and the community.

There is a need to focus on: physical needs, psychological needs, social needs, within the individual, family and community contexts. Thus, it is a biopsychosocial approach. We also need to be aware of spiritual needs, otherwise there is no sense of meaning or purpose.

Comics are useful for community awareness and education; flow charts helped community health workers.

(4) Programmes on Training and Employment: Ms S. Yu Seapat, ILO, Manila, The Philippines

Ms Yu pointed out that CBR involves vocational rehabilitation or programmes for the equalization of training and employment opportunities for persons with disabilities.

Community-integration programmes for vocational rehabilitation for persons with disabilities are favoured by ILO over the creation of special environments and services.

The Inter-departmental Project on the Urban Informal Sector is a means of addressing the above issues. The project has a focus on micro-enterprises, business advisory services, occupational health and safety, and social protection in the informal sector. This project targets credit provision, cooperatives, and employment creation. They build capacity in poor communities.

Children can then get to school (the family needs them less to work), commercial sex can be reduced, and the "richer" community may have less drug problems.

Project/Programme Descriptions by Participants

(1) Mrs Pramila Balasundaram, "Samadhan", New Delhi, India

Samadhan was registered as a Delhi-based NGO in 1981. An informal information gathering exercise highlighted the lack of services for families with mentally retarded children and for the children themselves.

Samadhan was therefore started to plug in the lacunae in the system of service delivery. We also identified the slums/poverty pockets in Delhi such as the "resettlement colonies" as most urgently in need of services. Our aims in brief were:

(a) To provide relief and support services to families living in low income areas with mentally handicapped children;
(b) To provide appropriate intervention programmes to the children themselves;
(c) To initiate and sustain a campaign for the awareness of mental handicap as a social problem in our target communities; and
(d) To identify disability as early as possible and provide appropriate intervention programmes to the family.

The first step was to sensitize the community to an acceptance of the disabled in their midst and particularly of those with mental handicap. This was done in different ways. The most successful programme was the puppet theatre which projected the problem of a family with a mentally handicapped baby and how they found help to educate and train the child and in the process trained themselves. Other methods were talks accompanied by slide shows by professionals on topics such as "identification of disability", "home management of a child with disability", "need for integration in the community", etc. There were also question-answer sessions.

Local schools were involved through conducting competitions on writing essays on specific themes dealing with disability, debates, training posters etc. The teachers and principals thus were automatically involved.

The next step was identifying motivated persons in the community itself who were willing to work with us and to undergo training to become full time workers with mentally handicapped children. Mostly women, these workers were trained in using the WHO Ten Question checklist to identify disability, and in the Postage System for early intervention. These workers were minimally qualified and had the desire but not the training to work within the community.

We began with conducting a survey of DAKSHINPURI, a resettlement colony in South Delhi with 55,000 households. Mostly migrant labourers from neighbouring states, this colony was a heterogenous mix of cultures, religions, languages and beliefs. The survey gave us a rough estimate of the approximate number of children and families needing help. From the data of the survey, we set up a small unit providing special education to mentally handicapped children the 5+ to 14 years age groups.

However, we added a Vocational Training Unit and later an Early Intervention Unit, since these two areas were increasingly being felt as areas of crucial need. Using the Curriculum Based Ecology method, we identified woodwork as the most useful in Dakshinpuri, stitching and tailoring in Trilokpuri, the centre in East Delhi.

Today we have five centres, four of which are in resettlement colonies and one in urban Delhi which caters only to the 0 to 6 years age group. We have progressed from a single disability to all disability programme, except the visually handicapped.

We have designed a training programme which is suitable for low socio-economic and minimally qualified workers from within the community itself. For this purpose, we have also made a video programme for training the workers.

We offer a five day week special education and vocational training programme in our low income centres. A Rehabilitation Clinic offers physio- and occupational therapy to children of all ages. Paediatric assessment, educational and psychological assessments and programme planning for individual children are done on a routine basis. Records are maintained.

Training for parents, workers, birth attendants, other NGOs and in-house training is done once every three months by the professional staff in the community itself.

We are now increasingly focussing on early intervention, prevention of disability and will conduct a survey of mothers at "risk" and children "at risk" for development delays through awareness, surveys and intervention strategies.

(2) Mr James Billy, The Harlem "Independent Living Centre", New York, USA

The Harlem Independent Living Centre is a community-based agency providing services free of charge to individuals with disabilities who live or work within the Greater Harlem area - a population that has historically been unserved and undeserved as a community. The centre provides services such as peer counselling, assistance with food stamps, public assistance, SSI and SSDI, Medicaid and Medicare applications, housing assistance, assistive device training, van transportation for the disabled (mobility impaired), architectural barrier removal assistance, and referral to other programmes. There are no age or other restrictions to obtaining services - the centre is open to people of all ages, races, and disabling conditions.

HILC's governing Board of Directors, decision-makers, and staff are made up of at least 51% of PWDs.

In addition to the core independent living services, the Harlem Independent Living Centre will focus on serving consumers who demonstrate signs of drug or alcohol abuse as a secondary disability as defined by the American with Disabilities Act (ADA).

Harlem is know as the drug capital of the United States, if not the world. However, no reliable statistics are available on the actual incidence of addition in the community. Of 20,155 persons discharged from Harlem Hospital in 1971, 1467, or 7.3%, were found with a diagnosis of drug addiction. To further this, a survey of a housing project in Central Harlem revealed that 80% of the 5,900 residents were on drugs (alcohol included).

Not much has changed in the twenty years since this study was first reported. In 1994, over half the patient population admitted to the rehabilitation ward at Harlem Hospital have self admitted incidence of substance abuse.

Given the overwhelming conditions that existed two decades ago, it is inconceivable to think that time alone could eradicate the depravation and impoverishment of a community. The impact of such conditions on a community can only contribute to a high morbidity rate. Allowing that there has been considerable monetary intervention made in the community, vis-a-vis community programmes and major efforts for improved health care, there is still a high incidence of poor health. Estimating prevalence of disability on a local basis can be intricate. Usually, such information is either derived from the number who have actually received services or is deduced from the National Survey; both approaches are questionable.

According to the Health Interview Survey for 1979 (the latest year for which fully tabulated results are available), some 31.5 million Americans (or 14.6%) of the non-institutionalized population, are limited in some way by a chronic health condition. An estimated 7.9 million (or 3.7%) are considered severely disabled, that is they are unable to carry on some major activity such as attending school, working or housekeeping.

Significant Action: HILC shall continue to develop linkage within its community to encourage referrals and to ensure consumers of centre services offered by the community. Activities to be undertaken include:

Substance Abuse

Based upon the many needs of the community as indicated by the response from several focus groups held at the centre and other community forums, HILC will focus on three to four major concerns. Although the needs are great and at the same time numerous, due to the shortage of personnel our efforts will have to be concentrated to ensure optimal success.

Prevention, both for substance abuse and disability remain an on-going project of HILC, in an attempt to balance the inequities of onset and recurrence of such. Prevention programmes will be designed to reach the temporary able-bodied (TAB's) population. Emphasis will be placed on the young: those who are considered to be more risk takers. There will be a concentration on substance abuse and relapse prevention beyond the "Just Say No" campaign.

Education and Awareness

To sponsor a series of Disability Law (ADA), Rehabilitation Act, Local Law 58, and NYS Executive Law training workshops, one designed for service agencies the other for local business, to enhance peoples' understanding of the acts in question, and, to foster "enforcement" linkages.

Health promotion for PWDs: health will be defined as the absence of illness or diseases beyond the primary disabling condition. To facilitate a self-perception of wellness that goes beyond one's disability, to determine where and when a person with a disability can obtain health and wellness information which takes into account the underlying disabling condition and the individual's life circumstances, as well as to encourage individuals with disabilities to exercise control over the maintenance of their own health, by proactive use of this information in conjunction with appropriate professionals, as needed.

To maintain and develop "consumer driven" peer support groups for people with disabilities, where participants will have the opportunity to share experiences, and help one another explore issues and techniques to deal with the on-going adjustment.

(3) Fr Norberto Carcellar, Payatas Community-Based Social Development Programmes, Vincentian Missionaries Social Development Foundation, Inc., Quezon City, The Philippines

Community Profile

Barangay Payatas is a fast-growing urban poor community in the North-Eastern District of Quezon City. It has recently been gaining public attention and concerns due to the presence of a 13 hectare open dumpsite that absorbs almost 35% of the daily waste generation of Metro Manila and serves as primary source of livelihood and daily survival through waste-picking. The "squatter status" of land tenure makes them suffer even more from absence of basic social services and access to credit, livelihood and education opportunities. Majority of the people have cast and almost confine their future to the Payatas dumpsite which also poses a major threat to the people's health and the environment. Hardest hit are the disadvantaged sectors who can hardly advocate and cope with the high risks of urban survival. Thorough community assessment would identify them as the lowest 20% of the population, including scavengers, handicapped, working children, malnourished infants, TB patients, low-income women and elderly persons.

Aim

- To set up integrated Community-Based Development Programmes for the lowest 20% of Payatas urban poor communities.

Methods

- Issue-based organizing addressing immediate survival concerns affecting the most disadvantaged sectors in view of long-range urban poor issues for land and shelter;
- Resource mobilization for basic service delivery systems;
- Setting-up community-based mechanisms and access for protection, care and rehabilitation;
- Fostering volunteers and involving the locals;
- Harnessing indigenous knowledge and skills through participatory approaches;
- Training and education based on adult learning principles and processes;
- Institution-building, status upliftment for access, linkages and leverage with formal institutions; and
- Community awareness-raising, networking and policy advocacy.

Achievements

Specific projects addressing the different target groups/sectors have been going on for the past three years:

- Scavengers' development programme for the status upliftment and institution-building of Payatas Scavengers into a Federation of 14 local chapters with 600 current membership;
- Savings and Credit Associations for low-income women with a total capitalization of P 3.5 million of revolving fund, and credit assistance for 10 associations of 250 mothers involved in various sorts of micro-enterprises;
- Rehabilitation programme for 200 tuberculosis patients directly affected by the open dumpsite;
- Rehabilitation programme for handicapped children and youngsters, involving stimulation and therapies, medical, educational and vocational rehabilitation;
- Rehabilitation programme for working (scavenging) children involving protection from dumpsites-born accidents, abuses and diseases, alternative vocational skills training and education and policy-making;
- Community-based health programme involving training and services of local paramedics and viable referral systems for tertiary and primary health care;
- Care for the elderly providing support mechanisms and organization among 100 elderly persons; and
- Child care programme catering for 500 infants through health care and nutritional support and training of care-givers.

(4) Ms Izabel Cristina da Silva Firmo, Salvador, Bahia, Brazil

My background is in promoting health care. I have experience of working in hospitals and, as a sociologist, in the organisation of public health programmes in rural areas. I also lived for seven years in a slum community in the city of Salvador as a personal option. My present position is as coordinator of Pastoral Care of Minors for the North-East 3 Sector of Brazilian Bishops Conference.

Salvador, capital of the State of Bahia, is the third largest city of Brazil in terms of population. More than a third of its people live in conditions of great poverty, and within this group those who suffer most are the children and adolescents. In Salvador, and in other smaller cities of the sector, these children either live on the streets or in slums and so called "invasion areas" of the periphery. They can be seen in the city centres each day selling peanuts, newspapers, or telephone tokens; offering to clean windscreens at traffic lights, or begging for small change. Others do the rounds of the city bars at nights, selling some home-cooked products if they are not involved in illicit activities such as passing drugs, theft or prostitution.

Our work has a two-fold focus: prevention and cure. In terms of prevention, activities are planned that help these children prepare for life and citizenship. This happens in the areas of the city centre and the periphery where the most needy children and adolescents still live precariously with their families. Here in Salvador, at present 3,500 children and their families are being reached, and similar proportions in other cities of the sector. In terms of cure, the work concentrates on accompanying these minors, boys and girls, already on the streets. About 350 minors are being accompanied in Salvador.

Our methodology involves winning the confidence and affection of these young people, building up their self-esteem, being present in their environment as a trusted friend and giving them orientation in language and terms understood by them.

Our objectives are:

- To train educators, social workers and volunteers who are, or will be, involved either in preventive or curative work with minors, offering them initial and in-service training.
- To create projects and opportunities where these minors can supply themselves, learn a trade, and formally enter the job market;
- To provide an ever stronger network of support and accompaniment for minors at high risk and their families in the poorest areas of the cities;
- To prepare volunteer families who offer to accompany young offenders and provide them with support and affection which many of them never had;
- To offer a professional advisory service to municipal authorities who wish to establish preventive/curative services for minors.

This work has been in the process of development over the past three years. We badly need more trained personnel and volunteers to cope with the ever-increasing demands of so many young people. Much remains to be done to persuade local authorities to assume their part in responding to this urgent need.

(5) Ms Veronica Mendoza, Community-Based Rehabilitation for Disabled Children and Youth, "NORFIL" Foundation Inc., Quezon City, The Philippines

NORFIL's vision statement:

> "Self-managing, interdependent persons and communities deeply rooted in spiritual and life values, socially and economically responsible/accountable in promoting unity, nationalism, social justice, sustainable development and peace in themselves and their future generations".

Introduction

Ten years ago, NORFIL Foundation embarked on a small project in two villages. Its aim then was to identify children with mental retardation and to find ways to help them. Today, we find ourselves in about 35 villages in three provinces in the Philippines extending services to more than 500 children and youth with varying disabilities, their families and the communities they belong to. The programme has facilitated the organization of parents and volunteer (AKAPIN Inc.) which has been registered with the Securities and Exchange Commission as a people's organization. This partner organization now holds a seat as one of the Board of Governors of the Federation of Disabled Persons in the Philippines. The project itself underwent a process of growth characterized by need-sensitive project services, trans-disciplinary approaches, developmental and participative methods/intervention and sustainable process.

NORFIL's community-based rehabilitation (CBR) project started in 1985. It stemmed from the need to bring down to the level of the community an intervention that is otherwise not easily accessible to many of the people. It emphasises the concept of integration/ normalization wherein the disabled person is trained to function in an environment where he/she found him/herself. This is also the principle that explains the integration of a CBR project to NORFIL's community development scheme. The rationale is that the development of a community implies the development of all members/sectors of that community and that includes the disabled.

Nature

Community-based rehabilitation is anchored on the principles of equalization of opportunities for and social integration of disabled persons and their families. As an intervention, it assures that the disabled persons and their families have access to services that are appropriate and

affordable. As a strategy, it solicits the participation of the community in implementing and sustaining a rehabilitation programme.

The main feature of the programme is the active involvement of family members and the community in the rehabilitation process as well as the provision of opportunities for full participation in the educational, social, economic, cultural, political and spiritual activities of that community.

Programme Goals

- To assist disabled children and youth in maximizing their abilities and in developing competency in the different areas of functioning so that they become more independent.
- To provide support to families especially parents in coping with the demands of bringing up a child with a disability.
- To promote disability prevention and rehabilitation and develop the capability of families and communities for programme involvement and sustainability.
- To insure that disabled children and youth have access to and equal opportunities in education, employment and other activities of mainstreamed society.

Guiding Principles

- CBR believes that the growth of a community depends on the growth of all its members, including those with disability. Self-reliance as a desired goal in rehabilitation ensures that disabled persons are perceived as participants and contributors to their own development.
- CBR believes that the family is the best agent in the development and rehabilitation of disabled children and youth. It therefore acknowledges the capability of families to care for its member with disability and their contribution to programme development.
- The community plays an important role in ensuring the full participation and integration of disabled persons. Thus, rehabilitation must be part of the on-going community development effort.
- CBR supports the right of disabled persons to live within their communities. Therefore, they must enjoy the same rights and privileges afforded by the non-disabled persons.
- Utilizing and maximizing the resources of the community for CBR guarantees the accessibility and affordability of services.

Programme Activities

(1) Rehabilitation Services

- Home/Centre-based Training Programme;
- Physical and/or Occupational Therapies;
- Diagnostic/Medical Assistance;
- Pre-/Vocational Skills Training;
- Livelihood Loan Assistance;
- Experiential Learning Activities; and
- Mainstreaming/Integrated Education.

(2) Family Support and Community Involvement Services

- Individual and/or Group Counselling;
- Training;
- Advocacy; and
- Organizational Development.

Programme Manpower

Manpower complement for CBR is multi-disciplinary to insure a holistic perspective in rehabilitation. The programme staff is composed of professionals in the field of special education, social work, psychology, occupational therapy and counselling.

A pool of volunteer consultants provides technical guidance to the staff as well as treatment and rehabilitative measures to programme participants. Comprising this team are specialists and practitioners in the fields of rehabilitation medicine, neuro-psychiatry, social work, psychology and other related professions.

The main manpower resource in CBR are the volunteer village rehabilitation workers (VRW) composed of parents, siblings, and community members who had been trained and are being supported by the programme staff in providing CBR services. In the communities, they are formed into Village Rehabilitation Committees (VRC) to plan, implement and evaluate its projects.

(6) Mr Moses Moshe More, "Work to Win Project", Johannesburg, South Africa

(a) What is "Work to Win"? A Programme that:

- identifies teams of youth leaders;
- trains them in project management;
- selects, plans and implements RDP projects;

- provides training and jobs to the unemployed;
- promotes youth activities and services;
- equips the youth to get jobs or start businesses; and
- upgrades the community's quality of life.

(b) What does the Training Include?

- discipline, conduct and employer expectations;
- team building and team management;
- language skills and numeracy;
- office management, administration and money management;
- computer literacy and business equipment;
- community development and consultation;
- project planning, costing and budgeting;
- publicity, fund-raising, transparency and accountability;
- operations and asset management;
- own business skills; and
- career planning and personal development.

(c) What has "Work to Win" Achieved so far?

- launched in Alexandra, Guguletu and Khayelitsha;
- trained about 30 youth leaders;
- cleaned up the badly polluted Jukskei river;
- finalist in the National Green Trust Environmental Awards;
- planted over 3,000 trees in Alexandra;
- converted a double-decker bus into a pre-school;
- renovated and expanded Skeen Combined School;
- created food gardens at Thusong Youth Centre;
- commissioned to repair Alexandra's sewerage system;
- maintained a successful publicity campaign; and
- attracted support from a fair range of donors.

(7) Dr Usha Nayer, Tash Foundation, Bombay, India. "The Community Experience: An Overview of the Situation in the Slum Settlements of Greater Bombay, India".

Bombay is the principal metropolis in India, and is home to approximately 8 million people, apart from the thousands who visit the city daily. Its truly cosmopolitan nature has encouraged entrepreneurs and mavericks alike, and still continues to attract thousands of migrants. The process of industrialization and economic liberalization have generated more economic opportunities.

Over 40% of Bombay's population live in the slums or slum-like conditions with limited civic or other public facilities.

The majority of the slum settlements are in the suburbs and come under the jurisdiction of the Greatest Bombay Municipal Corporation, which incidentally is one of the richest Municipal bodies in India!

The slum settlements in Bombay have distinctive characteristics, and a cursory glance at the row of settlements would give a definite idea about the general level of income, and the economical status of the occupants.

To illustrate, there are three types of slum settlements, the ones belonging to the mill workers (the blue collared) are distinct in that they are generally older settlements, they have amenities, which are mostly inadequate, and generally have strong-knit communities.

The second type would be the ones that have come around industries and close to major factories - these constitute the newer settlements, and have very informal living and staying conditions, with minimal or grossly inadequate facilities.

The third category would be the developing ones, the other-side-of-the-tracks-settlement, which grew continuously, aided by a combination of factors, like the growth in the service and non formal industries, huge residential complexes, improved and easily accessible transport.

We are here, primarily referring to the slum settlements with which we are most familiar, and while the predominant nature of these settlements are lower-middle and poor class, there would be a combination of all these classes living and sharing the same inadequate facilities, the only distinguishing factor would be the quality and style of the dwelling!

The slum community in Bombay contributes a great deal to the economy of the city, by providing muscle for labour (as well as political parties) and public services.

Many settlements have small scale units which deal in an astonishing variety of businesses, right from the export of garments, to providing snacks and other condiments to the thousands of small and informal eateries spread all over Bombay! In essence, within the Bombay slums one would find illustration of achievements against several crippling odds, and also the most deprived, exploited and apathetic human conditions.

What follows is an account based on our direct involvement with the community in the slum settlements of Govandi and Mankhurd, in North East Bombay.

These are a huge conglomerate of houses - officially illegal, yet several facilities, like telephone, water and electricity can be accessed, through a combination of political pressure

and influence or through informal means! Any structural change to the house invites demolition at the hands of the authorities, and until recently, housing meant resettlement at the Municipal or state designated houses.

Due to increasing pressure from all sections of the society, slum dwellers, and concerned NGOs, a plan of action, promoting in initiative between the slum dwellers and private builders have been ratified.

The progress however is slow, and has still not made an impact on the basic appearance and structure of most of the slums - baring some notable exceptions. Housing is one typical problem, and in spite of the numerous problems that they continually face, Bombay slum settlements are examples of enterprise, initiative and resilience.

A typical slum settlement would have shelters and shops, which are partly done up in concrete and the bulk made up of salvaged material. It might include jute bags, HDPE cloth, Asbestos and tin sheets. Electric cables and water lines would be all over the place, and so would be the sewers and garbage. An amazing aspect of the scene would be the large amount of informal businesses being conducted along with the regular ones!

Scrap merchants, automobile garages, communication centres and grocers all do business amidst this. Illicit liquor brewing and retailing, manufacturers wanting to avoid taxes and scrutiny by Government agencies are all tucked away in the inner settlements. There are Municipal Schools and dispensaries/hospitals, which cater to the deprived.

The economically deprived sections invariable gravitate towards these slums.

As mentioned earlier, the slums have gradations within them, and the general population would include the working class - illiterate but skilled, the small informal entrepreneur, and all those who cannot afford the exorbitant price of private apartments and real estate.

Of late, an increasing number of middle class families have also resorted to the slums, which we feel would slowly but surely change the nature of these settlements in times to come. It must be admitted here that this would take a long time and any attempt at rehabilitation would have to be community initiated and sustained.

An increasing number of graduates, the growth in the level of literacy, and an increase in the school-going population, have contributed to the general increase in awareness of the people to the need to organize and claim its legitimate share in the resources, by presenting a united and committed movement, that works in tandem with the Social and Political System at large.

So far, the inhabitants whose fear and ignorance of government regulations and the absence of any statutory documents, were exploited by all the political parties, have gradually witnessed a greater involvement of the residents and concomitantly a greater say in

determining their immediate issues and their redressal! In Bombay, some section of these slum pockets are known as vote banks!

Present day Bombay slums have people who are better organized than before, but invariably work at cross purposes. There would be a plethora of organizations - political, social, cultural and religious. Their agenda is invariably diffused and normally work with narrow objectives. Schools, mostly Municipal funded and organized, provide a fairly good class of eduction - though the medium of instruction is in the local languages - this aspect is important considering that when they finally graduate out, they are at a disadvantage, because the language of business and commerce is mostly English!

The biggest problems and the most obvious in the slum settlements are the lack of decent housing, education and unhygienic environment. Since the density of population is fairly high, and there is not a method of plan in the design and layout of the houses, health problems are frequent besides the lack of privacy and the uncontrolled influx of people compounds these problems.

It is obvious that this environment, by default, has at any given time, people who are socially and economically deprived and at times exploited. The plight of the obviously disabled is pathetic and so would be the conditions of the aged.

In other words, this setting provides any serious researcher with a variety of human conditions, disabilities and deprivations, whether socially, economically or otherwise, and also several examples of endurance and initiative.

Our own experience with the slum community has been characterized by a willingness on our part to support their initiative and have at times worked behind the scenes to get various groups within the community to come together and also sustain cooperation.

An example of our work was the development of a park, which was used for every other purpose except as a park. In fact, this was the open air defecation grounds for the children. It took us two patient years getting various groups to see the advantages, network with another organization, assure them about the feasibility and long term usage and so on.

20 organizations within the community, several elders, traders and shop-keepers, and other interested individuals were involved in an exercise that saw several stormy and frustrated meetings.

Today, the park is clean and has trees planted all over the border and is being taken care of by individuals and organizations alike, a police station to ensure that the park does not slip back to it original condition and at any given time one would find scores of children playing and screaming, as only happy and carefree children do!

This to our mind is an example of the effectiveness of CBR. It is a matter of identifying and sustaining a movement, and intervening only at critical junctures.

(8) Mr Eugenio Scannavino, Projeto Saude e Alegria, Santaren, Brazil. "Health and Happiness: A Community Experience in the Amazon", Santaren, Brazil.

The Project

The Health and Happiness Project works in the Amazon, in Santaren county, with 19 rural communities along the Amazon, Tapajos and Arapiuns Rivers. It is an experimental training project geared toward integrated development in the following areas: Health, Environment, Rural Production, Education, Culture, Arts and Communications. Presently, it provides direct coverage for 18,084 people, most of whom belong to the mixed Indian-White race, known as Caboclos.

These native people earn their living from gathering forest products, fishing and rural producing at the family level. Their livelihood is presently threatened, owing to the rapid depletion of natural reserves. The living situation is extremely critical, and health problems have grown to alarming proportions. At the same time, these people live in a land rich in developmental potential, although their labour and natural resources are improperly utilized, basically due to the lack of technical support, incentives and institutional backing.

Health and Happiness consists of a multi-disciplinary team that includes agronomists, biologists, communications specialists, artists, educators, physicians, nurses and other skilled personnel. Our team makes its appearance in the form of a small touring circus, the "Great Mocorongo Health and Happiness Circus" ("Mocorongo" is the local name given to the natives of this area). We consider it to be the project's main artistic tool for education and human interaction.

Beginning with the local situation, the Project endeavours to find simple solutions adapted to the most pressing needs. Its integrated programmes involve every community group with no age restrictions, consequently leading to education with community-wide participation.

Environmental education is the keystone to the entire process as it strives to establish people within their environment, providing them with the tools for interacting with their living situation while changing it in a conscientious and constructive way.

Objective

The objective of the Health and Happiness Project is to improve social and environmental technologies that are capable of promoting global and sustainable community development based on grass-roots participation and the proper utilization of the natural, human and cultural resources found in each location.

Background

The Health and Happiness Project arose out of a practical experiment involving riverbank dwellers in the area. In 1985 the Centre for Advanced Studies in Social Care (CEAPS) was founded, a not-for-profit, non-governmental environmental group that is the Project's parent organization. The Project got underway in 1987, with funding from the Finsocial programme through the National Economic and Social Development Bank (BNDES). It also began to receive funds from the National Environment Fund (FNMA) in September of 1990, through the Environmental Secretariat of the Presidency of the Republic (SEMAN-PR).

Through our Health Section, we began work geared toward community mobilization and development, since this was the most pressing demand from community members as well as representing a collective effort by everyone. There are presently some 120 health monitors working in communities, who are able to deal with around 70% of health problems that arise. Their tasks include regular house calls, and with support from the Project's technical staff, they engage in vaccination campaigns and sanitary treatment of foci of contamination, among other activities. Mini-clinics are being built in certain communities, along with wells and latrines. Most families now regularly treat their drinking water with chlorine, to the point where cases of diarrhoea and cholera are rare.

Community women, through Mothers' Clubs develop nutrition programmes, small farms and community gardens. Handicraft and cottage-industry programmes are also being implemented.

We work with Rural Producers in the following areas: increasing the food supply, rational utilization of cleared land, inter-cropping of annual plants, grain storage and fruit tree growing for reclaiming degraded areas.

Children and teachers are the focus of environmental education, art and culture workshops, and a so-called programme for "Kiddy Monitors" (youngsters between the ages of 6-14 who must take care of their younger siblings in the absence of parents).

By organizing and training young people interested in our Grassroots Communications Programmes, we now have 120 rural correspondents making up an Inter-community Communications Network with the following programs: Community and inter-community newspapers; "Live Radio", educational photo comics, and TV Mocoronga, a socially-oriented use of VHS television.

The "Great Mocorongo Health and Happiness Circus" was an offspring of our art education programme. It has become an open stage for cultural programmes and collective creativity while mobilizing a large segment for community action. Community members now put on their own circus, presented in their own language and thereby maintaining their cultural identity.

The Project has gained 100% acceptance from these people, and consequently has spontaneously multiplied as it moves into new communities. After four years of continuously working, of greatest importance is the fact that a movement involving social construction and learning has been consolidated in a joint effort by specialists and community members.

There is no question that Health and Happiness is expanding. It represents a comprehensive proposal that can be re-applied in numerous contexts, in each case generating its own paths and local models.

Programmes

(a) **Health:** Health Education; Training of Local Monitors; Basic Hygiene and Sanitation; Combatting of Waterborne Diseases; Epidemiological Control; Simplified Health Care; Vaccination and Health Monitoring (ages 0-5); Combatting Malnourishment; Women's Health; Midwife Training; Prenatal Care; Oral Health.

(b) **Education/Arts/Culture:** Dissemination of general knowledge; Art Education, Utilization of schools as a dynamic centre of culture; Participative Research; Curriculum Adaptation and Teaching Methods; Teacher Retraining; Alternative Sources of Nutrition; Home Economics; Handicrafts; Cottage Industry; "Fruition" project (seedling nurseries and school gardens); "Recycle Circus" (garbage recycling); Training of Kiddy Monitors; Cultural Revival (folklore, handicrafts, legends, etc.); Circus Workshop; Encouragement of Artistic Talent; "Talent Scouting".

(c) **Communications:** Documentation of Region and Project Activities; Community and Inter-community Newspapers; "Live Radio"; "TV Mocoronga", Training of Rural Correspondents; Intercommunity Creation Centre, Health and Happiness Publishers; Mobile Library.

(d) **Information and Research Centre:** Date Monitoring; Ongoing Evaluation; Participative Research and Evaluation; Support for Community Organizations and Leadership.

(e) **Production and Environment:**

Farm Production: Crop Rationalization; Inter-cropping of Annual Plants; Storage; Crop Diversification; Fruit Tree Seedling Production for Reclamation of Degraded Areas; Encouragement of Home Gardens; Development of Simple Management Techniques.

Animal Raising: Small Animal Raising; Support for Fisheries and Wild Animal Raising; Support for Small-scale Fishing.

Marketing Support: Study of market demands and potential production sources; Support for infrastructure and shipping of output; support for intercommunity market.

Community Reserves: Participative Zoning of Natural Reserves (forests and fisheries); Extractive Products and Means of Utilization; Support for Extractive Activities and Marketing; Phenology of Species Status of Landownership and Areas of Conflict; Technical-institutional Integration; Drafting of Management Plans Environmental Education and Community Inspection; Management of Reserves; Installation of Demonstration Units for Development of Integrated Production Management Techniques.

Institutional Upgrading: Infrastructure; Logistical and Administrative Support; Institutional Interchanges and Outside Consultation.

"Happiness is a contagious state of mind, and therefore it promotes success but it should be founded on consistency in order not to degenerate into out-of-control euphoria. Truth and strength should be kept in the heart, while gentleness should reveal itself in social relationships". (from the book "I Ching", p.177, hexagram 58, Richard Wilheim).

(9) Fr Alex Zanotelli, Kariobangi Catholic Church, Nairobi, Kenya. "Korogocho".

Korogocho (means "confusion" in Kikuyu) is one of the many slums of Nairobi, the capital of Kenya. A beautiful city surrounded by hundred of slums of the worst kind. Korogocho has a population of 100,000 people packed into a very tiny area. In fact, 55% of the people of Nairobi, which has a population of three million inhabitants, are packed in 1% of the land of Nairobi!!

In 1990, I decided to go and live in Korogocho. I have now been living inside for the last six years. It has been for me a profound human and spiritual experience: a baptism in humanity. The baptism of the poor. I spent the first two years just living with the people, sharing with them. Little by little, I understood the complexity of reality in Korogocho. I tried to identify the groups of people who were most despised and marginalized in Korogo cho.

After careful searching, we felt that the groups most despised were: the people picking refuse in the Mukuru, the young girls going to town, AIDS patients, the street children, the juvenile delinquents and handicapped children.

We started working with the people of Mukuru (Dumping place), seen by the people as the worst species of mankind. We decided, after a period of wooing them one by one, to meet as a community. We felt the community could have a forceful effect on them: Community and Gospel. After one year of such experience, we tried to start a cooperative of the recycled material. These people used to sell to middle-men who used to get the gain. The cooperative

supplanted the middle-men. Today, it is beginning to make a profit, giving work to twenty people and giving a good price to the poor who sell their refuse to the cooperative. A second community (20 members) was later started from the people of Mukuru which today is cleaning some of the main buildings in Nairobi. The good refuse in fact never comes to the Mukuru. It remains in the hands of the rich! That is why the second community moved into action into the heart of town.

We followed the same for many girls born in Korogocho and who have no choice but to go to town to survive. We started the community of the UDADA (Sisterhood). It took so much time and effort to get a few girls together. Now the girls, moved by fear of AIDS, come themselves to ask to enter the community. The girls do necklaces, bracelets, crosses to earn a living. Each girl has a life to be rebuilt to believe again in themselves. The community, gospel and work help them to believe in themselves. Some are also alcohol addicts.

The street children are another dramatic reality of Korogocho. We have three meeting points for them where they feel welcomed, loved and given dignity. Fourth, so many young people born in the slum have given themselves over to alcohol, drugs and especially stealing and robbing people in order to survive. A most difficult group. We have started with them the community of Kindugu (Brotherhood). We followed them for over eight months. But we don't know what will happen. They are being trained in sculpture and furniture-making using sisal material.

Then the AIDS patients: they constitute the most dramatic reality in Korogocho. They are the first priority in our pastoral work.

The same goes for the Handicapped in Korogocho. Sister Gill (Medical Missionary Sister) has done an incredible job for them.

In Korogocho, the marginalized people are at the centre of our action: they are our privileged people. They recover their strength and dignity as they feel welcomed and appreciated by the larger community. This happens in a variety of ways not least through ritual, liturgy, symbols. Little by little, our presence is perceived as a healing presence and/or a catalyst for these people to feel at home and proud of themselves.

(10) Dr Ron Brouillette, Christoffel-Blindenmission, Makati City, The Philippines "Deaf Community-Based Rehabilitation"

Background

Community-Based Rehabilitation approaches typically do not adequately meet the needs of the deaf and hard of hearing (prevalence rate is around 1%). Reasons for the lack of services for this group include the difficulties encountered in communicating with the deaf and in integrating this group within a hearing community.

Most deaf people see themselves as belonging to a linguistic minority rather than as being disabled. When deaf people take a leading role in CBR for the Deaf, meaningful assistance can be given within the hearing community while strengthening the deaf community.

Goal

The goal of the programme is to improve the quality of life of deaf people by empowering them to assist themselves and change non-supportive attitudes held by the hearing community.

Aims

The aims of the deaf- led programme are to:

- provide leadership and technical training to the deaf;
- identify deaf and hard of hearing children and adults;
- identify resources in the community;
- organize the deaf for self and social advocacy;
- provide sign language training to the deaf, their families as well as those who can use sign language;
- Sensitize the hearing community about the abilities and needs of the deaf and the deaf culture;
- network among service providers;
- training family members;
- provide training and salaries for interpreters;
- develop both integrated and segregated education;
- develop income generating schemes;
- provide assistive devices (preferably made by the dear and disabled people) such as hearing aids, sound switches, captioning of TV and videos, etc.

Outcomes

To date, the outcomes have been significant in that the deaf are taking over the deaf CBR which was initiated by hearing CBR specialists. A constraint has been the reluctance of hearing professionals to transfer the power, leadership and ownership of the CBR to the Deaf.

Another constraint has been the reluctance of the deaf community to integrate into the hearing community. Oral schools for the deaf have opposed the wide use of sign language in the home and community.

Since the programme began, there has been an increase in community awareness, use of sign language and in the number of deaf in education and employment. Hearing aids and other

adaptive devices are being produced by the deaf and disabled people and screening for hearing loss is increasing in the schools and the community.

Methods Used

A social model of CBR has been employed. The programme has fully mobilized and capitalized on the existing government and non-governmental services including church worker volunteers as interpreters and teacher aids. Since deafness is not considered a medical problem, health professionals have taken a less active role in the Deaf CBR programme.