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Relevance of CBR and Inclusive Development

in Post-2015 Development Agenda

Position Paper

CBR ASIA-PACIFIC NETWORK

The first Asia-Pacific CBR Congress was held in February 2009 in Bangkok, Thailand. There were 650 participants from 52 countries of the Asia-Pacific region and from other regions. The Congress provided an excellent platform for participants to network and to interact with persons with similar interests from across the region, in separate meetings during the 3 days. It was agreed that CBR should continue to be promoted in the region through the formation of the CBR Asia-Pacific Network in collaboration with the Asia-Pacific Development Center on Disability as the secretariat. Towards this end, Congress participants from each country met separately and selected a coordinator to represent their country in the CBR Asia-Pacific Network.

ASIA-PACIFIC DEVELOPMENT CENTER ON DISABILITY

The Asia-Pacific Development Center on Disability (APCD) is a regional center on disability and development. APCD was established in Bangkok, Thailand as a legacy of the Asian and Pacific Decade of Disabled Persons 1993-2002, with the joint collaboration of the Ministry of Social Development and Human Security, Royal Thai Government and the Japan International Cooperation Agency (JICA), Government of Japan. In cooperation with more than thirty countries in the Asia-Pacific region, APCD is currently managed by the APCD Foundation under the Patronage of Her Royal Highness Princess Maha Chakri Sirindhorn. The United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) identified APCD as the regional center on disability for the Incheon Strategy to "Make the Right Real", 2013-2022.

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ACCESSIBLE INFORMATION

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FOREWORD



The CBR Asia-Pacific Network has taken on the role and tasks of implementing Community-Based Rehabilitation (CBR) during the past decade as a strategy to achieve Community-Based Inclusive Development (CBID), the end result of ensuring all persons with disabilities are fully included in all aspects of community life and have full access to all facilities and services.

The Position Paper "Relevance of CBR and Inclusive Development in Post-2015 Development Agenda" has been developed in cooperation with the CBR Asia-Pacific Network and the Asia-Pacific Development Center on Disability (APCD) to move towards sustainable inclusive development, which has become a challenge for all engaging in empowering persons with disabilities to become "Agents of Change" within the community, in order to play the leading role to bring about positive changes and opportunities to forge their own future.

CBR AP Network

The booklet is designed to convey regional experiences and viewpoints on CBID with an aim to provoke thoughts, and to identify key elements for future direction regarding Post MDGs framework from the perspective of persons with disabilities in Asia and the Pacific, in regards to further develop the implementation of CBR, and to reassure the possibility of an inclusive, barrier-free, and rights-based society.

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INTRODUCTION

In April 2013, the United Nations (UN) and partners world-wide including governments, international organisations and civil society groups observed the 1,000 day mark to the 2015 target year of the Millennium Development Goals (MDGs). There are calls to build momentum to close gaps and accelerate progress on MDGs targets; and consultations are on to evolve the post-2015 development agenda.

The 2012 MDGs Report shows some impressive achievements: extreme poverty has reduced in every region; more people have access to improved sources of drinking water; there are improvements in the lives of poor people living in slums in the developing world; there is parity between girls and boys in primary education; enrolment rates of children in primary schools has risen; the number of under-five deaths has fallen; incidence of malaria and tuberculosis has declined; and there is increasing access to treatment for persons with HIV/AIDS. Despite progress, many grave challenges remain, related to hunger, maternal mortality, gender equality, access to safe water in rural areas and the increasing number of people living in slums.

The MDGs, a major international initiative towards inclusive development for the poor, had been criticised by stakeholders in the disability sector as the eight goals, their targets and indicators had not ***explicitly*** mentioned disability. It was said that inclusion of persons with disabilities were ***inherent*** in all goals; but this has never been a satisfactory justification for disability advocates, activists and programme implementers; and over the last few years, efforts have been made (regional and global) to add disability-specific targets and indicators to the MDGs, backed by the now famous quote from James Wolfensohn (2002), former President of the World Bank, that "Unless persons with disabilities are brought into the development mainstream, it will be impossible to cut poverty in half by 2015 or to give every girl and boy the chance to achieve a primary education by the same date which are key among the Millennium Development Goals agreed to by more than 180 world leaders at the UN Millennium Summit in September 2000."

MDGS AND DISABILITY

The rationale for inclusion of disability issues into each MDG goal is well illustrated by the World Bank (http://go.worldbank.org/G2UGT4F6R0) as follows:

MDG 1: Eradicate Hunger and Poverty
Disability and poverty are intertwined. In fact, the qualitative evidence suggests that persons with disabilities are significantly poorer in developing countries, and more so than counterparts without disabilities. Many persons with disabilities are denied education or jobs, the disorder may require chronic health care and these in turn drain the scarce household resources. Persons with disabilities make up as much as 1/5 of the world's poor. Malnutrition can result in a number of disabilities, such as stunting, blindness, and diabetes.

MDG 2: Achieve Primary Universal Education
The Constitution of the Kingdom of Thailand B.E 2550 (2007) states that a person shall enjoy an equal right to receive education for the duration of not less than 12 years, which shall be provided by the government. Currently, there are 22,722 public and private schools open to children with disabilities and 72 college institutions providing a Bachelor to Ph.D. degree for students with disabilities with services related to equipment, assistive devices, sign language interpreters and tutoring. Special vocational education is also provided by 9 public vocational training institutes and also by several private sector institutes.



Building a ramp in school

MDG 3: Promote Gender Equality and Empower Women
Women with disabilities are more likely to be victims of sexual abuse. Violence against women causes psychological disabilities, and some disabilities, such as obstetric fistula, are particularly stigmatizing. A dearth of community access and services for persons with disabilities may prevent the women and girls from taking advantage of school and work opportunities.

MDG 4: Reduce Child Mortality
Children with disabilities are at higher risk of dying because of medical conditions, but also because of lack of access to public services, and intense stigma–even within their own homes. Early detection, treatment and education may increase survival rates and minimize the consequences of disability later in life.

MDG 5: Improve Maternal Health
Women with disabilities have less access to public health information and they are often at higher risk of violence and sexual assault, placing them at greater risk of unintended pregnancies and HIV/AIDS. Women with disabilities may have a greater risk of forced sterilization. Pregnancy, especially in girls and young women may result in disabling conditions.

MDG 6: Combat HIV/AIDS, Malaria and Other Diseases
HIV/AIDS and other contagious diseases can, in and of themselves, be disabling. However, most significantly, efforts to halt these epidemics frequently do not encompass persons with disabilities, putting persons with disabilities at higher risk of contracting these diseases. Information on HIV/AIDS and other contagious diseases in accessible format should be available to ensure the equal rights of persons with disabilities.

MDG 7: Ensure Environmental Sustainability
Environmental dangers can lead to the onset of many types of disabilities. For instance, some pollutants can lead to a number of disabilities. Road design can have a tremendous impact on the safety

of pedestrians, potentially preventing road crashes that can lead to disabilities and protect persons with disabilities from being involved in accidents. Inaccessible environments prevent persons with disabilities from taking part in economic and social activities. The cost to retrofit environments is higher and the outcome less satisfactory, than when environments are designed, constructed and maintained for all users. Consideration of universal design is particularly important when addressing urban design and rapidly aging societies.

MDG 8: Develop a Global Partnership for Development

-Global Partnership for Development

The Convention on the Rights of Persons with Disabilities (CRPD) includes a specific article on international cooperation (article 32) to ensure that international development should be inclusive and accessible for persons with disabilities.

"A partnership implies inclusion, which means everyone."

The Department for International Development (DFID), the United Kingdom has been leading the debate on disability, poverty and the MDGs. As early as 2005, a report of the Policy Project of the DFID Disability Knowledge and Research Programme (Thomas, 2005), states:

"Overall the conclusions from the research conducted through the Policy Project of the Disability KaR programme, particularly the country level research in Cambodia, Rwanda and India, are clear with regard to the relevance of disability to poverty reduction and the achievement of the MDGs:



Activities on the International Day of Persons with Disabilities

•Persons with disabilities are typically among the very poorest; they experience poverty more intensely and have fewer opportunities to escape poverty than persons without disabilities

•Persons with disabilities are largely invisible, are ignored and excluded from mainstream development

•Disability cuts across all societies and groups. The poorest and most marginalised are at the greatest risk of disability. Within the poorest and most marginalised, women with disabilities, ethnic minorities with disabilities, members of scheduled castes with disabilities and tribes etc. will be the most excluded

•DFID cannot be said to be working effectively to reduce poverty and tackle social exclusion unless it makes specific efforts to address disability issues."

-Inclusion of disability in MDGs

Subsequently, there were increasing calls to include disability in the MDGs by different stakeholders including local, national and international disabled peoples' organisations (DPOs). This was first reflected in the UN Resolution "Realizing the Millennium Development Goals for Persons with Disability" (A/RES/64/131) adopted by the United Nations General Assembly (http://www.un.org/disabilities/documents/gadocs/a_res_64_131.doc).

In 2008, the UN ESCAP held the Expert Group Meeting on Developing Supplementary Targets and Indicators on Social Inclusion, Population, Gender Equality and Health Promotion to Strengthen the MDG Process. Disability-specific targets and indicators were evolved during this meeting (http://cop.mdgasiapacific.org/group/escap-mdgs).

In 2009, the World Health Organisation (WHO) and the UN Department of Economic and Social Affairs (DESA) organised the Expert Group Meeting on Mainstreaming Disability into MDG Policies, Processes and Mechanisms: Development for All. A publication titled Disability and the Millennium Development

Goals: A Review of the MDG Process and Strategies for Inclusion of Disability Issues in Millennium Development Goal Efforts was subsequently published by the UN in 2011.

In 2010, for the first time, disability was included in the MDG Progress Report with specific mention in Goal 2 on education of children with disabilities who are not in school.

International agencies, for example, APCD, CBM, Leonard Cheshire Disability and International Disability Alliance (IDA) have articulated their positions on inclusion of disability into post 2015 MDGs.

Although MDG goals and targets did not explicitly include disability issues, it is incorrect to assume that the response to address questions of inclusion and participation of persons with disabilities into development and poverty reduction policies and processes through other means has been limited. A significant response is Community-Based Rehabilitation (CBR), a strategy to promote inclusive development for persons with disabilities.



Training on Community-Based Inclusive Development at APCD

CBR AND INCLUSIVE DEVELOPMENT

CBR was initiated in the early 1980s, with the recognition that in many developing countries, the conventional system of rehabilitation had failed to address needs of persons with disabilities (Helander, 1993). The alternative proposed was based on the principles of primary health care, with emphasis on coverage of rehabilitation services for persons with disability living in rural areas in developing countries. The idea was that transferring skills to local people, including families (WHO, 1989), would reduce the need for expensive institutions, equipment and professionals, thus making the process affordable. Over the last 25 years, there have been major changes in the way CBR is understood and practiced. In the eighties and nineties, most CBR projects were vertical in nature and few were integrated into development programmes. CBR in those years focused on coverage of services like medical rehabilitation (mobility, daily living skills, communication, home based rehabilitation); education (school enrolment, special education); social security schemes; some livelihoods activities; some social activities like participation in community, and acceptance by friends/neighbors.

The change in CBR understanding and practice from the mid-nineties onwards is best illustrated in the Joint Position Paper of WHO, ILO and UNESCO (2004) that defined CBR as a "strategy within general community development for the rehabilitation, equalization of opportunities and social inclusion of all persons with disabilities. CBR is implemented through the combined efforts of persons with disabilities themselves, their families, organizations and communities, and the relevant governmental and non-governmental health, education, vocational, social and other services."

The two objectives of CBR according to the Joint Position Paper are:

- To ensure that persons with disabilities are able to maximize their physical and mental abilities, to access regular services and opportunities, and to become active contributors to the community and society at large.

•To activate communities to promote and protect the human rights of persons with disabilities through changes within the community, for example, by removing barriers to participation.

Gradually, the scope of CBR activities broadened from medical and education activities to addressing poverty and livelihoods; formation of self-help groups, self-help organizations of persons with disabilities, family associations; awareness raising, partnerships and networking; and inclusion of marginalised groups like women with disabilities, persons with intellectual or multiple disabilities, psychosocial disabilities or those living with HIV/AIDS. Words like 'empowerment', 'inclusion',' participation', 'barrier-free' began to be used in planning. Going beyond disability-specific entitlements, there were efforts to include persons with disabilities in general development and poverty reduction programme.

CBR practice has thus changed from a medical orientated, often single sector (e.g., health or education), service delivery approach, to a comprehensive, multi-sectoral, rights-based one, focusing on creation of inclusive societies where persons with disabilities have access to all development benefits like everyone in their communities (Thomas, 2013).

A WHO survey carried out in 2007 shows the growth of CBR: about 92 countries had CBR projects and programmes:35 in Africa, 26 in Asia, 24 in Latin America and 7 in Europe (Khasnabis and Heinicke-Motsch, 2008). In Africa alone 280 CBR programmes are listed in 25 countries (Adeoye and Hartley, 2008). CBR Congresses have been organised over the last decade in Africa, Asia-Pacific and Latin America; regional CBR Networks have been established to sustain the CBR movement through training and information exchange, and a global CBR network was recently launched.

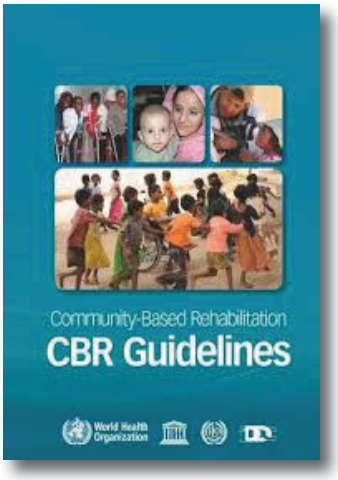
In the Asian region, specific reference to CBR is now found in national level policies of Bhutan, India, Indonesia, Myanmar, Pakistan, the Philippines, Sri Lanka, Thailand and Timor Leste, which is a significant change from the situation a decade ago. In Burkina Faso in Africa, CBR has been adopted as national strategy to support persons with disabilities.

CBR Guidelines

The CBR Guidelines of WHO (2010) are an attempt to synthesize experiences from across the world to provide a unified understanding of the concept and principles of CBR. By synthesizing CBR experiences from different regions of the world, the CBR Guidelines help to illustrate existing and new concepts; they endorse and build on field level practice.

The Guidelines provide a structure for CBR planners and practitioners, based on which they can develop activities according to their local context, needs and resources. They do not advocate any particular 'model', as it has been understood for many years that there cannot be a single model of CBR for the world.

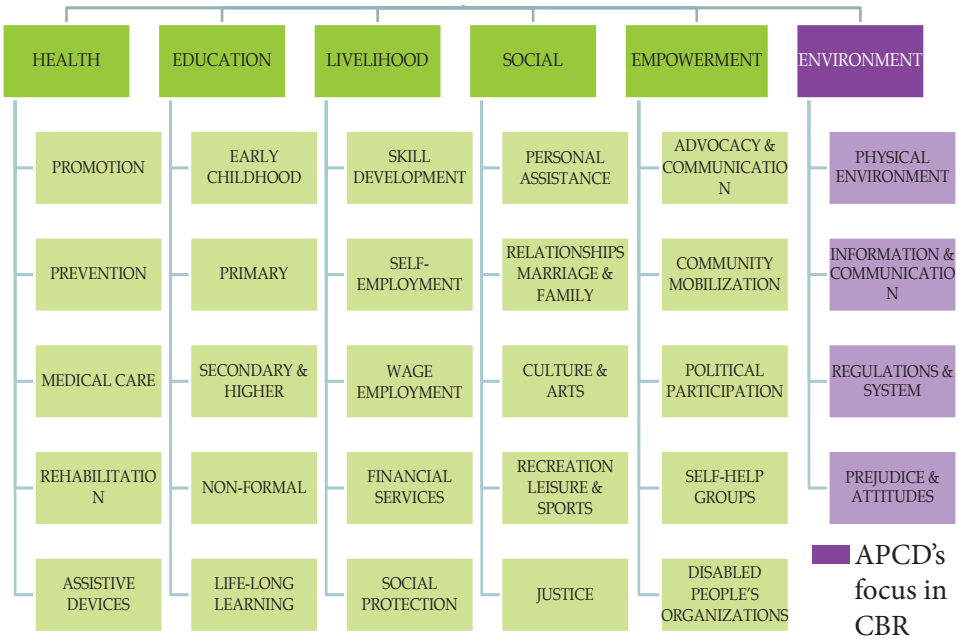
The ***CBR Matrix*** from the Guidelines summarises the 5 main components of CBR and their subsidiary elements.



CBR Guidelines

CBR Matrix

The CBR Matrix can be used as a framework for planning, but it is clear in the Guidelines that the Matrix in totality is not expected to be implemented in every context. Programmes can choose the areas that are best suited to their local context, needs and resources; and explore partnerships with other organisations in areas where they lack expertise.



CBR and CRPD

The UN Convention on Rights of Persons with Disabilities (CRPD), adopted in 2006 is the most significant legal development for persons with disabilities world-wide, illustrating the shift in attitudes and approaches to persons with disabilities, from seeing them as "objects" of charity and welfare, to viewing them as participating, contributing members of society, where they have the same rights as others in their community, and are capable of making decisions for their lives. The central tenet of the Convention is non-discrimination, its vision is that of an inclusive society; the text was developed with active participation of persons with disabilities and their representative organisations (IDDC, 2012).

The Principles of the CRPD, which are the basis for the WHO CBR Guidelines, are:

- Respect for inherent dignity, individual autonomy, including the freedom to make one's own choices, and independence of persons
- Non-discrimination
- Full and active participation and inclusion in society
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
- Equality of opportunity
- Accessibility
- Equality between men and women
- Respect for the evolving capacities of children with disabilities and respect for the rights of children to preserve their identities.

The CRPD is the supporting framework for CBR and is illustrated in the CBR Guidelines where it is stated that, "CBR is a multi-sectoral, bottom-up strategy which can ensure that the Convention makes a difference at the community level. While the Convention provides the philosophy and policy, CBR is a practical strategy for implementation. CBR activities are designed to meet the basic needs of persons with disabilities, reduce poverty, and enable access to health, education, livelihood and social opportunities – all these activities fulfil the aims of the Convention".

The CRPD contains reference to CBR in 3 articles, the relevant portions of which are given below:

Article 19: States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community.

Article 25 (c) Provide these health services as close as possible to people's own communities, including in rural areas.

Article 26. States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

(b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

The strong linkages between the core articles of the CRPD and the CBR Guidelines are illustrated in a report published by the International Disability and Development Consortium IDDC (2012):

CBR Guidelines	CRPD Core Articles
Introduction of CBR	3.General principles 4.General obligations
Main cross cutting themes: Women with disabilities; Children with disabilities; Principles of CRPD	3.General principles 4.General obligations 6.Women with disabilities 7.Children with disabilities
Health	20.Personal mobility 25.Health 26.Habilitation and rehabilitation
Education	24.Education
Livelihood	27.Work and employment 28.Adequate standard of living and social protection

CBR Guidelines	CRPD Core Articles
Social	12.Equal recognition before law 13.Access to justice 14.Liberty and security of person 15.Freedom from torture or cruel, inhuman or degrading treatment or punishment 16.Freedom from exploitation, violence and abuse 17.Protecting the integrity of the person 19.Living independently and being included in the community 23.Respect for home and family 30.Participation in cultural life, recreation, leisure and sport
Empowerment	4.General obligations 5.Equality and non-discrimination 8.Awareness raising 9.Accessibility 15.Freedom from torture or cruel, inhuman or degrading treatment or punishment 16.Freedom from exploitation, violence and abuse 17.Protecting the integrity of the person 21.Freedom of expression and opinion, and access to information 22.Respect for privacy 29.Participation in political and public life
Mental Health	25.Health
Emergencies and Disaster	11.Situations of risk and humanitarian emergencies

Source: IDDC. Community-Based Rehabilitation and the Convention on the Rights of Persons with Disabilities. Brussels, 2012, page 7.

Incheon Strategy and CBR

The Incheon Strategy to "Make the Right Real" for Persons with Disabilities in Asia and the Pacific, 2013-2022, espouses 10 goals, many of which are intrinsic to CBR programmes in low and middle income countries:

1.Reduce poverty and enhance work and employment prospects

2.Promote participation in political processes and in decision-making

3.Enhance access to the physical environment, public transportation, knowledge, information and communication

4.Strengthen social protection

5.Expand early intervention and education of children with disabilities

6.Ensure gender equality and women's empowerment

7.Ensure disability-inclusive disaster risk reduction and management

8.Improve the reliability and comparability of disability data

9.Accelerate the ratification and implementation of the Convention on the Rights of Persons with Disabilities and harmonization of national legislation with the Convention

10.Advance sub-regional, regional and interregional cooperation.



Home visit

Noting the Community-based Rehabilitation Guidelines, a joint document of the World Health Organization, the International Labour Organization, the United Nations Educational, Scientific and Cultural Organization and the International Disability and Development Consortium, which provides a comprehensive, multisectoral poverty reduction strategy for implementing the Convention on the Rights of Persons with Disabilities,

In order to realize and protect the rights of persons with disabilities in the Asin and Pacific region, the Incheon Strategy underscores the following policy direction to promote CBR:

(i) Community- and family-based inclusive development is promoted in order to ensure that all persons with disabilities, irrespective of socioeconomic status, religious affiliation, ethnicity and location, are able, on an equal basis with others, to contribute to and benefit from development initiatives, particularly poverty reduction programmes

(m) Organizations of and for persons with disabilities, self-help groups and self-advocacy groups, with support, as required by families and caregivers, participate in decision-making, as appropriate, to ensure that the interests of marginalized groups are adequately addressed



Persons with disabilities as "Agents of Change"

Community-Based Inclusive Development

The CBR Guidelines refer to 'Community-Based Inclusive Development', a term that is increasingly being used today in connection with some programmes for persons with disability; and is sometimes taken to mean the same as CBR.

Community-Based Inclusive Development is an aim or goal or an end result to be achieved – of making communities and society at large inclusive of all marginalized groups and their concerns, including persons with disability. The rationale is that no one should be excluded from development for any reason, be it gender, disability, ethnicity, refugee status, sexuality or any other issue. CBR is the tool or strategy to achieve the goal of Community-Based Inclusive Development for persons with disability, just as other interest groups in the community (gender etc.), use their own strategies to make development inclusive of their constituents.

Inclusive development means that partnerships and alliances are necessary between different stakeholders, especially between CBR, DPOs, families of persons with disabilities and governments (Thomas et al, 2010). The development of the CBR Guidelines is an example of effective partnerships between multiple stakeholders.

–UN agencies, DPOs, governments, donor agencies and civil society including national and international non-governmental organisations.

ACHIEVEMENT OF MDGS THROUGH CBR

The CBR Guidelines show how CBR activities have attempted to address different MDG goals over the last two decades. A few examples from various sources are cited here.

Poverty Reduction

With the understanding of the cycle of poverty and disability, the Joint Position Paper (2004) focussed attention on CBR as a strategy for poverty reduction. CBR programmes have since been building capacity of persons with disabilities and their families through skills training, promoting livelihoods opportunities in formal and informal economies, providing access to credit through self-help groups, changing attitudes of potential employers, and advocating for inclusion of persons with disabilities in poverty reduction programmes of government and mainstream development agencies.

An ILO publication (2008) provides examples of good practices on CBR and employment, together with practical suggestions for skills development, self-employment, and access to the job market.



In Malawi, one of the key objectives of priority policy area 7 (Economic Empowerment) of the National Policy on Equalisation of Opportunities for Persons with Disabilities is to improve access by men and women with disabilities to loans and credit opportunities. To this end, the Government of Malawi 's CBR programme supported by NAD, is promoting implementation of enabling and inclusive mechanisms within small and medium enterprises to ensure that persons with disabilities can access business loans. The loans are granted to groups (organised into clubs) that comprise persons with disabilities and others from the community. One of the key actions towards this end has been inclusion of a representative with disability on the committee responsible for implementation of the government's newly established Malawi Rural Development Fund. Through the Fund, low interest loans are made available to the rural poor. The role of the representative of persons with disabilities is to link up with CBR so that an increasing number of eligible persons with disabilities are identified to access loans. The representative also works with CBR programmes to ensure that potential loan beneficiaries are trained in basic business management skills. When necessary, he/she liaises with CBR and the Fund on rescheduling of repayments. Available statistics indicate that a total of 490 persons with disabilities in 75 groups from 18 of the 28 districts have accessed loans from the Fund, amounting to the equivalent to US$85 000. Most of the individuals are running profitable business ventures with considerable positive impact on their lives and the lives of their families.

Source: IDDC. Community-Based Rehabilitation and the Convention on the Rights of Persons with Disabilities. Brussels, 2012, page 12.



The "survival yard" programme is a result of collaboration between the "Projet de Réadaptation à Base Communautaire des Aveugles et Autres Handicapés" du Niger, CBM and the local community. The project began in response to the famine in the region and provides food security for persons with disabilities and their extended family throughout the year. Persons with disabilities and their families develop 25 by 25 meter survival yards with a well and simple watering canal. A border of bushy trees creates a microclimate that protects the garden from the harsh winds off the Sahara. The garden provides vegetables and fruit to eat and sell, fodder for livestock, and firewood and continue to flourish even in the hot season. Alongside, a package of services is provided to the persons with disabilities and their families, including education on disability inclusion, health and nutrition, water, sanitation and hygiene; access to immunization, improved pre and post natal care, schooling, rehabilitation services; construction of latrines and wood efficient stoves; creating access to markets; loans of donkey carts and animals for income generation. The outcomes reported by people include greater access to food, improved income, improved hygiene and improved attitudes towards persons with disabilities on the part of the community.

Source: IDDC. Community-Based Rehabilitation and the Convention on the Rights of Persons with Disabilities. Brussels, 2012, page 12-13.



In Heilongjiang Province of China, the China Disabled Persons' Federation (CDPF) successfully lobbied the provincial government to issue policies that require the inclusion of persons with disabilities in mainstream training centres and programmes. As a result, a major agricultural training initiative called the Green Certificate provides training and business development services for thousands of persons with disabilities. With credit provided from the rehabilitation fund (based on China's quota system), thousands of persons with disabilities have started their own businesses.

Source: CBR Guidelines, Livelihoods Component, Page 34



Chetanalya, a nongovernmental organization (NGO) working in six slum areas of Delhi, India, encourages poor people, including persons with disabilities, to set up self-help groups. The scale and amount of capital generated through the self-help group system has made substantial differences to the lives of many poor people. Chetanalya has 578 self-help groups in all six areas of its programme and their savings are substantial. Savings from a typical group over one year were used to pay for house improvement, debts, utility bills, education, travelling, marriage, business, vehicle repairs, medical expenses, funeral expenses, buying a rickshaw, festival expenses, opening a petty shop, opening a bank account, gas cylinders, school books and buying a TV.

In this programme, persons with disabilities and mothers of children with disabilities are integrated into the mainstream self-help groups and do not form self-help groups of their own. The proportion is about 6% members with disabilities.

Source: CBR Guidelines, Livelihoods Component, page 53

Education

Educational activities for children with disabilities have been part of CBR from the time of starting programmes. CBR activities that support inclusive education include referring children with disabilities to schools, advocating with school authorities to accept children with disabilities, assisting teachers to support children with disabilities, carrying out teacher training programmes, making schools accessible, providing assistive devices, teaching and learning materials, and creating links between the schools, families and communities.

In some countries, CBR programmes have been supporting home-based education for children who cannot attend school, and have helped in setting up community based day care centres for children with disabilities in partnership with families and local governments.



In Hambantota province in Sri Lanka, a number of preschool children with learning disabilities were identified. During the process of mapping the available services within the district, an international nongovernmental organization implementing preschool programmes was identified. The nongovernmental organization showed interest in including children with disabilities in its preschools, but said its teachers were not skilled to do this. The CBR programme identified resources within Sri Lanka for providing training on inclusive education and sponsored preschool teachers from the nongovernmental organization to attend. After the training, the teachers and CBR staff met with the parents and children, and together they developed a plan for inclusion. Much effort was made to ensure parents were part of the inclusion process, giving them responsibilities to make it a success. Children already attending the preschools and their parents were also made aware of disability issues and were involved in the inclusion process.

Source: CBR Guidelines, Education Component, page 24



When students with disabilities start at the Nepalese secondary school, they are first placed in a resource class. Here they receive training in mobility, and in the social and basic educational skills required to attend regular classes. They normally stay in this class for one year, depending on their speed of learning, after which they join their peers in mainstream classes with regular teachers. A specially trained teacher continues to help the students with disabilities to obtain the correct books, including translation into Braille, and, if applicable, logistical support, and assists in coaching them in their formal education. These teachers also coordinate with the regular classroom teachers to solve any problems faced by the students with disabilities.

Source: CBR Guidelines, Education Component, page 53

Health Care

The World Report on Disability (2011), in Chapter 3 on General Health Care, recognises the role of CBR in promoting and facilitating access to health care services for persons with disabilities and their families in low-income and lower middle-income countries.

In Chapter 4 on Rehabilitation, the Report recommends that in low-resource, capacity-constrained settings, efforts should focus on accelerating the supply of services in communities through CBR, complemented with referral to secondary services. The chapter cites examples of measures in CBR such as identification, referrals and follow up at community level, providing simple rehabilitation therapy at community level, providing individual or group-based educational, psychological, and emotional support services for persons with disabilities and their families and involving the community.

Apart from providing access to health care and rehabilitation services, CBR programmes are active in health promotion, including raising awarenss about HIV/AIDS, malaria and other diseases (MDG 6), and improving the quality of environments that can lead to disabilities (MDG 7).



Community Activities



In Chamarajnagar, one of the poorest districts of Karnataka, India, the quality of life is very poor, particularly for persons with disabilities. While Mobility India (MI), a nongovernmental organization, were carrying out a CBR project with the support of Disability and Development Partners UK, they discovered that many community members did not have access to basic sanitation facilities. Most people travelled far from their houses to use open fields. This was very difficult for persons with disabilities, and more so for women with disabilities. The Indian Government offered grants to families to construct toilets and MI assisted persons with disabilities and their families in Chamarajnagar to construct accessible toilets. Using existing community-based networks and self-help groups (SHG) to assist with this new project, MI organized street plays and wall paintings to raise awareness about hygiene and the role proper sanitation plays in preventing health problems. As people became interested and motivated, MI agreed to work with them to facilitate access to basic sanitation. The total cost to construct one toilet was an estimated US$ 150. While the Indian Government offered a grant to each family, funding the remaining amount was difficult for most people, particularly persons with disabilities. With financial support from MIBLOU, Switzerland and local contributions, MI was able to construct 50 good quality accessible toilets. SHG members were asked to select poor households with family members with disabilities who had the greatest need for a toilet. They also coordinated the construction work in partnership with families and ensured proper use of funds.

Many persons with disabilities no longer need to crawl or be carried long distances for their toileting needs. They have become independent and, importantly, have been able to reclaim their dignity. Their risk of developing health conditions associated with poor sanitation has also significantly reduced. Seeing the success of the MI project, the Indian Government has since increased the amount of the grant and directed local authorities to release these funds immediately. Persons with and without disabilities are benefiting from this project and it is gradually being scaled up to become a district-level project. Chamarajnagar will soon become a district where people have toilets in their houses, or at least near to their homes.

Source: CBR Guidelines, Health component page 22



Clubfoot or congenital foot deformities are birth defects that often lead to disability in low income countries. The Community Agency for Rehabilitation and Education of Persons with Disabilities, Belize (CARE-Belize), recognized that it was a significant issue for children in Belize. In partnership with the International Hospital for Children and the Ministry of Health, CARE-Belize developed a programme to ensure the early identification and treatment of children with clubfoot.

Local doctors, therapists and rehabilitation field officers were trained to embrace the Ponseti method, a nonsurgical method to correct clubfoot deformities at a very early age using gentle manipulation, serial casting and splinting. Through its CBR personnel, CARE-Belize identified children at a very early age and referred them to medical care services for correction of clubfoot. Although this was originally a local nongovernmental organization initiative, its success has led to the development of a national clubfoot programme.

Source: CBR Guidelines, Health component, Page 42

A CBR programme in South Sulawesi, Indonesia, has a multi-sectoral team including village health workers, primary-school teachers and community volunteers, many of whom have disabilities or are family members of a person with a disability. The CBR team has regular training sessions with personnel from all levels of the health system. These training sessions provide great opportunities for networking, promotion of the medical care needs of persons with disabilities and promotion of the role of CBR and medical care services.

Source: CBR Guidelines, Health component, Page 44

Gender Disparity

According to Akram et al (2010), "the goals of CBR cannot be achieved if some people are excluded, including and especially women with disability. While these programmes do not intend to exclude anyone, the reality is that exclusion happens not primarily as a result of prejudice but as a result of ignorance of the reality faced by certain groups of people, especially women with disability."

These authors state that neglect, lack of medical care and less access to food or related resources have resulted in a higher mortality rate for girls with disability, and cite a UNICEF study in Nepal that found that the survival rate for boys several years after they had polio is twice that for girls, despite the fact that polio itself affects equal numbers of males and females.

The authors suggest that for CBR programmes, "Perhaps most important of all, through peer-counseling, women peer-counselors with disability can support their peers to deal with issues by sharing their own experiences, and boosting their confidence to believe that every person has the capacity to live independently. Since peer-counselors are persons with disability who have similar experiences and face similar challenges, it is of great significance. Peer counseling provides a role model, who can serve as a link between the person seeking help and the service provider; and provides access to a wide range of unique experiences which cannot be observed by anyone else."



CBR programmes have made efforts to address needs of women with disabilities, for example, training women workers, including orthotic technicians, advocating with mainstream women's groups to include women with disabilities, imparting leadership skills to women with disabilities and ensuring inclusion of girls and women with disabilities in all CBR activities.

Several CBR programmes in Bangalore, India, identified a group of 10 young women with disabilities. All of these women faced disadvantages and discrimination because they were poor, uneducated, female and disabled – they were all seen as liabilities within their families and communities. In 1998 the 10 women trained as orthopaedic technicians and were provided with a loan from one of the CBR programmes to open a commercial workshop. Life has changed for the women since they started their business (Rehabilitation Aids Workshop by Women with Disabilities). The workshop started making a profit from the second year and by the end of the fourth year they had repaid the whole loan. They extended their business by becoming agents for several major companies that manufactured assistive devices and healthcare products and by establishing links with major private hospitals in the city. The women are now earning good incomes have good quality of life and are seen as active contributors to their communities. They are married, are assets to their families and are role models for many persons with disabilities.

Source: CBR Guidelines, Health component, page 68

Early Identification to Prevent Childhood Mortality

Early identification and intervention is another area that CBR programmes have addressed right from the time they were started in different countries. CBR workers assist in early detection and referrals, raise awareness in families and communities about disease and disability, health promotion and prevention of causes of impairments.

In Vietnam, CBR activities of early identification and referral are integrated into the existing primary health care structure and systems in one province, by building capacity of the health care personnel.



In Western Equatorial Region of South Sudan there is a high prevalence of epilepsy and a disease related to epilepsy called 'nodding disease'. Children with this disease have epilepsy associated attacks which causes a deterioration of their mental capacities and leads if untreated to death. The supply of epilepsy medication was often interrupted causing further deterioration of the children and loss of trust in the medical system. In the context of its CBR project, a local NGO, SEM collaborated with the local hospital to set up an epilepsy clinic where children would be better monitored and epilepsy medication would be available on a regular basis. An association of parents of children with nodding disease and epilepsy was formed to lobby for the proper care and rights of their children. South Sudan being a new and developing nation the regular supply of medicine has again been interrupted, and the struggle to get systems functioning again is to be resumed.

Source: IDDC. Community-Based Rehabilitation and the Convention on the Rights of Persons with Disabilities. Brussels, 2012, page 11.

Global Partnerships

The development of the CBR Guidelines is an example of global partnership between UN agencies, governments, donor agencies and civil society organizations including DPOs and other national and international non-governmental organisations.

The establishment of regional and global CBR Networks is another example of partnerships to promote inclusive development through CBR.



CBR Regional and International Congress and Meetings

RELEVANCE OF CBR AND INCLUSIVE DEVELOPMENT IN POST-2015 DEVELOPMENT AGENDA

"If inequalities continue to widen, development may not be sustainable, that is why equity is emerging as a central plank in discussions on the post-2015 development agenda." Ban Ki-moon, UN Secretary-General.

Discussion on the post 2015 agenda emphasises the importance of a human rights-based approach and stresses the importance of equality with renewed focus on the most vulnerable, the poorest and the marginalized.

There are some compelling reasons why CBR will continue to be relevant in the post 2015 agenda, in addressing inclusion of persons with disabilities.

CBR has grown and evolved into an internationally recognized strategy for rights-based, inclusive development for persons with disabilities, especially those from resource-poor settings. The World Report on Disability (2011) acknowledges that CBR pro¬grammes have been effective in delivering services to very poor and underserved areas. Evaluation studies from different parts of the world have documented the role of CBR in transforming lives of persons with disabilities. The CBR Guidelines summarises some outcomes of CBR, based on published reviews. These include: increased independence, enhanced mobility, and greater communication skills for persons with disabilities; increased income for persons with disabilities and their families; increased self-esteem and greater social inclusion.

Specific reference to CBR is found in national level policies of many countries in Asia and Africa. CBR practices are prevalent in many middle and low income countries today.There are indications of a recognition of the importance of rights based approaches to disability issues: many governments in low and middle income

countries have started mentioning the need for a paradigm shift from charity based approaches to a rights based approach in their policy documents. Countries with active civil society including DPOs that work in collaboration with governments have moved further ahead in this regard. These are positive developments, indicative of the will (in political and civil society sectors) to move towards a rights based approach (WHO, 2012).

Despite the progress, much remains to be done. The World Report on Disability (2011) has highlighted the fact that persons with disabilities lag behind in education and employment, have less access to health care, tend to be isolated from social, cultural and political participation, and families with a member with disabilities experience higher rates of poverty.

Another publication from the World Bank (Mitra, Poserac, Vick, 2011) provides a description of economic and poverty situation of working-age persons with disabilities and their households in 15 developing countries. The results reported are similar: persons with disabilities in a majority of developing countries show lower educational and employment rates, and are more likely to experience multiple deprivations due to poverty than those living without disabilities. The paper suggests that policies that promote access to education, health care and employment are of importance for the well-being of persons and households with disabilities.

An earlier World Bank Report (2009) on persons with disabilities in India sums it up aptly: "The slow progress in expanding opportunities for persons with disabilities in India results in substantial losses to persons with disabilities themselves, and to society and the economy at large in terms of under-developed human capital, loss of output from productive persons with disabilities, and impacts on households and communities." This report, while commending progress made, comments that policy commitments remain unfulfilled in a number of areas, and that persons with disabilities "remain largely outside the policy and implementation framework....." The situation is likely to be similar in many other developing countries.

Another recent study (WHO, 2012) has shown that the majority of persons with disabilities continue to live in poverty, in remote areas that have limited coverage of health and rehabilitation services. Poverty and the resultant poor health care, lack of access to health care, lack of awareness, poor hygiene and sanitation, and communicable diseases, continue to be the largest contributors to the causation of impairment and disability in these countries.

Many of these gaps have been appropriately addressed through CBR activities and can continue to be addressed in the future, provided governments and other key stakeholders commit to CBR promotion, especially in resource-poor countries.



Persons with disabilities in South Asia

CHALLENGES FOR CBR IN POST-2015 DEVELOPMENT AGENDA

CBR will need to pay more attention to some of the emerging challenges, listed by Yuenwah (2012) as relevant to the Asia-Pacific region, but which are common to other regions as well. These are: rapid urbanisation, increased incidence of non-communicable diseases, disasters and climate change, demographic transitions leading to increasing numbers of elderly persons, and economic challenges that can have an impact on poverty, food security and sustainability of development initiatives.

CBR can play an effective role in some of these critical areas in the future.

Urban poverty

The 2012 MDG Report estimates that about 863 million people now live in slum conditions in the world. According to some UN projections about the Asian and Pacific region, urbanisation will continue in the region, and a majority of the region's population will live in urban areas by 2025. "Urban" does not refer to only the mega-cities but to smaller cities and towns too. Rapid urbanisation and the consequent growth of urban poor communities are issues for concern and call for increasing attention to the inclusion of urban poverty in development agenda, including CBR programmes.

Over the last two decades, CBR programmes have been implemented in urban slums in different regions of the world. They have shown that CBR strategies and activities that are successful in rural areas cannot easily be replicated in urban poor communities.

Poverty and its associated problems are different for persons with disabilities in rural and urban areas. Availability of information, services and opportunities for persons with disabilities from poor communities may be higher in urban areas in terms of education, health care and livelihoods, but accessibility to these is low because

of poverty, higher costs of services, and the often extra-legal living and working status of these communities that excludes them from public services. Hunger in urban areas is a growing problem as most urban poor have to buy, not grow, their food. Given rising prices and low and often insecure incomes, ensuring food security for urban poor households living in informal settlements and working in the informal economy is a huge challenge. Because of poor working and living conditions, urban poor communities face many health problems.

Community mobilisation and organisation, a key pillar of CBR programmes, is relatively difficult to manage in urban poor communities that are diverse in nature, and where all adult family members are employed mainly in the unorganised sector. Past evaluations have shown that the 'community' in urban CBR programmes, comprises mainly mothers or other female care-givers, who tend to be passive recipients of services rather than 'partners'. The early experiences of CBR in urban slums point out the importance of enabling access to existing services and opportunities through information and advocacy, and promoting skills training and livelihoods for persons with disabilities and their families.

While the problem of rural poverty persists, as shown in the 2012 MDG Report, there are increasing calls for governments and civil society to develop appropriate strategies to address concerns of the urban poor. Policy makers, planners and implementing agencies in the disability sector, who had hitherto focussed on persons with disabilities living in rural areas, will now need to plan for appropriate CBR strategies for those living in slum conditions in urban poor communities. As the Incheon Strategy puts it, "Lifting persons with disabilities and their families out of poverty would contribute to the achievement of inclusive growth and sustainable development".

The Ageing Population

Thirty years ago when CBR programmes were started in low and middle income countries, they generally tended to focus on working with children and young adults with disabilities, because the incidence of impairments and disabilities was higher in this age group due to preventable causes such as infectious or communicable diseases. Lower life expectancy in many of these countries in the early years of CBR meant that there were fewer elderly persons in many families. As a result, older persons who acquired disabilities, or others who had age-related sensory or mobility difficulties, were not assisted much, beyond facilitating access to social security schemes. Older people in traditional rural communities who had age-related disabilities such as cataract for example, were not considered 'disabled', because their difficulties were seen as part of the normal ageing process.

Over the last few years, there has been increasing discussion about demographic and epidemiological transitions resulting in more elderly persons with disabilities in the community whose needs will have to be addressed. On the one hand, better health care access has led to increased longevity for many persons with disabilities; and on the other, longevity in persons without disabilities has led to higher incidence of age-related and other disabilities in the elderly population. According to recent UNESCAP reports, about 5 to 10 per cent of those aged over 65 show signs of Alzheimer's disease in the Asia-Pacific region and an estimated 33 million people will be living with dementia in this region by 2030.

As people age, they become more vulnerable and there is increased likelihood of their acquiring some physical or mental health condition leading to disabilities. In many low and middle income countries, there has been an increase in non-communicable and life-style related health conditions such as heart disease, stroke, cancer, diabetes, respiratory diseases, musculo-skeletal diseases, hearing or visual impairments, dementia or psychiatric illness,

which can result in disabilities in a significant proportion of the adult population. In some countries, older persons constitute a disproportionately large group among populations of persons with disabilities.

Older persons with disabilities have needs related to rehabilitation, for example, mobility, communication, daily living skills, assistive devices, home adaptation and living arrangements, and a variety of other support services. Needs for inclusion and social participation of older persons with disabilities, will also have to be addressed, to ensure better quality of life. All the challenges faced by persons with disabilities in low and middle income countries – barriers in access to services; low availability and affordability of need-based services, especially in rural communities; and lesser numbers of trained personnel - will be challenges for ageing persons with disabilities as well. The challenges are compounded by the fact that changes in traditional family structures have resulted in lower availability of care-givers and support systems in the community. In some low and middle income countries, population trends showing an increasingly ageing population has led to a situation where the younger people have to care for a disproportionately larger number of elderly persons in their families.

Addressing needs of elderly persons with disabilities, especially the varied health care and rehabilitation needs, can be cost-intensive. It is in this context that CBR programmes in low and middle income countries may be viewed as a possible cost-effective response to address the needs of older persons with disabilities in the community, since such programmes have many years of experience in working with families and communities in promoting inclusion and participation of children and younger adults with disabilities. In some countries, CBR programmes have already moved in this direction, for example, including elderly stroke survivors in home based rehabilitation activities, providing family education and counselling, and access to income generation.

CBR programmes will have to prepare themselves to meet the emerging challenge of the rapidly growing older age groups of persons with disabilities. Key stakeholders such as policy makers in government and international donor agencies that support CBR will need to re-orient their policies and perspectives to meet these emerging challenges, and to enable CBR programmes to work towards improving quality of life of the ageing population with disabilities in their communities.

Health care

Addressing inequities in health and rehabilitation access for persons with disabilities that has been repeatedly stressed as a gap in developing countries will need special attention from CBR. Declaring that "Disability is an important public health and development issue", a report of the Technical Briefing on Preparing for the General Assembly High-Level Meeting on Disability and Development: The Health Sector's Contribution from the 66th World Health Assembly, 23rd May 2013, states that

- "Persons with disabilities, who make up 15% of the population, face widespread barriers in accessing health services and therefore experience greater unmet health care needs, worse health outcomes, and higher rates of poverty than persons without disabilities.
- The disadvantage in relation to poorer health experienced by persons with disabilities has wider impacts on families, communities, and health systems.
- Improved access to health for persons with disabilities is not only a human right but also a critical enabling factor to achieving aspirations including education, employment, caring for and participating in family, community and public life.
- Good health will lead to better overall socio-economic outcomes for persons with disabilities and achievement of broader global development goals."

Sustainability

Globally, the economic downturn in most parts of the world is a matter of concern, and will continue to be so for some years. This has particular implications for the disability and development sector in developing countries, as fund allocations from some donor countries are being drastically reduced and may even stop in the coming years. Sustainability of programmes in disability and development in developing countries, including CBR, that have been largely dependent on external funding, assumes a special significance at this point in time. Case studies of how CBR programmes are sustaining themselves through successful self-help groups and local resource mobilisation; have been published and presented at various forums.

Local fund-raising within developing countries to facilitate sustainability has been tried by implementers in the disability and development sector for many years now. Although successful case studies for large scale local resource mobilisation are few, they do give some pointers for the way forward. Broad basing the sources of funding; involvement of the corporate sector in development; capitalising on the potential of the growing middle classes in many emerging economies to 'give'; use of retired volunteers; and formation of local NGO consortia in some countries to do joint fund-raising, are some examples. However, such attempts have had only limited success, especially in view of the current economic crisis in many countries.

A key principle for sustainability is to have the local government take over and sustain the programmes that are initiated with external support. It is important for external donor agencies to fit their own plans and ideas into the local governments' plans and budgets. In some countries, there are some good examples of more realistic planning in this context, such as partnerships with local governments to initiate innovative models of service delivery, with external agencies providing mainly technical and capacity building support. This way, the activities are more relevant and feasible, and the responsibility of implementing and sustaining them lies with the governments.

Anecdotal evidence from the Asian region shows that there are some good practices in sustaining CBR. Self-help groups and associations of persons with disabilities, who are the primary stakeholders for CBR, can contribute to sustainability. Linking these groups with other successful community based organisations such as women's federations, can also be of help. Collaboration between local government, parents, and CBR staff has been reported to be successful in continuing some CBR activities; while including persons with disabilities into local level development councils can ensure that disability issues are included in development planning.

The gloomy global economic outlook does indeed present a major challenge for the disability sector, but it can also be an opportunity in terms of more realistic planning, and a renewed focus on self reliance for all stakeholders involved, especially persons with disabilities and their families on the one hand and local governments and service providers on the other.



Community for All

CONCLUSION

It is evident that CBR continues to be relevant and needed, not only in low and middle income countriesbut CBID is also need of developed countries. CBR can be an appropriate response and strategy to deal with some of the emerging needs and challenges in these countries in the post-2015 agenda. There are some favorable conditions for continued CBR promotion world-wide (Thomas, 2013). These include the support of international frameworks like CBR Guidelines, CRPD and regional frameworks like the third Asia-Pacific decade; the increasing interest and involvement of key stakeholders like governments and DPOs in CBR; the emphasis on networking and sharing through national, regional and global CBR networks; and the current focus on evaluation and evidence-based practice to build up the body of knowledge on CBR.



Exchange in a Community

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ABBREVIATIONS

APCD : Asia-Pacific Development Center on Disability
CBR : Community-Based Rehabilitation
CBID : Community-Based Inclusive Development
CDPF : China Disabled Persons' Federation
CRPD : Convention on the Rights of Persons with Disabilities
DFID : Department for International Development
DESA : Department of Economic and Social Affairs
DPO : Disabled People's Organisation
ESCAP : Economic and Social Commission for Asia and the Pacific
IDA : International Disability Alliance
ILO : International Labour Organisation
MDGs : Millennium Development Goals
MI : Mobility India
NGO : Non-governmental organisation
UN : United Nations
UNESCO: United Nations Educational, Scientific and Cultural Organisation
WHO : World Health Organisation





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