World Health Organization
Regional Office for South-East Asia

Compilation of community-based rehabilitation practices in the WHO South-East Asia Region

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Contents

List of acronyms

AIDS	Acquired immuno-deficiency syndrome
APCD	Asia-Pacific Development Centre on Disability (Thailand)
BHS	basic health staff (Myanmar)
BDT	Bangladeshi Taka
CAHD	Community Approaches to Handicap in Development (CDD, Bangladesh)
CBR	community-based rehabilitation
CBR-AP	Community-based rehabilitation Asia-Pacific
CBR-MIS	Community-based rehabilitation management information system (Sri Lanka)
CDD	Centre for Disability and Development (Bangladesh)
CRPD	Convention on Rights of Persons with Disabilities
DS	Divisional Secretariat (Sri Lanka)
DPO	Disabled Persons' Organization
ENT	ear, nose and throat
ESCAP	Economic and Social Commission for Asia and the Pacific
IDPP	Institute on Disability and Public Policy (Thailand)
IEC	information, education and communication
ILO	International Labour Organization
JICA	Japan International Cooperation Agency
KM	knowledge management
LCECU	low-cost effective care unit (India)
LS	local supervisor
MLRW	middle-level rehabilitation workers (Myanmar)
NRCAT	National Resource Centre on Assistive Technology (Bangladesh)
NGO	Nongovernmental organization

RCRD	Resource Centre for Rehabilitation and Development (Nepal)
RUCODE	rural community development (India)
PHBC	Population and Housing Census of Bhutan
PHC	primary health care
PMR	physical medicine and rehabilitation
SADF	South-Asian Disability Forum
SbKM	story-based knowledge management (APCD, Thailand)
SEA	South-East Asia
UNESCO	United Nations Educational, Scientific and Cultural Organization
VDC	Village Development Council (Nepal)
VDRC	Village Disability Rehabilitation Committee
VHW	voluntary health workers (Myanmar)
WHO	World Health Organization

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Introduction

More than 1 billion people around the world live with disabilities; and 80% of them are from low-income countries, many from the WHO South-East Asia Region. Discriminatory practices and attitudes towards persons with disabilities have prevailed for centuries and resulted in their exclusion from mainstream developmental efforts. The number of persons with disabilities is increasing: war injuries, landmines, HIV/AIDS, malnutrition, chronic diseases, substance abuse, accidents, environmental damage, population growth, exposure to hazards, medical advances that preserve and prolong life including neonatal interventions for high-risk babies – all contribute to this increase. As a consequence, there is an overwhelming demand for health and rehabilitation services.

The 1978 “Health for All” Alma Ata Declaration promoted health as a human right and prioritized primary health care and community-based approaches. Following the Alma Ata principle, WHO initiated community-based rehabilitation (CBR) to give people with disabilities access to rehabilitation in their own communities using mostly local resources. In 2004 the International Labour Organization (ILO), United Nations Educational and Scientific Organization (UNESCO) and WHO Joint Position Paper repositioned CBR as a strategy for rehabilitation, equalization of opportunity, poverty reduction and social inclusion of people with disabilities.

The World Health Assembly Resolution WHA58.23 (May 2005) on “Disability, including prevention, management and rehabilitation” called on Member States and the WHO Director-General to increase action in these areas. Particular reference was made to the need “to promote and strengthen community-based rehabilitation programmes linked to primary health care and integrated into the health system”.

In 2008, WHO celebrated its 60th anniversary and the 30th anniversary of the declaration of Alma-Alta, and with it, the revitalization of primary health care. The Regional Director, Dr Samlee Plianbangchang, in his speech on the release of the World Health Report on 22 October 2008 stated that "Health for all is not a health call, it is a social call", and that "primary health care must be a development-oriented approach through education and empowerment process of the community and the population as a whole". These equally apply to community-based rehabilitation.

The year 2008 was a watershed year for persons with disabilities world-wide because the most important, comprehensive and enabling tool for the empowerment of persons with disabilities came into force – The UN Convention on Rights of Persons with Disabilities (CRPD).

The UNCRPD breaks the stereotypes of helplessness of people with disabilities and calls attention to their contributions. It reflects the paradigm shift from a charity and welfare approach to empowerment development and inclusion.

The Right to Health (Article 25) in the UNCRPD, elaborates on the need to ensure the highest attainable standards of health for persons with disabilities through the following elements:

- Fulfil: State parties must ensure the same range, quality and standards for free, affordable health care on an equal basis with others.
- Respect: prevent discrimination on grounds of disability, promote ethical standards of practice by health workers, and provide care on the basis of free and informed consent.
- Protect: The government must ensure that health service providers do not discriminate against or withhold health care or health insurance from someone on the basis of disability and provide gender-sensitive services.

Article 26 states: "Support participation and inclusion in the community so that all aspects of society are available to persons with disabilities as close as possible to their communities, including in rural areas". Article 19 refers to "the equal right of all persons with disabilities to live in the community, with choices equal to others".

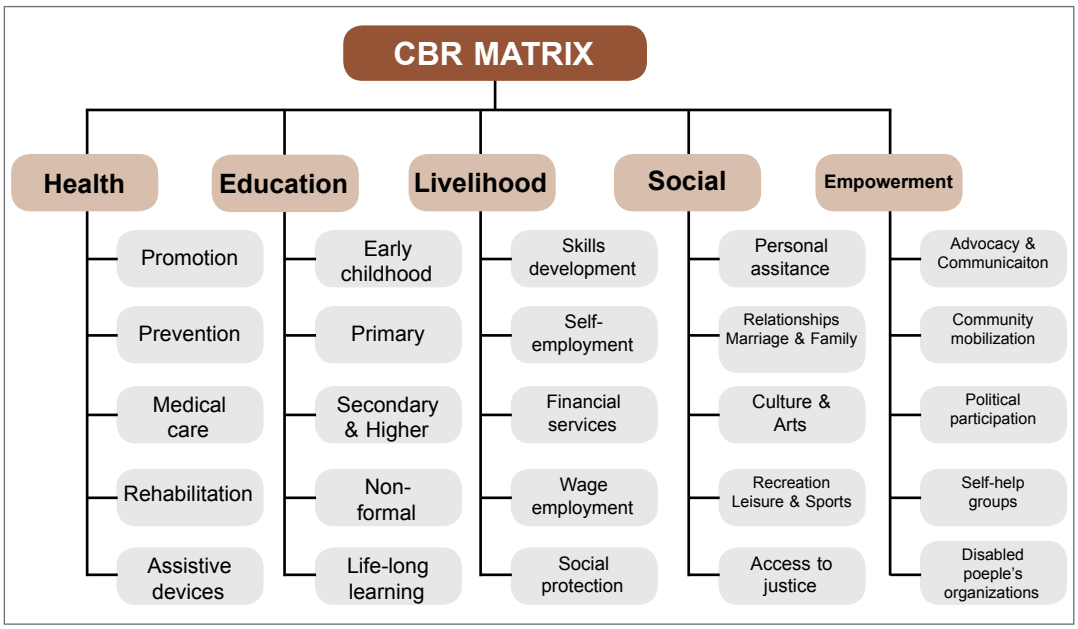
Both the UNCRPD and CBR are about participation and inclusion: inclusive health care, inclusive work places, inclusive communities and society; about access; about parity not speciality; and above all, about *rights.*

WHO is committed to raising the profile of disability, and focusing its contribution on those areas where it can make the greatest difference, namely, in strengthening community-based rehabilitation and medical rehabilitation, and their links with primary health care, improving data collection, and supporting policy development in accordance with the principles of the Convention.

WHO in partnership with ILO, UNESCO and IDDC, facilitated the development of CBR Guidelines (2010) to provide clear direction on how community-based development initiatives can work to ensure the rights of persons with disabilities, promote respect for their inherent dignity, and aim for an inclusive society, in accordance with the UN Convention. The CBR Matrix (Figure 1) captures the essence of a comprehensive CBR programme.

The similarities between UNCRPD, primary health care and CBR are obvious – all three are timeless concepts, philosophies, both in letter and in spirit**.**

Figure 1: CBR Matrix



Community-based rehabilitation

CBR is “a strategy that can address the needs of people with disabilities within their communities in all countries. This strategy promotes community leadership and the full participation of people with disabilities and their organizations. It promotes multisectoral collaboration to support community needs and activities, and collaboration between all groups that can contribute to meeting its goals” (2004: ILO, UNESCO, WHO). CBR cannot be delivered by one ministry or even one sector. People with disabilities and their families, organizations and communities must be central to the implementation of CBR along with the relevant governmental and nongovernmental health, education ,vocational ,social and other services. CBR makes a difference at the grassroots level, through individual empowerment, group empowerment and community change, which together contribute to meeting basic needs, reducing poverty, and creating access to health, education and livelihood.

Disability is no longer viewed as merely the result of impairment. The social model of disability has increased awareness that environmental barriers to participation can be major causes of disability.

Rehabilitation is now viewed as a process in which people with disabilities or their advocates make decisions about what services they need in order to enhance their participation in all aspects of their daily lives. The role of professionals is to provide relevant information so that people with disabilities can make informed choices and decisions.

CBR promotes the enjoyment of human rights and fundamental freedom of people with disabilities to live as equal citizens within their own communities, with equal opportunities for full participation in all dimensions of community life.

The growth of CBR in different regions of the world is evident from a WHO survey conducted in 2007: 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).

The Asian region, along with Africa, has been witness to the initiation, growth, changes and maturing of CBR over the past three decades. The first Asia-Pacific CBR Congress in 2009, and the subsequent formation of the

Asia-Pacific CBR Network, consolidated and strengthened the movement to a participatory, empowerment and rights-based model of rehabilitation. The regional CBR networks in Africa, Asia and Latin America will sustain the movement through training and information exchange.

CBR has evolved, from being a service delivery approach for persons with disabilities living in rural areas in developing countries, to a worldwide strategy and movement, based on inclusive community development principles. Most of the debates that raged over the past decade, over “medical vs social”, “rights vs services”, ‘Disabled People’s Organizations (DPOs) have CBR” have subsided. A better understanding among different stakeholders resulted in the development of the WHO CBR Guidelines in partnership between different interest groups.

Compilation of CBR Practices in the Region

There have been increasing calls for more evidence-based practices in CBR. This compilation of CBR Practices: s is an effort in that direction, describing examples of CBR work within the SEA Region. Questionnaires were sent to ministries of health and to some civil society organizations from countries in the Region. The information presented is restricted to countries and organizations that sent their responses to the questionnaire.

The compilation includes CBR programmes implemented by governments, and CBR projects of nongovernmental organizations (NGOs), disabled persons’ organizations (DPO), and teaching institutions. It also includes examples of resource organizations in the SEA Region that promote CBR Practice through training and capacity-building, materials development and information exchange.

Section 1
CBR practices: Government

Examples of country programmes promoted by governments

Bhutan

Background

Bhutan has adopted primary health care as the foundation of the health-care delivery system in the country. During the eighth five-year Plan, prevention and rehabilitation services were developed as a result of consultations that aimed at including rehabilitation as the fourth major component of primary health care.

As per the Population and Housing census of Bhutan (PHBC), 2005, it was estimated that about 3.4% of the population of the country comprised persons with disabilities.

Management and organization

The community-based rehabilitation programme was initiated as a pilot programme using the infrastructure of the primary health care delivery system in Khaling, Trashigang district in 1997 by the Department of Public Health, Ministry of Health, coinciding with the launching of the Eighth Five-Year Plan. The WHO manual (1989) was used for training, and the initial technical and financial support came from WHO. The Danish International Development Agency (DANIDA) started supporting the CBR programme from 1999, and the programme was expanded to Mewang gewog in Thimphu district in 2000. Subsequently, CBR was initiated in the rest of districts by using the existing

health care infrastructure. The Secretary, Ministry of Health and the Director, Department of Public Health are responsible for planning, implementation, supervision, coordination and provision of CBR-related technical support to districts. The CBR programme covers all categories of impairment.

Objectives, strategies

The Ministry of Health promotes an integrated and comprehensive approach in addressing the main health problems in the country, in compliance with the guiding principles of equity, accessibility, affordability and community involvement. The ministry aims to integrate CBR activities into the existing PHC system.

Activities

Health

Health care and treatment services are provided free of cost in the country. A separate, fully functioning primary eye care programme is in place to provide services related to blindness, low vision and other eye diseases.

The CBR programme attempts to provide effective eye, nose and throat (ENT) care in referral hospitals, through specially developed trained manpower. It also helps in early identification of preventable ear diseases. And periodic ear camps are held in rural communities to provide services to the unreached population.

Rehabilitation services are provided at physiotherapy units in hospitals, for persons with amputation, spinal cord injuries, poliomyelitis, cerebrovascular accidents, cerebral palsy, and other musculoskeletal and neuromuscular disorders. Although services are available mostly in hospitals, with the introduction of the CBR programme, these services are also being provided in communities through health workers and physiotherapy technicians.

A mental health programme under the Department of Public Health provides treatment services for those with psychosocial disorders, and the CBR programme carries out rehabilitation interventions in the community for this group.

A leprosy control programme is in place for curative services, while rehabilitation is provided through the CBR programme. Prosthetic and orthotic appliances are provided for persons affected by leprosy.

In addition, the CBR programme covers persons with epilepsy, cleft palate, loss of sensation/ nerve damage and burns.

Education

Education needs for persons with different categories of impairment are being addressed to some extent. The Ministry of Education has established a special education unit to address the special needs of schoolgoing children with disabilities. At the capital city Thimphu, two schools have been identified as special education schools. At Paro district, the Drugyel Lower Secondary School is identified as the school for hearing-impaired children. The CBR programme, in collaboration with the education sector, is also focusing on inclusive education for children with disabilities in other districts.

Employment

Employment opportunities are being provided to persons with disabilities, but with the difficult geographical terrain and physical barriers, accessibility to training facilities is the major constraint faced, especially by persons with physical disabilities.

Accessibility

As indicated above, accessibility is a major problem faced by persons with disabilities. With scattered population and highly mountainous terrain, most facilities such as post offices, banks and recreational facilities, are not accessible.

Political participation

The Election Commission has made provision for persons with disabilities to participate in elections through electronic voting machines.

Participation in social and cultural activities:

Participation of persons with disabilities in social and cultural activities tends to be restricted due to poor accessibility and communication barriers. Negative attitudes are another challenge.

Funding and sustainability

Financial support to the programme is provided by the Royal Government of Bhutan and WHO. Under the decentralization policy of the government, all developmental activities and programmes to be implemented in communities are now decentralized. Funds from the central programme are released for implementation at districts by the district health officials.

Lessons learnt

There is a need to intensify advocacy for CBR at the community level. Education for children with disabilities needs to be promoted more rigorously. There is also a need to promote associations of persons with disabilities through the CBR programme.

Although primary health care workers are trained in different CBR activities, they are not able to pay full attention to CBR, as they hold primary responsibilities for other programmes. The lack of a functional medical rehabilitation centre is a constraint for rehabilitation and follow-up services for persons with disabilities in their communities. The mountainous geographical terrain with scattered population, traditional structure of houses, lack of trained personnel for CBR, are barriers to successful implementation of the CBR programme.

Innovative approaches

The CBR services are well integrated into the comprehensive primary health care delivery system, and persons with disabilities are able to access these services free of cost as per the government policy.

Myanmar

Background

Although national representative data about persons with disabilities are still not available, some data from earlier programmes show a 3–5% prevalence rate, which indicates that there may be between 1.5 and 2.5 million persons with disabilities in the country. The majority live in rural villages, with little or no access to rehabilitation services.

The Government of Myanmar has been providing rehabilitation services for persons with disabilities since 1959 through the National Rehabilitation Hospital in Yangon and Mandalay, and through physiotherapy units attached to general and specialist hospitals at the state and division levels. However, about 70% of the country's population reside in rural areas where rehabilitation services are virtually inaccessible. Therefore, community-based rehabilitation was considered as an option to address the needs of rural communities, in line with the global trends on appropriate rehabilitation methods for developing countries.

Management and organization

In Myanmar, the national policy to achieve the goal of accessibility to health-care services has encouraged the development of community-oriented health care, based on primary health care approaches. Accordingly, a CBR programme was formulated and is being implemented from 1982, with assistance from UNDP, as an experimental one to test the feasibility of the CBR methodology.

The CBR programme is managed by the Ministry of Health, working through the government hospitals.

Up till 2007, with the assistance of UNDP, Mission Administer Fund, Canadian Embassy, World Vision Myanmar and World Health Organization, Myanmar have covered a population of 1 002 341 from 733 villages and wards of 28 townships. The programme identified 15 821 persons with disabilities, comprising a little less than 2% of the population. An external evaluation conducted recently has recommended the expansion of the programme to cover the whole country in a phased manner.

The CBR programme covers all categories of impairment.

Objectives, strategies

The general objective of the programme is to develop community rehabilitation services as an integral part of the comprehensive primary health care delivery system.

The specific objectives are:

- To introduce CBR services (based on the WHO training manual) in villages.
- To carry out research into production of rehabilitation aids, using appropriate technology.
- To strengthen the existing tertiary referral service in rehabilitation.

The strategies include:

- Expansion of CBR services gradually, and strengthening the coverage of CBR.
- Capacity building through international and local training courses.
- Establishing cooperation with NGOs.
- Fulfilment of resource requirements in rehabilitation hospitals.
- Collection and dissemination of data on rehabilitation at the central level.

Activities

- Advocacy meeting for awareness-creation for selected township authorities, health personnel and NGOs.
- Refresher training for trained workers after a period of six months.
- Production and distribution of information, education and communication (IEC) materials to the community, especially to persons with disabilities.
- Capacity-building of personnel from rehabilitation institutions, especially occupational therapy training.

- Capacity-building of physiotherapy units of the National Rehabilitation Hospital.
- Capacity-building of the prosthetic/orthotic workshop of the National Rehabilitation Hospital.

Health

The institutional or tertiary rehabilitation services provide advanced technical, prosthetic and orthotic support up to the community level in some instances.

At the community level persons with disabilities are identified and provided with primary rehabilitation services and home care through trained volunteers under the supervision of middle level rehabilitation workers (usually a physiotherapist). The community-level workers are trained to manage, motivate and train family members, and to refer identified cases.

At the tertiary level, rehabilitation services are provided by a team of rehabilitation personnel including physiotherapists, occupational therapists, prosthetic/orthotic technicians, rehabilitation nurses and medical social workers.

The programme emphasizes the integration of CBR into primary health care delivery services, by involving the PHC personnel at all levels through a cascade model of training in CBR for the PHC personnel, under the guidance of the CBR project management team.

Others

The Ministry of Social Welfare, Relief and Resettlement takes the major responsibility for fulfilling the needs of persons with disabilities in the areas of special education, vocational and pre- vocational rehabilitation, apart from providing grants to NGOs serving people with disabilities.

Special schools for different categories of impairment are established by the Department of Social Welfare as well as NGOs interested in disability issues.

The Department of Social Welfare has established vocational training centres for people with disabilities. Trainees are referred from national

rehabilitation centres and CBR projects. The centres encourage trainees to set up their own business preferably in their own community. Supportive services such as counselling, placement, follow-up and financial assistance are being carried out to a certain extent.

One of the activities of the Department of Social Welfare is to raise awareness directed at the general public by using the media, and by holding skill contests for people with various disabilities.

Funding and sustainability

International NGOs are the main source of financial support for the CBR programme. There is limited contribution from the community

Expected outcomes

The expected outcomes are:

- Health managers and representatives of selected NGOs will gain knowledge in CBR to facilitate participation of persons with disabilities, and to provide support in programme implementation, leading to early referral and prompt intervention.
- Addressing the needs of persons with disabilities (e.g. prosthesis, orthosis, vocational training) will ensure self-confidence and enhanced quality of life, enabling them to participate more in society.
- As the programme activities gain momentum, the service delivery of CBR is expected to be integrated into the existing community health programme of the country.

Lessons learnt

People with disabilities living in rural areas are outside the mainstream development mainly due to lack of awareness, negative attitudes among general population, scarcity of resources and lack of knowledge and skills on how to address the needs of people with disabilities within the development programmes. People with disabilities and their families lack knowledge and awareness about their rights and about rehabilitation services. Many family members are more interested in medical treatment such as drug therapy, in

the expectation that it will produce a cure, than in rehabilitation and therapy interventions.

Community workers cannot pay more attention to CBR activities as they are multi-purpose workers and have many priorities to address; there is limited supervision and support to these workers. The community-level personnel need more training.

The village leaders' interest in CBR intervention varies according to the economic situation – only those who are more affluent have some time and inclination to be involved.

Many employers are reluctant to employ people with disabilities, mostly due to ignorance about the potential of people with disabilities. In most places, the work environment is not accessible and employers lack interest to renovate or adapt the working environment for people with disabilities.

Multisectoral collaboration, especially with the education sector, is not yet fully achieved. Promotion of CBR activities with the involvement of the government and NGOs can be an effective approach for reaching out to people with disabilities in rural areas, raising awareness and advocacy for the inclusion of people with disabilities in the community, including social, cultural and religious activities.

Community rehabilitation services should be developed as an integral part of the comprehensive primary health care delivery system.

Close supervision and monitoring of voluntary health workers (VHWs) by basic health staff (BHS) and middle level rehabilitation workers (MLRW) should be emphasized.

Innovative approaches

The programme emphasizes integration of CBR into primary health care delivery services, by involving the PHC personnel at all levels through a cascade model of training in CBR.

Sri Lanka

Background

The Ministry of Social Service and Social Welfare (formerly the department of Social Services, established in 1948), Government of Sri Lanka, is the nodal agency for programmes for persons with disabilities. The Government has over the years, promoted policies and legislation, including Act 28 in 1996 for protection of the rights of persons with disabilities, the National Policy on Disability in 2003, and the Disabled Persons Accessibility Regulations in 2006. The community-based rehabilitation programme is a national programme under the Ministry of Social Service and Social welfare. CBR was first introduced in the state sector in 1981. Since 1994 the Ministry has supported the development of the national CBR programme together with other stakeholders like the Ministry of Health and Ministry of Education, Ministry of Vocational Training, and NGOs.

Management and organization

The Secretary, Ministry of Social Services and Social Welfare, and Director, National Secretariat for Persons with Disabilities, are the persons responsible for implementing the CBR programme.

The Ministry of Social Service and Social Welfare has a presidentially appointed committee called the National Council for Persons with Disabilities, which is a policy-level body supervising the National Secretariat for Persons with Disabilities. In addition there is also the National CBR Steering Committee.

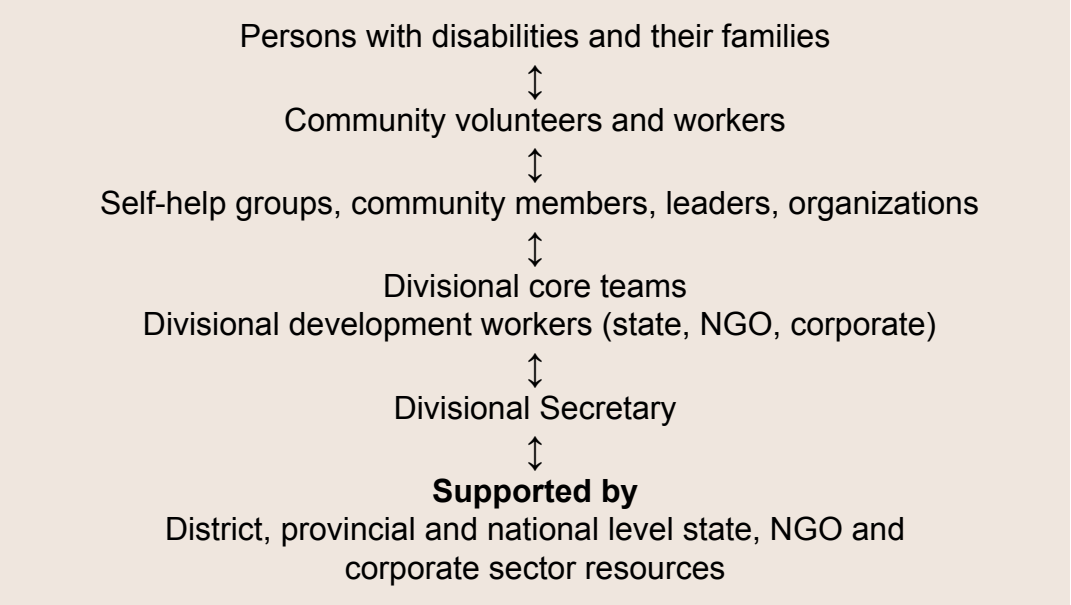
Sri Lanka has 9 provinces and 25 districts. In each district the Additional District Secretary acts as the District Coordinator for CBR. He is assisted by a senior social service officer acting in the capacity of CBR provincial assistant. Each district is divided into Divisional Secretariat (DS) divisions; each division has a Steering committee for CBR. The Divisional Secretary and the Social Service Officer are the Chairperson and Secretary respectively of the Steering Committee. Usually another Social Development Assistant or a related field officer is also part of this CBR core group.

Within the DS divisions are the lowest/community-level administration units that are equivalent to a village. At this level, there are Rural Rehabilitation Committees comprising the local social service official, religious leaders, other community leaders, a representative from the Ministry of Health, volunteers and other rural-level government officers. The volunteers are called "CBR community volunteers", and are mostly selected from the elders' committees set up in the area. They are trained to locate and identify persons with disabilities in their community, refer those identified to the nearest health facility, and carry out follow-up in the community.

A National Resource Group was appointed at the beginning of 2008, with the responsibility of revising the training courses, documents, booklets and handbooks to meet current needs.

The management of the CBR programme is illustrated in Figure 2.

Figure 2: Management of the community-based rehabilitation programme



A central-level resource team within the CBR programme assists in developing the CBR activities and in training personnel including volunteers. The team comprises physiotherapists, provincial assistants, medical officers and education officers. The WHO CBR Manual of 1989 has been updated and used as course material in training programmes.

Upto 2007, 106 900 persons with disabilities were identified through the National CBR Programme, of whom 58 902 persons have been supported in different ways. Of the country's 25 districts, 22 are covered by the CBR programme.

The CBR programme covers all categories of impairment.

Objectives, strategies

The aim of the CBR programme is to promote rehabilitation of persons with disabilities in order to enable them to enjoy their rights and to carry out their responsibilities; and to create opportunities through social development programmes to integrate them into society. The key objectives are:

- to promote early identification and early intervention;
- to educate parents to encourage home-based care rather than institution-based care;
- to improve the quality of life of persons with disabilities by promoting and protecting their rights;
- to empower persons with disabilities economically and socially, and to equip them with knowledge and skills;
- to meet the functional needs of persons with disabilities, including orientation, mobility, communication, self-care and household skills;
- to increase the participation and inclusion of persons with disabilities in mainstream development.

Activities

Health

The divisional Steering Committee includes a representative from the Ministry of Health. Through the CBR network, those who need medical assistance are referred to the Medical Officer. In addition financial assistance is given to persons with disabilities for medical services such as heart surgery, kidney implant, hip-bone surgery, knee cap surgery and medication.

Education

Through the CBR initiative, children with disabilities are identified and referred to special schools if available, or to regular schools. With the support of, and coordination with, the Ministry of Education, there is a provision for a special teacher to visit the child's home.

Employment

Community Social Service Officers from the Ministry of Social Services assist persons with disabilities in the community to seek employment. The Social Service Officer who is able to assist the most number of persons to gain employment gets recognized through an award at the national level, on an annual basis.

In addition the Ministry of Social Services and Social Welfare and the Provincial Council has a scheme to assist persons with disabilities to start self-employment schemes with a one-time payment of Rs 10 000.

Accessibility

This is one of the major areas addressed in the CBR programme. If there are accessibility issues related to public buildings, toilets or houses, a certain amount of funds (depending on the problem) is dispersed by the National Fund from the Ministry of Social Services and Social Welfare. Community contribution is expected in the form of voluntary labour. This increases community ownership and ensures sustainability.

Amendments to Disabled Persons (Accessibility) Regulations, No. 1 of 2006 are also under way.

Several awareness programmes are conducted on access to public buildings and places to create awareness among government institutions at district, provincial and divisional levels.

Social and cultural participation

All communities and ethnic groups are included in the national CBR programme. An annual event is organized on World Disability Day where persons with disabilities have the opportunity to display their talents in major

cities like Colombo, Kalutara and Kandy. The rural disability committees include persons with disabilities. In addition the committees have self-help groups of community members who provide assistance when needed.

New programmes for women and children with disabilities

The Disabled Women's Association, which was started in 1989 in Sri Lanka, works with women with disabilities to improve their skills and to realize their rights. The association is partly supported by the Ministry of Social Services and Social Welfare. A vocational training centre for women with disabilities and a centre for children with intellectual disabilities are managed by the Association of Anuradhapura in North Central Province.

A separate event was organized on International Women's Day in March 2007 for women with disabilities on the theme of "Empowering women with disabilities". Since then, women with disabilities participate in the annual national event organized by the Ministry of Women's Affairs as a combined effort between the two ministries.

The National Council for Persons with Disability, which is a presidentially appointed committee, includes women with disabilities.

Other schemes

From 2007, a scheme of providing a monthly allowance of Rs 3000 for families of persons with disabilities was initiated. Upto October 2008, 2125 families have benefited from this scheme.

The "*Supiri Vasana Sampatha*" scheme, supported by the National Lotteries Board provides housing assistance for persons with disabilities up to a sum of Rs 100 000. Upto October 2008, 359 houses had been constructed.

Provision of assistive devices through mobile services is a long-standing programme that covers many areas in the country. Upto October 2008, a total of 44 mobile services had been carried out: 29 119 spectacles, 76 wheelchairs, 75 elbow crutches and 45 crutches had been distributed.

The "Braille for Public Servants" project was launched in July 2007 to train public servants. With 2007 termed as "Accessibility Year", a total of 50

public officers from the Ministry of Social Service and other ministries were trained to teach Braille to visually-impaired persons and also to translate documents into Braille. Sign language courses were conducted for public officers of the Ministry of Social Service and Social Welfare from December 2007. A total of 40 officers have been trained.

Funding and sustainability

The main source of funding is the government. FRIDSRO, Sarvodaya and Christian Children's Fund also supported the Ministry in CBR projects for a limited time in selected districts. Some support is provided through the "NGO consortiums" at the district level.

At the community level, CBR is a component of integrated community development. It relies as much as possible on the mobilization of local resources. A person with disability and his/her family are considered the most important resource. Disabled community members and their families are involved in all discussions and decisions regarding interventions and opportunities provided for them.

Community volunteers take responsibility to ensure that persons with disabilities are approached at home by having one or more of its members trained to implement this programme. They also ensure that all local opportunities for education, skill development, jobs and poverty alleviation, etc. are open to persons with disabilities and that their rights are protected.

A community structure (the Community Rehabilitation Committee) that includes persons with disabilities provides the local management. When community work or assistance is rendered, a component of the total estimated cost is always borne by the community or families of persons with disabilities. This is normally in the form of voluntary labour, rather than actual financial contribution.

Impact

The CBR programme has contributed to the demystification of disability issues, and has brought down prejudice and negative attitudes towards persons with disabilities. Encouragement and education of parents of children with disabilities with regard to looking after them at home rather than lodging

them in institutional care has resulted in a reduction in the number of new admissions to institutions.

The Ministry of Social Services and Social Welfare is presently developing a CBR Management Information System (CBR MIS). This will enable the ministry to monitor the micro-level impact on the lives of persons with disabilities, their families and their communities on one hand; and on the other, macro-level management will be significantly improved through collation and analysis of relevant information from the field. In addition, it will also enable the ministry to compile a disability profile of any administrative area covered by CBR, which will have the potential of serving as a foundation for a comprehensive national disability survey.

The CBR – MIS is composed of the following elements:

- baseline information on the situation of persons with disabilities from a rights-based perspective;
- progress made in terms of the changes in their situation;
- records maintained by core personnel (community volunteers and core teams);
- quarterly reporting from home to community to divisional to ministry level;
- collation and analysis at divisional and ministry levels;
- feedback to communities and divisional stakeholders by the Divisional Secretary;
- feedback to all concerned stakeholders by the ministry including the distribution of a quarterly bulletin.

Lessons learnt

The need for multisectoral involvement is critical to a programme like this to achieve maximum impact. Equal commitment from all partners including the Ministry of Health, Ministry of Education, Ministry of Vocational Training and NGOs is an absolute must and when this is not forthcoming it becomes a major barrier.

Previously the ministries of health and social services were amalgamated under one minister; subsequent to their separation into independent ministries under their own ministers, the link between the two is probably not strong enough.

The CBR programme is dependent on volunteers for sustainability. However volunteer retention has become a major concern. The younger, unemployed youth used to come in as volunteers, but they were a mobile population who left the programme once they got employment. Subsequently volunteers are being selected from the elders' committees that have been established in communities. These volunteers remain in the community and work with a true spirit of volunteerism.

Innovative approaches

The programme has a well-planned management system from the village to the national level, with mechanisms for multisectoral coordination at central and peripheral levels. The use of elders in communities as volunteers is an innovative practice that effectively addresses the problem of volunteer retention.

Section 2
CBR practices: civil society

Examples of CBR projects implemented by the civil society

India

Background

Rural Community Development (RUCODE) was established in 1986 as a registered trust, to work with socially and economically deprived sections of the community in two districts in the state of Tamil Nadu in southern India. The aim of RUCODE is to build "self-reliant rural communities on the basis of collective participation". To supplement the available secondary data and for better planning, RUCODE carried out a detailed situation analysis in 1986 in the chosen areas, and started activities aimed at food security and empowerment of *dalit* and disadvantaged women, with support from Caritas, Netherlands. Women were mobilized to form self-help groups at the village level, which were later formed into the Federation of Women Associations. The Federation monitors and guides the activities of village-level groups. As a result of this project, the educational status of women improved as more girls started attending schools and colleges. As on date, 50 self-help groups of women with 866 members continue to function, with a total savings of Rs 1 458 000. The members have between them, made use of loans to the tune of Rs 11 856 595 from banks, the groups and the Federation.

From 2000 onwards, RUCODE initiated the CBR project for persons with disabilities, following a household survey in 110 villages with a total population of 144 853 and identified 2078 persons with disabilities.

The RUCODE has established linkages with government and NGOs at local and state levels for collaborative efforts not only in the field of disability, but also in disaster relief (after the 2004 tsunami), HIV/AIDS and environment protection.

Activities

All categories of impairment were covered in the CBR project.

Prevention of impairments, early identification and intervention

The RUCODE staff paid attention to prevention of impairments by raising awareness among the public, and visiting pregnant women in the area of operations to review their antenatal status. In particular, those identified as a high-risk group were motivated and guided towards hospital deliveries.

The programme of "Newborn screening" to screen infants for possible disabilities, helped to identify those in need of referrals for specialized intervention. The RUCODE staff have established linkages with community-level government functionaries such as village health nurses and nutrition workers, for the purpose of such screening. The project staff also trained primary school teachers, headmasters, crèche teachers and religious and village leaders in identifying children with disabilities, supporting them in accessing education and acquiring the required lifeskills.

The early intervention programme for children with disabilities in their home setting involves training parents on basic physiotherapy and stimulation techniques to support their children.

Community-based day care centres

As the services for children with intellectual disability and cerebral palsy were very limited in the rural areas, RUCODE initiated the concept of community-based day care centre for these children. The centres cater to around 10 children each, with one teacher and one attendant in each centre, in collaboration with local government and parents. The professional staff of RUCODE provides support to these centres. The space to run the centre is contributed by the community (local government and local leaders) as also the mid-day meal for the children. Currently there are 4 such centres,

looking after 46 children, with inputs of speech therapy, occupational therapy, physiotherapy, music and play therapy, and training on daily life skills. Some children who showed good improvement in academic and social skills were slowly integrated into regular schools.

An evaluation of these centres showed that the concept was very relevant and needed in rural areas; and the major outcomes were improved self-help skills in children, improved mobility and communication, and reduced behavioural problems. Not only did the children get a chance to improve their daily life skills, parents also got a respite, and were thus able to pay better attention to their children when they were with them. This activity is a good example of community participation and collaboration between local government, the community and parents.

Community-based skill development centres

Children above 15 years of age were admitted in the community-based skill development centres started by RUCODE. There are 7 such centres, with 74 children being trained in pre-vocational and vocational skills. Children who were able to develop vocational skills were attached to nearby workshops or business centres where they got employed on a part-time basis. On completing the training and acquiring other life-skills, they become full-time employees. Other children, depending on their skill level and family support, undertake some home-based, income-generating ventures.

Community-based physiotherapy centres

RUCODE has established community-based physiotherapy centres in places accessible to persons with disabilities from rural areas. Children and adults with disabilities from nearby areas visit these centres for regular physiotherapy provided by qualified staff.

Access to government schemes

The project facilitates inclusion of persons with disabilities in government schemes like national identity cards, scholarships for continuing education, transport concessions, assistive devices and maintenance grants. RUCODE was chosen as a resource centre for the National Trust under the Ministry

of Social Justice and Empowerment and as part of the scheme, the organization procured and distributed 850 health insurance cards to children with disabilities. RUCODE is also recognized by the government as one of the centres to train care-givers.

Awareness-raising

As part of awareness-raising on disability issues, RUCODE conducted public celebrations and important village events with participation of persons with disabilities. Community acceptance of persons with disabilities is shown by the support extended in running the day care and skills development centres, organizing public events, employing trained persons with disabilities and supporting them in different ways.

Self-help groups of persons with disabilities

With the aim of encouraging empowerment and self-advocacy efforts by persons with disabilities, RUCODE facilitated the formation of self-help groups of persons with disabilities and their families in different areas. Fourteen such groups were formed, with 290 members.

From these groups, eight "disability welfare organizations" were established and integrated into the Women's Federation. These groups have now taken up the responsibility of managing the day care centres and the skill development centres.

Funding and sustainability

RUCODE has been supported by external donors and by the government in its work in different developmental initiatives.

With the recognition gained, RUCODE has been successful in raising local resources through individual philanthropists, the Women's Federation, the church and locally elected body representatives.

RUCODE has demonstrated that a degree of sustainability can be addressed through successful facilitation of grassroots-level organizations such as the Women's Federation (that has been in existence for nearly 20 years), parent groups and disabled persons' organizations; building their

capacity and transferring the responsibility for some of the activities such as the day-care centre to them.

Impact

The impact of RUCODE's CBR project has been documented in evaluation reports as under:

- improved mobility, activities of daily living and communication skills, and reduced behavioural problems in children attending day care centres;
- skills acquisition and employment generation for those involved in vocational training;
- family and community participation in implementing CBR activities;
- involvement of the Women's Federation in integrating disability work into their activities;
- involvement of self-help groups of persons with disabilities in CBR implementation;
- recognition by the government at local, state and national levels of RUCODE as a resource centre.

Lessons learnt

Inclusion of disability issues into development programmes like those of the Women's Federation ensures community acceptance and participation.

Building strong partnerships with community-level groups, parents and local government is essential for successful implementation.

Innovative approaches

The successful facilitation of women's groups and linking them with self-help groups of persons with disabilities has enabled the group members to take responsibility for some of the project activities, thereby contributing to sustainability.

The project has built up good linkages with local health and education sectors of government, for more effective implementation of activities.

Nepal

Background

The CBR project of the Community-based Rehabilitation Organization – Bhaktapur, located about 12 kilometres away from Kathmandu was initiated in 1985. It is one of the first CBR projects to be started in the south Asian region. At the time of starting, there were no services for persons with disabilities in this area, and government initiatives were almost nonexistent.

The project works in two municipalities of Bhaktapur, covering a population of more than 300 000. Over the last 25 years, the CBR project has provided comprehensive rehabilitation services for nearly 3000 persons with disabilities. More than 70 000 children and youth from the local communities have been covered through preventive health services such as early childhood health checks, growth monitoring, immunization, ear care, school health checks, physiotherapy and counselling.

The Ministry of Women, Children and Social Welfare of the government is involved in supporting and guiding the CBR project since 2010. About 75 civil society organizations including 8 DPOs and 67 NGOs are given the responsibility of implementing the government-supported CBR programme in the 75 districts. The Bhaktapur CBR organization is one of the NGOs recognized by the ministry for this purpose.

In 2010 the Bhaktapur CBR organization carried out a household survey in the district, the results of which showed that about 2% of the population in Bhaktapur district had some form of disability, and about three fourths of persons with disabilities had had access to some kind of rehabilitation services.

The survey also revealed that 56% persons with disabilities were literate, and 85.42% children with disabilities between 5 and 18 years of age were in regular school. Only 39% of older persons with disabilities were involved in some kind of work, and about one fourth of persons with disabilities had received disability identity cards from the government.

Activities

Persons with all categories of impairment are covered in the project.

Health

The project carries out referral services for corrective surgery, essential medicine, identification and assessment, immunization, family planning, ear clinic and physiotherapy. Other services include mobile camps, home visits and counselling to children with disabilities and their families.

Education

Activities include campaigns for school admission, technical support to make schools accessible, special preparation class particularly for children with visual, hearing, intellectual or multiple disabilities, “day care” centre for children with multiple disabilities, regular home visits and counselling, sensitization programme for parents and teachers, organizing and mobilizing parents, youth with disabilities and community-level stakeholders into “Village Disability Rehabilitation Committees” (VDRC), training for teachers, mobilization of trained rehabilitation facilitators in various village development councils for rehabilitation of children with disabilities at community level and production and dissemination of social communication materials.

Employment

The project carries out vocational training for youth with disabilities.

Accessibility

The project provides assistive devices such as wheelchairs, crutches, artificial limbs and hearing aids in collaboration with other organizations. Advocacy is done with local government agencies to make public places accessible according to the building code, and inputs are provided to relevant government agencies for appropriate policies to address these problems. The project is also involved in sensitizing other stakeholders about the need for barrier-free environment for persons with disabilities.

Social and cultural participation

Sensitization and educational programmes for parents and other stakeholders about disability and the rights of persons with disabilities are conducted through posters, stickers, manuals, street drama, audio visual materials and interactive discussion, etc. Participation of children with disabilities in child clubs and in family activities are encouraged through family counselling. These efforts have helped to change negative and over-protective attitudes of families and the community.

Promoting people's participation and ownership

The Bhaktapur CBR project involves people with disabilities, parents and local stakeholders such as leaders of political parties, social workers, school management committees and local government authorities in planning, implementation and monitoring of project activities. Persons with disabilities are part of the decision-making body and staff of the organization. The CBR project has also ensured their participation in the locally formed "Village Disability Rehabilitation Committees (VDRC)" in various village development councils of Bhaktapur district.

The Bhaktapur CBR works in 16 VDCs of Bhaktapur district through the VDRCs. VDRCs are local-level committees comprising stakeholders such as leaders of political parties, authorities of VDC, persons with disabilities, social workers and parents of children with disabilities; and work for rehabilitation of persons with disabilities at the community level. The CBR project facilitates their formation, enhances their capacity, and provides technical resources. The VDRCs are involved in advocacy/lobbying for sensitizing society on disability issues, local resource mobilization for the promotion of disability rights and inclusion of disability issues in the other development agenda at the local level.

Bhaktapur CBRO as a resource organization in Nepal

At the national level the Bhaktapur CBR organization has worked in collaboration with the government on developing national CBR guidelines and a disability management strategy.

The Resource Centre for Rehabilitation and Development (RCRD) was established in 1997, for promoting the rights of persons with disabilities through human resource development, information-sharing, capacity building and advocacy. The RCRD, Nepal is working as a national CBR resource centre in partnership with the Ministry of Women, Children and Social Welfare and Save the Children International. The CBR Basic Facilitators Short Course Training Curriculum run by RCRD, Nepal is recognized by the government, and RCRD has conducted training for 300 CBR workers from 37 out of 75 districts in the country. The RCRD also provided technical support to the Ministry of Social Welfare in carrying out the District Disability Household Survey in all 75 districts.

The RCRD is now involved in strengthening CBR implementation in the country, based on the WHO CBR Guidelines, and in developing simple tools for planning, monitoring, reporting, survey, assessment and registration of persons with disabilities at the community level. All the government laws, policies, guidelines, facilities and services related to persons with disabilities have been compiled and published as the National Disability Resources Book and Disability Introduction Book in simple Nepali language. These books have been distributed in 4 000 villages in 75 districts in the country.

Funding and sustainability

The main source of funding was international NGOs like Save the Children Norway, World Vision and Handicap International.

At the community level, support is mobilized from the Village and District Development Committee, District Education Office, local schools, District Health Office and District Women's Development Office.

As of 2011, all 16 VDRCs were in place and able to mobilize village development resources of about Rs 50 000 each every year. They are part of the district CBR programme coordination committee. The Bhaktapur CBR project organizes regular meetings of VDRCs three times a year; helping them to develop their annual plan and budget, monitoring their work, organizing training programmes for capacity building and providing technical support related to assistive devices and referrals.

At present, the Bhaktapur CBR project does not have any external support for CBR work. About 80% CBR resources are mobilized from the government and about 20% are mobilized from local fund raising and from organizational internal funds.

Impact

The main impact of the project was on the every-day lives of persons with disabilities in terms of increased access to education of children with disabilities, improvement in daily living functions, access to preventive health services, local resource mobilization, involvement of persons with disabilities in village-level development, and transfer of CBR work to village-level committee.

Lessons learnt

Broader coordination and collaboration across various sectors are essential to sustain the programme.

Self-help groups are most effective in advocating with the local government for resource mobilization.

Attitudes of families, communities and other institutions in the community is the most common barrierfaced, so awareness and education are the key to address this.

Innovative approaches

The project has successfully mobilized parents, youth with disabilities and community-level stakeholders into Village Disability Rehabilitation Committees that are part of Village Development Councils, ensuring that disability issues are included in development planning at the local level.

Timor-Leste

Background

The Klibur Domin CBR Project, managed by an NGO, is located in Tibar village, Liquiça district, approximately 15 kilometres from the capital city of Dili.

Klibur Domin started outreach services in 2004 to address the needs of people with disabilities who had been discharged from hospitals in Dili, and had no support services in their communities. A full-scale CBR project was initiated in 2006.

The CBR project works in 11 villages in 2 districts: Liquica district with 3 subdistricts and Ermera district with 2 subdistricts.

Activities

There are currently 56 persons with disabilities who are being provided with services/support through the CBR project. While the focus is on children with disabilities, a few adults with disabilities are also part of the programme.

The CBR project covers persons with all categories of impairment. Education and health care are the main services provided. The main focus of the project is its work with schools, families and the community for inclusive education.

In Timor-Leste there is only one special school in Taibesse, Dili, which is not accessible to the children from Liquica and Ermera districts. Common problems that prevented children from attending school were related to accessibility; including access to the school, particularly during the wet season, as well as access to facilities (e.g. toilets) at school; limited teacher training and understanding about disability issues; limited resources; large class sizes; family and community beliefs about children with disabilities attending schools; and the reliance on family members to assist children to go to school. Often the family did not have time to assist the child to go to school due to other work and family commitments.

The CBR project has been working with children, schools and teachers to help children with disabilities attend local schools. Of the programme's 39 school-aged children with disabilities, 22 are currently attending local schools.

The CBR staff organize social communication events at local schools to provide information about accessibility issues, and about causes and prevention of impairments.

The CBR project organized a Paralympics event to encourage participation of children with disabilities, and to raise awareness in the community about disability issues.

Another major activity was to increase participation of persons with disabilities in a carpentry training course at the Don Bosco training facility in Dili. This programme was organized and supported by the Timor-Leste Ministry of Social Solidarity (MSS). Twenty two men with disabilities completed the course.

The CBR project has provided assistance to improve accessibility for persons with disabilities in the community, in terms of ramps at client houses and provision of water pipes. The community members worked together to build the ramps and the water system. The project staff also assisted families and community members with proposals for small-scale bridges and alternative accommodation options so that children could attend local schools.

The CBR project has forged good working relationships with local and international NGOs, teachers, local and national government agencies and local authorities like village heads. Since its establishment the CBR project has been a member of the Timor-Leste Disability Working Group and the CBR Working Group. These groups meet regularly to discuss issues related to disability in the country, and to link groups involved in disability issues from both NGO and government bodies. Continuing education for CBR workers has also been facilitated through these groups.

Funding and sustainability

The Klibur Domin CBR Project was funded solely by The Ryder-Cheshire Foundation of Australia till 2009. From 2009, the Ministry of Social Solidarity has started providing financial support to project activities.

The CBR project plans to start a volunteer base in local communities. This will involve a selection process (working with local communities/village leaders), training of volunteers and establishment of their positions in the local community. Volunteers will act as advocates for persons with disabilities in the community and liaise with the CBR project on community and client issues.

Impact

Feedback from persons with disabilities, families and communities about the impact of the project showed that it resulted in improved mobility and access; increased independence in activities of daily living skills and access to education for children with disabilities.

Lessons learnt

It is important to start a project by building up community relationships at the very beginning.

The barriers faced include lack of staff, lack of teacher training programmes on disability issues, limited number of trainers on CBR and on disability issues, and lack of impact measures

Innovative approaches

Started as an outreach activity, the project expanded to include activities of CBR, built up good linkages with local stakeholders, and became accepted as a member of a national resource group on disability and CBR.

Section 3

CBR practice: Disabled people's organizations

Example of CBR promoted by a disabled people's organization

Thailand

Background

Nakornpanom is located in the north-eastern part of Thailand. A CBR project had been implemented in this area by the Sirindhorn National Medical Rehabilitation Centre (SNMRC), supported by the Ministry of Public Health and some international NGOs. This project had focused on persons with mobility problems.

Subsequently the CBR project was taken over by the Nakornpanom Association of People with Disability, with SNMRC playing the role of facilitator and supporter.

There are approximately 8000 persons in Nakornpanom living with some kind of disability. Mobility disability is the most common, accounting for nearly 50% of the population of persons with disabilities, while intellectual and learning disability, hearing disability, seeing disability and mental disability account for 17%, 13%, 10%, and 10%, respectively, of persons with disabilities in this area.

At the time of starting the project it was found that only 50% persons with disabilities could access education and that too only at the primary and elementary levels. About 5000 persons who were in the active age group

of 23-60 years were in insecure jobs with little income. Attitudes of the community were negative, viewing persons with disabilities as useless and valueless, with no awareness of their potential.

The Nakornpanom Association of People with Disability includes blind persons, deaf persons and people with mobility disabilities. A woman with hearing impairment, who had worked for the Thai Deaf Association and for other international deaf agencies, started the association. She first started working with the local deaf persons to improve access to sign language, education, jobs and additional income. Later, she convinced groups of blind persons and persons with mobility impairment who were working on similar issues, to join hands with the Nakornpanom Association of People with Disability.

The general goal of the association is to improve the quality of life of persons with disabilities through improving basic services, promoting accessibility and social communication to raise awareness. The Association also carries out advocacy for policy changes with the relevant local authorities, and is involved in developing innovative models of care. Empowering the members of the Association and building up a strong network to bring about changes in the community and making them aware of the capacity of persons with disabilities, are the key areas of focus for the Association.

Activities

The CBR project tries to include all persons with disabilities and to address all types of needs identified. The activities include:

- Health: health security, and basic health service access
- Education: community-based early childhood learning centre
- Employment: community vocational training centre
- Accessibility: making changes in many places in Nakornpanom to become barrier-free
- Awareness and attitude change: through many events in the community.

Participation of persons with disabilities is the central theme in the CBR project. Multisectoral linkages have been developed: strengthening existing linkages and developing new ones.

Funding and sustainability

Many sources of funding were mobilized such as local government authorities and foundations, and the Ministry of Public Health.

The DPO is now implementing the project, thereby contributing to sustainability.

Impact

Persons with disabilities have had access to services to improve their functioning, and as a result, have started participating in their community activities.

Persons with disabilities have access to information related to education, health service and employment.

Changes have been made in the physical environment to improve accessibility for persons with disabilities.

Advocacy has helped to bring about changes in local policies related to persons with disabilities.

The community has started contributing to project activities.

Innovative approaches

The project is a good example of a single disability approach that grew into a cross-disability community-based rehabilitation process.

It was initiated a decade ago by the governmental health organization and nongovernmental organizations as part of a national vertical programme, and is still continuing as a successful project of a local DPO.

Section 4
CBR practice: Academia

Example of a CBR project promoted by an academic institution

India

Background

The Department of Physical Medicine and Rehabilitation (PMR) of the Christian Medical College, Vellore, India, has many years of experience with rehabilitation of individuals with disability. The staff of the PMR department have over the years, developed the expertise for comprehensive rehabilitation of persons with severe disabilities and those with different categories of impairment.

The Low Cost Effective Care Unit (LCECU) has been working with urban poor communities in Vellore Town for over 20 years, providing secondary care services as well as referrals to tertiary care centres as needed.

The team at LCECU/PMR had always been aware of the high costs of treatment of individuals, the preventable nature of several injuries that lead to disability, the inappropriateness of some of the training within the institution and the problem of accessibility for the majority of persons with disabilities in the community. Besides, disabilities due to hearing, seeing, difficulty in learning and development are taken care of by different departments in a tertiary care centre, and holistic care was hard to provide. Discussion on these issues with people with disabilities from local communities who sought treatment at LCECU, led to the idea of setting up a CBR project as a partnership between a team of professionals, community volunteers and persons with disabilities. The team used the WHO Manual: *Training in the*

Community for People with Disabilities (1989) as the basic guide, adding to it the experience and expertise of team members and consultants from different disciplines.

The aim of the CBR project is to empower persons with disabilities to achieve their potential through active participation of their family and wider community, thus transforming the community to be a better place for persons with disabilities.

Strategies

Volunteers as local supervisors

In order to base the rehabilitation services in the community, it was imperative to select volunteers from among the community. Volunteers (local supervisors-LS) were selected in consultation with the community.

Educational model

Rather than a purely medical or social model, the project attempted a judicious mixture of both, through an "educational model". This envisages the creation of trained resource people (LS) in the community who can then utilize the skills and knowledge acquired to help persons with disabilities.

Awareness creation

Community awareness was focused on prevention of impairments, eliminating social stigma and how to include persons with disabilities in the community.

Utilizing local resources

The primary emphasis was on using locally available resources wherever possible, e.g. innovative devices, mobility aids, support from local people.

Need-based approach

If the community and persons with disabilities are to be empowered, it is crucial to ascertain the needs as perceived or felt by them. A needs-based

approach was therefore adopted in planning, with the understanding that solutions that appear good to project personnel may fail because they have not addressed the felt need of persons with disabilities.

A young man with a disability sought help from the rehabilitation team. Deformities, contractures and other medical problems were quickly identified by the team. Surgical correction of deformities and corrective appliances were provided. The team felt that with all these expensive interventions the person could lead a productive life. Much to their dismay, he continued to be dissatisfied with the outcome. His expectation from the rehabilitation team was to get some support to start a shop i.e. vocational rehabilitation. This felt need was not recognized initially as attention was focused entirely on deformities. Subsequently, he was assisted to start a shop. He put away the appliances, and was quite satisfied on achieving his felt needs.

Activities

Defining the community or area of operations

The community and the target group for CBR should be clearly defined at the outset of any programme. This could be decided based on proximity to available resources, requests from the community, availability of infrastructure and possibility of linking with existing services, either government or NGO.

The CBR project chose a poorer area of the Vellore town with a population of 20 000. This was already part of the area served by LCECU, within easy physical reach. The existing links of the LCECU with the local community facilitated the process of CBR.

Entering the community

To initiate the CBR process, the community must become aware not only of the needs and problems of persons with disabilities, but also be confident that there are solutions possible within the community. This awareness may arise within the community through one or a group of its members. More

often it occurs because of the efforts of the third person or a group who act as a “facilitator”. The project team knew that getting to know the community and gaining their trust was the crucial first step for initiating CBR.

The team started with many initial visits to the community, spending time talking to people; having tea in the local teashops and chatting with the people around there. The clients and their relatives from the LCECU who lived in these communities, played a facilitative role for establishing initial contacts with local leaders in the community. The team also made contacts with leaders of youth groups, school teachers and women’s groups. The purpose of the project was explained and discussed with them. Once rapport and links were established, public meetings were held wherever there was a place available, like street corners, temple premises, playgrounds, under the trees, etc. The meetings were informal and interactive. Issues, priorities, and fears of all were openly voiced and discussed.

In many communities, people’s priorities were found to be different, for example, health and development needs of the *larger community* were not being met and people felt that this should have priority over the needs of persons with disabilities, who were any way less productive. However with discussions some community members understood that addressing the needs of persons with disabilities would eventually lead to overall development within the community. For example, an elderly person with stroke, if rehabilitated, would liberate the care-givers to carry out other productive functions. The initial meetings generated a lot of discussion, inspiring some people to volunteer their time, effort and service for the CBR project. The educational and training approach rather than direct service delivery approach seemed a novel idea that aroused their curiosity and interest. Also there were communities that were not keen on projects focused on the development of persons with disabilities. No volunteers came forward for the programme from these communities.

Among the community members who were willing to participate in the project, further discussions were held to select volunteers for the project.

Selection of volunteers

Although all the people who volunteer are deeply committed and want to help, there could be practical difficulties for some of them. Discussions

were held with potential volunteers and their families, as well as with local leaders before selection, about their aptitude, ability and availability. It was decided to have one volunteer for every 2000 people, to be called a local supervisor (LS).

The criteria to select local supervisors were:

- they should be from the local community;
- they should be able to read and write the local language;
- they should have family support;
- they should have time to spare for community activities (2–3 hours a day)
- they should have a positive attitude towards persons with disabilities and community development
- they should have experience in dealing with disability or could be persons with disabilities themselves.
- after discussions on the nature of the volunteer's work, some found that they could not spare time or that they could not cope due to poor literacy skills or aptitude.
- those who were not selected were encouraged to continue to be a part of the wider support network and to help in mobilizing resources, and joining in activities like health awareness camps in their areas.

Training

The aim of training was to create awareness, enhance knowledge and provide skills needed so that volunteers and persons with disabilities could be effective agents of change in the community.

The learning process took place within the community as well as in institutions outside the community. The WHO manual translated into the local language was found to be user-friendly, practical and effective.

The trainers included project staff, people with appropriate technical skills from the secondary and tertiary care centres, NGOs, government agencies, persons with disabilities, medical specialists and educators.

Various methods were used for training: lectures, discussion, role play, case studies, field visits, demonstration, practical work and participation in reviews. The modules of the WHO manual were used one at a time with a mix of theory and practical work relating to each module. The volunteers were encouraged to present existing local problems (or situations) and suggest relevant solutions to solve them with available resources.

Training also focused on communication, listening skills, and how to build rapport in the family and community. Many volunteers were able to spell out the basic principles involved in communication and listening from their practical life experience, although they were unaware that they possessed such skills and were unsure how to apply them formally. The field surveys were a sensitization process for the whole team regarding problems faced by persons with disabilities in the real world. This stimulated enthusiasm and motivation of among volunteers and trainers. Solutions to problems were planned along with persons with disabilities, their families, project team and experts. Positive results gave rise to further motivation, and failure to solve the problems led to repeating the process, looking for causes of failure and finding new solutions.

With time and experience, volunteers developed confidence and often the project staff drew inspiration and learned many valuable lessons from them and the approaches that they used. For example, one of the local supervisors suggested that inability to pick out the stones from grains of rice could be as effective a method as testing with formal charts to detect vision problems.

The problem-solving methodology was found to be an excellent “educative” model. The local supervisor would identify the problem faced by persons with disabilities with their help. Possible solutions were discussed with other project staff and resource persons, using the WHO manual as resource material. The suggested interventions were implemented after discussions with persons with disabilities and their family members. Problems encountered during intervention were solved locally, or brought back for discussion, during review meetings.

Some problems were complex enough to warrant field visits by the project staff including the medical team. During these visits, the team analysed the

situation along with persons with disabilities and suggested interventions including referral to secondary and tertiary centres as appropriate. Recognizing that a certain number of persons with disabilities do need intervention at secondary/tertiary set-up, the team planned to use the already existing facilities and infrastructure to make this care available as and when needed. These services would also be provided to other people in the community who had medical needs through the LS, thus strengthening their image in the community. Sometimes the problem needed the help of Government systems or of the local leaders, e.g. facilitating persons with disabilities to get identity cards from the District Disability Rehabilitation Office.

School education

Schools in the community served as a platform to sensitize children on disability issues. This increased the awareness on disability through dramas, role-plays, competitions and skits, necessitated involvement of teachers and parents and thus percolated down to the larger community.

Difficulties encountered

The difficulties related to getting suitable volunteers from certain areas. There was no response from five slum areas even after community meetings and repeated attempts to motivate people there to take on this challenge. In these areas the community felt that intervention for persons with disabilities was not a priority at present.

Lessons learnt

Role of camps

In almost all the communities there was a demand to conduct a health/medical camp. Although the project team originally believed that medical camps were not part of the strategy towards establishing CBR, this approach was explored due to persistent requests from all communities. It was then realized that camps could enhance community contact, help to better understand their needs and problems and enhance the local supervisors' status within their community. Seeing clients within the community rather than in a doctor's clinic, helped to remove some of the barriers of "professionalism". Exposure

to the reality of the lives of people in slums was an eye opener for most professionals. The community felt that professionals were more accessible to them and were able to see them as advocates for their development. Screening for nutrition deficiencies and diseases like hypertension/diabetes mellitus/obesity were carried out, along with health education on a variety of issues, through exhibitions/video shows, as part of the camp. The community was involved in the planning and organization of camps, and the leaders and young people played an active role, helping to set up the venue and providing other infrastructural support.

Visual impairments in the population were the major problem, as encountered by the local supervisors. As they began to use the module on "difficulty in seeing" it became apparent that many persons with visual impairments needed the help of specialists. Contacts were made with the eye department and links established with their ongoing community programmes for those with poor vision. Eye camps were organized in the CBR areas and people were referred for appropriate treatment including correction of refractive errors, surgery for cataract and so on. The local supervisors were the links between their communities and the staff of the ophthalmology department. The local supervisors gained knowledge, skill and confidence in dealing with persons with visual difficulty through these approaches.

Monitoring and evaluation

A process of ongoing evaluation was followed throughout the project. Through pre- and-post tests, the knowledge and attitude of local supervisors during the training were assessed. The LS gave feedback on the content and methods of training, which was used to improve the training programme. The LS were assessed during field visits by the staff and ongoing training focused on areas identified for further training.

Weekly reviews were utilized for modifying or changing programme plans. For example, it was decided to make a bar chart of LS attendance for the training each month and use this as a motivating tool to achieve excellence. Each special programme like a health camp, eye camp or school awareness project had a post-evaluation component, and the feedback was utilized to improve the next activity. As part of the health screening camp, it was decided

to keep one or two wheel chairs for the public to experience the problems faced by those in a wheel chair.

Both quantitative and qualitative information were collected in the project. The qualitative research that was part of this project has led to awarding of a PhD degree in social work from the Northumbria University, Newcastle upon Tyne, United Kingdom.

Sustainability

The project team developed the "education" model with the hope that "trained resources" who have particular knowledge and skill (local supervisor, schoolchildren, family or community) and who will continue to live in the community will ensure some degree of sustainability. The LS were given many skills which they acquired free of charge. A small scholarship amount was given to volunteers during the training period to offset expenses involved towards their training.

The official project was completed in 2005. Interestingly however, six of the nine volunteers continue to be in regular contact with the secondary and tertiary care centres. They are active resource persons for issues related to disability, health and development in their respective communities. Their spectrum of activities has broadened over the years. In addition to disability issues they participate in lifeskills training of youth, care of the elderly, mother-and-child care and general development in the community. The volunteers continue to meet with the project initiators on a monthly basis and as and when needed. During these meeting they raise issues and needs within the community related to general health, disability, rehabilitation and development. Through this collaboration several initiatives have taken place in the community. These activities and the example of volunteers have attracted many others in the community to come forward as volunteers. Training for these new volunteers in health, disability and development is an ongoing process, where the LS are resource persons along with the initiators.

The educative model has not only benefited the LS but attracted several others to come forward to act as volunteers, leading to greater sustainability. The secondary and tertiary care centres continue to function as resources for the community for continuing education, and preventive and curative care.

The financial implications of this way of working are much less as compared with those involving paid staff in the community. Finances are required for medical care and these are provided through already existing mechanisms within the secondary/tertiary care centres and the government. Finances are also required for conducting various types of training programmes; as these are carried out within the community or in the secondary care centre the budgets are limited and affordable. Although the initial investment in terms of time, money and effort could be considered high, these resources have been well spent because of the transformation of the community and the ongoing nature of the CBR activities in the community.

Section 5

CBR resource agencies in the Asia-Pacific Region

Centre for Disability in Development, Bangladesh

The Centre for Disability in Development (CDD) is working since 1996 towards an inclusive society for persons with disabilities. The CDD works with the vision of establishing equal opportunities and full participation for persons with disabilities in all spheres of life, by building the capacity of its partner organizations to ensure that persons with disabilities are included in development and social programmes.

The CDD along with its partners will implement the "CBR Rollout in Bangladesh" project from 2012 to 2016. It will develop training and information resources on CBR, build capacity of CBR actors and promote the development of a national CBR strategy and a coordination mechanism. Experiences and learning will be documented and disseminated.

CDD's training programmes

From 1996 to 2011, the CDD trained around 13 000 people, through 782 courses. It develops training courses based on needs assessment and periodic reviews. After training, the CDD extends follow-up support and also offers refresher training for selected courses. The follow-up visits by CDD found that a majority of the trained people are continuing their work in the field of disability.

Following training, a significant number of CDD partner organizations initiated disability mainstreaming as one of their priorities and started pilot

initiatives either on their own or with CDD's support. A number of organizations are supporting persons with disabilities to access the government's social safety net programmes and other services. Out of 64 administrative districts, CDD partner organizations are working in selected sub-districts of 58 districts.

It is estimated that more than 100 000 persons with disabilities have had access to health and rehabilitation services, education, livelihood and social opportunities, through the partner organizations of CDD. Many of these organizations are promoting self-help groups of persons with disabilities by building their capacity, creating linkages with government services and advocating for disability-inclusive policies and their effective implementation.

Out of 25 training courses on different topics, the three main ones comprising Programme Design, Implementation and Management; Community Handicap and Disability Resource Persons; and Social Communication on Handicap and Disability were designed first in 1995 and updated in 2001. The rest of the training curricula have been added gradually since 1995, and are regularly updated based on the needs and requirements of participants, and on the objectives of projects and programmes of CDD.

Material development by CDD

The CDD is developing and disseminating information, education and communication materials in different formats.

Booklets
Stroke, Epilepsy, Intellectual Disability, Cerebral Palsy, Amputation, Burn, Hearing Impairment, Communication Problem, Down Syndrome, Polio, Spina Bifida, Hydrocephalus, Club Feet, Cleft Palate and Lip, Contracture, Arthritis, Visual Impairment, Fever Management, Government-declared policies for persons with disabilities, A Booklet on Disability for the members of Union Parishads, I am for my friends with disability, UNCRPD [In Bangla], Disaster and my friend with disability

Flash Card Series
Preventing Disability During Pregnancy, Fever Management, Intellectual Disability and Us, Epilepsy,10 Awareness Messages on Disability, Preventing Stroke, Prevention of Ear Infection and Deafness, Severe Burn and Disability, Happy Village, Cerebral Palsy, Early Detection and Intervention, Basic Information on Assistive Devices, Awareness on Visual Impairment, Eye Disease and Intervention, Inclusive Education for Children with Visual Impairment, Inclusive Education for Children with Disabilities, Rights of Persons with Disabilities
Posters
Child Development, Disability Awareness [9 posters], Sign Alphabet and Numbers [Bangla and English], Disaster-related Awareness Posters [6], Disability-inclusive Disaster Risk Reduction, MDG and Disability
Manuals
Early Detection Manual, Helping children who are Blind, Sign Supported Bangla [5 books], Manual on ADL for People with Visual Impairment, Helping children who are Deaf
Books
Amena's Story, Sindabad and his friends [2 vols], Sign language pocket book, art and essay compilations,

CDD also produced an accessibility guideline, a CAHD manual, research reports, a disaster and disability booklet, a CAHD toolkit, sign language CD-ROMs, newsletters, audio-video and Braille materials. CDD has distributed more than 100 000 copies of IEC materials.

Other materials developed and distributed by CDD include Accessibility Guideline,CAHD Manual, research reports, Disaster and Disability Booklet.

All materials developed by CDD have been distributed among partner organizations. Some materials have been distributed among government departments. Some materials have been reproduced several times after

revisions and distributed among the partners and other relevant organizations. Since its initiation CDD has distributed an estimated 100 000 copies of different materials.

The impact of the materials produced and distributed by CDD was assessed through internal and external evaluations. It was found that the majority of the materials were being used by managers, social communicators, community rehabilitation and livelihood workers of partner organizations. The materials not only contributed to increase confidence of workers but also had an impact in reducing attitudinal barriers among parents, community people, local elected representatives, schools, community development organizations and other relevant stakeholders.

Materials on different impairments and their management helped in training community rehabilitation workers to manage clients and to transfer skills to care-givers, local artisans, and other people in the community. Materials on prevention of impairments helped to raise awareness on the implementation areas of partner organizations in almost all administrative districts of Bangladesh.

Materials on education strengthened the capacity and confidence of teachers, educators, school management committee members and relevant government officials to effectively mainstream children with disabilities into the educational sphere of life.

Materials on self-help groups helped in leadership development among persons with disabilities.

CDD's mobile resource centres

The CDD identified the need for advanced therapeutic services in the river islands and areas with large waterbodies of north-east and north-west districts of the country, and has been providing therapy services in these remote areas.

Using a well-equipped two-storey marine vessel and two mobile vans, 78 advanced therapeutic camps were arranged: 60 camps were organized during 2008 and 2010 under a European Union supported project, and 18 camps were arranged under a project supported by the Government of

Bangladesh, and other external donors. In these camps a multidisciplinary team provided services such as diagnosis, assessment, referral, advanced physiotherapy, occupational therapy, optometric and audiometric services, and assistive devices. These camps also organized awareness-raising activities for prevention of impairments. To ensure follow-up of services in the community, local community development organizations were involved in the arrangement of the camps. Local government authorities, health service providers of the government at secondary levels, and local elected leaders also helped with the camps.

The mobile vans have been used for screening camps in schools and in the community in ten districts, through local partner organizations.

CDD has supported the Ministry of Social Welfare, Government of Bangladesh to design, organize, plan and implement four advanced therapeutic camps in four districts through two mobile vans.

Altogether 8900 persons with disabilities have been covered in the 76 camps and another 400 persons with disabilities received services from the four camps organized by the Ministry of Social Welfare.

CDD's National Resource Centre on Assistive Technology

About 1584 devices made from metal and wood, and 416 prosthestic and orthotic assistive devices were produced during 2008 and 2010 under an EU supported project at CDD's National Resource Centre on Assistive Technology (NRCAT).

Table 1: Details of different types of devices produced

Type of device	No. produced between 2008 and 2010
Mobility devices	1398
Other devices	186
Orthotic devices	294
Prosthetic devices	132
Total	2000

Most clients who got services from NRCAT are poor; in fact, 83% of the NRCAT clients have a monthly family income below 2500 Bangladeshi Takas (BDT). Seventy one per cent clients were men, and 63% were adults.

The CDD established a network of 41 member organizations in 2008 for the production and distribution of assistive devices. Sixty staff members were selected from the network for a 12-day advanced training on assistive devices, with the objectives of:

- ensuring follow-up services for users in the field, including community-based rehabilitation, advising on home, school and workplace adaptations and promoting utilization of devices for inclusion within development activities;
- Referring clients to specialized centres, when appropriate, for device provision, modification or repair; and
- Supporting local artisans to manufacture good quality devices such as special seating, corner chairs, standing frames and auxiliary crutches through advice on product design and function.

The CDD has contributed to build the capacity of 123 local artisans on manufacture and repair of simple assistive devices through the network.

An assessment of this project was conducted in a sample of 900 persons with disability (338 of whom were children) in December 2010. From the clients who received assistive devices, 31% were included in income-generating activities and 34% were found to be independent in daily living activities. Twenty six per cent children with disabilities were reported to be attending schools after receiving appropriate assistive devices, and 33% children with disabilities were able to take part in daily living activities.

CDD's National Resource Centre on Deafblindness

CDD, in collaboration with Sense International (India), has been working with persons with Deafblindness under a project titled 'Developing a Sustainable Infrastructure for the Inclusion of Deafblind People in Bangladesh", with six development partner organizations in different locations in Bangladesh. "Deafblindness" had not been recognized or classified as a separate category of disability, despite the presence of about 500 disability organizations in the country. A majority of the disability organizations have inadequate

understanding of deafblindness and till date, the country had no infrastructure to address the needs of deafblind persons. This situation had left a large number of deafblind people in a state of complete isolation: they remained invisible in public policy and more importantly, were excluded from specialized services and from the development agenda.

The CDD has initiated appropriate support and technological assistance to enable persons with deafblindness to be active members of the society, by extending services to 374 persons with deafblindness in partnership with 16 organizations. It intends to cover 800 persons by 2013. The CDD is also advocating and working towards inclusion of the deafblindness issue in national policies and legislation, and intends to create a national infrastructure for deafblind persons and for persons with multi-sensory impairments in Bangladesh.

The Asia-Pacific Development Centre on Disability (APCD), Bangkok

The Asia-Pacific Development Centre on Disability (APCD) is a regional centre on disability and development established in Bangkok, Thailand as a legacy of the Asia and Pacific Decade of Disabled Persons, 1993-2002. Working with more than 30 countries in the Asia-Pacific region, APCD is a joint collaborative effort of the APCD Foundation and the Japan International Cooperation Agency (JICA).

APCD has been endorsed by the UN ESCAP, Bangkok, as a regional cooperative base for its Biwako Millennium Framework for an inclusive society in the Asia and Pacific Decade of Disabled Persons, 2003-2012.

The APCD's mission is to empower persons with disability and promote a barrier-free society in developing countries in Asia-Pacific. The APCD's strategy is to promote networking and collaboration between organizations in disability and development in the region, through human resource development and information support activities.

In APCD's endeavour to promote CBR, a "community" is considered as an inclusive and barrier-free place where local persons, regardless of disabilities, can participate in all local activities. In collaboration with UN ESCAP, WHO, UNESCO, ILO and other agencies, APCD has been promoting

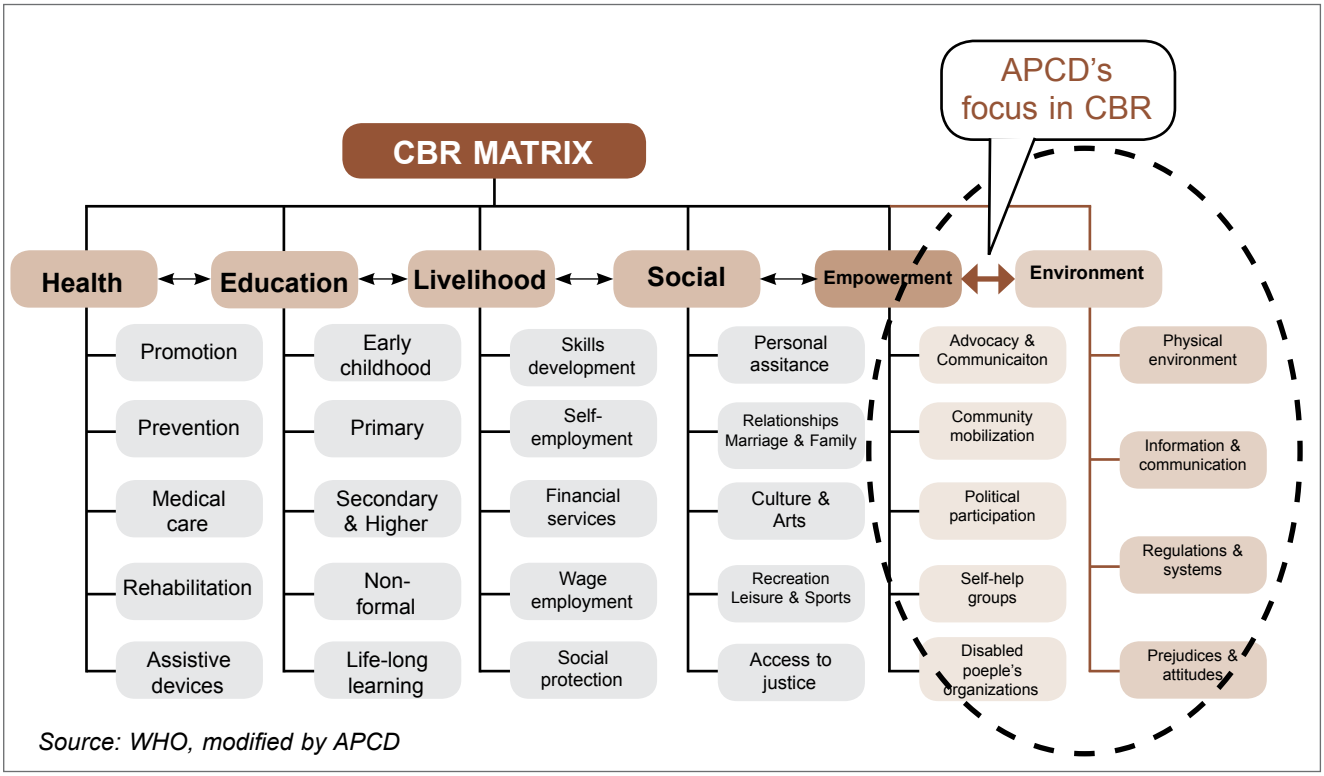
CBR policies and strategies at national as well as grass-root levels to support the empowerment process of persons with disabilities.

APCD's focus in CBR

The WHO CBR Matrix is a framework for inclusive development and all the components are crucial in ensuring full participation and equality of persons with disabilities in the community where they reside.

It is not possible for one ministry or agency to cover all the components of the CBR Matrix: it is essential that all the stakeholders develop alliances working in different fields to share responsibilities and utilize their comparative advantages. In line with its principles and focus. The APCD considers that it has an important role to play in the empowerment component of the CBR Matrix. In addition, the APCD focuses on "environment". Empowered persons with disabilities, by raising their voice through their own groups/organizations, can become powerful forces to bring about removal of barriers in physical environment, information and communication, regulations and systems, as well as prejudices and attitudes.

Figure 3: CBR Matrix



Source: WHO, modified by APCD

Since its establishment, the APCD has upheld the principle that persons with disabilities are valuable resources who can promote the development of their community, once they are empowered and given the opportunity to become agents of change. The APCD has been supporting such developments by building capacity of leaders of persons with disabilities and providing a forum for both persons with and without disabilities to work together towards creating an inclusive and barrier-free society.

Capacity development of CBR implementers

The APCD conducted training to strengthen CBR Practices: in the region through a "Participatory Comprehensive Approach" between 2003-2005. The participants included 8 persons from Cambodia, 15 from Laos, 9 from Myanmar, 9 from Viet Nam and 15 from Thailand. The APCD mobilized resource persons for the training from Bangladesh, India, Sri Lanka, Thailand and Japan, all within the Asia-Pacific region.

Between 2007 and 2011, the APCD conducted 7 CBR training courses, attended by 140 participants. Of these 79 were from the Mekong sub-region.

The follow-up of trainees is conducted through the following means:

- The APCD staff visit the projects of participants in their countries, to observe their activities and to assess the impact of the training.
- Questionnaires are sent to trainees through email to gather information about their activities and get their feedback about the usefulness of the training.
- The APCD supports the local capacity-building efforts of trainees in their countries, such as seminars, workshops or incountry training courses.
- Former participants are invited for refresher training courses.
- Former participants were supported to attend the First Asia-Pacific CBR Congress in Bangkok in 2009, and a post-congress workshop was conducted for them.

- Former participants were supported to attend the Asia-Pacific Convention on CBR in Kuala Lumpur in 2010 and post-convention workshop on WHO CBR guidelines was conducted for them.

APCD missions

The APCD carries out regular missions of visiting different countries for exchange, follow-up of trainees, networking and collaboration related to CBR, disability and development issues.

Between 2007 to 2011, 65 such missions were carried out, covering 20 countries that included Bangladesh, Brunei, Cambodia, China, India, Indonesia, Kyrgyzstan, Lao PDR, Malaysia, Myanmar, Nigeria, Pakistan, Papua New Guinea, Philippines, Republic of Korea, Singapore, Tajikistan, Thailand, Uzbekistan and Viet Nam.

From these missions, the APCD documented good practices related to CBR from Laos, Viet Nam and Thailand. Another outcome was the establishment of the South Asian Disability Forum.

Developing CBR networks

The process followed by APCD to develop CBR networks is as follows:

- Training activities: Since the APCD believes in networking and collaboration as key factors for success, in every training course conducted by APCD, the participants are encouraged to develop networking and collaboration among themselves, resource persons as well as APCD.
- Follow-up visit to maximize former participants' capacity: APCD dispatches mission teams to follow-up, visit and facilitate the former trainees to extend their activities.
- Summarize and share lessons learnt: One of APCD's key activities is to identify and document good practice of CBR implementation, and share lessons learnt by the process of Knowledge Management (KM) and Story-based Knowledge Management (SbKM).
- Co-ordinate and promote South-to-South approach: APCD coordinates and promotes South-to-South Cooperation among Asia-Pacific

countries. The APCD also mobilizes resources from one country to another from among the developing countries in Asia-Pacific.

Networks facilitated by APCD

The South Asian Disability Forum (SADF), Islamabad, Pakistan, is a network of DPOs and NGOs in South Asia, and focuses on the subregional point of view related to disability issues in South Asia. The SADF will work in collaboration with governments, APCD, corporate sector, international NGOs, subregional and regional agencies, UN agencies and other key stakeholders, to highlight inclusion of persons with disabilities as a development priority in this region.

The CBR Asia-Pacific Network was initiated after the first Asia-Pacific CBR Congress held in February 2009 in Bangkok, Thailand. Representatives of 24 countries from the region are the Regional Council members, from whom the executive members are elected. The APCD was chosen as the secretariat of the CBR-AP Network.

The ASEAN Autism Network was established by the APCD with the core principle of "Family Comes First", in cooperation with JICA in 2010. This initiative is meant to be an effective forum to advocate for the rights of persons with autism in the ASEAN region. In addition, the Network can work at national and subregional levels, and can support self-advocates to form their own groups at the community level. Representatives from Brunei, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Thailand, Viet Nam and Japan are part of this network.

The APCD "Empowerment Café (E-Café)" is a platform that promotes information and knowledge exchange on disability and development in Asia and the Pacific from the perspective of different subregions: South-East Asia, South Asia, Central Asia, Pacific and East Asia. Information on disability and development issues in the Asia and Pacific region is provided through the APCD E-Café on a daily basis.

The Institute on Disability and Public Policy

The Institute on Disability and Public Policy (IDPP), established by APCD will contribute to the overall vision of an ASEAN region that is inclusive,

barrier-free and rights-based, where people with disabilities are leaders in the determination of their own destinies.

The IDPP offers South-East Asia's first virtual Master's degree programme in Comparative and International Disability Policy. Flexible programmes of study are accessible to students regardless of disability, impairment, special need, or location. Students can participate from anywhere with an internet connection. The APCD's cyber infrastructure facilitates course delivery, administration and collaboration among students across different geographical locations.

APCD Publications

Books

- Community-based Inclusive Development Principles and Practice
- CBR and Inclusive Development in Asia and the Pacific
- CBR and Inclusive Community Development Booklet
- Empowerment Starts within Oneself

DVD

- CBR Initiative in Jodnongkae (Experiences in Thailand)
- Together We Can Make Changes (Experiences in Laos)
- Community for All (Experiences in Viet Nam)
- Yes, You Can! (Experiences in Viet Nam)
- Blind Architect (Experiences in the Philippines)

Training Reports

- Report on Training of Trainers for Community-based Rehabilitations (CBR) through an Inclusive Development Approach, 7th-18th June 2010, APCD Training Building, Bangkok Thailand
- Report on Workshop for the Capacity Development of Self-Help Organizations of Persons with Disabilities (CDSHOD), Bangkok, Thailand 26 – 29 January 2010

All publications are available on the APCD web site: www.apcdfoundation.org

Section 6

CBR practice in the South-East Asia Region

This document describes CBR practices in the South-East Asia Region from different perspectives: government-supported CBR programmes (Bhutan, Myanmar and Sri Lanka), NGO-promoted CBR projects (Nepal, Timor-Leste and India), a DPO-promoted CBR project (Thailand) and a CBR project promoted by a teaching institution (India). Two resource agencies that provide support to CBR Practices: in the region in terms of development of human and material resources are described as well.

This section provides an analysis and comparison of the practices described, according to different parameters.

CBR promoters

In Bhutan and Myanmar, the Ministry of Health is responsible for CBR programmes, implemented through the primary health care delivery system; while in Sri Lanka, the Ministry of Social Service and Social Welfare has a national CBR programme. Overall, the government programmes show a wider coverage and, in the case of Sri Lanka, almost the entire country (22 out of 25 districts) is included in the national CBR programme. However, the scope of activities tends to be largely related to health and medical rehabilitation, except in the case of Sri Lanka.

The NGO projects in Nepal, Timor-Leste and India have smaller geographical coverage in comparison with government programmes, but the scope of their activities is more comprehensive.

The DPO in Thailand is an interesting example of transfer of a project to primary stakeholders: a CBR project started a decade ago by governmental and nongovernmental organizations and continuing to be managed by a cross-disability local DPO, with support from the government.

The teaching institution in India started the CBR project as an extension activity, and this example offers good insights into the process of initiating CBR in a community by an external agency.

CBR Practices in relation to the WHO CBR matrix

Although the information for this document was collected before the publication of the WHO CBR Guidelines, an attempt is made to see how the CBR activities as they were implemented by different stakeholders, relate to the CBR Matrix domains (Table 2).

The government programmes in Bhutan and Myanmar have activities mainly in the health domain, and some collaboration with the education sector, while the Sri Lanka programme covers almost all the domains in collaboration with other stakeholders.

The projects of NGOs and the DPO have activities that comprise all domains, except in Timor-Leste where the project was in its inception at the time of data collection for this document.

The social domain is the one where activities are limited, even in NGO projects, to special events and celebrations with the participation of persons with disabilities, to raise awareness in their communities.

Challenges and lessons learnt in CBR implementation

Challenges

- Poverty and the resultant lack of awareness and access to rehabilitation services continue to be a challenge in remote rural areas in countries like Bhutan, Myanmar and Nepal. Negative attitudes of the community are another barrier to inclusion of persons with disabilities. Bhutan and Nepal have the additional challenges of mountainous terrain and scattered populations.

Table 2: CBR activities by different stakeholders in the South-East Asia Region, in relation to the CBR Matrix domains

	Government			NGO			DPO	Teaching Institution
CBR Matrix Domains	**Bhutan**	**Myanmar**	**Sri Lanka**	**Nepal**	**Timor-Leste**	**India**	**Thailand**	**India**
Health	Primary eye care, Hospital referrals for ENT, Hospital and community-based physiotherapy, Mental health treatment, Assistive devices, Leprosy control	Assistive devices, Home-based rehabilitation, Referrals, Multi-disciplinary specialist team at tertiary level	Referrals for medical rehabilitation, financial assistance for health and medical services	Referrals for medical rehabilitation, Physiotherapy, Mobile camps, Home based rehabilitation, Mobilization of trained rehabilitation facilitators, Assistive devices	Referrals	Early identification and referrals for medical rehabilitation, Home based rehabilitation, Physiotherapy, Assistive devices, Access to government schemes	Referrals, Access to basic health services, Health security	Multi-disciplinary camps, Referrals, Home based rehabilitation through community volunteers, School sensitisation
Education	Referrals for special education and Inclusive education	Referrals for special education and inclusive education	Referrals for special education, home based teaching	Campaigns for school admission, Technical support to make schools accessible, Special preparation classes, Day care centre, Home visit and counselling, Sensitization of parents and teachers, Training for teachers	Campaign for inclusion, Assisting admission to schools, Sensitization for teachers,	Community-based day care centres, Special school, Campaign for inclusive education	Community-based early childhood learning centre	NA

	Government			NGO			DPO	Teaching Institution
CBR Matrix Domains	**Bhutan**	**Myanmar**	**Sri Lanka**	**Nepal**	**Timor-Leste**	**India**	**Thailand**	**India**
Livelihoods	Limited	Referrals for vocational training and counseling	Schemes for self-employment, facilitation of placement, financial assistance for housing and social protection	Vocational training	Referral for vocational training	Community-based skills development centres, Self-employment, Access to government social protection schemes	Community vocational training centre	NA
Social	Limited	NA	Organizing special events, in collaboration with DPOs and NGOs	Special events and celebrations	Organizing a Paralympics event	Special events and celebrations, Access to justice	Special events and celebrations	Special events and celebrations
Empowerment	Limited	Limited	Collaboration with DPOs	Community mobilization, Capacity building of persons with disabilities, Inclusion in management and staff, Inclusion in village level committees	Limited	Community mobilization, Capacity building of persons with disabilities, Self-help groups, Political participation	Community mobilization, Self-help groups, Promotion of Disabled Persons' Organization	NA

- In government CBR programmes in Bhutan and Myanmar where CBR is integrated into the PHC system, there are difficulties related to overloading the community workers who have many tasks to perform.
- Mutisectoral collaboration is highlighted in most countries as the key factor for success of CBR, but it also continues to be a major challenge.
- Lack of sufficient numbers of trained personnel for CBR implementation is a problem, especially in new countries like Timor-Leste.
- Some CBR programmes, for example, Sri Lanka and Myanmar, are dependent on community volunteers, but retaining them is a challenge.

Lessons learnt

- Having a nodal ministry at the government level to coordinate all CBR activities is important for national coverage of CBR and to promote multisectoral collaboration.
- Collaboration between government and NGOs helps in promoting comprehensive CBR programmes.
- Community-level rehabilitation activities need to be closely linked to the primary health care system.
- Awareness raising and advocacy across different stakeholder groups is important at the time of inception of CBR programmes.
- Self-help groups and associations of persons with disabilities are the key to success in CBR programmes.
- CBR staff at the community level need effective supervision, guidance and training.
- Coverage of CBR in a country needs to be planned in a phased manner.

Funding sources and sustainability

Funding

- In most countries, the CBR activities started with support from external donors, and some of them, like Timor-Leste, continue to be supported by these agencies.
- In Thailand and to some extent in India, Nepal, Sri Lanka and Bhutan, the government provides substantial support to CBR programmes and projects.
- Contributions from local communities are limited in most countries, although in countries like Thailand, Sri Lanka, Nepal and India, local fund-raising is being increasingly emphasized.

Sustainability

- The CBR experiences across the Region have highlighted some good practices for sustaining CBR.
- Self-help groups and associations of persons with disabilities, who are the primary stakeholders for CBR, can contribute to sustainability. In Thailand, the local DPO took over the CBR project started by the government and NGOs a decade ago. In India, linking the self-help groups and parent associations with other successful community-based organizations such as the women's federation, has contributed to sustaining some of the CBR activities. Collaboration between local government, parents, and CBR staff in the Indian NGO project has helped to sustain the community "day care" centres. The Nepal experience shows that including persons with disabilities into village-level development councils ensures that disability issues are included in development planning.
- Using community-level volunteers has contributed to sustainability in Sri Lanka and India. The Sri Lankan CBR programme recruits older, retired people who do not leave the community in search of employment. In the extension project of the teaching institution in India, the local volunteers, who gained prestige in the eyes of the community during the project tenure, continued with and expanded their activities even after the project was officially closed.

In conclusion, we would like to quote Dr Samlee Plianbangchang, Regional Director, WHO SEA Region, who stated at the First Asia-Pacific CBR Congress in Bangkok in 2009, “In a broader context, PHC contributes to health equity, social justice; and ultimately to the well-being of all people in communities. Therefore, CRPD, primary health care and CBR reinforce each other and WHO is committed to their implementation. WHO strongly advocates for the removal of health and social barriers against people with disabilities; in this or other contexts, WHO focuses its contribution on the areas where it has comparative advantage; where it can make a difference. This is especially so in the strengthening and further development of community-based rehabilitation.”

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More than 1 billion people around the world live with disabilities; and 80% of them are from low-income countries, many from the WHO South-East Asia Region. Discriminatory practices and attitudes towards persons with disabilities have prevailed for centuries and resulted in their exclusion from mainstream developmental efforts. The number of persons with disabilities is increasing: war injuries, landmines, HIV/AIDS, malnutrition, chronic diseases, substance abuse, accidents, environmental damage, population growth, exposure to hazards, medical advances that preserve and prolong life including neonatal interventions for high-risk babies – all contribute to this increase. As a consequence, there is an overwhelming demand for health and rehabilitation services.

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