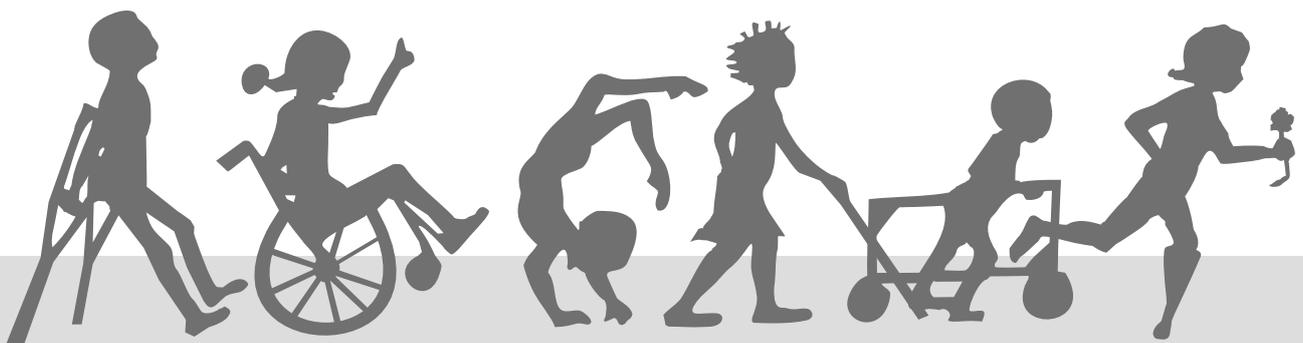# Behinderung und internationale Entwicklung

Disability and International Development

Von CBR zu Community Based Inclusive Development, Teil 2
From CBR to Community Based Inclusive Development, Part 2

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Editorial

Liebe Leserinnen und Leser,

in unserer letzten Ausgabe wurde das Konzept Community Based Rehabilitation (CBR) hinsichtlich seiner Aktualität und Relevanz vor dem Hintergrund der UN-Konvention über die Rechte von Menschen mit Behinderungen reflektiert, ausgehend von der Beschreibung seiner Ursprünge und Entwicklung sowie anhand eines konkreten Umsetzungsbeispiels im Bereich inklusiver Bildung.

In der vorliegenden Aussage nehmen *Sunil Deepak* und *Enrico Pupulin* den Bereich der Gesundheitsförderung als einen der Kernbereiche des CBR-Konzeptes in den Blick. Zugleich werden die Potentiale des CBR-Konzept für diesen Bereich beschrieben. *Peter Coleridge* reflektiert den Beitrag des CBR-Ansatzes zur Armutsbekämpfung durch die Unterstützung von Menschen mit Behinderungen in der vollen Entwicklung und Nutzung ihrer Potentiale. *Valerie Karr* und *Stephen Meyers* machen in einer Fallstudie aus Kambodscha die Notwendigkeit einer kontextuellen Sichtweise deutlich: Die Kehrseite einer versorgenden Tradition der Unterstützung von Menschen mit Behinderung kann die eher zögerliche Entwicklung menschenrechtsbasierter und die Selbstvertretung stärkender Programme sein. *Shuaib Chalklen* (derzeitiger Sonderberichterstatter der UN-Kommission für soziale Entwicklung für Menschen mit Behinderung) beschreibt gemeinsam mit *Hisayo Katsui* den Prozess der Etablierung eines kontinentweit agierenden African Disability Forum, um zu zeigen, dass die Realisierung von Menschenrechten nur auf der Basis von sozialer Sicherheit und Capacity Building gelingen kann.

Die Artikel beschreiben unterschiedliche Wege der Bewusstseinsbildung zu den Rechten von Menschen mit Behinderungen und der Befähigung zur Übernahme der Souveränität über die eigenen Lebensbedingungen. Wir wünschen uns, dass die Artikel zu neuen Ideen in dieser Richtung inspirieren und einen Beitrag leisten zur Realisierung von Menschenrechten durch gemeinwesenorientierte Projekte.

Ihr Redaktionsteam

Dear Reader,

in our last issue, Community Based Rehabilitation (CBR) has already been reflected with respect to its actuality and relevance in the light of the UN Convention on the Rights of Persons with Disabilities (CRPD). We started with a retrospect to the concept's origins and further development, and presented one example of realising CBR in the context of inclusive education.

In the present issue, *Sunil Deepak* and *Enrico Pupulin* focus on health promotion as one of the five key domains of Community Based Rehabilitation. Inversely, CBR-strategies can play an important role in the process of mainstreaming disability in the area of health and rehabilitation. *Peter Coleridge* points out the contribution of CBR to the fight against poverty, not primarily by enabling persons to have their own income, but by creating opportunities to develop one's full potential as a social human being. In a case study in Cambodia, *Valerie Karr* and *Stephen Meyers* show the importance of a contextual view on effects of development strategies: the downside of providing services for persons with disabilities may be that in order to serve their members or beneficiaries, organisations prefer the provision of services over rights education and advocacy. An initiative to establish a continent-wide African Disability Forum is presented by *Shuaib Chalklen* (the current UN Special Rapporteur on Disability of the Commission for Social Development) and *Hisayo Katsui*. The authors show that the realisation of human rights depends on both social security and capacity building. The African Disability Forum may contribute to awareness-raising about disability and human rights all over the continent and can provide policy advice to the national governments.

The articles show different ways of raising awareness on human rights and of enabling persons with disabilities to get the sovereignty over their living conditions. We hope the articles will inspire you to develop new ideas and to take part in realising human rights through community based concepts.

Your editorial board

CBR, Health and Rehabilitation

Sunil Deepak/Enrico Pupulin

Like all persons, persons with disabilities also have different health care needs, from childhood till old age. Some of them also have specific health care and rehabilitation needs linked to their impairments. Only a small percentage of persons with disabilities in the developing world has access to health care and rehabilitation services. This article looks at the barriers faced by persons with disabilities in accessing health care and rehabilitation services and the development of health care related activities in the CBR.

Introduction

The Alma Ata declaration in 1978 defined health "as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (unpaged). Article 25 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD 2006) asks the States to "recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination of disability". Articles 20 (accessibility) and 26 (habilitation and rehabilitation) outline the measures States Parties should undertake to ensure that people with disabilities are able to access health and rehabilitation services that are gender-sensitive.

The right to health is not only about access to health services; it is also about access to the underlying determinants of health, such as safe drinking water, adequate sanitation and housing. The right to health includes the right to be free from non-consensual medical treatment. The health-related entitlements include the right to a system of health protection, the right to prevention, treatment and control of diseases, access to essential medicines and participation in health-related decision-making (WHO/UNESCO/ILO/IDDC 2010, Health Module:1).

More than one billion people in the world live with some form of disability, of whom nearly 200 million people experience considerable difficulties in functioning. Studies from different parts of the world have revealed large gaps in health care needs of persons with disabilities (WHO/World Bank 2011:xi).

Health Care and Rehabilitation Needs of Persons with Disabilities

General health care needs: The general health care needs of persons with disabilities - as of all persons - vary during different phases of their lives, from vaccinations in childhood, to support for reproductive health care services as young adults, and to care and treatment for health conditions linked to old age.

Certain disabilities can be associated with specific health conditions. For example, children born with Down syndrome can also have heart problems and dislocated hips (Werner 1987:279). For such persons, needs for support from general health care services may be greater.

Specific health care needs of persons with disabilities: Not all persons with disabilities require specific health care and rehabilitation services. For example, persons who are deaf or blind may not require any specific support.

However, some disabling conditions require specific health care, rehabilitation and assistive devices. These needs may be occasional, periodic or ongoing and life-long. For example, persons with arthritis, diabetes or convulsions require life-long treatment for these conditions. On the other hand, a person with a disabling infectious disease such as leprosy or Buruli ulcer needs antibiotic treatment for a certain period to cure the infection.

Rehabilitation services for persons with disabilities: Rehabilitation is defined as "a set of measures that assist individuals who experience, or are likely to experience disability, to achieve and maintain optimal functioning in interactions with their environments" (WHO/World Bank 2011:96). Rehabilitation is a multi-sectoral concept and includes different activities such as barrier removal initiatives at societal level. Rehabilitation, as a part of health care, targets improvements in individual functioning. This article limits itself to those rehabilitation aspects that are part of health care services.

Rehabilitation services in the health care systems can involve different departments depending upon the specific disabling conditions. For example, a child with cleft lip or a person with reduced vision due to a cataract often need surgical interventions.

The kind of support required from the rehabilitation services may change with time. For example, persons who had a stroke may need hospital level specialised health care support in

the acute phase. After the person has stabilised with full or partial recovery, home or day-care centre based support may be adequate.

Many persons with disabilities also need to take daily care of their bodies to avoid worsening of impairments. Thus persons with paraplegia due to spinal cord injury or persons with nerve paralysis due to leprosy need to take regular and life-long care of their joints and limbs. An active role of persons and their families is needed for daily self-care.

Assistive devices: Assistive devices are used to increase, maintain or improve the functional capabilities of individual with disabilities. Different groups of persons with disabilities can benefit from different kinds of assistive devices. Some common assistive devices include crutches, wheel chairs and tricycles for persons with mobility difficulties; prostheses (such as artificial limbs for persons with amputations) and orthoses (equipment to correct or support specific body parts, such as shoes with braces); hearing aids; and, white canes, magnifiers and audio books.

CBR and Health Care Services

Health is one of the five key domains of Community Based Rehabilitation (CBR). The role of CBR programmes vis-à-vis health is "to work closely with health sector to ensure that the needs of people with disabilities and their family members are addressed in the areas of health promotion, prevention, medical care, rehabilitation and assistive devices. CBR also needs to work with individuals and their families to facilitate their access to health services and to work with other sectors to ensure that all aspects of health are addressed" (WHO/UNESCO/ILO/IDDC 2010, Health module:3).

Role of CBR in Promoting Access to Health Care and Rehabilitation Services

CBR Guidelines include a module on the health component of CBR. In addition, the supplementary module of CBR guidelines includes information about three specific health conditions - mental illness, HIV/AIDS and leprosy (WHO/UNESCO/ILO/IDDC 2010).

The five-by-five CBR matrix in the Guidelines divides the role of CBR in health care for persons with disabilities in five areas:

1 Health promotion activities aim to increase the control of persons over their health and its determinants. Promoting healthy food habits and doing regular physical activities are examples of such activities. CBR works to ensure that all health promotion activities at community level are inclusive of persons with disabilities.

2 Activities for prevention of health conditions include screening tests and vaccinations. These activities are also part of primary prevention (avoidance) of disabilities. For example, vaccination campaigns against polio have resulted in prevention of disabilities due to polio in large parts of the world. CBR works to ensure that all the prevention activities at community level are inclusive of persons with disabilities.

3 Medical care activities are for early identification and treatment of health conditions, and their resulting impairments, with the aim of curing or limiting their impact on individuals. For example, early diagnosis and treatment of leprosy and Buruli ulcer is important for preventing disabilities due to these conditions.

4 Rehabilitation activities serve to limit the impact of disabilities, to prevent their worsening and to avoid development of new impairments. CBR programmes can play an important role in the maintenance phase of rehabilitation activities. For example, making simple parallel bars in a village can be useful for a person recovering from a stroke who needs to learn to walk again.

5 Assistive devices require support for user education, environmental adaptations, repair and replacement when worn out or broken. CBR programmes can help in making simple assistive devices. More often, they help in providing information and facilitating access to assistive devices produced in specific workshops and centres. CBR can also play a role in user training and repair of assistive devices.

Implementation of Health Care Activities in CBR

Providing information and skills is a key role of CBR programmes. Persons with disabilities may not be aware of different services available and how these can be accessed. Lack of information can be even more significant among persons living in rural and isolated areas, and in persons from poor families.

Mainstreaming means ensuring that all existing health care and rehabilitation services are accessible to persons with disabilities. CBR programmes can play an important role in promot-

ing mainstreaming. For example, specialised assistive technology workshops based in large cities, often have difficulties in reaching and collecting information about the needs for assistive devices from rural areas and small towns. CBR programmes can facilitate access to these services.

A research on the impact of CBR showed that in the areas covered by a CBR programme the percentage of persons with disabilities having access to assistive devices was almost twice the percentage in an area not covered by the CBR programme (Biggeri et al. 2012).

However, sometimes there are no existing services and mainstreaming is not possible. Thus, a twin-track approach may be needed. This means, where mainstream activities are not available CBR programmes can provide or promote the organisation of specific activities for persons with disabilities. Networking with existing governmental and non-governmental stakeholders is a crucial part of the twin-track approach to ensure sustainability of services.

Promoting self-care skills: CBR programmes facilitate skills in self-care and autonomy in activities of daily living. A person may require continued support and assistance in using new skills and knowledge at home and in the community after initial rehabilitation at a specialised centre (WHO/UNESCO/ILO/IDDC 2010, Health Module:49).

The WHO CBR manual (WHO 1989) provides information for promoting self-care at home and in the community. This can be achieved during home visits, when CBR personnel can provide information and skills to persons with disabilities and their family members. Self-care can also be promoted through peer support activities in the self-help groups. Finally, it can be promoted through collaborations with rehabilitation centres, where persons with disabilities and their family members can visit to learn the different self-care skills.

Challenging barriers and facilitating access to referral services: Maintaining close links with specialised rehabilitation services for the referral of persons in case of specific needs is another role played by CBR programmes. Facilitating access to assistive devices produced at specialised centres is part of these activities. The role of the CBR is to work with people with disabilities and their families to determine their needs for assistive devices, facilitate access to assistive devices and ensure maintenance, repair and replacement when necessary (WHO/UNESCO/ILO/IDDC 2010, Health module:67).

In collaboration with DPOs, CBR programmes also work for creating awareness among health professionals and policy makers about dismantling of the different barriers faced by persons with disabilities in accessing the health care and rehabilitation services.

CBR programmes can also provide information to persons with disabilities about the advantages and disadvantages of different health care and rehabilitation interventions so that persons take informed decisions about their own lives.

Links Between Health Care Services and CBR

Community level activities of CBR need support from the referral services. Personnel skilled in rehabilitation technology who can train and support community workers, and provide referral support, is necessary.

Often specialised health service personnel have no or limited understanding of CBR programmes and activities. Thus, involving personnel from the referral services to take part in training activities and meetings organised by CBR programmes and visiting the CBR activities can be useful for promoting awareness and creating links with the health care institutions.

The community alone cannot meet all the needs of people with disabilities. In their various roles, physicians, nurses, health assistants, midwives, and other Primary Health Care (PHC) workers provide preventive, promotive, curative and rehabilitative care (WHO 1994:12).

Thus within the health services, CBR programmes should work in close collaboration with PHC services to ensure that all health care and rehabilitation services are also accessible to persons with disabilities. If no CBR programmes exist in some areas, personnel working in PHC services can promote a CBR approach by involving persons with disabilities and their families in activities such as self-care.

Health Care Services, CBR and Disabled Peoples' Organisations

Historically, the concepts and understanding about disability were closely linked to the health care services. The coming together of persons with disabilities to form their own organisations (DPOs) over the past decades, challenged those concepts and understandings. This process has also influenced the relationships between CBR and DPOs.

Classification of disabilities in the health care: A medical model of disability that located the disability in the individuals and proposed rehabilitation as an effort to the *normalisation* of the

person was developed in the industrial era. The international classification of impairments, disabilities and handicaps (ICIDH) adopted by WHO in 1980 was based on medical model of disability and proposed the following definitions:

$$\text{Disease} \longrightarrow \text{Impairment} \longrightarrow \text{Disability} \longrightarrow \text{Handicap}$$

In the ICIDH, impairment was defined as "any loss or abnormality of psychological, physiological, or anatomical structure or function", disability was defined as "any restriction or lack of ability to perform an activity in the manner or within the range considered normal for human beings" while handicap was defined as "a disadvantage for a given individual that limits or prevents the fulfilment of a role that is normal for that individual" (WHO 1980:13-14).

During the 1970s and 1980s, DPOs proposed a social model of disability that focused on physical, attitudinal, cultural and socio-economic barriers created by societies. *United Nations Standard Rules on the Equalisation of Opportunities for Persons with Disabilities* (1994) took note of the social model and proposed a human rights based approach for looking at disability issues.

The social model of disability influenced the modification of the concept of disability as defined in the ICIDH. A new classification system called *International Classification of Functioning and Disability* (ICF) was developed by WHO in 2001 in consultation with DPOs. It adopted the human rights approach and looked at the impact of a health condition on body functions, structures, activities and participation. ICF focuses on two kinds of factors - environmental and personal factors (WHO 2001b).

CBR and DPOs: The initial ideas of CBR came from the World Health Assembly in 1976, which adopted a resolution encouraging the application of effective and appropriate technologies to prevent disabilities while integrating disability prevention and rehabilitation into the health programme at all levels including primary health care (WPRO 1991).

The first version of the WHO Manual, *Training in the Community for people with disabilities*, was published in 1979. Its main focus was on the activities of daily living and simple exercises that could be done at home by the families and local preparation of simple technical appliances (WHO 1989).

In 1987, another CBR manual was produced, *Disabled Village Children, a guide for community health workers, rehabilitation workers and families*. Its aim was to help "village re-

habilitation workers and parents understand the basic principles behind different rehabilitation activities, exercises or aids" (Werner 1987:A5), so that they could adapt these to the local contexts.

In 1994, the first Joint Position Paper on CBR by three specialised organisations of the United Nations (ILO, UNESCO and WHO) presented the idea of multi-sectoral collaboration, where different aspects of life including health, education and livelihood were considered as equally important.

Thus initially, many of the ideas about CBR were closely linked with health care and rehabilitation services. Many DPOs considered CBR as dominated by the medical model. For example, in an international consultation in 2003, Disabled Peoples' International (DPI) raised the issue of domination of a medical viewpoint in CBR:

> "Some of our regions report that CBR is still medically oriented, not considering the human rights, social and economic needs of individual disabled persons. In other instances, regions report that even when their input is requested, their opinions are not equally weighted to that of professionals. Worst, there were instances when disabled peoples' ideas were totally disregarded. Their input therefore is meaningless" (DPI 2003:2).

However, in the recent past, collaborations between CBR programmes and DPOs have become much more productive. In 2009, in an international workshop on the United Nations Convention on Rights of Persons with Disabilities (CRPD) concluded in its recommendations that CBR offers an important opportunity for implementation of CRPD in the field (Deepak 2009).

During the past decade, a large number of persons with disabilities and DPOs from different countries took an active role in the preparation and field-testing of CBR Guidelines (WHO/UNESCO/ILO/IDDC 2010). Regional and global CBR networks have been set up in which persons with disabilities and DPOs are playing key roles. At the same time, in many countries, DPOs themselves are running CBR programmes.

Neglected Health Care Issues in CBR

There are some issues related to the health care needs of persons with disabilities that are often neglected in CBR.

Such neglected areas can be in relation to specific kinds of disabilities associated with social stigma such as leprosy related disabilities and psychosocial disabilities. For this reason, one module of the CBR Guidelines (supplementary module) contains detailed information about three specific groups of persons - persons affected with leprosy, persons with mental illness and persons with HIV/AIDS (WHO/UNESCO/ILO/IDDC 2010).

Some other areas linked to health care that require more attention from CBR programmes are the taboo areas such as issues related to sexuality, reproductive rights, violence, abuse and sexual abuse. Working at community level in close collaboration with the families, CBR programmes can play a significant role in looking at and raising awareness about some of these issues.

For example, during an international workshop on *Going beyond Taboo areas in CBR*, participants agreed on the key roles played by CBR workers in prevention of violence and abuse towards persons with disabilities: "CBR workers visit homes of persons with disabilities and this helps to reduce violence and abuse in the family. CBR workers talk to families and they understand that there is no need to be ashamed of their child's disability" (Deepak 2013b:18).

Challenges for Health Care and Rehabilitation Activities in CBR

There are different challenges for an effective role of CBR programmes in health care, rehabilitation and assistive devices related activities. Disability is closely linked to poverty. Poverty also means limited resources for obtaining health services and high risk of personal illness (WHO 1998:136). Sometimes, the referral services may even be free but for families of persons with disabilities living in isolated and rural areas, barriers exist due to the lack of accessible transport or high cost of the transport or due to the loss of income resulting from a prolonged stay near the referral services.

Lack of skills among specific CBR workers: In some countries, CBR programmes work with community volunteers who receive limited training. In other countries, CBR personnel is composed of full time CBR workers, but often they need to work with a very large number of persons with disabilities. At the same time, they may have a high turnover and they receive limited training.

A research involving CBR workers from seven countries showed that 96% of the CBR workers were involved in health related activities, and most of them were working with different groups of persons with disabilities. 83% of the workers identified *home based care* of persons with disabilities as their most important learning need. 30% of them identified assistive devices as the area in which they lacked skills and an additional 11% felt that they needed training about the use of medications linked with certain disabilities such as persons with convulsions and mental illness (Deepak/Kumar et al. 2011:85-97).

Lack of services in rural areas and small cities: Health care services, including rehabilitation services, are organised at different levels - national, intermediate (such as provincial or district level) and peripheral levels (primary health care services). In most countries, all specialised health care services and rehabilitation services are available only at national level and in some big cities. A few specialised services may also be available at district level.

Thus, if persons with disabilities living in rural areas and small cities need any specialised health care and rehabilitation services, they must go to a big city or the national capital. Sometimes, specialised health care and rehabilitation support may be needed for prolonged periods of time, for example among some persons with severe disabilities. Lack of accessible transport, loss of income, high cost of the services and leaving the families for long periods, are some of the barriers blocking access to health care services for persons living in rural and isolated areas.

Many of the specialised centres are run by non-governmental organisations (NGOs) or private service providers. Often, these services are fragmented and nor the relevant ministry or the different organisations are able to overview the different responsibilities and activities. For example, a survey in 29 countries of Africa (WHO 2004) showed that a large number of NGOs were involved in running rehabilitation institutions and care services, however specific information about their activities was not available.

Physical and attitudinal barriers: Physical barriers, lack of understanding about the needs of persons with disabilities, a narrow focus on the disability rather than a holistic vision of the persons and all their needs and sometimes, negative attitudes of health professionals are significant barriers.

For example, hospitals may not have staff who knows sign language to communicate with persons with hearing impairments. They may not understand the specific needs of persons with vision impairment and thus, the health education materials may not be accessible to

them. Sometimes, orthopaedic laboratories that provide some assistive devices are placed on higher floors and there are no lifts, so that persons with mobility difficulties need to be carried over the stairs, to access these services.

Among the persons with disabilities, women with disabilities often find it harder to get the health care they need. Some common barriers that they face include: lower beds or good quality catheters are often not available; the hours the health centre is open may not be convenient; and, there may be few women doctors even though many women feel embarrassed to go to a male doctor (Maxwell/Belser/David 2007:35).

In a workshop on sexuality and reproductive health issues for persons with disabilities (Deepak 2013a) a CBR worker explained: "If a woman with a disability gets pregnant, the health workers ask her - 'How did you become pregnant?' They cannot believe that a woman with disability can have sex or that a man would have sex with such a woman. Their attitude puts off women with disabilities. So when women with disabilities are pregnant they don't want to go to hospital for check-ups".

Organisation of health services for acute care: Health care systems were developed a couple of centuries ago, when certain acute infectious diseases were the leading cause of illness and death. The health care systems were designed to address pressing concerns. For example, testing, diagnosing, relieving symptoms, and expecting cure are hallmarks of contemporary health care. Moreover, these functions fit the needs of patients experiencing acute and episodic health problems. However, a notable disparity occurs when applying the acute care template to patients who have chronic problems (WHO 2002:29).

The *acute care* model of health services locates expertise in the health professionals, while the persons needing health care are seen as passive receivers. On the other hand, chronic conditions are usually life-long requiring continuous and regular care and life style changes. This means that persons with chronic conditions need to develop skills for self-care and take an active role in their own care. Impairments are also chronic conditions that require life-style changes. Thus health care and rehabilitation services responding to specific needs of persons with disabilities need to have active engagement with their clients to provide knowledge and skills for self-care.

The focus of the health and rehabilitation services, which are presently organised around *acute care* and based solely on the expertise of

professionals, needs to shift to a *chronic care* model of services, with greater role of persons with disabilities and their families in their self-care.

Difficulties of multi-sectoral collaboration: CBR programmes recognise the need for multi-sectoral collaboration, because the goal of CBR is to contribute towards the empowerment of persons with disabilities, facilitating an independent life style in which they participate in all aspects of community life. Multi-sectoral collaboration is therefore imperative if such a goal is to be achieved, as no sector alone can achieve such a broad objective. However, multi-sectoral collaboration is beset with different challenges including the lack of political commitment, rigid ministerial demarcations, poor communication and vertical management processes (O'Toole 1996:11-16).

Thus, if a CBR programme is not under the health ministry but is under another ministry or if it is managed by a NGO, then collaboration with health care services may face difficulties. Sometimes, even when a CBR programme is under a ministry of health, it may still face difficulties in accessing referral services as CBR programmes are usually under community health services and do not have direct links with services dealing with institutions and hospitals.

Other challenges: In many developing countries, national coverage of primary health services is often patchy and incomplete. Health centres, even if they exist, lack trained staff, medicines and medical supplies. Globalisation and linked changes such as increased privatisation of services have created additional challenges.

For example, in China, the government share of health expenditure fell by over half between 1980 and 1998, almost trebling the portion paid by families. This led to the growth of private delivery systems for those who could afford them, and increased cost-recovery schemes for services that were still under some form of public health insurance. In India, Government expenditure on health care accounted for just 18% of health care spending, with the rest financed by users - making it one of the world's most privatised health care systems (GHW 2005:19-20).

WHO Guide on referral health services (WHO 1994:ii-iii) underlined "the inadequacy of current services to meet the needs" of persons with disabilities - "In developing countries, even most basic services and equipment are lacking".

In 1999, the Disability and Rehabilitation team of the World Health Organisation (WHO/

DAR) conducted a survey to collect information on rule 2 (medical care), rule 3 (rehabilitation), rule 4 (support services) and rule 19 (personnel training) of the *U.N. Standard Rules on Equalisation of Opportunities for Persons with Disabilities* (1994) from Ministries of Health (MoH) and Non-Governmental Organisations (NGOs) including organisations of disabled people. All together, 104 ministries and 115 NGOs responded to this survey (WHO 2001a).

This WHO/DAR survey provided information about availability and access to different health care and rehabilitation services, including information about assistive devices and training of health care personnel. The reports of this survey identified different areas where health and rehabilitation services were inadequate and where persons with disabilities faced different barriers to access. For example, the survey showed that in almost 50% of the countries, less than 20% of population had access to rehabilitation services (WHO 2001a, Part 1, summary:21).

Promoting Greater Access to Health Care and Rehabilitation Services

Considering the continuing difficulties faced by persons with disabilities to receive health care, in May 2013, the World Health Assembly approved a resolution

> "… people with disabilities have the same need for general health care as non-disabled people, yet have been shown to receive poorer treatment from health-care systems than non-disabled people; Also recognising the extensive unmet needs for habilitation and rehabilitation services, which are vital to enable many people with a broad range of disabilities to participate in education, the labour market, and civic life, and further that measures to promote the health of people with disabilities and their inclusion in society through general and specialised health services are as important as measures to prevent people developing health conditions associated with disability" (WHO 2013:5).

This resolution invited member countries to:
- work to ensure that all mainstream health services are inclusive of persons with disabilities, an action that will necessitate, inter alia, adequate financing, comprehensive insurance coverage, accessible health-care facilities, services and information, and training of health-care professionals to respect the human rights of persons with disabilities and to communicate with them effectively;
- promote habilitation and rehabilitation across the life-course and for a wide range

of health conditions through: early intervention; integrated and decentralised rehabilitation services, including mental health services; improved provision of wheelchairs, hearing aids, low vision devices and other assistive technologies; and training to ensure a sufficient supply of rehabilitation professionals to enable people with disabilities to achieve their potential and have the same opportunities to participate fully in society;
- promote and strengthen community-based rehabilitation programmes as a multi-sectoral strategy that empowers all persons with disabilities to access, benefit from, and participate fully in education, employment, health and social services.

Future Trends in CBR and Health

The ratification of the CRPD in a large number of countries along with the preparation of national disability action plans for implementing the CRPD, have strengthened the CBR programmes in a number of countries. This tendency is likely to continue with the expansion of CBR activities through national programmes.

CBR programmes are about working together with persons with disabilities and their families at the community level. The gradual expansion of communication and information technologies over larger areas of the developing world can offer newer ways of implementing CBR. For example, the role of CBR programmes in providing information and promoting awareness can be reinforced through mobile telephony. Similarly, online training opportunities can provide more cost effective ways of reaching persons with disabilities, families, DPOs and CBR workers.

The majority of CBR programmes have been developed in rural areas, though there are some examples of successful urban CBR programmes. Growing urbanisation across the world may require a fine-tuning of new approaches to implement CBR programmes in urban areas.

Linking CBR programmes with the post 2015 development agenda so that international efforts like the Millennium Development Goals, the Mental Health Gap programme and the campaign around non-communicable disease are inclusive of persons with disabilities is another key area that is going to influence implementation of CBR programmes in future.

Conclusions

Health care including rehabilitation care and assistive devices are key components of CBR programmes. People with disabilities need health services for general health care needs like the rest of the population, including different needs in different phases of life. While not all people with disabilities have health problems related to their impairments, many will also require specific health care services, on a regular or occasional basis and for limited or lifelong periods.

CBR programmes promote health care activities in terms of health promotion, prevention, medical care, rehabilitation and assistive devices. The health care related activities of CBR include information and skill provision, mainstreaming, provision of some specific services, promotion of self-care and autonomy in activities of daily living, facilitation and advocacy.

Persons with disabilities face many barriers in accessing health care services. CBR programmes, in partnership with primary health care services and in collaboration with referral services can do a lot to overcome some of these barriers.

References

BIGGERI, M./DEEPAK, S./MAURO, V./TRANI, J.F./KUMAR, J. ET AL. (2012): Impact of CBR - CBR programme in Mandya district, Karnatakam, India. Bologna: AIFO.

CRPD, 2006 - United Nations Convention on Rights of Persons with Disability. Available at http://www.un.org/disabilities/default.asp?navid=14&pid=150. Visited on 18 April 2013.

DEEPAK, S. (2009): CBR and U.N. Convention on Rights of Persons with Disabilities. Report of an international workshop. Bologna: AIFO.

DEEPAK, S. (2013a): Social relationships, sexuality and reproductive rights and persons with disabilities. Report of an international workshop. Bologna: AIFO. Available at http://www.aifo.it/english/disability/documents/cbr_sexuality/Taboo_report_part01_Social_relationships_Sexuality_ReproRights.pdf. Visited on 27 March 2013.

DEEPAK, S. (2013b): Violence and abuse towards persons with disabilities. Report of an international workshop. Bologna: AIFO. Available at http://www.aifo.it/english/disability/documents/cbr_violenza/Taboo_report_part02_Violence_abuse.pdf. Visited on 10 April 2013.

DEEPAK, S./KUMAR, J./ORTALI, F./PUPULIN, E. (2011): CBR Matrix and perceived training needs of CBR workers - a multi-country study. Disability, CBR and Inclusive Development, vol. 22, no. 1.

DPI (2003): Disabled Peoples' International (DPI) position paper on Community-based Rehabilitation (CBR). Available at http://www.aifo.it/english/disability/documents/reviewofcbr/DPI%20on%20CBR.pdf. Visited on 20 March 2013)

GHW (2005): Global Health Watch 2005-06 Report. London: Zed Books.

MAXWELL, J./BELSER, J.W./DAVID, D. (2007): A Health Handbook for Women with Disabilities. Palo Alto; Hesperian Foundation.

O'TOOLE, B. (1996): Multi-sectoral approach in CBR. In Workshop on community-based rehabilitation and country experiences of CBR. Bologna: AIFO.

WERNER, D. (1987): Disabled Village Children, a guide for community health workers, rehabilitation workers and families. Palo Alto: Hesperian Foundation.

WHO (1980): International classification of impairments, disabilities and Handicaps - A manual of classification relating to the consequences of disease. Geneva.

WHO (1989): Training in the community for people with disabilities. Geneva.

WHO (1994): Community-based Rehabilitation and the health care referral services - a guide for programme managers. Geneva.

WHO (1998): The World Health Report - Life in the 21st century - A Vision For All. Geneva.

WHO (2001a): The UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities - Responses to the implementation of the rules on medical care, rehabilitation, support services and personnel training.

WHO (2001b): The international classification of functioning and disability. Geneva.

WHO (2002): Innovative care for chronic conditions - Building blocks for Action, Global Report, Non-communicable Diseases and Mental Health. Geneva.

WHO (2004): Disability and Rehabilitation status - Review of Disability Issues and Rehabilitation Services in 29 countries of Africa.

WHO (2013): Disability, Resolution EB132.R5. Executive Board of the WHO, 132 session, 23 January 2013.

WHO/ILO/UNESCO (1994): Joint Position Paper. Geneva.

WHO/AIFO (2002): Equal opportunities for all: Promoting CBR among urban poor populations - Initiating and sustaining CBR in urban slums and low income groups. Bologna. Available at http://whqlibdoc.who.int/hq/2002/WHO_DAR_02.1.pdf. Visited on 27 March 2013.

WHO/UNESCO/ILO/IDDC (2010): Community-Based Rehabilitation - CBR Guidelines. Geneva.

WHO/WORLD BANK (2011): World Report on Disability.

WPRO (1991): Report Inter-country workshop on planning and management of community-based rehabilitation programmes. Manila, Philippines.

Zusammenfassung: *Wie alle Menschen haben auch Menschen mit Behinderung verschiedene Bedarfe in der Gesundheitsversorgung, von der Kindheit bis ins hohe Alter. Manche von ihnen haben auch spezifische Bedarfe im Bereich Gesundheit und Rehabilitation, verbunden mit ihren Beeinträchtigungen. Nur ein kleiner Prozentsatz von Menschen mit Behinderung in Entwicklungsländern hat Zugang zur Gesundheitsversorgung und zu Rehabilitationsangeboten. Dieser Beitrag richtet den Blick auf die Barrieren, denen sich Menschen mit Behinderungen beim Zugang zu Gesundheitsversorgung und Rehabilitationsangeboten gegenüber sehen und beschäftigt sich mit der Entwicklung von medizinischen und damit verbundenen Aktivitäten in der CBR.*

Résumé: *Comme toute personne, les personnes handicapées ont différents besoins de soins de santé, de l'enfance au grand âge. Certaines ont aussi des besoins spécifiques liés à leur handicap. Seul un nombre restreint de personnes handicapées dans les pays en développement a un accès aux soins de santé et aux services de réadaptation. Cet article observe les barrières rencontrées par les personnes handicapées pour l'accès aux soins et les services de réadaptation ainsi que le développement des soins de santé dans le cadre des activités de RBC.*

Resumen: *Como todas las personas, las personas con discapacidad también tienen diferentes necesidades de atención de la salud, desde la infancia hasta la vejez. Algunos de ellos tienen además, dependiendo de su deficiencia, necesidades de atención o de de rehabilitación específicas. Sólo un pequeño porcentaje de personas con discapacidad en el mundo en desarrollo tiene acceso a servicios de salud y rehabilitación. Este artículo analiza las barreras que enfrentan las personas con discapacidad en el acceso a la asistencia de salud y los servicios de rehabilitación. Además se enfoca el desarrollo de las actividades de atención a la salud que son relacionadas con la RBC.*

Authors: Sunil Deepak is the Head of Scientific support department of AIFO, Italy. He has contributed to the chapters on health and leprosy in the CBR Guidelines.
Enrico Pupulin is ex-head of Disability and Rehabilitation team at World Health Organisation (WHO/DAR) and member of core group for the CBR Guidelines.
Contact: Sunil Deepak: AIFO, Via Borselli 4-6, 40135 Bologna, Italy; E-Mail: sunil.deepak@aifo.it.

Community Approaches to Livelihood: Creating Networks of Mutually Supporting Relationships

Peter Coleridge

The article considers the primary task of development to be empowerment and the building of mutually supportive relationships. It views Community Based Rehabilitation (CBR) as an approach whose main purpose is to build such relationships, and views livelihood development as central to the process. The language, philosophy, practice, and experience of CBR has an important contribution to make to the general debate about creating a more equitable approach to international development.

Introduction

"Development is what happens when relationships strengthen for the common good" (MacLachlan/Carr/McAuliffe 2010).

The framework for the Community Based Rehabilitation (CBR) Guidelines (WHO/UNESCO/ILO/IDDC 2010), the CBR Matrix, recognises that there are many factors which combine to make the life of a person with disability meaningful, and which can make inclusion a reality, not a hope. Within the broad perspective represented by the Matrix, the Guidelines identify livelihood, meaning work and employment, as the key to reducing poverty. There are a number of useful texts, which give practical advice on how disabled people can gain access to work and employment (E.g. ILO 2008).

But the purpose of this article is not to summarise the advice given in such texts. The issue for the vast majority of both disabled and non-disabled people in poor countries is how to manage their lives within a context of very meagre material resources. The article challenges the view that poverty is simply a matter of income, and considers the primary task of development to be empowerment and the building of mutually supportive relationships. It views CBR as an approach whose main purpose is to build such relationships, and views livelihood development as central to the process.

This article takes the view that the development of livelihoods goes well beyond the ability to earn an income. It involves creating opportunities to develop one's full potential as a social human being with increasing control over the factors that shape one's life, and the ability to contribute to the development of one's community and society.

The article also illustrates how CBR can contribute to the global discussion on the ethics and practice of international development. This is not as far from the title topic as it may at first seem. There is much fully justified criticism of

aid and development when viewed as a global phenomenon (Maren 1997; Calderisi 2007). The central problem is that, if a system is based on unequal relationships, it will fail, in human terms. A system defined primarily by the presence of donor and recipient is inherently one of unequal relationships characterised by dominance and subservience, and the distortion of self-image in both donor and recipient.

What does an inclusive society based on equality look and feel like? CBR presents a model, which is based on equal, reciprocal relationships where relationships strengthen for the common good (MacLachlan/Carr/McAuliffe 2010). This article illustrates some situations where this is a reality. The language, philosophy, practice and experience of CBR have much to offer the general debate about creating more equitable approach to international development generally.

A discussion of livelihoods provides an ideal context in which to examine this approach[1].

The Link Between Poverty and Disability

Disability is a complex topic and so is poverty. Both are context specific, and single definitions do not apply in all circumstances. For this reason the Convention on the Rights of Persons with Disabilities avoids giving a definition of disability.

Because disability has not been seen historically as a mainstream development topic, little research has been done on the direct link between disability and material poverty[2]. Academic organisations such as SINTEF (2003) and University College London, and government aid agencies such as DFID (2004), are conducting research to obtain both quantitative and qualitative data that can provide prevalence estimates and general links between poverty and disability. However, there is at present scant systematic data on the dynamics of how the

presence of impairments affects the economic and social life of people in developing countries (Coleridge 2011).

Nevertheless, it is clear that disability is both a cause and an effect of poverty. Classic indicators of poverty such as poor sanitation, poor nutrition, dangerous work conditions and transport, and lack of medical services especially around birth, all conspire to produce impairments. There is also much evidence that, once impaired, a disabled person and his or her family will find it more difficult to escape from absolute poverty and those who become disabled through accidents at work or other reasons are more likely to descend into chronic poverty (Coleridge 2011). Rates of material poverty around the world are significantly higher in households with a disabled person (World Bank 2007).

However, we cannot measure poverty only by whether passive material needs are met. There are other needs: "the need to be creative, to make choices, to exercise judgement, to love others and be loved, to have friendships, to contribute something of oneself to the world, to have social function and purpose. These are active needs; if they are not met, the result is the impoverishment of the human spirit, because without them life has no meaning" (Coleridge 1993, cited in Coleridge/Simmonot/Steverlynk 2010:33). The denial of these needs is a feature of disabled people's lives everywhere, not just in poor countries (Coleridge 2011). CBR, at its best, is an attempt to enable people with disabilities to meet both their material and psychological needs, as the examples below illustrate.

The UN Convention on the Rights of Persons with Disabilities

The UN Convention on the Rights of Persons with Disability (CRPD) marks a fundamental paradigm shift in attitudes and approaches to disability. Persons with disabilities are not viewed as objects of charity, medical treatment and social protection, but rather as subjects with rights, who are entitled to and capable of claiming those rights and making decisions for their lives. The CRPD views disabled people as agents of their own change, and an inclusive society as a partnership between disabled and non-disabled people.

While it is a major achievement, the CRPD will not change the lives of disabled people just by its existence. People cannot eat rights and legislation; they do not develop by an act of parliament (Cornielje/Bogopane-Zulu n.d.). An

implementation strategy and process is required. The Convention is a set of standards that need to be implemented through policy and practice. CBR, as described in the new WHO Guidelines, is a comprehensive approach to making these standards a reality.

Community Based Rehabilitation and Community Based Inclusive Development

As the CRPD marks a paradigm shift in attitudes to disability, CBR has itself gone through its own evolution. Whereas in the early eighties it was primarily focused on rehabilitation, it is now viewed within a much wider framework: it is a multi-sectoral strategy to address the broader needs of disabled people, ensuring their participation and inclusion in society and enhancing their quality of life. CBR is now primarily about making the right to inclusion a practical reality. It is also a strategy for poverty reduction, in which poverty is defined in the broadest terms and includes both material and psychosocial needs of the kinds referred to above.

This radical change from rehabilitation to inclusion has given birth to the concept of Community Based Inclusive Development (CBID). CBID is a way of describing positive, mutually supporting relationships. Many practitioners prefer this label over CBR because CBR appears to retain a focus on rehabilitation, when what is intended, described in the WHO Guidelines and enshrined in the CBR Matrix, is inclusive development from a community perspective. *CBID* therefore tends to be used interchangeably with *CBR*, but it means the same thing. In this article CBR is used, with the understanding that it is fundamentally about inclusive development, of which rehabilitation is a small (but essential) part.

However, the idea of an inclusive society is not new. Traditional value systems still exist in many countries, where mutual support mechanisms have been part of the social fabric for centuries. It is important to make connections between traditional value systems and the CRPD and CBR. Capitalist economies, with an emphasis on a competitive market, have tended to erode these value systems, but these two tools, the CRPD and CBR, can reawaken in us the age-old ideals of reciprocal, mutually supportive networks of relationships that are essential to a just and equitable society.

What Does Livelihood Mean?

Exclusion from economic activity is probably the

prime reason for discrimination against disabled people in poor countries. Work and employment are a crucial part of a person's identity and self-image. We all have a built-in desire to contribute, to make a difference. It is also the way in which we are valued by our families and society.

But livelihood does not only mean employment or income. It is the way in which we organise our lives not just to survive but also to flourish – as human beings with desires and aspirations.

There is a wide variety of ways CBR is implemented across the world depending on historical, cultural, political, economic, geographical, and other factors, but the common thread is that CBR, at its best, is a practical strategy for building mutually supportive relationships.

Take, for example, Opha in Zimbabwe. She is a wheelchair user who sells fruit in the Bulawayo market. Two things strike a visitor to her stall: first, she has a radiant smile, and is very outgoing. Second, her bananas are more expensive than her neighbours. How can this be? She says: "I have my customers who always buy from me, even though my bananas are a bit more expensive". On further enquiry it emerges that she belongs to four different community savings groups: one for meeting utility bills, one for funeral expenses, one for school expenses for her niece, and a disability group. She earns very little, about $50 a month. She is unmarried but supports her niece through school. She is part of a network of mutually supportive relationships that, despite a very low income, enable her not only to survive but to flourish.

The word used for such relationships in southern Africa is *ubuntu*. Archbishop Desmond Tutu describes it thus:

"Ubuntu is the essence of being human. It speaks of the fact that my humanity is caught up and is inextricably bound up in yours. I am human because I belong. It speaks about wholeness, it speaks about compassion. A person with ubuntu is welcoming, hospitable, warm and generous, willing to share. Such people are open and available to others, willing to be vulnerable, affirming of others, do not feel threatened that others are able and good, for they have a proper self-assurance that comes from knowing that they belong in a greater whole. They know that they are diminished when others are humiliated, diminished when others are oppressed, diminished when others are treated as if they were less than who they are. The quality of ubuntu gives people resilience, enabling them to survive and emerge still human despite all efforts to dehumanise them" (Tutu 2004:26).

The concept is not unique to southern Africa, and has been voiced by poets, philosophers, politicians, and spiritual leaders everywhere. Perhaps the most familiar in English-speaking cultures is the poet John Donne, writing in the 17th century:

"No man is an Island, entire of itself; every man is a piece of the continent, a part of the main… Any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee" (Donne 1624, Meditation XVII).

Paulo Freire, the Brazilian educator who has probably had more influence on development thinking than any other single individual in the past fifty years, wrote:

"To be human is to engage in relationships with others and with the world" (Freire, 1968; 1996:3).

Opha sells her bananas at a higher price than her neighbour because the principle of *ubuntu* still operates in Zimbabwe. She has a network of people who support her, and they are happy to pay more for her bananas simply because they are part of her support network.

Ubuntu also operates among the market traders. If Opha leaves her stall to go and collect fruit from the wholesaler, her neighbour looks after it - and sells her fruit at her price. The market traders all help each other in various ways. This gives a totally different view of *market force* than the one presented by modern economists, who see the market as fundamentally competitive.

Opha says: "I fear God. I do not use money recklessly. I have an eye for detail. I make friends with my customers. If I am regarded as successful it is because of these things."

But the real key to her success is that she does not sit at home demanding her rights. She is proactive, and approaches life with a positive and optimistic frame of mind. She reaches out to people, she makes friends, she gives, of herself, of her time, of her very limited money. She is part of a wide set of mutually supportive relationships.

Opha earns $50 a month, which theoretically places her on the threshold of absolute poverty. But is she poor?

Vocational Training Centres in India

A different kind of example is provided by vocational training centres (VTCs) in India run by the Leprosy Mission. These are for young people who have leprosy, or whose parents have leprosy. Nowadays leprosy can be completely cured with drugs but the stigma remains very

strong and is often a serious bar to employment.

These VTCs train young people (both boys and girls) in motor mechanics, carpentry, electrical fitting, tailoring and the other vocational skills that VTCs teach all over the world. But many VTCs around the world have a rather poor record of employment for their graduates. In the case of the Leprosy Mission schools, 90% of their graduates find employment within a year of graduating.

Why? There are three reasons.

First, these VTCs focus not just on technical skills but on life skills. It is not enough to learn motor mechanics. To be successful in employment one also needs to have: determination, aspirations, social responsibility, willingness to take risks, optimism, friendliness, persistence in the face of set-backs, creativity, openness to other views, critical thinking, and high personal standards.

These qualities can be taught, by example, by role models, and by creating a culture in the training centre where these values are demonstrated and prized. The Leprosy Mission schools recognise that operating a successful car repair business, for example, requires more than a knowledge of motor mechanics: relations with customers and relationships within the workforce are equally important. A reputation for honest and transparent dealing in business will establish a secure and sustainable customer base. This reputation overrides all other considerations, including the fact that a car repair business employs people who have had leprosy, with all the stigma that that carries.

Second, these VTCs have placement officers, whose job it is to develop relationships with potential employers in the formal sector. Once a company has seen that graduates from these VTCs have valuable personal qualities besides their technical skills, that they are conscientious, creative, positive, reliable, and honest, they regard the VTCs as excellent sources of new recruits.

Third, the schools have vibrant alumni associations, where previous graduates, now in jobs, can support younger graduates in finding and keeping employment. This network of peer support has the following vital functions:

(a) For young graduates trying to find their way in the bewildering world of work, those who have already navigated it successfully are much better placed to give guidance, and will be more effective, than school staff.

(b) It spreads and localises the task of giving support; it would be impossible for school staff to give such support to all their graduates.

(c) It solves a serious problem common to many VTCs around the world which lose touch with their graduates, and therefore do not know how many of them enter and keep employment. This in turn means that they do not know how effective their courses are. But in the case of the Leprosy Mission VTCs, the alumni associations, which keep in touch with the parent school, enable the schools to evaluate the success of their courses because they have an ongoing view of how many graduates enter and keep employment.

These three factors, life skill training, placement officers, and alumni associations, draw on the age-old principle of creating networks of supportive relationships. They also demonstrate a recognition that creating a successful livelihood has to be approached holistically, and cannot be seen as a matter simply of technical skills and income (Coleridge 2007).
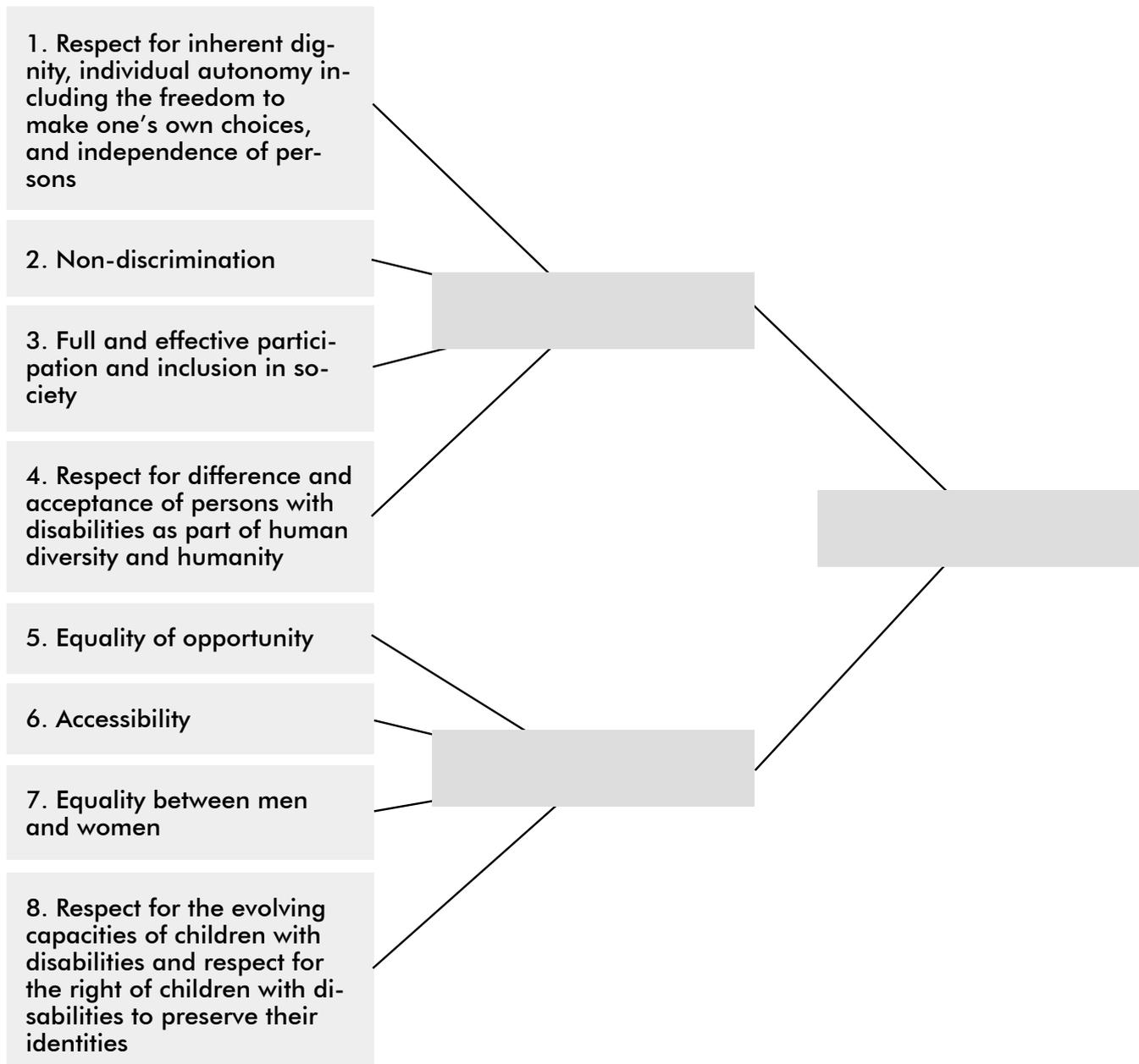
The Principles of the CRPD and CBR

Let us remind ourselves of the principles of the CRPD (United Nations n.d.).
1. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons.
2. Non-discrimination.
3. Full and effective participation and inclusion in society.
4. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity.
5. Equality of opportunity.
6. Accessibility.
7. Equality between men and women.
8. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

These eight principles can be summarised in two words: inclusion and empowerment. CBR, while adopting all the CRPD principles, adds sustainability.

These principles can also be summarised, in the African context, in one word: *ubuntu*. The CRPD and the new CBR Guidelines mark a paradigm shift in our view of disability because they see disabled people as agents of their own change, within a context of mutually supporting relationships. It is not that disabled people are now expected to do everything on their own and by themselves. The point is enshrined in the idea of *ubuntu*: if another human being is diminished, I am diminished. We are all part of

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2. Non-discrimination

3. Full and effective participation and inclusion in society

4. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity

5. Equality of opportunity

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7. Equality between men and women

8. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities

a common humanity, in which it is entirely in our own interests to help each other. CBR is, at its best, a network of supporting relationships which provide purpose and value to the lives of all those concerned, not just of disabled people.

The creation of a just society is a joint responsibility between government and citizens. Within the human rights framework governments are duty-bearers and citizens are rights holders. It is the responsibility of governments to enact legislation and to provide essential services, and it is the responsibility of citizens to hold governments to account for those primary functions. Legislation and essential services provide the baseline and framework for citizens to play their part, in which both disabled and non-disabled citizens work together to create

the network of mutually supporting relationships that are the basis of an inclusive society.

There are many examples where disabled people at the grass roots have been able to exert major influence on social attitudes, and on development policy and practice. Self-help groups of disabled people in India are a prime example. These groups also demonstrate an approach to livelihood, which goes well beyond income and shows the interconnection between all the elements in the CBR Matrix (WHO n.d.), and the power of reciprocal relationships.

Self-Help Groups in India[3]

Like other marginalised groups, it has become clear to disabled people in many countries that

the attainment of rights is an active, not a passive process, in which they take the lead. It is they who must take the initiative to solve their own problems and create their own opportunities through joint action in groups. Self-help groups open the doors of possibility to both individual and community development in the fullest sense. Through group action disabled people gain increased confidence and self-esteem, create economic opportunities, and make rights a reality.

Self-help groups of disabled people in India began in the 1980s at the instigation of Balakrishna Venkatesh, a blind disability activist, working at that time with Action on Disability and Development (ADD). At first the idea was neither understood nor accepted by disabled people themselves: they were accustomed to the charity and total dependency model that has been traditionally built into conditions of impairment, handicap and disability. The idea that they should take charge of their own development did not fit any of their previous experience. But ADD India persisted in its efforts and over the next ten years witnessed a proliferation of self-help groups for disabled people in South India. The self-help group has now, in 2013, become the dominant strategy used by CBR programmes throughout India.

Initially these groups were issue-based and did not handle savings; nor did they operate loans. Their primary concern was to obtain the benefits to which disabled people are entitled under the law from the state: medical certificates, bus passes, help with buying aids and appliances, income supplements (so called pensions), and scholarships for education. While these benefits are statutory entitlements, most of the disabled individuals or their families were not aware of them. The few who were aware and attempted to access them met with apathy, insensitivity and corruption in the government system. But while an individual with disability was easily dismissed or ignored, a group could not be.

Experience has shown that these groups have revolutionised the way disabled people think about themselves, and also the way they are regarded in their communities. Forming a group makes them more visible in the community, showing that they are as capable as anybody else of managing their own affairs. They come together for the purpose of solving their common problems through mutual help and collective actions. Members can support one another by sharing information on the availability of services and resources. They reach a better understanding of disability, discrimination and human rights. They provide a means for disabled people to be part of the community decision-making process. Most of all, membership of a group gives a disabled person the experience of being a contributor rather than a passive receiver, which is the first essential step to personal empowerment.

The following case study from a CBR programme supported by Leonard Cheshire Disability in India illustrates these points.

Self-Help Group Uppugundur Village, Prakasam, Andhra Pradesh, India[4]

The group started in 2006, and has 14 members. It is composed of ten people with mobility impairments (mainly polio), one with visual impairment, one with mental illness, one with speech and hearing difficulties, and one with an intellectual impairment (represented by her mother). They were given three days of training to start. This training covered: how to develop an action plan, how to maintain records, and how to keep the group animated.

There are 89 disabled people in the village (population 12,000, therefore 0.74%), but this is the only self-help group of disabled people. Members consider that 14 is the ideal number for a group: it is difficult to build a real consensus with a larger number, and a smaller number is non-representative and precarious. So they are not planning to increase its size; instead they encourage disabled people who are not in a group to form other groups.

The purpose of the group is to find solutions to their own problems by their own efforts. They say: "We have demonstrated by our own experience that a group is stronger than an individual".

They meet once a month. Besides the usual attention to medical certificates, bus passes, and pensions, their activities also include: identifying disabled people in the village, mainstreaming disabled children in schools, keeping group records, arranging opportunities for skill training, helping members with job applications, putting on film shows to inform and raise awareness about disability, sensitising other disabled people to form groups, arranging basic literacy training, forming links with the Association for Rural Poverty, organising training for writing requisitions to the local government, discussing the formation of a village organisation.

Members also participate in women's groups, and arrange extra activities for disabled children. They have addressed not only the

problems of disabled people but also general village problems such as water supplies, electricity, housing, old age pensions, widows' pensions, and road access.

They each put in Rs30 per month into the groups savings account.

Their achievements since starting in December 2006 have been: three members obtained bus passes, three obtained pensions, three were assessed for corrective surgery, one took a six month computer training course, four disabled children were enrolled in mainstream schools, special educational material was provided to three disabled children. They have shown four films to raise awareness about disability issues and have also put on street theatre performances for the same purpose. In addition they have succeeded in getting more drinking water taps fitted in the village. They intend to put candidates up for election to the *panchayat*.

When asked what they valued most about being in the group (Coleridge/Venkatesh 2010), members mentioned personal gains such as pensions, bus passes, skill training, house improvement loans, how to save, and how to manage their finances better. They also mentioned increased self-confidence, self-esteem and a significant change in the way they were regarded in the village. They showed a good level of knowledge about legislation applicable to disabled people, and were adamant that disability should be seen as a rights issue, not charity.

As a participant in a discussion about this programme put it:

> "Groups bring a change of concern about others. Self-help groups give their members the opportunity to learn, be aware and be exposed to wider realities of life and society. They discover that one person cannot raise his voice for everybody. Only a group can do this." (Coleridge/ Venkatesh 2010)

Over the two decades that self-help groups of disabled people have been developing in India they have evolved in significant ways:
a) they have advanced from focusing on personal needs of individuals to the collective needs of disabled people within the larger context of community and village;
b) they have moved into savings and credit based on credit capacity building as a strategy for economic self-reliance of the individual, family and group, replicating the successful model of women's groups;
c) they have formed federations, which means their voice is now raised above the village level to district and sometimes state level.

Only Connect: An Example from Uganda

David Luyombo in Uganda is a man who demonstrates par excellence the principles of *ubuntu*, the CRPD and the CBR Guidelines.

David runs an agricultural training centre in *Masaka*, about three hours drive west of Kampala. It runs short courses in animal husbandry and crop production using innovative and sustainable techniques. How it all happened is a remarkable story. David had polio as a small child. His father rejected him because of his disability. He got himself educated primarily because his mother insisted he did so; she carried him to school when he was small, but when he grew she insisted he got there by himself. He can walk with difficulty using a stout stave as a crutch.

After leaving secondary school he trained as an accountant in Kampala because it was a job that was sedentary. But he did not want to be an accountant. He wanted to work for the development of disabled people in his home rural area in *Masaka*.

He reasoned that in a rural area what disabled people need is agricultural skills, like everyone else. Teaching them handicrafts does not make them self-sufficient. So he trained as a veterinary technician at *Makerere* University, sponsored by a local NGO.

In 1990 he set out to mobilise disabled people on his own – by bicycle (despite the fact that polio made it hard for him to use a bicycle). He cycled all over the rural areas of his home district to identify families with disabled people. He focused on families, and not simply on individuals, for two reasons: first, in some cases the disabled person was a child and not ready to earn an income, or was too disabled to do so. Second, involving the whole family enabled them to see the disabled person as an asset, not as a liability.

He began to breed good quality cows, goats, pigs, turkeys and chickens, and to train disabled people and their families in better animal husbandry. He gave animals to these families on condition that they gave him the first offspring, which could then be given to another family.

David realised early on that to train people in better animal husbandry required a model farm and a training centre with accommodation, where people could come for training courses lasting several days. The farm has cows, crossbred goats and pigs, and good quality turkeys and chickens kept in well-constructed pens. The result is that the training

centre has now become a resource for rural development in the whole of Uganda, for both disabled and non-disabled people.

Lessons to be learned from David:

- David identified the most obvious source of income for rural farming families: livestock, not crafts.
- He works with families, not with individuals.
- He acts as a role model for disabled people.
- He has a large vision, but started small.
- He works by demonstration.
- He has linked disability to other development issues.
- He has attracted the notice of people in mainstream development who have never linked their work with disabled people.

David's sense of empowerment is reflected in his ambition to help others rather than just himself. He is making a success of his life because of a driving aspiration for development – of people, of disabled people, and of his area. This leads him to think creatively and positively, to plan, to continually seek ways to improve what he does. Initially people were sceptical about him; now they believe in him and he has become one of the driving forces for the development of a wide rural community.

David's disability is now more or less irrelevant. Or rather it has been a trigger for transformation, in himself, and in his community.

Conclusion

This article has tried to show what an inclusive society looks like when development is seen as a way of creating and enhancing mutually supportive relationships. It has also shown what happens when disabled people themselves take the initiative to achieve their rights and work as positive, proactive, and creative agents of change.

As we stated at the beginning, a paradigm of aid defined primarily by the presence of donor and recipient is inherently one of unequal relationships characterised by dominance and subservience. Such unequal relationships inevitably create a situation where justice is absent, and identities and self-image are damaged. The donor has an unreal sense of his/her own importance, and the recipient remains, whatever the language employed by the donor, an object of charity.

Development is not something that is done by one person to another, by one country to another, or by one aid agency to poor people. Development is about eschewing dominance, creating a situation where justice is achievable, and promoting a positive identity (MacLachlan/

Carr/McAuliffe 2010).

Creating networks of mutual support, illustrated by the examples given above, is a model of development that is already a reality for large numbers of people, both in fully developed CBR programmes, and in community initiatives like those of Opha and David. In this model there is no difference between helper and helped, and everyone is empowered to fulfil his or her potential.

Perhaps this model could be the greatest contribution that CBR can make to new thinking about aid and development. By joining the debate on these terms it would show that *disability and development* is not a marginal issue: viewed through the lens of creating networks of supportive relationships it is central to the whole concept of aid and development.

Notes

1   It should be noted that some people prefer the term Community Based Inclusive Development instead of CBR. It is indeed a more accurate reflection of the intent of community approaches to disability. But this article retains CBR because that is the title used in the WHO Guidelines.

2   The figure, common in the literature, that 20% of the world's poorest people are disabled, is not supported by any systematic research. It is based on an oversimplistic reading of a World Bank document (Elwan, A. (1999): Poverty and Disability. A survey of the literature. World Bank Social Protection Unit discussion document).

3   For a detailed description and analysis of self-help groups in India see Coleridge, P. and Venkatesh, B. (2010): Community Approaches to Livelihood Development: Self-help Groups in India, in Barron and Ncube: Poverty and Disability, Leonard Cheshire Disability. This section of the article draws heavily on that text.

4   For more information see Coleridge. P, & Venkatesh, B (2010): Community Approaches to Livelihood Development: Self-help Groups in India, in Barron and Ncube: Poverty and Disability, Leonard Cheshire Disability.

References

CALDERISI, R. (2007): The Trouble with Africa: Why foreign aid is not working. USA: Palgrave Macmillan.

COLERIDGE, P. (1993): Disability, Liberation and Development. Oxford: Oxfam.

COLERIDGE, P. (2007): The Leprosy Mission India. Evaluation of the Vocational Training for Earning Power Project. March 2007. Unpublished report.

COLERIDGE, P./SIMONNOT, C./STEVERLYNK, D. (2011): Study of disability in EC development. Available at

cooperation.http://ec.europa.eu/europeaid/what/social-protection/documents/223185_disability_study_en.pdf. Visited on 29 July 2013.

COLERIDGE, P./VENKATESH, B. (2010): Community Approaches to Livelihood Development: Self-help Groups in India. In BARRON, T./NCUBE. J (EDS.): Poverty and Disability. London: Leonard Cheshire Disability.

CORNIELJE, H/BOGOPANE-ZULU, H. (n.d.): The Implementation of Policies in Community Based Rehabilitation (CBR). In HARTLEY, S./OKUNE,J. (EDS.): CBR Policy Development and Implementation. Norwich: University of East Anglia.

DFID (2004): Disability KAR: Assessing connections to DFID's poverty agenda. Available at http://www.dfid.gov.uk/r4d/PDF/Outputs/Disability/Policy-Project_IsabelOrtizReportFinal1.pdf. Visited on 29 July 2013.

DONNE, J. (1624): Devotions upon Emergent Occasions, Meditation XVII.

FREIRE, P. (1968; 1996): Pedagogy of the Oppressed. New York: Continuum.

ILO (2008): Skills Development through Community Based Rehabilitation (CBR). A good practice guide. Available at http://www.ilo.org/wcmsp5/groups/public/---ed_emp/---ifp_skills/documents/publication/wcms_132675.pdf. Visited on 29 July 2013.

MACLACHLAN, M./CARR, S./ MCAULIFFE, E. (2010): The Aid Triangle. Recognizing the Human Dynamics of Dominance, Justice and Identity. London: Zed Books.

MAREN, M. (1997): The Road to Hell: The ravaging effects of foreign aid and international charity. The free press: New York.

SINTEF (2003): Surveys on living conditions among people with activity limitations in Southern Africa. Available at http://www.safod.org/Images/LCZimbabwe.pdf. Visited on 29 July 2013.

TUTU, A. D. (2004): God Has A Dream. A Vision of Hope for Our Time. New York: Doubleday.

UNITED NATIONS (n.d.): Convention on the Rights of Persons with Disabilities: Optional Protocol. Available at http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf. Visited on 29 July 2013.

WHO (n.d.): CBR Matrix. Available at http://www.who.int/disabilities/cbr/cbr_matrix_11.10.pdf. Visited on 29 July 2013.

WHO, UNESCO, ILO, IDDC (2010): Community Based Rehabilitation CBR Guidelines, Geneva.

WORLD BANK (2007): Social Analysis and Disability: a Guidance Note. Available at http://siteresources.worldbank.org/DISABILITY/Resources. Visited on 29 July 2013.

Zusammenfassung: *Der Beitrag betrachtet die vorrangige Aufgabe von Entwicklung zu Befähigung und den Aufbau von reziproken Beziehungen. Er betrachtet Community Based Rehabilitation (CBR) als einen Ansatz dessen Hauptziel der Aufbau solcher Beziehungen ist, und betrachtet Entwicklungen zur Existenzgrundlage als einen zentralen Aspekt in diesem Prozess. Die Sprache, Philosophie, Praxis und Erfahrung von CBR kann einen wichtigen Beitrag zur generellen Debatte zur Schaffung eines gerechteren Ansatzes in der internationalen Entwicklungsarbeit leisten.*

Résumé: *Cet article considère comme tâche première du développement le transfert de pouvoir et la construction de relations d'appui mutuel. Il voit la Réadaptation à Base Communautaire (RBC) comme une approche dont le but premier est de construire de telles relations et considère l'amélioration des conditions de vie comme centrale dans ce processus. Le langage, la philosophie et la pratique de la RBC peut être une contribution importante au débat général sur une approche plus équitable du développement international.*

Resumen: *El artículo enfoca la tarea principal de la cooperación al desarrollo, que es promover el empoderamiento y las relaciones de apoyo mutuo. Se comprende Rehabilitación Basada en la Comunidad (RBC) como un enfoque cuya finalidad principal es establecer este tipo de relaciones. En este proceso el mejoramiento de las condiciones de vida tiene la mayor importancia. El concepto, la filosofía, la práctica y la experiencia de RBC brindan una importante contribución al debate general sobre un enfoque más equitativo al desarrollo internacional.*

Author: Peter Coleridge has more than 30 years experience of working to make disability a mainstream development issue. For 13 years he was Oxfam's Middle East Coordinator, and made disability a central theme of Oxfam's programmes in Lebanon, Palestine, Jordan, Egypt and Yemen. From 1995-2001 he was the Programme Manager for a large national Community Based Rehabilitation programme in Afghanistan run by the UN and NGOs. He now works as a consultant, writer and researcher on disability and development. He is the author of *Disability, Liberation and Development*, (Oxfam 1993), an exploration of the empowerment model of disability in developing countries, and has written numerous articles and book chapters on disability and development. He was lead author for the Livelihood module in the WHO *Community Based Rehabilitation Guidelines* (2011).
Contact: peter.coleridge@googlemail.com.

Reactions to the Rights-Based Approach: Contextualising the CRPD in Cambodia

Valerie L. Karr/Stephen Meyers

The UN Convention on the Rights of Persons with Disabilities (CRPD) has encouraged Disabled Peoples' Organisations (DPOs) and Nongovernmental Organisations (NGOs) to prioritise awareness-raising, rights monitoring, and legislative advocacy as their core organisational practices. But in the context of a developing country, organisations for persons with disabilities may see the provision of services as a better way to serve their members or beneficiaries than rights education and advocacy. So DPOs and NGOs have to blend their priorities and practice in a hybrid fashion. The authors recommend that international organisations and donors keep these contextual priorities in mind when developing funding and program opportunities.

Introduction

Recent developments in the international disability field have brought important changes in the mission, priorities, and daily practice of international, as well as grassroots, Disabled Peoples' Organisations (DPOs) and Nongovernmental Organisations (NGOs) focused on disability. The discourse of human rights, which is undergirded by the United Nations Convention on the Rights of Persons with Disabilities (CRPD), prioritises rights-based organisational practices that include awareness raising, monitoring governments, and advocating for legislative change.

The significance of these new practices must be appreciated from two perspectives. The first is that disability NGOs and DPOs rooted in developing countries have a legacy of service provision and social support of their members and/or beneficiaries. As such, many organisations are undergoing new pressures to make fundamental changes in who they are as organisations and what they do. Responses range from a complete embrace of the new disability rights norm to either rejection or ambivalence towards new expectations. The second important perspective is that the expressed need of many persons with disabilities on the ground in developing countries is for basic aspects like income, housing, rehabilitation, assistive technologies (i.e. wheelchairs), and livelihood issues, rather than for new laws or more education concerning the rights enunciating in the CRPD.

This article presents research findings from an extended case study perspective that includes interviews, focus group discussions, and site visits conducted amongst international organisations (IOs), disability NGOs/DPOs, and government actors working in Phnom Penh, Cambodia. Data was collected during two separate research visits in the Spring and Summer of 2011 as a part of a larger Youth Empowerment Study. While that project specifically focused on youth, the data collected spans all types of organisations working with persons with disabilities and members of all ages.

As will be discussed below, organisations researched in Cambodia fell on a continuum of activities from a singular focus on rights advocacy, to hybrid organisations that combined advocacy and service provision, to a complete focus on service provision and social support. Analysis of the motivations behind organisational mission, priority, and practice will be related to two key factors: the integration of organisations into the international disability rights movement and the larger economic context of poverty and insufficient governmental capacity.

From the UN to the Streets of Phnom Penh: A Move Towards Rights Advocacy

When the CRPD entered into force in 2008, it was a major, global event. The CRPD was the first comprehensive human rights treaty of the 21st Century, breaking records for the speed by which it was negotiated and the number of states-parties to sign and ratify it in such a short period of time[1]. As a result of the CRPD, the rights-based approach to disability has replaced the medical/charity-based model[2] as the dominant logic of the international disability and development field. Rather than disability being understood as a problem with an individual who needs to be rehabilitated, the social (or rights)-based approach recasts disability as the outcome of discriminatory social attitudes best remedied through legislative action, holding governments accountable, and consciousness-raising. The United Nations' Program on Disability (UN-Enable) states that the "Convention marks a 'paradigm shift' in attitudes and ap-

proaches to persons with disabilities" (Secretariat for the Convention on the Rights of Persons with Disabilities 2011: unpaged).

Equal to the paradigm shift in the meaning given to disability, the CRPD promises to change the very structure of how persons with disabilities relate to their communities. As an international treaty, signatory States take on new responsibilities towards their citizens. These new responsibilities and relations, however, must be institutionalised if the Convention is to be more than a symbolic victory. Thus, advocacy activities are often the highest priority amongst international NGOs and local DPOs alike.

In many cases, legal advocacy – pressuring states to sign and ratify the CRPD and to make subsequent changes to national legislation – represents a shift in programming, activities and resource allocations carried out by local DPOs, many of whom have historically focused on service provision and social support for their members. This shift is often difficult for local DPOs, many of whom both old and new persist in service delivery.

Ubiquitous amongst comparisons between Western (or Northern) disability movements and those in the global South or Post-Soviet states is the observation that while disability organisations in the North are concerned with rights, and subsequently legislation, in "Southern countries, the groups themselves often feel that the most immediate needs are for practical programs of rehabilitation" (Ingstadt/Whyte 1995:24) and are "calling for meeting their survival needs in a context of widespread poverty" (Turmasani 2003:3). Another argument has been that the primary need for disability movements in low-income countries is to develop an "empowered consciousness" (Charlton 1998), and thus to take on a more activist role.

These concerns, with the ability of disability NGOs in non-western countries to make the jump from being primarily service providers to becoming rights advocates, were reflected from the very beginning of the process that eventually produced the CRPD. An international working group of UN agency representatives and international NGO advocates anticipated a disconnection between grassroots associations and the new human rights model at the beginning of the treaty writing process. In 2002, the working group lamented that the "disability NGOs [in developing countries] clearly possess the [experiential] knowledge but often fail to engage with the human rights system" and went on to argue that "there is therefore a need for a new kind of disability NGO – or

amalgam of NGOs – with a clear mandate to monitor human rights developments around the world…[and to] engage local education programmes on rights and disability" (Quinn/Degener 2002:179). From that point forward, international disability organisations began to plan and launch a program intent on changing the substance of what local disability organisations in developing countries do by altering the resource environment.

New funds, projects, and forms of technical assistance designed in the North have begun to flood the global South over the past few years. For example, the US-based Disability Rights Fund (DRF) was created in 2008 to support country-level Disabled Peoples' Organisations (DPO) "treaty ratification, implementation, and monitoring efforts" (Disability Rights Fund 2010: unpaged). Handicap International (HI), a European NGO, launched its Making It Work campaign to promote *evidence-based advocacy* for the implementation of the CRPD (Handicap International 2009) and Action for Disability and Development (ADD), headquartered in the United Kingdom, has prioritised organising and strengthening advocacy DPOs at the national and prefectural level. Cambodia represents HI's only Making It Work focal country in Southeast Asia and ADD credits itself with supporting 18 DPOs in Cambodia to which it is "providing counselling and helping to build their confidence and awareness of their rights as a person with a disability in order to challenge their own situation" (ADD Cambodia n.d.: unpaged). A variety of other international NGOs and funders, including the ABILIS Foundation (Finland) and CBM (Germany) support disability rights-based activities.

As can be seen above, at the international level, a human rights approach towards disability has been enshrined in the CRPD and, subsequent to that, NGOs have reached out to persons with disabilities and their organisations in developing countries with the specific intention of promoting advocacy activities focused on the CRPD and national law and public policy. Cambodia, specifically, has been singled out by several important international actors for funding, technical assistance, and other forms of support.

Context, Context, Context!

Cambodia is not only a poor country, but a country whose development continues to be impeded by devastation that took place in the recent past. The first half of the 1970s was spent in civil war following the assassination of

King Sihanouk in 1970 and ending with victory for Pol Pot of the Khmer Rouge Communist Party in 1975. The subsequent five years were spent in a massive *reeducation campaign* in which cities were evacuated, formal education abandoned, and private property outlawed. Thousands upon thousands of intellectuals, professionals, skilled workers, business owners, or religious minorities were either executed in the infamous *killing fields* or condemned to forced labour. The Khmer Rouge was finally pushed out of power by invading Vietnamese Forces in 1979 who then established the People's Republic of Kampuchea (PRK) whom became immediately embroiled in a decade long civil war with the residual Khmer Rouge forces who had retreated to Thailand. Finally, the international community intervened, resulting in a ceasefire in 1991 and Cambodia becoming essentially a protectorate of the United Nations, which established the UN Transitional Authority of Cambodia to administer the country and deal with its multitudinous problems of refugees, landmines, and virtually no government. Today Cambodia continues to face enormous problems from chronic malnutrition to the displacement of its population to armed conflict, and has until recently lacked the basic building blocks of a modern nation-state – educated professionals, functioning government, and an economy of any kind - to rebuild. The CRPD places enormous responsibilities on a government still learning the ropes of basic governance in a context of extreme poverty (Cambodia ranks 139 out of 187 on the UNDP 2012 Human Development Index).

Phnom Penh, Cambodia – A Case Study

Below we will present a case study contextualising the focus of international organisations, NGOs, DPOs, and government actors working in Phnom Penh, Cambodia as they transition or adjust to rights-based priorities and organisational practices in accordance with the CRPD. This case study will serve to illustrate the new transitional pressures, difficulties, and successes of conforming to the CRPD and larger international trends within a specific country context. It is important to note that our discussion does not argue for or against new disability-rights trends, but is simply meant to shed some light on how organisations are responding at the local and national level and why.

During the interview process groups identified common barriers faced by their organisation and persons with disabilities in general, aims of their respective organisations in order to address the needs of their members/beneficiaries/constituents, and future hopes and expectations. It is important to note that two of the three groups were primarily focused on working with young people with disabilities. In total, this article draws upon seven NGOs/DPOs, one international donor agency, and two focus groups of both DPOs and NGOs[3]. To protect the anonymity of the organisations they will be referred to generically rather than by their specific names.

As stated above, responses to new national and international pressures, including the redistribution of funding, have ranged from rejection to ambivalence to acceptance. The following data will be outlined within this framework. The NGO literature has made several attempts to classify organisations according to their attributes. The most common classification, which has broad application to my research, is between *service* versus *advocacy* NGOs (Teegan/Doh/Vachani 2004), although *hybrid* NGOs are an emerging third categorisation (Nelson/Dorsey 2008). These categories of advocacy, hybrid, and service overlap with the rights-based model, which emphasises advocacy above all else, through to those associations that reject the rights-based advocacy model and continue to provide services and/or organise social support.

Prioritising Rights-Based Practice

Three organisations interviewed clearly prioritised awareness raising, government monitoring, and legislative and policy advocacy above all else. These organisations included a national DPO network, an international donor agency (AID), and a government coordinating committee (GCC). During the focus groups, several participants also clearly prioritised rights advocacy.

Implicit in an advocacy approach is an adversarial view of state-civil society relations. States sign the CRPD, thus, as states-parties to the Convention, they are responsible for its implementation. However, it is understood that the implementation of new rights will only result from pressure exerted on government by engaged and effective civil society organisations who have educated their base (and the broader populace) about their rights, organised them into networks and campaigns, and vigilantly monitor government activities (or inactivity) regarding their rights. As such, the failure of the rights of persons with disabilities to be realised is interpreted from two perspectives: 1) as a failure of individuals with disabilities, their

representative organisations, and the general populace to fully understand and advocate for their rights and 2) as a failure of either political will or effective governance on the part of the state. In Cambodia, both views were expressed by the organisations that prioritise rights-based action.

Several focus group participants were adamant that there is a need for persons with disabilities to be "connecting to other persons with disabilities and connecting to knowledge of the CRPD and rights". One discussant from a local, as opposed to national, DPO, utilised this view when describing problems with advocacy at the grassroots level: "the [local council] Chief may not pay attention to the persons with disabilities in need and give the assistance to someone nearby" because "the voices of persons with disabilities are not strong".

One explanation for the weakness of voice is that persons with disabilities themselves do not believe they are people worth listening to because they have accepted negative attitudes held in society about them. Thus, their change and engagement as full citizens is dependent upon a general destigmatisation of disability within the larger culture, as one focal group participant explained:

"There is a need for societal education regarding disability. There is a need to change the mindset of youth in order to change societal views…the need to look to the culture and link to the feelings of shame and inadequacy of persons with disabilities."

Once individuals with disabilities are engaged, understand their role as citizens, and are organised into groups, the expectation is that those DPOs and other associations will engage government. The disability focal person of one of Cambodia's leading international donors stated this view in regards to adopting an inclusive education model when she stated "You need civil society participation, so you might have school management committees". But, as this type of engagement becomes institutionalised in permanent committees, the independence of civil society can be seen as threatened as the clear lines and separation of interests between civil society and the state become blurred.

Cambodia has had the somewhat unique experience of having a Government Coordinating Committee that originally began as an NGO. While the staff of the GCC, who discussed their transition as having moved them from a full NGO to "half NGO, half government—we are semi-autonomous, in the mid-way between an NGO and government," as no threat to their role as the national coordination and advisory mechanism for the government implementation of disability rights, other NGOs saw the GCC as having been co-opted: "The [GCC] should be a powerful organisation, but because it has gone under the auspices of the government, it has gone downhill". This illustrates the problems of civil society organisations maintaining legitimacy when they become too close or, as in the case of the GCC, cross the line separating civil society from government.

While the rights-based approach supports advocacy for legislative change, many of these organisations, fully engaged in its practice, expressed misgivings about the possibility for real change. Despite a continued commitment to organising DPOs and pressuring government, several understood that the Cambodian government simply lacked the ability to fulfil many of the rights promised. Thus, laws on paper could be changed, but little else because "the government has no money to support disabilities". The challenge of advocating for rights, but recognising that a poor country such as Cambodia lacks the basic resources necessary for implementation, has led many organisations to either prioritise services above all else or, as in the next section, blend service-provision with rights-advocacy.

Hybrid Organisations: Ambivalence Towards Rights-Based Practice

Three organisations interviewed expressed ambivalence towards rights-based practice: two international NGO field offices and one national DPO. The international NGO field offices indicated that they leaned closer to service-provision than advocacy, but their activities could be considered hybrid, especially as their international headquarters were involved as major CRPD advocates. The first international NGO, having been working in Cambodia since the 1980's, began by providing direct services (mainly rehabilitation) and indicated a shift in the past 15 years to a more hybrid (service and advocacy) approach. "We've both had community-based economic livelihood support projects, self-help group focused projects, and provided support to national disability rights movement projects". Both international NGOs were in a transitional phase of shifting their service provision programs (rehabilitation centres) to government control, but recognised that their stated goal from a rights-perspective, of government taking on full responsibility, was not feasible. At the time of the interview only two of eleven rehabilitation centres had been absorbed under the government umbrella. While

the NGOs understood that the government was primarily responsible for service provision, they expressed some concerns for the adequacy and capacity of the government to serve the needs of persons with disabilities effectively:

"The Ministry doesn't really have the financial or technical capacity to manage. So, they're having a difficult time. But at the same time, as an organisation that has been doing this for 20-30 years, it is time that we do something. Otherwise, we are going to be here for another 20 years".

In addition, they expressed that the basic needs of persons with disabilities were still unmet whether it be by NGO or governmental provision: "Services aren't readily available in Cambodia". Supporting the disability right movement was, however, seen in a positive light:

"It's important that we have an integrated disability rights movement; it's important that people learned that it's not about their specific impairment; but it's about their experience of disability in the community and that they share the same experience of discrimination regardless of their impairment".

The advocacy activities of many NGOs mainly focused on the creation of federations of self-help groups at the local and district level ostensibly to support disability rights, but they noted that self-help groups can also be formed more as a network of service delivery and data collection than a pure advocacy focus, being susceptible to having "been co-opted by NGOs who want to have distribution systems; and so they're just organising people to receive food, trainings and whatever in order to achieve their indicators".

Lastly, they expressed a cultural resistance to government provision of service, explaining that in the context of Cambodia, people have never relied on their government for services:

"There are lots of NGOs and there's a culture of responding to NGOs and not reacting to the government, which is a strange way to grow up. People think NGOs are here to stay, or that NGOs are working on behalf of the government. So, the idea that the government should be providing services and NGOs should only fill the gap, doesn't exist... people don't understand these concepts and they question it [government services] a lot. They're suspicious about it".

The hybrid national DPO interviewed also expressed concerns over the transition to government provision of services, stating that the government provision of disability services "might not work right now to have the expan-

sion desired but it should definitely happen in the future". Since the adoption of rights-based approaches, popularised by CRPD, they have observed a decrease in funding for service provision despite a continued need. An employment service they had, which was both successful and had a very long waiting list, had lost its funding, while at the same time funding opportunities for DPOs and advocacy activities was increasing. They, however, were determined to try to keep providing services because, while they felt that *rights* and the *social model* of disability were important, often became *just talk*, whereas their actual members were much more focused on meeting their basic needs.

Rejection of Rights-Based Practices (Basic Needs Focus)

Two local organisations, a local DPO and a local NGO, and some focus groups participants focused purely on services. While they did acknowledge barriers in terms of rights, such as the lack of opportunities for education as a result of a lack of access or reasonable accommodation or discriminatory attitudes amongst teachers and students, their solution was to provide those services rather than advocate that the government do so.

The local DPO, made up of university students, acted as a form of social support so that students with disabilities could pursue higher education. The major problem they cited was that students from the provinces, even when they had gained scholarships, could not support themselves in the capital where the universities were located. Thus, the DPO worked to find money to fund a house where over twenty of their members lived and pooled their resources to cook meals and so forth.

While the program was a success, helping twenty of their members to go to university, they had a long waiting list and struggled to secure funds to pay rent for the next year. When asked about what they wanted in life, students expressed that they wanted to live with dignity, which they self-defined as getting a college degree, gainful employment and being able to support themselves, and to be treated with equal rights. They did not, however, have an advocacy agenda, instead focusing on meeting the basic needs for housing and food for their members.

The second organisation, a local NGO, also continued to focus on meeting the basic needs of persons with disabilities in Cambodia. They provided food, money, transportation, and accommodation for students with disabilities to continue their primary or secondary education

when barriers, such as inaccessible schools or unsupportive families, prevented them from doing so. The NGO continued with an employment program post-secondary education, which was comprised of job skills training and microfinance programs. They indicated that finding funds to support their organisation was increasingly difficult, but remained committed to continuing service provision.

Both of these organisations purely focused on service provision, choosing not to engage government through advocacy or to promote rights education amongst their members. Instead, their scarce resources were used to directly address the needs of their members, in both cases to support them through education either through the provision of housing or through providing education and transition into employment services.

Conclusion

The Cambodian case study illustrates the reaction of civil society to the new rights-based approach popularised under the CRPD. While interviewees identified concerns with the transition to government provision of services, many indicated their support and have begun to align their priorities within the rights-based framework. The practical aspects of meeting the basic needs of persons with disabilities, however, continues to be a source of major concern in a developing country that is poor, whose government lacks capacity, and whose population has become accustomed to depending on NGOs, rather than government, for the provision of basic services. This is not necessarily a story about culture or political will. Cambodia has signed the CRPD and passed new disability legislation and there is an active civil society holding the government to account. But, in the context of a developing country, many organisations for persons with disabilities see the provision of services as a better way to serve their members or beneficiaries than rights education and advocacy.

As the movement progresses DPOs and NGOs will continue to blend their priorities and practice in a hybrid fashion. One national DPO explained that their funded projects were organising people with disabilities into advocacy networks: "Building the network making. Networking making, people with disabilities". But when that DPO's same leadership was asked about the most significant problems faced by their members, they immediately pointed to livelihood issues: "We refer livelihood as business, income, skill, business skill, education,

teach people with disabilities what they learn". How NGOs, DPOs, funders, and even governments balance their diverse priorities will continue to be determined by context as much as or even more so than by new international priorities.

Notes

1 The UN Convention was adopted by the General Assembly on December 13, 2006 and then opened to signatures of states parties on March 30, 2007. It broke records for the highest number of signatories on an opening day, with 81 Member States on March 30. As of October, 2010, 147 nation-states have signed and 95 nation-states have ratified the convention including Nicaragua. The CRPD entered into force in May, 2008.

2 The shift from a medical to social model is central to virtually all North American and Western European disability movements as well as the cornerstone of Disability Studies as a discipline. While there are many works that provide an introduction to this framework, Tom Shakespeare's Disability Rights and Wrongs (2006) is an excellent work written from the perspective of both a scholar and advocate.

3 The larger YES study, however, included several international organisations, mainstream development organisations, youth organisations, and the participants in leadership workshops in both Indonesia and Cambodia.

References

DISABILITY RIGHTS FUND (2010). Available at http://www.disabilityrightsfund.org Visited on 23 October 2010,

HANDICAP INTERNATIONAL (2009): Making it Work. Available at http://www.makingitwork-crpd.org. Visited on 22 September 2012,

INGSTAD, B./REYNOLDS WHYTE, S. (1995): Disability and culture: an overview. In INGSTAD, B./REYNOLDS WHYTE S. (EDS.): Disability and culture. Berkeley: University of California Press, pp. 1-37.

NELSON, P. J./DORSEY, E. (2008): The new rights advocacy: changing strategies of development and human rights NGOs. Washington D.C.: Georgetown University Press.

QUINN, G./DEGENER, T. (2002): Human rights and disability. New York: United Nations.

SECRETARIAT FOR THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (2011): United Nations Enable. Available at http://www.un.org/disabilities. Visited on 29 September 2012.

TEEGAN, H./DOH, J.P./VACHANI, S. (2004): The importance of nongovernmental organizations (NGOs) in global governance and value creation. Journal of International Business Studies, vol. 45, no. 3, pp.

463-483.

TURMASANI, M. (2003): Disabled people and economic needs in the developing world: a political perspective from Jordan. Hampshire, England; Ashgate Publishing.

Zusammenfassung: *Die UN Konvention über die Rechte von Menschen mit Behinderung (BRK) hat Disabled Peoples' Organisationen (DPOs) und Nichtregierungsorganisationen (NGOs) dazu ermutigt, Sensibilisierungsmaßnahmen, die Überwachung der Menschenrechte und ein Eintreten für rechtliche Rahmenbedingungen als ihre Kerntätigkeit zu priorisieren. Aber aus dem Kontext eines Entwicklungslandes betrachten Organisationen für Menschen mit Behinderungen die Serviceleistungen als einen besseren Weg, um ihre Mitglieder oder Anspruchsberechtigten zu begleiten, als Menschenrechtserziehung und Interessenvertretung. DPOs und NGOs müssen eine Mischung ihrer Prioritäten finden und hybrid arbeiten. Die Autoren empfehlen, dass internationale Organisationen und Spender diese kontextbezogenen Prioritäten im Gedächtnis behalten, wenn es darum geht, Entwicklungsfinanzierungen und Programmmöglichkeiten zu entwickeln.*

Résumé: *La CDPH a encouragé les OPH et les ONG à prioriser la sensibilisation, le suivi des droits et le plaidoyer législatif comme leurs pratiques organisationnelles de base. Mais dans le contexte des pays en développement, les organisations de personnes handicapées peuvent considérer la fourniture de services appropriés comme un meilleur moyen de servir leurs membres ou bénéficiaires que l'éducation aux droits et le plaidoyer. Ainsi les OPH et les ONG sont poussées à maquiller leurs priorités et activités pour une présentation hybride. Les auteurs recommandent que les organisations internationales et les bailleurs gardent ces priorités contextuelles à l'esprit lorsqu'ils développent leurs critères programmatiques et de financements.*

Resumen: *La Convención Internacional sobre los Derechos de las Personas con Discapacidad ha alentado las organizaciones de personas con discapacidad (OPD) para dar prioridad a la sensibilización, la vigilancia de los derechos y la defensa legislativa como sus prácticas organizativas básicas. Pero en el contexto de un país en desarrollo, las organizaciones puedan ver la prestación de servicios como una mejor manera de servir a sus miembros o beneficiarios que la educación y la defensa de los derechos. Así OPD y ONG tienen que mezclar sus prioridades y la práctica de una forma híbrida. Los autores recomiendan que las organizaciones internacionales y los donantes siguen tomando en cuenta estas prioridades contextuales en el desarrollo de la financiación y realización de programas.*

Authors: Valerie Karr, PhD is the Director of Research for World Enabled, an international NGO focused on empowering youth with disabilities, and a faculty member of Adelphi University. Dr. Karr's research interests are in inclusive education and disability rights education and training.

Stephen Meyers is a PhD candidate at the University of California in San Diego and a Project Associate of World Enabled. His research focuses on grassroots disability associations' responses to the rights-based development paradigm. In the past, Mr. Meyers has worked for a landmine survivor assistance NGO and as a consultant to the International Labour Organisation's Disability Inclusion Initiative.

Contact: Valerie Karr: E-Mail: valerie@worldenabled.org;
Stephen Meyers: E-Mail: sjmeyers@ucsd.edu.

Establishing an African Disability Forum: An African Disabled People's Organisations' Own Initiative Towards Capacity Building

Shuaib Chalklen/Hisayo Katsui

This article elaborates of the connection among social protection, capacity building and human rights of African persons with disabilities. Firstly, a general lack of social protection schemes for many persons with disabilities in Africa is presented. Subsequently, the lack of capacity of both duty-bearers and rights-holders is analysed, which explains the reinforcement of status quo. Lastly, the article introduces an initiative of African Disabled People's Organisations (DPOs) to establish an African Disability Forum as one of many ways forward towards realising the human rights, such as rights to social protection, of persons with disabilities in Africa on their own account with their own priorities.

Background

"They (the employers) don't give me any money. No money. I was not paid for my salary for so many months. I don't eat once in a while. No food in the morning. No lunch. Like that. I just keep praying. I clean and wash and everything but they don't give me any money. But I keep myself patient and wait that they get moralised. Even now, I have no money for porridge" (A deaf woman in Kampala, Uganda, personal interview on 17.2.2008).

Adequate standard of living and social protection is a stand-alone article in the United Nations Convention on the Rights of Persons with Disabilities (CRPD, Article 28), and it is part of the Continental Plan of Action for the second African Decade of Persons with Disabilities between 2010 and 2019. Social protection and redistributive mechanisms have been attracting attention as a strategy of poverty and inequality reduction (African Union 2012; European Union 2013:9). And yet, "Exclusion from social and economic processes in the form of access to health care and education, food, waged work and income contribute directly to the multi dimensional poverty being experienced by over 55 percent of Africa's population" (Taylor 2009:9). Among them are estimated to be disproportionally too many persons with disabilities as is the case for the aforementioned Ugandan deaf woman. It is estimated that 70% of African adults with disabilities are unemployed and live in poverty (United Nations Population Information Network, cited in Ugandan Ministry of Finance 2008:6). In Uganda, since the inception of the Ugandan Poverty Eradication Action Plan (PEAP) in 1997, which is equivalent to the Poverty Reduction Strategy Paper (PRSP) of other countries, poverty was reduced from 56% to 31% between 1997-2007

among the general population (Ugandan Ministry of Finance 2008: viii). Among persons with disabilities in *Iganga* District, however, poverty was as high as 83% (ibid. 20), which is much higher than the aforementioned average benchmark of 31%. This partially reveals the tendency of severe living conditions of persons with disabilities in Uganda.

Evidences have been accumulated on a significant correlation between disabilities and poverty (WHO/World Bank 2011; Yeo/Moore 2003; Benedict/Eide 2011:5). "Inequalities generally intersect, which increases the chances of being both poor and socially excluded" (European Union 2013:9). Hence social exclusion of many African persons with disabilities has been reinforced.

Lack of Capacity of Both Duty-Bearers and Rights-Holders

When analysing the reality from a human rights lens, extreme poverty is "the world's greatest single rights issue" (Ministry for Foreign Affairs of Finland 2012:7). The aim of a human rights-based approach to development is that "everyone, including the poorest people, know their rights and are able to act for them. It is equally important that the authorities know their human rights obligations and are capable of implementing them" (ibid.). That is, good capacity of both duty-bearers and rights-holders are indispensable for realising rights in principle.

The aforementioned tendency of social exclusion, however, has a number of negative implications to persons with disabilities as rights-holders. On the one hand, many African persons with disabilities tend to be further marginalised due to lack of access to statutory social protection. Hence, they have less access to

existing opportunities including information compared with peers without disabilities to be able to claim for their rights. On the other hand, therefore, primary duty-bearers, namely states, are too frequently ignorant of their duties to realise the rights, when few claim for them. Taylor (2008:11) analyses the African reality of social protection and states, "if a right exists, governments have an obligation to make sure it is fulfilled. In a region where the resources to redress rights are limited and where even material resources such as food is scarce the political will and commitment to actualise rights to social protection become critical". Nevertheless, capacity of primary duty-bearers to operationalise this right tend to be limited, even though low-income countries can afford social protection as the cost is equivalent to 1% of Gross Domestic Product (Pal et al. 2005:33). In Kenya, for instance, the 2009 Housing and Population Census by the Kenyan Bureau of Statistics shows that 3.5% of the entire population are persons with disabilities. Contrastingly, the World Report on Disability (WHO/World Bank 2011) lately estimated that 15% of the world population are persons with disabilities. When appropriate statistics and disaggregated data on persons with disabilities are missing, social protection coverage cannot be secured for those who need it. This phenomenon applies to many countries including African countries, as the Continental Plan of Action for the African Decade of Persons with Disabilities 2010 and 2019 highlights data and statistics as one of the strategic thematic areas.

Some attempts have been made to include persons with disabilities in Poverty Reduction Strategy Papers for instance in Uganda, Ethiopia and Malawi (Chataika 2012). Chataika (2012) found out that none of the states as primary duty-bearers automatically included persons with disabilities in the initial stage. Uganda has the highest political representation within the government structure, and yet unfortunately active participation of DPOs has been largely absent due to lack of their capacity (ibid.) and their participation remained tokenistic (Lang/Murangira 2009: 176-7). This example conversely epitomises an important role of DPOs: an advocate to address human rights of persons with disabilities as representatives of the rights-holders. This point will be revisited more thoroughly in the next part.

In regard to another duty-bearers, donors with extraterritorial obligations (CRPD, Article 32), mainstreaming disability into all development cooperation programs has not been on high priority in practice. This task is often handed over to civil society organisations (CSOs) including Northern and Southern CSOs. For instance, the Finnish government was criticised for outsourcing the interventions in this field mostly to CSOs (Stakes 2003) in the form of disability-specific projects. The strategic challenge remains how to scale up such pilot projects in the absence of accurate data on government capacity, and financial and institutional capacity (Taylor 2009:59). Furthermore, relatively new development modalities such as budget support and sector-wide approaches tend to ignore disability in the South, which both Northern and Southern DPOs cannot influence much on this situation. Under these circumstances, Northern actors, both governmental and non-governmental, are quite critical to the current situation except for their positive perception of their policy (Katsui 2008:17).

Based on her case studies in African countries, Chataika (2012:14) claims that "there was general lack of knowledge and awareness of disability issues at all levels of government, civil society and the development partners". Therefore, when many African persons with disabilities are systematically and structurally excluded from society at local, national, regional and continental levels, they tend to be constrained in this vicious circle. In other words, capacity must urgently be built within government, social partners, the wider private sector, civil society organisations and research centres (Wiman/Voipio/Ylönen 2007:14). As has been discussed, the challenges are intertwined, structural and diverse at different levels, which means that disability is not only a social development issue. Disability is a human rights issue that encompasses civil, political, economic, social, and cultural rights that are interdependent and indivisible, as the CRPD stipulates.

The African Union overview report on social protection states that it is important to establish connecting points among those who are excluded, and governments, the private sector, non-governmental organisations involved in development and the donor community. That is, the connection among local, national, regional and continental stakeholders is essential. It is necessary to promote the direct participation of people who are currently outside of social insurance and social assistance programs towards advancing an inclusive protection agenda (Taylor 2008:57-8), and inclusive development in general. Especially the capacity of African DPOs in representing their huge constituency and in negotiating with the governments and further with the African Union towards inclusion and policy coherence is of criti-

cal importance, due to the global slogan of "Nothing about us, without us". Maximisation of ownership of DPOs pertaining to inclusive and sustainable development processes is the key to realising human rights in practice. The next part introduces one of such examples.

African Disability Forum as a Way Forward

In the disability community in Africa, we find a number of cross-disability as well as single disability pan-African and sub-regional federations of DPOs. At present, however, none of the existing regional or sub-regional federations of DPOs is recognised by the African Union (AU) as the authoritative, representative voice of persons with disabilities in Africa. That is, the very diversity has been one of the biggest challenges for African DPOs to become the agents of change at the continental level, which hampers their participation at regional, national and local levels, and vice versa. Consequently, voices of African persons with disabilities have hardly been heard, for instance, for the forthcoming United Nations High-level Meeting on Disability and Development on 23rd September 2013. This is going to be a historical opportunity to promote the post-2015 agenda such as inclusive sustainable development and reduction of inequality. African disability stakeholders have been largely missing existing opportunities and information that are highly relevant to them at different levels.

The African Union has been undergoing a number of developments in the field of disability at three levels: legal, programmatic and institutional. The new African Union Disability Architecture (AUDA) will seek to promote equality as enshrined in the "International Disability Architecture", which consists of the CRPD and other international human rights and development instruments. The AUDA would benefit greatly from representatives and ownership of African persons with disabilities, if there were such an organ as an African Disability Forum (ADF).

A consultative meeting on the creation of the ADF took place on the 28th and 29th November 2012 at the UN Conference Centre in Addis Ababa, Ethiopia. The meeting was organised by the UN Special Rapporteur on Disability of the Commission for Social Development, with the support of the UN Department of Economic and Social Affairs and in partnership with the UN Economic Commission for Africa, African disability organisations, academic institutions and development partners. The meeting

participants welcomed and supported the initiative of the Special Rapporteur to establish an African Disability Forum, envisaged as a multi-stakeholder forum to advance the rights and inclusion of persons with disabilities in Africa. The ADF is to 1) facilitate broad-based dialogues, especially in conjunction with AU inter-governmental meetings and processes, to raise awareness about disability issues and provide policy and technical advice; 2) strengthen regional networking and partnership among key stakeholders in Africa; 3) foster and disseminate research to promote disability-inclusive development; and 4) build the organisational capacity of DPOs at all levels and of other key stakeholders. "Awareness of human rights and good communication are essential to the process of asserting rights. Thus, advocacy, learning, capacity development and social mobilisation are necessary strategies to pursue human rights" (UNDP 2006:34).

The ADF would seek to strengthen and unify the representative voices of DPOs and persons with disabilities in Africa. The African continent is immense with great regional diversity, and it is not possible for one organisation to expect to fully reflect and represent such diversity. Rather, the ADF would include and build upon existing structures, capacities and achievements. The ADF would not replace any existing continental or sub-regional organisation, but would consult with and seek their views. The ADF would be inclusive and invite all existing pan-African, sub-regional and national federations of DPOs to be members. With the help of existing DPOs, the ADF could make impacts on different modalities such as top-down (e.g. AU), bottom-up (e.g. DPOs) as well as horizontal (e.g. South-South) approaches.

At present, interim working group (IWG) members from 10 African DPOs with regional, gender, disability and age balance have been undergoing virtual discussions towards the establishment of the ADF. In autumn 2013, the IWG members meet to discuss on the establishment practicalities with the financial support of *Abilis* Foundation, while a launch event of the ADF is envisaged in the following year when suitable donors are found. The ownership and representation need to remain in the hands of African persons with disabilities in order to strengthen their capacity as well as that of duty-bearers at different levels. As challenges are intertwined, structural and diverse at different levels, solutions also have to be targeted to different levels. This initiative of African DPOs is one of the many ways forward, which is worth developing among the African disability stake-

holders to realise their human rights on own account with own priorities.

References

AFRICAN UNION (2012): Concept Note: Promoting the Rights and Welfare of Persons with Disabilities. 3rd Session of the AU Conference of Ministers of Social Development, Addis Ababa, Ethiopia 26-30 November 2012. Available at http://sa.au.int/en/content/3rd-session-au-conference-ministers-social-development-camsd3. Visited on 22.4.2013.

BENEDICT, I./EIDE, A. H. (2011): "Disability and poverty: a global challenge." In EIDE, A. H./BENEDICT, I. (EDS.): Disability and Poverty: a global challenge. The Policy Press. Bristol, p. 1-14.

CHATAIKA, T. (Oct 2012): Disability inclusion in development processes: Pathways to realising the and potential of disabled people through influencing development processes in Africa. Presented at conference Disability and Development: Rights, Politics and Practice, Oslo, Norway. http://www.jus.uio.no/smr/english/research/areas/development/docs/chataika.pdf. Visited on 15 April 2013.

EUROPEAN UNION (2013): European Report on Development 2013: Post-2015: Global Action for an Inclusive and Sustainable Future. European Union: Brussels.

KATSUI, H. (2008): Mainstreaming Disability Issues in Japanese and Finnish Development Policies and Practices. Working Paper Series of IDS at Helsinki University 1/2008.

LANG, R./MURANGIRA, A. (2009): Barriers to the Inclusion of Disabled People in Disability Policy-Making in Seven African Countries. In KUMPUVUORI, J./SCHEININ, M. (EDS.): United Nations Convention on the Rights of Persons with Disabilities: Multidisciplinary Perspectives. VIKE. Helsinki, p. 159-184.

MINISTRY FOR FOREIGN AFFAIRS OF FINLAND (2012): Finland's Development Policy Programme. Ministry for Foreign Affairs of Finland: Helsinki.

MINISTRY OF FINANCE, PLANNING AND ECONOMIC DEVELOPMENT OF UGANDA (2008): Disability and Poverty in Uganda: Progress and challenges in PEAP implementation 1997-2007, National Report. Ugandan Government: Kampala, Uganda.

PAL, K. ET AL. (2005): Can low income countries afford basic social protection? First results of a modelling exercise. ILO. Discussion paper 13. Available at http://www.ilo.int/public/english/protection/secsoc/downloads/policy/1023sp1.pdf. Visited on 16 April 2013.

STAKES (2003): Label us Able. Ministry for Foreign Affairs of Finland. Available at http://formin.finland.fi/public/download.aspx?ID=13528&GUID={C2043295-F121-4ED1-984D-B394F821C13D}. Visited on 21 June 2007.

TAYLOR, V. (2009): Social Protection in Africa: an Overview of Challenges. University of Cape Town: Cape Town. Available at http://south-south.ipc-undp.org/library/social-protection-in-africa-an-overview-of-the-challenges.html. Visited on 10 April 2013.

TAYLOR, V. (2008) Social Protection in Africa: An Overview of the Challenges. African Union. Addis Ababa. Available at http://south-south.ipc-undp.org/library/social-protection-in-africa-an-overview-of-the-challenges.html. Visited on 10 April 2013.

UNDP (2006): Applying a Human Rights-Based Approach to Development Cooperation and Programming. Available at http://www.hurilink.org/tools/Applying_a_HR_approach_to_UNDP_Technical_Cooperation--unr_revision.pdf. Visited on 7 May 2013.

WHO/WORLD BANK (2011): World Report on Disability. Available at http://whqlibdoc.who.int/publications/2011/9789240685215_eng.pdf. Visited on 16 December 2011.

WIMAN, R./VOIPIO, T./YLÖNEN, M. (EDS.) (2007): Comprehensive Social Polices for Development in a Globalizing World. Ministry for Foreign Affairs of Finland. Available at http://www.thl.fi/thl-client/pdfs/66e675ea-b245-4646-bc6b-f9e28a59e7f2. Visited on 10 April 2013.

YEO, R./MOORE, K. (2003): Including Disabled People in Poverty Reduction Work: Nothing about us, without us. World Development. Vol.31. No.3, p. 571-590.

Zusammenfassung: Dieser Artikel befasst sich mit der Verbindung von sozialer Sicherheit, dem Aufbau von Kapazitäten und den Menschenrechten afrikanischer Menschen mit Behinderungen. Zum einen besteht ein Mangel an sozialen Sicherungssystemen für viele Menschen mit Behinderungen in Afrika. Des Weiteren wird der Mangel an Leistungsfähigkeit sowohl von verpflichteten Trägern als auch von Inhabern von Schutzrechten analysiert, der die Verstärkung des Status Quo erklärt. Schließlich stellt der Artikel eine Initiative afrikanischer Behindertenorganisationen (DPOs) vor, als eine von vielen Wegen auf dem Weg hin zur Realisierung der Menschenrechte, wie das Recht auf soziale Sicherheit, von Menschen mit Behinderungen in Afrika in ihrem eigenen Namen mit ihren eigenen Prioritäten.

Résumé: Cet article évoque la connection entre la protection sociale, le développement des capacités et les Droits Humains des personnes handicapées africaines. Il présente d'abord le manque général de systèmes de protection pour la plupart des personnes handicapées en Afrique. Ensuite le manque de capacité aussi bien des autorités que des ayant-droit est analysé, qui explique le renforcement de cette situation. Enfin l'article présente une initiative d'OPH africaines pour créer un Forum Africain du Handicap comme un des multiples moyens pour réaliser les droits humains des personnes handicapées en Afrique, tel que celui à la protection sociale, de leur propre initiative et avec leurs propres priorités.

Resumen: En este artículo se elabora la conexión entre la protección social, la creación de capacidades y los derechos humanos de las personas con discapacidad de Africa. En primer lugar, se describe la falta de sistemas de protección social que existen para muchas personas con discapacidad en Africa. Posteriormente, se analiza la falta de capacidad de los titulares de deberes y de los titulares de derechos, lo que explica el refuerzo del estatus quo. Por último, el artículo presenta una iniciativa africana para establecer un Foro sobre Discapacidad de Africa como una de las muchas formas de avanzar hacia la realización de los derechos humanos, uno de los cuales como el de la protección social de las personas con discapacidad en Africa por su propia cuenta y con sus propias prioridades.

Authors: Shuaib Chalklen has been the current United Nations Special Rapporteur on Disability of the Commission for Social Development since 2009. He has vast national, regional and global experiences to the advancement of the rights of persons with disabilities. Previously, he worked among others as Senior Policy Analyst in the Presidency of South Africa (2006-2007); Chief Executive Officer of the Secretariat for the African Decade of Disabled Persons (2003-2006); and Director of the Office on the Status of Disabled Persons in the Presidency of South Africa (1996-2001).

Hisayo Katsui has been working as Assistant to the Special Rapporteur since 2012 and a post-doc researcher at the Institute for Human Rights, Åbo Akademi University, Finland. Her latest book is entitled *Disabilities, Human Rights and International Development: Human Rights-Based Approach and Lived Experiences of Ugandan Women with Disabilities* (The Centre for Human Rights of Persons with Disabilities in Finland. Publication Series No. 8; available at http://disability-uganda.blogspot.fi/).

Conact: Shuaib Chalklen:
E-mail: chalklenshuaib68@gmail.com,
disabilityrapporteur@un.org;
Hisayo Katsui: E-mail: hisayo@welho.com,
Homepage: http://srdisability.blogspot.fi/.

Kurzmeldungen/Announcements

Conference: Dis/ability, Participation and Community Involvement – Tracing the Roots of CBR

Within the framework of a subject-related partnership *Joint Undertaking to Multiply Powers – research and teaching in CBR and related fields* (JUMP CBResearch), Pwani University in Kilifi (Kenya) and Technische Universität München in Munich (Germany) are having a closer look at the basic elements of Community Based Rehabilitation from an academic perspective. In the project, which is funded by DAAD and financed by the German Ministry of Economic Cooperation and Development, capacity in teaching and research in the field of dis/ability, participation and community development shall be strengthened through an exchange of ideas and developing teaching and learning materials for students.

As a kick-off activity for the project the conference *Dis/ability, Participation and Community Involvement – Tracing the Roots of CBR* will take place in Kilifi on 2nd and 3rd December 2013. During this conference, researchers from Germany and Kenya as well as other East African countries will exchange their perspectives on socio-cultural aspects and definitions of dis/ability, participation and community involvement. Links to CBR-projects (especially in Kenya) shall be established to connect academia and practitioners in the field.

Going Beyond the Taboo Areas in Community-Based-Rehabilitation

An international event on Going Beyond the Taboo Areas in CBR was held after the First World CBR Congress in Agra (India) on the 29th November 2012. Two workshops where offered: *Supporting Social Relationships, Sexuality and Reproductive Rights of Persons with Disabilities through CBR* and *Violence and Abuse Towards Persons with Disabilities*. The discussions highlighted the innumerable barriers of negative attitudes and wrong beliefs that affect the rights of persons with disabilities to social relationships, sexuality and reproductive health as envisioned by article 23, CRPD. At the same time, persons with disabilities do not have equal access to reliable information about these issues. The lack of adequate learning material, which is suitable for the CBR context, and of training opportunities for persons with disabilities, their families and CBR personnel are significant challenges.

The discussions underlined the importance of involving and supporting persons with disabilities in self-advocacy for social relationships, sexuality and reproductive rights. There is a need to share these experiences and existing teaching and learning material. Promoting *easy to read and understand* material and making it accessible for persons with learning disabilities are further key issues.

Workshop participants acknowledged that most existing information about vulnerabilities of persons to violence and abuse as well as potential prevention strategies is aimed at persons without disabilities. Available information about violence and abuse towards persons with disabilities is almost exclusively addressing the situation of persons living in institutions in high-income countries. Children, women and elderly persons with disabilities are especially vulnerable to violence and abuse. Certain groups of persons with disabilities (such as deaf persons, persons with intellectual disabilities, persons with mental illnesses and those who need regular care and support) are also more vulnerable. Negative beliefs and social attitudes are among the biggest barriers in dealing with these issues.

There were some examples of how CBR programmes can play an effective role in identifying and preventing violence and abuse towards persons with disabilities, as well as in supporting persons who have been through these traumatic experiences.

Information: http://www.aifo.it/english/disability/documents/cbr_sexuality/index.htm; http://www.aifo.it/english/disability/documents/cbr_violenza/index.htm.

Addressing the Rights of Persons with Disabilities at Human Rights Council

The rights of persons with disabilities were dealt with extensively in the context of the 22nd session of the Human Rights Council (HRC) held from 25th February to 22nd March 2013. The fifth annual interactive debate on the rights of persons with disabilities (6th March 2013) focused on the thematic field of work and employment. The HRC also adopted without a vote a resolution on the work and employment of persons with disabilities (draft resolution A/HRC/22/L.4). The resolution calls upon States parties to the CRPD to adopt and implement appropriate measures, including legislative measures, to ensure that persons with disabilities enjoy the right to work on an equal basis with others.

Information: http://www.ohchr.org/EN/Issues/Disability/Pages/DisabilityIndex.aspx; http://www.iceland.is/iceland-abroad/efta/files/disabilites.pdf.

Toilets Provide Dignity for Persons with Disabilities in Nepal

Many people in Nepal live in a small cluster of homes that have just begun to end open defecation, which can contribute to water contamination and the spread of infectious diarrhoeal diseases, including cholera, says the World Health Organisation (WHO). According to local research organisations, a 2009 diarrhoea outbreak in Ne-

pal's Far West region killed hundreds of people.

The Nepal population and housing census (2011) indicated that nearly 40 percent of homes do not have toilets, leading millions of people to defecate outside.

Although the public health benefits of ending open defecation are widely touted, knowledge of the effects of such campaigns on the lives of people with disabilities remain only anecdotal, say experts.

Disability rights activists also see sanitation as a crucial part of inclusion. The UN special rapporteur on the right to sanitation has noted that technical provisions - including the construction of toilets - can contribute to the erosion of stigma against people with disabilities. In 2011, Nepal launched an extensive campaign to end open defecation across the country by 2017. According to UNICEF, seven of the country's 75 districts have been declared Open Defecation Free (ODF), and six are on track to complete the process by the end of 2013. In order for a village to be declared ODF, each household and public facility must have a functioning toilet.

Previous programmes in Nepal have focused on school-based sanitation targeting children, as studies have shown children suffer high rates of diarrhoea and stunting as a result of contamination that takes place in areas where people defecate in the open. Lack of accessible sanitation can also limit participation in society.

The Human Rights Watch (HRW) report of 2011 highlighted cases of children who are unable to access toilets at schools, one of the many barriers to education they face. Having toilets at schools is not enough - they must be accessible and safe as well.

The Nepal government's guidelines stipulate that all toilets must be disability-friendly, with ramps, sufficient space, and handrails. According to Andreas Knapp (UNICEF), the programme, by virtue of being holistic and community-driven, will benefit people with disabilities.

Information: http://www.irinnews.org/report/98121/toilets-provide-dignity-for-nepal-s-disabled, http://www.inseconline.org/pics/1257598337.pdf, http://cbs.gov.np/wp-content/uploads/2012/11/National%20Report.pdf, http://blogs.worldbank.org/water/ending-open-defecation-not-by-evidence-alone, http://www.hrw.org/sites/default/files/reports/nepal0811ForWebUpload.pdf, http://www.washinschoolsmapping.com/projects/pdf/Nepal%20Government%20Sanitation%20and%20Hygiene%20Master%20Plan.pdf.

International Day of Persons with Disabilities

The theme of this year's International Day of Persons with Disabilities on 3rd December is: *Break Barriers, Open Doors: For an Inclusive Society for All*. A major focus of the day is practical and concrete action to include disability in all aspects of development, as well as to further the participation of persons with disabilities in social life and development on the basis of equality. To make the most of the day, activities may highlight progress and obstacles in implementing disability-sensitive policies, as well as promote public awareness to break barriers and open doors to realise an inclusive society for all. By 3rd December 2013, the International Day of Persons with Disabilities, the outcome document of the High Level Meeting on Disability and Development will be available and may be used to provide a blueprint for action to help realising the full and equal participation of persons with disabilities in society and shape the future of development for all.

Information: http://www.un.org/disabilities/default.asp?id=1607.

All Different, all Human, all Equal

The International Conference on Human Rights held by the International Conference on Population and Development (ICPD) that took place in the Netherlands from 7th to 10th July 2013 ended with recommendations on how to ensure equality and protect the rights of every person. These recommendations were developed over three days by representatives of government, parliaments and civil society groups.

The conference dealt with the concepts of equality, quality of care and accountability as main topics. On equality, Ambassador Wijnroks said, women and girls living in poverty lack access to sexual and reproductive services, information and education. Moreover, many of these women and girls, including those with higher incomes, face multiple forms of discrimination. Participants at the conference further underlined the fact that adolescents, particularly girls, nearly everywhere face serious barriers in exercising their rights to comprehensive sexuality education and to sexual and reproductive health services.

Summarising views on quality of care, the chair said conferees had agreed that the right to health required that education, information and services must be available, accessible, affordable, acceptable and of good quality, without discrimination, coercion or violence.

Regarding accountability, the conferees felt it required national leadership and an enabling environment for civil society. Furthermore, States must enact policies and programmes with clear goals and budget allocations that can be monitored, prevent human rights violations and ensure all victims' right to effective remedy and reparations. Looking to the future and beyond 2014, Ambassador Wijnroks concluded that the unfulfilled ICPD commitments to provide universal access to sexual and reproductive health, and to protect and fulfil the human rights of all, with special attention to disadvantaged and marginalised groups, must be at the heart of global agendas. This should result in enhancing the autonomy and dignity of individuals. In the closing remarks, Dr. Babatunde Osotimehin, Executive Director of the United Nations Population Fund (UNFPA), said that the best practices identified at the forum for a world in which everyone counts equally and in which every individual life was valued equally define a renewed agenda for change. His remarks were

read by Kate Gilmore, UNFPA Deputy Executive Director (Programme), who said that the direction forward lies in ensuring that the issues of persistent inequalities still experienced by so many women, girls and marginalised and excluded groups are addressed and tackled. Around the world, this is the freedom of expression; the right to information, to participation; the right to be free from discrimination and violence; and the right to the highest attainable standard of health, including sexual and reproductive health, that have to be respected, protected and fulfilled.

Information: http://humanrights.icpdbeyond2014. org.php53-3.dfw1-2.websitetestlink.com/uploads/ browser/files/human_rights_conference_chair_ reflections_final_version.pdf, http://humanrights.icpdbeyond2014.org.

Draft Action Plan for the Prevention of Avoidable Blindness and Visual Impairment 2014-2019

The 66th World Health Assembly (WHA) adopted a resolution recalling the *Convention on the Rights of Persons with Disabilities* and endorsing the recommendations of the 2011 *World Report on Disability*. The resolution urges States to implement the CRPD, develop national action plans, and improve data collection. It also encourages States to ensure that all mainstream health services are inclusive and accessible to people with disabilities, provide more support to informal caregivers, and ensure that people with disabilities have access to services that help them acquire or restore skills and functional abilities as early as possible. It also calls on World Health Organisation (WHO) to support the United Nations General Assembly's *High-level Meeting on Disability and Development* (23rd September 2013) and prepare a comprehensive WHO action plan with measurable outcomes for next year's World Health Assembly.

Information: http://apps.who.int/gb/e/ e_wha66.html, http://apps.who.int/gb/ebwha/Zip_files/ WHA66/wha66_en.zip.

Literatur

Kuipers, P./Cornielje, H.
Alternative Responses to the Human Resource Challenge for CBR

This commentary outlines some ways of understanding CBR and offers suggestions for responding to the contemporary human resource challenge it is faced with. It is argued that CBR exists within an increasingly complex reality, characterised by new challenges, new approaches to development and numerous international principles and guidelines. In response, the authors advocate the use of multiple research methods, participatory action and contextualised ways of addressing human resource issues. They suggest that new understandings are required for future CBR workers to be enablers of people with disabilities, agents of change in communities and societies, and *champions* of human rights. The complex reality of CBR suggests the need for a CBR cadre which is capable of creative and reflective reasoning. This might be achieved through the participatory development of contextualised training curricula, practical hands-on learning, the use of mentoring, and an emphasis on reflection and adaptability.

Bezug: Disability, CBR and Inclusive Development 23 (4), 2012; http://dcidj.org/article/view/176/95, http://dcidj.org/article/download/176/95.

United Nations Development Programme (UNDP)
2013 Human Development Report. The Rise of the South: Human Progress in a Diverse World

The 21st century is witnessing a profound shift in global dynamics, driven by the fast-rising new powers of the developing world. China has overtaken Japan as the world's second biggest economy, lifting hundreds of millions of people out of poverty in the process. India is reshaping its future with new entrepreneurial creativity and social policy innovation. Brazil is raising its living standards by expanding international relationships and antipoverty programmes that are emulated worldwide.

But the *Rise of the South* is a much larger phenomenon. Indonesia, Mexico, South Africa, Thailand, Turkey and other developing countries are becoming leading actors on the world stage. The 2013 Human Development Report identifies more than 40 developing countries that have done better than expected in human development in recent decades, with their progress accelerating markedly over the past 10 years.

The 2013 Human Development Report examines the causes and consequences of the *Rise of the South*, and identifies policies emerging from this new reality that can promote greater sustainability, social cohesion and human development progress throughout the world in the decades to come.

Bezug: http://hdr.undp.org/en/reports/global/hdr2013/, https://unp.un.org/hdr/.

United Nations General Assembly
The Way Forward: A Disability-Inclusive Development Agenda Towards 2015 and Beyond

During the past decade, the General Assembly has sought urgent action for the realisation of internationally agreed development goals, particularly the Millennium Development Goals, for persons with disabilities (see A/64/180, A/65/173, A/66/128 and A/67/211).

The current report reviews good practices and existing approaches to disability-inclusive development, drawing on the experience of the United Nations system in mainstreaming crosscutting issues. The report concludes by recommending steps to include disability as an integral part of all development efforts, with a view to contributing to an action-oriented outcome document of the upcoming High-level Meeting.

Bezug: http://www.un.org/disabilities/default.asp?id=1590, http://www.un.org/disabilities/documents/gadocs/a_68_95.doc.

Office of the High Commissioner for Human Rights
Study on the Situation of Indigenous Persons with Disabilities

The *Study on the Situation of Indigenous Persons with Disabilities,* with a particular focus on challenges faced with respect to the full enjoyment of human rights and inclusion in development (E/C.19/2013/6) reviews the situation of indigenous persons with disabilities in regard to their human rights. The study examines areas such as political participation, access to justice, education, language and culture, and issues specific to indigenous women and children with disabilities. Recommendations are made to United Nations agencies and other relevant stakeholders on ways to increase the inclusion and participation of indigenous persons with disabilities, as well as to help develop the capacity of organisations of indigenous persons with disabilities.

Bezug: http://www.un.org/disabilities/default.asp?id=1605, http://www.un.org/disabilities/documents/ecosoc/e.c.19.2013.6.pdf.

Pearce, E.
Refugees and Displaced Persons with Disabilities

Refugees and Displaced Persons with Disabilities – From 'Forgotten' to 'Vulnerable' to 'Valuable' is a recent article which was published as part of Forced Migration Review's special 25th anniversary collection. This article by Emma Pearce of the Women's Refugee Commission lays out the needs and rights of persons with disabilities among displaced populations.

Bezug: http://www.fmreview.org/25th-anniversary/pearce, http://www.fmreview.org/en/25th-anniversary/pearce.pdf.

Fembek, M./ Butcher, T.H./Heindorf, I./ Wallner-Mikl, C.
Zero Project Report 2013
The Zero Project Report 2013 was presented at the 22nd session of the Human Rights Council during a side-event: *Advancing the rights of persons with disabilities: Innovative Policies and Practices & the Post-2015 MDG agenda*. The event was organised by the Permanent Missions of Austria, Finland, New Zealand and Thailand as well as the International Disability Alliance, in collaboration with the Essl Foundation, the World Future Council and their Zero Project. The 250-page report resulting from the project focuses on the crucial subject of employment and disability and provides indicators, along with innovative practices and policies that promote the employment of persons with disabilities.
Bezug: http://www.zeroproject.org/about/presentations/geneva/, http://www.zeroproject.org/wp-content/uploads/2012/12/Zero-Report-2013-GB1.pdf.

UNICEF
The State of the World's Children 2013 – Children with Disabilities
Im Mittelpunkt des internationalen UNICEF-Berichts steht die schwierige Lage von Kindern mit Behinderungen in weiten Teilen der Welt – insbesondere in Entwicklungs- und Schwellenländern. Bis heute leben diese Kinder und ihre Familien in vielen Ländern in großer Armut und sind oft vom Leben in der Gemeinschaft ausgeschlossen. Statt bestmöglicher Förderung in der Familie und in den Gemeinden gilt in vielen Ländern nach wie vor die Unterbringung in Heimen. Tief sitzende Vorurteile und Stigmatisierungen führen dazu, dass Kinder mit Behinderungen als ‚minderwertig' betrachtet und an den Rand gedrängt werden. Bis heute verfügen nur wenige Staaten über umfassende Informationen darüber, wie viele Menschen mit Behinderungen in ihrer Gesellschaft leben, mit welchen Einschränkungen sie konfrontiert sind und wie sich diese auf ihr Leben auswirken. Weil sie isoliert und „unsichtbar" sind, werden Kinder mit Behinderungen immer wieder von öffentlichen Dienstleistungen, wie zum Beispiel Schulen, ausgeschlossen und somit in ihren Grundrechten verletzt.
Bezug: http://www.unicef.de/presse/2013/internationaler-unicef-bericht/,
http://www.unicef.ch/sites/default/files/attachments/unicef_pb_zusammenfassung_sowc13_de.pdf,
http://www.unicef.de/fileadmin/content_media/projekte/Themen/Kinder_schuetzen/UNICEF-SOWC-Report-2013-English.pdf.

Office of the High Commissioner for Human Rights
OHCR Report 2012
The Office of the High Commissioner for Human Rights (OHCHR) Report 2012 presents the annual report of the organisation and shows a growing emphasis on human rights within the international discourse on peace, security and development. It provides information on treaty body strengthening, substantive input into the Rabat Plan of Action against incitement to discrimination, hostility or violence, servicing the second cycle of the Human Rights Council's Universal Periodic Review, and supporting council-mandated activities, including two new intergovernmental working groups and three new special procedures mandates. It also reports on technical assistance to implement recommendations issued by the human rights mechanisms, training on human rights principles for the judiciary and law enforcement agents, and advice to civil society to help rights-holders exercise their rights. The Office of the UN High Commissioner for Human Rights (OHCHR) celebrates 20 years of existence in 2013. Disability and persons with disabilities are covered throughout the publication, and specifically included in a section under the chapter on Discrimination.
Bezug: www2.ohchr.org/english/ohchrreport2012/web_en/index.html, http://www2.ohchr.org/english/ohchrreport2012/web_en/allegati/downloads/1_Whole_OHCHR_Report_2012.pdf.

Leonard Cheshire Disability
Young Voices – Our Statement to the World
In Leonard Cheshire Disability's (LCD's) new publication: *Young Voices – Our Statement to the World*, young people with disabilities from across the globe have come together to agree on a common statement of what needs to happen to make the rights of people with disabilities a reality. The publication also features case studies of Young Voices groups taking action to achieve change. Leonard Cheshire Disability's Young Voices project brings together groups of young people with disabilities from 23 countries across Africa, Asia and America to campaign for their rights.
Bezug: http://youngvoices.lcdisability.org/file_download/16/YoungVoices_GlobalStatement_interactive2.pdf,
http://www.lcint.org/6389/news/young-voices-read-their-statement-to-the-world.html.

Human Rights Watch
As Long as They Let Us Stay in Class: Barriers to Education for Persons with Disabilities in China
The 75-page report *As Long as They Let Us Stay in Class: Barriers to Education for Persons with Disabilities in China*, documents the struggles of children and young people with disabilities to be educated in mainstream schools in their communities.
The Human Rights Watch report is based on more than 60 interviews, mostly with children and young people with disabilities and their parents, and draws on government data and expert policy assessments. The Chinese government adopted regulations and rules on the education of people with disabilities, promised to raise the enrolment rate of children with disabilities, and waived miscellaneous school fees for them. However, the report details the ways schools deny these students admission, pressure them to leave, or fail to provide appropriate classroom accommodations to help them overcome barriers. The report also documents the failure of the quasi-governmental body China Disabled People's Federation (CDPF) and the Ministry of Education to address discrimination, to ensure reasonable accommodation in mainstream schools, and to inform parents and children with disabilities about their educational rights and options.
Bezug: http://www.hrw.org/node/117059,

http://www.hrw.org/reports/2013/07/15/long-they-let-us-stay-class, http://www.hrw.org/sites/default/files/reports/china0713_ForUpload.pdf,
http://www.hrw.org/node/117133.

CBM (Christoffel-Blindenmission)
Disability Inclusive Disaster Risk Management

As disasters have such a huge impact on human lives, it is vital to make Disaster Risk Management inclusive. In a key publication by CBM, there are eleven good practices of Disability inclusive disaster risk management, which show concrete practical examples of how persons with disabilities are active participants in various interventions.
Bezug: http://www.cbm.org/article/downloads/54741/Disability_Inclusive_Disaster_Risk_Management.pdf,
http://www.cbm.org/Publication-on-Inclusive-Disaster-Risk-Management-389451.php.

UNICEF
All-Staff Disability Orientation and Training Video

The web-based *Disability Orientation for Staff* is a multimedia, 40-minute training video that presents statements, resources and good practices from UNICEF and its part-ners from around the world. The objective of the orientation is to strengthen both the understanding of and the capacity to support programming for children and women with disabilities. The Disability Orientation consists of two main modules, each module has five lessons. The first part of the orientation provides an overview of the disability movement and what disability means according to the CRPD. The second part of the orientation focuses on how to mainstream disability through UNICEF's work.
Bezug: http://www.unicef.org/disabilities/.

Handicap International/French Agency for Development
Disability and Development: Concepts, Strategies and Tools for Disability-Inclusive Development

A new online resource on disability-inclusive development, available in French and English, was developed by Handicap International and the French Agency for Development. It highlights why disability needs to be addressed by international cooperation and provides key facts as well as more in-depth resources to promote disability-inclusive development.
Bezug: http://www.hiproweb.org/fileadmin/cdroms/Handicap_Developpement/www/index.html,
Email: publications@handicap-international.org.

Bewerbungsschluss für den Freiwilligendienst „weltwärts alle inklusive"

Wer im Sommer 2014 einen Freiwilligendienst mit Menschen mit Behinderung in Afrika, Asien oder Lateinamerika machen möchte, sollte sich bis 30.September 2013 bei bezev bewerben.

Behinderung und Entwicklungszusammenarbeit e.V. (bezev) ist anerkannte Entsendeorganisation für das staatlich geförderte Programm weltwärts vom Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung. Einzige Voraussetzung des Programms: Die BewerberInnen müssen zwischen 18 und 28 Jahre alt sein.

Mehr zu den Einsatzstellen und dem Bewerbungsverfahren unter www.inklusivefreiwilligendienste.de.

Dort stehen auch Videos von Marlene, 25, gehörlos, und Kay, 28, Rollstuhlfahrer, die von ihrem Freiwilligendienst berichten.

Tipp: Manchmal sind noch nach dem 30.9.2013 Einsatzstellen frei – einfach auf der Website nachschauen!

Kontakt: Stephanie Fritz, weltwärts-Koordination, bezev (Behinderung und Entwicklungszusammenarbeit e.V.), Wandastraße 9, 45136 Essen;
Tel: 0201-1788963; Fax: 0201-1789026;
www.bezev.de,
www.inklusivefreiwilligendienste.de;
E-Mail: kontakt@bezev.de.

VERANSTALTUNGEN/EVENTS

02.09. - 13.09.2013 10th session of the Committee on the Rights of Persons with Disabilities, Geneva.
Information: http://www.ohchr.org/EN/HRBodies/CRPD/Pages/Session10.aspx, Kontakt: crpd@ohchr.org.

09.09. - 11.09.2013 6th International Urban Design Conference – UrbanAgiNation: urbanisation | agitation | imagination, Sydney.
Information: http://urbandesignaustralia.com.au, Kontakt: Conference Secretariat; Tel.: (61 7) 5502 2068; Email: conference@urbandesignaustralia.com.au.

10.10.2013 Inklusive Katastrophenvorsorge, Bonn.
Information: http://www.aktion-deutschland-hilft.de/de/fachthemen/katastrophenvorsorge/katastrophenvorsorge-menschen-mit-behinderung/.

16.10. - 18.10.2013 2nd International Conference of the World Federation of the Deaf (WDF) – *Equality for Deaf People*, Sydney.
Information: www.wfdsydney2013.com; Kontakt: ICMS Pty Ltd, PO Box 170, Hawthorn VIC 3122, Australia; Tel.: 1300 792 466; Fax: +61 3 9818 7111, E-Mail: wfdsydney2013@icms.com.au.

24.10. -26.10.2013 Fourth International Conference on Information and Communication Technology and Accessibility – Design 4 all, Hammamet, Tunisia.
Information: http://www.icta.rnu.tn; Kontakt: Prof. Mohamed Jemni; Tel.: +216 71 602 944; Fax: +216 71 601 930; E-mail: mohamed.jemni@fst.rnu.tn.

25.10.2013 Fortbildung: Arbeit und Beschäftigung inklusiv gestalten, Köln.
Information: www.inie-inid.org; Kontakt: Institut für inklusive Entwicklung, Wandastr. 9, 45136 Essen; Tel.: 0201/17 89 123; Fax: 0201/17 89 026; E-Mail: info@inie-inid.org.

01.11. -02.11.2013 Workshop: Wie soll die Welt von morgen aussehen? Zukunftsfähige Entwicklung inklusiv gestalten, Köln.
Information: www.bezev.de; Kontakt: Behinderung und Entwicklungszusammenarbeit, Wandastr. 9, 45136 Essen; Tel.: 0201/17 89 123; Fax: 0201/17 89 026; E-Mail: kampagnen@bezev.de.

22.11.2013 Seminar: Migration - Kultur - Behinderung, Gelsenkirchen.
Information: www.inie-inid.org; Kontakt: Institut für inklusive Entwicklung, Wandastr. 9, 45136 Essen; Tel.: 0201/17 89 123; Fax: 0201/17 89 026; E-Mail: info@inie-inid.org.

29.11. - 30.11.2013 Tagung: Globales Engagement im Unterricht mit Kindern mit Behinderung? Haben wir nicht andere Probleme?, Bonn.
Information: www.bezev.de, http://www.venro.org/fileadmin/redaktion/material/Termine/2013/bezev_Ankuendigung_Tagung.pdf; Kontakt: Behinderung und Entwicklungszusammenarbeit, Wandastr. 9, 45136 Essen; Tel.: 0201/17 88 963; Fax: 0201/17 89 026; E-Mail: inklusion@bezev.de.

06.12.2013 Menschenrechtstag: Menschenrechte, globale Armut und Behinderung, Berlin.
Information: www.bezev.de; Kontakt: Behinderung und Entwicklungszusammenarbeit, Wandastr. 9, 45136 Essen; Tel.: 0201/17 89 123; Fax: 0201/17 89 026; E-Mail: kampagnen@bezev.de.

Schwerpunktthemen kommender Ausgaben der Zeitschrift
Focal Topics of Upcoming Issues

3/2013:   Inklusion in der Entwicklungszusammenarbeit/Inclusion in Development Cooperation (Arbeitstitel) (verantwortlich/responsible: Gabriele Weigt)

1/2014:   Diskriminierung überwinden/Overcoming Discrimination (verantwortlich/responsible: Jana Offergeld)

2/2014:   Barrierefreiheit in den Bereichen Information und Kommunikation/Information and Communication without Barriers (Arbeitstitel) (verantwortlich/responsible: Christine Bruker/Isabella Bertmann)

Interessierte Autorinnen und Autoren mögen sich für nähere Informationen und unseren *Leitfaden für AutorInnen* bitte an die oben genannten Verantwortlichen wenden. Darüber hinaus sind Vorschläge für weitere Schwerpunktthemen willkommen unter info@inie-inid.org.
If you are interested in contributing, please contact the respective member of the editorial board mentioned above for more information and our Guidelines for Submissions. Moreover, we welcome ideas and suggestions for future focal topics which you can submit to our editorship at info@inie-inid.org.

Deadlines for the upcoming issues:

	3/2013	1/2014	2/2014
Hauptbeiträge/Focal articles	15.08.2013	15.11.2013	21.03.2014
Kurzbeiträge/Other contributions	15.09.2013	15.11.2013	21.03.2014

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Behinderung und internationale Entwicklung
Disability and International Development

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