COMMUNITY APPROACHES TO HANDICAP IN DEVELOPMENT (CAHD): STRATEGY TO IMPLEMENT COMMUNITY-BASED REHABILITATION (CBR) IN LESS DEVELOPED COUNTRIES

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Table of Contents

Abstract

By exploring the link between disability, poverty and development in developing Asian countries, with a focus on Bangladesh, this paper exposes disability as a cross-cutting development issue that requires a comprehensive strategy. This paper describes and analyzes Community Approaches to Handicap in Development (CAHD), a new strategy for addressing disability in less-developed countries, and contrasts CAHD with more widely-practiced approaches.

CAHD is not a totally new concept, but another way to achieve the objectives of the Community Based Rehabilitation (CBR) model. The CBR model focuses on community development to handle important issues such as equalization, rehabilitation and social integration for persons with disabilities. CBR programs in less developed countries are successful in implementing interventions related to medical needs; they fail, however, to achieve the same level of success with equalization and integration, i.e., with changing the social and economic environment in which persons with disabilities live. CAHD fosters the inclusion of persons with disabilities in development activities in order to address their poverty and economic exclusion and change negative social attitudes about disability.

This paper argues that development is incomplete when persons with disabilities are excluded. Through introducing the CAHD approach into the activities of community development organizations, negative and exclusionary environments may be transformed into productive ones for persons with disabilities and for whole communities.

Introduction

During the last fifty years there have been significant changes around disability issues, especially in western and developed countries. These changes happened due to the continuous efforts of persons with disabilities[1] and their supporters. Rehabilitation services for persons with disabilities in developing countries[2] are still in their infancy, and the lifestyle of persons with disabilities has changed little. In other words, they are invisible. Persons with disabilities are not only the most underprivileged groups of people in society; they are also the most neglected. The needs of persons with disabilities are seen separately and their roles in families and communities are ignored. Consequently, they are still segregated in their own families and also in communities.

In developing countries, persons with disabilities are members of the most disadvantaged groups of society. This means that they are lacking the usual necessities and comforts of life, such as proper housing, educational and employment opportunities, and adequate medical care. Discrimination and segregation are normal phenomenon of their everyday lives. Instead, there is limited assistance for them. Today the lives of more

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[1] This paper utilizes the term 'persons with disabilities in keeping with the (1993) UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities. It reasons that "the terminology [disability] reflected a medical and diagnostic approach, which ignored the imperfections and deficiencies of the surrounding society" (¶ 19). As people come first and disability comes second, the term 'persons with disabilities' is appropriate to use. This is, however, with the acknowledgement that there is no international consensus on language. Scholars in the UK, for example, use "disabled person", to emphasize disability as a political identity, whereas "handicapped" remains the preferred term in Bangladesh.

[2] The term 'developing countries' is used to describe countries that lack of industrialization, infrastructure, and modern technology, but are beginning to become more advanced socially and economically.

than “400 million persons with disabilities in developing countries are still dominated by the ignorance, fear and superstition” held by others (CDD, 1998; CNDD, 2006). The direct result of these beliefs is the neglect of persons with disabilities. This neglect manifests itself through their exclusion from economic, social, and political activities in their families and communities.

In 1976, the World Health Organization (WHO) proposed the Community-Based Rehabilitation (CBR) model as a pioneering strategy for rehabilitation of persons with disabilities (WHO, 2004; Lightfoot, 2004; Deepak & Sharma, 2003). The CBR strategy started out with a focus on disability related service provision in countries of the developing world. The prime objective of the CBR model is to improve the quality of life of the majority of the world’s persons with disabilities. More specifically, persons with disabilities who live in absolute and relative poverty in urban and rural areas in developing countries (Lang, 1999). The concept of CBR has been derived from the International Conference on Primary Health Care (PHC) [held in 1978 in Alma-Ata, USSR] with a view to achieve the goal of “Health for All by the year 2000” (Helander, 2000; Lightfoot, 2004; Sharma, 2007). While the year 2000 has passed, “the needs of persons with disabilities still remain unmet in many developing countries” (Deepak, 2003, p. 179). Regardless, a large number of developing nations are waiting to implement CBR as a strategy to provide rehabilitation assistance.

The World Bank estimates that one-fifth of the world’s poorest people have some sort of disability (CNDD, 2006) and ninety percent of them live in developing countries (World Bank, 2006). Persons with disabilities in these countries face more challenges

than those living in the industrialized West. These challenges primarily are limited access to healthcare, nutritious food, shelter, education, and employment. Several studies identify the causes of these challenges and report that all of these challenges are directly linked to poverty and negative attitudes about disability in society (Krefting, 2002; Heijnen, 2000; Nagata, 2007 et al.). The study of the World Health Organization (2004) has shown that persons with disabilities have higher rates of unemployment as compared to non-disabled peers even in developed countries. In developing countries, the rates of unemployment and underemployment are undoubtedly higher (WHO, 2004). Clearly, a majority of persons with disabilities in developing countries live in poverty. For this reason, they can not afford institutions-based health care and rehabilitation services since it is more expensive than community-based rehabilitation services.

Impairment, Disability and Handicap

As understandings and the concepts of disability differ from one country to the next, the World Health Organization (WHO) in cooperation with other international agencies has taken initiative to work on a series of general definitions and models of disability. In 1980, the World Health Organization (WHO) published a document entitled *International Classification of Impairments, Disabilities and Handicaps* (*ICIDH*) in order to promote a comprehensive understanding of *impairment, disability and handicap*. This document defines the terms *impairment, disability and handicap* in the following ways. Impairment is "any loss or abnormality of a psychological, physiological, or anatomical structure or function" (WHO, 1980, p. 47). Disability is "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range

considered normal for a human being" (WHO, 1980, p. 143). Handicap is "any disadvantage for a given individual, resulting from impairment or a disability, that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual" (WHO, 1980, p. 183).

The *ICIDH* was criticized for the way in which it implied that impairment itself caused “restriction of activities”, and “limited opportunities,” (Gray, Welch & Hollingsworth, 2000, pp. 171-178). This implication made “limited opportunities” seem inevitable for persons with impairments, and thus seemed to remove responsibility from governments and citizenry to ensure equal opportunities for persons with disabilities.

In addition, examples of different disability rates of developed and developing countries lead to the conclusion that disability is difficult to measure and to define. The World Health Organization (WHO) estimates the prevalence rates of disability is about 10 percent worldwide (WHO, 2006). In some developed countries like Australia, Britain, Canada and the USA, disability prevalence is about 18 percent (Krefting, 2002). In developing countries, figures vary widely as compared to those of developed countries. In Bangladesh, different surveys conducted by national and international organizations indicate disability rate is between 5 to 8 percent, which is very close to WHO statistics for other Asian developing countries (World Bank, 2006).

In response to these issues, WHO developed a framework entitled *International Classification of Functioning, Disability and Health (ICF)* for measuring health and disability both in individual and population levels (WHO, 2008). The *ICF* was officially endorsed in the 54th World Health Assembly on 22 May 2001 (WHO, 2008). The

significant contribution of *ICF* is that it "takes into account the social aspects of disability and does not see disability only as 'medical' or 'biological' dysfunction" (WHO, 2008, ¶ 2).

Definitions of disability reflect society's view of disability and people with impairments. For this reason, disability scholars and activist groups have developed alternative definitions and models of disability as a way to explain their role in society. Most influential among these models has been the social model, developed by persons with disabilities in response to the medical model of disability (Oliver, 1990). The social model has been developed with the aim of removing social barriers so that persons with disabilities have the same opportunities as everyone else, to establish their own life styles. The social model sees persons with disabilities as part of our economic, environmental and cultural society. The barriers that prevent any individual from fully participating in society are the problems of society, not the individual.

One criticism against the social model from a global south (developing country) perspective, however, is that government services have a fairly minor role in the everyday lives of poor people in developing countries. Families, kin, religious groups, neighborhoods are more important to quality of life since people see themselves very much as part of larger groups, and also because governments are doing a little in terms of social welfare. The social model emphasizes barriers but does not emphasize mutual help and solidarity. As Shakespeare (1996) suggests:

> Sometimes the values of the disability movement - for example, autonomy, independence, choices and rights - may in fact be specifically white,

> western values. Perhaps an eastern or Islamic approach would want to stress family, and solidarity, and mutuality rather than what sometimes seems a very individualistic model of liberation (Shakespeare, 1996, pp. 108-109).

More importantly, models of disability have been developed by researchers and disabled people's organizations in the industrialized west. Little consideration has been given to the cultural context of less developed countries. This has its consequences; these models do not necessarily fit other country contexts and cultural backgrounds. The modifications of existing models in the last few years and the emergence of new definitions of the terms: *impairment, disability and handicap*, lead to the further conclusion that we are still in a process of understanding *disability.*

There are several reasons for which I have chosen to use the terms *impairment, disability and handicap* in my research paper. One of the main reasons is that there is a lack of common understanding of the distinction between *impairment, disability and handicap* in Bangladesh. As the terms *impairment, disability and handicap* do not have equivalent words, there are many different types of words instead in different languages around the world. Developing non-discriminatory words for these terms in other languages is crucial. Being aware of this situation, Disability Resource and Documentation Centre (DRDC)[3] in Bangladesh has translated these terms: *impairment, disability and handicap* which are culturally acceptable, non-discriminatory in nature and

[3] A network of NGOs in Bangladesh which was formed in 1994 with the aim to translate, publish and disseminate disability related books and documents in local languages.

are not in the same way as those currently proposed in the new World Health Organization (WHO) *ICIDH*-2 (2) nor those used in the past (Krefting, 2002).

In Bangladesh, rehabilitation services for persons with disabilities are still in the early stages of development. People are just beginning to understand the term *impairment, disability and handicap*. Both old and new terminologies have been developed by western specialists and transferred to the developing countries. At this point, changing the term and meaning of it will create further confusion. In the West, many words that were commonly used are now considered derogatory by persons with disabilities. In developing countries, development professionals are beginning to educate people about the understandings and concepts of the old terminology. Significant changes to the meaning of these terms will only create misunderstanding among people who already have the understanding of the term *impairment, disability and handicap*. For this valid reason, program implementers in developing countries focus more on the causes and consequences of *impairment, disability and handicap* rather than developing new ways of defining these terms.

Disability in Developing Countries

Poor overall health conditions, poverty and malnutrition are major factors resulting in higher rates of disability in many developing countries. Lightfoot (2004) writes that the "most common causes of childhood disability in these countries are malnutrition of pregnant mother and child, injuries before and during birth, exposure to toxic substances and infectious diseases" (p. 456). As a result, a large number of children in developing countries are born with a wide range of disabilities. This is due to lack of

care and treatment at all levels. It is well-known that institutional rehabilitation services in less developed countries are insufficient as compared to the industrialized west. This leads to an increase in the number of persons with disabilities in developing countries. However, some of the causes of disabilities are treatable through medical interventions; for example, a child born with clubfeet or cleft palate. These simple conditions can be treated at the very early stage of the child's development. Otherwise, the child could have a certain degree of mobility impairment for the rest of his or her life.

Heijnen (2000) notes that "lack of rehabilitation services for children with disabilities at the community level constitute a higher rate of disability in less developed countries" (p. 1). It is, however, hard to ascertain the exact number of persons with disabilities in less developed countries, due both to "difficulties in estimation and to the notion that disability itself is a social construct that is difficult to define" (Lightfoot, 2004, p. 456). For this reason, the prevalence rates of disabilities in developing countries vary widely in different studies of the same regions. For example, in Bangladesh, government findings based on surveys conducted in 1982, 1986 and 1998 estimated a national prevalence rate of 0.64 percent, 0.5 percent, and 1.60 percent (Alam & Bari, 2005, ¶ 2). Nonetheless, sample surveys conducted by national and international organizations have found prevalence rates to be much higher than government findings. A recent study by Handicap International (HI) has estimated about 5.6 percent as the prevalence rate of disability in Bangladesh. The United Nations (UN) has estimated that 5 percent of the world's population has some sort of disabilities while WHO's estimation is 10 percent (Alam & Bari, 2005; CNDD, 2006; WHO, 1992). If these figures are

calculated for Bangladesh, "the number of persons with disabilities should range from a minimum of seven million to a maximum of fourteen million, based on the country's population of 140 million" (Alam & Bari, 2005, ¶ 2). Whatever the estimation is reported by national and international organizations, there is an immediate need for basic rehabilitation services for millions of persons with disabilities in less developed countries. It is important to note that in these regions the number of persons with disabilities is increasing much faster than the annually added supply of rehabilitation services (CNDD, 2006). Instead, the inequality in the sharing of rehabilitation services in developing countries generates numerous challenges for persons with disabilities particularly those who live in poverty.

Poverty and Economic Exclusion

It is widely acknowledged that there is a strong correlation between poverty and disability (WHO, 2004). Much has been written about the mutual relationship between poverty and disability, but there is a lack of empirical evidence that poverty causes disability in most literature (Kampen, Zijverden, & Emmett, 2008). As many researchers have defined the relationship between poverty and disability, it is necessary to review their definitions prior to making any claim that poverty causes disability.

In their study Reflections on Poverty and Disability: A Review of Literature, Kampen et al. (2008) note that "the way poverty is conceptualized is inherently about value preferences that vary between individuals, organizations and societies" (p. 21). According to Miles (2006), the United Nations describes poverty as "the denial of opportunities and choices most basic to human development-to lead a long, healthy,

creative life and to enjoy a decent standard of living, freedom, dignity, self-esteem and the respect of others"(as cited in Kampen et al., 2008, p. 21). The more practical definition is developed by the World Bank. The Bank determined monetary indicator to identify poverty using a poverty line of income of less than US $ 1 a day. As seen by the different definitions of poverty, one can realize that poverty is multidimensional in nature and many different factors influence the poverty of a country. It is hard to consider a universal definition of poverty. However, efforts have already been initiated by a number of development organizations in developing countries to eliminate poverty, but there is no such notable initiative has undertaken for the majority of persons with disabilities. Therefore, "poverty is still among the most important causes of impairment in most Asian developing countries" (Nagata, 2007, p. 5).

The linkage between disability and poverty has gained global recognition. The international communities have turned their focus towards disability mainstreaming and the empowerment of persons with disabilities in developing countries. They proposed that poverty is a cause and consequence of disability (DFID, 2000; Khan & Bari, 2002). For this reason, development donors and program implementers in many developing countries have sought out new ways and means to reduce the causes and consequences of disability through eliminating poverty from society (CNDD, 2006; DFID, 2000). Nagata (2007) notes that "poverty is not only a dependent variable of social processes and social barriers, but also a root cause of many forms of impairments and disability" (p. 1). It is now widely accepted that poverty and disability have reinforced each other and

contributed to the increased vulnerability and exclusion of persons with disabilities (Khan & Bari, 2002).

Being aware of this situation, international development organizations and their interest groups have begun to realize that the needs and rights of persons with disabilities cannot be fully addressed unless the underlying causes of poverty are tackled. In 2000, the *Millennium Declaration* by UN Member States set eight *Millennium Development Goals (MDGs)*. The following three goals are directly related to persons with disabilities and their families:

1. Eradicate severe poverty and hunger;
2. Achieve universal primary education;
3. Promote gender equality and empower women (WHO, 2004, p. 5).

Persons with disabilities in developing countries are not only experiencing unreasonably high rates of poverty, but being poor increases the probability of disability. In this way, negative attitudes towards persons with disabilities are reinforced by poverty, which creates impairments and these impairments in turn lead to disabilities. The linkage between poverty and disability shows that the vicious cycle of underdevelopment begins as a result of economic poverty, which then leads to malnutrition that causes disease, which then further leads to impairment and disability. It assumes in many situations that people with impairments have low productivity; they could not contribute as much to the labor market as their peers. Their income levels become lower and they live in poverty. As this increases the effect of his or her impairments and leads to permanent disability,

they continually face discrimination, segregation and stigma the moment they are perceived to be affected by impairment (World Bank, 2004).

Recent research shows that persons with disabilities are systematically excluded from all development activities in many societies. This, in turn, limits their rights and challenges their ability to fulfill their socio-economic obligations (Nagata, 2007). For example, in Bangladesh, parents think that children with disabilities do not need to attend schools. Though some children with disabilities do attend schools, their special needs are unlikely to be met by schools. When this is the case, how can a child get access to employment when he or she becomes adult? As education is the basis for reducing poverty and inequality, improving health, enabling the use of new technologies, and creating and spreading knowledge, how can an uneducated adult with disabilities avoid reaming poor the rest of his or her life? Therefore, there is a need to integrate persons with disabilities into all components of mainstream development co-operation. But, in practice, integration of persons with disabilities remains a distant dream in most developing countries.

The United Nations has classified Bangladesh as one of the least developed countries in the world (Heijinen, 2000). As most of the citizens of Bangladesh live in poverty, they compete amongst themselves to avail of the resources granted to everyone (Thomas, 1998). Clearly, persons with disabilities cannot compete for resources with their non-disabled peers. Persons with disabilities lag behind from their justified needs and rights in society, their economic situation changes a little, and they remain at the bottom of poverty. Therefore, more importance for the empowerment of persons with disabilities

needs to be given to establish equal opportunity and full participation. Only communities can empower persons with disabilities and help them achieve their rights.

There are numerous examples of the conditions of poverty of persons with disabilities in developing countries. The study by the Department for International Development (DFID) cites the following example:

> [Analysis of] Tanzanian survey data revealed that households with a member who has a disability have a mean consumption less than 60% of the average, leading [the author] to conclude that disability…..is a hidden face of African poverty. (p. 4)

Clearly, poverty has multifarious dimensions and several factors influenced the conditions of poverty. As the meaning of poverty varies from one place to the other, it is, however, very difficult to have one universal definition of poverty. In general, most developing countries across the world have determined their own poverty line based on peoples' survival needs: food, clothing, health and housing. In some developed countries, these determinants are quite different. As every country adopts different indicators to set poverty line, it is very difficult to make any comparison with regard to poverty between two countries.

CBR implementers in developing countries, however, debate whether it is worthwhile to advocate for establishing the rights of persons with disabilities, rather than providing rehabilitation services (Thomas, 1998). At this point, CAHD implementation strategies differ from CBR. The vision of CAHD is to establish activities that will minimize the negative impacts of disability through changing the social environment and

attitudes of both people in communities and organizational policies in order to eliminate the barriers that result in the exclusion of persons with disabilities (Khan & Bari, 2002). At the same time, the central goal of CAHD program activities is to make persons with disabilities aware of their rights and obligations in communities. It should be acknowledged that if the needs and rights of persons with disabilities are left unaddressed, it will lead to a series of cumulative exclusions resulting in social disabilities.

Changes in the Attitudes of People and Organizations

Much research has indicated that social exclusion or isolation is a result of disability (Kampen, Zijverden, & Emmett, 2008). I have just discussed that exclusion of persons with disabilities from economic development initiatives of society leads them to poverty. Despite persons with disabilities facing various forms of challenges which include exclusion, isolation and neglect, these challenges sometimes lead persons with disabilities to chronic poverty (Kampen et al. 2008). One study by Lwanga (2003) showed that the needs of persons with disabilities vary from one individual to the other and persons with disabilities are affected differently by poverty. The author further concluded that "social values are very important when it comes to considering who is disabled" (as cited in Kampen et al., 2008, p. 28). Clearly, social values of persons with disabilities are important considering factor in the inclusion of persons with disabilities in mainstream development. Misconceptions and traditional beliefs on disability and subsequent negative attitudes are major challenges in the process of inclusion in the context of developing countries.

Although few studies have been conducted in relation to negative attitudes towards persons with disabilities especially in Indian sub-continent, there are numerous studies on cultural beliefs and practices about disability in these regions. All of these studies concentrate on the impact of traditional beliefs on the lives of persons with disabilities and families who have children/adults with disabilities. The study by Dalal and Pande (1999) in India noted that "cultural beliefs about disability play an important role in determining the way in which families perceive disability and the kind of measures it takes for prevention, treatment and rehabilitation" (p. 57). The authors also indicated that parents have very negative attitudes towards their children/adults with disabilities and their expectations from them are somewhat unrealistic. There is, however, a strong belief in the "metaphysical causation" rather than physical causes of disability.

In India, for example, people have the belief in the theory of karma which means that "all good and bad deeds accumulate over previous births and the present suffering [child born with a disability] is explained as a consequence of the misdeeds of previous births" (p. 57). As people have a tendency to accept that their own disability has resulted from their past karma, persons with disabilities and their families are reluctant to struggling the limitations that are caused by disability. Despite medical advances in these regions and the massive interventions of CBR programs about the causes and consequences of disability, the stigma, traditional beliefs and negative attitudes towards persons with disabilities are prevalent in most communities in the developing world.

In the rural parts of Bangladesh, the most predominant example of traditional beliefs is that when a child born with a disability. It is often considered as a curse from

God or a result of previous sins of parents or close relatives (CDD, 1998). For this reason, children with disabilities are kept hidden. Parents are reluctant to provide even medical treatment when their children are sick as they believe that it is not worth to spend money for children with disabilities. Therefore, children with disabilities are more likely to die young or to be neglected in families and societies.

In Bangladesh, almost ninety percent of citizens belong to the religion of Islam. In Islam, disability is seen as neither a blessing nor a curse. Musse (2002) notes that "Islam sees disability as 'morally neutral' and disability is considered as being an inevitable part of the human condition" (¶ 4). Despite the teachings of Islam and massive awareness raising initiatives about the cause and consequence of disability, people in remote areas in Bangladesh still perceive disability negatively.

In addition, people in Bangladesh believe that children will take care of their parents when they become adults. In the case of children with disabilities, parents and family members need to provide more care for their children as compared to other members of family. Parents believe that children with disabilities, when they grow up, are unable to perform any everyday activities. Some other factors such as the lack of knowledge about disability and the conditions of poverty at all levels play a vital role in excluding children with disabilities from their families and communities (CDD, 1998). In most cases, parents avoid sending their children for early childhood education. This has its consequences. When these children become adults, they will not be able to find a job because of the lack of education. Therefore, they remain poor the rest of their lives. The impact of the exclusion of children with disabilities from education is that:

> In many countries disabled children are not required to go to school and, even if they want to enroll, their specific needs are unlikely to be met by schools. But if this is the case, how can such a child gain access to employment when he becomes an adult? And how can such an uneducated adult find a productive job and avoid remaining poor the rest of his life? (World Bank, 2004, p. 2)

Clearly, stigma, neglect and superstition contribute to excluding persons with disabilities from a social life. As persons with disabilities often face barriers that are related to the environment, accessibility, and legal and institution, the process of changing the negative environment to a positive one is crucial. Admittedly, attitudinal barriers are one of the major hindrances that persons with disabilities face in every society. It is also a cause of social exclusion. As social exclusion is directly associated with feelings of shame, fear and rejection, it is considered as one of the hardest barriers to overcome (DFID, 2000).

The study by Tjandrakusuma (1998) indicated that changes in the negative attitudes of people in communities are more important in order to advance the process of integration into mainstream development, than changes in the lives of persons with disabilities themselves. The barriers that resulting from the negative attitudes towards persons with disabilities such as the lack of opportunities for education, employment and income generation activities must be resolved first in order to establish equal opportunities and full participation of persons with disabilities. In 2001, the baseline survey of Voluntary Health Association of Tripura (VHAT), India, a CAHD implementing organization, indicated that the majority of people in community

considered persons with disabilities as of no use to the society (HI, 2001). Most of the respondents expressed that children with disabilities should not be admitted in schools, and that they would neither like their own children to study in the same class nor allow their children to interact with children with disabilities.

When this is the situation, changes in the negative attitudes towards persons with disabilities are important in order to advance the inclusion process. In response, the VHAT initiated programs on social communication and awareness- raising through different culture-specific innovative mediums. They also arranged professional skill training for persons with disabilities and organized them into self-help savings groups. Towards the end of 2001, Voluntary Health Association of Tripura (VHAT), India found the following changes:

> The inclusion of children with disabilities in schools has increased in the project areas. There is a distinct attitudinal change in behaviour towards children with disabilities. There are fewer reservations among children about playing with children with disabilities or sitting next to them in the classroom. They willingly help their disabled peers [children with disabilities] in reading, writing and completing exercises. (HI, 2001, pp. 27-28)

Clearly, the problems faced by persons with disabilities in their daily lives are the result not only of their individual impairment, also of the attitudes of the communities, there is a need to change the attitudes of people and community to enhance the inclusion process of persons with disabilities (Tjandrakusuma, 1998). It should be acknowledged that

changing the attitudes and beliefs of the communities is depended on change in the people of communities who are not affected by disability and do not receive any benefits from it. Therefore, it is not easy to change such a non-disabled population who are not directly benefited. Thomas and Thomas (1999) noted that changing in the non-disabled population may sometimes require "incentives or legal sanctions to make them comply with the social regulations" (p. 187). Implementing these regulations also involve certain costs which need to be raised from the same population. In such a situation, it takes a longer time to bring the desired changes in communities. The authors acknowledged that though the community based rehabilitation are successful in implementing programs related to medical interventions, they fail to achieve the same level of effectiveness in changing contextual factors of society.

Rehabilitation and Prevention

The concept of prevention and rehabilitation in the developing world is viewed as significantly important because so many impairments can be avoided. Research shows that "up to 50 percent of some types of disabilities could be prevented by immunizations, environmental improvements and better overall health care" (Lightfoot, 2004, p. 456). For example, polio can be prevented by vaccination and, in other cases; adequate pre- and post-natal care can also reduce birth related disabilities.

A study from the Department for International Development (DFID) in 2000 reported that "as many as 50% of disabilities are preventable" (p. 3). Because many of the causes of impairments are preventable, community development organizations in developing countries initiate community-based programs to provide basic prevention and

rehabilitation services for persons with disabilities in a "low-cost, but highly accessible manner" (Lightfoot, 2004, p. 455). The objective of rehabilitation is to reduce the impact of disabling conditions and to enable persons with disabilities to achieve equal opportunity and full participation in community development activities (Lightfoot, 2004; WHO, 2004). Consistent with this objective, disability specialists in the West developed different rehabilitation models to provide basic prevention and rehabilitation services for persons with disabilities. These rehabilitation technologies from the industrialized West have been transferred rapidly to the developing countries. The following discussion explores two of the most predominant models: Institution-based rehabilitation (IBR) and Community-based rehabilitation (CBR).

Institution-based Rehabilitation

The Institution-based rehabilitation (IBR) model in many developed countries is recognized as an effective way to provide medical rehabilitation for persons with disabilities. Under the IBR model, rehabilitation services have been provided from established institutions which are usually based in urban areas. Persons with disabilities come to these service institutions from far distances for interventions. It is important to acknowledge that institution-based care and treatment is well-suited for two different situations. First, for situations, when a person has some sort of impairment, such as physical effects of leprosy, the progression of which can be halted through treatment. Secondly, for situations, where a child's disabling condition such as cerebral palsy cannot be cured, but the child could become more independent if he or she was provided special assistance that built upon the child's ability.

Despite few exceptions, most of the services under the IBR approach are urban based, address mainly one specific disability group, and focus disability more on the "Medical Model of Disability" than the "Social Model of Disability" (Oliver, 1990, ¶ 4). As Oliver (1990) states, "the medicalisation of disability is inappropriate because it locates the problems of disability in the wrong place, within the individual rather than in society" (¶ 5). For more than a decade, disability specialists in the West have taken the initiative to depart from the medical model of disability with the aim of removing social barriers so that persons with disabilities have the same opportunities as others to establish their own life styles. The social model sees persons with disabilities as part of our economies, environment and cultures. From this perspective, the barriers that prevent any individual from fully participating in society are the problems of society, not the individual. As indicated above, an institution-based service is absolutely necessary but health and rehabilitation of persons with disabilities in this model are viewed as a medical problem rather than a social problem. Under this model, rehabilitation for persons with disabilities is treated simply as a medical service. For this reason, the method of providing services for persons with disabilities is debated in many jurisdictions.

A related drawback of the institution-based rehabilitation model is that it relies heavily on trained specialists who are capable of using modern equipment to provide essential rehabilitation services for persons with disabilities (Lightfoot, 2004). Institutional rehabilitation services are expensive and require an adequate amount of resources to purchase of state-of-the-art equipment. As it requires professionally-trained

specialists and sophisticated equipment, there is a need for substantial resources to provide institutional care and services for persons with disabilities.

In developing countries, most persons with disabilities who live in rural areas can not afford institutional care, and ultimately do not have access to its services. For example, in Bangladesh, government health services for poor people are at no cost. But government has limited resources to catering services for persons with disabilities. It is worth noting that a number of privately owned institutional care and rehabilitation services for persons with disabilities are available in urban areas. These institutions have modern technologies and therefore services are expensive. A small but influential, educated and comparatively rich urban middle class of persons with disabilities can afford these expensive services. As most persons with disabilities in need of real help are from the marginalized groups of society, they seldom receive services from these private institutions.

Finally, the expensive and sophisticated equipment used in these institutions require trained professionals to operate this equipment. Sometimes, there is a need to send personnel abroad for technical training. Therefore, a large amount of resources are required for equipment purchase, personnel training, and operational costs in order to provide services to a small segment of persons with disabilities in developing countries. In addition, “the Western concern about the segregation caused by institution-based services is also a valid concern in less developed countries” (Lightfoot, 2004, p. 458). As a large number of persons with disabilities in developing countries do not benefit from the institution-based rehabilitation services, disability scholars, international

communalities and activist groups in the West are concerned about the systematic exclusion of persons with disabilities under the process of institution-based care and treatment.

Being aware of the limitations of institution-based care and treatment, the World Health Organization (WHO) has popularized the community-based rehabilitation model for providing immediate assistance to a large number of persons with disabilities in developing countries. According to Thomas and Thomas (1998), the CBR approach gained prominence in the decade of eighties and came to be considered the most suitable method of rehabilitation for persons with disabilities in developing countries.

Community-based Rehabilitation

During the last two and half decades, the concept of rehabilitation services for persons with disabilities has changed. Rehabilitation should no longer be imposed without the consent and participation of people who are using the services. Rehabilitation is viewed as a process in which persons with disabilities make decisions about what services they need to enhance participation (WHO, 2004). WHO, ILO and UNESCO view "CBR as a strategy that can address the needs of people [persons] with disabilities within their communities in all countries" (WHO, 2004, p. 2).

The concept of community-based rehabilitation (CBR) has emerged as an outstanding strategy in the field of disability and rehabilitation (Lightfoot, 2004; WHO, 2004). The CBR model focuses on community development to handle important issues such as equalization, rehabilitation and social integration for persons with disabilities. This is achieved through the efforts of all involved: persons with disabilities, their

families, communities and the appropriate professional services. The CBR model is more appropriate strategy to disability issues, since the model sees the wholeness of persons with disabilities and is concerned with their integration into families and communities.

Currently more than a quarter of the less developed countries in the world have initiated CBR programs (Lightfoot, 2004; WHO; 1992). Although there are some controversies in the way the CBR model is being practiced in developing countries, the rehabilitation programs for persons with disabilities under the CBR approach in these countries have found it successful.

Benefits of the CBR Approach

As noted above that CBR is inexpensive as compared with institution-based care, community development organizations in developing countries consider community-based rehabilitation the only feasible way of providing support to persons with disabilities. Though the majority of these organizations implementing CBR are disability focused organizations, the CBR model has gained prominence because it meets the needs of persons with disabilities who live in rural areas and do not have access to urban-based institutional care and treatment. In developing countries, the majority of persons with disabilities lives in rural areas and cannot get access to urban-based rehabilitation institutions for any services. They have no other options except to depend on organizations that carry the community-based rehabilitation programs in local areas. It is also true that a small number of comparatively wealthier and educated groups of people who can afford services from institutions may be critical of CBR programs (Contact, 2002). To some extent, their arguments against CBR may be correct, but given the fact

that CBR programs are absolutely necessary for people who live in remote areas in less developed countries. For example, in Bangladesh, persons with disabilities are the most vulnerable of the disadvantaged groups of society. In many cases, they receive little or no assistance. In such a situation, persons with disabilities in rural Bangladesh are the ones who will benefit the most from CBR initiatives (Contact, 2002).

The CBR model is widely accepted by the most developing countries around the world because it focuses on the "cultural meanings of disability" (Lightfoot, 2004, p. 463). It is well known that people from different cultures view or perceive disability differently. CBR programs in rural Bangladesh, however, are beginning to address people's negative attitudes about disability. It is clear that in developing countries rehabilitation programs will only be successful if negative attitudes towards persons with disabilities change. CBR may be the only feasible way to get close to marginalized groups of society and the easiest means for changing negative attitudes towards persons with disabilities in communities.

One of the major arguments for a CBR program is that by integrating persons with disabilities into the economic life of the community, it helps improve attitudes of people in communities to the abilities of persons with disabilities. A recent study of a CBR program in Guangzhou, China reported that attitudes of people in communities towards persons with disabilities have significantly improved where CBR programs are implemented as compared to the areas where there are no such initiatives (Guozhong, 2006). Clearly, CBR programs have an impact on community attitudes to the abilities of persons with disabilities. When people in communities will recognize the abilities of

persons with disabilities, they often create more opportunities for them to contribute to socio-economic development in society. For example, in Bangladesh, community development organizations that have integrated persons with disabilities in their community-based 'Savings & Credit' programs suggest that social status and acceptance of persons with disabilities in the community have improved as a result of their inclusion in their programs (Thomas, 2000). The study also indicated that persons with disabilities' self-esteem improved, their involvement in community participation increased, and community attitudes to the abilities and social worth of persons with disabilities significantly improved (Thomas, 2000).

It should be acknowledged that changing community attitudes is the key to sustaining rehabilitation activities in the community and to enabling persons with disabilities to achieve equal opportunities. People in communities will never help to integrate persons with disabilities into the social, economic and political activities until their negative attitudes about disability change.

Controversies of the CBR Approach

Despite some positive aspects of CBR, the needs of persons with disabilities in developing countries still are unmet due to poorly coordinated health care systems, the low priority on rehabilitation services, and the shortage of funds to initiate appropriate CBR programs (Lightfoot, 2004; WHO, 1992). Though CBR is culturally sensitive to a given society, in many situations CBR initiatives almost ignore that disability is both a cause and consequence of poverty (DFID, 2000). The conditions of poverty of persons with disabilities and their families lead them to engage more in meeting the basic needs

such as housing, nutritious food and other life-sustaining elements. As a result, persons with disabilities and their families show low motivation to overcome the disabling conditions. In developing countries resources are limited to ensure even basic needs of non-disabled population and a little allocation for persons with disabilities. For this reason, a large number of persons with disabilities live in poverty. As a result, most of the CBR programs do not pass their pilot phase due to resource constraints and success is obviously far away.

CBR is supposed to be managed by the community, but in reality, "many early CBR projects have adopted a top-down approach and are run by outsiders without adequate attention towards community concerns and participation" (Cheausuwantavee, 2007, p. 2). Much research has been conducted on the community participation in CBR programs (Thomas, 1999; Lang, 1999). In his book of *Disability and Development: Learning from Action and Research on Disability in the majority world*, Lang (1999) noted that community-based rehabilitation is supposed to involve all people in local communities, but in reality local communities are totally ignored due to the way CBR is being practiced in developing countries. For example, one mid-term evaluation of the CBR project in 1993 in India found that the rehabilitation services for persons with disabilities were provided in a very "top-down" manner. The findings also showed that rehabilitation professionals provided services that they thought met the needs of person with disabilities, without consulting local people themselves. For this reason, local people remained recipients not participants in the CBR programs (Lang, 1999). In the light of these criticisms, aid agency completely withdrew its funding. CBR program managers

then redrafted the program priorities and developed strategies where participation of persons with disabilities and local community were ensured.

Though international definitions of CBR highlight the critical role of the local community, it should be acknowledged that the most CBR programs have been managed and directed with few real inputs from the community and persons with disabilities (Lang, 1999). The author also reported that CBR experts have the tendency to adapt medical approach and apply it in community settings. Though CBR specialists give emphasis to the involvement of community decision-making and support a "bottom-up" approach, in most of the cases CBR programs are from a "top-down" approach as rehabilitation professionals remain the decision-makers of the programs.

It is, however, difficult to ensure community participation in community-based programs in the context of developing countries. As Thomas and Thomas (1999) indicated that there is a significant difference between developed and developing countries with regard to the concept of community participation in CBR programs. The authors explained their view in the following paragraph:

> In western countries, given an opportunity, communities are ready and have the skills to participate in development programmes [programs]. In developing countries however, the concept of community participation is not as simple to implement, because the communities are traditionally not ready to take on this responsibility. In the authors' [Thomas & Thomas] opinion, development programmes [programs] are more likely to succeed

> if a well planned strategy to enhance participation is also incorporated into the programme [program] planning. (Thomas, 1999, p. 3)

Clearly, the way Western professionals view the concept of community participation in CBR programs that vary between their perception and the way these programs are being practiced in developing countries. Helander (2000) indicated that professionals in the West transfer rehabilitation technologies to developing countries without prior understanding of these methods and techniques; they are often severely criticized for copying and transferring these technologies to developing countries. The author also noted that not much effort had been given to adapt these technologies to the culture or the socio-economic conditions of the recipient countries.

Another major concern of CBR specialists is that it needs colossal co-ordination and support from government agencies to achieve success. It is inevitable that in developing countries, health-care systems, planning, and service delivery systems are poorly coordinated. As a result, rehabilitation services for persons with disabilities are also less coordinated and there exist different rehabilitation technologies for persons with disabilities in different locations of same regions. In developing countries, the lack of support from centralized governments and tightly conditional funding from foreign donors may be a barrier to success of CBR.

One of the major arguments against the CBR approach is that it attempts to provide ‘something for everyone’ rather ‘everything for a few’ (Thomas, 1998). At the commencement of CBR programs, governments in developing countries invest adequate amount of resources for rehabilitation programs. As there is a need for immediate

assistance for persons with disabilities in many developing countries, CBR program implementers in these countries, are trying to serve the majority of persons with disabilities with inadequate resources. As the resources are limited as compared to the needs, the quality of services for persons with disabilities becomes very poor and most of their needs remain unmet. For this reason, implementation strategies of CBR in developing countries are debated in many jurisdictions (Lightfoot, 2004).

Helander (2000) noted that at least three components of community development activities are required to be included into CBR strategies: the integration of persons with disabilities from target communities, the establishment of the rights of persons with disabilities, and the provision of rehabilitation assistance. But, although they try to reach most persons with disabilities, most of the CBR programs in developing countries focus too much on one component and exclude the others (Thorburn, 2000). The reasons are not only that the CBR implementers in developing countries are not aware of the principles of CBR model but also have limited resources, a shortage of funds, and issues specific to various cultural contexts hinder the successful process of implementing CBR programs.

Thomas (1998) notes that "there is no universal model of CBR which is applicable everywhere and each programme has to evolved its own strategies and methods as appropriate to its context" (p. 4). For this reason, implementation strategies of CBR vary from one country to the other. Therefore, in many developing countries, disability experts, advocates and professionals have developed strategies appropriate to their cultural setting to achieve the objectives of CBR.

Lightfoot (2004) indicated that professionally-trained rehabilitation specialists such as doctors, nurses, and therapists may not accept community-based workers of CBR programs and, in some cases; professionals are reluctant to work with minimally trained health workers. Some of their arguments against community-based workers are that they have little training as well as they have very limited knowledge about rehabilitation techniques. As a result, professionally-trained health workers presume that community-based rehabilitation workers are not capable of providing even basic rehabilitation services for persons with disabilities. Therefore, in some situations, professionals do not put much attention to the effort of community-based workers (Lightfoot, 2004). The lack of support from the professionally trained health workers become a barrier for CBR workers for its successful implementation. In this way, persons with disabilities who live in rural areas are the ones who face challenges to receive rehabilitation assistance and referral services at the community level.

Though the CBR model encourages the use of community resources and personnel to provide basic rehabilitation services in a low-cost, but highly accessible manner, some researchers have found it to be high-cost (Lightfoot, 2004; Lang, 1999). Their argument is that an adequate amount of resources such as routine follow-ups, staff training and transportation costs are essential to provide minimum services for persons with disabilities at community levels. Although it is conceived that the CBR model are cheaper per person than institutional rehabilitation, still it requires external funding to continue CBR programs in many developing countries (Lightfoot, 2004).

International organizations have conducted numerous researches in regards to CBR sustainability around the world. For an example, International Labor Organization (ILO) has reviewed CBR programs of organizations that have minimum of ten years of working experience around the world and could not name even one program that was fully sustainable after external funding had been withdrawn (Lang, 1999). CBR programs in developing countries still are heavily relied on external funding, and this funding is for a limited time. Governments in these countries not only have limited allocation of resources for persons with disabilities; they also consider disability one of the lower-priority issues of development co-operation. As a result, the needs of persons with disabilities remain unmet.

During the last twenty-five years, the CBR model received many changes to its concept but the lives of persons with disabilities changed little (Helander, 2000). This change is around the concepts of disability and rehabilitation. For example, the "Joint Position Paper on CBR" in 2004 placed emphasis on human rights and action to address inequalities and alleviate poverty, and on the active role of Disabled Peoples' Organizations (DPOs) (WHO, 2004). Several studies conducted to measure the extent of rehabilitation services and found that still "2-3 percent of persons with disabilities have access to rehabilitation and appropriate basic services in most developing countries" (CNDD, 2006; Thomas, 1998). It is also worth noting that "as many as two out of every three people become disabled [or] are dying for reasons that are directly related to poverty and negative attitudes about disability" (Krefting, 2002). The community-based rehabilitation model is in its infancy to address the problems associated with poverty and

negative attitudes about disability in many of its existing programs. This is a valid concern that CBR programs are unable to provide services to a large number of persons with disabilities. But the needs of persons with disabilities are increasing steeply in developing countries. Therefore, in Bangladesh, the Centre for Disability in Development (CDD) has developed a new strategy 'Community Approaches to Handicap in Development (CAHD)' for implementing CBR. The CAHD approach makes direct working links with existing community development organizations and utilizes their potentials to directly address the needs of persons with disabilities (Khan & Bari, 2002).

In the past, the needs of persons with disabilities in developing countries were ignored, and disability was considered a charity concern. Recently, development donors and program implementers are changing their program and beginning to approach disability as an issue of development rather than charity (DFID, 2000; HI, 2001; CNDD, 2006 et al.). Currently, community development organizations in developing countries such as Bangladesh, India and Nepal have also begun to explore the idea of disability in the context of development (HI, 2001).

In developing countries, a large number of non-profit organizations are working at community levels. They have multifarious development components: micro credit programs, adult education programs, child education programs, and several income generating programs. These organizations never include persons with disabilities as their program recipients (Thomas, 2000). These organizations are reluctant to integrate persons with disabilities in their development components as they perceive they lack the necessary skills and knowledge to work with persons with disabilities.

There are no exact statistics that show how many countries have initiated CBR programs in the Asia Pacific region. However, countries that have implemented a CBR program have done so using their own strategy, rather than following a common program (Tjandrakusuma, 1998). Thomas (1998) noted that "there is no universal model of CBR which is applicable everywhere and each programme [programs] has to evolve its own strategies and methods as appropriate to its context" (p. 4). For this valid reason, implementation strategies of CBR vary from one country to the other. Therefore, in many developing countries, disability experts, advocates and professionals have developed strategies appropriate to their cultural setting to achieve the objectives of CBR. The new concept of implementing CBR, Community Approaches to Handicap in Development (CAHD) is an example of such strategy. It is an effort to systematically address the issues of disability in the context of development (CDD, 1998; Khan & Bari, 2002; HI, 2001; Krefting, 2002 et al.). The following discussion explores the concept of CAHD, the importance of developing this strategy and how this concept directly responds to poverty in communities and negative attitudes about disability.

Community Approaches to Handicap in Development (CAHD)

The concept of Community Approaches to Handicap in Development (CAHD) was developed in Bangladesh in 1997 to ensure equal opportunity and full participation of persons with disabilities in mainstream development. The Centre for Disability in Development (CDD), a non-profit voluntary resource organization, initiated the CAHD concept in Bangladesh. CAHD sets out to rectify the situation that only a limited number of the community development organizations working in Bangladesh were working

for/with persons with disabilities. The community development organizations focus on the poor and vulnerable of the community, but they were not integrating persons with disabilities into their existing development components. Since that time, CDD has been working with other community development organizations through providing training (see appendices- i) necessary to integrate persons with disabilities in their intervention programs (Khan & Bari, 2002). It is clear that total development is only possible when persons with disabilities are included in every community development activity.

The objective of the CAHD approach is to enhance the quality of life of persons with disabilities in communities. It sees disability as a development issue that needs to be included in mainstream development. CAHD assumes that communities and their organizations can increase persons with disabilities' contributions to development activities and help them achieve equal opportunity and full participation. This can be done by implementing activities to:

1. Combat ignorance, fear and superstition at all levels in every society;
2. Ensure inclusion of persons with disabilities and their interests in all levels of activities throughout society; and
3. The provision of rehabilitation services (CDD, 1998).

The aforesaid three activities should be implemented by the community development organizations that are working with persons with disabilities. These organizations that are actively involved in providing development assistance to people in communities will implement CAHD. People and organizations have been given training on awareness and knowledge about disability initially in the following major topics:

- Causes of impairment, disability, and handicap;
- Roles of family members and organizations that create handicap;
- Activities that will prevent impairment, disability, and handicap and
- Rehabilitation practices that will minimize the impact of impairment and maximize the personal development of persons with disabilities (Krefting, 2002).

In developing countries, the personnel of community development organizations have already been trained and experienced in working in the community and now they have the training on disability issues. Therefore, it is much easier for these organizations to include persons with disabilities in their development activities.

In Bangladesh, where a large number of community development organizations work, we see an example of the efficacy of educating development workers in disability. Here as elsewhere, very few organizations had integrated disability issues in their development activities. Just after the inception of CAHD in Bangladesh in 1997, some mid-level organizations were invited for disability related training by the CAHD initiator organization. They began to include persons with disabilities in their program of interventions on a pilot basis. As their projects successfully passed the pilot phase, people and organizations of neighboring communities recognized the abilities of persons with disabilities. Currently, national level organizations in Bangladesh such as BRAC and Proshika show their keen interest on initiating disability programs as an integral part of their development programs (CDD, 1998). Once people and organizations receive training on disability, their attitudes change and they include persons with disabilities in

their communities and organizations. But in reality, these organizations accept persons with disabilities for two reasons. First, people and organizations have skills and knowledge to work with persons with disabilities. Secondly, disability is a new development area in Bangladesh and donor agencies give priority to provide funding to organizations that have programs on disability. For these reasons, organizations are interested in initiating programs for persons with disabilities to expand their areas of interventions. It is not that people and organizations' negative attitudes towards persons with disabilities have permanently changed. However, this is one of the major entrances for persons with disabilities to existing community development programs in the context of developing countries.

The CAHD initiator organization, Centre for Disability in Development (CDD), in Bangladesh plays a leading role in motivating government and general development organizations to recognize the importance of persons with disabilities and their contribution to society (HI, 2000). In Bangladesh, the initiation of inclusive approaches by CAHD initiator organization has led to the inclusion of a large number of persons with disabilities in education, social and livelihoods development processes (HI, 2001). More importantly, the enrolment of children with disabilities in mainstream education systems reflects a considerable achievement of CAHD approach. For example, BRAC Bangladesh, in cooperation with CAHD approaches, "first began to provide a limited range of services to children with special needs at rural areas under its basic education program in 2001" (BRAC Education Program, 2007, p. 1). The government of Bangladesh with technical support from CAHD initiator organization started programs

for inclusive education for children with disabilities. The government now recognizes the importance of inclusion of children with disabilities in mainstream education and has taken the ownership of this program.

As general development organizations are accepting persons with disabilities in their development initiatives whether it is to satisfy the criteria of aid agencies or changing in the attitudes, persons with disabilities eventually are benefited from these interventions. In this way, persons with disabilities can contribute more in society and their socio-economic status also improves. Poverty will have less influence in their lives as they are fully integrated in communities and share economic benefit with others in society.

It is important to note that persons with disabilities of all types live in communities and their needs vary. One of them may need medical intervention, another person needs small loans, and some other requires mobility aids. Not all of these services for persons with disabilities are available in one geographical area. As the personnel of CAHD implementing organizations receive skill development training on how to work with persons with disabilities and information on disability related service institutions, they can refer persons with disabilities to these institutions for additional assistance. In this way, persons with disabilities receive appropriate basic rehabilitation services. Since limited resources hinder the process of providing services even to non-disabled people in developing countries, CAHD initiator organization manage funds for providing training to the personnel of community development organizations. In some cases, CAHD initiator

organization provides a short-term financial support to initiate CAHD program in these organizations.

Reasons for Developing CAHD Approach

The most significant reasons for implementing CAHD are to provide immediate assistance for persons with disabilities; use community resources in the best possible way; establish sustainable programs for persons with disabilities; and prepare communities so they can take ownership of programs for persons with disabilities (CDD, 1998).

One study by Thomas (1998) reported that in developing countries persons with disabilities who need rehabilitation assistance do not receive meaningful services, but the needs of persons with disabilities are increasing much faster than available rehabilitation services in these countries. The reason for increase in the needs of persons with disabilities in these countries is rapid economic development in all sectors of society. The overall health-care delivery systems in the 21st century in developing countries have dramatically improved as compared to the late 20th century. For example, just after independence on December 16, 1971, the economy of Bangladesh started to develop and is still in transition. The ready made garments industry is responsible for nearly half of the country's export revenues. Other sectors such as seafood, ceramics, pharmaceuticals and software development are growing and contributing positively to Bangladesh's economies which lead to the increase in country's Gross Domestic Products (GDP). Tjandrakusuma (1998) reports that "when a country raises its GDP, it is usually assumed that there is improvement in the health status too" (p. 3). In Bangladesh, GDP has been

growing rapidly: 4.40% in 2003 and 6.00% in 2008. Therefore, the conditions of health delivery system improve, people enjoy a longer life expectancy and the needs of people are also increased. The study of Tjandrakusuma (1998) notes that there is impressive economic development occurred in the Asia and Pacific region. The study finds the following:

> A study by ESCAP in 1995 of the economic development in Asia and the Pacific region states that there is impressive development in this region. The world economic growth in 1990 was 1.5 percent, while in 1995 it was 3 percent. In developing countries however, the economic growth in 1990 was 3 percent, which grew to 5.5 percent in 1995. (p. 3)

Clearly, there is significant economic development observed during the last decade in developing countries. This has an impact on all sectors of development: education, employment and health care. Therefore, the lifestyles of persons with disabilities in Asia and the Pacific region are changed significantly as compared to earlier decades. This was possible due to the rapid transfer of technology, knowledge, and skills of health-care delivery systems from the industrialized West. As a result, people in this region enjoy a longer life; better health care; and access to education and employment. As persons with disabilities live longer, their needs for rehabilitation services increase. Research showed that CBR programs alone are unable to address the growing needs of both persons with disabilities as well as the community (Tjandrakusuma 1998). Therefore, meeting the needs of a large number of persons with disabilities in developing countries requires a systematic planned approach.

One of the significant aspects of the CAHD approach is that it utilizes existing community development organizations as the service providers for persons with disabilities (Khan & Bari, 2002). In many developing countries, a large number of non-profit organizations are working at community levels. These organizations have multifarious development components: micro credit programs; adult and child education programs; and several other income generating programs. In the past, these organizations seldom addressed the needs and rights of persons with disabilities. One of the major reasons was that they did not have skills and knowledge necessary to integrate them and lacked resources to initiate a new program. As noted above, the CAHD initiator organization identifies these general development organizations give them training on disability and manage funding for them to initiate a new program. In the past, there was no organization like CAHD initiator organization that carried out such systematic approaches to include persons with disabilities in the activities of general development organizations.

One of the major implementation strategies of CAHD is to educate people and organizations about disability. As discussed before, people and organizations in communities have been given training on disability necessary to integrate persons with disabilities. It is important to note that the personnel of community development organizations have already invested their time in community development interventions and gained people's acceptance in communities. As people and organizations have now the skills and knowledge on disability issues, it is much easier for them to include persons with disabilities in their development initiatives.

Khan and Bari (2002) reported that each year the number of grassroots level organizations requests for training and technical support from CAHD initiator organization on disability have increased; from 50 in 1997 to 200 in 2001. Although disability is still a new development area in Bangladesh, the growth in the number of requests indicate that general development organizations are interested in initiating programs for persons with disabilities. As noted above, national level organizations in Bangladesh have also shown their interest in integrating disability issues as part of their development co-operation.

As outcomes and impacts of CAHD in the field of disability are steadily bringing changes at local and national levels, this approach is recommended in the Regional Symposium on Disability 2003 [held in Bangladesh] as "one of the components for implementation to facilitate inclusion of disability issues into mainstream development" (NFOWD, 2003, p. 2)). The major argument of CAHD is that this approach is sustainable and requires a minimal expenditure of human and economic resources. Sustainability is an important consideration as activities for persons with disabilities must be permanent (CDD, 1998). Persons with disabilities and the issues of disabilities will never disappear from societies. Therefore, programs for persons with disabilities need to be sustained in communities. CAHD conceives that sustainability starts with the community. Where communities are included in development programs and end up owning them, the program activities are more likely to be sustained by the community.

CAHD and Development

The Community Approaches to Handicap in Development (CAHD) is not a new strategy, but a further development of CBR. The concept of CBR was developed more than 25 years ago. The programs using the title of CBR exist in about 90 countries in the world (Helander, 2000). Much research has mentioned that there are still controversies of the implementation of CBR programs in many developing countries (Thorburn, 2000; Thomas & Thomas, 1998). It is not surprising that persons with disabilities are still being systematically excluded from socio-economic development of communities. Being aware of this situation, development donors as well as program implementers have identified three major aspects of disability related problems: rehabilitation through medical treatment; persons with disabilities are part of both vulnerable and non-vulnerable groups of society; and lack of awareness about disability in communities (Krefting, 2002).

Medical treatment can only solve certain aspects of the problems that affect the overall lives of persons with disabilities. As mentioned earlier, institution-based care and treatment is well-suited for a person who has some sort of impairment which can be treated. The disabling conditions such as ‘autism’ which cannot be cured but the child could become more independent if he or she was provided special assistance. Clearly, medical interventions can only reduce the effects of impairments, not take into account the problems faced by persons with disabilities in societies. Oliver (1990) reported that economic, environmental and cultural barriers are the direct result of social structures and attitudes, rather than person’s impairment or medical condition.

It should be acknowledged that the lack of awareness about disability in communities leads to exclusion, isolation, and societal barriers, as well as increases in the

number of problems faced by persons with disabilities. In many Asian developing countries, the needs of persons with disabilities are seen separately and their human rights receive no respect. They are systematically excluded from education, employment, and other socio-economic development in society. For these reasons, international organizations like WHO, UNICEF and other bilateral and multilateral aid agencies realize that the needs and rights of persons with disabilities cannot be properly addressed unless disability is considered as a development issue (Nagata, 2007; WHO, 2004; HI, 2001, DFID, 2000). Therefore, these organizations have begun to change in their policies and taken the initiative to include persons with disabilities in all areas of development co-operation. Though the international organizations and aid agencies have changed their policies, a few general development organizations that are ready to work directly with persons with disabilities are lacked necessary skills and training on disability. As noted before, one of the major components of CAHD is providing training to people and general development organizations on disability issues as they can include persons with disabilities in their development activities.

In the past, CBR programs were designed to address only the needs of persons with disabilities by trying to rehabilitate them into their existing communities. Their program focus was top-down in nature. As a result, persons with disabilities faced a number of social barriers that resulted from the lack of awareness about disability in communities. As program planners in CBR became aware of these problems, they began to shift their program focus from top-down to bottom-up (Krefting, 2002). This change in focus gives program planners of CBR program an opportunity to design activities

necessary for changing negative attitudes towards persons with disabilities. Despite this effort, persons with disabilities still remain the primary focus of all CBR program activities. Therefore, there is a need to expand program focus from one aspect of community to all aspects of community. Krefting (2002) explains this shift as follows:

> Completing the shift from a vertical to a horizontal focus means changing the entire community, it means changing to a horizontal, community-development focus that includes and addresses the needs of the entire community. The problem for programme [program] planners then becomes much larger and requires consideration of all aspects of the disabling process from impairment to disability to handicap (Krefting, 2002, p. 3).

As soon as the focus of programs of community-based programs will change from persons with disabilities and their needs to communities and their needs, the range of community development activities will increase (Krefting, 2002; Khan & Bari, 2002). As many early CBR projects have adopted a top-down approach and run by outsiders, the shifting of program focus in CBR programs from top-down to bottom-up is crucial and needs colossal coordination (Cheausuwantavee, 2007). On the other hand, the strategy for implementing CAHD programs start with the changing the focus of the activities of existing community development organizations (Krefting, 2001). This means that CAHD programs are trying to change the entire community and the focus changes from persons with disabilities and their needs to communities and their needs. As a result, the range of development activities increases and program implementers consider new areas and ways

of implementing their existing activities. Once this happens at the grassroots level and people take the initiative to change the entire community, persons with disabilities will easily be integrated into all areas of development activities.

The study of Department for International Development (2000) reported that "women with disabilities suffer a double discrimination, both on the grounds of gender and of impairments; their literacy rates are lower than their male counterparts" (p. 3). Therefore, inclusion of gender issues into community development programs is essential in the context of development. It should acknowledged that support for girls with disabilities at an early age is essential for promoting optimal development, preparing them for the educational opportunities that become available when they start school, and reducing the need for more intensive support as they grow older. In many developing countries, parents raising child/adults with disabilities face barriers such as financial hardship, time constraints, and social isolation. To accommodate these needs, integration of gender issues in community-based rehabilitation programs is more than essential in the context of developing countries. International development organizations such as DFID, Handicap International (HI) and other bilateral and multilateral aid agencies put great importance in the inclusion of women with disabilities in the mainstream development.

Recently, the Department for International Development (DFID) has adopted a 'twin-track' approach in order to "take account of women's needs and rights in the mainstream of development co-operation work, as well as supporting specific initiatives aimed at women's empowerment" (p.11). The 'twin-track' approach urges to initiate specific programs to enhance the empowerment of persons with disabilities by addressing

inequalities between disabled and non-disabled peoples in all strategic areas of development work (DFID, 2000).

One example of the effectiveness of gender issue integration is the change in the situation of women and girls in Bangladesh. In the late seventies, women and girls were very much sheltered and protected and were not allowed to participate in any activities outside their families. Their lives were dominated and controlled by the male members of their families and they had little choice in what would happen in their lives (CDD, 1998). To some extent, the lives of many women and girls in Bangladesh have changed due to continuous efforts by international aid agencies, governments and development organizations. Though male members have still dominance over the lives of women in Bangladesh, the economic and political situation of women has changed remarkably (CDD, 1998). For example, the Grameen Bank's micro credit program alone has given economic freedom to more than a million women in Bangladesh. Women also now participate openly in politics and have a major voice in national elections (Khandker, 1994). As many national and grassroots level organizations in Bangladesh still do not include gender issues in their development activities, the needs and rights of girls and women with disabilities and their participation in development co-operation are a distant dream. Not much research, however, has been done about participation of women with disabilities in community development programs. The following example of the Grameen Bank illustrates how women with disabilities are excluded from development initiatives in Bangladesh.

Khandker (1994) noted that "to better meet its ultimate goal of social and economic development, [the] Grameen Bank targets women more than men" (¶ 2). The Grameen Bank gives credit (loans) to the poorest and the least empowered women in communities in order to improve the living standards of their families. Though the Grameen Bank is pioneering in poverty reduction in Bangladesh, it still does not have any programs for women with disabilities. It is not only the case of women with disabilities; all persons with disabilities are excluded from "Savings and Credit" programs of most community development programs.

Thomas (2000) points out a number of factors that contribute to exclusion of persons with disabilities from 'Savings and credit' programs. The most common reasons that contribute to exclusion are that the 'Savings and credit' programs are primarily managed by non-disabled people, the negative attitudes about disability, and the lack of awareness about the abilities of persons with disabilities. Most of these reasons, however, are technical in nature which means that there is a need to educate people in communities about different aspects of disability. In most cases, personnel of community development organizations do not have the necessary skills and training even to identify persons with disabilities. They do not know how to address their needs. Therefore, persons with disabilities are excluded from socio-economic benefits of society and poverty becomes a normal phenomenon of their everyday lives.

It is important to note that persons with disabilities are the primary focus under CBR programs and that these programs do not implement all kinds of development activities. Often, only one CBR program does not have access to the considerable range

of skills and resources necessary to provide multiple services for persons with disabilities. When this is the case, persons with disabilities are segregated and remain dependent. Despite the fact that program activities under CBR programs are designed only to educate persons with disabilities and their families, very little importance is given to provide disability-related knowledge to all people and organizations in communities. Though some CBR programs address both persons with disabilities and communities, they cannot reach the majority of people due to their resource constraints.

In one study, Neufeldt (1995) reported that in the Philippines, the International Labor Organization and the Philippines Government, with technical support from the United Nations Development Program (UNDP), experimented with a community- based vocational rehabilitation strategy. Its purpose was to see whether a community-based approach could raise the awareness of both the community and persons with disabilities as to the possibility that full community participation was possible. One of the major components of this project was training for volunteers to identify persons with disabilities in their communities and assisting them to make contact and form relationships. The impact of the training on disability issues is as follows:

> Four hundred volunteers had been trained who in turn reach 1,500 persons with disabilities of these 289 disabled people had been assisted by 56 volunteers to engage in some means of income generation; often participating with family or other local enterprises. These included persons with disabilities of all types (Neufeldt, 1995, p. 172).

This exemplifies that systematic training on disability issues impacts on properly identifying persons with disabilities and helps to form a close relationship between trained workers and persons with disabilities. But this example does not provide any information that whether people who receive training are from existing organizations in communities or are newly recruited for CBR programs. However, the program concept of the CAHD strategy is that it makes close networks with existing organizations in communities and provides training in all aspects of disability issues to these organizations. Researchers like Krefting (2001); Tjandrakusuma, (1995) have mentioned that the need to develop liaisons with other organizations involved in community development for more bottom-up planning.

In Solo, Indonesia, the Community Based Rehabilitation Disability Training Centre (CBRDTC), an applied research and development organization, develops different training manuals and provides training on different disability and handicap issues to other local-level community development organizations in Indonesia. The training program of CBRDTC was evaluated in 1995 and the outcome indicates that the organization needed to develop liaisons with other organizations involved in community development initiatives to exchange information and encourage mutual support. These community development organizations also needed to modify the implementation strategy to allow for more “bottom-up” planning (Tjandrakusuma, 1995). As the implementation strategy of CAHD is “bottom-up” in nature, the number of networking organizations in CAHD implementing areas of Bangladesh has increased remarkably (Khan & Bari, 2002). Therefore, the number of trained community disability workers has been gradually

increasing as an outcome of disability training by the CAHD initiator organization. These participating organizations and the personnel are from existing community-based programs, organizations of persons with disabilities, and government operated community-based organizations.

The inclusion of persons with disabilities into mainstream development components is as important as other development activities in communities. Therefore, many Asian developing countries such as Bangladesh, India, and Nepal already have considered "disability as a more or less cross-cutting development issue" (World Bank, 2006). This increases in the number of participation of persons with disabilities in all sectors of development co-operation. Though organizations have begun to consider disability as a development issue, the lives of persons with disabilities in many parts of the developing world have changed little. Because, most of them are kept hidden and left unnoticed.

According to Krefting (2002), the prevalence rate of disability in some developed countries [like Australia, Britain, Canada, and in the US] is estimated about 18 percent of the total population. Though the disability incidence in developing countries is much higher than developed countries, the prevalence rate of disability in developing countries is about 10 percent of the total population (WHO, 2004). Why is there a difference of 8%? Different definitions of disability, inaccurate disability incidence, and premature death of children with disabilities in developing countries may account for this difference. In addition, a significant number (10%) of children with disabilities are dying prematurely due to poor overall health conditions, poverty and malnutrition, and are left

unaddressed in the prevalence studies (Krefting, 2001; Lightfoot, 2004). Research shows that the inequality in resources between developed and developing countries are resulted in the increased number of premature death in developing countries (DFID, 2000; Krefting, 2001).

The main indicator of the difference between developed and developing countries is calculated in terms of its average Gross National Product (GNP). An example of this difference is very large. In most cases, GNP is about US$ 200 in developing countries as compared to US$ 25,000 in developed countries (Krefting, 2001). More significantly, sharing of resources to provide services for persons with disabilities widely differ from developed to developing countries. These differences are not only between countries but also within countries. Nagata (2007) mentioned that women in rural areas in Asian countries with no income and education are more severely disabled than wealthy, highly educated, urban men in these countries with same physical and mental impairment. This inequality of resources locally, nationally, and internationally is a global problem but the resulting poverty may be local. Clearly, there is a significant difference in the number of resources (both financial and technical) between developed and developing countries. It is well known that persons with disabilities in the industrialized West enjoy longer life expectancy, improved health, better education, higher incomes as compared to the developing world. This leads to the further conclusion that poverty plays a significant role in the lives of persons with disabilities in the most developing countries. As mentioned above that many persons with disabilities in developing countries are dying prematurely that are primarily related to poverty. Even more significant is the evidence

that negative attitudes about disability in communities also have an effect that lead to the disabling process from impairment to disability to handicap (Krefting, 2002; Krefting, 2001).

Based on this understanding, the CAHD initiator organization, Centre for Disability in Development (CDD) has established a framework for developing CAHD program activities (see appendices – ii) to change the entire community, to educate people in communities about disability, and to establish a positive environment in which the quality of life of persons with disabilities increases. Because making the transition from negative to productive environments in both people and communities is crucial, there is a need for efforts in raising awareness and knowledge to people and organizations about disability. Doing this effectively, CAHD proposes certain activities that can minimize the negative impacts of impairment, disability and handicap and create changes in attitudes to eliminate handicap.

It is important to note that eliminating handicap does not mean eliminating disability. According to CAHD, "eliminating handicap means increasing the numbers of disabled persons who survive to contribute to the on-going development of their societies" (Krefting, 2001). Though the presence of handicap declines in society, impairment and disability will still be with us. But this will exclude "poverty, barriers and premature death" (Krefting, 2001). The central goal of the CAHD concept is that people and community development organizations and their activities need to be more focused on the decline of the presence of handicap. When the condition of handicap declines, rehabilitation services for persons with disabilities increase. Therefore, persons with

disabilities will enjoy a longer life expectancy, improved health, better education, higher incomes and more opportunities to pursue their desired economic and social aspirations. In this way, persons with disabilities will become more productive members of society and they will contribute significantly to the development of their families as well as in communities.

It is, however, not clear that implementation strategies of CAHD have impact on the empowerment of persons with disabilities and ensuring their voices are heard in mainstream decision making processes. During the last two decades, disability researchers such as Oliver (1990), Titchkosky (2003) and Thomas (2007) in the West express their concern about the empowerment, self-determination and voice of persons with disabilities at all levels of society. They have emphasized on promoting social changes that empowered and incorporated the experiences of persons with disabilities, asking society itself to adapt (DFID, 2000). The conventional approaches to disability were criticized for being driven by a perception that persons with disabilities need special assistance to adapt to society's demands. As the concept of the models of disabilities has changed in the West, the empowerment, participation and equal control of persons with disabilities has come to be recognized as the most appropriate means of overcoming a disability, rather than medical intervention alone (DFID, 2000).

In developing countries, rehabilitation services for persons with disabilities are still in their infancy and policies and practices of existing development organizations for providing services to persons with disabilities are mostly traditional. As awareness of the meaning of disability is changed among development organizations in the last decade,

they have begun to recognize that disability is not simply a medical condition but a series of social barriers that generates from discrimination. Despite the changes in the policies of development organizations, implementation of theses changes are required to develop further activities about the concept of disability which include providing training to people and organizations, developing awareness raising materials, training of community disability workers. These also involve certain costs.

As most general development organizations depend on external funding and governments have little allocation for disability programs, these organizations cannot easily implement activities related to new developments. When this is the case, it takes a long time to bring about the desired changes. For this reason, development professionals and program implementers put emphasis on strengthening existing organizations of persons with disabilities and their networks in order to expedite information/activities among people at all levels of society. When people become aware of new developments on disability issues by the efforts of disability networks, disability policies will be redefined based on new developments. Only organizations of persons with disabilities, organizations working for persons with disabilities, and their networks can influence policies which promote the empowerment, participation and equal control of persons with disabilities. The following discussion will review the impact in influencing mainstream policy making decisions due to the active participation of organizations of persons with disabilities in development networks.

Roles of Organizations of Persons with Disabilities

Persons with disabilities should have equal rights and full participation in all aspects of development initiatives in society. The needs for cooperation and partnership of organizations of persons with disabilities and their networks have made a priority in many international declarations. The United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993) indicates that "States should recognize the right of the organizations of persons with disabilities to represent persons with disabilities at national, regional and local levels" (¶ 1). In 2006, the World Bank proposed a national plan, the *Poverty Reduction Strategy Paper* (PRSP), as a means to reduce poverty in developing countries. The PRSP stressed the need for the active participation of people and organizations of persons with disabilities (DPOs) in the PRSP process. The paper also indicated that the participation of DPOs in national level policies leads to a very different approach to the concept of disability (World Bank, 2006). As it explains, "Without DPOs for example most activities proposed for persons with disabilities follow a concept based on charity, while with the participation of DPOs, the focus shifts clearly to education, training and employment" (pp. 7-8).

As persons with disabilities and their organizations influence the development of new polices such as the *Poverty Reduction Strategy Paper* of the World Bank, the active participation of persons with disabilities in the process of mainstream policy-making decisions give them the right to combat discriminatory behavior, practices and policies by concerned agencies. According to the World Bank (2006), the lack of participation of persons with disabilities in mainstream policy-making decisions seldom addresses the real problems faced by persons with disabilities. According to Ashraf (2008), the

conditions of poverty, the constraints for training opportunities, and the lack of organizational efficiency of persons with disabilities reduce the chances of effective contributions to mainstream decision making processes. Therefore, self-help organizations are considered key to the empowerment of persons with disabilities.

Self-help organizations promote opportunities for the development of skills in various fields among persons with disabilities. The objectives of self-help organizations are changing the situation of persons with disabilities by utilizing their own resources and potentials. According to DeJong (1979), self-help organizations are "the knowledge-giving, awareness providing organizations that help to confer sovereignty on the consumer" (p. 439). As mutual support and co-operation is the basis for collective action to improve the situation of persons with disabilities, they came forward and formed organizations in order to advocate their rights in society. Though self-help initiatives are a pioneering means of empowering persons with disabilities, there is a significant difference between developed and developing countries in the practice of this movement.

In developed countries, persons with disabilities are undoubtedly having more opportunities to establish their rights and needs as compared to their counterparts in the developing world. They have more opportunities for education, employment and health-care. In this way, they become the experts of their own issues and have their voices heard in order to fulfillment of their needs and rights in society. As a result, persons with disabilities in developed countries can overcome some common barriers through the exchange of information, skills and knowledge. This leads to a significant increase in the

participation and influence in policy-making decisions at local, national and international levels (WHO, 2004).

As the role of organizations of persons with disabilities (DPOs) in developing countries is to identify needs and priorities, to contribute to public awareness, and to advocate change, persons with disabilities become more active to change the entire community and to develop new areas of development. They also can create more opportunities to enhance participation of more people in development initiatives. When this is the case, the role of DPOs will be developed and strengthened to ensure that they influence matters at community level. Therefore, DPOs are considered as a major strength of community-based rehabilitation programs (WHO, 2004).

As noted above, the proclamations from 1982 to 2006 of the United Nations and its specialized agencies such as WHO, ILO, UNICEF stress the need for the establishment and growth of DPOs in the Asian and Pacific region to promote equal opportunity and full participation of persons with disabilities. Despite these numerous efforts, persons with disabilities in these regions are still facing many challenges which are possible to overcome through the active involvement of persons with disabilities and their organizations in mainstream decision making processes. As discussed earlier, general development organizations do not take into account the needs and rights of persons with disabilities in developing countries. Their needs are seen separately and their participation in community development initiatives is ignored. Their human rights receive little or no respect. As a result, persons with disabilities in these countries are unable to make their own decisions and gradually become dependent on other members of family

and community. When this is the case, the need for the development of networks of persons with disabilities and their interest groups become obvious. According to WHO (2004), the community-based rehabilitation programs stress the need for developing networks, where DPOs are weak, in order to enhance their capacity to promote individuals' rights and needs in society.

The emergence of the CBR model gives persons with disabilities in developing countries a possible means to overcome some of the common barriers which include lack of access to basic rehabilitation services, education, employment, and other life-sustaining elements. The goals of the CBR model which are very similar to the goals of DPOs in that both aimed to promote equalization of opportunities and social integration of persons with disabilities. Camara (1998) notes that "in spite of the differences in origins and strategies, the DPOs and the CBR approach have similar goals: equality of opportunities and social integration of disabled people" (¶ 3). For this reason, there is a need for active cooperation and partnership between CBR and DPOs in order to reduce any conflicts that hinder the process of mutual understanding by these two movements. This partnership is also required to establish areas of activities aiming at common objectives which should be based on mutual confidence and interest (Camara, 1998).

Despite the efforts of community-based programs, long-term care of persons with disabilities still is primarily responsibility of family in the developing world (Dalal & Pande, 1999, p. 58). The governments and community development organizations in these countries catering to the needs of persons with disabilities are very scarce. As a result, organizations are spent most of their time to ensure optimum rehabilitation

services for persons with disabilities. On the other hand, DPOs in developing countries are more involved in educating people in communities, raising awareness about the needs and rights of persons with disabilities, and participating in different aspects of rehabilitation interventions (Camara, 1998). As both of these organizations are involved more in providing services for persons with disabilities, they have limited time left to contribute to the active cooperation and partnership between DPOs and the CBR.

In Bangladesh, DPOs are reluctant to participate in other networks of general development organizations such as network of CAHD implementing organizations, as they think that the problems faced by persons with disabilities are the responsibilities of persons with disabilities themselves and their organizations to overcome such barriers. Therefore, they formed separate networks to enhance their participation in policy-making decisions. As a result, there develops an unintentional conflict between the network of DPOs and non-DPOs. The complex interplay of power relations between two different networks sometimes thwarts the desired achievement of policy decisions. It is worth noting that changes in policy whether it is concerned with disability or any other area of development, influence all people in community. Therefore, the representation of DPOs becomes essential in building a strong alliance with different networks of organizations (WHO, 2004; Camara, 1998).

The key strategy of the CAHD concept is the development and continuation of effective networks with both organizations of persons with disabilities, organizations that are working for persons with disabilities and different types of alliances. Persons with disabilities are the central focus of the effective development of the concept of CAHD.

Persons with disabilities play major roles in changing attitudes of people in communities, advocating for changing policies, contributing in the development of new policies, and ensuring that program activities for persons with disabilities are effective and efficient during CAHD implementation process (Krefting, 2001). The CAHD concept also stresses the need for active participation of persons with disabilities and their organizations in existing networks as well as the need to strengthen these networks to achieve a common purpose. For this reason, CAHD initiating organization encourages other general community development organizations, which have just initiated disability-related programs, to participate in local as well as national-level development networks.

In Bangladesh, one important national level networking organization is the National Forum of Organizations Working with the Disabled (NFOWD) which was formed in 1991 in order to create linkages between strategic agencies (World Bank, 2006). It is the leading national level coordinating body of NGO agencies working on disability issues in Bangladesh. NFOWD was launched with a very few organizations of persons with disabilities. As awareness of the needs of persons with disabilities increases among general development organizations, this in turn leads to the increase in the number of participating organizations in NFOWD. This has happened through the continuous efforts of CAHD implementing organizations. According to the World Bank (2006), NFOWD has 176 member organizations. As a large number of organizations are actively involved in advocacy efforts, this gives NFOWD a strong voice to influence the government of Bangladesh in national level policies in favor of persons with disabilities.

In developing countries, rehabilitation programs for persons with disabilities are dependent on tightly-conditional project funding, they still have to fight to survive. Therefore, the participation of persons with disabilities in policy making-decisions gets less priority. As a result, when policies have been developed by a few professionals, it seldom addressed the real problems of persons with disabilities. For example, in Bangladesh, the *Poverty Reduction Strategy Paper* (PRSP) was written by just two foreign experts, because the government wanted to speed up the process so as to receive loans and credits quicker (World Bank, 2006). Representatives of non-profit organization (NGOs) in Bangladesh have criticized the fact that "consultations were only conducted with professional elite and not with people actually living in poverty" (World Bank, 2006, p. 28). The professionals who are involved in the development of the PRSP process have negative perception of disability. The following example clearly illustrates the need for development networks to establish the rights of persons with disabilities and to change negative perceptions about disability even among professional elites.

In early 2002, an NGO meeting with Planning Commission representatives of Bangladesh, the way PRSP treated disability thwarted NGO representatives. According to the World Bank (2006), the Planning Commission of Bangladesh states that "only one part dealt with persons with disabilities, and this simply read we will take care [regarding] difficult social cases, such as persons with disabilities" (World Bank, 2006). This negative perception of disability led NFOWD, Handicap International (HI), United Nations Children's Fund (UNICEF) and other networking organizations in Bangladesh to establish the reality that disability is a development issue rather than a difficult social

case. Therefore, the inclusion of disability is an issue that is not only important for the PRSP, but for development in general. Through the combined efforts of networking organizations, the Planning Commission includes disability as a more or less cross-cutting development issue in the current PRSP document in Bangladesh (World Bank, 2006).

There are some other achievements of DPOs and their networks in Bangladesh such as the enactment of the Disability Welfare Act of 2001 and the establishment of the National Foundation for the Disabled both which indicates the importance of the development and participation of DPOs to different networks. These examples also prove that partnerships and alliances with relevant national and international organizations are a key to the development of more accountable governments in relation to disabilities in developing countries.

Conclusion

In developing countries, general development organizations do not include persons with disabilities in their areas of interventions. In most of the cases, they do not take into account the needs and rights of persons with disabilities because these organizations have policies that systematically exclude persons with disabilities. The other reason is that general development organizations do not understand the impact of disability. Disability does not affect only one individual; it has an impact on the whole community. Therefore, the cost of excluding persons with disabilities from development initiatives becomes high and is required to borne by community itself (DFID, 2000). Some other development organizations view disability as a medical problem and needs to

be solved through medical interventions. They often think that the problems associated with persons with disabilities are the responsibility of organizations which only work for persons with disabilities. For this reason, general development organizations never include them in their development initiatives. In some other cases, these organizations assume that persons with disabilities cannot make any contributions to their development programs. According to Krefting (2001), this negative perception of disability leads general development organizations in the development of policies to exclude persons with disabilities "as a bad risk" in any programs.

Over the past few years, awareness of the needs and rights of persons with disabilities increases among international communities and they are beginning to change in their policies and taking significant steps to include persons with disabilities in all areas of development. The United Nation's proclamation of *Millennium Development Goals (MDGs)* and current policy of Department for International Development (DFID) stress the need for inclusion of persons with disabilities in all community development initiatives (WHO, 2004; DFID, 2000). These policies are seeking ways to include persons with disabilities into general development organizations' programs in order to reduce the conditions of poverty. For example, the DFID introduces twin-track approach to take account of women's needs and rights in the mainstream of development co-operation.

Many studies have indicated that about 97% of persons with disabilities in developing countries who need rehabilitation services do not receive any meaningful services (CNDD, 2006; Helander, 2000; Lightfoot, 2004 et al.). The effect of the lack of rehabilitation services is made even worse when the number of persons with disabilities

in developing countries is increased much faster than annually added supply of services (CNDD, 2006; Krefting, 2001). Therefore, the development of the community-based rehabilitation (CBR) model to provide basic rehabilitation assistance for persons with disabilities becomes essential in the context of developing countries. Though community based rehabilitation projects are successful in implementing programs related to medical interventions, they fail to achieve the same level of success in changing contextual factors in society (Thomas & Thomas, 1999).

Researchers like Krefting (2001), Khan (2002), and Thomas (1999) put emphasis on changing the implementation strategies of CBR to meet the current needs of persons with disabilities in developing countries. Therefore, disability experts, advocates and professionals in these countries have developed strategies appropriate to their cultural settings to achieve the objectives of CBR. According to Thomas and Thomas (1999), one may find a large number of development initiatives for persons with disabilities in developing countries which are based on different shapes and approaches. For example, home based services for persons with disabilities; self-help initiatives; and projects of community development organizations. People sometimes called these programs as community-based rehabilitation.

As CAHD is another way of implementing CBR, it shares most of the principles and concepts of CBR (Krefting, 2001). The most important part of CAHD is that it is as flexible as it considers the context of culture, economies, geography and politics of a given society. It is based on various strategies that are suitable for varying contexts. The model can be varying differently from one country to the other and even within different

areas of a same country. As seen by the discussion of CAHD's effectiveness and sustainability, it can be an appropriate strategy to shift program focus from persons with disabilities and their needs to communities and their needs. The changes in program focus give CBR program implementers a possible means to consider new areas of activities and new ways of implementing their existing activities. In this way, the inclusion areas of persons with disabilities in development components will increase. Once this happens at grassroots level, and when people take the initiative to change the entire community, persons with disabilities will easily be integrated into all areas of development. In this way, the needs of persons with disabilities will be met; the problems associated with poverty will be decreased; and the negative attitudes about disability will also be changed at a quick pace.

References

Alam, Jahurul. Khandakar & Bari, Nazmul. (2005). *Community-based rehabilitation: Practices and alleviation of poverty of people with disabilities in Bangladesh.* Bangladesh: The National Forum of Organizations Working with the Disabled (NFOWD).

Ashraf, M. (2008). *Self-help initiatives: A key to empowerment of people with disabilities in Bangladesh.* Retrieved July 20, 2008, from http://dpobd.blogspot.com

Asia-Pacific Development Centre on Disability (2008). *Profile of non-governmental organizations of/for persons with disabilities.* Retrieved August, 19, 2008, from http://www.apcdproject.org/countryprofile/bangladesh/nongov.html

Camara, T. (1998). Disabled people's organizations and community based rehabilitation in Africa. *Asia Pacific Disability Rehabilitation Journal, 9*(1), 1-2.

Canadian Network on Disability and Development (CNDD). (2006). *Disability and development*. Toronto: Canadian Network on Disability and Development (CNDD).

Centre for Disability in Development (CDD). (1998). *Current situation of people with disabilities*. Bangladesh: Centre for Disability in Development (CDD).

Cheausuwantavee, T. (2007). Beyond community-based rehabilitation: Consciousness and meaning. *Asia Pacific Disability Rehabilitation Journal, 18*(1), 1-9.

Contact. (2002). *Community-based rehabilitation.* Retrieved May, 31, 2008, from http://www.wcc-coe.org/wcc/news.contact.html.

Dalal Ajit K. & Pande, Nomita. (1999). Cultural beliefs and family care of the children with disability. *Psychology and Developing Societies, 11*(1), 55-75.

Deepak, Sunil & Sharma Manoj. (2003). An inter-country study of expectations roles, attitudes and behaviours of community-based rehabilitation volunteers. *Asia Pacific Disability Rehabilitation Journal, 14*(2), 179-190.

Dejong, G. (1979). Independent living: From social movement to analytical paradigm. *Archives of Physical Medicine and Rehabilitation, 60*, 435-446.

Department for International Development (DFID). (2000). *Disability, poverty and development*. London: Department for International Development (DFID).

Frantz L. Beverly, & Carey C. Allison & Bryen N. Diane. (2006). Accessibility of Pennsylvania's victim assistance programs. *Journal of Disability Policy Studies, 16*(4), 209-219.

Gray, David B., Welch, Patricia M. & Hollingsworth, Holly. (2000). Comparing perspectives of people with disabilities and professionals on the ICIDH - 2 beta 1. *Journal of Disability Policy Studies, 11*(3), 171-178.

Guozhong, Z. (2006). Inclusion of persons with disabilities in china. *Asia Pacific Disability Rehabilitation Journal, 17*(2), 1-10.

Handicap International (HI). (2001). *Disability in development: Experiences in inclusive practices*. France: Handicap International (HI).

Heijnen, E. (2000). An innovative approach to assist early childhood development for rural children with disabilities. *Asia Pacific Disability Rehabilitation Journal, 11*(1), 1-4.

Helander, E. (2000). 25 years of community-based rehabilitation. *Asia Pacific Disability Rehabilitation Journal, 11*(1), 1-10.

Kampen, Marlies, Zijverden, Ingrid M. & Emmett, Tony. (2008). Reflections on poverty and disability: A review of literature. *Asia Pacific Disability Rehabilitation Journal, 19*(1), 19-37.

Khan, Noman & Bari, Nazmul. (2002). Disability in development: From charity to equity people with disabilities in Bangladesh. *Journal for International Development, 13*(1), 100-105.

Khandker, S. R. (1994). *Poverty reduction strategy: The Grameen bank experience.* Retrieved July 16, 2008, from http://gdrc.org/icm/grameenbank.html

Krefting, D. (2001). *Understanding community approaches to handicap in development (CAHD)*. France: Handicap International.

Krefting, Laura & Krefting, Douglas. (2002). *Community approaches to handicap in development (CAHD): The next generation of CBR programmes.* Retrieved May, 25, 2008, from http://www.aifo.it/english/resources/online/apdrj

Lang, R. (1999). Empowerment and CBR? issues raised by the south Indian experience. In E. Stone (Ed.), *Disability and development: Learning from action and research on disability in the majority world* (pp. 130-148). Leeds: The Disability Press.

Lightfoot, E. (2004). Community-based rehabilitation: A rapidly growing method for supporting people with disabilities. *International Social Work, 47*(4), 455-468.

Miles, M. (2000). Disability in south Asia-millennium to millennium. *Asia Pacific Disability Rehabilitation Journal, 11*(1), 1-6.

Musse, I. A. (2002). *Disability:An islamic insight.* Retrieved March 10, 2008, from http://www.icv.org

Nagata, K. K. (2007). Perspectives on disability, poverty and development in the Asian region. *Asia Pacific Disability Rehabilitation Journal*, *18*(1), 1-13.

National Forum of Organizations Working for the Disabled (NFOWD). (2003). *Dhaka declaration on disability* Retrieved from http://www.pwd.org.au/publications/Dhaka%20Declaration%20on%20Disability%202003.doc

Neufeldt, A. (1995). Self-directed employment and economic independence in low-income countries. In Brian, O'Toole and Roy, McConkey (Ed.), In *innovations in developing countries for people with disabilities* (pp. 171-172). England: Lisieux Hall Publication.

Oliver, M. (1990). The individual and social models of disability. Retrieved from www.leeds.ac.uk/disability-studies/archiveuk/archframe.htm

O'Toole,Brian & McConkey, Roy. (1995). Towards the new millennium. In Brian O'Toole and Roy McCokey (Ed.), In *innovations in developing countries for people with disabilities* (pp. 1-5). England: Lisieux Hall Publication in association with Assciazione Amici di Raoul Follereau.

Shakespeare, T. (1996). Disability, identity and difference. In Colin Barnes and Geof Mercer (Ed.), *In exploring the divide: Illness and disability* (pp. 94-113). Leeds: The Disability Press. Retrieved from http://www.leeds.ac.uk/disability-studies/archivuk/Shakespeare/Chap6.pdf

Sharma, M. (2007). Community participation in community-based rehabilitation programs. *Asia Pacific Disability Rehabilitation Journal, 18*(2), 146-157.

Thomas, M & Thomas MJ. (1998). Controversies on some conceptual issues in community based rehabilitation. *Asia Pacific Disability Rehabilitation Journal, 9*(1), 1-5.

Thomas, M & Thomas, MJ. (1999). A discussion on the shifts and changes in community based rehabilitation in the last decade. *Neurorehabilitation and Neural Repair, 13*(3), 185-188.

Thomas, M. (2000). Feasibility of integrating people with disabilities in savings and credit programmes in Bangladesh. *Asia Pacific Disability Rehabilitation Journal, 11*(1), 1-6.

Thomas, C. (2007). Theories and traditions in medical sociology: Illness and disability as social deviance. *In Sociologies of Disability and Illness: Contested Ideas in Disability Studies and Medical Sociology*,15-48.

Thorburn, M. J. (2000). Training of CBR personnel: Current issues-future trends. *Asia Pacific Disability Rehabilitation Journal, 11*(1), 1-8.

Titchkosky, T. (2003). Disability: A social phenomenon. *Disability, self, and Society* (pp. 3-15). Toronto: University of Toronto Press.

Tjandrakusuma, H. (1998). Towards the 21st century: Challenges for community based rehabilitation in Asia and the pacific region. *Asia Pacific Disability Rehabilitation Journal, 9*(1), 1-7.

Tjandrakusuma, Handojo, Krefting, Douglas & Krefting, Laura. (1995). Changing CBR concepts in Indonesia: Learning from programme evaluation. In Brian, O'Toole and Roy, McConkey (Ed.), In *innovations in developing countries for people with disabilities* (pp. 255-277). England: Lisieux Hall.

United Nations. (1993). *United Nations standard rules on the equalization on opportunities for persons with disabilities.* Retrieved July 20, 2008, from http://www.un.org/documents/ga/res/48/a48r096.htm

World Bank. (2004). *Poverty reduction strategies: Their importance for disability.* Retrieved June 30, 2008, from http://web.worldbank.org

World Bank. (2006). *Making PRSP inclusive.* Retrieved July 25, 2008, from http://siteresources.worldbank.org/DISABILITY/Resources/280658-1172608138489/MakingPRSPInclusive.pdf

World Health Organization. (1992). *The work of WHO,1990-1991: Biennial report of the director-general*. Geneva: WHO.

World Health Organization. (1980). *International classification of impairments, disabilities, and handicaps : A manual of classifications relating to the consequences of disease*. Geneva: WHO.

World Health Organization. (2004). *CBR: A strategy for rehabilitation, equalization of opportunities, poverty reduction and social inclusion of people with disabilities*. Geneva: WHO.

World Health Organization (n.d). *International classification of functioning, disability and health (ICF).* Retrieved July 10, 2008, from http://www.who.int/classifications/icf/en/

Training Courses of CAHD initiator Organization[4]

1. Community Handicap and Disability Resource Person Training (CHDRP)

One of the major activities of CAHD is to provide the rehabilitation services that are necessary if persons with disabilities are to be enabled so that they can participate. This 65 days theoretical training will provide participants an in-depth knowledge about all types of disabilities and they will have the skills necessary to provide Primary Rehabilitation Therapy to persons with disabilities. A 15 days long extensive field experience is included in this training course. Participants will be attached in the CAHD implementing organizations at local level. Participants will be provided to an extensive practical knowledge of handling specific person with disability and other relevant issues on disability and handicap.

1.1. Follow up visit of Community Handicap and Disability Resource Persons (12 days)

After completion of CHDRP theoretical training, CDD trainers will visit to each of the CHDRPs working areas within six- month's period and stay 5 days with CHDRPs in order to provide on hand training and do follow up on difficult cases.

1.2. Refresher training of CHDRPs (10 days)

Just after completion of CHDRP theoretical training and subsequent follow up visits, CDD will invite CHDRP participants for 10 days refreshers training at CDD campus. The refresher training will be focused on the problems and topics that were not covered in the CHDRP theoretical training. All CHDRPs can share their experiences of field level interventions in their own working areas.

[4] CDD Training Brochure (Bangladesh: CDD Materials, 1998)

1.3. CHDRP'S Conference (3 days)

All trained CHDRPs will be invited for a 3 days long CHDRP conference at CDD. In this conference, CHDRPs can share their experiences and get an access to exchange their ideas, case histories etc. This will benefit CHDRPs from different corners and they can facilitate their learning in their own working areas.

2. Social Communication on Disability and Handicap (SCDH)

This is a ten-day course for the community educators of the implementing organizations. It focuses on the strategy of changing community attitudes and raising the level of awareness on different issues related to disability and handicap. Different community education materials are disseminated in the training course. This training course is specially designed for community educators to convince community members to enable persons with disabilities to participate in social, religious, economic and political activities to the best of their ability. Information about the causes of disability and what can be done to provide assistance to persons with disabilities are also included.

3. Integrating children with disabilities in non-formal and mainstream education

This is a five day long course. Data from CDD's monitoring system reveal that 37% of all persons with disabilities are from the age group of 6 to 14. A major portion of these children with disabilities have the potential to be included in education process. But due to lack of information, negative attitudes, scope and care most of the children are deprived from education. Education is and will be the fundamental requisite for any development. Development in the field of education excluding the children with disabilities can not be considered appropriate.

The training course takes the effort to facilitate the integration of children with disabilities into non-formal and mainstream education. The course benefits organizations in their skill development necessary to involve concerned people and authorities to take essential interventions in including children with disabilities with the process of education.

4. Early detection and interventions of children with disabilities

Much impairment identified at an early stage, followed with appropriate interventions allow minimization and in cases prevention of disabilities. This training course will allow participants to develop necessary skills required to identify impairments/disabilities at an early stage and to provide necessary interventions. The course is of three-day duration.

5. Training of Trainers

The trained CHDRPs are prepared to work with persons with disabilities in their own homes. Effort is taken to involve the family members with the process of providing therapy. The primary care-giver of persons with disabilities will have to assist in the work of the CHDRP. This training course is designed for CHDRPs on the techniques of training/involving family members of persons with disabilities and volunteers in the communities. This is a five-day training course.

Framework for Developing CAHD program Activities[5]

The vision of CAHD is to establish activities that will minimize the negative impacts of impairment, disability and handicap. In other words, CAHD creates changes in attitudes to counter the existence of or to eliminate handicap. To reach towards the vision of CAHD, programs focus on activities that:

1. Change the attitude of people and their organizations to create a more equitable sharing of resources of all people, especially those who are disabled;
2. Change the social environment and the attitudes of people and their organizations to eliminate the barriers that result in the exclusion of disabled persons; and
3. Reduce the impact of impairment and disability on individuals and families through prevention of impairment and provision of adequate services (Khan & Bari, 2002).

CAHD is comprised of four components on which interventions are directed. Simultaneous activities are essential in all of these four components. These are:

1. SOCIAL COMMUNICATION: Providing knowledge to people and organizations about:
    - Causes of impairment, disability and handicap.
    - Roles of family members and organizations, in creating handicap.
    - Activities that will prevent impairment, disability and handicap.

[5] Krefting, Laura & Krefting, Douglas. (2002). *Community approaches to handicap in development (CAHD): The next generation of CBR programmes.* Retrieved May, 25, 2008, from http://www.aifo.it/english/resources/online/apdrj

- Rehabilitation practices that will minimize the impact of impairment and maximize the personal development of disabled persons.

2. INCLUSION AND RIGHTS: Providing disabled persons the equal opportunity to access their rights as citizens and to participate in all of the activities in their families and communities enables:
    - Disabled persons to improve the quality of their lives.
    - People and their organizations have positive experiences with disabled persons, which will change their attitudes.
    - Organizations to include disabled persons in their existing programs to give them equal access to opportunities for education, economic activities, and health services.
    - Disabled persons to promote their right to play active roles in social and economic activities in their families and communities.
    - National organizations to promote for legislation, policy and regulations for recognition of the rights of disabled persons.
3. REHABILITATION: Providing assistance to people who have impairments and disabled persons that will minimize the functional difficulties that are the result of their impairments and maximize their personal development by:
    - Providing basic rehabilitation service in the community.
    - Providing referral and transfer services to meet the special needs of disabled persons.

- Developing linkages and transfer options between basic therapy service delivery in the home and referral services.

4. MANAGEMENT: An organizational function necessary to make sure that the previous three activities are implemented simultaneously and that these activities are relevant, `efficient and effective by:

   - Developing a monitoring, research and evaluation system.
   - Capacity building of local partners.
   - Including disabled persons, their families and the community in the design and monitoring, research and evaluation process to ensure accountability of the CAHD system.
   - Developing and facilitating networks.
   - Documenting the development and evaluating the impact of the CAHD system.
   - Using monitoring, research, documentation, and evaluation information to facilitate and direct the creation of changes to the CAHD system.

References

Khan, Noman & Bari, Nazmul. (2002). Disability in development: From charity to equity people with disabilities in Bangladesh. *Journal for International Development, 13*(1), 100-105.